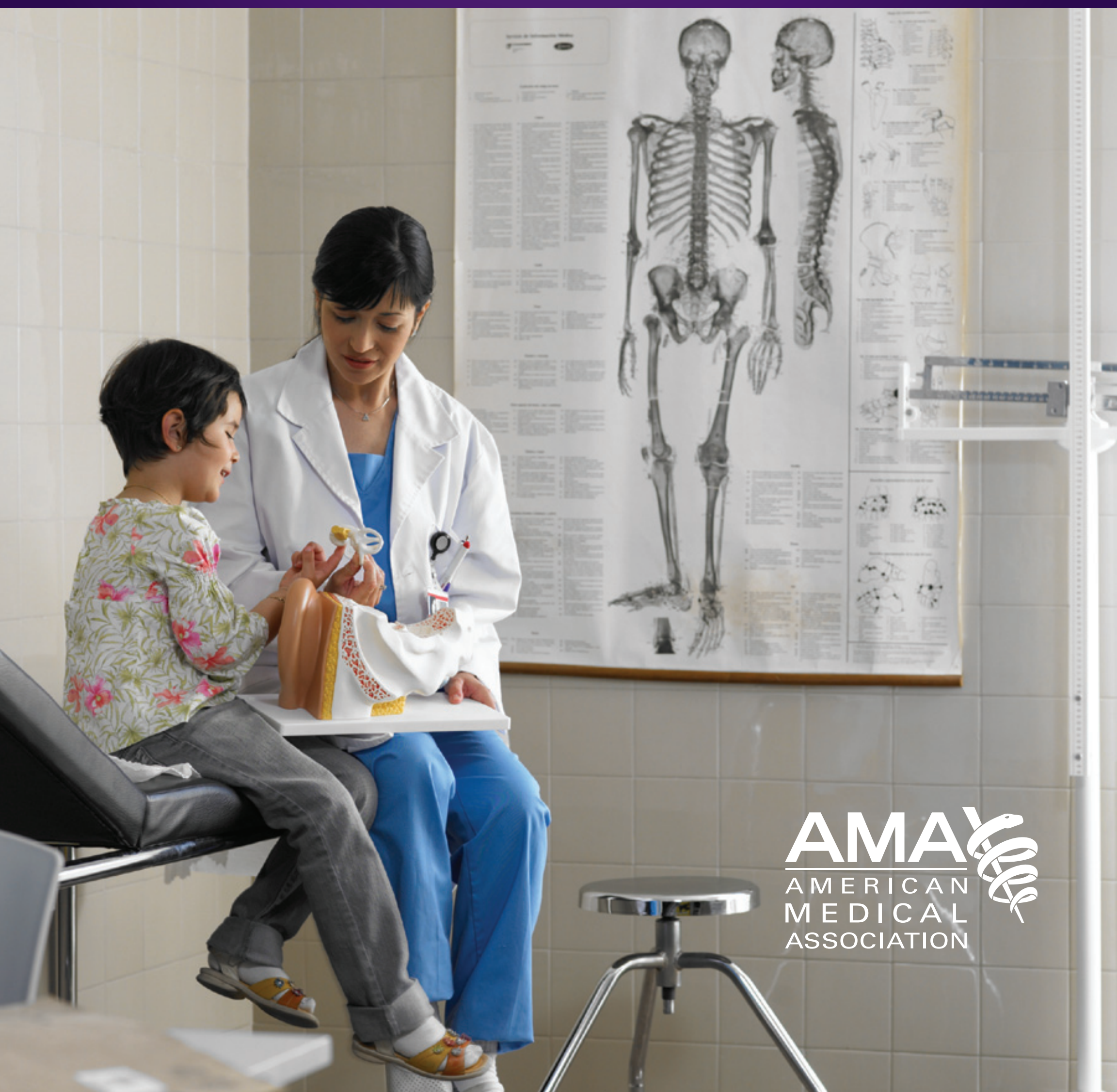
WHAT HEALTH SYSTEM REFORM MEANS TO PHYSICIANS AND PATIENTS

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT



INTRODUCTION TO HEALTH SYSTEM REFORM LEGISLATION

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (P.L. 111-148). This new legislation, which was amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), represents a landmark in the history of health care in the United States. Not since the establishment of Medicare in 1965 has such sweeping legislation been passed. The new legislation:

- Expands health insurance coverage to 32 million more Americans by 2019
- Provides Medicare bonus payments for primary care physicians and general surgeons, as well as increased Medicaid primary care payments
- Increases geographic adjustments to Medicare physician payments in portions of 42 states and territories
- Provides small business tax credits, for which many physician practices are eligible to apply, to assist in the purchase of health insurance for employees
- Replaces some of the worst excesses and abuses of the health insurance industry with strong consumer protections and administrative simplification provisions
- Prevents denials of care and coverage, including those for pre-existing conditions
- Makes health insurance more affordable for families and small businesses through the creation of state health insurance exchanges and the provision of sliding-scale premium tax credits and cost-sharing subsidies
- Expands and improves coverage of preventive services in the public and private sectors, including the elimination of cost-sharing, and provides grants for small employer wellness programs
- Expands state demonstration grants to develop, implement and evaluate alternative medical liability reform initiatives

- Requires employers with more than 50 employees to offer coverage or pay a penalty
- Requires individuals to have minimum coverage or pay a penalty, effective 2014
- Improves Medicare prescription drug benefits by reducing the coverage gap (e.g., “doughnut hole”)

The new law will affect your medical practice and your role as an employer and small business owner. Given the new direction for the nation’s health system, the American Medical Association (AMA) has developed this booklet to help you understand the new law and how it will affect you, when certain provisions are scheduled to take effect, how you can be ready when the regulations go into effect, and what key information your patients need to know.

HOW HEALTH SYSTEM REFORM AFFECTS YOUR PRACTICE

A number of key provisions in the new law may have an immediate impact on your practice and your patients, while others will take effect over a longer period of time. Below is a snapshot of key provisions in the new law that affect physicians and their practices.

MEDICARE AND MEDICAID PAYMENT CHANGES

Medicare Payment Changes

- **10 percent incentive payments for primary care physicians.** All physicians in family medicine, internal medicine, geriatrics and pediatrics whose Medicare charges for office, nursing facility and home visits comprise at least 60 percent of their total Medicare charges will be eligible for a 10 percent bonus payment for these services from 2011–2016.

- **10 percent incentive payments for general surgeons performing major surgery in health professional shortage areas.** All general surgeons who perform major procedures (with a 10- or 90-day global service period) in a health professional shortage area will be eligible for a 10 percent bonus payment for these services from 2011–2016.

- **5 percent incentive payment for mental health services.** For 2010, Medicare will increase payment for psychotherapy services by 5 percent.

- **Increased geographic payment adjustments.** The national average "floor" on Medicare's Geographic Practice Cost Indices (GPCIs) adjustment for physician work expired at the end of 2009. The law re-establishes that floor in 2010. In 2010 and 2011, Medicare will also provide new funding to help primarily rural and low-cost payment areas with physician practice expense GPCIs of less than 1.0. And, beginning in 2011, the practice expense GPCI adjustment will be brought up to the national average for "frontier" states (Montana, North Dakota, South Dakota, Utah and Wyoming). All of these GPCI adjustments will benefit physicians in 56 localities in 42 states and territories.

- **Medicare quality reporting incentive payments extended.** Incentive payments of 1 percent in 2011 and 0.5 percent from 2012–2014 will continue for voluntary participation in Medicare's Physician Quality Reporting Initiative (PQRI). An additional 0.5 percent incentive payment will be made to physicians who participate in a qualified Maintenance of Certification Program (i.e., quality practice-based learning programs through specialty boards). Following the practice now in place for hospitals, and beginning in 2015, physician payments will be reduced if they do not successfully participate in the PQRI program. In 2015, the penalty will be 1.5 percent; in subsequent years it will be 2.0 percent.

Medicaid Payment Changes

The new law raises Medicaid payments to family medicine physicians, general internists and pediatricians for evaluation and management services and immunizations to at least Medicare rates in 2013 and 2014. The law also provides 100 percent federal funding for the incremental costs to states of meeting this requirement.

STREAMLINING THE INSURANCE CLAIM PROCESS

Beginning in 2010, national rules will be developed—and implemented between 2012 and 2016—to standardize and streamline health insurance claims processing requirements. In particular, national rules will be developed for eligibility, claims status transactions, electronic fund transfers, payment and remittance advice, and enrollment and disenrollment. Physicians should benefit from the changes, which will make it easier to track claims and, in many cases, should improve physician revenue cycles and reduce overhead costs.

MEDICAL LIABILITY PROTECTION AND GRANTS

The Secretary of Health and Human Services (HHS) is authorized for five additional years to award demonstration grants to states to develop, implement and evaluate alternative medical liability reform initiatives, such as health courts and early offer programs, beginning in 2011. Medical liability protections under the Federal Tort Claims Act will be extended to officers, governing board members, employees and contractors of free clinics.

PREVENTIVE AND SCREENING BENEFIT EXPANSIONS

Beginning in 2010, Medicaid will be required to cover tobacco cessation services for pregnant women. In 2011, cost-sharing for proven preventive services will be eliminated in Medicare and Medicaid. Medicare payments for certain preventive services will be increased to 100 percent of payment schedule rates (that is, co-payments will be eliminated), and incentives will be available to encourage Medicare and Medicaid beneficiaries to complete behavior modification programs.

In the private sector, beginning in 2010, health plans will be required to provide a minimum level of coverage without cost-sharing for preventive services such as immunizations, preventive care for infants, children and adolescents, and additional preventive care and screenings for women.

MEDICARE PRESCRIPTION DRUG COVERAGE

Medicare patients whose prescription expenses reach the so-called Medicare Part D coverage "doughnut hole" ($2,700 to $6,150) in 2010 will receive a $250 rebate. During the next 10 years, the beneficiary co-insurance rate for this coverage gap will be narrowed in phases from the current 100 percent to 25 percent in 2020. Beginning in 2011, a 50 percent discount on brand-name prescriptions filled in the doughnut hole will apply. A phased-in federal subsidy reaching 75 percent of the drug costs by 2020 for generic drug prescriptions filled in the donut hole will begin in 2011. A phased-in federal subsidy reaching 25 percent of the drug costs by 2020 for brand-name drug prescriptions filled in the doughnut hole will begin in 2013. Between 2014 and 2019, there will be a phased-in reduction in the out-of-pocket amount that qualifies an enrollees for catastrophic care.

PHYSICIAN DISCLOSURE REQUIREMENTS

- Physicians who receive nearly any kind of payment or gifts of $10 or more from a drug manufacturer, device maker, or other medical industry firm will see the information listed on a publicly searchable Web site starting Sept. 30, 2013.

- The "sunshine" provisions of the law also apply to teaching hospitals.

- Any manufacturer of drugs, devices, biologics or supplies covered under Medicare, Medicaid or the state Children's Health Insurance Program (CHIP) must report food, entertainment, gifts, consulting fees, honoraria and other items or services of value that they give to physicians and teaching hospitals.

- Pay or gifts of less than $10 need not be disclosed publicly unless the aggregate annual value exceeds $100. Physicians will have a chance to review and correct the information before it is released to the public. Research funding also must be reported, but does not have to be disclosed publicly for four years or until the product under development is approved, whichever comes first.

PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE

Funding is provided in 2010 to establish a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments without regard to relative cost. Finding from the institute's clinical effectiveness research may not be construed as mandates, guidelines, or recommendations for payment or denials of coverage.

TAX PROVISIONS AFFECTING EMPLOYERS AND EMPLOYEES

Effective 2013, the hospital insurance payroll tax (Medicare Part A) will be increased by 0.9 percent on higher-income workers earning more than $200,000 and on joint filers earning more than $250,000. A 3.8 percent Medicare tax also will be imposed on net investment income (e.g., interest, dividends) and taxable net gain for these same individuals. The threshold for claiming the itemized tax deduction for unreimbursed medical expenses will increase from 7.5 percent to 10 percent for taxpayers under age 65 beginning in 2013. The increased threshold applies to individuals 65 years and older in 2017.

Employer Requirement to Offer Coverage

Employers with more than 50 full-time employees that do not offer coverage and have at least one full-time employee who obtains coverage through a health insurance exchange and qualifies for an individual premium tax credit or cost-sharing subsidy* will be assessed penalties beginning in 2014. The penalty amounts to $2,000 multiplied by the number of full-time employees in excess of 30. If an employer offers coverage but has at least one employee who is entitled to a premium tax credit because the employer's plan is too costly, the penalty is $3,000 for each employee receiving a credit or $2,000 for each full-time employee, whichever is less. Employers of 50 or less, which include the vast majority of physician practices, are exempt from the requirement to provide coverage.

Subsidies for Small Businesses

Beginning in 2010, small business tax credits will be available to employers with 25 or fewer employees with average annual wages below $50,000 if they

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* e.g., individuals with income between 100 percent and 400 percent of the federal poverty level; the federal poverty level in 2010 is $22,050 for a family of four

HEALTH SYSTEM REFORM TIMELINE

2010	2011	2012
Prohibition on pre-existing condition exclusions for children, recissions and lifetime benefit caps	Primary care/general surgery Medicare bonus payments begin	Reduction in Medicare Advantage payment rates begin
Dependent coverage of adult children to age 26 under parents' policies	Extended bonus payments for participation in Medicare PQRI	Medicaid demonstration projects for bundled payments for episodes of care begin
Establishment of high-risk pools for adults with pre-existing conditions	Medical liability reform demonstration grant program authorized for an additional five years	Adoption of unique health plan identifier
Elimination of cost-sharing for preventive care in private insurance	Cost-sharing for proven preventive services eliminated from Medicare and Medicaid	Government Accountability Office study on whether new federal policies create causes of action against providers
Phase-in begins for small business tax credits for employee health plans	Health plans required to provide rebates if medical-loss ratios exceed minimums	
Geographic adjustments to Medicare physician payments increase	Restrictions on physician ownership of specialty hospitals	

2013	2014	2015 AND BEYOND
Health plans operating rules for eligibility and claims status transactions take effect	State-based insurance exchanges for individuals and small business begin	Implementation of Independent Payment Advisory Board recommendations
Public reporting of physician performance information begins	Premium tax credit and cost-sharing subsidies provided to individuals up to 400% of FPL	Individual Medicare physician payments adjusted to reflect cost and quality outcomes
Medicare Part A payroll tax raised 0.9% for higher-income workers	Medicaid eligibility provided to all Americans up to 133% of FPL	Penalties begin for those practices not participating in Medicare PQRI
Flexible Spending Account contributions capped at $2,500	Employers with 50+ workers required to provide coverage or pay penalty	Health plan operating rules for enrollment/disenrollment and referral/authorizations take effect
Increased Medicaid payments to Medicare rates for visit service provided by primary care physicians in 2013–2014	Individuals required to have minimum coverage or pay penalty	Multi-state compacts begin to allow insurers to sell policies across state lines
	Prohibition on pre-existing condition exclusions for adults	

purchase health insurance for their employees. (This tax credit is separate and distinct from the individual tax credit that low-income individuals may be eligible to receive if they purchase insurance through an exchange.) Between 2010 and 2013, the tax credit can be up to 35 percent of the employer's contribution toward the premium, provided the employer contributes at least 50 percent of the total premium cost. The full 35 percent credit will be available to employers of 10 or less with average annual wages below $25,000. The credit phases out as firm size and average wage increase. In 2014 and beyond, for eligible small businesses purchasing coverage through the state exchanges, the tax credit increases to 50 percent of the employer's contribution toward the premium, provided it is at least 50 percent of the total premium cost. The credit will be available for two years. The full credit will be available to employers of 10 or fewer with average annual wages of less than $25,000. According to the IRS, the wages and hours of physician business owners and partners will not be counted in calculating either the number of full-time employees or the average annual wages.

Limitations on Employer Deductions

- Expenses allocable to Medicare Part D subsidy—Effective 2013, employers that currently sponsor retiree prescription drug plans will no longer be able to deduct amounts contributed to them. However, future Medicare Part D subsidies will continue to be tax-free to the employer.

- Limitation on excessive health insurance company compensation—Effective 2013, the deduction for executive and employee compensation for health insurance providers is limited to $500,000 per applicable individual. The limit applies to all officers, employees, directors and other workers.

HSA, MSA and FSA Changes

Effective 2011, the tax on distributions from a Health Saving Account (HSA) or Archer Medical Savings Account (MSA) that are not used for qualified medical expenses is raised to 20 percent. Also effective 2011, the cost of over-the-counter medicines may not be reimbursed through a Flexible Savings Account (FSA), HSA, Archer MSA, or Health Reimbursement Arrangement, unless obtained with a prescription. Effective 2013, contributions to FSAs are capped at $2,500.

HOW HEALTH SYSTEM REFORM AFFECTS YOUR PATIENTS

The law will initiate changes right away in 2010 to reduce health care costs for your patients, expand coverage, restrain some of the worst insurance industry practices, and toughen consumer protections. For example, your patients will have the security of knowing that insurers cannot deny coverage to their children because of a pre-existing condition. They will no longer have to live in fear of having their insurance taken away if they get sick. And for new plans, insurance companies won't be able to place lifetime or restrictive annual limits on the amount of care patients receive.

IMMEDIATE PATIENT BENEFITS IN 2010

- Eliminates pre-existing condition denials for children, rescissions and lifetime health benefit caps. Restricts the use of yearly limits in individual and group health plans.
- Permits young adults to stay on their parents' health care plan until age 26. This applies to all plans in the individual market, all new employer plans, and existing employer plans if the young adult is ineligible for employer coverage on his or her own.
- Creates a temporary state-based high-risk pool program to provide health coverage to individuals with pre-existing medical conditions, until the state exchanges become operational in 2014. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. A temporary national risk pool will be established to cover states that opt not to establish their own.
- Requires health plans to report the proportion of premium dollars spent on clinical services ("medical-loss ratio").

- Provides a $250 rebate to Medicare patients who reach the Medicare Part D coverage gap (the "doughnut hole").

- Requires health plans to provide a minimum level of coverage without cost-sharing for preventive services such as immunizations, preventive care for children, and additional preventive care and screenings for women.

- Establishes an interim health plan, the Early Retiree Reinsurance Program, for companies that have early retirees between the ages of 55 and 64 years.

- Establishes an Internet portal to help individuals and small businesses identify insurance options in their state.

- Ensures that Americans can access an independent appeals process so they can appeal decisions made by their health insurance plan.

PATIENT BENEFITS IN 2011

- Provides a free annual wellness visit and personalized prevention plan for Medicare beneficiaries without cost-sharing.

- Provides a 50 percent discount on all brand-name drugs in the Medicare Part D coverage gap ("doughnut hole") and begins phasing-in additional discounts on brand-name and generic drugs.

- Cost-sharing for proven preventive services is eliminated from the Medicare and Medicaid programs.

- Requires all health plans to provides rebate to enrollees if the medical-loss ratio is less than 85 percent in large plans and 80 percent in the individual and small group markets.

PATIENT BENEFITS IN 2014

- Establishes state-based insurance exchanges for individuals and small business a choice of private health plans.

- Offers standardized, understandable information through the exchanges about the various health insurance plans offered in a geographic region so families can easily compare prices, benefits, and health plan performance and to decide which option is best for them.

- Requires the Office of Personal Management to contract with health insurers to offer at least two multi-state plans through exchanges in each state.

- Provides sliding-scale premium tax credits to individuals up to 400 percent of the federal poverty level (FPL) to purchase private insurance on the exchanges and related cost-sharing subsidies. *(See footnote, page 6.)*

- Requires individuals to have minimum health insurance coverage or pay a penalty, with exemptions for those who cannot afford coverage or have religious objections.

- Expands Medicaid eligibility to all individuals under age 65 up to 133 percent of the FPL.

- Eliminates pre-existing condition denials for adults.

- Requires that health plans accept every employer or individual who applies; plans must renew or continue coverage for all members; requires no waiting period more than 90 days.

- Requires health plans to cover participation in clinical trials.

- Caps group health plan deductibles at $2,000 for individuals and $4,000 for others subject to cost-of-living adjustments.

- Requires states to maintain their current income eligibility levels for children in Medicaid and the CHIP until 2019.

WHAT'S NEXT?

While the new law represents a tremendous step forward on the path toward meaningful health system reform, it is not the last step, but rather the beginning. A number of key provisions in the law will be implemented this year, but many others will not become effective until a number of years in the future, allowing the AMA and state and specialty societies to have maximum input in the regulatory process and to seek further legislative changes.

The AMA will continue to advocate to impact and make changes in the following:

MEDICAL LIABILITY REFORM

As previously noted, the new law authorizes the Secretary of HHS to award competitive grants to states for the development, implementation, and evaluation of alternative models to current tort litigation. It also includes a provision that allows patients to opt out of these alternatives at any time and pursue their liability claim in court. The secretary will consult with a review panel on grant proposals. The secretary must enter into a contract with a research organization to conduct an evaluation of the effectiveness of the grants and to annually prepare and submit a report to Congress. The law states that such an evaluation must start within 18 months of the implementation of the first program funded by a grant. The Medicare Payment Advisory Commission (MedPAC) is required to conduct an independent review of the impact of state-implemented alternative liability reforms on the Medicare program and its beneficiaries. The Medicaid and CHIP Payment and Access Commission (MACPAC) is also required to conduct an evaluation of the Medicaid and CHIP programs and their beneficiaries.

The AMA had continuously urged Congress and the administration to include meaningful medical liability reform as a critical component of health system reform. To preserve patients' access to care and help reduce health care costs, the AMA will continue to lead an aggressive, multi-year campaign to reduce medical liability premiums and to fix the broken medical liability system for both patients and physicians:

- The AMA is urging Congress to pass Medical Injury Compensation Reform Act (MICRA)-like reforms, including a $250,000 cap on non-economic damages.
- The AMA will continue to work with HHS and the Agency for Healthcare Research and Quality (AHRQ) on the implementation and evaluation of the grant programs.
- At the state level, AMA is collaborating with state medical associations to pursue traditional medical liability reforms as well as assisting states as they investigate and implement promising alternative reforms.
- The Litigation Center of the AMA and State Medical Societies continuously works to defend medical liability reforms in the courts.

INDEPENDENT PAYMENT ADVISORY BOARD

One of the most controversial provisions of the Patient Protection and Affordable Care Act was the establishment of an Independent Payment Advisory Board (IPAB). The AMA is opposed to the current scope and authority of the IPAB and the lack of flexibility in its mandate. Modification of the IPAB authority and framework is one of the highest legislative priorities for the AMA in the next session of Congress. Next year, there will be extensive debate in Congress regarding changes in the IPAB framework and authority.

The Act established the 15-member IPAB to extend Medicare solvency and reduce spending growth through the use of a spending target system and fast-track legislative approval process. By April 30 of each year—beginning in 2013—the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary will project whether Medicare's per-capita spending growth rate in the following two years will exceed a targeted rate. Initially, the targeted rate of spending growth will be based on the projected five-year average percentage increase in the Consumer Price Index for all urban consumers and the Consumer Price Index for all urban consumers for medical care.

If Congress fails to pass legislation by August 15 each year to achieve the required savings through other policy changes, the IPAB's recommendations will automatically take effect. The IPAB is prohibited from submitting proposals that would ration care, increase revenues, change benefits, modify eligibility, increase Medicare beneficiary cost-sharing (including Parts A and B premiums), or change the beneficiary premium percentage or low-income subsidies under Part D.

NEW PAYMENT AND DELIVERY REFORM MODELS

The law establishes several demonstration programs to test and evaluate a variety of new payments models which are voluntary and generally do not begin until 2012. The AMA will advocate strongly to impact the development and implementation of these demonstrations:

- CMS Center for Innovation (2012)—test care models to improve quality and slow rate of growth in Medicare costs. Secretary of HHS may use models that promote the patient-centered medical home, care coordina-

tion for chronically ill individuals, and compensation for physicians using patient-support tools.

- Medicare Shared Savings Program (2012)—a three-year accountable care organization (ACO) pilot test that can include groups of physicians, networks of individual practices, partnerships between hospitals and physicians, and hospitals employing physicians.

- National Bundling Pilot Program (2013)—Medicare pilot for integrated care that will include episodes of care involving a hospitalization to improve coordination, quality and efficiency of services.

- Independence at Home Demonstration Program (2012)—pilot to bring primary care services to the homes of high-cost Medicare patients with multiple conditions.

- Extension of Gainsharing Demonstration—existing gainsharing demonstration between hospitals and physicians is extended for two more years.

- Community Health Teams to Support the PCMH—Secretary of HHS to provide grants or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional "health teams" to support primary care practices within local hospital areas.

ADDITIONAL PRIORITIES

The AMA also will be pursuing needed regulatory and/or legislative changes to address the public reporting of physician claims data to develop performance reports (2013), implementation of a value index adjustment to individual physician payments based on cost and quality incomes (2015), and penalties for not participating in the Medicare Physician Quality Reporting Initiative (2015).

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HEALTH SYSTEM REFORM RESOURCES

The American Medical Association (AMA) has developed a series of resources to help you navigate the ins and outs of health system reform. Visit our site often as we continue down this important path on behalf of America's physicians and patients.

www.hsreform.org

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