

**H.R. 3962, Affordable Health Care for America Act**  
**Snapshot of Key Issues**

Introduced Oct 29, 2009

KEY ISSUES IN H.R. 3962	CONSISTENT WITH ACP POLICY?
<b>Coverage</b>	
Medicaid expanded to cover the poor (133% of FPL)	Yes. Medicaid eligibility is increased to 150% FPL. Some Medicaid-eligible individuals can receive exchange-based coverage during “transition periods.” ACP has endorsed expanding Medicaid to 133% of FPL, compared to 150% in H.R. 3962.
Sliding scale tax credits	Yes. Premium assistance available for qualified legal resident individuals with incomes between 133-400%. Cost-sharing credits and out-of-pocket limits are also in the bill.
People can keep own insurance or buy coverage through an exchange	Yes. Individual market health insurance purchased before Y1 is considered acceptable. After 5 year period beginning Y1, employment-based insurance operating prior to enactment must meet requirements relating to insurance reforms and minimum benefits. Uninsured (or underinsured) individuals and some small businesses permitted to purchase coverage in an insurance exchange.
Health plans must cover people with pre-existing conditions, guarantee renewability, not vary premiums based on health	Yes. Qualified health plans (QHP) cannot exclude coverage based on pre-existing conditions nor can they rescind coverage. All insurance plans must abide by guaranteed issue and renewal requirements. Premium rates for QHPs can vary only by age (2 to 1), geographic area, family enrollment.
Employers required to fund health insurance coverage	Yes. Employers must either provide coverage to employees or pay a fee to the Health Insurance Exchange Trust Fund based on the amount of average wages paid by employer. Fee is capped at amount equal to 8% of average wage. Businesses with annual payroll of under \$500,000 are exempt from fee. Fee is phased in for applicable businesses.
Individuals required to have coverage	Yes. Individuals who do not acquire acceptable coverage must pay a fee of 2.5% of taxpayer’s modified adjusted gross income for taxable year. Tax is capped at level of national average premium. Exceptions made for nonresident aliens, dependents, religious objectors, etc.
Plans must provide essential benefits, including preventive services; no cost-sharing for preventive services	Yes. QHP must provide coverage of essential benefits package which includes among other things hospitalization, outpatient/emergency dept care, physician care, and preventive care including svcs recommended w/ grade A or B by Task Force on Clinical Preventive Services and vaccines. No cost-sharing for preventive and well-child/baby care. Cost-sharing on the package is also limited.
<b>Workforce</b>	
Advisory council to recommend workforce goals	Yes.
Scholarships and loan repayment programs for primary care physicians	Yes, includes increased funding for NHSC plus the option of part-time service in NHSC for half the reward amount. Full time awards increased from \$35k to \$50k. Also includes the Frontline Health Providers Loan Repayment Program for needed specialties including primary care that are not in HPSA’s (90% of awards are for primary care providers). Faculty Loan Repayment awards

	increased from \$20k/year to \$35k/year.
Increased GME slots for primary care Other primary care workforce provisions: Includes a demonstration program to direct GME funds directly to certain Teaching Health Centers to develop and operate primary care training programs rather than the hospital; primary care training and enhancement grants under Title VII, grants for interdisciplinary training under Title VII. Eliminates barriers to ambulatory training and calls for an OIG study on the impact of changing these rules on increased ambulatory training.	Yes, redistributes unused residency slots to hospitals that agree to maintain their current primary care levels and use the new slots only for primary care.  All training program related provisions are in line with ACP policy.
<b>Delivery and Payment System Reform</b>	
Eliminates current Sustainable Growth Rate and accumulated cost	Yes, but addressed in separate bill, HR3961, introduced today as the Medicare Physician Payment Reform Act of 2009.
Higher updates for primary care (separate and higher spending target for primary care)	Yes, but addressed in HR3961.
Bonus payments for primary care: 5% for designated services by primary care physicians, increased to 10% in health professional shortages areas; permanent beginning in 2011.	Yes
Patient centered medical home to be tested on a national scale	Yes. Creates community-based pilot, independent practice pilot.  The provision could be improved through:  -Modifying the language to include a requirement that the pilots be designed to encourage the participation of physicians in practices with fewer than three full-time equivalent physicians to recognize the extent that small practices provide a significant amount of Medicare services.  -Modifying the patient participation requirements under the Independent Practice to include a broader group of patients. More specifically, to replace the patient eligibility threshold that includes the sickest 50 percent of patients with the more inclusive threshold of "one or more chronic conditions" or all patients.
IOM study on Medicare Geographic Variation in Medicare Payments and Payment Reform with fast-track implementation	Neutral--This provision is much more restricted in focus than the proposed Senate IMAC or Medicare Commission provision. It meets most, but not all of College policy, but, at the same time, provides adequate input for the College and Congress to address proposed Medicare recommendations that are contrary to the interest of our members.
Establishes Innovation Center to fast-track testing of new payment models	Yes
Improves PQRI and refrains from imposing punitive payment penalties	Yes
Medicaid primary care pay increased to Medicare rates	Yes. Medicaid primary care payments will increase to 80 percent of Medicare in 2010, 90 percent of Medicare in 2011, and 100 percent in 2012 and thereafter.
Funding for a transparent process to conduct Comparative Effectiveness Research (CER)	Yes. Broadly consistent with College policy. Most of the troubling amendments added during the E & C mark-up were excluded or positively modified. The provision is silent on considering cost issues in research, or use of comparative effectiveness cost information by Secretary. Does contain prohibition against CE information being used to ration or deny care.

<b>Administrative Simplification</b>	
Standardize language and forms	Yes
Establish standard operating rules and companion guides for using and processing health care transactions	Yes
Increase consistency of claims edits and code corrections	Yes
Increase electronic exchange of administrative and clinical data	Yes
Development of machine-readable "smart card" technology	Yes
Plans must spend at least 85% of premiums on patient care instead of administration	Yes. Plans must annually spend at least 85% of premium dollars on medical care, known as the medical loss ratio (the Secretary can set the required percentage but the minimum is 85%). Plans that spend less than the required minimum must provide rebates to enrollees that total the amount in which their medical care spending is deficient.
<b>Public Plan Option</b>	
Offers a public plan to compete on level playing field with private insurers	Yes. Beginning in Y1, public plan will be established as an exchange-participating health plan. Premiums would be set at level sufficient to fully fund costs of health benefits provided and admin costs. Public plan will receive \$2 million in start-up funds but will be required to pay back that amount. Federal bail-out is prohibited.
Physician participation is voluntary---not mandated if you also accept Medicare	Yes. Medicare-participating physicians are considered public plan-participating unless they opt-out. Sec. 325 states that Sect'y shall establish conditions of participation for providers under public plan.
Secretary shall negotiate rates with providers. Not based on Medicare rates	Yes. Sect'y will negotiate rates for physicians and other providers and services (incl. prescription drugs). Negotiated rates cannot be lower than Medicare or higher than average rates of other QHPs. Sect'y is authorized to pay for innovative delivery services such as PCMH and cost-sharing and payment rates may be modified to encourage their use.  Sec. 325 establishes payment terms for preferred physicians (those who accept public plan rates) and non-preferred physicians (those who balance bill based on Medicare policy). Negotiated payments will be reduced for non-preferred physicians. Non-physician providers are required to accept negotiated rates as payment in full.
<b>Medical Liability Reform</b>	
Establishes caps on damages; provides alternative methods for resolving disputes.	Somewhat. States shall be given incentive payments if a state enacts an alternative medical liability law that allows for certificate of merit or early offer or both but the law cannot limit attorneys' fees or impose caps on damages.