

HR 3200, the Senate Finance Proposal, and the HELP Proposal
“A Comparison”
Oct. 13, 2009

This document contains a brief comparison of the three health reform proposals in their current forms as of Oct. 13, 2009. This includes an analysis of the legislative language of HR3200 and the HELP proposal. The Senate Finance proposal, throughout its progression to this point, has been available in conceptual format only. To date, both HR3200 and the HELP proposal have gone through markup in committee. The Senate Finance Committee (SFC) has now completed markup of its proposal, and this analysis reflects the final SFC product, as released on Oct. 2. The House and Senate will then work independently to reconcile their respective health reform bills, and then vote on each respectively.

HR3200	Finance Proposal	HELP Proposal	ACP Policy
COVERAGE			
<p>Grace Period for Group Health Plans: With some exceptions, within a five year period starting in 2013 (Y1), an existing group health plan must meet same requirements as "qualified health benefits plans" (QHBP), including minimum benefit requirements. Individual market coverage will not achieve QHBP status unless it is grandfathered in or is purchased through Exchange.</p>	<p>Current group plans are also permitted to keep what they currently have, though these grandfathered small plans are subject to phased-in rating reforms.</p>	<p>Existing coverage will not be affected; allows new employees and family members to enroll in existing employer-sponsored health plans</p>	<p>No relevant policy</p>
<p>Insurance reforms: Prior to 2013, when insurance reforms go into effect for qualified health benefit plans (other than group plans subject to a grace period), the bill limits the consideration of pre-existing conditions by reducing “look-back periods” and pre-existing condition limitation periods. The limitations go into effect 6 months after enactment of bill (collective bargaining agreements are exempt). Pre-existing condition exclusions are also limited for individual health insurance plans. (Sutton amdt/E&C)</p>	<p>Pre-existing condition exclusion prohibitions and other rating rules likely go into effect in 2013</p>	<p>All health insurers will be barred from issuing or renewing policies based on an applicant’s health status or medical history or denying coverage due to a pre-existing condition.</p>	<p>ACP recommends that premiums should not be risk-rated for pool enrollees, and participating plans should not decline coverage for subsidy recipients enrolling through the pool. The Secretary should develop, and pool operators should use, age-based and/or other specific risk adjustment mechanisms that, without affecting enrollee premium payments, effectively compensate plans for higher-cost enrollees.</p>
<p>Guaranteed issue and renewal: Such protections shall apply to coverage purchased in the Exchange or any group health plan.</p>	<p>Guaranteed issue and renewal is required.</p>	<p>All health insurers must take all comers, especially those individuals and small employers seeking coverage for their workers. Open enrollment restrictions are permitted.</p>	<p>ACP supports guaranteed issue and renewal of health plans</p>
<p>Insurance Rating Rules: Premiums for an insured qualified health benefits plan would be based on modified community rating. Premiums can vary only by age (no more than 2 to 1), geography (premium rating area), family size.</p>	<p>Premiums would be able to vary by tobacco use, age, and family composition within certain limits such as: age 4:1, tobacco use 1.5:1, family 3:1. Geographic differences in premiums permitted. Premiums cannot vary by more than 6:1.</p>	<p>Premiums charged by health insurers should vary only by family composition, community rating area, actuarial value of the benefit, tobacco use, and age (which cannot vary by more than 2 to 1), within</p>	<p>As noted above, ACP opposes risk-rating of health care premiums and supports use of modified community rating to determine premium levels</p>

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		<p>clear and reasonable limits, unlike the current market where rates in most states may vary without limit (states will define the size of the community rating area), based on recommendations of the National Association of Insurance Commissioners and size limits created by Secretary. Rates specifically will not be permitted to vary based on gender, class of business, or claims experience.</p>	
<p>Coverage of Essential Benefits Package: QHBP must offer at least the essential benefits package. A QHBP may not impose limits (other than cost-sharing) unrelated to clinical appropriateness on the coverage of health care services and items.</p> <p>Essential Benefits Package Defined: Preventive services with no cost-sharing and professional services of physicians and other health professionals will be included in essential benefit package. Annual cost-sharing limits will also be established. Other benefits included in the essential package include hospitalization, outpatient, prescription drugs, rehabilitative and habilitative svcs, mental health and substance abuse disorder services, maternity, well-child and baby care. Children under age 21 may receive oral health, vision, hearing services, equipment and supplies.</p> <p>Cost-sharing limits in 2013 are \$5,000 for individual and \$10,000 for family. Levels shall be adjusted based on CPI-U.</p> <p>Health Benefits Advisory Committee: House language would establish an Advisory Council chaired by Surgeon General and made up of practicing providers and other health care experts to recommend a benefit package. The Secretary will determine if recommended standards should be</p>	<p>Prevention: Plans could be prohibited from applying annual or lifetime limits on benefits. Cost-sharing could be eliminated for preventive services except where value-based insurance design is used, and out-of-pocket limits for all benefit categories would be tied to current HSA standards.</p> <p>Benefits: All plans would be required to cover the following benefits: preventive and primary care (Preventive services include those recommended by the U.S. Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices), physician services, outpatient services, emergency services, hospitalization, day surgery and related anesthesia, diagnostic imaging / screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical / surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that meet minimum standards set by federal and state laws.</p> <p>Advisory The Secretary of HHS would be required to define and update the categories of covered treatments, items and services within benefit classes no less than annually through a transparent</p>	<p>For plans created under America's Health Benefit Exchange (the Gateway), the Secretary will determine recommendations on essential health benefits eligible for premium credits.</p> <p>All insurers are prohibited from imposing more than minimal cost sharing for certain preventive services including, (1) items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and (3) with respect to infants, children and adolescents, preventive care and screenings provided for the comprehensive guidelines supported by the Health Resources and Services Administration.</p>	<p>ACP supports establishment of an expert advisory committee to recommend a core set of benefits that health plans will be encouraged to offer which would be subject to Congressional approval. ACP recommends that in the exchange, coverage should be equal to a benchmark (either most popular FEHBP plan or other) or its actuarial equivalent.</p> <p>Expert advisory commission will forward annual biennial reports to Congress on essential benefits (among other issues) and the legislature will either approve or reject the recommendation.</p>

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<p>adopted.</p> <p>Adoption of benefit standards: The Secretary will determine if recommended standards should be adopted.</p>	<p>and public process that allows for public input, including a public comment period. The Secretary cannot define a package that is more extensive than the typical employer plan as certified by the Centers for Medicare and Medicaid Services, Office of the Actuary. Some flexibility in plan design is allowed but the Secretary must ensure that plan design does not encourage adverse selection. The Secretary would be required to update or modify these definitions to account for changes in medical evidence or scientific advancement or to address any gaps in access or changes in the evidence base.</p>	<p>Commission: Develops a one-time, temporary, and independent commission to advise the Secretary in the development of the essential benefit package. The essential benefits will include ambulatory patient services and preventive and wellness services, among others. The Secretary will also determine what amount of coverage is considered minimum qualifying coverage. The Secretary will release recommendations to Congress for review but the legislature will not be able to approve or disapprove of the recommendations.</p>	
<p>HI Exchange: Eventually, all employers will be permitted to buy coverage through the exchange. States have option of operating exchange, otherwise it's up to the Secretary</p>	<p>State-based "exchanges" will be established to facilitate enrollment for individuals and separately for small group. Individual and small group exchanges may be combined.</p>	<p>Grants will be offered to states (or a regional operator) to establish American Health Benefit Gateways to facilitate the purchase of qualified insurance for consumers and eligible businesses.</p>	<p>Tax credit recipients and small businesses shall be able to access the insurance exchange.</p>
<p>CO-OP plan grants: No later than 6 months after establishment of the Act, Secretary shall establish Consumer Operated and Oriented Plan to make grants and loans for the establishment of non-profit, member-run insurance cooperatives.</p>	<p>CO-OP plan grant distribution begins prior to 2012.</p>	<p>N/A</p>	<p>ACP has no relevant policy on cooperative plans</p>
<p>Individual Mandate: House language includes an individual mandate (with a hardship waiver to be determined by Secretary) for those unable to afford coverage. Mandate is in effect once market reforms and affordability credits are in effect. Penalty (or tax) will be based on 2.5% of modified adjusted gross income above a specified level. The penalty cannot exceed the applicable national average premium for that year. Mandate is enforced through tax code/returns of health insurers beginning after December 2012.</p>	<p>Beginning in 2013, individuals must acquire individual market, public program, small business coverage at Bronze level, or large group coverage that includes preventive services (with limitations) in order to meet minimum creditable coverage.</p> <p>Hardship exemption is available for individuals and select groups who are unable to afford coverage.</p> <p>The consequence for not maintaining insurance would be an excise tax of \$750 per adult in the household. This per adult penalty would be phased in as follows: For 2013, \$0; \$200 for 2014; \$400 for 2015; \$600 in</p>	<p>Individuals would be required to have qualifying health insurance (however, qualified individuals are permitted to buy nonqualified insurance offered outside of the Gateway). Those who do not acquire coverage will be required to pay a fee (minimum penalty will be no more than \$750) as determined by the Secretary. Exceptions are allowed for those who are unable to access affordable insurance or if the State in which they reside is not a participating state. The</p>	<p>ACP supports an individual mandate for legal residents provided health insurance is made affordable, employer-sponsored insurance is maintained to the greatest degree possible, fines for noncompliance are not excessive, and insurance reforms such as guaranteed issue/renewal are implemented.</p>

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	2016 and \$750 in 2017.	<p>bill alludes that an individual who purchases nonqualifying coverage outside of the Gateway will be penalized.</p> <p>Insurers are required to provide to the federal government notification of enrollee information. The Internal Revenue Service (IRS) will notify individuals without qualified coverage and provide information regarding insurance services provided through the Gateway.</p>	
<p>Employer mandate: Includes a pay-or-play employer mandate. Employers contributing will be required to meet minimum benefit and contribution requirements. HR 3200 includes exemptions for certain small businesses with an annual payroll that does not exceed \$500,000 per year. For small business above that threshold, there is a gradual increase in the penalty.</p>	<p>Employers would not be required to offer health insurance coverage. However, employers with more than 50 full-time employees (30 hours and above) that do not offer health coverage must pay a fee for each employee who receives the tax credit for health insurance through an exchange. If an employee is offered employer-provided health insurance coverage, the individual is ineligible for the tax credit for health insurance purchased through an exchange. An employee who is offered unaffordable coverage by their employer, however, can be eligible for the tax credit. Unaffordable is defined as 10% of the employee's income.</p>	<p>Employers with more than 25 employees not offering coverage (or not contributing enough towards coverage) to employees are required to make a payment to the Secretary. The annual amount is \$750 for each uninsured full-time employee and \$375 for part-time employees. For employers required to pay a fee, the first 25 employees are exempt. It is unclear if the fees allocated will be directed to the state Gateway or to another entity to fund coverage.</p>	<p>ACP supports an employer mandate once insurance is made affordable.</p>
<p>Affordability credits: For legal residents with incomes up to 400% FPL. Would limit cost of insurance to 12% at an actuarial value of 70% if the person has an income of 400% FPL</p>	<p>Premium and cost sharing credits for those with incomes between 134-300% FPL. Cost-sharing credits for people with income up to 200%. Individuals with incomes between 100-133% FPL would have option of Medicaid coverage or exchange-based coverage. Individuals between 300-400% of poverty would be eligible for a premium credit at a flat percent of income. Liability for premiums would be capped at 12% of income for the purchase of a Silver plan. Cost-sharing assistance would not be provided.</p>	<p>Legal residents ineligible for public insurance programs and with modified adjusted gross income of less than 400% FPL will be given income-related credits for the purchase of health insurance through the Gateway. The bill seems to suggest that those with incomes below 150% FPL would not be considered qualified individuals and therefore would not be eligible for credits (presumably, this income group would be made eligible for Medicaid in the SFC bill, as HELP has no</p>	<p>While the ACP paper <i>Achieving Affordable Health Insurance for All within Seven Years</i> states that the College supports advance, refundable and sliding scale tax credits to individuals up to 200% FPL and supports the creation of an expert advisory council to issue recommendations on how to expand coverage to those with incomes about 200% FPL, the College has since endorsed the House Tri-Committee legislation (HR 3200) which extends subsidies for health insurance to people with incomes up to</p>

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		jurisdiction over Medicaid).	400%. ACP policy states that credits should go to legal residents
<p>Medicaid expansion: Medicaid coverage is expanded to those with incomes below 133 1/3% FPL. Federal government pays for 100% (reduced to 90% for periods beginning with 2015) of the expansion (Ross/Blue Dog amendment/E&C). Coverage of preventive services are also mandated in the bill (Sec. 1711).</p>	<p>By 2014, Medicaid would be expanded to all with incomes up to 133% FPL. States would receive funds from federal government to assist with cost but it is unclear whether funds would cover complete cost of expansion. CBO estimates that the federal share would average about 90% of the cost of the expansion. Federal share is capped at 95% the cost of expansion.</p>	N/A	<p>Although ACP's paper <i>Achieving Affordable Health Insurance Coverage for All within Seven Years</i> states that the College supports giving states the option of expanding Medicaid to all individuals up to 100% FPL, the College has since endorsed HR 3200, which expands Medicaid eligibility to all with incomes up to 133% FPL. ACP policy also recommends that coverage expansions should be funded by the federal government and CHIP and Medicaid programs should be authorized to merge into a single program.</p>
<p>Establishment of Public Plan: Beginning in 2013: The public plan would be established and administered by the Secretary of HHS or their contracted administrator (not the Commissioner that runs the Exchange). The public plan insurance option will be available only through the Health Insurance Exchange. The Secretary shall also appoint an Ombudsman with duties similar to the Medicare Ombudsman.</p>	<p>No mention of public plan in SFC proposal</p>	<p>The HHS Secretary shall establish a Community Health Insurance Option (CHIO) through each Gateway which would offer "coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States." The CHIO will be administered by a nonprofit entity. Providers are not required to participate. The Secretary would negotiate reimbursement rates although such rates will not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Gateway. A State Advisory Council (SAC) may develop or encourage the use of innovative payment policies that promote quality, efficiency and savings to consumers. Start up funds would be provided but need to be</p>	<p>If public plan is created, ACP supports it being funded through premiums; Physician and patient participation should be voluntary; safeguards need to be in place including independent assessment of public plan's payments compared to private sector and ensuring sufficient participation by physician specialty and locale.</p>

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		paid back within 10 years; CHIO would be required to abide by the State-established solvency standard, as established by Secretary.	
PAYMENT AND DELIVERY SYSTEM REFORM			
<p>SGR: Eliminates current Sustainable Growth Rate and accumulated cost; Higher updates for primary care (separate and higher spending target for primary care). Provides GDP plus 2% for visits and consults and preventive services, GDP plus 1% for other services</p>	<p>Medicare Sustainable Growth Rate. The scheduled 21% reduction in Medicare physician payment rates in 2010 would be replaced with a 0.5% increase. Does not eliminate the “cliff” in future years.</p>	N/A	<p>ACP policy calls for SGR to be replaced with a formula that creates permanent, positive updates. Budget costs associated with elimination of the Medicare SGR cuts should be reflected in the Medicare baseline assumption going forward and not fall under pay-go rules. Link growth targets for physician services to MEI and not GDP. Provide higher update for primary care/prevention.</p>
<p>Determination of misvalued service codes: Secretary is to identify misvalued service codes and make adjustments. The Secretary is to identify misvalued codes using a variety of criteria. The numerous and expansion criteria essentially encompass any potential service, e.g. low volume codes, and codes that have not been reviewed since the Harvard study that determined the initial valuation of services. While “misvalued” is used, the emphasis is clearly on identify and correcting over-valued services, e.g. a criterion is review of service three years after its initial valuation.</p> <p>To determine appropriate changes to misvalued codes, the Secretary can:</p> <ul style="list-style-type: none"> --Accept recommendations through the existing processes—this, presumably, is a reference to the RUC process; --Conduct surveys, data collection, and other analytics; --Use conductors to identify and adjust values; --Make appropriate revisions to codes to reflect how services are provided and bundle payment; this can be done through existing processes for determining code changes—this, presumably, is a reference to the CPT Editorial Panel process. 	<p>Misvalued Relative Value Units (RVUs). Requires Secretary to periodically identify physician fee schedule services as being potentially misvalued and make appropriate adjustments to the relative values of such services. Provides criteria, including services representing new technology and services that have not been reviewed since 1992 RBRVS implementation, that would trigger review of the accuracy of the valuation that would essentially make every physician service eligible for review and correction. Adjustments to misvalued procedures would be subject to budget neutrality requirements.</p>	N/A	<p>Consistent with ACP policy.</p> <p>HR 3200 and the SFC proposal call for rigorous evaluation of all physician services to identify and correct overvalued services. HR 3200 provides more direction as to how to focus the review than the SFC approach. Under both approaches, any savings generated by correcting overvalued services would stay within the physician payment pool and be distributed through a slight increase in payments for all services.</p> <p>Neither HR3200 nor SFC proposal establish an expert panel as called for by ACP policy. CMS would not be precluded from establishing one under either approach, however.</p>
<p>Productivity Adjustment: No such language in HR 3200</p>	<p>This provision would reduce payment updates for Part B</p>	N/A	<p>ACP is unsure as to the impact of the SFC</p>

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	providers by an estimate of increased productivity.		proposal, as the current SGR system applies a reduction for an assumed increase in productivity.
<p>Medicare Commission (resembles IMAC concept)</p> <p>No such language in HR3200</p>	<p>This provision would establish an independent Medicare Commission (MC) that would submit proposals to Congress to extend Medicare solvency and improve quality in the Medicare program. Proposals would have to generate a specific level of savings (that increases annually) when the projected increase in expenditures exceeds inflation in a particular year. Congress would have an opportunity to pass an alternative proposal with an equivalent amount of budgetary savings. Congress would consider proposals from HHS if MC fails to meet its obligations. Should Congress not pass an alternative measure, the Secretary of HHS would be required to implement the provisions included in the original MC proposal.</p>	N/A	<p>The College supports the IMAC concept to implement payment reform that promotes quality and value (and not simply focus on cost). The policy calls for the IMAC to have certain elements, or safeguards that pertain to the need: for adequate physician/primary care physician representation; for sufficient time for Congress to review; to preserve the Administrative rulemaking process; and to avoid automatic draconian or overly disruptive payment cuts/changes. The SFC approach meets some of the ACP-recommended elements but overall, it is in conflict with several key policies that would need to be met for the College to support it. ACP is seeking improvements to the SFC provision. It is also seeking clarification pertaining to the MC's scope and function as the language in the provision is unclear.</p>
<p>Primary Care Bonus: Bonus payments for primary care: 5% for designated services by primary care physicians, increased to 10% in health professional shortages areas; permanent beginning in 2011, paid for by \$5 billion in "new money"</p>	<p>Primary Care and General Surgery Bonuses. Primary care practitioners in all areas would receive a primary care bonus payment of ten percent for five years. General surgeons practicing in a health professional shortage area would receive a 10% Medicare payment bonus for five years. Half of the cost of the bonuses would be offset through an across-the-board reduction in all other services of approximately 0.5%.</p>	N/A	<p>ACP has been advocating for at least a 10% bonus for all primary care services. Eligibility criteria should ensure that general internists and other primary care physicians are not excluded from receiving the bonus because the definition of primary care services excludes many services typically performed by such physicians; Funded in a way that does not require budget neutral cuts to other physicians. Accordingly, ACP continues to advocate for new money to fund a substantial bonus, emphasizing that access to</p>

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			primary care is associated with system-wide savings that are an appropriate funding source.
<p>Medical home: Patient centered medical home to be tested on a national scale. Provides \$1.5 billion to fund the pilots. Independent practice pilot restricts patient eligibility to high need only.</p>	<p>Medicaid Medical Home Projects: This proposal would create a new Medicaid state plan option for beneficiaries with chronic conditions. Medical home providers would have to demonstrate that they have the systems and infrastructure to qualify as a medical home. Providers would also be forced to report to the state on quality measures.</p>	<p>The Secretary shall establish a program to provide grants to eligible entities to establish community-based multidisciplinary, inter-professional teams (referred to in this section to support primary care practices within the hospital service areas served by the eligible entities). Grants shall be used to establish health teams to provide support services to primary care providers; and provide capitated payments to primary care providers as determined by the Secretary. A primary care provider who contracts with a community—based team must: provide a care plan for each patient participant to the community-based care team; provide the team with access to patient records; and meet regularly with the team.</p>	<p>ACP is advocating for testing of a national pilot of the medical home. An inclusive eligibility threshold should be adopted, such as the one used under the currently authorized Medicare Medical Home Demonstration that includes patients with one or more chronic conditions. There is little direct overlap between any of the three approaches. The three approaches could all be included in a final, single bill, with expanded, more inclusive eligibility for the envisioned Medicare (HR 3200) and Medicaid (SFC) programs being optimal.</p>
<p>Accountable Care Organization Pilot Program: The Secretary shall conduct a pilot program to assess various payment models designed to improve quality and decrease expenditures under Medicare Part A and B within qualified Accountable Care Organizations (ACOs).</p>	<p>The SFC proposal also mentions the creation of Accountable Care Organizations – groups of providers who work together to improve the quality of care they deliver to Medicare beneficiaries would be able to keep half of the savings they achieve for the Medicare program over a three year period.</p>	<p>N/A</p>	<p>ACP has no specific policy on ACOs, however, it has policy supporting fast-track testing of innovative payment models The ACO concept, while still somewhat undefined, has many of the elements that ACP prefers in a payment reform model. The College is working to develop more specific policy on ACOs.</p>
<p>Establishment of Medicare and Medicaid Center for Payment Innovation within CMS:</p> <p>Establishes a Center within CMS by January 2011 that tests payment models in Medicare/Medicaid to determine the effect on the cost and quality in the respective program.</p>	<p>CMS Innovation Center: Requires Secretary to create an innovation center within CMS to test, evaluate, and expand different payment structures and methodologies designed to foster patient centered care, improve quality, and slow the rate of Medicare growth; Center required to test and evaluate patient-</p>	<p>N/A</p>	<p>These proposals are largely consistent with the ACP position that Congress provide the Health and Human Services (HHS) Secretary (“the Secretary”) with the authority to conduct voluntary tests of innovative models to better</p>

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<p>In selecting models to test, the Secretary shall give preference to models determined by the CMS “professional staff” and by input from outside of CMS that the Secretary deems appropriate for which evidence shows focus on a population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Secretary shall focus on models that are expected to reduce program costs while preserving or increasing quality.</p> <p>Medicare Part B Trust Fund will provide \$350 million in 2010 to design, test, and evaluate projects, as well as to pay for additional services in the context of projects; inflation adjustment of \$350 million will be provided in 2011. For Medicaid, \$25 million shall be provided from the Treasury in 2010 and annually thereafter to fund the costs of administering projects.</p> <p>Secretary shall not require that a test project be designed to be cost-neutral to be selected for testing.</p>	<p>centered delivery and payment models; Center required to consider testing: models that promote broad payment and practice reform in primary care, including patient-centered medical homes for high need beneficiaries, medical homes that address women’s health needs, and models that transition primary care practices away from fee-for service and toward comprehensive payment</p> <p>Other criteria that would guide CMS selection of projects relevant to ACP include: varying payment based on extent to which physician advanced imaging ordering is consistent with evidence-based guidelines; home-based primary care programs led by physicians and other providers; models that promote close relationship between care coordinators, primary care practitioners, specialist physicians, and other health care providers, and allowing states to test all-payer payment reforms.</p> <p>Secretary given authority to expand the duration or the scope of any project undertaken by the center if the Secretary determines that doing so would improve the quality of patient care and reduce Medicare expenditures; Provides \$10 billion in funding over 10 years. Initial testing exempt from budget neutrality requirements.</p>		<p>align physician payment to improve quality, cost-effectiveness, and efficient patient-centered care using a fast-track process that allows for widespread adoption of the models that demonstrate success.</p>

WORKFORCE			
<p>Non-hospital training sites: Eliminates barriers for time spent by residents in non-hospital settings by changing cost-reporting rules. Also calls for OIG study on impact of training of residents in non-provider settings. And includes a demonstration project for approved teaching health centers (federally qualified health center or rural health center) to receive payment for not only the direct costs of its own GME activities for primary care residents but also for the direct costs of GME activities of its contracting hospitals in a manner similar to the manner in which payments would be made to a hospital if the hospital were to</p>	<p>The proposal would also encourage additional training in outpatient settings and ensure communities retain vital training slots if a hospital closes.</p> <p>The proposal would also provide community based training sites funding to establish and operate primary care residency programs as —Teaching Health Centers - a facility which would be a community-based, ambulatory patient care center and is establishing a new or expanding an existing primary care residency program. Grants would be awarded for up to 2 years and</p>	<p>N/A</p>	<p>This is consistent with ACP policy, as general policy is to eliminate barriers to ambulatory training.</p>

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operate such a program.	would be used to cover the costs of establishing or expanding a medical residency training program and technical assistance provided by an eligible entity.		
Advisory Council: Creation of Advisory Council Advisory to recommend workforce goals	The proposal would also establish a Workforce Advisory Committee made up of external stakeholders tasked with working with HHS and other relevant federal agencies to develop and implement a national workforce strategy.	Establishes a national health care workforce commission to review of the health care workforce and annual reports, making recommendations to Congress and the Administration on national health care workforce priorities – priorities include health workforce supply and projections, education and training capacity, implications of new and existing Federal policies (Medicare/Medicaid GME, Titles VII and VIII, NHSC, etc).	ACP calls for the federal government to develop a national health care workforce policy to ensure an adequate supply and spectrum of primary care physicians trained to manage care for the whole patient; Establish a permanent national commission on the health care workforce to provide explicit planning at the federal level by setting specific targets for increasing primary care capacity.
GME: Redistributes unused GME slots to primary care	GME: Redistributes unused GME slots to primary care	N/A	As a preliminary target, ACP recommends that the number of Medicare-funded graduate medical education positions available each year in adult primary care specialties be increased in order to graduate 3,000 additional primary care physicians each year for the next 15 years to meet the nation’s anticipated health care needs.
Federally Supported Student Loan Funds: Establishes loan repayment program in exchange for service in a Health Professional Need Area, an area that is not a HPSA, not addressed by the NHSC, but experiencing an insufficient capacity of health professionals or high needs for health services in one or more fields. For primary health service providers this means having fewer than 1 physician or other health professional per 2,000 residents in the area; Award can be no more than 50% of that paid under the NHSC loan repayment program.	N/A	Federally Supported Student Loan Funds: Reduces the rate of interest by 2% from the current rate as described in Higher Education Act (section 722 of Public Health Service Act). Also makes adjustment to section 723 related to medical schools and primary health care. Reinstates the 20/220 pathway loan deferment program.	ACP has endorsed S. 646/ H.R. 1615, which would reinstate the 20/220 pathway for loan deferment during residency.
Workforce programs: National Health Service Corps-Allows for part-time service in exchange for decreased amount of loan repayment. Also increases loan	N/A	Workforce programs: Permanently reauthorizes the National Health Service Corps; reauthorizes the Title	ACP supports increased funding for NHSC and programs under Title VII in order to meet the demands of a high

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<p>repayment amount from \$35,000 to \$50,000.</p> <p>Scholarships for Disadvantaged Students, Loan Repayments and Fellowships Regarding Faculty Positions, and Educational Assistance in the Health Professions Regarding Individuals from Disadvantaged Backgrounds</p> <p>Increases faculty loan repayments and fellowships regarding faculty positions from \$20,000/yr to \$30,000/yr.</p>		<p>VII, Sec. 747 program, Training in Family Medicine, General Internal Medicine, General Pediatrics, Physician Assistants, General Dentistry, and Pediatric Dentistry; reauthorizes the Scholarships for Disadvantaged Students.</p>	<p>performing primary care workforce.</p>
QUALITY IMPROVEMENT			
<p>PQRI: No mandate on physicians to participate. Extends the current 2% incentive payment for 2010, 2011, and 2012.</p> <ul style="list-style-type: none"> By January 2011, the Secretary shall: make feedback reports to physicians that indicate reporting accuracy and projection toward qualifying for the bonus; and establish a mechanism by which physicians can appeal bonus payment determination. By January 2012, the Secretary shall develop a plan to integrate clinical reporting on quality measures with reporting requirements pertaining to meaningful use of EHRs. 	<p>PQRI: This provision would reduce the 2 percent PQRI bonus payment in 2011 (for 2010 reporting year) that is called for in current law to a 1 percent bonus in 2011 (for 2010 reporting year) and would establish a 0.5 percent for 2012 (2011 reporting year). The provision would establish PQRI penalties for failure to successfully participate—with a 1.5% penalty for failure to report in 2012 and a 2% penalty for failure to report in each subsequent year.</p> <p>This provision would make improvements to the PQRI program: provide more timely feedback, establish a mechanism to appeal CMS determinations, allow efforts related to Maintenance of Certification to count for PQRI credit. It would also require CMS to coordinate PQRI with the requirements for demonstrating “meaningful use” of an electronic health record program in a way that is necessary to get an American Recovery and Reinvestment Act of 2009 (stimulus bill) authorized EHR incentive payment.</p>	<p>N/A</p>	<p>ACP supports the HR 3200 provisions. ACP opposes the SFC approach to institute a payment penalty for failure to successfully report beginning in 2014 as the College continues to advocate for positive and not punitive incentives. The College supports that the SFC approach would enable PQRI credit for MOC, and require CMS to coordinate PQRI reporting requirements with requirements for demonstrating meaningful use (and is pleased that the other SFC improvements overlap with the HR 3200 improvements).</p>
<p>Resource-Based Feedback Program for Physicians in Medicare [New Section Established by an amendment in E&C (AINS)] Instructs the Secretary to develop a measurement tool providing information to physicians about their resource use compared to local and national peers. The Secretary is to work with physicians and others to develop episode grouper system to</p>	<p>Expansion of Physician Feedback Report Program. Expands the Medicare physician feedback program, and penalizing physicians who utilize significantly more resources than their peers beginning in 2014.</p> <p>Budget Neutral Adjustment of Physician Payments Based on Individual Measurement of</p>	<p>N/A</p>	<p>ACP has no objection to providing physicians with confidential feedback on quality and resource use/cost. Reports must be accurate to engender physician confidence and cogent as to be actionable. ACP is concerned that the methods available to evaluate quality and cost</p>

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<p>try to more accurately measure resource use. The Secretary is to include quality data in addition to resource use/cost information. Directs the Secretary to deliver reports via physician contacts, local organizations, or by a method that allows for larger-scale dissemination. Instructs the Secretary to confidentially disseminate reports in significant scale beginning in 2011. The Secretary is to test different means for communicating results to physicians.</p>	<p>Cost and Quality. Requires CMS to beginning modifying payments to individual physicians in a budget neutral manner based on relative resource use (cost) and quality beginning in 2015 based on 2014 performance year.</p>		<p>are not yet sophisticated enough to be reliable. Accordingly, ACP has significant concern with tying payments to measurement of a physician's cost and quality in a budget neutral manner. ACP expressed strong concern about the SFC provision to make a budget neutral adjustment in payments based on the assessment of an individual physician's cost and quality.</p>
<p>Strengthening the Quality Infrastructure. The HHS Secretary shall establish and periodically update national priorities for performance improvement, to create a national consensus standard for measuring the performance and improvement of population health, or of institutional providers of services, physicians, and other health care practitioners in the delivery of health care services; defines a process in which qualified consensus-based entities are eligible to receive grants and make recommendations to the Secretary regarding performance measures; the measures are to be made available to the public; allows the GAO to conduct periodic evaluations of the implementation of the data collection processes; provides multi-stakeholder pre-rulemaking input into the selection of quality measures.</p>	<p>Additional resources would be provided to HHS to strengthen the quality measure development processes for purposes of improving quality, informing patients and purchasers, and updating payments under federal health programs. Specifically, the Secretary would be directed to develop a national quality strategy; establish an interagency working group on health care quality; provide additional resources for quality measure development and endorsement; and establish a process for HHS to work with external stakeholders, such as the National Quality Forum, to select quality measures to be included in Medicare value-based purchasing and pay-for-reporting programs.</p>	<p>HHS Secretary shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health; establish an Interagency Working Group on Health Care Quality; identify and publicly report gaps where no quality measures exist, or where existing quality measures need improvement, updating, or expansion, consistent with the national strategy; defines a process in which qualified consensus-based entities are eligible to receive grants under this section make recommendations to the Secretary regarding performance measures; disseminate quality measures; establish a public reporting process of the selected measures; collect, and validate, aggregate data on quality measures to facilitate public reporting.</p>	<p>ACP, through its role in Stand for Quality, a coalition of over 200 organizations focused on improving quality and affordability of health care, indicated support for the SFC approach in a September 2009 letter to Committee Chair Baucus. The letter also indicates the groups' interest in working with SFC to further develop quality improvement tools and support a robust data collection and aggregation mechanism.</p>
<p>Comparative Effectiveness Research: The Secretary shall establish within the Agency for Healthcare Research and Quality a Center for Comparative Effectiveness to conduct, support, and synthesize research with respect to the outcomes, effectiveness, and appropriateness of health care</p>	<p>This proposal would create a non-profit institute to provide for the conduct of comparative effectiveness research. The institute would be governed by a multi-stakeholder board that is appointed by the Comptroller General. Once fully implemented, the institute would</p>	<p>The Secretary shall establish within the Agency the Center for Health Outcomes Research and Evaluation; an entity to collect, conduct, support, and synthesize research with respect to comparing</p>	<p>ACP strongly supports establishing an entity to conduct unbiased comparative effectiveness research and disseminate the results. The College takes no position on where the entity is housed. ACP wants to see adequate</p>

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<p>services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed, clinically.</p> <p>The Secretary shall establish an independent Comparative Effectiveness Research Commission to oversee and evaluate the activities carried about by the Comparative Effectiveness Research Center. The membership of the Comparative Effectiveness Research Commission must be a majority of physicians, other health care practitioners, consumers or patients and that perspectives represented on the Commission include someone with expertise in health disparities.</p>	<p>be funded with \$600 million per year that would come from multiple sources, including mandatory appropriations, the Medicare trust funds, and a fee on health plans.</p> <p>This proposal would also include patient safeguards and provisions to prohibit the Secretary from using the research to ration care through any federal program.</p>	<p>health outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.</p>	<p>funding and preempt efforts that would unduly restrict the ability to use the information to provide better care of patients and more rational use of resources.</p>
<p>Imaging: In HR3200, beginning January 2011: the assumption on the utilization of equipment for advanced imaging services increases from the current 50% to 75%.</p>	<p>Imaging Use-Rate Assumption. The utilization rate for calculating the payment for advanced imaging equipment would be increased from 50% to 90%. The Secretary would be authorized to exempt, on a case-by-case basis, providers who were expected to face a significant hardship from the change, such as a provider who practices in a rural area.</p> <p>Imaging Self-referral Sunshine Beginning January 1, 2010, for advanced imaging and other designated health services identified by the Secretary, the referring physician who has an ownership interest must inform the individual at the time of the referral that the individual may obtain the services from another physician and provide a list of options.</p>	<p>N/A</p>	<p>ACP has long-advocated for increasing the assumed rate for advanced imaging equipment to ensure more rational payments. The College has not attempted to identify the most accurate rate. ACP appreciates the SFC sensitivity that equipment may be used less in rural areas. ACP policy calls for CMS to develop category-of-equipment-specific use assumption rates as a lower-term approach.</p> <p>ACP supported the imaging self referral sunshine concept in a May 2009 memo in response to inclusion of the provision in the April 2009 SFC options document.</p>
ADMINISTRATIVE SIMPLIFICATION			
<p>Standardize language and forms; Establish operating rules and companion guides for using and processing health care transactions; Increase consistency of claims edits and code corrections; Increase electronic exchange of administrative and clinical data; Standardize quality reporting requirements; Development of "smart card" technology; Plans must spend at least 85% of premiums on patient care instead of</p>	<p>The proposal would simplify the administration of health care by accelerating the development and adoption and implementation of standard, consensus based operating rules for four HIPPA transactions: eligibility verification, claims status, payment/electronic funds transfer, and remittance advice. The Secretary would issue a final rule concerning these four HIPPA</p>	<p>The Secretary shall adopt and maintain standards to enable administrative and financial transactions. Clear, unambiguous, authoritative, and robust standards shall be in place within two years after law's enactment. Initial standards shall: refine and expand on HIPAA transition</p>	<p>ACP strongly advocates for meaningful administrative reform. All proposals are positive but also are short on detail and require interpretation by HHS/CMS to implement. The HELP provisions are the most sweeping. The HR 3200 approach contains a unique aspect that requires plans to spend</p>

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administration	<p>transactions if they are deemed consensus based by the National Committee for Vital and Health Statistics. Health insurance plans would be required to comply with consensus operating standards by 2014 or face a penalty.</p> <p>Medicare Advantage Benefit Protection and Simplification; Uniform Exceptions and Appeals. The Mark would require sponsors of prescription drug plans and Medicare Advantage prescription drug plans to develop a uniform exceptions and appeals process by 2012.</p>	<p>standards; govern claim receipt; provide for electronic funds transfer; provide information pertaining to points in claims adjudication process, including denial management; and simplification of other requirements identified by the Secretary in consultation with stakeholders. Requires final rule on HIPAA-mandated health plan unique identifier within one year of law's enactment.</p>	<p>a minimum threshold on care as opposed to plan administration. College policy calls on this percentage to be made public but does not specify that it meet a minimum threshold.</p> <p>ACP strongly supports the SFC provision that requires uniform prescription drug exception and appeals processes as it is explicitly called for in College policy.</p>
MEDICAID IMPROVEMENTS			
<p>Medicaid coverage of preventive services is mandated in the bill (Sec. 1711).</p>	<p>Improving Access to Preventive Services for Eligible Adults. A state that opts to provide Medicaid coverage for all recommended preventive services and immunizations and removes cost-sharing for these services would receive a one percentage point increase in the federal share of its Federal Medical Assistance Percentage (FMAP) for those services.</p>	N/A	<p>ACP supports coverage of preventive services; Increasing the FMAP is also consistent with ACP policy</p>
<p>Medicaid payments for primary care: Medicaid payments to primary care physicians and practitioners for primary care services are increased/at least, 80% of Medicare rates in 2010, 90% in 2011, and 100% in 2012 and thereafter. Primary care services are defined as: office medical services, emergency department services, home medical services, skilled nursing, intermediate care, and long-term care medical services, or nursing home, boarding home, domiciliary, or custodial care medical services. This will be new spending, i.e. not through explicit offsetting cuts in Medicaid payments for other services. Specifies that physicians will receive 100 percent of Medicare rates for primary care services and other primary care practitioners will also receive the Medicare rate for their services, which is generally 80-85 percent of the physician rate).</p>	N/A	N/A	<p>ACP is supportive of increasing Medicaid payment rates for physicians to those of Medicare.</p>
MEDICAL LIABILITY REFORM			
<p>Doyle en bloc amendment /adopted in E&C: Provides financial incentives to states that enact certificate of merit and/or early offers</p>	<p>Includes a Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and</p>	N/A	<p>ACP supports imposing caps on non-economic damages; and testing and funding new models--like</p>

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<p>programs in medical liability cases. The amendment encourages the states to explore alternatives to the costly liability system through reforms that ensure court cases have merit and that allow providers to quickly compensate patients without litigation.</p>	<p>medical liability insurance; that states should be encouraged to develop and test alternatives; that Congress should consider establishing a state demonstration program to evaluate alternatives.</p>		<p>health courts, which would have cases heard by an expert panel rather than by a lay jury.</p>
NOTEABLE REVENUE PROVISIONS			
<p>Partially financed by a surcharge imposed on families with incomes above \$350,000 and individuals with incomes above \$280,000. The surcharge is equal to 1% for families with modified adjusted gross income between \$350,000 and \$500,000; 1.5% for families with modified adjusted gross income between \$500,000 and \$1,000,000; and 5.4% for families with modified adjusted gross income greater than \$1,000,000. These surcharge percentages may be adjusted if federal health reform achieves greater than expected savings (KFF.org).</p>	<p>High Cost Insurance Excise Tax. An excise tax of 40% would be levied on insurance companies and insurance administrators for any health insurance plan that is above \$8,000 for singles and \$21,000 for family plans. The tax is applied to insurance cost in excess of the threshold. Threshold amounts for retirees over the age of 55 and individuals in high-risk professions are higher. The tax would apply to employer-sponsored plans including self-insured plans. The threshold would be indexed for inflation, and a transition rule would raise the threshold by 20%, 10%, and 5% for the 17 highest cost states for the first three years.</p>	<p>N/A</p>	<p>ACP calls for cap on existing income tax exclusion for employer-sponsored health insurance to be established with insurance reforms and improved access to affordable coverage; Cap on the income tax exclusion should be set at an initial level, and updated annually to reflect insurance premium increases, maintain employment-based coverage as possible, promote cost-effectiveness and prudent use of health care, provide fair treatment to modest income workers, and should help fund expansion of affordable health care. Changes to current income tax exclusion for ESI should recognize variations in health status of covered individuals and regional variations in costs of providing medical care, health insurance benefits related to collective bargaining contracts, and the experience rating of employers offering coverage.</p>