FRAMEWORK FOR COMPREHENSIVE HEALTH REFORM

This document constitutes a framework of a plan for consideration by the Bipartisan Six. The policies outlined here represent many of the policies discussed with Finance Committee members and described in previous options papers. In addition, the policies also reflect the group's conversations and the group's work throughout the summer, including throughout the August recess. Chairman Baucus proposes this framework for consideration and response by the next meeting scheduled for Tuesday, September 8, 2009.

This is not a final product, should not be construed as a Chairman's Mark and does not include everything that might be in a Mark. Members may suggest individual modifications or offer whole or partial counters to specific provisions. As discussed, suggestions to reduce the cost of the package are welcome. If, however, a modification will increase the cost of the package, then the member making that suggestion should offer offsets to keep the package budget neutral.

I IMMEDIATE RELIEF FOR FAMILIES AND SMALL BUSINESSES I

Small Business Tax:Credits. Tax credits would be available for tax years 201 1 and 2012 for firms with fewer than 25 employees and average wages below $40,000. Qualifying employers could receive the credit for up to two years with a maximum credit of 35%.

Part D Drug Discount Program. Beginning in 2010, in order to have their drugs covered under Medicare, manufacturers must provide a 50% discount off the negotiated price for brand-name drugs covered on plan formularies when beneficiaries enter the coverage gap. Beneficiaries are eligible provided they do not qualify for low-income subsidies, do not have employer sponsored coverage, or do not pay higher Medicare premiums under Part B or Part D.

Health Insurance Exchange. States would establish an exchange in 201 0 to provide easier, more efficient comparison of health insurance plan benefits and premium costs. Information about coverage and cost-sharing would be available in a standard format. So-called "mini-medical" plans with limited benefits and low annual caps would not be offered in the exchange.

Ombudsman. In 2010, states would be required to establish an ombudsman office to act as a consumer advocate for those with private coverage in the individual and small group markets.

Policyholders whose health insurers have rejected claims and who have exhausted internal appeals would be able to access the ombudsman office for assistance.

Transparency. Beginning in 201 0, to ensure transparency and accountability, health plans would be required to report the proportion of premium dollars that are spent on items other

than medical care. Also, beginning in 2010, hospitals would be required to list standard charges for all services and Medicare DRGs.

High Risk Pools. In 201 0, the proposal would increase funding for state high risk pools, so long as the funds are not used to replace current premium assessments and are not distributed to high risk pools that have a waiting list.

ENSURING AFFORDABLE HEALTH COVERAGE

Insurance Reform in the Non-Group Market. Beginning January 1,20 13, health insurance plans in the individual market would be required to offer coverage on a guaranteed issue basis and would be prohibited from excluding coverage for pre-existing health conditions. Limited benefit plans and lifetime limits would be prohibited, and health insurance companies would be prohibited from rescinding health coverage.

Health insurance premiums would be allowed to vary based only on tobacco use, age, and family composition according to the following ratios:

Tobacco use -1.5: 1

Age-5:l

Family composition:

- Single-1:l
- Adult with child -1.8: 1
- Two adults -2: 1
- Family-3:l

Premiums could also vary to reflect geographic differences. Taking all these factors together, premiums could not vary by more than 7.5: 1.

Individuals with current coverage in non-group market can keep what they have.

Insurance Reform in the Small Group Market. The rules for the small group market would be the same as those for the non-group market, except that they would be phased in over a period of up to five years beginning January 1,2013. Some states may enact reforms quicker but others may take the entire five years.

For purposes of these reforms, small group is defined as 1-50 employees (or up to 100 depending on state law). In 2017, states must develop a phase-in schedule (not to exceed five years) for incorporating larger groups (up to 100 employees).

Current group plans are also permitted to keep what they currently have, though these grandfathered plans are subject to phased-in rating reforms.

Risk Sharing. To protect newly reformed markets against adverse risk selection and facilitate market entry of new plans, the proposal includes three mechanisms to share risk: risk adjustment, reinsurance and risk corridors.

Interstate Sale of Insurance. Starting in 2015, states may form "health care choice compacts" to allow for the purchase of non-group health insurance across state lines. Such compacts may exist between two or more states. Once compacts have been formed, insurers would be allowed to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued.

State Health Insurance Exchanges. State-based "exchanges" will be established to facilitate enrollment for individuals and separately for small group (through a SHOP exchange modeled after S. 979, the "Small Business Health Options Program Act"). The exchange will provide a standardized enrollment application, a standard format for describing insurance options and marketing, call center support and customer service. The exchanges must be self-sustaining after the first year.

Beneflt Options. Four benefit categories would be created: Bronze, Silver, Gold and Platinum, with the following actuarial values:

Bronze (minimum creditable coverage) = 65%

Silver = 73%

Gold = 81%

Platinum = 90%

A separate "young invincible" policy would be available in addition to these benefit options. This policy would be targeted to young adults who desire a less expensive catastrophic coverage plan but with a requirement that preventive services be covered below the catastrophic amount. Cost-sharing for preventive benefits would be allowed.

No health insurance policies could be issued (other than grandfathered plans) that do not meet the actuarial standards set for these plans. All health insurance plans in the non-group and small group market would be required, at a minimum, to offer coverage in the Silver and Gold categories.

All plans sold in the non-group and small group market would be required to cover the following benefits: preventive and primary care, physician services, outpatient services,

emergency services, hospitalization, day surgery and related anesthesia, diagnostic imaging / screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical / surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that meet minimum standards set by federal and state laws.

Plans would be prohibited from applying annual or lifetime limits on benefits. Cost-sharing would be eliminated for preventive services except where value-based insurance design is used, and out-of-pocket limits for all benefit categories would be tied to current HSA standards.

Health Care Affordability Tax Credits. Beginning in 20 13, tax credits would be available on a sliding scale basis for individuals and families between 134-300% of poverty 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% of poverty. The credits would be refundable and advanceable and would be based on the percent of income the cost of premiums represents, rising from three percent of income for those at 100% of poverty to 13% of income for those at 300% of poverty. The share of premium enrollees pay would be held constant over time. Premium credits would be tied to the Silver plan.

In addition to tax credits for premiums, cost-sharing assistance is also available for those between 100-300% of poverty. For those between 100-1 50% of poverty, assistance would be tied to Platinum-level coverage, and for those between 150-200% of poverty, assistance would be tied to Gold-level coverage. Those between 200-300% of poverty would receive coverage equivalent to the Silver plan. Additionally, the out-of-pocket limit for those below 300% of poverty is capped at a lower level than the HSA amount. For those between 100-200% of FPL, the out-of-pocket maximum is equal to one-third of the HSA out-of-pocket limit. For those between 200-300% of FPL, the out-of-pocket maximum is equal to one-half of the HSA out-of- pocket limit.

Individuals between 300-400% of poverty would be eligible for a premium credit at a flat percent of income. Liability for premiums would be capped at 13% of income for the purchase of a Silver plan. Cost-sharing assistance would not be provided.

No illegal immigrants will benefit from the health care tax credits.

Small Business TaxCredits. In addition to the temporary small business tax credits provided in 201 1 and 2012 and described above, the proposal also includes a permanent program to provide small business tax credits once the small group insurance reforms have been implemented. Beginning with tax years ending after December 3 1,2012, small business tax credits will be available to new businesses and firms newly offering health coverage through an exchange once the exchange is established. Credits are again limited to firms with fewer than 25 employees and average wages below $40,000, and the maximum credit available would be 50%.

Individual Responsibility. Beginning in 2013, all US citizens and legal residents would be required to purchase health insurance or have health coverage from an employer, through a public program (i.e., Medicare, Medicaid, or CHIP), or through some other source that meets

the minimum creditable coverage standard. Exemptions from the requirement would be allowed for religious objections consistent with those allowed under Medicare and for undocumented immigrants. Individuals who choose to keep the plan they have today would be deemed to have satisfied the requirement.

An exemption from the penalty is permitted if coverage is deemed unaffordable -defined based on a circumstance where the lowest cost premium available exceeds 10% of a person's income. Exemptions from the penalty are also allowed based on hardship, for Native Americans and for individuals below 100% of poverty. Additionally, in 20 13, individuals at or below 133% of poverty will be exempt from the penalty.

For taxpayers between 100-300% of poverty, the penalty for failing to obtain health coverage is $750 per year with a maximum penalty per family of $1500. For taxpayers with incomes above 300% of poverty, the penalty for failing to obtain coverage is $950 per year with a maximum penalty per family of $3800.

Employers with 200 or more employees must automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of employer coverage, however, if they are able to demonstrate that they have coverage from another source. Additionally, states would have the option of establishing a process for auto-enrollment of individuals and families into policies offered in the non-group and small group markets.

Employer Responsibility. Employers would not be required to offer health insurance coverage. However, employers with more than 50 full-time employees (30 hours and above) that do not offer health coverage must pay a fee for each employee who receives the tax credit for health insurance through an exchange. The assessment is based on the amount of the tax credit received by the employee(s), but would be capped at an amount equal to $400 multiplied by the total number of employees at the firm (regardless of how many receive a credit in the exchange). Employees participating in a welfare-to-work program, children in foster care and workers with a disability are exempted from this calculation.

As a general matter, if an employee is offered employer-provided health insurance coverage, the individual is ineligible for the tax credit for health insurance purchased through an exchange. An employee who is offered unaffordable coverage by their employer, however, can be eligible for the tax credit. Unaffordable is defined as 13% of the employee's income. The employee would seek an affordability waiver from the exchange and would have to demonstrate family income and the premium of the lowest cost employer option offered to them. Employees would then present the waiver to the employer. The employer assessment would apply for any employee(s) receiving an affordability waiver. Within five years of implementation, the Secretary must conduct a study to determine if the definition of affordable could be lowered without significantly increasing costs or decreasing employer coverage.

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.

Coverage offered by an employer of any size, including hlly insured and self insured plans, is not required to comply with the list of benefits required of plans in the non-group and small group markets. Employers must provide first dollar coverage for prevention services (except where value-based insurance design is used), however, and cannot have a maximum out-of- pocket limit greater than that provided by the standards established for Health Savings Accounts (HSAs).

The proposal authorizes funding for the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of nonprofit, member-run health insurance companies that serve individuals in one or more states. CO-OPS would compete in the reformed non-group and small group insurance markets. Federal loans would be provided to assist with start-up costs, and federal grants would be provided to meet state solvency requirements.

In order to be eligible for federal funds under the CO-OP program, an organization must meet the following requirements:

1. It must be organized as a nonprofit, member corporation under State law.

2 It must not be an existing organization that provides insurance as of July 16,2009, and must not be an affiliate or successor of any such organization.

3 Its governing documents must incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference.

4 It must not be sponsored by a state, county, or local government, or any government instrumentality.

5 Substantially all of its activities must consist of the issuance of qualified health benefit plans in the individual and small group markets in each state in which it is licensed to issue such plans.

6 Governance of the organization must be subject to a majority vote of its members (i.e., beneficiaries).

7 As provided in regulations promulgated by the Secretary of Health and Human Services (HHS), it must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

8 Any profit must be used to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to members.

CO-OPs would be permitted to enter into collective purchasing arrangements for services and items that increase administrative and other cost efficiencies, especially to facilitate start-up of the entities, including claims administration, administrative services, health information technology, and actuarial services.

Grants and loans will be awarded by the Secretary of HHS based on recommendations made by an advisory board. The advisory board will be chaired by the Secretary (or a delegate)

with other members appointed by the Majority Leader of the Senate (4 members), the Minority Leader of the Senate (3 members), the Speaker of the House of Representatives (4 members) and the Minority Leader of the House of Representatives (3 members).

Priority in awarding grants will be given to statewide proposals, integrated care models, and applications with significant private support. In making awards, the Secretary, in consultation with the advisory board, shall ensure there is sufficient funding for at least one CO-OP in all 50 States and the District of Columbia. Multiple awards per state are allowed. The Secretary shall begin distribution of funds by January 1, 2012. The board will disband upon completion of its duties, but no later than December 3 l, 2015.

In the event that CO-OPs are not established in every state, the Secretary is authorized to use planning grants to encourage CO-OP formation or expansion of existing CO-OPs from other states.

Medicaid Coverage for the Lowest Income Populations. In January 20 1 1, prior to the expansion, states would be given the option to cover non-elderly non-pregnant adults through a state plan amendment (SPA) at their current match rate. Effective January 1,2014, the proposal would expand Medicaid income eligibility levels nationwide. Existing eligibility levels for pregnant women would not change, but modifications would be made for other groups as follows: (1) parents increased to 133% of poverty, and (2) children ages six and older increased to 133% of poverty. Additionally, a new eligibility category would be created for all non-elderly individuals (childless adults) otherwise ineligible for Medicaid at or below 133% of poverty. During 2013, the penalty for failing to comply with the individual responsibility to obtain insurance would not apply to individuals at or below 133% of poverty, nor would they be eligible for tax credits in the exchange.

As part of the expansion, all newly eligible non-pregnant adults would be guaranteed a benchmark benefit package consistent with section 1937 of the Social Security Act. The benchmark and benchmark-equivalent packages would be amended to ensure that they meet the requirements for a Silver-level plan. Populations currently exempted from mandatory enrollment in section 1937 packages would continue to be exempted.

States would be required to maintain existing income eligibility levels for all populations upon enactment. This "maintenance of effort" provision would expire when the state-based exchanges become fully operational (expected January 1,20 13), except as it applies to coverage at income levels of 133% of poverty and below, for which it would continue through January 1,2014.

Effective January 1,2014, income disregards would no longer apply, and income would be measured based on modified adjusted gross income (MAGI) as defined for eligibility for the tax credits in the exchange. An exception to this rule would be those groups eligible for Medicaid through another program, like foster children, low-income Medicare beneficiaries, and individuals receiving Supplemental Security Income, for whom existing income counting rules would continue to apply.

Individuals with income below 100% of poverty would be deemed ineligible for subsidies in the exchange. Non-elderly non-pregnant adults between 100-133% of poverty would be able

to choose between Medicaid and subsidized coverage through the exchange. States must ensure that all children of parents who choose coverage through the exchange would continue to receive the benefits, including early and periodic screening, diagnostic, and testing (EPSDT) benefits, to which children are entitled under Medicaid. Additionally, for every adult who chooses the exchange, states would be required to pay an amount equal to the state's average cost of coverage for an individual in that same Medicaid eligibility category.

In an effort to defray the cost of covering newly eligible individuals, additional federal financial assistance will be provided to all states. "Newly eligible" means non-elderly non-pregnant individuals below 133% of poverty who were not previously eligible for a full or benchmark benefit package, or who were eligible for such a package through a capped waiver but were not enrolled, as of the date of enactment. Those states that do not currently cover the newly eligible population will receive more assistance initially than those states that currently cover at least some non-elderly non-pregnant individuals. Between 20 14 and 20 19, the additional assistance to the two types of states will be adjusted downward and upward, respectively, so that, by 2019, all states will receive the same level of additional assistance for covering newly eligibles.

The federal and state governments would share in the costs of services provided to existing eligibility groups, and under existing Medicaid waivers authorized in the Social Security Act.

Beginning January 1, 20 14, states would be required to provide premium assistance to any Medicaid beneficiary who is offered employer-sponsored insurance, if it is cost-effective for the state to do so.

Beginning in FY 201 1, all territories' FMAP rate would be increased from 50% to 55% and all spending caps would be increased by 30%. The cost of covering newly eligibles would not count towards the spending cap.

The proposal would reauthorize and continue funding for Aging and Disability Resource Centers (ADRC) and the Money Follows the Person Rebalancing Demonstration (MFP) program.

Children's Health Insurance. To ensure that children will not lose benefits or coverage under reform, states would be required to maintain their current CHIP eligibility levels through 2012. Additionally, beginning in 20 13, CHIP beneficiaries would enroll in exchange plans and states would provide a "CHIP-wrap" to provide supplementary benefits, including EPSDT benefits for all children. A federal floor for CHIP income eligibility would be set for children and pregnant women at 250% of poverty. Income eligibility would be determined using MAGI and income disregards would be eliminated. States would continue to be reimbursed for CHIP at the enhanced FMAP rate.

Enrollment Simplification. State Medicaid programs would be required to operate a website that coordinates with state exchange websites to ensure that individuals are able to enroll in a plan offered through the exchange or the state's Medicaid program.

Hospitals would have the option to make presumptive eligibility determinations, on the basis of preliminary information, for any individual who may be eligible for Medicaid.

Prescription Drug Coverage. Prescription drugs would become a mandatory Medicaid benefit. The status of drugs used to promote smoking cessation, barbiturates, and benzodiazepines would be changed from "excludable" to "non-excludable." Medicaid prescription drug rebates would be applied to Medicaid managed care organizations. Similarly, the rebates would be applied to new formulations of existing drugs, with an exception for orphan drugs. The rebate amounts would be increased, with the minimum rebate percentage for single-source and innovator multiple source drugs going from 15.1 % to 23.1 % and from 1 1 % to 13% for generic drugs. For clotting factors and drugs approved by the FDA for pediatric use only, the rebate would be increased from 15.1 % to 17.1 %.

The federal upper limit (FUL) would be changed to no less than 175% of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer price (AMP).

Transparency in Medicaid and CHIP Waivers. The Secretary and states would be subject to requirements regarding transparency in the development, implementation, and evaluation of Medicaid and CHIP section 1115 demonstration programs.

Medicaid Disproportionate Share HospitaJ Payments. A state's Disproportionate Share Hospital (DSH) allotment would be reduced by 50% once the number of uninsured individuals in the state is reduced by 50%. Thereafter, the state's DSH allotment would be further reduced at a rate that corresponds with any further reduction in the rate of uninsured. A state's DSH allotment would not decrease by more than 65% of the allotment in 2012.

Dual Eligibles. Medicaid waivers serving dual-eligible beneficiaries (including section 1115 and 1915 waivers) could be approved for up to five years. A new Office of Coordination for

Dual Eligible Beneficiaries (OCDEB) would be established to coordinate care for dual-eligible beneficiaries, monitoring access to and quality of benefits under Medicare and Medicaid.

Medicaid QuaJiW. The Secretary would create procedures to identify health care quality measurements for Medicaid-eligible adults similar to the procedures already underway for children. The Secretary would also establish procedures for and provide grants to states to collect and voluntarily report health care quality data for Medicaid-eligible adults. Additionally, the Secretary, in consultation with states, would be required to identify specific preventable health care acquired conditions and would prohibit payments for services related to such conditions. And finally, a demonstration project to evaluate the use of bundled payments for acute and post-acute care and/or concurrent physician services in up to eight states would be mandated.

Indians. American Indians and Alaska Natives (AIJAN) with incomes at or below 300% of poverty would be exempted from any cost-sharing requirements in Medicaid and Exchange plans. Additional provisions would be included to simplify enrollment for AVANs like

monthly enrollment periods and an expansion of Express Lane to all Indian Health Service, Tribal, and Urban Indian organizations (UTIU) able to make eligibility determinations.

Addressing Health Disparities. Racial and ethnic data collection would be standardized across all federal health care programs and new standards would be established for access and treatment of individuals with disabilities.

Maternal, Infant, and Early Childhood Visitation. The proposal would provide funding to states, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Model options would be targeted 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.

PROMOTING DISEASE PREVENTION AND WELLNESS

Coverage for a Personalized Prevention and Wellness Plan. Beginning January 1**,** 2011, Medicare would cover a health risk assessment and wellness visit with a primary care provider for all beneficiaries every other year. During this visit, beneficiaries would receive a personalized health improvement plan and schedule for Medicare covered and recommended preventive screenings.

Coverage of Preventive Services. Cost-sharing would be removed for preventive services recommended by the U.S. Preventive Services Task Force (USPSTF). The proposal would give the Secretary authority to modify coverage of existing preventive services consistent with USPSTF recommendations.

Incentives for Healthy Lifestyles. The proposal would require the Secretary to establish a five- year initiative to explore providing incentives to Medicare beneficiaries who improve their health status and complete scientifically-based healthy lifestyle programs. The programs would target specific risk factors including high blood pressure, high cholesterol, tobacco use, overweight or obesity, diabetes, and falls prevention.

Improving Access to Preventive Services for Eligible Adults. A state that opts to provide Medicaid coverage for all recommended preventive services and immunizations and removes cost-sharing for these services would receive a one percentage point increase in the federal share of its Federal Medical Assistance Percentage (FMAP) for those services.

Removing Barriers to Preventive Services. States would be required to provide coverage under Medicaid for tobacco cessation services for pregnant women without cost-sharing.

Incentives for Healthy Lifestyles. States could design a proposal and apply for funds to provide incentives to Medicaid enrollees who improve their health status and complete scientifically- based healthy lifestyle programs. The programs would target specific risk factors including high blood pressure, high cholesterol, tobacco use, overweight or obesity, diabetes, and other conditions like depression. The Secretary would be authorized to distribute $1 00 million in grants for this program.

Medical Home State Option for Beneficiaries with Chronic Conditions. This provision would create a new Medicaid state plan option under which Medicaid beneficiaries with chronic conditions could designate a provider as their medical home. Qualifying providers would have to demonstrate that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. Designated providers would be required to report to the state on all applicable quality measures in the state Medicaid program.

IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Hospital Value-Based Purchasing. The proposal would establish a value-based purchasing program for hospitals starting in 201 1. 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 make improvements to the Physician Quality Reporting Initiative (PQRI) program, including requiring all eligible health professionals to participate by 201 1, establishing payment incentives for physicians to appropriately order high-cost imaging services, expanding the Medicare physician feedback program, and penalizing physicians who utilize significantly more resources than their peers.

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, this provision would direct the Secretary to submit a plan to Congress by 201 1 outlining how to effectively move these providers into a value-based purchasing payment system.

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 requiridg the Secretary to implement quality measure reporting programs for certain providers in 201 1. Providers who do not successfully participate in the program would be subject to a reduction in their annual market basket update.

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

Accountable Care Organizations. Groups of providers who work together to improve the quality of care they deliver to Medicare beneficiaries would be able to keep half of the savings they achieve for the Medicare program over a three-year period.

CMS Innovation Center. This provision would establish an Innovation Center at CMS that would have the authority to test new provider payment models. Payment reforms that are shown to improve quality and reduce costs could be expanded throughout the Medicare program. The Innovation Center's funding would be set at $10 billion.

National Pilot Program on Payment Bundling. This provision 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 HospitalAcquired Infections. Starting in 201 1, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare.

Reducing Avoidable Hospital Readmissions. 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 201 1, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20% if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days or by 10% if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days.

Transitional Care Program. This provision would fund eligible hospitals and community-based partnership organizations that provide patient-centered, evidence-based transitional care services to Medicare beneficiaries at the highest risk of preventable re-hospitalization.

STRENGTHENING PRIMARYCARE WORKFORCE AND OTHER IMPROVEMENTS

Primary Care and General Surgery Bonuses. Primary care practitioners, as well as general surgeons practicing in a health professional shortage area would receive a 10% Medicare payment bonus for five years. Half of the cost of the bonuses would be offset through an across- the-board reduction in all other services of approximately 0.5%.

Graduate Medical Education Improvements. Graduate medical education (GME) training positions for primary care would be increased through a slot re-distribution program for currently unused training slots. The proposal would also encourage additional training in outpatient settings and ensure communities retain vital training slots if a hospital closes. It would also establish a Workforce Advisory Committee made up of external stakeholders tasked with working with HHS and other relevant federal agencies to develop and implement a national workforce strategy.

ENSURING BENEFICIARYACCESS CARE AND OTHER TO PHYSICIAN SERVICES

Medicare Sustainable Growth Rate. The scheduled 21% reduction in Medicare physician payment rates in 2010 would be replaced with a 0.5% increase.

Ensuring More Appropriate Physician Payment Rates. This provision would establish a panel comprised of health care providers, experts, and stakeholders to identify physicians' services that are overvalued in the Medicare physician fee schedule. In consultation with the expert panel, the Secretary would be required to adjust payments for those services that have increased at an unusually high annual rate without evidence supporting the clinical appropriateness of such growth.

Provider Access. Certified Diabetes Educators would be added to the list of professionals eligible to provide outpatient diabetes self-management training services. Physician assistants would be permitted to order post-acute care services and would be recognized as attending physicians to serve hospice patients. Small pharmacies would be exempt from the October I, 2009 accreditation requirement in Medicare.

Home Health Payment Reform. The Secretary would be directed to improve payment accuracy through rebasing home health payments in 201 3 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% 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 provision would also reinstate an add-on payment for rural home health providers from 201 0-201 5.

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 by 201 1. 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.

Medicare Disproportionate Share Hospital Payments. This provision would require the

Secretary to update reporting requirements to better account for hospitals' uncompensated care costs, excluding bad debt, in 201 1. Based on this information, 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.

Medicare Improvement Fund. Remaining funds in the Medicare Improvement Fund (MIF) would be accessed.

Imaging Use-Rate Assumption. The utilization rate for calculating the payment for advanced imaging equipment would be increased from 50% to 90%. The Secretary would be

authorized to exempt, on a case-by-case basis, providers who were expected to face a significant hardship from the change, such as a provider who practices in a rural area.

Oxygen Payment Improvements. This provision would repeal the 36 month rental cap, reduce the current rental amount paid through the fee schedule for stationary equipment and contents, and increase the rental amount paid through the fee schedule for portable oxygen contents.

Power Wheelchair Payment Improvement. This provision would eliminate the option for a wheelchair supplier to purchase a power-driven wheelchair with a lump-sum payment (except for complex, rehabilitative power wheelchairs).

Wage Index Report. The Secretary would have to report to Congress by December 3 1,20 11 with recommendations for comprehensive reform of the Medicare wage index system.

Durable Medical Equipment Outlier Payment Rule. This provision would reduce payments in non-competitive-bidding metropolitan statistical areas (MSAs) with spending levels that exceed a benchmark of 1 10% of the national average. MSAs above the benchmark would have payment rates reduced by an amount equal to *75%* of the difference between its spending and the benchmark.

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

This proposal would compute Medicare Advantage (MA) benchmarks based on the weighted average of plan bids beginning in 2014. Plans could keep 100% of the difference between their bids and the new benchmarks as a rebate. This proposal would also pay plans up to two percent of national per capita Medicare costs for operating care coordination programs and up to three percent of national per capita Medicare costs for quality achievement or improvement on a five- star rating system similar to the rating system that is used under current law.

The proposal would also provide for a transition to new benchmarks beginning in 2011.

Specifically, in 201 1 the update to the MA benchmarks would be reduced by three percentage points. In 2012 and 2013, the benchmarks would be computed as a blend of current law benchmarks and plans' bids. In 2014, benchmarks would be set in advance as the average of the 20 13 plan bids increased by the estimated national per capita Medicare growth rate. In 201 5 and beyond, the MA benchmarks would be set by plans' bids for that year.

This proposal would simpli@ extra benefits that plans can offer beneficiaries if they (the plans) earn rebates or bonus payments. The proposal also includes a technical correction to network requirements for private fee-for-service plans.

Special needs plans (SNPs) and cost plans would be extended through 2013, along with some policy changes to the SNP program. It would also move up the start of the annual election period for Medicare Parts C and D from November 15 to October 20 and eliminate the annual enrollment period through March for Part C. Erickson demonstrations would become permanent under Part C beginning in 2011, and Medigap C and F plans would be required to have nominal cost sharing beginning in 2015.

Low-Income Subsidy Provisions. For purposes of calculating the low-income subsidy (LIS) benchmark, this proposal would count Medicare Advantage bids net of rebates and bonus that may be used to buy down Part D premiums. This proposal would also allow LIS plans to waive a de minimus amount of their premiums if they fall above the low-income subsidy benchmarks. It would also extend the LIS redetermination period for widows and widowers by one year. It would require LIS plans to share drug use data for beneficiaries who are auto-reassigned by CMS, and provide outreach/education funds for SHIPS, AAAs, and ADRCs.

Part D Premium Means Testing and Indexing. The proposal would reduce the Part D premium subsidy amount for beneficiaries whose income is at or above the Part B income-relating thresholds. These thresholds would experience a freeze through 2019.

Other Provisions. This proposal would codify existing Part D six-protected classes, simplify and categorize Part D plan information provided to beneficiaries, and prohibit Part D plan sponsors from changing formularies except during open enrollment and under certain circumstances.

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. This provision would reduce payment updates for Part B providers by an estimate of increased productivity.

Temporary Adjustment to the Income-Related Premium for Part B of Medicare. This provision would freeze the current thresholds for income-related Part B premiums at 2009 levels through December **3** 1,20 19.

Medicare Commission. This provision would establish an independent Medicare Commission (MC) that would submit proposals to Congress to extend Medicare solvency and improve quality in the Medicare program. Congress would have an opportunity to amend the proposal or pass an alternative proposal with an equivalent amount of budgetary savings. Should Congress not pass an alternative measure, the Secretary of HHS would be required to implement the provisions included in the original MC proposal.

This proposal would create a non-profit institute to set a research agenda and provide for the conduct of comparative effectiveness research, per the Patient-Centered Outcomes Research Act of 2009. The institute would be governed by a multi-stakeholder board that is appointed by the Comptroller General. Once fully implemented, the institute would be funded with $600 million per year which would come from multiple sources including mandatory

appropriations, the Medicare trust funds, and a fee on health plans. This proposal would also include patient safeguards and provisions to prohibit the Secretary from using the research to ration care through any federal program.

The proposal would simplify the administration of health care by accelerating the development, adoption and implementation of standard, consensus-based operating rules for four HIPAA transactions: eligibility verification, claims status, payment/electronic funds transfer, and remittance advice. The Secretary would be permitted to use interim final rule making to adopt operating standards if they are deemed consensus-based by the National Committee for Vital and Health Statistics (NCVHS). Health insurance plans would be required to comply with consensus operating standards by 2014 or face a penalty. Finally, the proposal would create a process for periodic review and updates to all HIPAA standards.

TRANSPARENCYAND PROGRAM INTEGRITY

Limitation on the Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals. Physician-owned hospitals with a Medicare provider agreement on or before September 1,2009 would be permitted to continue to participate in Medicare, subject to limitations on expansions of beds, operating rooms, or procedure rooms, and new disclosure requirements. Physician-owned hospitals that do not have a Medicare provider agreement before September 1,2009 would be prohibited from participating in Medicare.

Transparency Reports and Reporting of Physician Ownership or Investment Interests. Drug, device and biologic manufacturers would be required to report any payments or transfers of value, with limited exceptions, made to a physician or teaching hospital. The Secretary would publish such information in a clear and searchable format. The provision would not preempt any state or local laws that go beyond the scope of this federal requirement.

Improving Transparency of Nursing Home In formation. Nursing homes participating in Medicaid and Medicare would be required to report certain information pertaining to operations and staffing. These facilities would also be required to adhere to new reporting requirements.

Prescription Drug Sample Transparency. Drug manufacturers and authorized drug distributors would be required to report to the Secretary information already collected pursuant to the Federal Food, Drug and Cosmetic Act. Specifically, manufacturers and distributors would be required to report the type and amount of drug samples requested by and distributed to practitioners, along with the practitioners' names, addresses, professional designations and signatures. The reported information would not be made publicly available.

FRAUD, WASTE, AND ABUSE

Fraud, waste, and abuse in Medicare and Medicaid would be reduced by a series of provisions to prevent and deter wasteful or fraudulent activity as well as assist in the identification and prosecution of such activity once it has occurred. These policies include: a new enrollment process for providers and suppliers, including an application fee; data matching and data sharing across federal health care programs; increased civil monetary

penalties; increased authority to suspend payment during creditable investigations of fraud; and new procedures to disclose and repay overpayments.

REVENUE PROVISIONS

High Cost Insurance Excise Tax An excise tax of 35% would be levied on insurance companies and insurance administrators for any health insurance plan that is above $8,000 for singles and $21,000 for family plans. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market. The tax would apply to the amount of the premium in excess of the threshold. The threshold would be indexed for inflation, and a transition rule would raise the threshold by 20%, lo%, and 5% for the 17 highest cost states for the first three years,

Increasing Transparency in Employer W-2Reporting of Value of Health Benefits. The proposal would require employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

Limit Health Flexible Savings Account Contributions. Contributions to health Flexible Savings Accounts (FSAs) would be limited to $2,000 per year under this proposal.

Eliminate Exclusion for Employer Part D Subsidy. The proposal would eliminate the exclusion from gross income for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

Standardize the Definition of Qualified Medical Expenses. The definition of qualified medical expenses for Health Savings Accounts (HSAs), Flexible Savings Accounts (FSAs), and Health Reimbursement Arrangements (HRAs) would be conformed to the definition used for the itemized deduction. An exception to this rule would be included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.

Increase the Penalty for Use of Health Savings Account Funds for Non-qualified Medical Expenses. This proposal would increase the additional tax for Health Savings Account (HSA) withdrawals prior to age 65 that are not used for qualified medical expenses from 10% to 20%.

Corporate Information Reporting. The proposal would require businesses that pay more than $600 annually to corporate providers of property and services to file an information report with each provider and with the Internal Revenue Service (IRS). Information reporting is already required on payments to non-corporate providers for services.

Non-profit Hospitals Requirements. This proposal would establish new requirements applicable to nonprofit hospitals. The requirements would include a periodic community needs assessment.

Pharmaceutical Manufacturing Companies Fee. Under this proposal, an annual fee of $2.3 billion would be imposed on the pharmaceutical manufacturing sector beginning in 2010. The fee would be allocated by market share.

Medical Device Manufacturers Fee. Under this proposal, an annual fee of $4 billion would be imposed on the medical devices manufacturing sector beginning in 201 0. The fee would be allocated by market share.

Health Insurance Provider Fee. The proposal would impose an annual fee of ***$6*** billion on the health insurance sector beginning in 201 0. The fee would be allocated by market share.

Clinical Laboratories Fee. Under this proposal, an annual fee of $750 million would be imposed on clinical laboratories beginning in 2010. The fee would be allocated by market share, except for small businesses.