



“America’s Healthy Future Act”

Summary
October 13, 2009

Providing Quality Coverage to All Americans

Americans who like their health insurance and want to keep it can do so. For the millions of Americans who don’t have employer-sponsored coverage, can’t afford to purchase coverage on their own, or who are being denied coverage due to a pre-existing condition, the Chairman’s Mark reforms the individual and small-group markets, making health coverage affordable and accessible.

Individual Market Reforms - Beginning in 2013, the Mark would require insurance companies to issue coverage to all individuals regardless of health status; insurers would no longer be allowed to limit coverage based on pre-existing conditions. Limited variation in premium rates would be permitted for tobacco use (no more than 1.5:1), age (no more than 4:1), and family composition (no more than 3:1 for a family). Variation in rating would be allowed between geographic areas, but would not differ within a geographic area. Total variation in premiums would be limited to 6:1.

Small Group Market Reforms - Rating rules for the individual market would also apply to the small group market, as defined by states. This would include groups of one to 50 employees. The bill would add larger employers to the new market over time, starting with groups up to 100 in 2015.

Large and Midsize Group Market Reforms -The Chairman’s Mark takes steps to protect employees by precluding midsize and large employers with group health plans from imposing unreasonable annual and lifetime limits on coverage, requiring them to provide first dollar coverage for preventive care and to cap out-of-pocket costs at the amount equal to Health Savings Accounts (HSA), which will be \$5,950 for an individual and \$11,900 for a family in 2010.

Health Insurance Exchanges - The Mark would make purchasing health insurance coverage easier and more understandable by using the Internet to give consumers information about available plans. The Mark would create state-based web portals, or “exchanges” that would direct consumers seeking to purchase coverage in the individual market to all the health plan options available in their zip code. The exchanges would offer standardized health insurance enrollment applications, a standard format companies would use to present their insurance plans, and standardized marketing materials. The exchanges would have a call center for customer support. The exchanges would also enable users to determine whether they are eligible for Health Care Affordability Tax Credits or subsidies to offset the cost of their monthly premium or public programs like Medicaid and CHIP, and would enable consumers without access to the Internet to enroll through the mail or in person in a variety of convenient locations.

Small Group Purchasing Through SHOP Exchanges - Under the Chairman’s Mark, small businesses would have access to state-based Small Business Health Options Program (SHOP) exchanges. These exchanges – like the individual market exchanges – would be web portals that make comparing and purchasing health care coverage easier for small businesses.

Preserving Employer-Sponsored Retiree Coverage - The Chairman’s Mark would help employers struggling with rising health care costs to continue to provide health care benefits to retirees without increasing premiums. The policy would add \$5 billion to create a reinsurance program to provide assistance to employer-sponsored retiree coverage.

Transitioning to a Reformed Insurance Market - Once the insurance market reforms take effect, people who want to keep the insurance they have today can do so. Plans would be allowed to continue to offer the coverage they offer today and this coverage would be grandfathered. These grandfathered plans would be available to anyone with coverage today or, in the case of an employer, to new employees and their dependents. People who qualify for the health care affordability tax credits in the reformed market would not be able to use the credits to purchase grandfathered plans. Tax credits would be offered only to purchase plans offered in the reformed market that meet the new benefit and rating standards.

Transitioning for Rating Requirements - Federal rating rules for the individual market (other than for grandfathered plans) would take effect on July 1, 2013. Federal rating rules for the small group market would be phased in over a period of up to five years, as determined by each state, with approval from the Secretary of HHS.

Medicaid - The Chairman's Mark would standardize Medicaid eligibility for all parents, children, pregnant women and childless adults at or below 133 percent of the Federal Poverty Level (FPL), or \$30,000 a year for a family of four (\$14,400 for an individual), beginning in 2014. Individuals between 100 percent of FPL and 133 percent of FPL would be given the choice of enrolling in either Medicaid or in a private health insurance plan offered through a health insurance exchange. The federal government would provide significant additional funding to states to cover the cost of providing services to newly eligible Medicaid beneficiaries.

Improving Access to Home and Community Based Care - The Chairman's Mark would improve access to Home and Community Based Services (HCBS) for low income individuals in Medicaid and create incentives for states to offer these services as alternatives to nursing home care.

Prescription Drug Benefits - Medicare beneficiaries who enroll in the Medicare Part D prescription drug program will receive significant help purchasing prescription drugs when they hit the coverage gap portion, or "donut hole" of the benefit. Instead of paying 100 percent of their drug costs in the gap, Part D beneficiaries with low to moderate incomes will receive a 50 percent discount on the price of brand-name drugs covered by their plan. The discount makes expensive medicines more affordable and helps beneficiaries stay on treatments that their doctors prescribe.

Children's Health Insurance Program - The Chairman's Mark would require states to maintain their current CHIP eligibility levels through fiscal year 2019. Beginning in 2014 and continuing for six years, states would receive a 23 percentage point increase in their CHIP match rate, subject to a cap of 100 percent.

Addressing Health Care Disparities - The Chairman's Mark would require federal health programs to collect uniform data on race, ethnicity, sex and disability to help program administrators and researchers work to end disparities among these groups.

Promoting Maternal and Child Health - The Chairman's Mark would provide funding to states, tribes and territories to develop and implement one or more evidence-based Maternal, Infant and Early Childhood Home Visitation programs. Program options would provide training and consultation aimed at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency and family economic self-sufficiency.

Making Coverage Affordable

The cost of health insurance has increased five times faster than wages over the last eight years. Estimates show that just seven years from now, most Americans will spend nearly half their income on health insurance. American businesses pay nearly three times more than our major trading partners for health care benefits. Unaffordable coverage prevents these companies from competing in the global market. The Mark makes coverage more affordable by providing tax credits and subsidies for low and middle-income individuals and small businesses, and by strengthening public programs.

Executive Compensation Limitations - This provision would limit the deductibility of executive compensation under Section 162(m) for insurance providers if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements in the Mark ("covered health insurance provider"). The deduction is limited to \$500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services, for or on behalf of, a covered health insurance provider. This provision is effective beginning in 2012 with respect to services performed after 2009.

Health Care Affordability Tax Credits - The Mark would provide an advanceable, refundable tax credit for low and middle-income individuals to subsidize the purchase of health insurance. Beginning in July 2013, tax credits would be available on a sliding scale for individuals and families between 134-400 percent of FPL (Federal Poverty Level) to help offset the cost of private health insurance premiums. Beginning in 2014, the credits are also available to individuals and families between 100-133 percent of FPL. The credits would be the amount required to prevent the individual from having to pay more than a certain percentage of income on premiums, rising from two percent of income for those at 100 percent of FPL to 12 percent of income for those between 300 and 400 percent of poverty. Undocumented immigrants are prohibited from benefiting from the credit.

Cost Sharing Subsidies - A cost-sharing subsidy would be provided to limit the amount of out-of-pocket costs that individuals and families between 100-200 percent of FPL have to pay. The cost-sharing subsidy would be designed to buyout any difference in cost sharing between the insurance purchased and a higher actuarial value plan. For individuals between 100-150 percent of FPL, the subsidy brings the value of the plan to 90 percent actuarial value, so individuals would pay, on average, ten percent of the cost of their medical care, up to the out-of-pocket max. For those between 150-200 percent of FPL, the subsidy brings the value of the plan to 80 percent actuarial value, so individuals would pay, on average, twenty percent of their medical care, up to the out-of-pocket max.

Small Business Health Care Affordability Tax Credits - This provision would provide a tax credit to small businesses that contribute at least 50 percent of the cost to the health insurance premiums of their employees. In 2011 and 2012, eligible employers can receive a small business credit for up to 35 percent of their contribution. Once the exchanges are up and running in 2013, qualified small employers purchasing insurance through the exchange can receive a tax credit for two years that covers up to 50 percent of the employer's contribution. Small businesses with 10 or fewer employees and with average taxable wages of \$20,000 or less will be able to claim the full credit amount. The credit phases out for businesses with more than 10 employees and average taxable wages over \$20,000, with a complete phaseout at 25 employees or average taxable wages of \$40,000. Non-profit organizations with 25 or fewer employees would also be eligible to receive tax credits if they meet the same requirements. These organizations would be eligible for a 25 percent credit from 2011-2013 and a 35 percent credit in 2013 and thereafter.

Options for Standard Benefits - The Mark creates four benefit categories for the reformed health insurance market: bronze, silver, gold and platinum. No policies (except grandfathered policies) would be issued in the individual or small-group markets that do not comply with one of the four categories. All plans would be required to provide primary care and first-dollar coverage for preventive services, emergency services, medical and surgical care, physician services, hospitalization, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, including x-rays, maternity and newborn care, pediatric services (including dental and vision care), prescription drugs, radiation and chemotherapy, and mental and behavioral health, and substance abuse services. Those age 25 or under will also have access to an affordable young invincible plan that would provide catastrophic coverage and first dollar coverage for prevention. Plans would not be allowed to set lifetime or annual coverage limits.

Out-of-Pocket Limits - Plans would have out-of-pocket limits no greater than \$5,950 for an individual and \$11,900 for a family (which is the out-of-pocket limit for Health Savings Accounts (HSAs) in 2010). For individuals between 100-200 percent of FPL, the out-of-pocket limit would be equal to one-third of those amounts. For those between 200-300 percent of FPL, the benefit will include an out-of-pocket limit equal to one-half of those amounts. For those between 300-400 percent of FPL, the benefit will include an out-of-pocket limit equal to two-thirds of those amounts.

Making Coverage for Small Business Employers More Affordable – The Chairman's Mark would require small employers to provide a plan with a deductible that does not exceed \$2,000 for individuals and \$4,000 for families, unless offering contributions which offset any increase in deductible above these limits.

Cafeteria Plan Changes - This provision creates a Simple Cafeteria Plan - a vehicle through which small businesses can provide tax-free benefits to their employees. This change would ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees. This provision is effective beginning on January 1, 2011.

Consumer Owned and Oriented Plan (CO-OP) - The Mark creates authority for the formation of the Consumer Owned and Oriented Plans (CO-OPs). These plans can operate at the state, regional or national level to serve as non-profit, member-run health plans to compete in the reformed non-group and small group markets. These plans will offer consumer-focused alternatives to existing insurance plans. Six billion dollars in federal seed money would be provided for start-up costs and to meet state solvency requirements.

Personal Responsibility - The Mark would create a personal responsibility requirement for health care coverage, with exceptions provided for religious conscience (as defined in Medicare) and undocumented individuals.

Individuals who fail to meet the requirement are subject to a penalty. The penalty phases in over a four-year period beginning in 2014, when the penalty is \$200 per adult, rising to \$400 in 2015, \$600 in 2016 and \$750 in 2017.

Exemptions from the penalty will be made for individuals where the full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds eight percent of their adjusted gross income (AGI); those below 100 percent of FPL; any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs (e.g., such as those participating in Health Sharing Ministries); those experiencing hardship situations (as determined by the Secretary of Health and Human Services); and an individual who is an Indian as defined in section 4 of the Indian Health Care Improvement Act.

Individuals who would otherwise qualify for the exemption from the individual requirement penalty would be allowed to purchase the "young invincible" policy in the exchange, which is effectively a catastrophic plan that also includes coverage for preventive benefits and services.

Responsibility for Employers - The Mark would not require employers to offer health insurance. However, effective July 1, 2013, all employers with more than 50 employees who do not offer coverage will have to reimburse the government for each full-time employee (defined as those working 30 or more hours a week) receiving a health care affordability tax credit in the exchange equal to the average national exchange credit and subsidy up to a cap of \$400 per total number of employees (whether they are receiving a tax credit and subsidy or not).

As a general matter, if an employee is offered employer-provided health insurance coverage, the individual would be ineligible for a Health Care Affordability Tax Credit for health insurance purchased through a state exchange. An employee who is offered coverage that does not have an actuarial value of at least 65 percent or who is offered unaffordable coverage by their employer, however, can be eligible for the tax credit. Unaffordable is defined as 10 percent of the employee's income. A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid. In this circumstance, the employer is not required to pay a fee.

Making Indian Tribal Health Services More Affordable - The Chairman's Mark would allow Native Americans to exclude the value of specified Indian tribe health benefits from gross income for tax purposes.

Strengthening Coverage of Preventive Services

For the nearly one in three Americans covered under Medicare or Medicaid, the Chairman's Mark makes critical investments in policies that will promote healthy living and help prevent costly chronic conditions like diabetes, cancer, heart disease and obesity. Preventive screenings enable doctors to detect diseases earlier, when treatment is most effective, thereby averting more serious, costly health problems later.

Providing an Annual Wellness Visit - The Chairman's Mark provides Medicare beneficiaries with a free visit to their primary care provider every year to create and update a personalized prevention plan designed to address health risks and chronic health problems and to develop a schedule for regular recommended preventive screenings.

Improving Access to Preventive Services - The Mark eliminates out-of-pocket costs for recommended preventive services for Medicare beneficiaries. Beneficiaries will no longer face financial deterrents for seeking preventive care. The Chairman's Mark also encourages states to cover preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) and immunizations recommended by the Advisory Committee on Immunizations (ACIP) to adults enrolled in Medicaid. States that opt to cover recommended services and immunizations without cost-sharing would receive a one percent increase in the federal share of the FMAP reimbursement rate for those services. All states would be required to provide comprehensive tobacco cessation services to pregnant women enrolled in Medicaid.

Moving Toward Patient-Centered Care - The Chairman's Mark creates a new state option and rewards states for providing chronically ill individuals enrolled in Medicaid with a health home. Participating enrollees will receive comprehensive care coordination and management, transitional care and, if relevant, referral to community-based programs and social services. States that take up this option will receive an enhanced match for two years.

Rewarding Healthy Lifestyles - The Mark establishes an initiative that will reward Medicare and Medicaid participants for healthier choices. Funding will be available to provide participants with incentives for completing evidence-based, healthy lifestyle programs and improving their health status. Programs will focus on lowering certain risk factors linked to chronic disease such as blood pressure, cholesterol and obesity.

Promoting Workplace Wellness - The Mark modifies current regulations to allow employers to give larger rewards to their employees for meeting certain health status targets related to a wellness program.

Reforming the Health Care Delivery System

Medicare currently reimburses health care providers on the basis of the volume of care they provide. For every test, scan or procedure conducted, providers receive payment – regardless of whether the treatment contributes to helping a patient recover. Medicare must move to a system that reimburses health care providers based on the quality of care they provide. The Chairman's Mark includes various proposals to move the Medicare fee-for-service system towards paying for quality and value. These proposals include the following:

Hospital Value-Based Purchasing - The provision would establish a value-based purchasing program for hospitals starting in 2012. Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality measures included in the program (and in all other quality programs in this section) will be developed and chosen in cooperation with external stakeholders.

Physician Value-Based Purchasing - This provision would strengthen and expand the Physician Quality Reporting Initiative (PQRI) program, including requiring all eligible health professionals to participate by 2012. It would also improve the Medicare physician feedback program and ensure that all physicians are paid on the basis of quality and efficiency by 2017.

Medicare Home Health Agency and Skilled Nursing Facility Value-Based Purchasing - CMS is currently testing value-based purchasing models for these providers. Building on this effort, the provision would direct the Secretary to submit a plan to Congress by 2011 related to home health providers and 2012 related to skilled nursing facilities outlining how to effectively move these providers into value-based purchasing.

Quality Reporting for Other Providers - This provision would set providers – long-term care hospitals, inpatient rehabilitation facilities, PPS-exempt cancer hospitals and hospice providers – on a path toward value-based purchasing by requiring the Secretary to implement quality measure reporting programs for certain providers. Providers who do not successfully participate in the program would be subject to a reduction in their annual market basket update.

Encouraging Collaboration Among Health Care Providers

Patients receive the best possible care when doctors collaborate and work together to coordinate care. Current payment systems often discourage such care coordination. When providers in different settings – like doctor's offices, hospitals, nursing homes and rehabilitation facilities – work together, patients benefit from receiving better care and costs in the system are lower.

Payment for Accountable Care - To encourage providers to improve patient care and reduce costs, the Mark would allow high-quality providers that coordinate care across a range of health care settings to share in the savings they achieve for the Medicare program.

CMS Innovation Center - This provision would establish an Innovation Center at the Centers for Medicare & Medicaid Services (CMS) that would have authority to test new patient-centered payment models designed to encourage evidence-based, coordinated care for Medicare, Medicaid, and CHIP. Payment reforms that are shown to improve quality and reduce costs could be expanded throughout the Medicare program.

National Pilot Program on Payment Bundling - The Chairman's Mark would direct the Secretary to develop a voluntary pilot program encouraging hospitals, doctors and post-acute care providers to achieve savings for the Medicare program through increased collaboration and improved coordination of patient care by allowing the providers to share in such savings.

Reducing Avoidable Hospital Readmissions - To improve quality of care, this provision would direct CMS to track national and hospital-specific data on the readmission rates of Medicare participating hospitals for certain high-cost conditions that have high rates of potentially avoidable hospital readmissions. Starting in 2012, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days or by 10 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days.

Infrastructure Investments: Tools to Reduce Costs and Improve Quality

Efforts to reduce costs and improve quality in the health care delivery system will require equal efforts to modernize the system with new tools that support coordinated quality care. Investments in the health care infrastructure are essential to creating a more effective, efficient delivery system.

Strengthening the Quality Infrastructure - Additional resources would be provided to the Department of Health and Human Services (HHS) to strengthen the quality measure development processes for purposes of improving quality, informing patients and purchasers, and updating payments under federal health programs. Specifically, the Secretary of HHS would be directed to develop a national quality strategy; establish an interagency working group on health care quality; provide additional resources for quality measure development and endorsement; and establish a process for HHS to work with external stakeholders, such as the National Quality Forum, to select quality measures to be included in Medicare value-based purchasing and pay-for-reporting programs.

Research and Information - The Mark would invest in research on what treatments work best for which patients and ensure that information is available and accessible to patients and doctors, such as through the establishment of an independent institute to research the effectiveness of different health care treatments and strategies. These provisions are carefully crafted so that patients would never be denied treatment based on age, disability status or other related factors as a result of the research findings.

Transparency - To increase transparency, the Chairman's Mark would provide patients with information about physician-industry relationships – so called “physician payment sunshine,” close loopholes in physician self-referral laws that allow conflicts of interest, and provide patients and families with more information about nursing home facilities and hospital charges to help them make better decisions. The Chairman's Mark would also require drug manufacturers and distributors to report information they already collect regarding the number and type of drug samples given to physicians. The Mark would also require the nation's hospitals to make their average charge information for commercial payers and self-pay patients available to the public.

Credit to Encourage Investment in New Therapies - This provision creates a two-year temporary credit subject to an overall cap of \$1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. The credit would be available for qualifying investments made in 2009 and 2010.

Strengthening Primary Care and Other Healthcare Workforce Improvements

Primary care physicians play a critical role in our health care system. They are vital to reducing costs and improving quality in the health care system. Primary care doctors provide preventive care, help patients make informed medical decisions, assist with care management, and help coordinate with a patient's other care providers. Despite their critical function, primary care doctors receive significantly lower Medicare payments than other doctors. Inadequate reimbursement has played a role in the current shortage of primary care providers.

Promoting Primary Care - To encourage more primary care doctors to be part of the system, the Chairman's Mark would provide primary care practitioners and targeted general surgeons with a Medicare payment bonus of ten percent for five years.

Health Care Workforce - Ensuring America's health care system has a sufficient supply of health care professionals to meet the demands of a changing and aging population is essential to maintaining focus on high-quality, cost efficient care. To strengthen the health care workforce, the Mark would increase graduate medical education (GME) training positions through a slot re-distribution program for currently unused training slots, with priority given to increasing training in primary care and general surgery. The provision would also encourage additional training in outpatient settings, including teaching health centers, and ensure communities retain vital training slots if a hospital closes. The Mark also includes funding for a demonstration program on increasing graduate nursing education. It would establish a Workforce Advisory Committee made up of external stakeholders tasked with working with HHS and other relevant federal agencies to develop and implement a national workforce strategy. The Chairman's Mark establishes competitive demonstration grant programs designed to help low-income individuals obtain the education and training needed for well-paying, high-demand health care jobs. The Mark also includes demonstration grants for up to six states to develop training and certification programs for personal and home care aides.

Ensuring Beneficiary Access and Payment Accuracy in Medicare

The Chairman's Mark ensures that Medicare beneficiaries will continue to have access to physicians and other critical health care providers. The Mark also improves the accuracy of Medicare payments to providers. Reducing overpayments to providers saves money for seniors and taxpayers without limiting beneficiary access.

Physicians - Due to the flawed Sustainable Growth Rate (SGR) formula, physician payments are scheduled to be reduced by 21.5 percent in 2010. To ensure that Medicare beneficiaries continue to have access to physician services, the Chairman's Mark replaces the impending cut with a positive update.

Medicare Advantage - Private insurers that participate in Medicare should bring value to the program and to beneficiaries. The Chairman's Mark would improve the value of Medicare Advantage by reforming payments so that the program appropriately pays insurers for their costs and promotes plans that offer high quality, efficient health care for seniors.

Specifically, the Mark would transition current Medicare Advantage payments based on statutory benchmarks to payments based on competitive bids from the insurers. It would eliminate overpayments to Medicare Advantage plans and address the inequitable distribution of rebates paid to plans by making any extra payment contingent on plan performance. Under the Mark, plans would be eligible for bonus payments based on their performance on quality measures and the operation of evidence-based care management programs. Plans that provide care at lower costs than traditional Medicare would also be eligible for an efficiency bonus. Rebates and bonuses paid to MA plans would need to be used to provide additional benefits that are not covered under Medicare. The Mark would preserve plans' ability to offer benefit packages that differ from or supplement traditional Medicare. The Mark would add important protections and transparency for beneficiaries by limiting cost sharing for certain services, like chemotherapy and skilled nursing care, and by creating more consistency in the extra benefits that plans can offer beneficiaries throughout the country.

Ensuring Benefit Stability in High Cost Areas - The Chairman's Mark would preserve Medicare Advantage (MA) benefit stability for seniors living in high cost areas where plans deliver benefits below the average cost of traditional Medicare. This policy would grandfather MA plans in areas where plans currently bid at or below 75 percent of traditional fee-for-service Medicare to deliver benefits, so plans will continue to offer the plans they currently offer and pay what they currently pay to deliver benefits for existing beneficiaries.

Medicare Disproportionate Share Hospital Payments - This provision would require the Secretary to update hospital payments to better account for hospitals' uncompensated care costs. Starting in 2015, hospitals' Medicare Disproportionate Share Hospital (DSH) payments would be reduced to reflect lower uncompensated care costs relative to increases in the number of insured.

Home Health Payment Reform - The Secretary would be directed to improve payment accuracy through rebasing home health payments beginning in 2013 based on an analysis of the current mix of services and intensity of care provided to home health patients. It would also establish a 10 percent cap on the amount of reimbursement a home health provider can receive from outlier payments, which are designed to help providers cover the costs of treating sicker patients. The Chairman's Mark would also reinstate an add-on payment for rural home health providers from 2010-2015.

Hospice Reform - Based on recommendations by the Medicare Payment Advisory Commission (MedPAC), this provision would require the Secretary to update Medicare hospice claims forms and cost reports. Based on this information, the Secretary would be required to implement changes to the hospice payment system to improve payment accuracy. The Secretary would also impose certain requirements on hospice providers designed to increase accountability in the Medicare hospice program. In addition, the Mark would require the Secretary to conduct a demonstration program that would allow Medicare beneficiaries receiving hospice care to also receive other Medicare covered services during the same period of time.

Appropriate Payment for High-cost Imaging Services - Because payment rates for imaging services should reflect the rate by which they are used, the Mark would increase the utilization rate assumption for advanced imaging equipment. In addition, the Mark pays more accurately for multiple imaging services performed during a single patient visit.

Updating Outpatient Payments for PPS-Exempt Cancer Hospitals - The Secretary of Health and Human Services would be directed to update payment rates for outpatient care provided by cancer hospitals that are exempt from the prospective payment system.

Rural Health Care Protections

The Chairman's Mark includes several provisions to ensure rural health care facilities and providers have the resources they need to continue delivering quality care in their communities. Specifically, the Mark would extend and improve many rural access protections, including the following:

FLEX Grants for Health Care in Rural Communities - The Medicare Rural Hospital Flexibility Program provides grants that rural health care providers can use to improve quality, and to strengthen health care networks. Funds can be used for services ranging from ambulance transport to the development of small local hospitals. The Chairman's Mark will extend the FLEX Grant program through 2012 and will add a new component that Flex grant funding can be used to support rural hospitals' efforts to implement delivery system reform programs, such as value-based purchasing programs, bundling, and other quality programs.

Hospital Outpatient Department Hold Harmless for Small Rural Hospitals - Small rural hospitals that are not sole community hospitals (SCHs) can receive additional Medicare payments if their outpatient payments under a new payment system are less than under the prior reimbursement system. The Chairman's Mark would ensure that small rural hospitals receive 85 percent of the payment difference in 2010 and 2011.

Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals - Certain rural areas with low population densities used to receive reasonable cost reimbursement for laboratory services, but this policy ended in 2008. The Chairman's Mark would reinstate reasonable cost reimbursement, thus improving access to laboratory services for those in rural communities.

Rural Community Hospital Demonstration Program - The Centers for Medicare & Medicaid Services has been conducting a demonstration program to test the feasibility of reasonable cost reimbursement for small rural hospitals. The Chairman's Mark extends the program for two years and expands eligible sites to additional rural states.

Medicare Dependent Hospital Program - Small rural hospitals with a high proportion of patients who are Medicare beneficiaries receive special treatment, including higher payments. This assistance for Medicare dependent hospitals (MDHs) is scheduled to expire in September 2011. In order to protect access to health care in rural communities, the Chairman's Mark will extend crucial support to MDHs for an additional two years. In addition, the Mark would require HHS to study whether certain urban hospitals should qualify for the MDH program.

Temporary Medicare Hospital Payment Improvements - The Chairman's Mark would temporarily increase payment for certain low-volume hospitals, ensuring that rural hospitals are adequately reimbursed for serving their communities.

Technical Correction Related to Critical Access Hospitals (CAHs) - The Chairman's Mark clarifies that CAHs continue to be eligible to receive 101 percent of reasonable costs for providing outpatient care regardless of eligible billing method the facility uses and for providing qualifying ambulance services.

Community Health Integration Models in Certain Rural Counties - The 2008 demonstration project allowed eligible rural entities to develop and test new models for the delivery of health care services in order to improve access to and integrate the delivery of acute care, extended care and other essential health care services for Medicare beneficiaries. The Chairman's Mark will expand the 2008 project to more eligible counties and will also allow physicians to participate in the demonstration project.

Ensuring Medicare Sustainability

Sharply rising costs throughout the health system threaten Medicare's sustainability in the long term. If costs are not constrained, the Medicare program will be insolvent by 2017. To ensure the fiscal solvency and sustainability of the Medicare program, the Chairman's Mark includes the following provisions:

Medicare Commission - The Chairman's Mark creates a 15-member, independent Medicare Commission tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Commission's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Commission would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

Revisions to Annual market-Basket Adjustments for Part A Providers - The provision would reduce annual market basket updates for hospitals, home health providers, nursing homes, hospice providers, long-term care hospitals and inpatient rehabilitation facilities, including adjustments to reflect expected gains in productivity.

Part B Productivity Adjustments - Payment updates for Part B providers would be reduced by an estimate of increased productivity.

Reduce Part D Premium Subsidy for High-Income Beneficiaries – This provision would reduce the premium subsidy under Part D for beneficiaries with incomes at or above the Part B income thresholds.

Medical Malpractice - The Chairman's Mark expresses the Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. The Mark further expresses the Sense of the Senate that states should be encouraged to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court. The Mark expresses the Sense of the Senate that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.

Transparency and Accountability for Insurance Companies

The provision improves the transparency of insurance products to ensure that individuals know what they are purchasing, the services which are covered and the associated out-of-pocket costs. The Mark creates standards that will ensure that each individual receives an outline of coverage which is presented in a uniform format that does not exceed four pages in length and does not include print smaller than 12-point font. The Mark would also require insurance companies to publish the share of their premium revenue that is used for administrative expenses. In addition, the Mark would impose new requirements on insurers to meet standards for the electronic exchange of payment and other health care information with hospitals, doctors and other providers. By 2014, insurers must comply with standards for certain transactions or face a penalty fee assessed annually by the Secretary of Health and Human Services and collected by the Secretary of the Treasury. The fee would represent the inefficiency cost that an insurer imposes on the health care system when its electronic transactions with providers are not conducted in a standard way.

Combating Fraud, Waste, and Abuse

Reducing fraud, waste, and abuse in Medicare, Medicaid and CHIP will reduce costs and improve quality throughout the system. The Medicare improper payment rate for 2008 was 3.6 percent of payments, or \$10.4 billion and the National Health Care Anti-Fraud Association estimates that fraud amounts to at least three percent of total health care spending, or more than \$60 billion per year. The Chairman's Mark includes several provisions to combat fraud, waste and abuse in our health care system.

Enhanced Screening - The Chairman's Mark would institute a tougher screening process, including a \$350 application fee, before granting billing privileges to providers and suppliers under Medicare, Medicaid or CHIP. Additionally, new providers participating in the programs would be subject to a 6-12 month period of enhanced oversight. During this period, CMS would review claims before issuing payments and would have the option of capping the amount providers could bill the programs.

Swift and Sufficient Penalties - The Chairman's Mark would increase civil and criminal monetary penalties for committing fraud in Medicare, Medicaid or CHIP. In addition, the Mark would clarify that HHS has the ability to suspend payments to providers while investigations are pending.

Strengthening Enforcement Programs - The Recovery Audit Contractor Program (RAC), administered by CMS, has had great success identifying improper payments in Medicare Parts A and B. RACs are independent contractors who identify overpayments and underpayments and are paid a percentage of the improper payments they collect. The Chairman's Mark would expand this program to help identify improper payments in Medicare parts C and D and Medicaid as well. The Chairman's Mark would also provide an additional \$10 million annually for the next 10 years for the Health Care Fraud and Abuse Control program that funds efforts to prevent health care fraud, waste and abuse through audits and investigations.

Leveraging Technology - The Chairman's Mark would require CMS to complete development of the comprehensive "One PI" Integrated Data Repository, a data sharing system designed to allow CMS to compare Federal health care claims and payment information among HHS, SSA, and the Departments of Veterans Affairs, Defense and Justice. Data sharing will help CMS to better evaluate claims and detect fraud throughout the system.

Face to Face Referrals - The Chairman's Mark would require Doctors to conduct face to face meetings with patients before making referrals for home health care services and durable medical equipment, which are highly susceptible to fraud.

Surety Bonds - The Chairman's Mark would allow the Secretary of HHS to collect surety bonds from certain providers before allowing them to participate in Medicare, Medicaid or CHIP. The bonds would work as security deposits the programs could collect from in the case of fraud.

Financing an Investment in Quality, Affordable, Health Care

High Cost Insurance Excise Tax - Beginning in 2013, this provision would levy a non-deductible excise tax of 40 percent on insurance companies and plan administrators for any health insurance plan that is above the threshold of \$8,000 for singles and \$21,000 for family plans. The threshold would be \$1,850 higher for individual plans and \$5,000 for family plans for workers with high risk jobs or for retirees aged 55 and up. The tax would apply to the amount of the premium in excess of the threshold. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market. The threshold would be indexed for inflation by an amount equal to CPI-U (Consumer Price Index for All Urban Consumers) plus one percentage point. A transition rule would increase the threshold for the 17 highest cost states for the first three years.

Transparency in Employer W-2 Reporting of the Value of Health Benefits - This provision would require employers to disclose the value of the benefit provided by employers for each employee's health insurance coverage on the employee's annual Form W-2. The policy would be effective beginning in 2010.

Limit Health FSA Contributions - This provision would limit the amount of contributions to health Flexible Spending Accounts (FSAs) to \$2,500 per year, beginning in 2011.

Eliminate Deduction for Employer Part D Subsidy - This provision would eliminate the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. This would be effective beginning in 2011.

Standardize the Definition of Qualified Medical Expenses - Beginning in 2010, this provision would conform the definition of qualified medical expenses for Health Savings Accounts (HSAs), health FSAs, and HRAs to the definition used for the itemized deduction. An exception to this rule would allow amounts paid for over-the-counter medicines with prescriptions to continue to qualify as medical expenses.

Penalty for Use of HSA Funds for Non-qualified Medical Expenses - This provision would increase the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 percent to 20 percent, beginning in 2011.

Increase the Threshold for Claiming the Itemized Deduction for Medical Expenses - This provision increases the threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent of adjusted gross income beginning in 2013. Individuals over the age of 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

Corporate Information Reporting - This provision would require businesses that pay \$600 or more during the year to non-corporate and corporate providers of property and services to file an information report with each provider and with the IRS. Information reporting already is required on payments for services to non-corporate providers. This applies to payments made after December 31, 2011.

Non-profit Hospitals - This provision would establish new requirements applicable to nonprofit hospitals beginning in 2010. The requirements would include a periodic community needs assessment.

Pharmaceutical Manufacturers Fee - This provision 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 provision would impose an annual flat fee of \$4 billion on the medical device 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 or Class II products that retail for less than \$100 under the FDA product classification system.

Health Insurance Provider Fee - This provision would impose an annual flat fee of \$6.7 billion on the health insurance sector, beginning in 2010. This non-deductible fee would be allocated across the industry according to market share.

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