TOP LINE CHANGES
Between Tri-Committee Discussion Draft (June 19, 2009) and America's Affordable Health Choices Act of 2009
July 13, 2009

Division A – Health Reform

Medical Loss Ratio. Moves up the effective date of the medical loss ratio requirements so that, beginning in 2011, health plans are required to meet standards regarding minimum percentage of premium dollars that must be spent on medical care as determined by the Secretary of Health and Human Services (HHS).

Prohibiting Rescissions. Moves up the effective date to October 1, 2010, prohibiting rescissions of health insurance policies except in clear instances of fraud.

Temporary Reinsurance Program for Businesses Providing Retiree Health Coverage. Creates a $10 billion fund to finance a temporary reinsurance program to help offset the costs of expensive health claims for employers that provide retirees age 55-64 with retiree health care.

Administrative Simplification. Fills in the placeholder language from the discussion draft to require the Secretary of HHS to adopt criteria to standardize transactions between insurers and providers such as claims submission and eligibility determination, building on efforts from the Health Insurance Portability and Accountability Act of 1996.

Health Insurance Exchange Eligibility. Clarifies that people are always eligible to enter the Exchange and purchase health insurance on their own and without affordability credits as long as they are not enrolled in other acceptable coverage.

Eligibility for Affordability Credits. Eliminates the year five provisions in the discussion draft that allowed Medicaid-eligible individuals and those with an offer of employer-sponsored insurance the choice of going into the exchange and applying for affordability credits.

There is an affordability test exception. If employer insurance would cost an employee more than 11% of their income, they are eligible to come into the exchange and apply for affordability credits. For Medicaid eligible individuals, if they had acceptable coverage in the past 6 months, they have a choice of going to the Exchange or enrolling in Medicaid.

A new report is required of the Commissioner to study access to insurance and benefits to determine if those eligible for employer-sponsored insurance or Medicaid should be made eligible to receive affordability credits in the future.

Value of Affordability Credits. Affordability credits have been scaled back and restructured to clarify that the assistance decreases as income increases. In general, the lowest-income households receive the maximum amount of assistance, while households with incomes approaching 400% of the Federal poverty level receive very limited assistance. No assistance is available for households whose income is over 400% of the Federal Poverty level.

Coverage of Newborns Not Otherwise Insured. Clarifies a provision in the discussion draft that deems babies born without health insurance eligible for Medicaid. The initial Medicaid eligibility is for up to 60 days while a determination is completed to enroll the newborn in appropriate insurance.

Public Health Insurance Option. Clarifies that Medicare providers have a choice of being a participating provider in the public health insurance option. The bill considers Medicare providers to be participating in the public health insurance option unless they elect to opt-out of such participation. Clarifies that aggregate payments after year three should remain consistent with the initial levels, but provides flexibility for the Secretary to purse delivery system reforms, make adjustments to offset geographic variation, and adjust rates to assure competitiveness with Exchange participating plans. The public health insurance option is provided with $2 billion in startup administrative funding and receives an additional one-time investment of 3 months of reserves for claims payments to cover initial costs prior to the collection of premiums to finance claims. All of these costs shall be amortized as a part of the premiums and repaid to the Treasury.

Outreach and Information. Clarifies that information that is provided to consumers be in a culturally and linguistically appropriate manner and using plain language.

Whistleblower Protections. Establishes protections for individuals who report violations of the law and are retaliated against by their employer.

Individual Mandate. The rate of the additional tax if an individual does not obtain acceptable coverage is changed from 2 percent to 2.5 percent. The tax is applied with respect to modified adjusted gross income, which is determined by adding any tax-exempt interest or foreign earned income to the individual's adjusted gross income.

Small Employer Exemption. Exempts employers with payrolls at or under $250,000 from the healthcare contribution requirements, and establishes a graduated rate of contribution requirements for employers with payrolls of $250,000 to $400,000 if the employer elects to not offer at least the essential benefits package. The graduated rates are 2% of payroll for employers with payrolls above $250,000 to $300,000; 4% for employers with payrolls above $300,000 to $350,000; and 6% for employers with payrolls above $350,000 to $400,000.

Automatic Enrollment into Employer-Sponsored Health Insurance. Require employers offering health insurance to provide for a process to automatically enroll employees into the health plan with the lowest premium. Requires that employees be able to opt-out of the plan.

Revenue. The bill would impose a surcharge the top 1.2% of earners with adjusted gross income in excess of $350,000 (married filing a joint return) and $280,000 (single). The surcharge would be imposed at progressive rates so that for married households income in excess of $350,000 and below $500,000 would be subject to a surcharge of 1%, income in excess of $500,000 and below $1 million would be subject to a surcharge of 1.5% and income in excess of $1 million would be subject to a surcharge of 5.4%. The first two rates would be increased to 2% and 3%, in the event that certain health cost savings are not achieved. The bill also contains three revenue provisions that have been previously approved by the House of Representatives: (1) a delay in the effective date of a liberalized rule for allocating interest expenses; (2) provisions that would prevent foreign multinational corporations incorporated in tax haven countries from avoiding tax on income earned in the United States; and (3) clarification of the manner in which the economic substance doctrine should be applied by courts when deciding tax cases.

Division B – Medicare and Medicaid Improvements

MEDICARE

Part A:

Skilled Nursing Facility. Modifies the provisions directing the Secretary to improve payment accuracy for non-therapy ancillary services and therapy services.

Reductions in Medicare DSH Payments. Directs the Secretary of HHS to reduce Medicare DSH payments to the empirically justified level, plus an adjustment for uncompensated care, if the uninsured rate drops by a certain number of percentage points between 2012 and 2014. This policy will yield $10 billon in savings. There will be an additional $10 billion reduction in Medicaid DSH payments to states (see below).
Graduate Medical Education. Modifies the preference list for redistributed residency slots to include hospitals that currently operate residency programs over their cap.

Parts A & B:

Hospital Readmissions. Fine-tunes language from the discussion draft to ensure post acute providers are appropriately included.

Post Acute Bundling. Converts a demonstration from the discussion draft into a pilot program that is open to all providers and not time limited.

Elimination of the 190-day Inpatient Psychiatric Hospital Lifetime Limit. Eliminated.

Medigap Guaranteed-issue Changes. Eliminated.

Part B Premium Adjustment to Compensate for a Zero COLA. Eliminated.

Part B Premium Adjusted for Capital Gains. Allows capital gains from the sale of a primary residence to count as a life-changing event for purposes of using a more recent tax year for determination of the Part B income related premium.

Healthcare Associated Infections. Requires hospitals and ambulatory surgical centers to report public health information on healthcare-associated infections to the Centers for Disease Control and Prevention.

Extend Qualified Individuals Program. Reduced to a two-year extension like other extended provisions in the bill.

Extend Brachytherapy and Therapeutic Radiopharmaceuticals Payment at Cost. Eliminates the radiopharmaceuticals extension as CMS has proposed to permanently resolve the issue.

Part B:

Productivity Adjustments. Expands productivity adjustments to Medicare providers who receive CPI updates in addition to those that receive market basket updates. These providers are: ambulatory surgical centers, ambulances, clinical laboratories, and durable medical equipment not competitively bid.

Telehealth. Expands Medicare's telehealth benefit to beneficiaries who are receiving care at freestanding dialysis centers. Also establishes a Telehealth Advisory Committee to provide HHS with additional expertise on the telehealth program.

Quality Measures. Creates a timely process to allow for a multi-stakeholder group to provide the Secretary with input into the selection of quality measures and provides for consultation by the Secretary of a consensus-based entity in the use of quality measures.

Demonstration Program on Shared Decision Making. Uses decision aids and other technologies to help patients and consumers improve their understanding of the risks and benefits of their treatment options and make informed decisions about their medical care.

Medical Home Pilot Program. Includes physician assistants as participants of the medical home model, and adds medication therapy management services and care plan setting as applicable functions for the medical home model.

SGR Reform. Clarifies language to prevent discrimination based on specialty as to what qualifies as a primary care service for purposes of the SGR reform. Also clarifies the Accountable Care Organization language to make sure it is understood that doctors can join with hospitals and others when forming these organizations.

Payment for Imaging Services. Excludes low-tech imaging devices (including ultrasound, EKGs, and x-rays) from the adjustment in practice expense.

Study on Bone Density Payment Rates. Inserts a new study by the Institute of Medicine with regard to Medicare's payment for bone density measurement services.

IOM Study of the Appropriateness of Medicare Payment Rates Based by Geography. Within one year of enactment, the Institute of Medicine is required to report to CMS on the validity and effects of the geographic adjusters used for Medicare physician and hospital payments, and any recommendations for improvements. CMS is instructed to respond to such recommendations and may spend up to $4 billion per year, for two years, to effect any needed increases in payment rates.

Durable Medical Equipment in Medicare. Provides protections for beneficiaries receiving oxygen therapy in the event an oxygen supplier goes out of business. Exempts certain pharmacies from the surety bond requirement and the need to be accredited to sell diabetic testing supplies and certain other items.

Parts C & D:

Fully Integrated Dual Eligible Special Needs Plans. Eliminated. States with waiver programs to integrate Medicare-Medicaid benefits as of 2004 are extended through 2015.

Part D Drug Rebates. Narrows the requirement for drug manufacturers to provide rebates to drugs used by dual eligibles only. Funds raised by this provision are used to close the Part D donut hole.

Voluntary PhRMA Discounts. Incorporates the voluntary PhRMA agreement to provide discounts of 50 percent for brand-name drugs for seniors in the Part D donut hole into the bill.

Automatic Re-enrollment into Part D Low-income Subsidy. Eliminated.

Medicare Advantage Open Enrollment Period. Eliminates open enrollment period; beneficiaries can continue to enroll in Medicare Advantage during the annual election period, November 1 – December 15.

Study of Medicare Advantage Risk Adjustment. Expanded to include additional populations and require CMS to improve risk adjustment system taking into account results from such study.

Other:

Comparative Effectiveness. Amends the membership of the Comparative Effectiveness Research Commission to ensure that a majority of the members of the commission are physicians, other health care practitioners, consumers or patients and that perspectives represented on the Commission include someone with expertise in health disparities.
Fraud and Abuse. Specifies $100 million in new annual funding for the Health Care Fraud and Abuse Control fund for ten years. Incorporates technical changes recommended by CMS and the HHS Inspector General.

Reports on Financial Relationships between Manufacturers and Distributors of Covered Drugs, Devices and Biologicals or Medical Supplies. Revised to incorporate federal preemption of state laws that require reporting of the same types of payments of value or physician relationships. Wholesale drug distributors are excluded from the definition of an "applicable distributor" that must report financial relationships. National provider identifier numbers (NPIN) are collected, but not disclosed publicly. Reporting of payments associated with clinical trials may be delayed until the trial is registered with the NIH or two years, whichever is earlier.
The Secretary is directed to establish procedures for covered persons to submit corrections to incorrect data reported about them, though the responsibility for reporting correct data remains with the reporting manufacturer, distributor, hospital or other entity.

MEDICAID

Reductions in Medicaid DSH Payments. Directs the Secretary of HHS to reduce Medicaid DSH payments to States by a total of $10 billion ($1.5 billion in FY 2017, $2.5 billion in FY 2018, and $6.0 billion in FY 2019) using a methodology that considers the uninsurance rate in each State and the amount of uncompensated care provided by hospitals.

Preventive Services. Continues to require coverage of preventive services in Medicaid, but reduces enhanced federal matching rate to regular federal matching rate and maintains Medicaid cost sharing for such services.

School Based Health Clinic Services. Eliminates provision that would have required States to furnish Medicaid eligible children health services in school based health clinics.

Medicaid Payments to Primary Care Practitioners. Clarifies that physicians will receive 100 percent of Medicare rates for primary care services and other primary care practitioners will receive the Medicare rate for their services (generally 85 percent of the physician rate).

Coverage for HIV Infected Individuals. Sunsets this option on January 1, 2013, when broad-based coverage will be available through the new Health Insurance Exchange or expanded Medicaid.

CHIP 12-month Continuous Eligibility. Requires stand-alone CHIP programs to implement 12-month continuous eligibility.

Electronic Eligibility Systems. Eliminates provision that would have provided enhanced match for implementation of electronic eligibility systems to integrate Medicaid and the new Health Insurance Exchange.

Extending Drug Rebates to Medicaid MCO Enrollees. Directs manufacturers to make rebate payments to State Medicaid agencies rather than to Medicaid managed care organizations.

Additional Waste, Fraud and Abuse Provisions. Adds several provisions to prevent waste, fraud, and abuse in Medicaid.

Division C – Public Health and Workforce Development

Additional Years of Funding for Public Health and Workforce Development. Provides funds for years FY 2015 through FY 2019.

Primary Care Residencies in Community Health Centers. Establishes a new grant program to support the development and operation of primary care residency programs in community-based settings such as community health centers.

Treatment of Teaching as Obligated Service. Provides discretionary authority to the Secretary to allow up to 20 percent of teaching time to count toward meeting obligated service requirements under the National Health Service Corps program.

Data Collection and Analysis on Health Disparities. Directs a new Assistant Secretary for Health Information to set standards for the collection of data on a broad set of population and subpopulation categories and to facilitate and coordinate analyses of health disparities within HHS and in collaboration with other departments.

Community Preventive Services Grants. Clarifies that programs receiving grants that target health disparities may focus their efforts on subpopulations of racial, ethnic or other population categories.

School-Based Health Clinics. Establishes a new grants program to support school-based health clinics that provide health services to children and adolescents.

National Medical Device Registry. Establishes a national directory for class III medical devices and class II devices that are permanently implantable, life-supporting, or life-sustaining. Device information in the registry would be linked with patient safety and outcomes data from various public and private databases to facilitate analyses of post-market device safety and effectiveness.

Expanded Participation in 340B Program. Extends the section 340B discounts for certain rural and other hospitals to inpatient as well as outpatient drugs.