

TALKING POINTS AMERICA'S AFFORDABLE HEALTH CHOICES ACT (H.R. 3200)

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I. PHYSICIAN PAYMENT

Medicare Physician Payments – Sustainable Growth Rate

- H.R. 3200 takes the unprecedented step of enacting long-term Medicare physician payment reforms necessary to maintain the physician workforce, thereby ensuring access to physician care for our nation's seniors. The bill would provide for a rebasing in 2010 as well as a one year update consistent with the Medicare Economic Index, followed by annual updates based upon a more realistic, revised formula. The total investment in physician payment provisions included in this section of H.R. 3200 exceeds \$250 billion.
- Since Medicare's inception, we have seen a significant increase in the percentage of care provided in the ambulatory setting versus the inpatient hospital setting. A targeted restructuring of the Medicare physician payment formula, as contained in H.R. 3200, would facilitate a community-based, comprehensive health care delivery model.
- In 2010, physicians face a 21 percent reduction in their Medicare payments with additional cuts totaling greater than 40 percent over the next decade. This legislation would avert these drastic cuts and set the Medicare program on a path toward a fair, equitable and stable reimbursement system that reflects the cost and value and of providing high quality physician care. The revised formula recognizes the importance of primary care by allowing these services to grow at a higher rate than other services, and does not reduce physician pay rates for increases in spending on drugs or lab services.
- Reforms to the Medicare physician payment methodology must take into account variations in the rate of health care inflation relative to that of the economy as a whole. H.R. 3200 establishes more reasonable targets to ensure long-term stability in the system.
- All evaluation and management services, along with designated preventive care services, would be reimbursed using a methodology that promotes their delivery and provides adequate compensation to physicians. The approach taken in this legislation, whereby the current payment methodology is bifurcated into independent physician service targets, addresses the existing inequities in physician payment.
- Establishes new requirements that Medicaid physician payment rates be 100 percent of allowable Medicare rates.

Primary Care Bonus

- This legislation provides "bonus payments" of five percent to primary care physicians providing designated services and a 10 percent bonus to primary care physicians in health profession shortage areas. While this is a laudable effort to incentivize primary care, bonuses payments for primary care physicians should be increased to a minimum of 10 percent in order to achieve the goal of bolstering the primary care workforce.
- General surgeons, like their primary care colleagues, face shrinking numbers within their ranks. The extension of bonus payments to general surgeons would deter these essential generalist physicians from subspecializing as a result of inadequate reimbursements.

II. PATIENT-CENTERED MEDICAL HOME

Medicare

- Establishes a medical home pilot program to assess the feasibility of reimbursing for qualified patient-centered medical homes.
- Requires use of two models in the patient-centered medical home pilot program:
 - Independent patient-centered medical home (PCMH) – this would be structured around a provider, and is targeted at the top half of high-need Medicare beneficiaries with multiple chronic diseases.
 - Community based medical home, is targeted at a broader population of Medicare beneficiaries with chronic diseases and allows for State-based or non-profit entities to provide care-management supervised by a beneficiary designated primary care provider.
- Payments will be made on a monthly basis to Independent PCMH for each targeted high need beneficiary
- Allows nurse practitioners and physician assistants to lead a medical home so long as they act consistent with State law
- Expands the eligibility criteria to allow OB/Gyns to participate in the medical home pilot program
- Provides approximately \$1.6 billion from the Trust Fund for the 5 year pilot programs. The Secretary is authorized to expand the program only if quality measures have been met and budget neutrality is demonstrated.

Medicaid/SCHIP

- Establishes a 5-year pilot program to test the medical home concept with high-need Medicaid beneficiaries, including medically fragile children and high-risk pregnant women.
- The federal government would match costs of community care workers at 90% for the first two years and 75% for the next 3 years, up to a total of \$1.235 billion.

III. PHYSICIAN WORKFORCE

- Secretary can grant waivers whereby National Health Service Corps recipients could satisfy all or part of obligation by providing services part time. Changes maximum loan repayment benefits from \$35,000 to \$50,000. Teaching time could be treated as clinical practice for up to 20% of the obligated service.
- Creates new Frontline Health Providers Loan Repayment Program for those serving in “health professional needs areas” and not eligible for NHSC program. Loan rate for primary care student loan funds would be 2% below otherwise available rates. Provides funding to support training programs in family medicine, general internal medicine, general pediatrics, and geriatrics and to develop faculty capacity in these areas.
- Creates a new primary care training and capacity building program that would award grants and contracts to plan, develop or operate accredited training programs for medical students, interns, residents or practicing physicians in family medicine, general internal medicine, general pediatrics, and geriatrics.
- Establishes preferences for awarding such grants or contracts to applicants that “have a record of training the greatest percentage of providers or that have demonstrated significant improvements in the percentage of providers who enter and remain in primary care practice” or those from underrepresented minorities or disadvantaged backgrounds or that target vulnerable populations.
- Establishes a program to support training residents in community-based settings, with grants and contracts for planning or developing new primary care residency programs.
- Establishes a Public Health Workforce Corps, with scholarship and loan repayment programs.
- Establishes an Advisory Committee on Health Workforce Evaluation and Assessment to assess the adequacy and appropriateness of the health workforce and make recommendations to the Secretary.
- Establishes a National Center for Health Workforce Analysis to gather data for evaluating the effectiveness of federal workforce programs and to award grants and contracts for health workforce analysis.

Student Education Financing

- The bill does not include provisions aimed at reducing the education debt load of medical students, residents, and young physicians. The AOA will be promoting inclusion of provisions that re-establish the “20/220” pathway whereby resident physicians can defer interest payments on their student loans throughout their training.

IV. GRADUATE MEDICAL EDUCATION

- Establishes resident redistribution pool that would redistribute 90% of unused resident slots. Eligible hospitals eligible would have to maintain the current number of primary care residents plus the additional slots. Preferences would be established for hospitals that: lost slots in the pool; are over their caps; have 3-year primary care programs; have formal arrangements for training in FQHCs, rural health clinics and other nonhospital settings; that emphasize training in health professions shortage areas or health professions needs areas; and that have low resident-to-population ratios or are located in states with such ratios. IME would be the same as for other residents.
- Does not “break the caps” or create any new resident positions.
- Allows a hospital to count all resident time spent in patient care without regard to setting if it pays resident salaries and benefits for time spent in the setting. The OIG would conduct a study to determine if the changes increase training in nonhospital settings.
- Establishes a demonstration project whereby “approved teaching health centers” would be eligible for payment of their own direct costs of training primary care residents plus the direct costs of the hospitals they contract with for the residents’ in-hospital training. “Approved teaching health center” would be defined as an FQHC or rural health center that develops and operates an accredited primary care residency program. The center would be required to contract with an accredited teaching hospital for the inpatient portion of the training and to pay the hospital for the residents’ salaries and benefits for time spent there.
- Allows teaching hospitals to count the time residents spend in non-patient care didactic activities in the hospital, in hospital outpatient facilities, and in non-hospital settings engaged in furnishing patient care, for both DGME and IME purposes. As now, time spent in research not associated with the treatment or diagnosis of a particular patient could not be counted for Medicare GME payment purposes.
- Redistributes to other hospitals in the state. resident caps of hospitals that close on or after 2 years before date of enactment
- Establishes goals for medical residency programs to foster preparation of a physician workforce that would: work effectively in a variety of settings; coordinate patient care within and across settings; understand the cost and value of various diagnostic and treatment options; work in inter-professional teams and multi-disciplinary team-based models in a variety of settings; be knowledgeable about methods of identifying systematic solutions; and be knowledgeable users of EHR
- Mandates a GAO study to evaluate the extent to which residency programs meet these goals and have appropriate faculty expertise to do so. Requires the GAO to issue a report within 18 months with recommendations on additional ways programs could meet the goals, including the development of curriculum requirements and the assessment of the accreditation processes of ACGME and the AOA and their effectiveness in accrediting programs that meet the goals.

V. COVERAGE AND ACCESS

Insurance Reforms

- Protects choice for individuals by allowing them to keep their current employer-based coverage as “grandfathered plans” and provides a 5 year grace period for current group health plans to meet specified standards.
- Creates new standards to guarantee individuals have access to affordable coverage
 - Prohibits pre-existing condition exclusions
 - Requires guaranteed issue and renewal
 - Prohibits differential pricing based upon race, gender, or other demographic criteria.
- Creates new standards for benefits packages
- Requires qualified plans to meet medical loss ratios specified by Health Choices Commissioner
- Eliminates co pays for preventive care services

Medicaid

- Expands Medicaid eligibility to individuals up to 133 1/3% of the Federal Poverty level
- requires coverage of preventive services, tobacco cessation products
- reduces DSH payments by \$10 billion between FY 2017 and FY 2019

Health Insurance Exchange

- Establishes a Health Insurance Exchange (HIE) within the Health Choices Administration and under the direction of the Commissioner. The Exchange facilitates access through a transparent process for individuals and employers to a variety of choices of private and public health insurance coverage. The Health Choices Commissioner establishes a process for obtaining bids, negotiating and entering into contracts with qualified plans offering benefits through the Exchange; and ensuring that the different levels of benefits are offered with oversight and enforcement. The Commissioner also facilitates outreach and enrollment, creates and operates a risk pooling mechanism and ensures consumer protection.
- All individuals are eligible to obtain coverage through enrollment in an Exchange-participating health benefits plan unless they are enrolled in another qualified health benefits plan or other acceptable coverage (i.e., most federal health programs and other qualified coverage). Individuals are always eligible to enter the Exchange and purchase insurance on their own and without affordability credits so long as they are not enrolled in other acceptable coverage.
 - Participation is phased in: Year 1 – individuals not enrolled in other coverage are allowed into the Exchange and small employers with 10 or fewer employees. Year 2 – employers with 20 or fewer employees can enter. In the following years, the Commissioner has the authority to expand employer participation with the goal of allowing all employers access to the Exchange.
 - Medicaid-eligible individuals will generally be enrolled in Medicaid, not the Exchange, with the exception of childless adults with incomes under 133 percent of poverty (\$14,400 per year for an individual) who had other qualifying coverage within the previous six months. They can get coverage through Medicaid or the Exchange.
 - Once an individual or an employer enrolls in coverage through the Exchange, they remain eligible for Exchange coverage even if their circumstances change and would otherwise exclude them. Employers who offer coverage through the Exchange are required to contribute at least the required contribution toward such coverage and permit their employees the freedom to choose any plan within the Exchange. The Commissioner will conduct satisfaction surveys of individuals and employers regarding the Exchange and participating health benefits plans. The Commission also will conduct a study to determine if there are any groups and types of individuals and employers who are not eligible, but would have better and affordable benefits if they were made Exchange eligible. The report with recommendations is due to Congress in Year 3 and Year 6 and thereafter.

- The Commissioner is required to specify the benefits to be made available under Exchange-participating health benefits plans during each plan year. Each participating plan is required to provide one basic plan for such service area, then the plan has the option to offer one enhanced plan and one premium plan. The differences between the three plans are the levels of cost-sharing, not the benefits. The Commissioner establishes a cost-sharing variation range for the three plans of not more than plus (or minus) 10 percent with regard to each benefit category. In addition to the three main plans, there is the premium-plus plan, which can offer extra benefits (i.e, dental and vision). Plans may offer multiple premium-plus options and must detail the cost of the extra benefits separately. In addition, States can require the application of state benefit mandates to all participating plans, provided there is an agreement with the Commissioner that the state will reimburse the Commissioner for any additional costs of affordability credits due to the state benefit requirements.
- The Commissioner will have contracting authority including soliciting bids, negotiating with plans and entering contracts with approved plans. Participating plans must: be licensed to offer health insurance coverage; abide by data reporting requirements; provide for implementing affordability credits; participate in risk pooling; provide for culturally and linguistically appropriate communication and health services; and with respect to the basic plan, contract for outpatient services with essential community providers; and other requirements specified by the commissioner.
 - The Commissioner outlines the bid process, the term of the contract is for a minimum of one year, and the Commissioner enforces network adequacy including an allowance for enrollees to receive services out of network at no greater cost if the provider network does not meet the standards for adequacy. The Commissioner also is required to establish processes to oversee, monitor, and enforce requirements on the plans. The Commissioner has the authority to terminate plans that fail to meet required standards.
- The Commissioner shall conduct outreach activities to inform and educate individuals and employers about the Health Insurance Exchange and Exchange-participating health benefits plan options. Such outreach shall include outreach specific to vulnerable populations, such as children, individuals with disabilities, individuals with mental illness, and individuals with other cognitive impairments. Outreach activities also include a toll-free hotline, maintenance of a website, outreach materials in culturally and linguistically appropriate language, and community locations for enrollment. The Commissioner will establish an annual open enrollment period as well as special enrollment periods for special circumstances. The Commissioner is required to create an auto-enrollment process for individuals who are Exchange eligible but have not selected a plan.
 - The legislation establishes rules to ensure continuity of coverage for certain newborns in Medicaid and for children eligible for CHIP. The Commissioner is required to enter into a memorandum of understanding with State Medicaid agencies to coordinate enrollment in Medicaid and the Exchange for Medicaid eligible individuals.
- The Commissioner shall coordinate the distribution of affordability premium and cost-sharing credits as well as coordinate risk pooling so as to minimize the impact of adverse selection of enrollees among the plans offered. In addition, a Special Inspector General will be appointed by the President to prevent waste, fraud and abuse within the program. The Office will terminate five years after the enactment of the legislation.
- The Health Insurance Exchange Trust Fund is created to provide funding for the Health Choices Administration. Payments to the trust fund are amounts equivalent to taxes on individuals not obtaining acceptable coverage, employment taxes on employers not providing acceptable coverage, and an excise tax on failures to meet certain health coverage requirements.
- States may opt to offer their own Exchange or join with a group of states to create an Exchange in lieu of the national Exchange so long as the states follow the federal rules. No more than one State Exchange can operate with respect to any one state. The State-based Exchange can cease operations after giving timely notice and the Commissioner can terminate the state exchanges if they are not meeting their obligations.

Public Plan Option

- Extends high-quality, affordable health care coverage to all Americans through a genuinely competitive market in which health plans must compete on the basis of price, benefits and quality. H.R. 3200 requires the Secretary of Health and Human Services to develop a public health insurance option to be offered starting in 2013 as a plan choice within the Health Insurance Exchange.
- Competition among all payers must be on a level and equitable playing field. Appropriate measures must be taken to ensure that a potential public plan does not operate under rules and regulations that afford an unfair market advantage. According to this legislation, the proposed public plan option must compete with private plan choices, offering the same benefits, abiding by the same insurance market reforms and following provider network requirements. The public plan option outlined in this legislation is not sufficiently detailed at this time to determine whether introducing a new government-sponsored plan would enhance, maintain or hinder the benefits afforded through a free market system.
- All health plans, whether public or private, must promote delivery models that place a greater emphasis on prevention and primary care services. H.R. 3200 empowers the Secretary to move forward with delivery system reforms to change the way the public option pays for medical services to promote better quality and more efficient use of medical care.
- Tying the proposed public plan option to Medicare at the outset threatens to replicate these flaws and create a new web of administrative and structural problems for the federal government to solve. This legislation grants the Secretary of Health and Human Services broad authority to determine the need for adjustments to the plan after 3 years but does not explicitly provide for the development of a more innovative and competitive payment system.
- Physician participation in a potential public plan should not be based upon their Medicare participation. While participation in a government-sponsored plan should ideally be unambiguously voluntary, this legislation does allow physicians to “opt-out.”
- Physician reimbursement under a public plan option must reflect the market rates established in the private sector and must not be unduly suppressed as a means of containing overall costs. H.R. 3200 has taken appropriate steps to ensure that physician payments under the proposal are five percent higher than those paid by the Medicare and are not subject to unsustainable targets.