

Review of the Tri-Committee Affordable Health Care Choices Sections of interest to physicians

The House Tri-Committee bill expands health insurance coverage primarily through two mechanisms: the creation of a Health Exchange and expansion of Medicaid.

The Exchange

Plans that are sold through the Exchange will be required to meet minimum standards, and can offer more benefits to obtain one of several higher benefit levels. An advisory committee Chaired by the Surgeon General would be responsible for making recommendations to HHS about the coverage required to meet the various levels of plans in the Exchange.

Companies will still be able to offer packages outside of the Exchange that do not meet the Exchange standards (but would have to meet the appropriate state regulations, as is currently the law).

The Exchange will have a step-wise availability to the population. It will initially be open to those currently in the individual market, as well as employees of firms with less than 10 employees. In subsequent years, the Exchange will become available to more employees at larger firms until everyone has the option in year 5. Medicaid-eligible families would be enrolled only in Medicaid rather than the Exchange for the first five years, then would be able to enroll through the Exchange. There will be credits available to families up to 400% Federal Poverty Level for plans purchased through the Exchange. These credits will not be available to families currently offered insurance through an employer unless that plan costs more than 10% of their income.

The Public Health Insurance Option would start in 2013, to be available through the Exchange. It would be under the same regulations as the private insurance. Premiums will be geographically-adjusted and must cover the cost of the program (ie, no tax dollar support). Payment rates for the first three years (2013-15) will be based on Medicare rates plus 5%. After three years, the HHS can change the rates as necessary to ensure access, affordability and efficient delivery of care. The payment system can further be changed to develop new ways to reimburse for care to enhance health outcomes, reduce health disparities, manage chronic illnesses and encourage care-integration.

The Public Health Insurance Option can negotiate for drug prices. The Medicare Part D Donut is phased out by 2023. Part D beneficiaries can change plans mid-year if a formulary change adversely affects them.

Providers currently participating in Medicare would be automatically enrolled in the Public Health Insurance Option unless they opt out. "Balance billing" would be limited. The Sustainable Growth Rate is repealed. Medicare will increase payment for primary care services and psychiatry. Primary care reimbursement will be allowed to increase at a faster rate than other providers. It also provides incentives to physicians practicing in areas that provide cost-efficient care (lowest quintile of per-capita costs nationally).

Payment to hospitals will be linked to re-admission rates for three conditions (to be named later) starting in 2011. Integrates post-acute care providers into the payment system in the following years.

Medicare will have an alternative payment system through Accountable Care Organizations, which are physician grouped around a common delivery system (hospital or integrated practice). Spending will be benchmarked; quality care delivered at reduced costs will be rewarded.

Demonstration projects for language services, which will be studied by IOM.

Eliminates cost-sharing for preventive services in Medicare and Medicaid. Requires smoking cessation to be covered as prevention by State Medicaid programs.

Cost effectiveness research center in AHRQ to be guided by public/private stakeholder commission. The commission cannot mandate coverage for public or private plans (advisory role only).

Physician Payment Sunshine Provisions requires disclosure of any payment from a device or pharmaceutical company to a provider of value above \$5.