



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Patient Protection and Affordable Care Act Senate Health Care Bill November 30, 2009

SUMMARY

The Congressional Budget Office (CBO) has determined that Senator Reid's *Patient Protection and Affordable Care Act* is fully paid for, will provide coverage to more than 94 percent of Americans while costing some \$894 billion over ten years and reducing the deficit over the next ten years.

A number of provisions which AAFP had supported were dropped from the *Patient Protection and Affordable Care Act* including:

- The provision to end the health and medical liability insurance industry antitrust exemptions in order to make health and malpractice insurers accountable under antitrust laws that ban price-fixing, bid-rigging and dividing markets between them.
- The provision to reinstate the student loan deferment program known as the 20/220 pathway which allowed for the deferment of interest and principal payments on educational loans during residency based on a defined debt-to-income ratio.

The Senate leadership's bill did make two changes that AAFP asked for:

- The bill eliminates the provision that physician payment would be reduced by 5 percent if the physician's resource use was at or above the 90th percentile of national utilization.
- The PQRI penalties remain in the bill, but their effective date has been pushed back two years to 2015.

Compared to the House bill, the Senate is missing a number of significant provisions:

- Primary care bonus payment, while lower in the House bill, is permanent and the threshold is lower as well.
- The Senate bill does not have the House bill's Increased payment for primary care in Medicaid and mandated coverage of preventive services, along with the elimination of cost-sharing for preventive services
- The House bill expands Medicaid enrollment to 150 percent of the Federal Poverty Level (FPL) compared to 133 percent in the Senate bill.
- Codifying Medicaid payment for GME is missing in the Senate bill.

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Primary Care in the Senate Bill

The Senate bill:

- Identifies essential health benefits that must be included in any health care insurance plan offered in the newly created health exchange. The list of services includes:
 - (A) **Ambulatory patient services.**
 - (B) Emergency services.
 - (C) Hospitalization.
 - (D) Maternity and newborn care.
 - (E) Mental health and substance use disorder services, including behavioral health treatment.
 - (F) Prescription drugs.
 - (G) Rehabilitative and habilitative services and devices.
 - (H) Laboratory services.
 - (I) **Preventive and wellness services and chronic disease management.**
 - (J) Pediatric services, including oral and vision care. (Sec. 1302)
- Directs HHS to work with the National Association of Insurance Commissioners to develop **standards for exchanges** and qualified plans. Requires states to adopt the standards by 2014 and allows HHS to establish an exchange in a state if the state has not adopted the standards. Provides a process for states with existing exchanges to meet the standards. (Sec. 1321)
- Provides \$6 billion to aid in the **establishment of co-ops** before July 1, 2013. Bars private insurers and government programs from qualifying for funds. Allows co-ops to purchase items and services, but disallows setting of provider payment rates. (Sec. 1322)
- Establishes a community health insurance option (**the public option**) to be offered on the exchange and sets its broad parameters. Allows states to opt-out of offering the community health insurance option in that state's health insurance exchange. Requires CMS to negotiate payment rates with providers. (Sec. 1323)
- Requires public-supported programs—community/public option or co-ops—offered through a state exchange **to conform to the same state and federal laws as private plans.** (Sec. 1324)
- Creates a waiver program that will allow states to experiment, for a period of up to five years, with **alternative ways of structuring various provisions** of the act (qualified health plans, exchanges, cost sharing, mandates, etc.), provided such waiver plans provide coverage that is at least as affordable and comprehensive and does not increase the federal deficit. (Sec. 1332)
- Permits states, beginning in 2016, to enter into **interstate compacts** that will allow qualified health plans to be offered across state lines. Provides that the consumer protection laws of the purchaser's state hold jurisdiction, but requires disclosure to purchasers that not all laws of their state apply. (Sec. 1333) Requires private insurers to pay a total of \$25 billion from 2014 through 2016 to fund a new non-profit entity to provide reinsurance to insurers covering high-risk individuals. Requires the Secretary of HHS to define "high-risk individual." (Sec. 1341)
- Requires HHS to establish **risk corridors** for qualified health plans from 2014 through 2016. If a plan's costs (other than administrative costs) exceed 103 percent of total premiums, HHS makes payments to the plan to defray the excess. If a plan's costs (other than administrative costs) are less than 97 percent of total premiums, the plan makes payments to federal government. (Sec. 1342)

- Requires states to assess a **levy on insurers** with enrollees of lower-than-average risk and make payments to insurers whose enrollees are of higher-than-average risk. The provision only applies in the individual and small group markets, not to grandfathered plans. (Sec. 1343)
- Creates **refundable tax credits** to assist individuals and families in purchasing qualified health plans. Tax credits are provided on sliding scale phasing out at 400 percent of the Federal Poverty Level. (Sec. 1401)
- Sets **cost-sharing limits** for enrollees in qualified health plans based on a sliding scale that phases out at 400 percent FPL. (Sec. 1402)
- Requires states to enroll individuals applying for insurance through the state's exchange in Medicaid, CHIP or other state-provided coverage if the applicant is eligible for one of those plans. (Sec. 1413)
- Beginning in 2014, most **individuals will be required to maintain minimum essential coverage or pay a penalty** of \$95 in 2014, \$350 in 2015, \$750 in 2016 and indexed thereafter; for those under 18, the penalty will be one-half the amount for adults. Exceptions to this requirement are made for religious objectors, those who cannot afford coverage, taxpayers with incomes less than 100 percent FPL, Indian tribe members, those who receive a hardship waiver, individuals not lawfully present, incarcerated individuals, and those not covered for less than three months. Any individual or family who currently has coverage and would like to retain that coverage can do so. This coverage is deemed sufficient to meet the requirement to have health coverage. Similarly, employers who currently offer coverage are permitted to continue offering such coverage. (Sec. 1501)
- Requires employers with more than 200 employees to **enroll automatically new full-time employees in coverage**. Any employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit will make a payment of \$750 per full-time employee. An employer with more than 50 employees that offers coverage that is deemed unaffordable or does not meet the standard for minimum essential coverage and but has at least one full-time employee receiving the premium assistance tax credit because the coverage is either unaffordable or does not cover 60 percent of total costs, will pay the lesser of \$3,000 for each of those employees receiving a credit or \$750 for each of their full-time employees total. (Sections 1511-1513)
- Requires HHS to develop **interoperable and secure HIT standards** and protocols to help people enroll in the federal and state health and human services programs. For example, this section allows the development of a capability for people to apply, recertify and manage their information online. These provisions may be a condition of receiving federal funding. (Sec. 1561)
- Provides Medicaid coverage for individuals **below 133 percent of the Federal Poverty Level** (FPL) beginning in 2014. Eligibility is expanded beyond the traditional Medicaid categories (low-income women and children, the disabled, low-income elderly) to previously ineligible individuals. The federal government would cover the cost of the expansion fully from 2014 through 2016 and phase it down to a higher FMAP by 2019. States will retain the option to expand coverage beyond the 133 percent. (Sec. 2001)
- Increases Medicaid **payments to Puerto Rico and the territories** by raising funding cap by 30 percent and FMAP by 5 points beginning in 2011. (Sec. 2005)

- Increases **payments to states for CHIP** by 23 points, capped at 100 percent, through 2019. Children affected by the cap would be eligible for exchange credits. (Sec. 2101)
- Simplifies enrollment in Medicaid, CHIP and the insurance exchanges through creation of **state-run benefit application web sites**. Requires that state programs and exchanges coordinate enrollment and application procedures. (Sec. 2201)
- Adds **freestanding birth centers** to the list of Medicaid providers. (Sec. 2301)
- Allows children to receive **Medicaid hospice services** while receiving treatment for terminal illness at the same time. (Sec. 2302)
- Grants states the option of including **family planning services** in the state's Medicaid program. Providers will be permitted to provide, and pay for, services rendered to patients presumed to be eligible for such services based on preliminary information. (Sec. 2303)
- Establishes a new option for states to provide **community-based attendant services** through Medicaid to those who otherwise might require a nursing home, hospital or intermediate care facility. (Sec. 2401)
- Authorizes a 5-year **national pilot program on payment bundling** that would feature integrated care during an episode of care provided to a beneficiary with one or more of 8 selected conditions around a hospitalization to improve the coordination, quality, and efficiency of health care services. An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency may apply to provide applicable services. (Sec. 2303)
- Increases **prescription drug rebates** under the Medicaid program. (Sec. 2501)
- Requires that **additional drugs be covered under Medicaid**, such as smoking cessation drugs, barbiturates and benzodiazepines. (Sec. 2502)
- Allows states the option of funding a **medical home** for enrollees with chronic conditions (Sec. 2703)
- Directs the new **Medicaid and CHIP Payment Advisory Commission (MACPAC)** to examine payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, among others. The commission is to look at how beneficiaries may obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations. The commission also will examine enrollment and retention processes; coverage policies; quality of care; interactions with Medicare and Medicaid and submit reports and recommendations. Finally, the commission must consult with MedPAC and members should include physicians and other health professionals, among others. (Sec. 2801)
- Revamps the **Physician Quality Reporting Initiative (PQRI)** to postpone penalties for non-reporting to 2015. The penalties are a Medicare payment reduction of 1.5 percent in 2015 and 2 percent after that. The incentive payments for those physicians who do report are 1 percent in 2011 and 0.5 percent in 2012-2014. The Maintenance of Certification process still would automatically qualify the physician for the PQRI bonus. (Secs. 3002 and 3003)

- Establishes the **Center of Medicare and Medicaid Innovation (CMI)** within CMS. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, CMS shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals. This is where the medical home demonstration will be tested. (Sec. 3021)
- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012) (Sec. 3022)
- Increases the **physician payment update for 2010 by 0.5 percent**. It does not address changes in the SGR, but does postpone the 21.2 percent reduction pending in the current formula. (Sec. 3101)
- Extends the **work geographic index floor** and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule for one year. (Sec. 3102)
- **Provides rural protections** by extending the outpatient hold harmless provision, allowing small rural hospitals and Sole Community Hospitals to receive this adjustment through FY2010 and reinstates cost reimbursement for lab services provided by small rural hospitals from July 1, 2010 to July 1, 2011. (Secs. 3121 - 3122)
- Extends the **Rural Community Hospital Demonstration Program** for one year and expands eligible sites to additional states and hospitals. (Sec. 3123)
- Improves the Demonstration Project on **Community Integration Models** in certain rural counties by removing references to rural health clinics and including physician services in scope of demonstration project. (Sec. 3126)
- Directs the Medicare Payment Advisory Commission to conduct a study on the **adequacy of payments** for items and services furnished by providers of services and suppliers **in rural areas** under the Medicare program. (Sec. 3127)
- Allows HHS to **identify misvalued physician services** and make appropriate adjustments to the relative values of those services (Sec. 3134)
- Extensively changes the Medicare Part D program, most importantly by moving to **close the prescription drug gap** under the current program. Specifically, beginning in 2010 and in the years following, manufacturers would have to provide discounted drugs to patients at 50 percent of their negotiated price. The so-called donut hole would be closed in 2019 beginning with a \$500 reduction in 2010. It is paid for by mandating that drug manufacturers provide rebates to Medicaid for drugs to dual-eligibles. In addition, beneficiaries who are moved from one prescription drug program to another must be provided detailed information about the changes within 30 days and additional funding is provided to programs serving low-income people to provide outreach and assistance. The bill also requires the drug programs to include medically necessary prescription medications on their formularies with only a few exceptions. This section also reduces the Part D premium subsidy for high-income beneficiaries; eliminates cost-sharing for dual-eligibles; improves

the current complaint system and requires the establishment of a model electronic complaint form and requires a single, uniform exceptions and appeals process for all plans. (Section 3301)

- Creates an **Independent Medicare Advisory Board (IMAC)** to reduce the per capita rate of growth in Medicare spending by having CMS estimate the per capita growth rate under Medicare. The IMAC must present Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years in which Medicare costs are projected to be unsustainable, the commission's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Hospitals and hospice programs are exempt from these recommendations for 10 years; however, costs in Medicare Part C and D are included. The Board of the IMAC will consist of 15 members, who are "individuals with national recognition for their expertise in health finance and economics." The bill lists a number of representatives that shall be included on the Board, and this list includes physicians (not specifically primary care), employers, third-party payors and health care research experts. Consumers are not mentioned, although there is a Consumer Advisory Council created by the bill. There is no public comment period apart from the Congressional consideration of the IMAC recommendations. (Sec. 3403)
- Establishes a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional "**health teams**" to provide support services to primary care providers; and provide capitated payments to primary care providers as determined by the Secretary. (Sec. 3502)
- Authorizes **competitive grants**, requiring a non-federal match, to medical schools for demonstration projects to develop and implement academic curricula that integrate quality improvement and patient safety in the clinical education of health professionals. (Sec. 3508)
- Provides Medicare coverage of an **annual wellness visit** and a visit providing a personalized prevention plan. (Sec. 4103)
- Allows HHS to enter into contracts with manufacturers for the purchase and delivery of recommended **vaccines for adults**. The bill also establishes a demonstration program for states to improve their provision of recommended vaccines to children, adolescents and adults, such as reminders, education, reduced cost, etc. and requires a study of Medicare beneficiaries' access to vaccines. (Sec. 4204)
- Establishes a 15-member **national health care workforce commission** to review health care workforce and projected needs and to provide comprehensive information to Congress and the Administration to align workforce resources with national needs. (Sec. 5101)
- Improves the **primary care student loan program** by easing federal student loan criteria for schools and students to qualify for loans, shorten payback periods; decreases the non-compliance fee on HRSA's health professions student loan programs to make it more attractive to medical students, requires HRSA to update their student loan guidelines, sets the maximum service obligation at 10 years reduced from 20 years, and includes a Sense of the Congress that funds should not be rescinded from the program. (Sec. 5201)
- Increases funding for the **National Health Service Corps** and for the NHSC scholarship and loan repayment program for FYs 2010-2015 to \$1.15 billion by FY 2015. (Sec. 5207)

- Reauthorizes **Title VII Section 747 Training in family medicine**, general internal medicine, general pediatrics, and physician assistantship to provide grants to training programs, financial assistance to trainees and faculty, faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority is given to programs that educate students in team-based approaches to care, **including the patient-centered medical home**. (Sec. 5301)
- Creates a **Primary Care Extension Program** to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The Agency for Healthcare Research and Quality will award planning and program grants to state hubs including, at a minimum, the state health department, State-level entities administering Medicare and Medicaid, and at least one health professions school. These state hubs may also include Quality Improvement Organizations, AHECs, and other quality and training organizations. (Sec. 5405)
- Beginning in 2011, primary care providers will receive a **10-percent bonus** for all claims made to Medicare for primary care services. To be eligible for this bonus, the physician must have a primary specialty designation of family medicine, general internal medicine, general pediatrics or geriatrics and must have at least 60 percent of the allowed Medicare charges for primary care services (as defined by specific HCPCS codes). If nurse practitioners have independent practice by state law, they can be eligible for the bonus. (Sec. 5501)
- Distributes **unused residency positions to primary care** with preference given to states with physician resident shortages. (Sec. 5503)
- Allows for the **counting of resident time in outpatient settings** and allowing flexibility for jointly operated residency training programs; for counting resident time for didactic and scholarly activities and other activities; and **preserves resident cap positions from closed hospitals**. (Secs. 5504 – 5506)
- Establishes demonstration projects to address **health professions workforce** needs and extension of family-to-family health information centers. (Sec. 5507)
- Directs the Secretary to establish a grant program to support new or expanded primary care residency programs at **teaching health centers** and authorizes \$25 million for FY2010, \$50 million for FY2011 and FY2012 and such sums as may be necessary for each fiscal year thereafter to carry out such program. Also provides \$230 million in funding under the Public Health Service Act to cover the indirect and direct expenses of qualifying teaching health centers related to training primary care residents in certain expanded or new programs. AFMAA and AAFP staff are concerned that this mandatory account conflicts with the \$240 million included in the House bill to establish a Public Health Investment Fund which would provide funding, in addition to annual appropriations, for the Title VII sections 747, 748, and 749 programs. (Sec. 5508)
- Requires drug manufacturers to report **“gifts and transfers of value” to “covered entities,” including physicians**. Beginning in 2013, this section would require reporting on any items of more than \$100 in value. (Sec. 6002)
- Defines **patient-centered outcomes research** as "research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of two or more medical treatments, services, and items." The section establishes a new Institute to "assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and

relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments and services." The bill charges the Institute with identifying national priorities. The bill also ends the current Federal Coordinating Council on Comparative Effectiveness Research. (Sec. 6301)

- **Medicare providers are to be screened** for purposes of preventing fraud and will be charged \$200 whenever they are screened. (Sec. 6401)
- Institutes a new "approval pathway" of 12 years for **biologics**. (Sec. 7001)