

September 18, 2009

## SUMMARY OF SENATOR BAUCUS'S HEALTH CARE REFORM BILL: *AMERICA'S HEALTHY FUTURE ACT OF 2009*

### Background

Senate Finance Committee Chairman Max Baucus (D-MT) this week released the chairman's mark of the "America's Healthy Future Act of 2009." The health care reform bill expands health care coverage to 91 percent of those residing in the U.S. and 94 percent of legal residents, through an individual mandate, low-income subsidies, Medicaid expansion, insurance reforms, and state-based web portals, or "exchanges." The bill would not require employers to offer health insurance, but would impose a "free rider" tax on larger employers with employees that receive governmental health affordability tax credits. In addition, it calls for the creation of new non-profit, consumer owned and oriented plans (or co-ops), rather than a public plan, that would compete in the reformed non-group and small group insurance markets.

The Congressional Budget Office (CBO) scored the cost of the bill at \$774 billion over 10 years. Financing for the legislation includes taxing high-cost health insurance plans, imposing annual fees on the pharmaceutical, medical device, clinical laboratory and health insurance industries, and reducing Medicare and Medicaid provider payments.

Among the key provisions affecting hospitals, the reform bill:

- Reduces the market basket updates for inpatient and outpatient hospitals, inpatient psychiatric hospitals, inpatient rehabilitation facilities (IRF), and long term care hospitals (LTCH) by 0.25% in federal fiscal years (FY) 2010 and 2011. Beginning in FY 2012 and beyond, the market basket updates would be reduced by an annual productivity adjustment plus an additional reduction of 0.2 percent. This provision would cut payments by \$106.3 billion over 10 years.
- Reduces both Medicare and Medicaid disproportionate share hospital (DSH) payments by \$22.9 billion and \$24.9 billion respectively, which would occur only after corresponding decreases in the percentage of the uninsured are achieved. This provision would save \$47.8 billion over 10 years.
- Creates a new 15-member independent Medicare commission to submit proposals to Congress, beginning in 2015, to extend the solvency of Medicare and slow Medicare cost growth. Establishes a process where the commission's proposals to Congress would take

effect unless Congress passes an alternative measure to reduce Medicare spending. This provision would save \$22.6 billion over 10 years.

- Beginning FY 2013, hospitals with “high” readmission rates would have payments for the original hospitalization for eight select conditions reduced by 20% if a patient is re-hospitalized within seven days of the original hospitalization, or reduced by 10% if re-hospitalized within 15 days of the original hospitalization. Re-hospitalizations that were planned or unavoidable are excluded. This provision would save \$2.1 billion over 10 years.
- Establishes voluntary pilot projects to allow hospitals, physician groups, post acute entities and other providers to test bundled payment and share in Medicare cost savings. Requires evaluation and congressional approval before becoming a permanent program.
- Establishes a budget neutral, value-based purchasing program for hospital beginning in FY 2013 based on hospitals’ performance on measures that are part of the hospital quality reporting program.
- Penalizes hospitals with high risk-adjusted rates of hospital-acquired conditions beginning in FY 2014. Penalties are imposed on hospitals in the top quartile of national risk-adjusted hospital-acquired conditions. This provision would save \$1.2 billion over 10 years.
- Does not reduce indirect medical education (IME) or direct graduate medical education (DGME) payments. Includes a redistribution of unused residency training positions.
- Establishes a one-year temporary fix to physician payments, providing physicians a 0.5 percent increase in payments for 2010 rather than the scheduled 21 percent reduction. Spends \$10.9 billion over 10 years.
- Eliminates the exception for physician-owned hospitals under the whole hospital exception and rural provider exceptions under the Stark law, but grandfathers those with a Medicare provider agreement in place by November 1, 2009. Saves \$0.8 billion over 10 years.

The Finance Committee is scheduled to “mark up” the legislation beginning next Tuesday, September 22. It is likely that a number of amendments will be offered and changes will be made to the bill before it is taken to the full Senate floor.

Attached is a detailed summary of key proposals affecting hospitals.

### **Further Questions**

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HEALTH CARE REFORM BILL:  
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# SUMMARY OF SENATOR BAUCUS'S HEALTH CARE REFORM BILL: AMERICA'S HEALTHY FUTURE ACT OF 2009

## COVERAGE AND INSURANCE REFORMS

### **Insurance Market Reforms –**

*Individual Market:* Reforms for the individual market would include rules on rating (adjusted community rating), guaranteed issue, renewability, pre-existing condition, and rescission. Premiums could vary based only on age, family size, and tobacco use. A temporary high-risk pool is created immediately upon enactment for those individuals denied coverage based on pre-existing conditions. The high-risk pool terminates in 2013.

*Small Group Market:* The reform rules for the individual market apply to the small group market but will be phased in as determined by each state over five years beginning on January 1, 2013. A safe harbor is created for cafeteria health plans for small employers meeting certain requirements, including the offering of qualified long-term care insurance.

*Pooling Requirements For Individual and Small Group Markets:* State governments would be required to apply new federal premium rating requirements to the individual and small group markets. States can define the size of small group markets as being from one to 100 employees, and can merge the individual and small group markets for purposes of the pooling and rating requirements. A risk adjustment process would be required that would include such techniques as risk corridors and reinsurance to balance any adverse or favorable risk selection. The Health and Human Services (HHS) Secretary would define qualified risk adjustment models to be used by states as well as pre-qualify entities that states can use to conduct the risk adjustment. For the years 2013-2015, all health insurers would be required to contribute to a reinsurance program administered by a reinsurance non-profit entity. The National Association of Insurance Commissioners (NAIC) would develop model plans for state reinsurance programs. For plans in the individual and small group market, risk corridors would be required for the period 2013-2015 and modeled based on the risk corridors in Medicare Part D.

State insurance commissioners would define the rating areas, subject to review by the Secretary. In addition, the state insurance commissioners would oversee consumer protections, solvency requirements and other insurance reform responsibilities. Within a year of enactment, the NAIC would develop model regulation for states on all matters related to insurance market reform. The bill allows for current plans in the small group market to be grandfathered, with federal insurance rules phased in over time, and allows the interstate sale of insurance, including a national plan with uniform benefits that can be offered across state lines.

*ERISA and Collective Bargaining Plans:* The bill suggests that current ERISA plans would be exempt from the list of proscribed health benefits, except for first dollar coverage of

preventive services. However, the bill is silent on how ERISA plans and collective bargaining plans are to be treated in terms of insurance market reform.

### **Exchanges and Tax Credit Subsidies –**

*Exchanges:* States are required to establish, by 2010, state-based exchanges for the individual and small group markets. The state can have a single exchange with separate resources for the individual and small group markets. The separate small group market exchange would be known as the Small Business Health Options Program (SHOP). In the period 2010-2012, the exchange cannot offer limited benefits plans with low annual caps. All insurance plans participating in the individual and small group markets must offer their plans through the exchange and, beginning in 2013, must comply with the insurance market reforms. The functions of the exchange are largely to facilitate and manage enrollment, including the use of Web-based resources. The exchange also has responsibility for managing the tax-based premium subsidies, including eligibility determinations. The exchange does not perform risk-based operations; those responsibilities are left to federally qualified entities that states choose. State insurance commissioners would review plans offered through the exchange. States could permit multiple exchanges once the state-based exchange is fully operational. States could form interstate compacts to establish regional exchanges. In 2017 states must submit to the Secretary a plan to incorporate larger firms into the exchange (large firms as defined by state law). The exchanges will receive federal start-up funds but must become self-sustaining.

*Benefit Options:* Four benefit categories would be available: bronze, silver, gold and platinum. Plans participating in the individual and small group markets must offer, at a minimum, the silver and gold categories. All plans must include the full range of services, including: inpatient and outpatient, physician, diagnostic, maternity and newborn, pediatric, radiation, diagnostic imaging, mental health services, and first dollar coverage for preventive services. Plans cannot have lifetime or annual limits on coverage. Insurers must charge the same price for the same product offered in the service area. The minimum level of creditable coverage (MCC) is the bronze package, defined as equal to 65 percent of the actuarial level with out-of-pocket limits up to the Health Savings Account (HSA) limit (\$5,950 for an individual and \$11,900 for a family in 2010). The actuarial value reflects the share of costs for covered services that are paid by the plan. The silver benefit package would be equal to 70 percent of the actuarial value of the MCC with the same out-of-pocket limits as the MCC; the gold package would be equal to 80 percent with the same out-of-pocket limits as the MCC; and platinum would be equal to 90 percent, with the same MCC out-of-pocket limits. A “young invincible” policy would be available for those 25 or younger; this policy would be a catastrophic-only policy with levels tied to the HSA limits.

*Premium Tax Credits:* A refundable, advanceable premium tax credit would be available to individuals and families purchasing insurance through the state exchanges with incomes up to 300 percent of the Federal Poverty Level (FPL) (\$66,150 for a family of four, \$32,490 for an individual). The value of the premium tax credit is tied to the silver benefit package (reference plan). The credit is calculated on a sliding scale and would be the difference between the premium for the reference plan and the share of the individual’s income. The share of income would start at 3 percent for incomes at 100 percent FPL and rise to 13 percent for income at 300 percent of FPL. Beginning in 2013, the tax credit would be available first to those between 133 – 300 percent of FPL and in 2014 tax credits would be available to those with incomes between 100-133 percent of FPL. (Individuals with incomes

below 100 percent FPL are exempt from the individual mandate penalty and individuals at or above 100 percent to 133 percent of FPL are exempt for the first year.)

*Eligibility Verification (Undocumented Immigrants):* The state exchange has the responsibility to set up information systems with federal agencies to verify citizenship for those individuals purchasing insurance through the exchange.

*Small Business Tax Credit:* Small employers with up to 25 employees with average annual per employee wages of no more than \$40,000 would be eligible for a tax credit for the contributions to purchase employee health insurance. The value of the tax credit is based on the applicable percent of the employer's contribution toward purchasing health coverage. The maximum credit available would be 50 percent. The initial phase of the tax credit would cover 2011 and 2012. Beginning in calendar year 2013, the tax credit would only be available to small employers purchasing insurance through the state exchange.

*Abortion:* Abortion cannot be a mandated benefit as part of a minimum benefit package. No federal tax credit or cost-sharing credits could be used to pay for abortions. State laws would not be pre-empted regarding abortion, nor would federal conscience protections be affected.

#### **Shared Responsibility –**

*Personal Responsibility (Individual Mandate):* Beginning in 2013, all U.S. citizens and legal residents would be required to secure insurance, either through the individual market, public programs such as Medicare, Medicaid, TRICARE and the Veteran's Health Care Program, or their employers. Individuals, insurers and employers would be expected to report coverage status to the Internal Revenue Services (IRS).

An annual open enrollment process would be established for the individual and small group markets. Employers with 200 or more employees must automatically enroll their employees (an opt out is available if employees can demonstrate they have coverage from another source). States can establish auto enrollment programs for the state exchange.

An excise tax is the penalty for failure to secure health coverage. The annual excise tax for those with incomes from 100 – 300 percent of FPL, is \$750 for individuals and \$1,500 for families. For those with incomes above 300 percent of FPL, the penalty tax is \$950 for individuals and \$3,600 for families. Exemptions would be available based on religious objections, or for those that have an income of less than 100 percent of FPL, or for those for whom the lowest cost option net contributions or subsidies is more than 10 percent of their adjusted gross income, or for those facing hardships (as defined by the Secretary). Individuals at or below 133 percent of FPL are exempt from the excise tax for 2013.

*Employer Responsibility:* Employers are not required to offer coverage to their employees. Current tax preferences would apply if the employer offers coverage regardless of whether the employer offers coverage through the exchange. In general, employees offered coverage are ineligible for premium tax credits unless the health coverage offered is unaffordable. The test of affordability is whether the employee's premium is 13 percent of his or her income. In this case, the employee would have to seek an unaffordability waiver from the state exchange and present the waiver to their employer.

- *Free Rider Assessment* – An employer with more than 50 employees but one that doesn't offer coverage would be assessed a fee for each employee who receives a premium tax credit. The “free rider” assessment would be based on a yearly flat dollar amount set by the Secretary. The employer would pay the lesser of the flat dollar amount multiplied by the number of employees receiving the premium tax credit, or \$400 multiplied by the total number of employees.
- Medicaid-eligible employees could choose to enroll in Medicaid; the employer is not required to pay a fee to the Medicaid program or to the state exchange.

### **Cooperatives and Transparency –**

*Health Care Cooperatives:* The Consumer Operated and Oriented Plan (CO-OP) program would be established to foster the creation of non-profit, member-run, health insurance companies, using \$6 billion in federal grants and start-up funds. Qualified CO-OPs must be non-profit, cannot be an existing insurer, its affiliate or successor, and cannot be sponsored by any government instrumentality (state, county or municipality). The Secretary would award CO-OP grants with the assistance of a temporary advisory board appointed by congressional leaders. The grant awards would give preference to statewide proposals, integrated care models, and those with significant private financing. Multiple awards to CO-OPs within a state would be allowed. If a state does not form a CO-OP, the Secretary could use grant funds to encourage CO-OP formation.

*Transparency and Accountability:* States are required to create an ombudsman office to act as a consumer advocate for those in the individual and small group markets. Beginning in 2010, health plans would be required to report the proportion of premium dollars spent on non-medical care, and hospitals would be required to list all charges for all services and Medicare DRGs. The NAIC is tasked with developing, within one year of enactment, standards for insurance companies to ensure consumer information provided to enrollees accurately describes the health coverage offered.

### **Medicaid and CHIP –**

*Medicaid Program Expansion:* Beginning in 2014, the Medicaid program would expand to cover non-elderly individuals, including parents, children, and childless adults up to 133 percent of FPL (\$30,000 for a family of 4 and \$14,000 for an individual). A maintenance of effort requirement would be imposed on states for all covered populations at the time of enactment and until the state exchange is fully operational. Effective 2014, Medicaid eligibility would be based on an individual's modified adjusted gross income as defined by the state exchange (income disregards apply for certain categories such as foster children and low-income Medicare beneficiaries). Newly eligible, non-pregnant adults would receive a benchmark benefit package that would have to meet the minimum creditable coverage threshold. Also beginning in 2014, individuals with incomes below 100 percent of FPL would be eligible for Medicaid and not be eligible for premium tax credits in the state exchange. The newly eligible, non-pregnant adults with incomes between 100 – 133 percent of FPL could choose coverage from Medicaid or the state exchange with access to premium tax credits. States would be required to pay into the exchange an amount equal to the average cost of coverage for an individual in the same Medicaid eligibility group for all those choosing to obtain coverage through the state exchange. Children of parents that choose the state exchange would continue to receive Early Periodic Screening Diagnostic and Treatment (EPSDT) benefits.

*Medicaid Federal Assistance to States:* Beginning in 2014, states would receive federal assistance to help defray the cost of the newly eligible populations. Federal assistance would be in the form of an enhanced Federal Matching Percentage (FMAP) with a specified percentage point increase in a state’s FMAP. States would be divided into two groups: expansion states and other states. Expansion states would be those that covered, prior to 2014, parents and childless adults at 100 percent of FPL or above. The other states would be the remaining states that did not expand coverage prior to 2014. States that expanded coverage would receive less federal funding for the first five years of the expansion requirement. Beyond year five, all states would receive the same FMAP enhancement. No state could receive more than a 95 percent FMAP for the newly eligible populations in any year. For existing populations, the FMAP would remain unchanged.

Below is the enhanced FMAP table for the first five years of eligibility expansion.

Year	Expansion State Increase	Other State Increase
2014	27.3	37.3
2015	28.3	36.3
2016	29.3	35.3
2017	30.3	34.3
2018	31.3	33.3
2019	32.3	32.3

Beginning in 2013, states would be required to offer premium assistance and wrap around benefits to Medicaid beneficiaries offered employer sponsored coverage if cost effective.

*Children’s Health Insurance Program (CHIP):* Upon enactment, states would be required to maintain their CHIP programs until September 30, 2013. After this date, states would be required to provide children between Medicaid eligibility levels and 250 percent of FPL with wraparound coverage to supplement their coverage through the state exchange. Wraparound coverage would include EPSDT and CHIP cost-sharing protections would apply.

## **KEY DELIVERY SYSTEM REFORMS**

**Hospital Readmissions** (*Saves \$2.1 billion over 10 years*) – Beginning in FY 2012, CMS would calculate national and hospital-specific readmission rates of PPS hospitals (including Maryland) for eight conditions selected by the Secretary of Health and Human Services (HHS) based on spending and readmission rates, and would post the data on the *Hospital Compare* Web site. Beginning in FY 2013, hospitals with readmission rates above the 75<sup>th</sup> percentile nationally for selected conditions would have payments for the initial hospitalization reduced by:

- 20 percent, if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days, or
- 10 percent, if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days.

“Preventable readmissions” would be defined as all readmissions that could have been reasonably prevented, as determined by the Secretary. Certain readmissions would be excluded, such as readmissions related to cancer, trauma or burns; planned readmissions; readmissions for patients who leave against medical advice; and patients transferred to another short-term acute care hospital.

The Secretary would develop a methodology for calculating the national and hospital-specific preventable readmission rates for each condition. The calculations would be risk-adjusted for patient severity of illness, other patient characteristics, such as having a diagnosis of substance abuse or mental illness, and differences in case type.

Hospitals with readmission rates above the 75<sup>th</sup> percentile nationally for selected conditions would be subject to the readmissions payment policy for those conditions. Any payment penalties would be applied as edits to the Medicare claims processing system only after it is determined that a preventable readmission occurred within one of the specified timeframes. The payment penalty would be applied to an applicable hospital regardless of whether the patient is readmitted to the same hospital or to a different hospital.

The payment adjustment would apply only to the relevant fiscal year, based on the prior year’s performance, and would not be taken into account in calculating payments in future fiscal years. Three years after implementation of the readmissions payment policy, the Secretary would have the authority to expand the policy to include other conditions.

**Community Care Transitions Program** (*Spends \$0.5 billion over 10 years*) – Beginning in 2011, this three-year Medicare pilot program would be available to hospitals identified as having readmission rates above the 75<sup>th</sup> percentile for selected conditions.

- Hospitals serving medically underserved populations, small community hospitals and rural hospitals would be given priority for participation.
- Hospitals could elect to join the pilot program with a community-based partnership organization.
- Under the pilot program, hospitals must engage in at least one evidence-based care transition intervention, such as conducting comprehensive medication review and management, targeted toward Medicare beneficiaries who are at high risk for a readmission or a poor transition from the hospital to their post-hospital site of care.

The Community Care Transitions program would be funded at \$500 million over three years; after the three years, the Secretary could continue or expand the program if it would improve quality of care and reduce projected Medicare spending.

**National Pilot Program on Payment Bundling** (*No savings*) – The bill would require the Secretary, beginning in 2013, to develop, test and evaluate alternative payment methodologies through a national, voluntary pilot program designed to provide incentives for providers to coordinate patient care and to be jointly accountable for the entire episode of care. If the pilot program improves patient outcomes, reduces costs and improves efficiency, then the Secretary would be required to submit an implementation plan to Congress in FY 2016 to make the pilot permanent in FY 2018, although participants could remain in the program subject to the Secretary’s determination.

Prior to the start of the pilot program, the Secretary would be required to identify a patient assessment instrument that would determine the most clinically appropriate site for post-acute care for a given patient, and to develop episode-of-care and post-acute care quality measures. The Secretary also would be required to determine which Medicare statutory provisions and related regulations would be appropriate to waive in order to conduct the pilot program, such as the 60 percent compliance threshold necessary to qualify as an inpatient rehabilitation facility, or the 25-day average length of stay necessary to qualify as a long-term care hospital. The Secretary could waive other requirements, such as the anti-kickback or the civil monetary penalty statute, after consultation with the Inspector General.

The Secretary would select eight conditions to be included in the pilot program, including:

- a mix of chronic and acute conditions;
- a mix of surgical and medical conditions;
- conditions for which there is evidence of opportunity for providers to improve quality of care while reducing total expenditures;
- conditions with significant variation in readmissions and post-acute care spending;
- conditions with high volume or high post-acute care spending; and
- conditions that are deemed most amenable to bundling across a spectrum of care given current practice patterns.

The pilot program may cover inpatient and outpatient hospital services, physician services (both in the inpatient and outpatient settings), services associated with acute-care hospital readmissions, post-acute care services, and other services that the Secretary determines appropriate. The episode of care would start three days prior to a qualifying hospital admission and end 30 days after the patient's discharge. However, the Secretary would have the authority to use another timeframe if appropriate.

The bill would require the Secretary to test alternative payment methodologies for the pilot program, which would include bundled payments or arrangements in which providers continue to receive reimbursement under current payment systems, but are held jointly accountable for the quality and cost of care provided to Medicare patients. The bundled payment for each of the eight selected conditions would be based on the average hospital, physician, and post-acute care payments made over the hospitalization period. Payments would be adjusted for geographic factors (wages, practice expense), severity, and other patient characteristics, including having a major diagnosis of substance abuse or mental illness. The payment methodology would also take into account whether care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities were provided. Any Medicare provider, including hospitals, physician groups or post-acute entities interested in assuming responsibility for the bundled payments, could apply to participate. An arrangement with an acute hospital for initiation of bundled services would be required.

The pilot program's bundled payment would include the costs of any preventable readmissions that occur during the covered period. However, where a condition selected for the pilot program is also subject to Medicare's readmissions policy, hospitals participating in the pilot would be exempt from a readmissions penalty for that condition. In the case where a patient with a selected condition is readmitted for a preventable readmission at a different hospital than the initial hospitalization, the Secretary would reimburse the subsequent hospital its base operating and capital diagnosis-related group payment amounts and the

physicians at the subsequent hospital the amount that would otherwise be made if this policy did not apply. The Secretary would then adjust the bundled payment to recoup these same amounts. This payment correction would not apply to patient readmissions associated with trauma-related, and burn-related diagnoses, and other areas as outlined in the readmissions section of the bill, and as determined by the Secretary.

The Secretary would establish risk-adjusted quality measures related to care provided across all providers participating in the pilot. All providers who participate in the pilot would be required to report to the Secretary on quality measures during each year of the program.

The bill requires the Secretary to consult with representatives of small and rural hospitals, including critical access hospitals (CAHs), to determine appropriate and effective methods for hospitals to participate in the pilot program or in a similar pilot program. The Secretary should consider innovative methods of bundling, including challenges due to low volume or lack of access to post-acute care. Within two years of enactment, the Secretary would submit a report to Congress on the results of this consultation, including recommendations with respect to the appropriate application of bundling to small and rural hospitals, including CAHs.

After implementation of the pilot program, the Secretary would be required to conduct an independent evaluation of the pilot program and submit reports to Congress after two years and after three years. If the Secretary finds that the pilot program resulted in significant improvements in quality and outcomes and reductions in cost, then the Secretary would submit a plan to Congress to make the pilot permanent in FY 2018. If the Secretary finds that the pilot program did not result in significant improvements in quality and outcomes or reductions in cost, the Secretary would submit a report to Congress in FY 2016 providing recommendations on how the pilot could have been improved. In the event the Secretary determines that the pilot program results in significant improvements in quality and outcomes and reductions in cost, the Secretary may extend the pilot program for those who participated.

**Medicaid Payment Bundling** – The bill would establish a bundled payment demonstration project under Medicaid in up to eight states. Hospitals would receive and manage the bundled payment for the pre-hospital, hospital, and post-hospital services. The demonstration would begin October 1, 2011.

**Hospital Value-Based Purchasing (VBP)** (*No savings*) – The proposal would establish a VBP program to pay hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in FY 2012. The program, funded by reductions to inpatient prospective payments, is budget-neutral.

The VBP program would apply to all acute-care PPS hospitals, with certain hospitals excluded, including those that do not have a sufficient number of patients within the related conditions. The first year of the program, FY 2012, would be a data collection year. Beginning in FY 2013, hospital payments would be adjusted based on performance under the VBP program.

Measures would be selected from those used in the Medicare pay-for-reporting program, including measures for heart attack, heart failure, pneumonia and surgical care, and measures

assessing patients' experience of care. The Secretary would have the discretion to expand the list in FY 2014 and beyond and would be mandated to include measures assessing efficiency in future years. Such measures would include Medicare hospital spending per beneficiary for selected medical conditions and would be adjusted by factors including age, sex, race, severity of illness and other factors determined by the Secretary. Selected quality measures would need to be endorsed by the National Quality Forum (NQF) and agreed to by a multi-stakeholder organization, although the Secretary would have discretion to implement other measures under certain circumstances.

Funding for the program would be generated by reducing all Medicare inpatient PPS Medicare-severity diagnosis-related group (MS-DRG) payments to participating hospitals using a phased-in approach. Payments would be reduced by 1 percent in FY 2013, 1.25 percent in FY 2014, 1.5 percent in FY 2015, 1.75 percent in FY 2016, and 2 percent in FY 2017 and beyond. The reduction would be applied to all MS-DRGs but would not affect disproportionate share, indirect medical education, low-volume adjustment or outlier payments.

A hospital would be rewarded for quality improvement or quality attainment, whichever level is higher. A methodology for assessing hospital performance would be developed by the Secretary; a hospital that meets or exceeds the performance standards would be eligible to earn back the initially withheld money. A hospital's total composite performance score would be used to determine whether the hospital meets the overall performance standard. Hospitals that meet or exceed performance standards would receive value-based incentive payments.

The payment adjustment would apply only to the relevant fiscal year, based on the prior year's performance, and would not be taken into account in calculating payments in future fiscal years. Individual hospital performance on each measure would be publicly reported. An appeals process would be established to allow hospitals to contest performance score calculation and the resulting value-based incentive payments.

The program would be budget-neutral; that is, all of the money withheld to fund each year's incentive payments would be returned to hospitals. Demonstration projects would be created to test VBP models for critical access hospitals and small hospitals that do not qualify for the VBP program. Both the Secretary and the Government Accountability Office would conduct ongoing monitoring and submit reports to Congress.

**Accountable Care Organizations (ACO)** (*Saves \$4.9 billion over 10 years*) – Beginning in 2012, groups of qualifying providers – such as physician group practice arrangements, networks of practices, hospital-physician joint ventures and hospitals employing physicians – would be allowed to voluntarily form ACOs and have the opportunity to share in the cost savings they achieve for the Medicare program.

To qualify as an ACO, an organization would have to meet several criteria. For example, it must:

- Agree to become accountable for the overall care of its Medicare fee-for-service beneficiaries;
- Agree to a minimum three-year participation;
- Have a formal legal structure enabling it to receive and distribute bonuses to participating providers;

- Include the primary care physicians of at least 5,000 Medicare beneficiaries;
- Have contracts in place with a core group of specialist physicians;
- Have a management and leadership structure in place, including clinical and administrative systems;
- Define processes to promote evidence-based medicine, report on quality and cost measures and coordinate care; and
- Demonstrate that it meets any patient-centeredness criteria determined by the Secretary.

To earn incentive payments, ACOs must meet certain quality thresholds. Reporting measures would be set by the Secretary and include: clinical processes and outcomes; patient and caregiver perspectives on care; and utilization and costs. The ACO would then be able to share in any savings provided to the Medicare program at a rate determined by the Secretary. CMS would assign Medicare fee-for-service beneficiaries to ACOs based on the beneficiaries' use of services in preceding periods. Achievement thresholds and rewards for the ACOs would be established.

The Secretary would be required to set a minimum threshold of savings that would need to be achieved by the ACO before savings would be shared. Spending benchmarks would be based on total Medicare spending in the most recent three-year period for the beneficiaries that belong to the ACO, plus a dollar amount equal to the risk-adjusted average expenditure growth for beneficiaries nationally. The benchmark would be re-set at the end of the three-year period.

**Medicare Commission** (*Saves \$22.6 billion over 10 years*) – The bill would establish an independent Medicare commission that would develop and submit proposals to Congress to extend the solvency of Medicare, slow Medicare cost growth, and improve the quality of care delivered to Medicare beneficiaries. The commission would be composed of 15 members appointed by the President and confirmed by the Senate, who would serve six-year terms. Congressional leaders each would recommend three appointees to the President, but the President would not be required to nominate them. Qualifications would be similar to those for members of the current Medicare Payment Advisory Commission (MedPAC), but MedPAC would continue to exist in its current form and advise Congress.

If, beginning in 2013, growth in Medicare per-capita spending were projected by the CMS Office of the Actuary to exceed growth in the average of the Consumer Price Index (CPI) and the CPI-Medical in 2015, the commission would be required to submit a proposal to Congress by January 1, 2014 that would reduce excess cost growth by 0.5 percentage points in 2015. The commission would submit a draft of its proposal to MedPAC and CBO by September 1, 2013. By April 1, 2014, the Senate Finance Committee, along with the relevant House committees, would be required to report out either the commission's proposal or an amended proposal that achieves the same level of reductions in excess cost growth. The bill would require the package to be brought to the floor within 15 days of being reported by a committee. If a package that meets the level of Medicare savings described above is not enacted by August 15, 2014, the bill would require the commission's original proposal to go into effect automatically.

The bill would require the Commission to make additional proposals on January 1 of 2015, 2016 and 2017, based on the procedures described above. However, the targeted level of Medicare savings would increase each year:

- the proposal delivered to Congress in 2015 would be required to reduce excess cost growth by 1.0 percentage point in 2016.
- the proposal delivered to Congress in 2016 would be required to reduce excess cost growth by 1.25 percentage points in 2017
- the proposal delivered to Congress in 2017 would be required to reduce excess cost growth by 1.5 percentage points in 2018.

In any year where excess cost growth is not projected, the commission would not be required to submit a proposal to Congress with a specific savings target, but would submit purely advisory proposals that fall under the commission's purview. These advisory proposals would not automatically go into effect absent congressional action. In 2019, the bill would require Congress to pass a joint resolution to continue further proposals and subsequent action by the commission.

**Medicare Hospital Wage Index** – The bill would require the Secretary to provide a plan to Congress by December 31, 2011, to comprehensively reform the Medicare hospital wage index. This plan would take into account the goals in the June 2007 MedPAC report, including establishing a new hospital compensation index system that:

- uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages;
- minimizes wage index adjustments between and within metropolitan and statewide rural areas;
- includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;
- analyzes the effect that implementation of the proposal would have on health care providers and on each region of the country;
- addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of implementation of policy in this section; and
- provides for a transition period.

**CMS Innovation Center** – The bill would require the Secretary to create an Innovation Center within CMS. The Innovation Center would be authorized to test, evaluate, and expand different payment structures and methodologies that aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. Payment models would be evaluated based on, for example, coordination of services across settings, reductions in preventable hospitalizations and the prevention of hospital readmissions, and reductions in emergency room visits. The tested models would be exempt from budget neutrality and CMS would be able to terminate, modify, and expand the scope or duration of the models. One of the models that could be tested would be a new continuing care hospital that offers inpatient rehabilitation, long-term care, and home health or skilled nursing care after an inpatient stay. The bill would appropriate \$10 billion over 10 years for these activities.

**Extension of Gainsharing Demonstration** – Section 5007 of the *Deficit Reduction Act of 2005* authorized a gainsharing demonstration. The three-year demonstration was delayed, with the first projects awarded 19 months late. To compensate for the delay, all of the deadlines under the demonstration project have been pushed forward by an equal amount of

time, so that HHS' final report to Congress would be due September 30, 2012. Additional funding of \$1.6 million would be appropriated in FY 2010.

**Physician-Owned Hospitals and Self-Referral** (*Saves \$0.8 billion over 10 years*) – The bill includes provisions amending the *Ethics in Patient Referrals Act*, better known as the “Stark” law, by cutting off the ability of physicians to self-refer to hospitals in which they have an ownership interest if those hospitals were not operating with a Medicare provider number by November 1, 2009. Existing hospitals meeting that requirement would be “grandfathered” and allowed to continue to self-refer, subject to certain conditions. The grandfathering exception includes several conditions for those physician-owned hospitals such as:

- Ethical investment practice rules to ensure bona fide investment and proportional returns on investment;
- Disclosure of physician ownership interests in hospitals to patients at the point of referral and again at the earliest point of an admission, to the public through notices on the hospital's Web site, and in reporting to CMS, which is charged with providing ownership information on its Web site;
- Patient safety requirements to ensure that such hospitals are capable of responding appropriately to complications or emergencies and safely transferring patients who need care beyond their ability, as well as patient disclosure at admission if the hospital does not have 24-hour/7-day onsite physician coverage; and
- Required approval by HHS of any increase in the number of operating rooms, procedure rooms and beds, as well restrictions on growth overall and conditions that must be met.

**Administrative Simplification** – The bill would accelerate the development, adoption, and implementation of a set of operating rules for each HIPAA transaction for which there is an existing standard, in order to reduce the significant variations in how health plans and clearinghouses have implemented transaction standards. The operating rules would be developed by a non-profit entity through a consensus-based process involving all stakeholders. They would then be reviewed by the National Committee on Vital and Health Statistics (NCVHS), and adopted by the Secretary through interim final rules. The bill would add the electronic funds transfer (EFT) of health claims payments as a HIPAA transaction and provide for the adoption and enforcement of a standard for EFT.

The first priority would be the adoption of a single set of operating rules for eligibility verification, claims status, claims remittance/payment, and electronic funds transfer. The bill also would require adoption of unique health plan identifiers and development and adoption of those HIPAA transactions that have never been implemented, such as claims attachments, enrollment/disenrollment, health plan premium payments, and referral certification and authorization. Aggressive timelines are set for adoption of these operating rules, spanning July 1, 2011 to July 1, 2014. Specific target dates are also set by which health plans must certify their compliance with the standards and operating rules in groupings of specific requirements that span December 31, 2013 through December 31, 2015. Failure to do so would result in penalties assessed on the health plans. An enhanced enforcement process would also include a more rigorous complaint review and resolution process, also with penalties against health plans demonstrated to be not in compliance.

The bill also establishes an NCVHS process for reviewing, updating, and improving standards and operating rules.

## **MEDICARE AND MEDICAID PAYMENT CHANGES**

### **Disproportionate Share Hospitals (DSH) –**

*Medicare DSH Changes (Saves \$22.9 billion over 10 years):* Beginning in 2015, the bill would cut DSH payments to 25 percent of the current level of DSH payments, or the “empirically justified” amount of DSH as defined by MedPAC. However, a new payment would be made to hospitals to reflect their continuing uncompensated care costs. This new payment would be equal to 75 percent of current DSH funds and phase out proportionally as the percentage of uninsured is reduced. Funding for the payment would come from the difference between the 25 percent level and the amount under current law. For every percentage point reduction in the uninsured in each period, the percent of funding would be reduced by a proportionate amount. The Secretary would calculate the insurance coverage levels in 2015, 2016 and 2017. In 2018, the Secretary would use the most recent Census Bureau data.

*Medicaid DSH Changes (Saves \$24.9 billion over 10 years):* State Medicaid DSH allotments would be reduced based on the decrease in the rate of the uninsured in each state. Once a state’s uninsured rate decreases by 50 percent, using Census Bureau data, the state DSH allotment would be reduced by 50 percent. After this point, state DSH allotments would continue to be reduced if the rate of uninsured continues to decline. The DSH allotment reduction is the product of the percentage point reduction in uninsurance multiplied by 35 percent. No state DSH allotment could fall below 35 percent of the 2012 DSH allotment level plus CPI.

Low DSH states would have their allotments reduced by 25 percent when they hit the trigger of a 50 percent decrease in the rate of uninsurance. Low DSH allotments would be further reduced by the percentage point reduction in uninsurance, multiplied by 17.5 percent. The same DSH allotment floor of 35 percent of the 2012 DSH allotment level plus CPI applies to low-DSH states.

Any portion of a state’s DSH allotment that is currently being used to expand eligibility through a section 1115 waiver is exempt from DSH reductions. Five states are reported to have such 1115 waivers.

### **Medicare Market Basket Reductions (Saves \$106.3 billion for hospitals over 10 years) –**

The bill reduces annual updates for inpatient and outpatient hospital services, inpatient psychiatric facilities, inpatient rehabilitation facilities, and long-term care hospitals by the full market basket minus 0.25 percentage point in FYs 2010 and 2011. Starting in FY 2012, the updates for these hospitals would be market basket minus an adjustment for “productivity” growth and minus an additional 0.2 percentage point. These updates would continue through FY 2019. Productivity for FY 2010 is estimated by MedPAC at 1.3 percent, but would be projected every year. In any year from 2014 through 2019, the 0.2 percent reduction amount could be “given back” to hospitals if the percentage of the population that is insured is more than five percentage points below projections at the time of the bill’s enactment.

Adjustments for productivity growth would be applied to all Part A providers who are subject to annual market basket updates and to Part B providers who receive consumer price index

(CPI) updates. Productivity adjustments would begin in 2012 for skilled nursing facilities, 2013 for hospice services, 2015 for home health agencies and in 2011 for all other Part A and Part B providers.

Home health agencies would receive a 1 percentage point cut to their update in 2011 and 2012. Hospices would receive an additional 0.5 percentage point cut on top of the productivity adjustment starting in 2013. However, this reduction of 0.5 percent could be “given back” in 2014 through 2019 if the percentage of the population that is insured is more than 5 percentage points below projections at the time of the bill’s enactment.

#### **Payments to Rural Hospitals –**

*Payment Adjustment for Low-Volume Hospitals (Spends \$0.3 billion over 10 years):* The bill would improve the low-volume adjustment by making a temporary add-on payment for low-volume hospitals for FY 2011 and FY 2012. A low-volume hospital is more than 15 road miles from another comparable hospital and has up to 2,000 Medicare discharges. The add-on payment would be determined by the Secretary using a linear sliding scale ranging from 25 percent for low-volume hospitals with Medicare discharges below a certain threshold, to no adjustment for hospitals with more than 2,000 Medicare discharges.

*Demonstration Project on Community Health Integration Models:* The bill would revise the demonstration project created by *The Medicare Improvements for Patients and Providers Act of 2008* that allows eligible entities to develop and test new models for the delivery of health care services in certain rural counties for the purpose of improving access to, and better integrating delivery of, acute care, extended care, and other essential health care services to Medicare beneficiaries. The bill would remove the existing cap on the number of counties that can participate in each state. It would also allow physician services to be included within the scope of the demonstration.

*Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas:* The bill would require the Medicare Payment Advisory Commission (MedPAC) to report to Congress on Medicare payment adequacy for rural health care providers by January 1, 2011. MedPAC would analyze rural payment adjustments, beneficiaries’ access to care in rural communities, adequacy of Medicare payments to rural providers, and quality of care, and would make recommendations on appropriate changes to rural payment adjustments.

#### **Payments to Physicians –**

*Sustainable Growth Rate (SGR) (Spends \$10.9 billion over 10 years):* The bill would set the conversion factor update, used to determine payments under the physician fee schedule, to a 0.5 percent increase in 2010, thus avoiding the 21 percent reduction in physician fees slated to take effect in 2010. The proposal would not provide a permanent solution for the SGR payment problem, but provides one year of relief. After 2010, the formula would determine fee schedule updates. A 25 percent reduction is estimated for calendar year 2011.

*Extension of Floor on Medicare Work Geographic Adjustment (Spends \$1.1 billion over 10 years):* The bill would extend the 1.00 floor for the geographic index for physician work under the physician fee schedule for an additional two years through December, 2012.

*Misvalued Relative Value Units:* The bill would require the Secretary of HHS to periodically identify physician services as being potentially misvalued, and make appropriate adjustments

to the relative values of such services under the Medicare physician fee schedule. Adjustments to misvalued procedures would be subject to budget neutrality requirements.

*Extension of Treatment of Certain Physician Pathology Services under Medicare (Spends \$0.2 billion over 10 years):* The bill would extend until January 1, 2012, the grandfathering provision that allows certain independent laboratories to receive direct payments for the technical component for physician pathology services that are furnished to certain hospital inpatients and outpatients.

*Medicare Diabetes Self-Management Training:* The bill would recognize state-licensed or registered health care professionals who are certified diabetes educators as Medicare providers of diabetes outpatient self-management training services.

#### **Payments to Home Health Agencies –**

*Rebasing Payments:* Starting in CY 2013, the bill requires the Secretary to rebase home health payments to reflect the number and mix of home health services, the level of intensity of services and the average cost of providing care, as well as differences between hospital-based and freestanding home health providers and urban/rural providers. The new system is to be phased in over four years, as follows: 25 percent of payment of the standard payment would be rebased in CY 2013; 50 percent in CY 2014; 75 percent in CY 2015, and 100 percent in CY 2016. Annual adjustments in Medicare home health spending would be no greater than 3.5 percent per year during this transition. MedPAC would be directed to report to Congress in CY 2014 and CY 2016 on the impact of the new system.

*Cap on Outlier Payments (Saves \$6.8 billion over 10 years):* Starting in CY 2011, the bill would have the Secretary establish a provider-specific cap on annual outlier payments at 10 percent of annual revenues.

*Reinstatement of Rural Home Health Payment Adjustment (Spends \$0.5 billion over 10 years):* The bill would provide a 3 percent add-on payment from CY 2010 through CY 2015 for rural home health agencies.

*Study to Ensure Access to Care and Quality Services:* The bill would require the Secretary, with input from stakeholders, to conduct a study and provide a report to Congress by March 2011 on the costs and quality of home health care, including recommendations on reforms to payments and case mix adjustments. In addition, by January 2012, the Secretary would establish a temporary Medicare payment adjustment of up to 3 percent to ensure access to care for beneficiaries with high severity of illness or to improve access to care for low-income or underserved beneficiaries. Payments made on this basis would not exceed \$500 million over the 10-year period.

**Payments for Hospice** (Saves \$0.1 billion over 10 years) – Beginning in 2011, the bill would require the Secretary to collect additional data and information in order to revise hospice payments in FY 2013, after consulting with stakeholders and MedPAC. The Secretary would be required to implement changes to the hospice payment methodology as appropriate based on the data collected. Any changes would be budget neutral. In addition, hospices would be required to have patients visited by a physician or advanced practice nurse prior to the 180<sup>th</sup> day and for subsequent re-certifications to assess medical need for continued stays. For certain hospices with high rates of stays over 180 days, all stays exceeding 180 days would require medical review by CMS.

**Payments to Hospitals in Puerto Rico and the Territories** – The bill would increase Medicaid spending caps for the territories by 30 percent. Also, the bill would raise the applicable Federal Medical Assistance Percentage (FMAP) by five percentage points – to 55 percent – beginning on January 1, 2011, for territories. The cost of covering newly eligibles would not count toward the spending caps.

**Treatment of Certain Cancer Hospitals** – Under the bill, the Secretary would be required to conduct a study to determine whether the outpatient costs incurred by non-PPS cancer hospitals exceed those incurred by PPS hospitals. If the costs in the non-PPS cancer hospitals are “excessive,” the Secretary would be required to adjust payments for those services starting January 1, 2011. No payment rates could be adjusted downward after the study.

**Payments for Imaging Services** (*Saves \$3 billion over 10 years*) – The bill would reduce payments under the physician fee schedule for advanced imaging services by assuming a higher rate of utilization of equipment in the calculation of the fee schedule reimbursement rate from 50 percent to 65 percent for 2010 through 2013. The bill would also require that HHS conduct a study by January 1, 2013 on the impact of this change on beneficiary access and utilization, and its estimated savings over 10 years. In addition, the bill would increase the payment reduction from 25 percent to 50 percent for the technical component of services when sequential imaging services on contiguous body parts are furnished during the same encounter.

**Durable Medical Equipment, Prosthetics and Supplies (DMEPOS)** (*Saves \$.8 billion over 10 years*) – The bill would eliminate the 2 percent add-on to the annual update for DMEPOS payments in 2014. Starting in 2010, the bill would limit the option to purchase a power-driven wheelchair with a lump sum payment. A lump sum payment could only be used for complex rehabilitative power wheelchairs. In addition, certain pharmacies would be exempted from CMS’ accreditation requirements for DMEPOS suppliers. The number of metropolitan areas for round two of the DMEPOS competitive bidding program (beginning in 2011) would be expanded from 79 to 100 of the largest metropolitan statistical areas (MSA), and to remaining areas by 2016. Certain areas, such as rural areas, would remain exempt.

**Medicare Extenders** –

*Hospital Outpatient Department (HOPD) Hold Harmless Payments* (*Spends \$0.4 billion over 10 years*): The bill would extend the HOPD hold harmless payments for small rural hospitals for two additional years, through 2011. It would also make sole community hospitals eligible to receive these hold harmless payments. For 2010 and 2011, these hospitals would receive 85 percent of the difference between outpatient PPS payments and those that would have been made under the prior reimbursement system.

*Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals* (*Spends less than \$50 million over 10 years*): Reasonable cost reimbursement for clinical diagnostic laboratory services for qualifying rural hospitals with fewer than 50 beds would be reinstated

beginning July 1, 2010 and extended for two years, ending July 1, 2012.

*Increased Payments for Ambulance Services under Medicare (Spends \$0.1 billion over 10 years):* The bill would extend the existing add-on payment for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas through December 31, 2011.

*Payment Adjustment for Medicare Mental Health Services (Spends \$0.1 billion over 10 years):* The bill would extend the 5 percent increase in Medicare physician payments for certain mental health services through December 31, 2011.

*Medicare Rural Hospital Flexibility Program:* The bill would extend the Medicare Rural Hospital Flexibility Program through 2012. *The Balanced Budget Act of 1997* established this program, which created CAH designation under Medicare and authorized a grant program that is administered by the Health Resources and Services Administration.

*Rural Community Hospital Demonstration Program:* The bill would extend the Rural Community Hospital Demonstration Program for an additional two years, through December 31, 2011, increase the maximum number of participating hospitals from 15 to 30 and expand the eligible sites to rural areas in *all* states. *The Medicare Prescription Drug, Improvement and Modernization Act of 2003* created this five-year demonstration program to test the feasibility and advisability of reasonable cost reimbursement for rural hospitals with fewer than 51 beds.

*Medicare-dependent Hospital Program (Spends \$0.1 billion over 10 years):* The bill would extend the Medicare-dependent hospital program for two years, through September 30, 2013.

*Section 508 Reclassifications (Spends \$0.5 billion over 10 years):* The bill would extend Section 508 wage index reclassifications for inpatient PPS through September 30, 2011.

*Therapy Caps (Spends \$1.8 billion over 10 years):* The bill would extend the exceptions process for outpatient therapy caps for two years, through December 31, 2011. These caps do not apply to hospital outpatient therapy departments.

*Extension of Long Term Care Hospital Provisions (Spends \$0.2 billion over 10 years):* The bill would extend for two years selected long-term care hospital (LTCH) provisions in the *Medicare, Medicaid and SCHIP Extension Act of 2007*. This provision would further delay full implementation of the 25 Percent Rule, the short-stay outlier cut, and the one-time budget neutrality adjustment planned by CMS. The current moratorium on new LTCH beds and facilities, with exceptions, would also be extended.

**Improvements to Medicaid** – The bill includes numerous provisions to improve the Medicaid program. Hospitals participating in the Medicaid program would be permitted to make presumptive eligibility determinations beginning January 1, 2014. New requirements would be imposed on states regarding transparency, development, implementation and evaluation of 1115 waiver and state plan amendments. The bill makes several changes to the Medicaid drug rebate program, including requiring drug manufacturers to pay rebates for beneficiaries in managed care plans. An office of coordination for dual eligibles would be created within the Centers for Medicare & Medicaid Services.

**Medicaid and CHIP Payment Assessment Commission (MACPAC)** – MACPAC’s initial charge to review how payment policies affect children’s access to care would be expanded to include adult access to services, including dual eligibles.

## **GRADUATE MEDICAL EDUCATION AND WORKFORCE**

**Graduate Medical Education (GME)** – (*Spends \$1 billion over 10 years*)

*Indirect Medical Education (IME):* The bill does not propose any changes to existing Medicare IME payments to teaching hospitals.

*Redistribution of Unused Residency Positions:* The legislation would redistribute unused residency training slots as a way to encourage increased training of primary care physicians and general surgeons. With limited exceptions, the *Balanced Budget Act of 1997* capped the number of residents that Medicare will recognize for direct graduate medical education (DGME) and IME at a teaching hospital’s 1996 level. *The Medicare Prescription Drug Improvement and Modernization Act of 2003* authorized a redistribution of resident cap positions effective July 2005. This proposal would be the second time that residency positions are re-allocated.

Under the bill, hospitals would lose 80 percent of their unused or unfilled residency positions (based on the past three years) and qualifying hospitals would be able to request up to 75 new slots. Certain hospitals, including rural teaching hospitals with fewer than 250 beds, would be exempt from redistribution of any of their unused slots. The new positions would be distributed within two years after enactment.

Priority for the new slots would be given to:

- hospitals that demonstrate the likelihood that they would fill the positions within three cost report periods, beginning on or after July 1, 2010;
- hospitals that take part in innovative delivery models that promote quality and care coordination, such as payment bundling;
- hospitals that have an accredited rural training track residency program;
- hospitals in states with resident-to-population ratios in the lowest quartile;
- hospitals that are located in the top 25 states in terms of population living in a health professional shortage area (HPSA); and
- hospitals located in rural areas.

Hospitals receiving additional slots would be required to maintain at least their current level of primary care residents in their training programs over the average of the three most recent years. Additionally, at least 75 percent of the increased positions would be designated for primary care or general surgery. The redistributed slots would receive full DGME payment but only half of the current IME payment adjustment (i.e., 2.7 percent vs. 5.5 percent).

*Promoting Greater Flexibility for Residency Training Programs:* In order to help promote training in outpatient settings, the bill would provide increased flexibility in the laws and regulations governing GME funding. Currently, hospitals are reimbursed for DGME only if

they incur “all, or substantially all” of the costs for the training program in that setting. Effective for cost reporting periods beginning on or after July 1, 2010, if the hospital continues, or in the case of a jointly operated residency program the involved entities continue, to incur the costs of a resident’s stipends and benefits, then all time spent by a resident in patient care activities in a *non-hospital setting* will count towards Medicare IME and DGME payment.

*Counting Resident Time:* Under certain conditions, hospitals have been allowed to count toward hospital DGME and IME payments the time residents spend training in sites that are not part of the hospital. Currently, hospitals may receive Medicare payments only if residents spend their time in patient care activities. The bill would allow DGME reimbursement for certain non-patient care activities in non-hospital settings, including didactic conferences and seminars, but would not include research that is not associated with the treatment of a particular patient. The Secretary would determine appropriate effective dates. In addition, Medicare would count all vacation, sick leave and other approved leave spent by resident in an approved training program as long as the leave time does not extend the program’s duration. For IME payments, Medicare would adopt the same rules about counting residents’ leave time.

*Resident Cap Positions from Closed and Acquired Hospitals:* Currently, if a teaching hospital closes, the resident cap positions associated with it are eliminated. The bill would allow the residency caps from closed hospitals to be distributed to other hospitals based on the following priority order:

- hospitals located in the same or contiguous core-based statistical area;
- hospitals located in the same State;
- hospitals located in the same region of the country;
- priorities determined under the section on redistribution of unused GME slots.

Special rules for acquired hospitals would be established.

## **Workforce –**

*National Workforce Strategy:* The bill creates a Workforce Advisory Committee to develop a comprehensive and coordinated national strategy to address workforce shortages and encourage training in key areas. The committee will examine the current and projected health care workforce supply; the current and projected demand for health professionals; the health care workforce education training capacity; the implications of new and existing federal policies that will affect the health care workforce; and the health care workforce needs of specific populations. In addition, the committee would report on specific topics including efforts to integrate the health care workforce into a reformed delivery system, the implications for the health care workforce as a result of greater utilization of health information technology, nursing workforce capacity, mental and behavioral health care workforce capacity, and the geographic distribution of health care providers.

The committee would be comprised of external stakeholders and representatives of health professionals, schools of higher education for health professionals, public health experts, health insurers, business, labor and any other health professional organizations as the Secretary determines appropriate, and would consult with relevant federal agencies, such as HRSA, as well as state and local entities. The committee would present biannual reports to Congress and others outlining its findings and policy recommendations.

*Demonstration Project to Address Health Professions Workforce Needs:* The bill creates a demonstration grant program to provide low-income individuals the opportunity to receive education and training for occupations in high demand health care fields.

*Primary Care/General Surgery Bonus (Spends \$1.6 billion over 10 years):* The bill would establish a new 10 percent bonus on certain evaluation and management codes under the Medicare fee schedule for five years, beginning January 1, 2011. The groups of codes would be office visits, home visits, nursing facility visits and rest home or custodial care services. The bonus would be available only to primary care practitioners in the specialties of family medicine, internal medicine, geriatric medicine, pediatric medicine, advanced practice nursing and physician assistants who furnish 60 percent of their services in these codes. Qualifying practitioners providing care in a HPSA would also receive the 10 percent bonus on hospital visit codes that are typical of primary care medicine, though only 10 percent of these visits would count toward the 60 percent threshold. In addition, general surgeons providing care in a HPSA would also be eligible for a 10 percent bonus on major procedure codes for five years, beginning January 1, 2011. Half of the cost of the bonuses would be offset through an across-the-board reduction to all other codes, except for physicians who primarily provide services in a HPSA zip code.

*Permitting Physician Assistants to Order SNF Services (Spends less than \$50 million over 10 years):* The bill would allow a physician assistant who does not have a direct or indirect employment relationship with a skilled nursing facility (SNF), but who is working in collaboration with a physician, to certify the need for SNF services, beginning January 1, 2010.

*Recognizing Attending Physician Assistants to Serve Hospice Patients (Spends less than \$50 million over 10 years):* Beginning January 1, 2010, the bill would allow physician assistants to develop a hospice written plan of care. However, only physicians would be able to certify an individual as terminally ill.

## **QUALITY, DISPARITIES AND COMPARATIVE EFFECTIVENESS**

**Reducing Hospital-acquired Conditions (Medicare)** (*Saves \$1.2 billion over 10 years*) – The proposal would apply a new financial penalty to hospitals with high risk-adjusted rates of hospital-acquired conditions. Beginning in FY 2013, the Secretary would calculate national and hospital-specific rates of hospital acquired conditions, share these data with hospitals, and post the data on the *Hospital Compare* Web site. Beginning in FY 2015, hospitals in the top quartile of national hospital-acquired condition rates would receive 99 percent of their otherwise applicable Medicare payments. The payment adjustment would apply only to the relevant fiscal year, based on the prior year's performance, and would not be taken into account in calculating payments in future fiscal years.

The Secretary would determine the definition of a hospital-acquired condition. It is unclear whether the conditions in the current Medicare hospital-acquired condition policy would be included. The bill does not specify how the rates would be risk adjusted, or whether the payment penalty would apply to all of the hospital's Medicare IPPS payments or only to payments for patients with the selected hospital-acquired conditions.

**Reducing Health Care-acquired Conditions (Medicaid)** – The proposal prohibits payments to states for Medicaid services related to health care- acquired conditions. The Secretary would identify conditions consistent with Medicare, but would not be limited to conditions acquired in hospitals. The Secretary would consider existing state policies that limit payment for health care acquired conditions.

**National Strategy to Improve Health Care Quality** (*Spends \$0.3 billion over 10 years*): – The bill calls for the Secretary to establish a national quality improvement strategy that includes priorities to improve care delivery, patient outcomes, and population health. It would also include a comprehensive strategic plan to achieve priority improvements and coordinating activities among HHS agencies. To develop these priorities, the Secretary must consider the recommendations of a national consensus organization, such as the National Quality Forum (NQF), which must convene a multi-stakeholder group that includes hospitals, doctors, payers, nurses, post-acute care providers, health plans, consumers, and others. The national strategy would be updated every three years at most, with the first report due to Congress on December 31, 2010, and the selected priorities would become the basis for further work to develop and implement measures to foster improvement and public reporting.

**Value-Based Purchasing for Home Health Agencies and SNFs** – The Secretary would be directed to submit to Congress value-based purchasing implementation plans for HHAs and SNFs by 2011 and 2012, respectively. These plans would be created in consultation with stakeholders and would address the development, measurement, and modification of quality and efficiency measures; the reporting, collection, and validation of quality data; the structure of proposed value-based payment adjustments; criteria for both reductions and incentives; and methods for public dissemination.

**Quality Reporting for Physicians** (*Saves \$1.2 billion over 10 years*):– The proposal would modify the physician quality reporting initiative (PQRI) to:

- Allow eligible professionals to receive incentive payments if they participate in a qualified American Board of Medical Specialties maintenance of certification program (or an equivalent program) and complete a qualified maintenance of certification practice assessment;
- Establish an appeals process for providers who participated in the program but did not qualify for incentive payments;
- Require CMS to provide more timely feedback to providers on their performance; and
- Extend the PQRI incentive program beyond 2010. Eligible professionals (physicians, nurse practitioners, physician assistants, clinical psychologists and therapists) who successfully report in 2010 would receive a 2 percent bonus payment in 2011. Eligible professionals who do not successfully participate would be penalized 1 percent of their Medicare payment in 2012 and two percent of their payment in 2013 and beyond.

The proposal also would require the Secretary, beginning in 2012, to provide feedback reports to physicians that compare their resource use with that of other physicians or groups of physicians caring for patients with similar conditions. Beginning in 2015, physician payment would be reduced by five percent if the physician’s resource use is at or above the

90<sup>th</sup> percentile of national utilization. The Secretary would have the authority to later change the 90<sup>th</sup> percentile to another utilization benchmark.

**Quality Reporting for Inpatient Rehabilitation Facilities, LTCHs and Hospice** (*Saves \$0.2 billion over 10 years*) – The Secretary would be directed to implement quality reporting programs for IRFs, LTCHs and hospices by 2014, with the quality measures selected during the prior fiscal year. Market basket updates for providers failing to report quality measures would be reduced by 2.0 percentage points. Selected measures would cover all dimensions of quality as well as efficiency, to the extent possible

**Quality Reporting for IPPS-Exempt Cancer Hospitals** – The proposal would direct the Secretary to establish a quality reporting program for cancer hospitals that are exempt from the IPPS payment system by selecting quality measures by FY 2013 and implementing a mandatory quality reporting program by FY 2014. Hospitals would be required to report as part of their Medicare provider agreements. Selected quality measures would need to be endorsed by the NQF and agreed to by a multi-stakeholder organization, although the Secretary would have discretion to implement other measures under certain circumstances.

**Medicaid Quality Measures** (*Spends \$0.3 billion over 10 years*) – The bill would direct the Secretary, in consultation with the states, to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid. The bill would establish the Medicaid Quality Measurement Program, which would expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures and consult with relevant stakeholders. The Secretary, along with states, would regularly report to Congress the progress made in identifying quality measures and implementing them in each state's Medicaid program. States would receive grant funding to support the development and reporting of quality measures.

**Comparative Effectiveness Research** (*Spends \$2.2 billion over 10 years*) – The bill would create an independent “Patient-Centered Outcomes Research Institute” governed by a multi-stakeholder board to conduct and disseminate comparative effectiveness research. The private, non-profit corporation would:

- identify research priorities and establish a research project agenda;
- carry out the research project agenda;
- study and report on the feasibility of conducting research in-house;
- collect appropriate data from CMS;
- appoint advisory panels;
- support patient and consumer representatives;
- establish a methodology committee;
- provide for a peer-review process for primary research;
- disseminate research findings;
- adopt priorities, standards, processes, and protocols;
- coordinate research and resources and build capacity for research; and
- submit reports to the Congress, the President, and the public.

The institute's 21-member board would consist of patients and health care consumers, physicians, agencies administering public health programs, private payers, pharmaceutical, device and diagnostic manufacturers, and others. It would also include the Secretary of

HHS, the director of AHRQ, and the director of the NIH, or their respective designees. Board members would be appointed by the comptroller general of the United States and hold six-year terms, serving a maximum of two terms. The board would employ an executive director and other staff, appoint expert advisory panels as appropriate, and create a methodology committee to establish standards for comparative effectiveness studies. The comptroller general would have a number of oversight responsibilities with respect to the institute.

The institute would review existing research and conduct new research. It would be allowed access to data from federal, state and private entities, including data from clinical databases and registries. It would also be able to enter into contracts with federal agencies, such as AHRQ, and private contractors. The research would be prioritized based on disease incidence and prevalence, evidence gaps in terms of clinical outcomes, practice variations, the potential to improve health and quality of care, and expenditures associated with a health care treatment strategy or condition, among others. The research would be designed to take into account differences in outcomes among subpopulations. Research findings would be disseminated in an understandable manner to help clinicians and patients make health care decisions. All research would be conducted under a set of requirements to ensure transparency, public input, adherence to ethical standards, and disclosure of any conflicts of interest.

The bill establishes several limitations around the use of the institute's comparative effectiveness research findings:

- The institute would not mandate coverage, reimbursement, or other policies for any public or private payer, and none of its reports or research findings would be construed as mandates, practices guidelines, or policy recommendations.
- The Secretary would be prohibited from making coverage determinations based solely on the institute's research or findings.
- The institute would be prohibited from developing a "dollars per quality adjusted life year" (or similar measure) to determine what health care services or treatments are cost-effective or recommended. And, it would be prohibited from using such a measure as a threshold to determine coverage, reimbursement, or incentive programs.

The bill would create a Patient-Centered Outcomes Research Trust Fund (PCORTC) to fund the institute and its activities. The PCORTC would be financed in a public/private manner using general funds from the U.S. Treasury, an assessment per Medicare beneficiary, and a fee for insured and self-insured health plans. The fee on health plans would be based on an amount per number of lives covered in the plan and would sunset after FY 2019.

*The American Recovery and Reinvestment Act of 2009* would be amended to require that the Federal Coordinating Council (FCC) provide support and coordination for the institute, including having the chair of the institute serve on the FCC board.

**Reducing Health Disparities** – Under the bill all federally funded data collection efforts on race and ethnicity would be required to adopt uniform categories for the collection of data on race, ethnicity, primary language and gender. For race and ethnicity, the Secretary would be required to adhere to Office of Management and Budget (OMB) Directive 15 on Standards for the Classification of Federal Data on Race and Ethnicity. The use of OMB policy on aggregation and allocation of subgroups also would be required. These OMB standards would apply to CMS, Medicaid and CHIP (for both enrolled children and their parents).

HHS also would be required to collect access and treatment data for people with disabilities. Public reporting of health care quality data by race, ethnicity, primary language, gender and disability would be required. Federally funded studies and surveys would be required to collect sufficient data to yield statistically reliable results, and HHS would be required to share health disparities data, measures, and analyses with other relevant agencies.

## **WELLNESS AND PREVENTION**

**Medicare Annual Wellness Visit** (*Spends \$3.7 billion over 10 years*) – All Medicare beneficiaries would be eligible for an annual wellness visit. This visit would include a comprehensive health assessment to identify chronic diseases, modifiable risk factors and emergency or urgent health needs, and development of a personalized prevention plan. Referrals would be given for such things as screening tests, Medicare-covered immunizations, and others necessary items. No co-payment or deductible would apply.

**Medicare Coverage of Preventive Services** (*Spends \$0.1 billion over 10 years*) – *The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)* gave the Secretary the authority to cover new preventive services if they were recommended by the U.S. Preventive Services Task Force (USPSTF). The Finance Committee bill allows the Secretary to modify coverage of existing preventive services based on recommendations provided by the USPSTF. It would allow, but not require, the Secretary to withdraw Medicare coverage for services rated “D,” or harmful, by USPSTF. And, it would eliminate out-of-pocket costs (co-payments and deductibles) for preventive screenings and services receiving a recommendation of “A” or “B” by USPSTF. The bill would provide funding for CMS to educate providers and patients as to what preventive services are covered, and it would require a GAO study to identify barriers preventing Medicare beneficiaries from receiving covered preventive services.

**Medicaid Preventive Services** (*Saves \$1.8 billion over 10 years*) – The bill encourages states to improve coverage of and access to recommended preventive services and immunizations, including incentives increasing the states’ federal portion of their FMAP. The Secretary is directed to develop healthy lifestyle programs for Medicaid beneficiaries. States would have a new state plan option that would allow Medicaid beneficiaries with one chronic condition, who are at risk for developing a second chronic condition to designate a provider as their medical home.

## **REGULATORY OVERSIGHT AND REFORM**

**Hospital Average Charge Information** – Beginning in 2011, the bill would require acute care hospitals to make their charges for each Medicare DRG available to the public. Hospitals would be required to make available to the public upon request, average charge information, including the range of charges at the second and fourth quintiles, across all commercial payers and self-pay patients for each DRG. Hospitals would be required to update this information on an annual basis. Hospitals that fail to comply would be subject to civil monetary penalties of \$50,000.

**Imaging Self-Referral Sunshine** – Physicians referring patients for certain imaging services that are provided in the physician’s office would be required to inform the patient that the services can be obtained elsewhere and to provide a written list of suppliers in the area where the patient resides. The imaging services covered are: magnetic resonance imaging, computed tomography, positron emission tomography, and any other determined by the Secretary. This requirement applies to referrals that would be prohibited except for the “in-office ancillary” exception to the law. This new requirement would apply after January 1, 2010.

**SNF and Nursing Home Transparency** – The bill would make numerous changes to improve SNF and nursing home transparency, enforcement of standards and rules, and other provisions to ensure the well-being of patients. These include expanded requirements to disclose SNF ownership, the implementation of compliance and ethics programs, and expanding the information posted on Medicare’s *Nursing Home Compare* Web site. In addition, more specific data on staffing, wages and benefits for direct care staff would be required. Also, the process for patient quality of care complaints would be standardized, and the Secretary would be required to promulgate regulations regarding a new dispute resolution process.

The Secretary and the states would receive new authority to issue civil monetary penalties to respond to cases of actual harm and immediate jeopardy. The Secretary would also implement a two-year pilot for an independent monitor to oversee quality and safety in large interstate and intrastate SNF and nursing home chains. SNFs and nursing homes would be required to notify state and federal officials and residents of impending closure. The Secretary would be authorized to conduct two demonstration projects and report to Congress on best practices regarding culture change and the use of information technology to improve care. New staff training requirements on dementia management and abuse prevention would be implemented.

**Increased Funding to Fight Waste, Fraud, Abuse** – (*Saves \$1.1 billion over 10 years*)  
*Provider Screening:* Applications for Medicare provider enrollment would be expanded to include more required information (as determined by the Secretary). A fee would be assessed to pay for screening costs, and penalties would be applied for false statements made on the application. Some new providers would be granted a provisional participation agreement with enhanced oversight, such as pre-payment review and payment limitations. The states would be given authority to impose similar screening procedures in Medicaid; those without effective screening programs would have a reduction in their FMAP.

*Database Creation and Data Matching:* CMS would be required to establish a new, comprehensive program integrity (“One PI”) database. The new single database would allow for the integration of existing and new sources of data, including, survey and certification data, encounter data and adverse actions data. It would enhance sharing of claims and payment data across federal and state Medicaid programs as well as across other federal departments (HHS, the Social Security Administration, the Departments of Veterans Affairs, Defense, and Justice, and the Federal Employees Health Benefit Program).

*Provider Compliance and Penalties:* Medicare and Medicaid providers, as a condition of participation, would be required to have a compliance program in place with core elements determined by the Secretary in consultation with the OIG. The Civil Monetary Penalties

(CMP) law would be expanded and include a hospital's failure to report (presumably to the National Practitioner Data Bank) an adverse action regarding a physician's clinical privileges. The amount of many penalties would be increased. The repayment of Medicare overpayments would be required within 60 days of receipt or the date the corresponding cost report is due. In addition, it appears to amend the antikickback statute, civil and criminal, to include actions that currently are not illegal, which would significantly increase the discretion of assistant U.S attorneys and investigations.

*Provider Self-Disclosure Protocol:* The Secretary would be required to establish a process for voluntary disclosures of potential violations of the physician self-referral law. Violations of the antikickback law that involve less than \$50,000 could also be addressed through the process. The stated intent is to create an incentive for providers to use the process (no specifics are provided).

*Program Integrity Funding and Reporting Requirements:* Funding would be increased for Medicare and Medicaid program integrity and anti-fraud activities, as well as for better coordination of reporting requirements between the two programs.

*Recovery Audit Contractors:* The bill would extend the Recovery Audit Contractor program to include audits of Medicare Parts C and D and Medicaid payments.

*Provider Compliance and Penalties:* The maximum period for submission of Medicare claims would be reduced from 36-months to not more than 12 months. The Secretary, in consultation with HHS OIG and CMS, could suspend payments to providers and suppliers pending an investigation of credible allegations of fraud. The 30 days providers and suppliers have to repay Medicare overpayments to avoid interest would be modified to either 60 days after the date on which the overpayment was made or the date the corresponding cost report is due. Providers and suppliers would be required to repay any Medicare or Medicaid overpayment identified through an internal compliance audit. Additionally, any person who knows of an overpayment would be required to return the overpayment to the Secretary, the state, or a Medicare contractor and notify the aforementioned party in writing to whom the overpayment was returned.

**Tax-Exempt Hospital Requirements** – New requirements would apply to section 501(c)(3) hospitals in addition to, and not in lieu of, the requirements otherwise applicable for tax exemption. The requirements generally would apply to any section 501(c)(3) organization that operates at least one hospital facility.

*Needs Assessment:* Each hospital facility would be required to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the community needs identified through the assessment. Failure to complete a community needs assessment in any applicable three-year period would result in a penalty on the organization of up to \$50,000.

*Financial Assistance Policy:* Each hospital facility would be required to adopt, implement, and widely publicize a written financial assistance policy. Each hospital facility would be required to bill patients who qualify for financial assistance no more than the amount generally billed to insured patients. A hospital facility may not use gross charges when billing individuals who qualify for financial assistance. Amounts billed to those who qualify

for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.

*Debt Collection:* A hospital facility (or its affiliates) generally would be required to follow current Medicare law and regulations regarding collection of debts, but may not undertake certain extraordinary collection actions (even if otherwise permitted by law) against a patient without first making reasonable attempts to inform the patient about the hospital's financial assistance policy.

*Reporting and Disclosure:* The IRS would be required to review information about a hospital's community benefit activities (currently reported on Form 990, Schedule H) at least once every three years. The HHS Secretary would annually report to Congress the levels of charity care, bad debt expenses, unreimbursed costs of means-tested government programs, and unreimbursed costs of non-means tested government programs incurred by private tax-exempt, taxable, and governmental hospitals as well as the cost of community benefit activities incurred by private tax-exempt hospitals. In addition, the Secretary of the Treasury, in conjunction with the HHS Secretary, would conduct a study of the trends in these amounts with to the results of the study provided to Congress five years from the date of enactment.

## **REVENUE PROVISIONS**

**35% Excise Tax on Insurers That Offer High-Premium Plans** – Beginning in 2013, insurance policies with relatively high total premiums would be subject to a 35 percent excise tax on the amount by which the premium exceeds a specified threshold. Except as described below, the threshold would be set (beginning in 2013) at \$8,000 for individual policies and \$21,000 for family policies. After 2013, those amounts would be indexed to overall inflation (CPI-urban). The full premium would continue to be excluded from enrollees' taxable income and thus would not be subject to income or payroll taxes. All tax-excluded contributions toward flexible spending arrangements, health reimbursement arrangements, and health savings accounts would be included in the determination of the total premium that is subject to the tax. The excise tax would be payable by insurers, would apply to self-insured plans, and would not be deductible for federal income tax purposes.

In 2013, health insurance plans maintained in the 17 states in which health care was least affordable in 2012, would have a threshold for the excise tax that is 20 percent higher than other states. Over the ensuing two years, the adjustment to the threshold in high-cost states would decrease by half each year thereafter, so that in 2016 and subsequent years, the same cap would apply in all states. The provision raises \$214.9 billion over 10 years.

**Modify the Definition of Qualified Medical Expenses** – The provision generally conforms the definition of "medical expenses" to the definition used in determining itemized deduction amounts for medical expenses. The bill redefines allowable medical expenses for the purposes of employer-provided health coverage, including health reimbursement arrangements, health flexible spending arrangements, and Archer medical savings accounts, to exclude over-the-counter medicines, unless prescribed by a physician. The provision raises \$5.4 billion over 10 years.

**Health Savings Accounts** – The bill would increase the additional tax for health savings account withdrawals prior to age 65 that are not used for qualified medical expenses from 10 percent to 20 percent, beginning in 2010. The provision raises \$1.3 billion over 10 years.

**Limit on Health Flexible Spending Arrangement Contributions** – The plan would limit pre-tax contributions to these arrangements to \$2,000 per year beginning in 2013. This provision raises \$16.5 billion over 10 years.

**Corporate Information Reporting** – Beginning January 1, 2012, the proposal would require businesses that pay any amount over \$600 per year to corporate providers of property and services, to file an information report with each provider and with the Internal Revenue Service. Information reporting is already required on payments for services to non-corporate providers. The provision raises \$17.1 billion over 10 years.

**Eliminate Deduction for Employer Part D Subsidy** – The bill would eliminate the deduction of the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. The provision raises \$4 billion over 10 years.

**Pharmaceutical Manufacturers Fee** – This proposal would impose an annual flat fee of \$2.3 billion on the pharmaceutical manufacturing sector, beginning in 2010. This non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of branded pharmaceuticals of \$5 million or less.

**Medical Device Manufacturers Fee** – This proposal would impose an annual flat fee of \$4 billion on the medical devices manufacturing sector, beginning in 2010. This non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of medical devices in the U.S. of \$5 million or less. The fee does not apply to sales of Class I products under the Food and Drug Administration's product classification system.

**Health Insurance Provider Fee** – This proposal would impose an annual flat fee of \$6 billion on the health insurance sector, beginning in 2010. This non-deductible fee would be allocated across the industry according to market share. An employer that self-insures its employees' health risks is not considered an insurance company for purposes of the fee.

**Clinical Laboratories Fee** – This proposal would impose an annual flat fee of \$750 million on clinical laboratories, beginning in 2010. This non-deductible fee would be allocated across the industry according to market share and would not apply to clinical laboratories with revenue of \$500,000 or less. For hospitals that offer clinical laboratory services, only revenue above \$500,000 for laboratory services performed for non-inpatients (e.g. outpatient laboratory testing and community outreach testing) would be subject to the annual fee.