



APPENDIX B

THE AFFORDABLE HEALTH CARE FOR AMERICA ACT (H.R. 3962) U.S. HOUSE OF REPRESENTATIVES

AS PASSED BY THE HOUSE OF REPRESENTATIVES ON NOVEMBER 7, 2009

I. INSURANCE COVERAGE PROVISIONS

Insurance Market Reforms

The Affordable Health Care for America Act (H.R. 3962) would require all insurance carriers providing coverage through the new health insurance exchange or through group insurance markets to accept every individual and employer who applied for coverage (guaranteed issue) and would not allow rating on the basis of health status, with new restrictions on preexisting condition look-back periods and condition exclusions going into effect as early as 2010. Premiums could reflect age (with a maximum rate variance between age bands of 2:1), family structure, and the community-rating area. Annual or lifetime limits on benefits would be prohibited beginning in 2010.

The bill would require qualified health benefits plans sold within the exchange and those offered through the large- and small-group employer markets to meet a medical-loss ratio of not less than 85 percent. If the plan does not meet the ratio, it would be required to offer rebates to enrollees to meet the ratio. This requirement would go into effect in 2010 for plans in the large- and small-group market and in the individual market as long it did not “destabilize” the market. Establishes in 2010 an annual review of premium increases by the secretary of HHS and the states that would require insurance carriers to justify premium increases. The bill outlaws the use of rescissions by insurance companies except in cases where there is “clear and convincing evidence of fraud,” beginning in 2010.

The bill would also extend eligibility for COBRA until the insurance exchange is up and running. In addition, an interim national high risk pool program would be available

temporarily for uninsured people and those denied a policy because of pre-existing conditions until the health insurance exchange is established.

All health insurers must allow young adults through age 26 to remain on their parent's health plans at their parents' choice, beginning in January 2010.

The bill would repeal the anti-trust exemption for insurers.

Insurance Exchange

H.R. 3962 establishes a health insurance exchange to facilitate the offer of health insurance choices to individuals and small businesses that are eligible to participate. The exchange would be run by a new independent agency within the executive branch called the Health Choices Administration. The agency would be headed by a commissioner appointed by the president, with advice and consent of the Senate. The commissioner would be responsible for setting qualified health benefit standards, setting and administering premium subsidies or "affordability credits" for health plans, and establishing and operating the exchange. States would play a role in the operation of the exchange as state insurance regulators would jointly oversee and enforce requirements for participating plans as well as those that do not sell policies through the exchange. The bill does allow the commissioner to consider applications by states or groups of states to establish state-based exchanges, but requires that there be only be one exchange per state, that the exchange operate under the same rules and requirements established for the national exchange, and that it not result in a net increase in expenditures to the federal government.

Who Is Eligible to Participate?

The House bill would open the exchange to individuals who do not have access to employer coverage that is in compliance with the employer-shared responsibility requirements and who are not eligible for Medicaid. The bill would allow employers with 25 or fewer employees to purchase coverage through the exchange in the first year of implementation in 2013. Those with up to 50 employees could buy plans in the exchange in year 2014, and up to 100 in 2015. Larger employers with more than 100 employees could buy plans, as permitted by the commissioner, after 2015.

Participants would join the exchange during an open enrollment period each fall for benefits in the following year. But there will also be special enrollment for people who lose access to acceptable coverage, for those whose marital or dependent status changes, those who move outside of the service area of an exchange-based plan, or

individuals who experience a significant change in income. In addition, the commissioner would establish an auto-enrollment mechanism for exchange-eligible individuals, those who are eligible for premium subsidies and have not selected a plan, and for those people whose plan has been terminated and have not yet enrolled in another plan.

Standard Benefits Package

A new independent Health Benefits Advisory Council would advise the commissioner on developing an essential benefit package to be offered through the exchange. The essential benefit package must include hospitalization; outpatient hospital and outpatient clinic services, including emergency department services; professional services of physicians and other health professionals; medical equipment; prescription drugs; rehabilitative and habilitative services; mental health and substance use disorder services including behavioral health; preventive services, including services recommended by the Task Force on Clinical Preventive Services and vaccines recommended by the director of the Centers for Disease Control and Prevention; maternity care; well-baby and well-child care; and oral health, vision, and hearing services; durable medical equipment, prosthetics, and orthotics.

The exchange would offer four benefit tiers, with a varied level of cost-sharing being the only difference among the lower three tiers. All health plans, including employers, must provide at least the “basic” essential benefit package inside and outside the exchange. The basic plan would include the essential benefits package with cost-sharing (a combination of deductibles, co-payments and out-of-pocket limits) that would leave 70 percent of medical costs, on average, covered by the plan (the actuarial value of the plan). The “enhanced” plan would include the essential benefits package with reduced cost-sharing that would leave 85 percent of medical costs, on average, covered by the plan. The “premium” plan would include the essential benefits package with further reduced cost-sharing that would leave 95 percent of costs covered. The “premium plus” plan is identical to the premium plan but would provide additional benefits including oral health and vision care for adults and children.

Annual out-of-pocket spending in the essential benefits package is limited to \$5,000 for an individual and \$10,000 for a family, with lower limits for families with incomes under 350 percent of poverty.

If a state requires that carriers provide health benefits beyond the essential benefits package, this requirement would continue to apply to an exchange-participating

health plan. However, the state must enter into an agreement with the commissioner to pay for any increase in premium subsidies that resulted in an increase in premiums because of the additional benefits.

Sliding-Scale Premium and Cost-Sharing Subsidies

The House bill establishes premium “affordability credits” on a sliding scale where the reference premium for determining the credit amount is the average of the three lowest premiums for the “basic” plan in the local market area. The exchange would pay the aggregate amount of credits to qualified health benefit plans for all enrollees eligible for the credits. Credits would be available in years 1 and 2 only for the basic plan and then, in year 3 the commissioner would establish a process by which credits could be used toward an enhanced plan with the enrollee paying the difference between the credit and the premium.

Premium credits would be available on a sliding scale for families eligible to purchase coverage through the exchange and who have incomes between 133 percent to 400 percent of the federal poverty level. Eligibility for credits is limited to families with incomes under 400 percent of poverty who are not employed full-time with employer-based coverage that meets the standard for a qualified health benefits plan, or that meets the employer shared responsibility requirement, and who are not eligible for Medicaid. But beginning in year 2, full-time workers with employer coverage whose share of premium costs exceed 12 percent of income would be eligible for coverage and credits through the exchange. Credits would begin by capping individual or family premium payments at no more than 1.5 percent of income for those earning 133 percent of poverty (\$29,327 for a family of four) and rise to no more than 12 percent of income for those with incomes at 400 percent of poverty (\$88,200 for a family of four).

Cost-sharing credits would effectively reduce cost-sharing in the basic plan so that covered costs would rise from 70 percent to 97 percent for those earning 133 percent to 150 percent of poverty, 93 percent for those earning 150 percent to 200 percent of poverty, and so on with costs sliding out at 72 percent of costs covered for those earning 350 percent of poverty.

Choice of Plan

Private plans. The House bill would require that health plans participating through the exchange meet the standards set for “qualified health benefits plans.” In addition, plans would have to at least offer the basic benefit plan through the exchange. Offering higher

tiers of health plans would be optional, but a carrier could not offer a higher tier plan without offering the basic plan. Participating plans would have to participate in the risk-pooling mechanism established by the commissioner.

Public plan. The House bill provides for the establishment of a public insurance plan by the secretary of health and human services (HHS) that would be offered under the same conditions as private qualified health plans through the exchange. The secretary would establish geographically adjusted premium rates for the public plan that complies with the rules established by the commissioner. The premium rates must be at a level that fully finances the cost of health benefits and administration of the public health insurance option. The bill allocates \$2 billion in start-up funds to establish an initial reserve, which are to be recouped within 10 years, with no additional funding.

The House bill would require the secretary to negotiate payment for health care providers and services, including prescription drugs, for the public plan. Health care providers participating in Medicare will be considered participating providers in the public plan unless they opt out. Providers have a year to decide whether to participate and there are no penalties for opting out. Innovative payment initiatives such as incentives for providers to establish medical homes, accountable care organizations, value-based purchasing, bundling of payment, differential payment rates, and performance-based payment, would be pursued by the secretary through the public plan option. The goals of these new payment methods would be to improve outcomes, reduce disparities, provide efficient and affordable care, prevent or manage chronic illness, and promote care that is integrated and patient-centered.

Co-op plan. The bill would establish a Consumer Operated and Oriented Plan (CO-OP) program. Under such a program, the commissioner could make grants and loans to establish and initially operate nonprofit, member-run health insurance cooperatives that provide insurance through the exchange. The commissioner could make loans to cooperatives to assist them with start up costs and grants to assist in meeting state solvency requirements. The amendment would authorize \$5 billion between fiscal 2010 and 2014 for grants and loans under the program. Priority for grants and loans would be for cooperatives that: 1) operate on a statewide basis, 2) use an integrated delivery system, or 3) have a significant level of financial support from nongovernmental sources. To be eligible for loans or grants, a cooperative must:

- be structured as a nonprofit, member organization under the laws of the state in which it offers, intends to offer, or issues insurance coverage and the members of the cooperative must all be beneficiaries of such insurance coverage;
- not offer insurance on or before July 16, 2009, and not be an affiliate or successor to an insurance company offering insurance on or before such date;
- incorporate into its governing documents ethical and conflict-of-interest standards that are designed to protect against industry involvement and interference in the governance of the cooperative;
- not be sponsored by a state government;
- have substantially all of its activities consist of issuing qualified health benefits plans through the exchange or a state-based exchange;
- be licensed to offer insurance in each state where it offers insurance;
- govern the cooperative by a majority vote of its members;
- operate with a strong consumer focus (as provided in guidance issued by the HHS secretary); and
- use any profits to lower premiums, improve benefits or otherwise improve the quality of health care delivered to its members.

Medicaid Expansion

Beginning in 2013, the House bill expands eligibility for all people in Medicaid with incomes up to 150 percent of poverty (or \$33,075 for a family of four in 2009). People eligible for Medicaid are not eligible for premium subsidies through the exchange. Medicaid would be required to reimburse primary care providers at no less than 80 percent of Medicare rates in 2010, 90 percent in 2011, and 100 percent in 2012 and thereafter. The federal government would provide 100 percent federal financing of the coverage expansions and 100 percent of costs required to increase payment for primary care services through 2014 and 91 percent federal financing beginning in 2015.

Medicaid would be required to cover preventive services identified by the U.S. Preventive Services Task Force beginning July 1, 2010. In addition, state Medicaid programs would be required to cover:

- tobacco cessation products;
- home visits by nurses to first-time pregnant women or children under two years old who are eligible for Medicaid; and
- family planning services for low-income women who are not pregnant.

States would be required to ensure 12-month continuous eligibility for all children enrolled in the Children's Health Insurance Program (CHIP), in families with incomes below 200 percent of the federal poverty level.

States would be required to permit individuals to apply for Medicaid coverage at locations—known as “outstations”—other than welfare offices. Enrollment at outstations would be effective July 1, 2010.

Individual Mandate

The House bill requires all individuals to have health insurance that meets the requirements of a qualified health benefits plan or pay a penalty of 2.5 percent of the difference between adjusted gross income (modified to include tax-exempt interest and certain other sources of income) and the tax filing threshold, up to the cost of the average national premium for the basic benefit plan offered through the insurance exchange. A qualified health benefits plan provides coverage that meets the applicable requirements in the bill for affordable coverage, the essential benefits package, and consumer protections. All insurance coverage must meet the requirements of the qualified health benefits plan whether it is offered inside or outside the exchange. Oversight and enforcement of requirements for the qualified health benefits plan would be carried out by the commissioner in conjunction with state insurance regulators. Exceptions to the mandate would be made for dependents, religious objections, and financial hardship.

Shared Employer Responsibility

The House bill would require employers to offer coverage to their employees and contribute at least 72.5 percent of the premium cost for single coverage and 65 percent of the premium cost for family coverage of the lowest-cost plan that meets the bill's essential benefits package requirements or pay 8 percent of payroll into the health insurance exchange trust fund. It would require firms to auto-enroll employees into the lowest-cost plan they offer if an employee neither elects nor opts out of employer coverage.

Exemptions for Small Businesses

Small businesses with annual payrolls of less than \$500,000 would be exempt from the bill's 8 percent payroll contribution for employers that do not offer health insurance. The contribution would phase-in starting at 2 percent for firms with annual payrolls exceeding \$500,000 and up to \$585,000, rise to 4 percent for firms with payrolls between \$585,000

and \$670,000, rise to 6 percent for firms with payrolls between \$670,000 and \$750,000, and rise to 8 percent for firms with payrolls above \$750,000.

Premium Subsidies for Small Businesses

The House bill provides a tax credit equal to 50 percent of the amount paid by a small employer who is in compliance with the mandate or paying 65 percent of premium for family coverage and 72.5 percent of premium for single coverage, for up to two years. The tax credit is phased out for employers with 10 to 25 employees, and is also phased out for employers with average wages of \$20,000 to \$40,000 per year. The credits could not be used to cover coverage expenses of employees earning more than \$80,000.

II. DELIVERY SYSTEM REFORM PROVISIONS

Investing in Primary Care

The House bill includes a 5 percent payment bonus for primary care services when provided by a physician, nurse practitioner, or other non-physician provider in family medicine, internal medicine, general pediatrics, geriatrics, and obstetrics–gynecology for whom primary care represents a majority of practice income. The bonus is increased to 10 percent for practice in health professional shortage areas. The HHS secretary would periodically identify primary care services that are potentially incorrectly valued through current coding and adjust the values of these services. Medicaid fees for primary care services under Medicaid fee-for-service payment and under managed care plans are phased up to Medicare levels over a three-year period.

In addition, the House bill would address the shortage of primary care professionals through a number of measures including loan repayment, increased resources for the health service corps, and residency training in community health centers.

To make primary care more accessible to Americans, the House bill eliminates cost-sharing for proven preventive services for Medicare, Medicaid, and essential health benefits plan beneficiaries.

Geographic Variations

The House bill calls for two studies of geographic variations in health care spending by the Institute of Medicine, along with recommended strategies for addressing this variation by promoting high-value care. CMS will implement the recommendations unless disapproved by Congress. Another provision would add 5 percent to Medicare physician payments in geographic areas with the lowest utilization of services (bottom quintile).

Pilots for Rapid-Cycle Testing of Innovative Payment Methods

The House bill calls for the creation of a Center for Medicare & Medicaid Payment Innovation within CMS by 2011 charged with rapid-cycle testing of innovative payment methods to encourage higher quality and lower costs of primary care services. The pilot programs would begin within two years of the enactment of the bill and extend for up to five years. If retrospective review finds the methods are successful in improving quality or reducing costs as determined by the secretary of HHS, the programs must be expanded on a larger scale.

Medical Homes

The bill would establish a medical home pilot program to evaluate the effectiveness of reimbursing qualified patient-centered medical homes for furnishing services to high-need beneficiaries. The pilot program would include two medical home models. Starting within six months of the bill's passage, the patient-centered medical home pilots would provide primary care through a physician or nurse practitioner who is in family medicine, general internal medicine, geriatric medicine, or pediatric medicine; provides ongoing primary or principal care; coordinates care provided by a team; provides for all of the patient's health care needs or arranges for appropriate care with other providers; provides continuous access to care; provides support for patient self-management and coordination with community resources; integrates information on patients that enables the practice to treat patients comprehensively and systematically; implements evidence-based guidelines; permits qualified nurse practitioners to lead a patient-centered medical home as permitted under state law; and permits physician assistants to participate in patient care. The secretary would establish a payment methodology including a risk-adjusted, per-member-per-month payment, paid prospectively.

A community-based medical home would be a nonprofit community-based or state-based organization that would provide medical home services, headed by a primary care physician or nurse practitioners and employing community health workers. This pilot would provide additional prospective payments to facilitate care coordination: one to the nonprofit or state-based organization and one to the primary care practice.

Accountable Care Organizations

The House bill also provides for Medicare and Medicaid pilot programs to test payment incentive models for accountable care organizations, and further provide for continuing this model of care permanently if pilot programs prove successful in improving quality or reducing costs. These payment methods could include shared savings for accountable

care organizations that slow the growth in Medicare outlays below a target rate. This would provide upside rewards for productivity and efficiency gains, without the downside financial risk of a fixed premium or full capitation payment which could lead to losses if expenses exceed premium or capitation revenues.

Hospital Readmissions and Bundled Fees

The traditional Medicare fee-for-service program currently pays hospitals fixed amounts, based on the diagnosis, for each hospital discharge. This model creates an incentive for hospitals to provide efficient care during the patient's stay, but it does not support or provide incentives for hospitals to help patients during their transitions home or to post-acute care settings, nor does it support or provide incentives for hospital to ensure that patients receive follow-up care. As a result, hospitals lack financial support or incentives to take measures to prevent complications that could lead to rehospitalizations. One way to more appropriately align incentives, provide better care for vulnerable patients, and prevent readmissions would be to expand the scope of bundled payments to encompass acute hospital care and post-acute care and hold hospitals accountable for the costs of both the initial hospitalization and any readmissions. With estimates that as many as 75 percent of readmissions may be preventable, such policy options have the potential to improve patient care and lower health care costs.

The House bill calls for reducing payments under Medicare for potentially preventable hospital readmissions, with estimated savings of \$9 billion between 2010 and 2019. It also authorizes the secretary to conduct Medicare pilot programs to test payment incentive models for bundling of post-acute care payments. The Center for Medicare and Medicaid Payment Innovation would test payment models that address populations experiencing poor clinical outcomes or avoidable expenditures, and fund an evaluation of all payment innovation models, with the authority to expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both.

Cost-Containment

The House bill incorporates a productivity improvement allowance of 1 percent across all Medicare services other than physician services. The update is reduced by 1 percentage point per year based on the expectation that such savings are achievable in a reformed health system with substantial reductions in bad debt and charity care and enhanced revenues for care for the newly insured. This productivity improvement adjustment and

other payment update changes yield a 10-year budget savings of \$176 billion (excluding interactions), according to the CBO.¹

Changes are also made to Medicare disproportionate share hospital payments and to Medicaid disproportionate share hospital payments in anticipation of a reduction in the need for those payments with the additional revenues resulting from coverage expansion. These changes are estimated to yield an additional \$20 billion in savings over 2010–2019.

The House bill would eliminate the Part D coverage gap known as the “doughnut hole” and would require the secretary of HHS to negotiate directly with pharmaceutical manufacturers to lower drug prices for Medicare Part D plans and Medicare Advantage Part D plans. It would also require drug manufacturers to provide drug rebates for dual-eligibles enrolled in part D plans, and would increase the Medicaid drug rebate percentage and extend the prescription drug rebate to Medicaid managed care plans. These provisions would yield an estimated savings of \$75 billion over 2010–2019, according to the CBO.²

The current method of setting benchmarks for payments to Medicare Advantage plans results in payments estimated to average 13 percent higher than costs would have been under the traditional Medicare fee-for-service program. Under the current method for determining payments, plans submit bids for covering Medicare beneficiaries based on their expected costs for providing coverage. The bid is then compared with benchmark rates for each county. If the plan’s bid is below the benchmark, the plan receives a payment equal to the amount bid plus 75 percent of the difference between the bid and the benchmark. The additional amount must be matched by additional benefits provided to the beneficiaries who enroll in the plan, either through coverage of additional services or reductions in premiums or out-of-pocket costs. In every county, benchmarks exceed the costs expected under traditional Medicare fee-for-service, and this gap is greater in some areas than in others. The House bill would restructure payments to Medicare Advantage plans, phasing to 100 percent of fee-for-service payments in three years, with bonus payments to plans for high quality.

The creation of health insurance exchanges would yield substantial administrative savings to individuals and small businesses. CBO estimates the exchange would lower

¹ Congressional Budget Office, Letters to the Honorable Charles B. Rangel, the Honorable Henry A. Waxman, and the Honorable George Miller, October 29, 2009, <http://www.cbo.gov/doc.cfm?index=10688>, referred to as “October 29 CBO letter to Hon. Charles Rangel.”

² October 29 CBO letter to Hon. Charles Rangel.

nongroup premiums by 3 to 4 percentage points.³ Inclusion of a public plan in the insurance exchange could yield further savings to families and employers, as well as reduce the cost of sliding-scale premium assistance. The House bill would include a public plan for which the secretary of HHS would negotiate provider payment rates that would be between Medicare and commercial payment rates. The House bill restricts entry to the health insurance exchange and the public plan to small firms initially, but would expand participation to include larger firms over time.

The House bill also seeks to lower costs by requiring health plans immediately to meet a medical loss standard of 85 percent. In addition, the bill would establish in 2010 an annual review of premium increases by the secretary of HHS and the states that would require insurance carriers to justify premium increases.

Quality Improvement

The House bill includes numerous provisions aimed at improving quality and reducing variations in care. It would create a center for quality improvement headed by the Agency for Healthcare Research and Quality director. The center would identify existing best practices for high-quality, efficient care; develop, evaluate, and implement new best practices; ensure best practices are consistent with standards for collecting and reporting quality information using health information technology; and prioritize areas for quality improvement activities in the delivery of health care services, such as reducing health care-associated infections, increasing hospital and outpatient surgery safety, improving hospital emergency rooms, and improving the provision of obstetrical and neonatal care.

A new position of assistant secretary for health information would develop standards for collection, reporting, and publication of information on key health indicators and performance of the national health care system and publish statistics on such indicators. The assistant secretary would submit an annual report to Congress containing a description of national, regional, or state changes in health or health care on these key health indicators, and a plan and recommendations for addressing gaps.

The House bill also calls for establishment of a center for comparative effectiveness research to conduct, support, and synthesize research to determine the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically. An independent comparative effectiveness research commission would oversee and evaluate the activities

³ Congressional Budget Office, Letter to the Honorable Max Baucus, Sept. 22, 2009.

of the center. The revised bill ensures the Commission is fully independent of HHS with separate funding. The revised bill further clarifies that the Center's reports will not be used to mandate payment, coverage or treatment practices.

III. REVENUE AND FINANCING PROVISIONS

Under the Congressional Budget Act of 1974, the CBO is directed to score the impact legislation has on the federal deficit, relative to the federal baseline projections. Under the Act, the Joint Committee on Taxation (JCT) is also required to estimate the impact on revenues when legislation involves the tax code and CBO is required to incorporate JCT estimates into its analysis. All estimates in this description are in billions, unless otherwise noted, and refer to cumulative spending or savings over the 10-year period, 2019–2019, and refer to the legislation as introduced on October 29, 2009, unless otherwise noted.

Total Budgetary Impact

The total net impact on the federal budget of The Affordable Health Care for America Act (H.R. 3962) in the 10-year period, 2010–2019, is a reduction of \$104 billion. This figure reflects the federal costs of expanding coverage (\$894 billion), offset by both reductions in health system spending (\$426 billion) and new revenues (\$572 billion).

Cost of Coverage Improvement and Expansion

The federal costs of coverage improvement and expansion in H.R. 3962 are estimated to be \$894 billion over 10 years.⁴ Premium subsidies for low-income Americans, increased expenditures to expand eligibility for Medicaid and the Children's Health Insurance Program (CHIP), and subsidies for small employers account for the full cost of improving and expanding coverage.

Health System Spending Changes

The payment and system reforms in H.R. 3962 would yield \$426 billion in federal savings, partially offsetting the cost of expanding coverage while making the health care system—and Medicare in particular—more efficient. Earlier versions of legislation in the House (H.R. 3200) included a permanent fix to the sustainable growth rate (SGR), the mechanism for developing physician reimbursement levels in Medicare, in the cost of the reform legislation. By removing the cost of fixing the SGR formula (\$219 billion over 10 years), H.R. 3962 yields significantly more system savings than in H.R. 3200 and is able to apply that savings toward the cost of coverage expansion.

⁴ October 29 CBO letter to Hon. Charles Rangel.

Provider Payment Changes and Productivity Updates

The Medicare fee-for-service payment policy reimburses physicians and caregivers at a variety of institutions based on preset fee schedules. The base payment rates are updated annually to reflect changes in the price of medical services. H.R. 3962 would update provider payment rates (excluding fees for physician services) to incorporate expected productivity updates in the base payment rate and would modify various other payment updates. These changes would yield an estimated \$176 billion in federal savings over 10 years.⁵

Medicare Advantage Reforms

H.R. 3962 would reduce Medicare Advantage benchmarks to fee-for-service levels over three years, reaching equal payment rates in 2013.⁶ CBO estimates that this and other provisions to improve the quality and equity of the Medicare Advantage program would result in \$170 billion in federal savings from 2010 to 2019.⁷

Primary Care, Prevention, and Geographic Adjustment

H.R. 3962 would invest in primary care, including new payment and delivery system models to provide high-quality care, increases in the primary care workforce, and enhanced reimbursement for primary care providers, at an estimated federal cost of \$9 billion over 10 years.⁸

In addition, H.R. 3962 would revise Medicare payment systems for Parts A and B to address geographic inequities, which is estimated to save \$14 billion over 10 years.⁹ In total, CBO estimates that these provisions will result in a net \$6 billion in federal savings between 2010 and 2019.

Payment Innovations

H.R. 3962 includes a provision to further develop post-acute care bundled payments through the conversion of an existing demonstration project to a pilot program, by expanding the program to include bundled payments for hospitals and post-acute care providers, and by directing the secretary to develop a plan for implementing post-acute bundled payments. CBO estimated that this provision would be deficit neutral, requiring

⁵ October 29 CBO letter to Hon. Charles Rangel, Sections 1101–03, 1122, 1131, and 1146.

⁶ Affordable Health Care for America Act Section-by-Section Analysis, October 28, 2009, Section 1161.

⁷ October 29 CBO letter to Hon. Charles Rangel, Sections 1161–1168.

⁸ October 29 CBO letter to Hon. Charles Rangel, Sections 1301–1313.

⁹ October 29 CBO letter to Hon. Charles Rangel, Sections 1157–1159.

no additional spending and producing no new federal savings or revenues over 10 years.¹⁰

In addition, H.R. 3962 would establish a new Center for Medicare & Medicaid Innovation within the Centers for Medicare & Medicaid Services (CMS) to research, develop, test, and expand innovative payment and delivery system methods to improve quality and reduce the cost of care.¹¹ CBO estimated that this would lead to a net reduction in Medicare spending for benefits and would yield \$2 billion in federal savings between 2010 and 2019.¹²

Reducing Hospital Readmissions

Under H.R. 3962, beginning in 2012, hospitals with readmission rates above a certain threshold for three conditions would face reduced reimbursement rates.¹³ The secretary would expand the policy beyond the three readmissions measures endorsed by the National Quality Forum to include additional conditions in future years and could modify the reimbursement adjustment based on a hospital's performance in readmissions compared to a ranking of hospitals nationally. This provision would yield an estimated \$9 billion in federal savings over 10 years.¹⁴

Disproportionate Share Hospital Adjustment

Hospitals that serve a disproportionately large number of low-income patients can receive higher Medicare and Medicaid payments through the disproportionate share hospital adjustment. Under H.R. 3962, these adjustments would be modified beginning in 2017 to reflect a decrease in the number of uninsured in each state, resulting in an estimated \$20 billion in federal savings through 2019.¹⁵

Prescription Drug Payment Changes

H.R. 3962 makes a number of improvements to the Medicare prescription drug benefit, including eliminating the Part D coverage gap (known as the "doughnut hole") over 12 years, allowing the secretary to negotiate lower drug prices for beneficiaries, and discounting certain Part D brand-name drugs in the original coverage gap. Additionally,

¹⁰ October 29 CBO letter to Hon. Charles Rangel, Section 1152.

¹¹ Affordable Health Care for America Act Section-by-Section Analysis, October 28, 2009, Section 1907.

¹² October 29 CBO letter to Hon. Charles Rangel, Section 1907.

¹³ Affordable Health Care for America Act Section-by-Section Analysis, October 28, 2009, Section 1151.

¹⁴ October 29 CBO letter to Hon. Charles Rangel, Section 1151.

¹⁵ October 29 CBO letter to Hon. Charles Rangel, Sections 1112 and 1704.

the bill would increase the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs and extend prescription drug discounts to enrollees of Medicaid managed care organizations. These changes result in estimated federal savings of \$75 billion over 10 years.¹⁶

Changes to Home Health Payments

Home health agencies currently receive a single prospectively determined payment to cover all a beneficiary's services for a 60-day period. This single amount is determined by a national base payment rate adjusted to account for differences in patients' case mix, for geographic variation of prices, and for extraordinarily costly patients (through outlier adjustments). The base payment is updated annually. H.R. 3962 would rebase the home health payment rates in 2011 to better reflect actual costs of home health agencies and incorporate productivity improvements into market basket updates in future years, resulting in an estimated \$58 billion in federal savings from 2010 to 2019.¹⁷

Other Improvements and Interactions Between Provisions

H.R. 3962 includes a wide range of other provisions to improve the quality and efficiency of Medicare and Medicaid, such as investing in the Medicare Improvement Fund, reducing health disparities among Medicare beneficiaries, improving specific Medicare benefit coverage, improving quality measurements, and reducing fraud, waste, and abuse. These changes, along with the effect of interactions between various provisions, yield an estimated \$90 billion in additional federal spending from 2019 to 2019.

Increased Revenues

Along with the system savings described above, new revenues outlined in H.R. 3962 offset the majority of the cost of expanding and improving coverage. The JCT estimates that the bill would produce \$572 billion in new revenues from 2010 to 2019. Of that amount, \$461 billion, or 61% of the new revenue, would come from a new income surcharge on high-income earners. Payments made by employers under the play-or-pay requirement accounts for \$135 billion, or 18% of the new revenue, uninsured payments account for \$33 billion, a new excise tax on medical devices accounts for \$20 billion, and other revenues total \$91 billion over 10 years. These other revenue sources are not solely health-related, with provisions including requirements for businesses to report certain information about payment made to corporations (\$17 billion), delay of implementation

¹⁶ October 29 CBO letter to Hon. Charles Rangel, Sections 1181–89 and 1741-1743.

¹⁷ October 29 CBO letter to Hon. Charles Rangel, Section 1153-1155.

of worldwide interest allocation until 2020 (\$26 billion), and codification of the economic substance doctrine with penalties for underpayments (\$6 billion).

Surcharge on High-Income Earners

Imposing a surcharge for certain levels of annual gross income (AGI) accounts for \$461 billion in increased federal revenues over 10 years. Starting in 2011, a surcharge of 5.4% would be applied to individuals with incomes above \$500,000 or families with incomes over \$1,000,000. Income thresholds would not be indexed for inflation.¹⁸ The structure of the high income surtax under the House bill is a departure from the approach to the surtax in H.R. 3200. As designed in H.R. 3200, the surtax was expected to generate \$543.9 billion over 10 years, roughly \$80 billion more than the surtax in the House bill is expected to generate. Under the earlier version of the legislation, the surtax was graduated and was imposed on a range of incomes over \$280,000 for individuals and \$350,000 for families. Importantly, the surtax was indexed for inflation to ensure that the number of tax filers that were impacted by the surcharge didn't grow each year. In the House bill, the surtax applies to fewer tax filers but the lack of indexing means that as incomes rise, more and more filers could be impacted by the surtax each year.

¹⁸ *Estimated Revenue Effects of Possible Modifications to the Revenue Provisions of H.R. 3962, the "Affordable Health Care For America Act"*, Joint Committee on Taxation, October 29, 2009, JCX-43-09, <http://jct.gov/publications.html?func=startdown&id=3619>.

SOURCES

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