California Medical Association
Physicians dedicated to the health of Californians

THE PROS AND CONS OF HEALTH CARE REFORM

Senate Health Reform (HR 3590): Patient Protection and Affordable Care Act
Budget Reconciliation (HR 4872): Affordable Health Care for America

(All provisions take effect in 2014, unless otherwise indicated.)

PROS

- Covers 80% of California's 6.5 million uninsured.
    - 1.4 million undocumented and new legal immigrants not covered
    - 1.7 million to Medi-Cal (under 133% of FPL; $26,000 family of four)
    - 2.3 million to private health plans in the exchange (133-400% FPL, $88,000 for a family of four)
    - 1 million to private health plans in or out of the exchange (above 400% FPL)
    - ~ 2/3 of those eligible may choose from a variety of private health plans.
- Provides tax credits to individuals and small businesses to afford health insurance. Some small business credits begin in 2010.
- No public option. No mandate for physicians to participate at Medicare levels.
- 100% federal financing of the Medicaid expansion through 2016 and phases down to 90% in 2020 and later years.
- Catastrophic-only coverage option for those under 30 years old. Effective 2010.
- Option to extending parent's coverage to children under age 26. Effective 2010.
- Temporary national high-risk pool with subsidized premiums for low-income uninsured with pre-existing conditions who have been denied health care coverage. Effective 2010 to 2014.
- Temporary reinsurance program for employers providing coverage to retirees ages 55-65.

Ending Insurance Industry Abuses

- 85% Medical Loss Ratio requires health plans to dedicate 85% of revenues to direct patient care rather than overhead and profit. Effective 2010.
- Health plans must have adequate provider networks.
- No insurance denials for pre-existing conditions. For children, Effective 2010.
- Prohibits insurance companies from dropping coverage when a patient gets sick. Effective 2010.

- No life-time or annual limits on benefits. Effective 2010.

- State-based Health Insurance Exchanges will provide wide choice of plans and benefits. Exchanges are state-based, not national. Same program that Members of Congress and federal employees use, known as the Federal Employees Health Benefits Plan (FEHBP).

Medicare

Medicare Primary Care Bonus

All primary care physicians (internists, geriatricians, family physicians and pediatricians) whose Medicare charges for office visits, home visits and nursing facility services (HCPS codes 99201-99215; 99304-99340; and 99341-99350) that comprise at least 60% of their total Medicare charges will be eligible for a 10% bonus payment for these services over a five year period 2011-2016. The bonus could be paid on a monthly or quarterly basis for each service that qualifies for payment. The bonus payments are not cumulative.

Medicare Rural General Surgeons Bonus

All general surgeons practicing in a health care professional shortage area (HPSA) who perform procedures with a 10- or 90- day global service period will be eligible for a 10% bonus payment for these services over a five year period 2011-2016. The bonus payments are not cumulative.

- Bonus payments for medical homes. Demonstration programs begin 2012.

- Bonus payments for physician who coordinate care through new Accountable Care Organizations (can be a small group of loosely affiliated physicians or large organized groups of physicians who report on quality and coordinate care). The group can involve a hospital but they do not have to do so. If there is reduced Medicare spending in their region from fewer ER visits or unnecessary hospitalizations, the group can share in the savings. Effective 2012.

- Accountable Care Organizations could provide a path to anti-trust relief for small or large groups of physicians to negotiate better contracts with Medicare and private plans.

- Quality reporting programs are voluntary in 2010-2014 with annual bonus payments.

- Elimination of the donut hole for Medicare prescription drugs. Effective 2010.

- New investments in physician medical training, physician workforce. Effective 2011.

- Equalizes Medicare Advantage health plan payments with Medicare FFS payments. Phased-in starting in 2011.

Medicaid

- 100% federal financing for the Medicaid expansion of 1.7 million new California enrollees. The federal match phases down to 90% in 2020 and thereafter.

- **40-50% payment increase for primary care**: internists, family physicians and pediatricians for E&M services and immunizations up to Medicare levels for 2013-2014. 100% federally financed.

Other Issues

- Requires administrative simplification by all payers to reduce physician billing hassles. Effective 2010.
- Stops the escalating growth in the number of uninsured and uncompensated care.
- Investments in prevention and wellness. Effective 2010.
- Comparative effectiveness research to provide clinical tools to help physicians. This includes strong prohibitions against using information for coverage and payment. Effective 2010.
- Allows patients to privately contract with the physician of their choice in the private sector.
- Non-partisan Congressional Budget Office estimates that the bill will reduce the deficit by over 20 years. $138 billion in first 10 yrs and $1.2 trillion in second decade. Slows rate of health care spending growth from 6%/yr to 5% yr.

CONS

- **Three major California physician payment issues are not addressed.**
    - No Repeal of the Medicare SGR: While the House passed legislation to repeal the SGR, the Senate has not yet acted. AMA is in the final stages of high-level negotiations with the President and Senate leaders to reform the SGR. They are hoping to announce an agreement this spring.
    - No Medicaid Rate Increase for All Physicians: Unlike the House bill, the final bill does not provide a Medicaid rate increase to all physician specialties. The rate increase is only for primary care. Chairman Waxman has vowed to revisit this issue in the near future.
    - No CA GPCI Fix: There is no California GPCI payment update for physicians in 14 CA counties. The House bill would have updated California's Medicare physician payment locality borders and increased rates as much as 13% in 14 counties. The California GPCI fix was removed from the final bill with all of the other single-state deals (i.e., Nebraska cornhusker deal). However, California Congressional leaders have committed to CMA to work to include it in the Medicare SGR legislation later this year.
- Independent Medicare Payment Advisory Board (IPAB). The Independent Medicare Commission removes Congress's accountability to physicians and seniors for the Medicare program. It mandates provider payment cuts if Medicare spending exceeds general health care spending. Due to the Congressional rules, changes to the IPAB could not be included in the reconciliation bill. Therefore, the IPAB must be dealt with in subsequent legislation. California's Democratic House leaders strongly oppose the IPAB and have vowed to reform it in future legislation.

Medicare

- Quality Reporting Data Made Public. While CMA and AMA were able to win many amendments to protect the validity of physician data, CMA believes these programs should continue to be tested and improved to ensure the accuracy of the information before wide implementation. CMA and AMA both attempted to get changes in the reconciliation bill but they were ruled out of order. The quality issues will be addressed in clean-up legislation. Effective 2013/2015.

- $1.2 Billion in Cuts to Advanced Imaging Services. However, the reconciliation bill reduces the cuts so they are not as severe and only applied them to expensive equipment priced at more than $1 million. Initial savings from the cuts was $4 billion. Phased-in starting in 2010.

- Does not allow private contracting in Medicare.

- Allows nurse practitioners to lead medical homes but only within state scope of practice laws. California state law currently prohibits nurse practitioners from running medical homes.

- Ban on future physician-owned hospitals. Effective date changed to December 21, 2010.

- Medicare Advantage health plan payment cuts reduce payments to California's medical groups. However, plans that meet quality standards are eligible for bonus payments. Effective 2011.

Other Provisions

- Requires health plans to accommodate ancillary providers in their networks.

- No funding for care provided to uninsured undocumented immigrants.

- Cadillac Tax falls disproportionately on Californians.

- CMA was able to get additional liability protections in the House bill but they were not included in the final bill. This issue will need to be addressed in clean-up legislation.