



1501 M Street NW | Seventh Floor
Washington, DC 20005-1700
Tel: (202) 466-6550 | Fax: (202) 785-1756

MEMORANDUM

To: PPSV Clients and Friends
From: Peter Thomas; Adam Renfro Chrisney; Theresa Morgan
Date: September 18, 2009
Re: **Senate Finance Committee Health Reform Bill - Summary**

Senate Finance Committee Chairman Max Baucus (D-MT) released an \$856 billion health care reform proposal September 16th which requires individuals to get health insurance coverage, establishes a web-based health insurance “exchange,” dramatically reforms the private insurance system, provides federal subsidies and tax breaks for the purchase of health insurance, expands Medicaid, and establishes state-based cooperatives to compete with private health plans. The bill is notable for what it does not do as well. It does not include a public plan option, nor does it include an employer mandate to provide employees with health insurance.

While the plan is the result of months of negotiations with a group of six Finance Committee Democrats and Republicans, no Republicans have endorsed the package to date. Chairman Baucus hopes Republican support will build as a result of changes made during the markup process expected to begin September 22, and as the bill proceeds to the Senate floor.

The bill is completely paid-for through \$409.8 billion in Medicare and Medicaid spending reductions over 10 years, a tax on insurers offering so-called “Cadillac” insurance plans, which would raise \$215 billion, new fees on certain providers, such as device manufacturers and importers, and other provisions.

Insurance Reform:

- Insurance Market Reforms – Establishes federal rating, issue, renewability, and pre-existing condition exclusion rules for the individual market. Issuers in the individual market would be required to offer coverage on a guaranteed issue basis, with exceptions for capacity limits. Issuers would be prohibited from excluding coverage for pre-existing health conditions and from rescinding health coverage. On a temporary basis, any uninsured individual with a pre-existing condition can enroll in a new federal high-risk pool.
- Premium Rating Practices – Plans could adjust premiums only based on age, smoking, family status, and geographic variation, with ratios to ensure that coverage is not unaffordable.

There are additional premium protections for low income individuals and families based on a percentage of income.

- Long Term Care Insurance – Allows a cafeteria plan to offer, as a qualified benefit, contributions to a qualified long-term care insurance contract.
- Grandfathered Plans – Allows people to keep their current coverage. Plans could only continue to offer such coverage in a “grandfathered” policy to those who are currently enrolled, dependents, or in the case of an employer, to new employees and their dependents.
- Interstate Sale of Insurance – Starting in 2015, states may form “health care choice compacts” to allow for the purchase of individual health insurance across state lines. Insurers would only be subject to the laws/regulations of the state where the policy is written/issued. This provision would nullify most state mandated benefit laws.
- National Plans – The bill allows for national plans which would offer coverage through the state exchanges. Such national plans would preempt state benefit mandates – thereby allowing them to offer a single, uniform benefit package.
- State Exchanges – All private insurers that meet the new requirements in the individual and small group markets would be available in newly established state exchanges. States would be required to establish an individual market exchange and a Small Business Health Options Program exchange for the small group market. Eventually, states must provide a phase-in period for incorporating firms with 50 or more employees into the state exchanges. Regional and other types of exchanges could be established after the first three years of the state exchanges being operational.
- Benefit Options – Four benefit categories would be available: bronze, silver, gold and platinum. All health insurance plans in the individual and small group market would be required, at a minimum, to offer coverage in the silver and gold categories. All plans must provide a minimum level of benefits and plans are prohibited from including lifetime limits on coverage or annual limits on any benefits. The standard benefits package does not include explicit coverage of rehabilitation or habilitation services or devices such as durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).
- Individual Mandate – Beginning in 2013, all U.S. citizens and legal residents would be required to purchase coverage through the individual market, a public program or through an employer. Exemptions would be allowed for religious objections that are consistent with those allowed under Medicare, and for undocumented aliens. The consequence for not maintaining insurance would be an excise tax, with some exceptions including one for economic hardship.
- Employer Fee – All employers with more than 50 employees that do not offer coverage would be required to pay a fee for each employee who receives a tax credit for health insurance through a state exchange. A Medicaid-eligible individual could enroll in Medicaid without the employer paying a fee.
- CO-OP – Authorizes \$6 billion for the creation of non-profit, member-run health insurance companies to compete in the reformed individual and small group insurance markets.

Medicaid:

- Basic Benefit - Establishes 133 percent of the federal poverty limit (FPL) as the new mandatory minimum Medicaid income eligibility level for all non-elderly individuals – parents, children, and childless adults – beginning on January 1, 2014. Additional Federal

financial assistance would be provided to all states to defray the costs of covering newly-eligible beneficiaries.

- Premium Assistance - Effective January 1, 2013, requires states to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered Employer Sponsored Insurance.
- Rx Drugs – Elevated to mandatory benefit for the categorically and medically needy in 2014.
- Excluded Drug List - Removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's list in 2014.
- Hospice - Medicaid eligible children could receive hospice services without forgoing any other service entitled under Medicaid.
- Medicaid Rebate - Increases the flat rebate percentage used to calculate Medicaid's basic rebate for outpatient brand name prescription drugs from 15.1 percent to 23.1 percent, except for certain clotting factors, for which the basic rebate would increase to 17.1 percent.
- State DSH Allotments - To remain intact until a state trigger is tripped (once a state's uninsured rate decreases by at least 50 percent, compared to an initial uninsured rate on the date of enactment). Once the trigger is tripped, state disproportionate share hospital (DSH) allotments decrease by 50 percent. Low DSH state allotments would be decreased by 25 percent. Levels could be further lowered in out years based on a formula which accounts for decreasing numbers of uninsured.
- Dual Eligibles - Establishes a new CMS office, the Office of Coordination for Dual Eligible Beneficiaries (OCDEB).
- Health Care Acquired Conditions – Expands upon Medicare policy to prohibit Federal payments to states for Medicaid services related to conditions acquired during the course of care, including from a hospital stay.
- Bundle Demo - Establishes a Medicaid bundled payment demonstration project in up to eight states. Hospitals would receive a single bundled payment from Medicaid for acute care provided in hospitals and post-acute care provided in acute care hospitals and nonhospital settings, and/or hospital and concurrent physicians' services.

CHIP changes: Establishes a Federal floor for eligibility at 250 percent of FPL, requiring states to offer State Children's Health Insurance (CHIP) to all children between 134% and 250% of FPL. CHIP benefit package would include state exchange coverage and state wrap-around benefits.

Health Care Workforce: To invest in the provider workforce, includes 1) an increase in graduate medical education (GME) training positions through a slot re-distribution program (preserves resident cap positions from closed/acquired hospitals), 2) encourages additional training in outpatient settings, 3) development of a national workforce strategy, and 4) establishment of a competitive education and training demonstration grant program to help low-income individuals.

Comparative Effectiveness Research (CER): Establishes a patient-centered outcomes research institute to use research and evidence synthesis to determine the relevance of CER clinical evidence. No findings could be used to deny coverage. Establishes strong protections for use of CER with subpopulations such as disability community. Creates a related trust fund to support the institute (authorizing about \$2 billion/10 years).

Quality & Care Coordination:

- Quality Programs (Pay-for-Reporting/Outcomes) - Includes various proposals to further move the Medicare fee-for-service system towards paying for quality and value: 1) establishes a hospital value-based purchasing (VBP) program starting in 2012 and ties a payment percentage to outcomes on common high-cost conditions; 2) expands the Physician Quality Reporting Initiative (PQRI) program, including requiring all professionals to participate by 2011 and penalizes physicians with high resource usage; 3) develops new VBP plans for home health (by 2011) and SNF (by 2012); and 4) develops new VBP programs for LTC, IRF, PPS-Exempt and hospice providers with penalties for non-participation.
- Infrastructure Investments to Improve Quality - Includes development of a national quality strategy, establishment of an independent institute to research the effectiveness of different health care treatments and strategies.
- Care Coordination/Provider Collaboration – Provides for a national pilot program on Medicare payment bundling amongst hospitals, doctors, and post-acute care providers. Provides for development of Accountable Care Organizations to coordinate care across a range of providers to improve patient care and reduce costs. Establishes an Innovation Center to encourage new patient-centered payment models that encourage evidence-based, coordinated care. Directs CMS to track readmission rates for certain high-cost conditions with significant penalties (20% and 10%) applied starting in 2012 for preventable hospital readmissions.

Medicare Provider & Payment Adjustments:

- Physicians – Replaces the impending 21% SGR cut with a 0.5% update in 2010. The conversion factor for 2011 and subsequent years would be computed as if the increase in 2010 had not been applied. Extends for two years the 1.0 (average) floor on the geographic adjustment for the work component of the Medicare physician fee schedule.
 - Medical Malpractice – Includes non-binding encouragement to states to develop alternatives to the current civil litigation system and for Congress to consider establishing a state demonstration program to evaluate alternatives.
 - Physician-Industry “Sunshine” - Provides patients with new information on these relationships and closes loopholes in physician self-referral laws that allow conflicts of interest.
 - Primary Care – To promote primary care doctors and general surgeons, includes a Medicare payment bonus of ten percent (10%) for five years.
- Access to Outpatient Rehabilitation Services – Extends the therapy caps exceptions policy for another two years.
- Rural Health Care Policies – Extends many rural access protections to ensure that rural health care facilities and providers have the resources they need to continue delivering quality care, including the FLEX grant program, the outpatient hold harmless provision, reasonable cost for lab services and the rural community hospital and dependent hospital demo programs.
- Medicare and Medicaid Preventive Services - Improves coverage and access to preventive services including the elimination of out-of-pocket costs for recommended preventive services (Medicaid: 1% FMAP increases when states cover these services). Includes a 2-year enhanced FMAP for states providing chronically ill patient-centered care. Provides

incentives for patients to complete evidence-based healthy lifestyle programs and lowering risk factors for certain chronic diseases.

- Hospital Payments - Extends Section 508 geographic reclassification payments for an additional two years. Requires the development of a plan to reform the wage index system. Starting in 2015, reduces DSH hospital payments to reflect lower uncompensated care costs relative to increases in the number of insured. In addition, certain hospitals as of 1/11/09 would be exempt from the prohibition on self-referrals.
- Home Health Payment Reform - Reinstates the 3% rural add-on for five years. Establishes an annual 10% cap on outlier payments for treating sicker patients. Starting in 2013, rebases home health payments to reflect the current mix, intensity of service, and cost of care for every provider.
- Skilled Nursing Facilities - A number of changes are proposed aimed at improving transparency of ownership, quality assurance, performance improvement, use of a “compare” website, expenditure reports, staffing accountability, and other standards and rules.
- Hospice Reform - Data collection proposal to review industry payments in order to update forms and cost reports as well as recommend payment system changes as appropriate.
- Imaging Services - To more accurately reflect usage, the bill includes a phased-in increase in the utilization rate assumption for advanced imaging equipment. In addition, the technical component reduction is doubled for sequential imaging on contiguous body parts. The in-office ancillary exception would include a self-referral “sunshine” requirement.
- Health Disparities Data – Requires CMS to survey providers in order to determine a variety of information on the level of care provided to patients with disabilities. Requires quality reporting on patients by race, ethnicity, gender, primary language, and disability.
- Durable Medical Equipment – Eliminates the 2% add-on fee schedule payment slated to occur in 2014. Prohibits Medicare beneficiaries with mobility impairments from choosing to purchase their mobility device up front with a lump-sum payment, rather than renting the device for 13 months. Complex, rehabilitative power wheelchairs are exempt.
- DMEPOS Competitive Bidding Program Adjustments – Round Two Metropolitan Statistical Areas (MSAs) will be increased from 70 to a total of 100 and reimbursement levels achieved under competitive bidding will be extended to non-competitive bidding areas.
- Medicare Provider Market Basket Cuts –
 - Home Health: 1% off market basket in 2011 and 2012;
 - Hospice: 0.5% in 2013 – 2019*
 - Hospitals (in/out patient, IPF, IRF, LTCH): 2010 & 2011 – 0.25%; 2012 – 2019 – 0.2%*
 - Skilled Nursing Facilities: No market basic adjustment* = Out-year gains in productivity would lead to further market-basket adjustments.
- Medicare Commission - Created to develop proposals to reduce cost growth and improve quality to go into effect in high-cost years unless Congress passes alternative measures.
- Medicare Advantage Reforms – Transitions current Medicare Advantage payments from being based on statutory benchmarks to payments based on competitive bids from insurers. Eliminates overpayments to Medicare Advantage plans. Bonus payments are available for using quality measures, operating evidence-based care management programs, and providing care at lower costs than traditional Medicare.

- Part D (Prescription Drug) Improvements – Provides a 50% discount program for beneficiary payments for prescriptions drugs in the “donut hole.” Lowers low-income benchmarks to increase the number of plans serving low-income beneficiaries. Reduces the premium subsidy for high-income beneficiaries.
- Waste, Fraud & Abuse – All providers and suppliers would be screened (state licensure checks, criminal background checks, site visits, etc.) before being granted Medicare billing privileges. Provides that states would do the same for Medicaid with FMAP penalties for non-compliance. CMS to develop comprehensive, integrated claims/payment data repository to increase program integrity across agencies. Existing provider databases to be consolidated with a national patient abuse registry into a centralized sanctions data system. Recovery Audit Contractor (RAC) program extended to Medicare Parts C and D.

Revenue Items:

- High Cost Plans – Beginning in 2013, insurance policies with relatively high total premiums (policies over \$8,000 for individuals or \$21,000 for families, indexed) would be subject to a non-deductible 35% excise tax on the amount by which the premiums exceeded a specified threshold. (\$215 billion savings).
- Flexible Spending Accounts (FSAs) – Limits annual contributions to \$2,000/year as of 2013.
- Employer Part D Subsidy – Eliminates this deduction in 2011.
- Qualified Medical Expense Definition – Standardizes definition of qualified medical expenses reimbursable through any FSA, HRA, HSA or Archer-MSA. Over the counter medicine costs will no longer be covered by these plans.
- HSAs – The additional tax on distributions from an HSA not used for qualified medical expenses is increased to 20%.
- Rx Manufacturer Fee - \$2.3 billion annually across the industry allocated according to market share.
- Medicare Device Manufacturer and Importer Fee - \$4 billion across the industry annually allocated according to market share.
- Insurer Fee - \$6 billion across the industry annually according to market share.
- Clinical Lab Fee - \$0.75 billion across the industry.