American Hospital Association

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Summary of Health Reform Legislation

President Obama, on February 22, released a summary of his health care reform proposal, followed by a letter on March 2 to Congressional leaders with additional recommendations, which the White House says will attempt to "bridge the gap between the House and Senate bills." The Senate's Patient Protection and Affordable Care Act (H.R. 3590) is the basis for the President's plan with a set of changes that "reflect policies from the House-passed bill and the President's priorities," according to the White House. The President contends that his plan includes several Republican policy priorities raised at the White House Summit on February 25. The summary below highlights some of the key changes to the Senate bill.

Key Policy	Senate Reform Bill Passed December 24, 2009	President's Plan Released February 22, 2010
Coverage Expansion	Coverage is expanded to 94% of those "legally" residing in the United States by 2019 – 92% of all residing in the US. 23 million individuals will remain without coverage (an increase of 31 million more individuals covered compared to 2010 levels).	The White House claims 31 million will be covered, but the Congressional Budget Office (CBO) has not yet determined the actual coverage numbers.
Individual Mandate	Requires U.S. citizens and legal residents to have health coverage. Those who elect to remain uninsured must make either a flat dollar payment or pay a percentage of their income, whichever is higher.	Similar to the Senate bill, but the proposal would lower the flat dollar amount and raise the percent of income amounts.
Premium Increases	Establishes a process for reviewing increases in health plan premiums and requires plans to justify increases.	Creates a Health Insurance Rate Authority charged with working with the states to conduct "rate reviews" to determine if insurance premium increases are reasonable and justified. The Authority would provide federal oversight of insurance market behaviors and help the states determine how rate review will be enforced.

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Other Insurance Requirements	Requires guarantee issue and renewability and allows rating variation based only on age (limited to 3 to 1 ratio), and premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange. Prohibits insurers from rescinding coverage, and prohibits the imposition of lifetime or annual limits on the dollar value of benefits. Requires risk adjustment in the individual and small group markets and in the Exchange. In addition, these immediate reforms would impose transparency and administrative simplification standards and requirements for insurance companies to establish an appeals process. (Effective January 1, 2014)	Requires "grandfathered" health plans to cover dependents up to age 26, prohibits plans from rescinding coverage, and revises the appeals process. Beginning in 2014, prohibits annual and lifetime limits; bans exclusions for pre-existing conditions. Beginning in 2018, requires "grandfathered" plans to cover proven preventive services at no cost.
Medicaid Expansions	Expands Medicaid eligibility to those at or below 133% of the federal poverty level. States would receive 100% federal funding for 2014 through 2016 to finance the coverage for the newly expanded populations. Beginning in 2017, states would receive an enhanced federal medical assistance percentage (FMAP) that would vary depending on whether the state already expanded coverage to adults. The exception is Nebraska which would receive 100 percent federal funds after 2017 for its newly eligible population.	Same as Senate. Eliminates the Senate provision that would have fully funded Nebraska's Medicaid expansion and extends 100 percent assistance to all states from 2014 until 2017, 95 percent assistance from 2018-2019, and 90 percent assistance from 2020 onward. Increases Medicaid reimbursement to Medicare levels for physician primary care services.
Public Plan Option	No public plan; creates non-public, non-governmental health care co-operatives and non-public, multi-state health plans similar to FEHBP (administered through the federal Office of Personnel Management).	Same as Senate.
Employer Mandate	Does not require employers to provide coverage, but does include "free rider" assessments on employers if their employees purchase health coverage from the Exchange with premium tax credit subsidies.	Similar to the Senate with an increase in the "free rider" assessment, but a reduction in employee payment calculation.

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Medicaid Disproportionate Share Hospital Payments	Reductions of $18.5 billion would be made against state DSH allotments with no reallocation criteria. States would be categorized based on whether they are a low-DSH state and how much of their previous DSH allotments they spent. The allotment methodology would remain the same. Reductions would be made by reducing the yearly allotment. Differs from the House in that it makes no changes in the distribution of DSH funds. A trigger on DSH cuts would be set at a 45% reduction in the uninsured within a state, and reductions could begin as soon as 2015. A DSH floor would be set limiting the reductions in state DSH allotments to 50 percent of 2012 allotments.	Same as Senate.
Medicare Disproportionate Share Hospital Payments	In FY 2015 and beyond, DSH payments would be reduced to the "empirically justified" amount – 25% of the current amount. However, a portion of the reduced DSH funds would be used to create a new payment stream to hospitals to reflect their continuing uncompensated care costs. Savings would equal $24.4 billion. The amount of money that would be available for the "new" payments for uncompensated care would be the amount of the reduction in DSH payments described above times one, minus the percent reduction in the uninsured for that year.	Same as Senate.
Hospital Payment Updates	Reduces hospital payment updates by $102.7 billion over 10 years. Reduces hospital updates by 0.25 percentage point in 2010 and 2011. Beginning in 2012, market basket reduced by productivity adjustments and added reductions of 0.1 percentage point in 2012 and 2013 and 0.2 percentage point in 2014 through 2019.	Same as Senate.
Bundling	Beginning 2013, requires the Secretary to establish a national, voluntary, five year pilot program on bundling payments to providers around ten conditions. If successful, the Secretary may expand the pilots after 2015.	Same as Senate.

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Readmissions	Beginning FY 2013, imposes financial penalties on hospitals for so-called "excess" readmissions when compared to "expected" levels of readmissions. Performance would be based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program. Reductions would amount to $7.1 billion over 10 years. Excludes critical access hospitals and post acute care providers.	Same as Senate.
Accountable Care Organizations (ACOs)	Beginning in 2012, allows hospitals, in cooperation with physicians, to provide leadership in voluntary ACOs, which would be responsible for managing the care of certain beneficiaries, and allows the HHS Secretary to share some of the savings from improved care management with providers.	Same as Senate.
Value-Based Purchasing	Establishes a VBP program for hospital payments beginning in FY 2013 based on hospitals' performance in 2012 on measures that are part of the hospital quality reporting program. The program is budget neutral, and 1 percent of payments would be allocated to VBP in FY 2013, 1.25 percent in 2014, 1.5 percent in 2015, 1.75 percent in 2016 and 2 percent in 2017 and beyond.	Same as Senate.
Physician Self-Referral	Eliminates the exception for physician-owned hospitals under the Stark Law and grandfathers existing entities as of August 1, 2010.	Same as Senate.
Hospital-Acquired Conditions (HACs)	Beginning in FY 2015, adds a 1 percent penalty to hospitals in the top quartile of rates of HACs, resulting in reductions of $1.5 billion over 10 years.	Same as Senate.
Independent Payment Advisory Board (IPAB)	Creates a new Independent board that would make binding recommendations on Medicare payment policy, and make non-binding recommendations for changes in private payer payments to providers. Does not apply to hospitals through 2019.	Same as Senate.
Medicare Extenders	Includes one-year extensions of certain Medicare provisions, including: • Section 508 wage index reclassifications. • Increasing the work geographic index to 1.0. • Grandfathering direct billing for anatomic pathology technical component services. • Add-on payment for ground ambulance. • Outpatient therapy caps. • 5% increase in physician payment for certain psychiatric therapeutic procedures.	Same as Senate.

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Rural Hospital Provisions	Sustains and improves access to care in rural areas through various improvements: • Outpatient hold-harmless payments for certain hospitals in rural areas. • Improves payments for low-volume hospitals. • Ensures that CAHs are paid 101% of costs for all outpatient services regardless of the billing methods elected. • Extends and expands the Rural Community Hospital Demonstration Program. • Extends the Medicare Dependent Hospital program for one year. • Extends the Medicare Rural Hospital Flexibility Program through 2012. • Extends reasonable cost reimbursement for laboratory services in small rural hospitals.	Same as Senate.
Community Health Center	Invests $8.4 billion in community health centers over five years.	Invests $11 billion over five years versus $8.5 billion in the Senate bill and $12 billion in the House bill
340B Drug Program	Expands access for existing 340B hospitals to cover inpatient drugs and adds to the inpatient and outpatient programs children's, cancer and critical access hospitals as well as certain sole-community hospitals and rural referral centers.	Same as Senate.
Graduate Medical Education	Contains no reductions in IME payments. Redistributes 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.	Same as Senate.
Long-Term Care Hospitals (LTCHs)	Extends for two years selected LTCH provisions in the *Medicare, Medicaid and SCHIP Extension Act of 2008*. Would further delay full implementation of the 25% rule, the short-stay outlier cuts, and the one-time budget-neutrality adjustments planned by CMS. Extends current moratorium on new LTCH beds and facilities, with exceptions.	Same as Senate.
Liability	Authorizes the HHS Secretary to award demonstration grants to states for alternatives to current tort litigation.	Provides $50 million in appropriated funds for medical liability demonstrations.

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Fraud and Abuse	Contains a number of provisions that increase funding to fight waste, fraud and abuse by $1.1 billion over 10 years.	• Establishes a Medicare and Medicaid sanctions database under the office of the Health Human Services Inspector General to allow a central location for law enforcement to access information on sanctions on health care providers, suppliers and related entities. • Tightens restrictions to ensure entities that bill Medicare on behalf of providers are in good standing and strengthens the Secretary's ability to exclude individuals from the program who knowingly have submitted false claims. • Allows quality control, peer review organizations and private plans that provide services reimbursed by federal health plans greater access to the Healthcare Integrity and Protection Data Bank; includes penalties for misuse. • Increases accountability for Medicare Administrative Contractors to ensure they deny payment to individuals or entities excluded from federal health programs. • Prevents fraudulent health care providers or suppliers from discharging overpayments due to HHS through filing for bankruptcy. • Creates a real-time system for analyzing claims and payment data for public programs. • Includes sanctions for individuals who knowingly and with intent to defraud "purchase, sell or distribute" Medicare beneficiary identification numbers or Medicare or Medicaid billing privileges. • Requires a report to Congress on the costs and benefits of using universal product numbers (UPNs) for select items and services under Medicare. • Grants the Federal Trade Commission authority to take action when a generic drugmaker receives "anything of value" from a brand-name drugmaker in return for limiting or foregoing research, development or other actions to delay a generic alternative. • Uses medical professionals to conduct random undercover investigations of health care providers that receive reimbursements from federal health programs.
Medicare Advantage	Includes a Medicare Advantage provision which provides transitional extra benefits for Florida and other states.	Eliminated.

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HSAs	No provision.	Allows Health Savings Accounts to participate in the proposed insurance exchanges.
Brand-Name Pharmaceutical Assessment	No provision.	Increases the fee by $10 billion to a total of $33 billion over 10 years and delays implementation until 2011.
Excise Tax on High-Cost Health Plans	Beginning in 2013, imposes an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $8,500 for individual coverage and $23,000 for family coverage.	Delays the excise tax until 2018 for insurers of employer sponsored health plans and raises the threshold for the tax from $8,500 to $10,200 for an individual plan, and from $23,000 to $27,500 for a family plan.
Medicare Payroll Tax	Beginning January 1, 2013, raises the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly; funds are dedicated to the Medicare Part A Trust Fund.	Same as Senate on Medicare Part A tax. Imposes a new 2.9 percent assessment on unearned income such as interest, dividends and rents for individuals with incomes over $200,000 and couples making more than $250,000 (Effective January 1, 2013).
Fee on Health Insurance Providers	No provision.	Includes an assessment of $67 billion over 10 years beginning in 2014.
Medical Device Tax	Charges an annual fee to medical device companies, beginning with $2 billion per year in FY 2011 and increasing to $3 billion per year in FY 2018 for a total savings of $20 billion over 10 years. Fee would be assessed based on device manufacturers' market share.	Converts the Senate bill's medical device fee of $20 billion over 10 years to an excise tax; tax would take effect in 2013.

*Please note that this side-by-side is a summary of key issues. For information on other issues for which AHA is advocating, please refer to the AHA's 27-page letter sent to congressional leaders on January 7, 2010 or our detailed summaries of the House and Senate bills. To view a copy, visit www.aha.org.