Senate Health Reform Bill

December 23, 2009

Summary of Senate Health Reform Bill

Background

With the Senate Democrats appearing to be poised this week to pass the Patient Protection and Affordable Care Act, H.R. 3590, and that President Obama will sign a comprehensive health care reform bill into law during January 2010, WHA is providing members with this summary and analysis of H.R. 3590, focusing on four major themes:

- Insurance reform
- Expansion of Coverage
- How it is financed
- Impact on Wisconsin Hospitals

Insurance Reform

A number of major changes are made in the way health insurance is sold and regulated:

- **Pre-existing Conditions, Rating Limitations, and Lifetime Limitations:** Insurance companies will be barred from discriminating based on pre-existing conditions and health status. Premium rate differences (rating bands) by age and gender would be limited. Beginning in 2014, no health care plan could establish lifetime limits or annual limits. All individuals enrolled in group health coverage or individual coverage on the date of enactment can maintain that coverage through a grandfathered plan.
- **Expanded Health Plan Transparency and Policyholder Rebates:** All plans must annually report to the HHS Secretary annual full disclosure of health care costs, including claims payment policies and rating practices, expenditures for clinical services, health care quality improvement expenditures, non-claims based costs and premium revenues, and beginning in 2014, the minimum medical loss ratio for the large group market is 85 percent and the medical loss ratio for the small group market is 80 percent.
- **Health Insurance Exchanges:** The bill would establish new insurance exchanges (at the state level) and would subsidize the purchase of health insurance through those exchanges for individuals and

families with income between 133 percent and 400 percent of the federal poverty level (FPL). Policies would have to meet several requirements: In particular, insurers would have to accept all applicants, could not limit coverage for preexisting medical conditions, and could not vary premiums to reflect differences in enrollees' health. The exchanges must consider the reasonableness of premium increase when certifying plans participation in the exchange.

- **No Public Plan Option:** Instead of the much-discussed public plan option, the final bill will include new national option under which at least two private plans (one of which must be nonprofit) would be included in the Exchanges and supervised by the federal Office of Personnel Management.

Expansion of Coverage

Health insurance coverage is made available through expansion of Medicaid eligibility and imposing mandates on individuals and employers.

- **Broadening Medicaid Eligibility:** Starting in 2014, most nonelderly people with income below 133 percent of the FPL would be made eligible for Medicaid. The federal government would pay all of the costs of covering newly eligible enrollees through 2016; in subsequent years, the federal share of spending would vary somewhat from year to year but would average about 90 percent by 2019.
- **Individual Mandates and Subsidies:** Beginning in January 1, 2014, all U.S. citizens and legal residents would be required to maintain minimum essential coverage. The tax penalty for individuals that fail to secure coverages ranges from $95 in 2014 to $750 in 2016 (to 2 percent of income). The exchanged would subsidize the purchase of health insurance for individuals and families with income between 133 percent and 400 percent of the federal poverty level (FPL).
- **Employer "Mandate" and Small Employer Credits:** Firms with more than 50 workers that did not offer coverage would have to pay a penalty of $750 for each full-time worker if any of their workers obtained subsidized coverage through the insurance exchanges. Starting in 2010, small business tax credits would be made available to firms with relatively few employees and relatively low average wages to cover up to half of their contributions toward health insurance premiums. The full tax credit is available to firms with average wages up to $25,000 and extends the credit for firms with average wages up to $50,000.

Medicare Payment Cuts and Other Changes

In total, $483 billion would be cut from the Medicare and Medicaid programs over 2010-2019. The provisions that would result in the largest budget savings include:

- Permanent reductions in the annual updates to Medicare's payment rates for most services in the fee-for-service sector (other than physicians' services), yielding budgetary savings of $186 billion over 10 years. $103 billion come from hospitals.
- Setting payment rates in the Medicare Advantage program on the basis of the average of the bids submitted by Medicare Advantage plans in each market, yielding savings of an estimated $118 billion.
- Reducing Medicaid and Medicare payments to hospitals that serve a large number of low-income patients, known as disproportionate share hospitals (DSH), by about $43 billion—composed of roughly $19 billion from Medicaid and $24 billion from Medicare DSH payments. These cuts are subject to the extent to which insurance coverage meets the projections in the bill.

In addition to the cuts, there are a number of significant changes in payment and to promote quality care.

- **Readmissions:** Hospitals would be penalized if their readmission rates exceed their expected level of readmissions.
- **Accountable Care Organizations (ACOs):** Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others).
- **Bundling:** The HHS Secretary is directed to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models.
- **Independent Medicare Advisory Board:** Creates an independent, 15-member Medicare Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries.
- **Physician Self-Referral:** The exception for physician-owned hospitals under the Stark law would be eliminated.
- **Physician Payment:** The manager's amendment repeals the one-year fix to physician payment that was contained in the bill.
- **Graduate Medical Education (GME): R**edistributes 65 percent of unused residency training positions as a way to encourage increased training of primary care physicians and general surgeons. Qualified hospitals would be able to request up to 75 new slots. Priority would be given to hospitals in states with low resident-to-population ratios and hospitals in rural and high health professional shortage areas.
- **Special Rural Hospital Provisions:**
    - The bill significantly expands the Medicare inpatient PPS adjustment for low-volume hospitals, changing the measure from all discharges to Medicare only, and increasing the maximum to 1,600 discharges per year. It also decreases the mileage requirement, from 25 miles to the next nearest hospital down to 15 miles.
    - Extends the rural community hospital demonstration program for five years. In addition, the base year for determining cost payments for hospitals included in the first five years of the demonstration to be the first cost report beginning on or after the first day of the five-year extension period.
- **Value-Based Purchasing:** The VBP section has been amended to exclude any measures related to hospital readmissions.
- **Hospital-Acquired Infections:** Mandates that the HHS Secretary publicly report on hospital-acquired infections using the claims data generated through the hospital-acquired conditions policy that was initiated last year. Certain infections and other complications that arise during hospitalization and are considered by CMS to be preventable cannot be a reason that the patient moves from a lower-paying to a high-paying DRG.

Medicaid Cuts

The cuts apply to disproportionate share hospital (DSH) allotments to states. States' disproportionate share hospital allotments would be reduced by 45 percent once a state's uninsurance rate decreased by 50 percent (low DSH states would receive a 25 percent reduction). As the rate continued to decline, states' DSH allotments would be reduced by a corresponding amount. At no time could a state's allotment be reduced by more than 65 percent compared to its FY 2012 allotment.

How the Bill is Paid For

The cost of the bill - at $848 billion - is paid for with a combination of taxes and penalties, together with payment reductions in Medicare and Medicaid. The table below provides a summary.

Excise tax on high-premium plans	$149 billion
Employer/individual penalties and other	$225 billion
Reductions in Medicare FFS rates	$188 billion
Medicare Advantage rates based on plans' bids	$118 billion
Medicare and Medicaid DSH payments	$43 billion
All other	$138 billion

Impact on Wisconsin Hospitals

In evaluating the impact on Wisconsin hospitals, it is important to outline how Wisconsin differs from the rest of the country, namely our:

- High rate of coverage, both in commercial insurance and in Medicaid programs
- High quality and the good value we provide to the Medicare program

The Cuts: It is clear that the Medicare payment updates will be made. We project that these cuts will amount to over $1.8 billion over the ten years starting in Federal fiscal year 2010. The Medicare DSH payment reductions are also very likely, since after 2015 all Medicare DSH payments must be "empirically justified" by MedPAC. Those are projected at $200 million. All of these cuts apply to PPS payments.

Medicaid DSH payment cuts are much less likely, given that Wisconsin's Federal DSH allotment has been used to expand Medicaid eligibility. Since the money was used for expanding coverage, Wisconsin will have already accomplished the goal incorporated in the bill.

The Benefits: It is difficult to see any significant benefits to Wisconsin hospitals from the Medicaid expansions included in this bill. Much of what the bill is attempting to accomplish - expanded coverage - is something Wisconsin already has.

However, Senators Kohl and Feingold were successful in securing future federal matching payments for our already covered Childless Adults Medicaid population. In addition, the establishment of the health insurance exchanges will enhance the ability of individuals to access commercial insurance.

And there is a provision in the bill that will eventually lead toward rewarding high quality, low cost providers - a hallmark of Wisconsin's Medicare providers - as well as correcting some long-standing physician payment inequities.

WHA was very active, and the Wisconsin delegation was instrumental, in ensuring that the Medicare program begins to reward value by requiring payment enhancements to physicians for high quality and beginning to fix the flawed GPSI methodology. Finally, the Accountable Care Organization (ACO) language was broadened to include other payment methods such as capitation and to make it possible for hospitals to take leadership positions in ACOs.