

**Health System Reform  
Legislative Summary Chart  
of Major Provisions  
December 21, 2009**

Issue	House of Representatives HSR Bill H.R. 3962 Affordable Health Care for America Act	Senate HSR Bill H.R. 3590 Patient Protection and Affordable Care Act	Senator Reid's Manager's Amendment To H.R. 3590 Significant Changes to Key Provisions	AMA Policy and Comments
Health Insurance Market Reforms	<p>Establishes new federal health insurance standards in individual and small group markets (most effective in 2013): bans coverage exclusions of pre-existing health conditions or rating or coverage restrictions based on health status; requires guaranteed issue and guaranteed renewability, and modified community rating, with limited premium variation allowed based only on age (2:1), geographic area, and family size. Imposes federal standards regarding network adequacy and requires minimum medical loss ratios. No annual or lifetime limits allowed. Requires health plans to allow young people to remain on their parents' insurance policy up to their 27<sup>th</sup> birthday. Allows states to enter into compact permitting sale of insurance across state lines when the state legislatures agree. National plans, with uniform benefit packages that are offered across state lines, are allowed. Sec. 211-217; 309</p> <p>Provides for immediate reforms in 2010 including: ending health insurance rescission abuse; requiring pre-implementation review of increases in health insurance premiums; elimination of lifetime limits; limits on pre-existing condition exclusions by group health plans in advance of new prohibition on pre-existing condition exclusions; and creation of a temporary national high-risk pool program with financial assistance for those who have been uninsured or denied a policy due to pre-existing conditions (expires when Exchange is operational). Also extends COBRA coverage for individuals until Exchange is running.</p>	<p>Establishes new federal health insurance standards in individual and small group markets: bans coverage exclusions of pre-existing health conditions or rating or coverage restrictions based on health status; requires guaranteed issue and guaranteed renewability and modified community rating, with limited premium variation allowed based only on age (3:1), geographic area, tobacco use, and family size. Requires health plans to allow young people to remain on their parents' insurance policy up to their 26<sup>th</sup> birthday. Requires insurers to report medical loss ratios and provide rebates. Interstate sale of insurance permitted; national plans, with uniform benefit packages that are offered across state lines, are allowed (with state opt-out). Title I, Subtitles A, C; Subtitle D, Sec. 1333.</p> <p>Provides for immediate reforms in 2010 including: a temporary high-risk pool with subsidized premiums for those with pre-existing conditions who have been denied health coverage and have been uninsured for at least six months; ending health insurance rescission abuse; standards for medical loss ratios to ensure that premiums are spent on health benefits, public disclosure of overhead and benefit spending by health insurance issuers, and premium rebates for insurers that exceed standards for overhead expenses; coverage of certain preventive health services without cost-sharing; ban on lifetime limits on benefits and restricting annual limits on benefits; and development of uniform explanation of coverage documents for</p>	<p><u>No lifetime or annual limits.</u> Prohibits all plans from establishing lifetime limits, and annual limits beginning in 2014, on the dollar value of benefits. Prior to 2014, plans may not have lifetime limits and may only establish restricted annual limits, as defined by the HHS Secretary, on the dollar value of benefits with respect to the essential health benefits; requires the Secretary to ensure access to needed services with minimal impact on premiums. Sec. 1001(5).</p> <p><u>Transparency in coverage.</u> Requires plans to provide a summary of coverage to applicants and policyholders, as well as to enrollees. Requires all plans to disclose information such as claims payment policies and rating practices to the Exchange (except for non-Exchange participating plans), the Secretary, the state insurance commissioner, and the public. Sec. 1001(5), 1311(e)(3).</p> <p><u>Medical loss ratio.</u> Beginning in 2011, requires a medical loss ratio of at least 85 percent for large groups, and 80 percent for small group and individual market plans or rebates must be provided to enrollees. Clarifies requirement applies to grandfathered plans. Sec. 1001(5)</p> <p><u>Patient protections.</u> New section requires that plan enrollees be allowed to select their primary care provider (or pediatrician for a child) from any available participating primary care provider. No prior authorization or increased cost-sharing for emergency services, whether provided by in-network or out-of-network providers. Requires direct access to obstetrical</p>	<p>These provisions are generally consistent with AMA policy (e.g., Sub. Res. 203 and other policy) opposing pre-existing condition exclusions and supporting modified community rating, guaranteed issue in the context of an individual mandate, guaranteed renewability, insurer transparency regarding medical loss ratios, and ending rescission abuse.</p> <p>Provisions allowing the sale of health care insurance across state lines should clarify that state patient and provider protections are not preempted.</p>

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	Title I	enrollees. Title I, Subtitles A and B.	<p>or gynecological care. Sec. 1001(5)</p> <p><u>Medical reimbursement data centers.</u> Allows for the creation of medical reimbursement data centers at academic or non-profit institutions to collect medical reimbursement data from insurers, develop fee schedules that reflect market rates for medical services, and make such information available to the public through the Internet. Sec. 1003</p> <p><u>Rating requirements/waiting periods.</u> Clarifies that rating requirements would apply only to insured plans in the large group market, not self-insured plans, and that restriction on waiting periods of more than 90 days applies only to group plans. Sec. 1201(4).</p> <p><u>Pre-existing conditions.</u> Applies prohibition on pre-existing condition exclusions with respect to children effective six months after enactment. Sec. 1253.</p> <p><u>Clinical trials coverage.</u> Prohibits insurers from dropping coverage because an individual participates in an approved clinical trial that treats cancer or other life-threatening diseases, and from denying coverage for routine patient costs. Sec. 1201(4).</p> <p><u>National plans.</u> Replaced with multi-state plans—see below under public plan option.</p>	
Insurance Exchange	Creates a national Health Insurance Exchange through which individuals not enrolled in acceptable coverage and small employers (beginning with 25 or fewer employees in Year 1, and phasing up to more than 100	By 2014, states must create state-based exchanges for the individual market and small business health options program (SHOP) exchanges for the small group market. States may be granted a waiver from HHS to opt-out	<u>Direct primary care medical home plan.</u> Similar to provision in House bill, allows qualified health plans to provide coverage through a qualified direct primary care medical home plan that meets requirements established by the	Exchanges are generally consistent with AMA policy supporting mechanisms that assist consumers and employers in obtaining information about their available insurance options.

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	<p>employees in Year 4) can buy private coverage or a public health insurance option and which would be administered by a new independent federal agency, the Health Choices Administration. Only qualified health benefit plans (QHBP) meeting specific criteria could be sold in the Exchange. However, direct primary care medical home plans, with wrap-around coverage for catastrophic events, would be allowed to participate as QHBPs in Exchange. Insurers could offer plans outside the Exchange through employer and grandfathered plans, but new individual policies issued post-enactment could only be offered through the Exchange. Existing group plans would have to meet QHBP standards by 2018. Premium and cost-sharing credits would only be available within Exchange. Title III</p> <p>The HHS Secretary would establish a minimum benefits package with limits on cost sharing levels, based on recommendations from a Health Benefits Advisory Council that is chaired by the Surgeon General. Four plan benefit categories, with varying cost-sharing, would be offered through the Exchange. Sec. 221-224, 303.</p> <p><u>Appeals Process.</u> Health Insurers required to meet standards for timely internal grievance and appeals mechanisms and to establish an external review process that provides for an impartial, independent and de novo review of denied claims. The determination is binding. Sec. 232.</p>	<p>from the exchange requirement if they provide coverage at least as comprehensive as that required under the Act. Only qualified health benefit plans (QHBP) meeting specific criteria could be sold in the Exchange. Insurers may sell policies outside the Exchange. Large employers would be phased into the exchanges beginning in 2017. Sec. 1311, 1312.</p> <p>Plans may not discriminate against any health care provider, acting within their state scope of practice law, that wants to participate in the plan, but plans are not required to contract with any willing provider. Sec. 1201.</p> <p>The HHS Secretary would establish a minimum benefits package with limits on cost sharing levels and four plan benefit categories. A separate catastrophic-only policy would be offered to those 30 years or younger, or to those without affordable coverage. Provides for child-only plans and stand-alone pediatric dental plans. Sec. 1302.</p> <p>Plans sold in the exchanges are required to contract with hospitals that meet certain requirements, including the requirement that the hospital utilize a patient safety evaluation system as specified in the Patient Safety and Quality Improvement Act. Sec. 1311</p> <p><u>Appeals Process:</u> Health Insurers required to implement a process for appeals of coverage and determinations and claims. Sec. 1001.</p>	<p>Secretary. Sec. 1301.</p> <p><u>Certification criteria.</u> Adds a new transparency requirement in order for plans to be certified to participate in exchanges: requires plans to publicly disclose information on claims payment policies, enrollment, denials, rating practices, out-of-network cost-sharing, and enrollee rights. Sec. 1311</p> <p><u>Health disparities.</u> Requires qualified health plans to implement activities to reduce health disparities, including the use of language services, community outreach, and cultural competency trainings. Sec. 1311.</p> <p><u>Quality Measures.</u> Requires exchange-participating insurers to report to the Secretary on pediatric quality measures consistent with the measures established under CHIPRA.</p>	<p>The AMA has concerns, however, regarding the prescriptive nature of the requirements for benefits and benefit structures. The AMA supports using existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the U.S. Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) to assess whether a given plan would provide meaningful coverage.</p> <p>AMA policy does not support the provision in the Senate bill that requires the utilization of a patient safety evaluation system. AMA policy supports voluntary reporting of patient safety events as established under the Patient Safety and Quality Improvement Act.</p> <p>The AMA supports strong appeal rights that provides an internal and external review process.</p>

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Public Health Insurance Option/ CO-OPs	<p>The HHS Secretary would create and administer a new public health insurance option to be offered through the Exchange, beginning in 2013. Secretary could enter into no-risk contracts to administer public option. Must meet the same insurance market reforms, benefits requirements, consumer protections, and provider network requirements as private plans in the Exchange. Must offer three cost-sharing options and vary premiums geographically, with contingency margin. Financing through start-up funding to be repaid, and then self-sustaining through revenues from premiums. Sec. 321</p> <p>Secretary must negotiate payment rates with providers so that rates in aggregate would not be lower than Medicare rates and not higher than the average rates paid by private plans in Exchange. Medicare providers are presumed to be participating in public plan unless they opt out. No penalties for opting out and physicians have at least one-year period prior to beginning of public plan to opt out. Secretary can develop conditions of participation. Allows two classes of participating physicians: preferred physicians, who agree to accept the PHIO's payment rate (without regard to cost-sharing) as payment in full; and participating non-preferred physicians, who agree not to impose charges in excess of balance billing limitations set by the Secretary. Sec. 323, 325</p> <p>Authorizes Secretary to use innovative payment methods and modify cost-sharing to encourage the use of medical homes,</p>	<p>Community Health Insurance Option (CHIO) would be offered through the state exchanges. Authorizes Secretary to contract out the administrative functions to one or more nonprofit entities. Physician and individual participation would be voluntary, with no penalties for non-participation. Requires Secretary to negotiate payment rates with physicians and other providers (rates that are not higher, in aggregate, than the average rates paid by private qualified health plans through the Exchange). Requires Secretary to set geographically-adjusted premium rates that cover expected costs (self-sustaining). Requires CHIO to be subject to all federal and state laws that apply to private health insurers relating to guaranteed renewal, rating, preexisting conditions, non-discrimination, quality improvement and reporting, fraud and abuse, solvency and financial requirements, market conduct, prompt payment, appeals and grievances, privacy and confidentiality, licensure, and benefit plan material or information (Level playing field). Requires the public plan to also be subject to a federal solvency standard to be established by the Secretary and state consumer protection laws. Sec. 1323, 1324.</p> <p>Creates the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to compete on a level playing field with the private market. To be eligible to receive funds, an organization must not be an existing organization, substantially all of its</p>	<p><u>Strikes the community health insurance option.</u></p> <p><u>Multi-state plans.</u> New section that requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) to provide individual or small group coverage through exchanges in each state. Requires OPM to negotiate contracts in a manner similar to the manner in which it negotiates contracts for FEHBP, and allows OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums. Requires multi-state plans to cover essential health benefits and meet all of the requirements of a qualified health plan; states may require multi-state plans to offer additional benefits, but must pay for the additional cost. Multi-state plans must comply with 3:1 age rating, except states may require more protective age rating. Multi-state plans must comply with the minimum standards and requirements of FEHBP and state law, unless they conflict with the PPACA. Guarantees that FEHBP will maintain a separate risk pool and remain a separate program. Requires that multi-state qualified health plans and co-op plans must play on a level-playing field.</p> <p><u>State Basic Health Plan.</u> Legal immigrants whose income is less than 133 percent of the federal poverty level, and who are not eligible for Medicaid by virtue of the five-year waiting period, would be eligible for the basic health program.</p>	<p>The AMA does not believe a public option is necessary in a reformed insurance market that provides a choice of private plans.</p> <p>It is AMA policy (Sub. Res. 203) that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements, not receive special advantages from government subsidies, include payment rates established through meaningful negotiations and contracts, not require provider participation, and not restrict enrollees' access to out-of-network physicians.</p>

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	<p>accountable care organizations, value-based purchasing, bundling of services, partial capitation, direct contracting with providers, differential payment rates, and performance or utilization based payments. Sec. 324</p> <p>Requires the Health Choices Commissioner to make grants and loans to assist organizations that wish to establish not-for-profit, member-run health insurance cooperatives to provide insurance through the Exchange. Sec. 310</p>	<p>activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. Grants would be provided to meet state solvency requirements. Ban on insurer or insurance industry involvement. No CO-OP can operate until state has implemented the individual and small group insurance market reforms required under the Act. Sec. 1322</p> <p>States would have option to establish a federally-funded, non-Medicaid state plan for people with incomes above Medicaid eligibility (133% of FPL) but below 200% FPL instead of providing such individuals with tax credits to purchase coverage through health insurance exchanges. States would negotiate contracts with health care systems (licensed HMOs, licensed insurers, or a network of health care providers) to provide services under the basic health plan. State Basic Health Plan administrators would negotiate payment rates and benefit packages and would seek to contract with managed care systems. Sec. 1331</p>		
Individual Mandate	Beginning 1/1/13, requires most individuals to have "acceptable health coverage" or pay a penalty of 2.5% of their adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. Exceptions	Requires most individuals to have minimum acceptable coverage or pay a tax penalty of \$95 for 2014, \$350 for 2015, \$750 for 2016, and indexed thereafter. Penalties for families are capped. Exemptions will be granted for those who cannot afford coverage, religious objectors, or if the individual has income	Revises penalty amounts. Individuals who do not purchase coverage will pay <u>the greater of \$95 in 2014, \$495 in 2015 and \$750 in 2016, or up to two percent of income by 2016, up to a cap of the national average bronze plan premium.</u> Families will pay half the amount for children up to a cap of \$2,250 for the entire family. After	Generally consistent with AMA policy supporting personal responsibility, as long as subsidies/tax credits are sufficient to enable individuals to obtain affordable coverage.

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	granted for those with incomes below the filing threshold (in 2009 the threshold for taxpayers under age 65 is \$9,350 for singles and \$18,700 for couples), religious objections and financial hardship. Sec. 401, 501	below 100% of poverty. Sec. 1501	2016, dollar amounts will increase by the annual cost of living adjustment.	
Employer Requirements	Beginning 1/1/13, requires employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay up to 8% of payroll into the Health Insurance Exchange Trust Fund. Employers that provide coverage but fail to meet minimum health coverage participation requirements are subject to a penalty tax. Small employers with payrolls under \$500,000 are exempt from the pay or play assessment; firms with payrolls between \$500,000 and \$750,000 subject to graduated penalty. Sec. 411-413; 511-512.	Requires an employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit to make a payment of \$750 per full-time employee. An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay \$400 for any full-time employee in a 30-60 day waiting period and \$600 for any full-time employee in a 60-90 day waiting period. An employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$750 for each of their full-time employees total. The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments. Sec. 1513	Amends the employer share responsibility policy to provide that a large employer requiring a waiting period before an employee may enroll in coverage of longer than 60 days will pay a fine of \$600 per full-time employee to whom the waiting period applies.  Requires employers that offer coverage and make a contribution to provide free choice vouchers to qualified employees for the purchase of qualified health plans through exchanges. The free choice voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their required contribution under the employer's plan would be between 8 and 9.8 percent of their income. Excludes free choice vouchers from taxation and voucher recipients are not eligible for tax credits.	The AMA does not have policy on an employer mandate.
Premium Subsidies to Individuals	Provides advanceable, sliding scale affordability credits for premiums to eligible individuals/families with incomes up to 400% of FPL to purchase insurance through the Exchange. The credits limit individual family spending on premiums for the essential benefit package to no more than 1.5 % of income for those at the lowest incomes, and phase up to no more than 12% for those at 400% of FPL. In addition, cost-sharing subsidies would be	Provides refundable, advanceable, and sliding-scale premium credits to individuals and families with modified gross incomes up to 400% FPL to purchase coverage through the Exchange. The credit starts at 2% of income for those at or above 100% FPL and phasing out to 9.8% of income for those at 400% FPL. Also provides cost-sharing subsidies to eligible individuals and families with incomes between 100-400% FPL. Employees who are	<u>Federal poverty level study</u> . Directs the HHS Secretary to study adjusting the definition of FPL to reflect cost of living variations among different geographic areas within the U.S.	Generally consistent with AMA policy supporting the provision of tax credits or subsidies to lower-income individuals to help them purchase health insurance.

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	<p>provided on a sliding scale basis, based on six income tiers and phasing out at 400% of FPL. Sec. 341-347</p> <p>In general, employees who are offered employer coverage are not eligible for credits within the Exchange. In year two, employees who can show that coverage under their employer-provided plan would cost more than 12% of their income are eligible to go into the Exchange to choose a plan and apply for affordability and cost-sharing credits.</p>	<p>offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or unless the employee share of the premium is 9.8% or more of income. Sec. 1401-1402.</p>		
Premium Subsidies to Employers	<p>Small employers (up to 25 employees) that provide qualified health coverage to their employees would be eligible for a tax credit, up to 50 percent of aggregate coverage expenses. The credit phases out based on average compensation of employees, and no credit is allowed with respect to highly compensated employees (over \$80,000). Sec. 521</p>	<p>Provides a tax credit to small employers with no more than 25 full-time equivalent employees and average annual wages of no more than \$40,000 that purchase health insurance for their employees. Full amount of credit available only to employer with ten or fewer FTEs, with annual wages of less than \$20,000. To be eligible for tax credit, the employer must contribute at least 50% of the total premium cost or 50% of a benchmark premium. Sec. 1421</p>	<p>Starts small business tax credit in 2010 (one year earlier), expands the full credit to firms with average wages up to \$25,000 instead of \$20,000, and makes the credit available to firms with average wages up to \$50,000 (instead of \$40,000).</p>	<p>AMA policy prefers that tax credits or subsidies go to individuals, rather than employers, but supports initiatives to enable small employers to obtain affordable coverage for their employees.</p>
Expansion of Public Programs	<p>Expands Medicaid to all individuals under age 65 (children, pregnant women, parents, and for the first time, adults without dependent children) with incomes up to 150% FPL. Maintains the traditional Medicaid benefits package. Provides Medicaid coverage for all newborns who lack acceptable coverage and provides optional Medicaid coverage to low-income HIV-infected individuals (with enhanced matching funds) until 2013 and for optional coverage of family planning services to certain low-income women. Increases Medicaid physician payment rates for primary care services to 100% of Medicare rates by</p>	<p>Expands Medicaid to all individuals under age 65 (including for the first time, adults without dependent children) with incomes up to 133% FPL. Income eligibility will be based on modified gross income and income disregards and asset tests would no longer apply in most cases. Sec. 2001-2002</p> <p>Newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits. Requires states to provide premium assistance and wrap-around benefits to any Medicaid beneficiary with access to employer-sponsored</p>	<p>Clarifies that for the definition of “newly eligible,” current coverage levels are pegged to December 1, 2009. Provides a limited matching rate increase to states that have already undertaken a Medicaid expansion that would not have any “newly eligible” beneficiaries (Vermont and Massachusetts). Requires states to share the increased federal match with political subdivisions (e.g., counties) that contribute to the non-federal share of Medicaid costs. Applies pre-2017 matching rate to subsequent years in Nebraska (e.g., permanent 100 percent FMAP).</p> <p>Makes the state option to cover former foster</p>	<p>AMA policy supports: maintaining and strengthening the safety net provided by Medicaid; basic national standards of uniform eligibility for all persons below the poverty line, and the elimination of the existing categorical requirements, which would allow for the coverage of low-income individuals based solely on financial need; and setting Medicaid payment rates at a level that encourages widespread physician participation in the program. AMA policy supports the prevention provisions.</p>

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	<p>2012. Requires states to submit a state plan amendment specifying the payment rates to be paid under the state's Medicaid program. The coverage expansions (except the optional expansions) and the enhanced provider payments will be financed with 100% federal financing through 2014 and 91% federal financing beginning in year 2015. States would be required to maintain eligibility levels with regard to beneficiaries currently enrolled in Medicaid (as of 6/16/09). Sec. 1701-1703; 1721</p> <p>Medicaid would be required to cover preventive services, as recommended by the U.S. Preventive Services Taskforce, and vaccines recommended by the Director of the Centers for Disease Control and Prevention. Tobacco cessation counseling for pregnant women would be covered, and tobacco cessation drugs would be covered for all beneficiaries. A medical home pilot program is created. Extends the current increase in FMAP under the Recovery Act to states with high unemployment rates. Sec. 1711, 1712, 1722, 1749.</p> <p>Ends the Children's Health Insurance Program (CHIP) at the end of 2013 and requires CHIP enrollees with incomes above 150% FPL to obtain coverage through the Health Insurance Exchange beginning in 2014. CHIP enrollees with incomes between 100% and 150% FPL would be transitioned to Medicaid and states would receive the CHIP enhanced match rate for children above current levels and up to 150% FPL. Requires a report to Congress</p>	<p>insurance if it is cost-effective for the state. No provision to increase payment rates to physicians. Sec. 2001, 2003</p> <p>To finance the coverage for the newly eligible, states will receive 100% federal funding for 2014 through 2016. Beginning in 2017, financing for the newly eligible will be shared between the states and the federal government through an increase in the federal medical assistance percentage (FMAP). For states that already cover adults with incomes above 100% FPL (as of date of enactment), the percentage point increase in the FMAP will be 30.3 in 2017 and 31.3 in 2018. For all other states, the percentage point increase in the FMAP will be 34.3 in 2017 and 33.3 in 2018. Beginning in 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. Sec. 2001.</p> <p>Maintenance of income eligibility required for all adults through 12/31/2013. For calendar years 2011 through 2013, state exemption available for MOE for optional non-pregnant non-disabled adult populations above 133% FPL if state has budget deficit or is projected to have deficit in next fiscal year. This requirement would be extended through 9/30/19 for all children currently covered in Medicaid or CHIP. Sec. 2001</p> <p>Maintains current CHIP structure. In FY 2014, through FY 2019, states to get a 23 percentage point increase in the match rate, with a cap of 100%. CHIP-eligible children who cannot enroll in CHIP due to federal</p>	<p>children in Medicaid mandatory, moves the effective date up to 2014, and limits it to only those children who have aged out of the foster care system as of the date of enactment.</p> <p>Increases the transparency of the Medicaid waiver development and approval processes, including requirement of public notice and public input. Requires the Secretary to issue regulations.</p> <p>Directs the GAO to conduct a study as to whether implementation of certain provisions (including adult health quality measures, payment adjustments for HCACs) in the PPACA would result in the establishment of a new cause of action or claim.</p> <p>Extends the current reauthorization period of CHIP for two years, through September 30, 2015. Clarifies that children who cannot enroll in CHIP because allotments are capped are deemed ineligible for CHIP and, therefore, eligible for tax credits in the exchanges. However, such children must first be screened for Medicaid eligibility, and enrolled if eligible. Requires the HHS Secretary to review and certify which plans in the exchanges provide CHIP-comparable benefits and cost sharing.</p> <p>States will still receive a 23 percentage points increase in their CHIP match rate but the increase is delayed for two years until October 1, 2015. Extends and increase funding provided in CHIPRA for Medicaid and CHIP enrollment and renewal activities. Creates a new option for states to provide CHIP coverage to children of</p>	

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	with recommendations to ensure that coverage in the Health Insurance Exchange is comparable to coverage under an average CHIP plan and that there are procedures to transfer CHIP enrollees into the exchange without interrupting coverage or with a written plan of treatment. (Report due by December 31, 2011) Sec. 1703	<p>allotment caps would be eligible for tax credits in the state exchange. Sec. 2101</p> <p>Covers only proven preventive services and provides incentives to Medicaid beneficiaries to complete behavior modification programs. Requires Medicaid coverage for tobacco cessation services for pregnant women, and for states that provide coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provides a one percentage point increase in the FMAP. Sec. 4106, 4107. Allows states the option of covering family planning services for certain low-income women and providing community-based attendant supports and services to disabled individuals. Sec. 2303, 2401.</p> <p>Creates a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or serious and persistent mental health condition to designate a provider as a health home. Sec. 2703</p>	<p>state employees eligible for health benefits.</p> <p>Removes the requirement that Medicaid programs offer premium assistance for employer-sponsored insurance (instead reverts back to current law under which states may elect to offer premium assistance).</p>	
Long-Term Care	Creates a national, voluntary, long-term care insurance program to help purchase services and supports for people who have functional limitations, in order to help such individuals maintain personal and financial independence. (CLASS Program). Financed through voluntary payroll deductions; all working adults would be enrolled in the program, unless they opt out. Would supplement, not supplant Medicaid and/or private long-term	Creates a national, voluntary long-term care insurance program to help purchase services and supports for people who have functional limitations, in order to help such individuals maintain personal and financial independence (CLASS program). Financed through voluntary payroll deductions. Would supplement, not supplant Medicaid and/or private long-term care insurance. Sec. 8001-8002.	Adds a new policy that creates financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). The provision provides FMAP increases to States to rebalance their spending between nursing homes and HCBS.	AMA policy supports Medicaid reform to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports. The AMA also supports investments in home and community-based services.

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	care insurance. Sec. 2581	Also creates the Community First Choice Option in Medicaid to provide community-based attendant supports and services to disabled individuals who require an institutional level of care. Provides states that undertake reforms to increase nursing home diversions and access to home and community-based services in their Medicaid programs with a targeted increase in their FMAP for 5 years. Sec. 2401-2402.		
Prevention/ Wellness	Develops a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. Improves prevention by covering only proven preventive services in Medicare and Medicaid. Creates a Prevention and Wellness Trust Fund, providing \$34 billion in mandatory funding over the next 10 years, for programs including community-based prevention and child obesity. Establishes a grant program to help small employers create or strengthen workplace wellness programs. Title III	Develops a national prevention and health promotion strategy that sets specific goals for improving health. Creates a prevention and public health investment fund, providing \$5 billion (cut from \$30 billion in HELP bill) in funding from 2010 through 2014 to expand and sustain funding for prevention and public health programs. Sec. 4001-4002.  Permits insurers to create incentives for health promotion and disease prevention practices through significant premium discounts and encourages employers to provide wellness programs and provide premium discounts for employees who participate in these programs. Sec. 1001 (PHSA 2705), 4303. See more prevention provisions in Medicaid section.	Authorizes an appropriation of \$200 million to give employees of small businesses access to comprehensive workplace wellness programs.	The prevention and wellness provisions are generally consistent with AMA policy. However, regarding employee wellness programs, we are concerned that language in the Senate bill allowing employer-sponsored plans to provide significant premium discounts or other rewards (up to 50% of the cost of coverage) could allow discrimination against individuals based on their health status. AMA policy supports reward-based incentive programs to promote healthy lifestyles that reward behaviors, not health status. Incentives should be integrated into an ongoing risk-reduction and behavior change program to encourage and support long-term changes in habits and behaviors.
Advance Care Planning	Provides for Medicare coverage of optional consultations between physicians and patients about advance care planning, every 5 years, beginning in 2011. More frequent consultations permitted if there is a significant change in the health of an individual. Patient participation is voluntary. Requires health insurers in the Exchange to provide enrollees with information about	No provision on advance care planning. Prohibits discrimination against any individual or institutional health care entity receiving federal, state, or local government funding on the basis that the entity does not provide assisted suicide, euthanasia, or mercy killing. Sec. 1553.		Consistent with AMA policy supporting Medicare reimbursement to physicians for advance care planning consultations with their patients and with policies supporting the importance of such planning by all patients.

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	advance care planning. Prohibits the promotion of assisted suicide. Sec. 1233; 240			
Comparative Effectiveness Research	<p><u>Center for Comparative Effectiveness Research.</u> Would establish a Center for Comparative Effectiveness Research in the Agency for Healthcare Research and Quality (AHRQ) within HHS.</p> <p><u>Governance:</u> HHS Secretary has ultimate authority; Commission appointed by U.S. Comptroller would serve as advisory body and membership required to include a representative of practicing clinicians.</p> <p><u>Use of CER Findings:</u> Would allow the Center to issue recommendation concerning practice guidelines, coverage, and policy, but would not be considered mandates.</p> <p><u>Dissemination.</u> Findings must be disseminated with consideration given standards and protocols of clinical excellence developed by relevant expert organizations that could include medical specialty societies.</p> <p><u>Personalized Medicine:</u> Provisions ensure CER supports the advancement of personalized medicine.</p> <p><u>Medicare National Coverage Determinations:</u> Research would not be used to make more</p>	<p><u>Patient-Centered Outcomes Research Institute.</u> Would establish an independent non-profit CER institute tasked with supporting research on comparative clinical effectiveness.</p> <p><u>Governance:</u> Independent Board of Governors appointed by U.S. Comptroller would be responsible for all activities and would include physician representation.</p> <p><u>Use of CER Findings:</u> Would allow the institute to issue recommendations concerning practice guidelines, coverage recommendations, or policy, but prohibits construing recommendations as mandates.</p> <p><u>Dissemination:</u> AHRQ required to expand CER capacity through training grants for researchers, coordination of access to federal health care program data in order to build data capacity including support for clinical registries and health outcomes research data networks; AHRQ required to consult with medical and clinical associations and obtain regular, structured feedback to promote uptake of CER findings in clinical practice. AHRQ is prohibited in this capacity from issuing either mandates or</p>	<p><u>Governance:</u> The number of individuals appointed to the Institute's board of governors who represent physicians was increased to four.</p> <p><u>Use of CER Findings.</u> The Manager's Amendment prohibits the Institute from issuing practice guidelines or coverage, payment, or policy recommendations. The substitute amendment would have prohibited mandates, but would have allowed the Institute to issue recommendations.</p> <p><u>Other Data Uses.</u> Includes requirement that researchers enter into a data use agreement with Institute prior to using data from original research in work-for-hire contracts with individuals, entities, or instrumentalities that have a financial interest in the outcome.</p> <p>Clarifies that the limitations on use of comparative effectiveness data apply to the development of the National Strategy for</p>	<p>AMA policy supports establishing an independent entity responsible for comparative clinical effectiveness research with an established funding source and governance structure with central and substantial physician representation and participation to oversee and support CER.</p> <p>AMA policy opposes conferring the CER entity with authority to issue recommendations (or mandates) concerning practice guidelines, coverage, payment, or policy.</p> <p>AMA policy supports expanding CER capacity, including expansion of clinical registries and engagement of medical specialties to facilitate rapid consideration of CER findings for use by clinicians and specialties for their development of practice guidelines, protocols, and ultimately use.</p>

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	<p>stringent standards or otherwise change the standards or requirements for coverage of items and services under the health system reform legislation.</p> <p><u>Funding.</u> Trust Fund established with appropriated funds initially and subsequently with fees imposed on private and public insurers.</p> <p>Sec. 1401, 1802</p>	<p>recommendations concerning clinical guidelines, payment policy, or reimbursement policy.</p> <p><u>Personalized Medicine:</u> Provisions ensure CER supports the advancement of personalized medicine.</p> <p><u>Medicare NCD:</u> Would authorize the use of CER findings in Medicare NCDs, but prohibits HHS from using CER findings as the sole basis for such determinations and clarifies that the “reasonable and necessary” standard used to make NCDs is not modified by this legislation.</p> <p><u>FCC CER.</u> Disbands the Federal Coordinating Council for CER established by the American Recovery and Reinvestment Act of 2009 (ARRA).</p> <p><u>Funding.</u> Trust Fund established; \$100 million transfer of funds appropriated to HHS in the ARRA and annual fees from public and private health insurance companies. Funding will terminate in 2019.</p> <p><u>Methodology:</u> Would prohibit the utilization of methodology that discounts value of life because of a person’s disability.</p> <p>Sec. 6301, 6302</p>	<p>Quality Improvement. Sec. 10302.</p>	
Physician Sunshine/Gift Registry	<p><u>Reporting Entities:</u> manufacturers and distributors of drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, or CHIP.</p>	<p><u>Reporting Entities:</u> manufacturers of drugs, devices, biologicals, or medical supplies participating in the Medicare program.</p> <p><u>Covered Entities:</u> physician, a physician</p>		<p>The AMA would not oppose a reporting and public disclosure program that is consistent with legislative principles that include: (1) industry (not physician) responsibility for reporting; (2) exclusion of samples, unrestricted transfers, de</p>

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	<p><u>Covered Entities</u>: physicians, physician group practices pharmacists/pharmacies, hospitals, medical schools, organizations of health care providers, sponsors of continuing medical education, health insurance issuers, patient advocacy groups, and pharmacy benefit managers.</p> <p><u>Samples</u>: Required to submit records on drug samples distributed, but disclosure limited to researchers.</p> <p><u>Reportable Transfers</u>: Would require manufacturer and distributors report to the government transfers of value to physicians (and other covered entities) and with some exception would be subject to public disclosure.</p> <p><u>Preemption</u>: Prohibits states from regulating in areas specifically covered by legislation.</p> <p><u>Due Process</u>: Provides physicians (and other covered entities) an opportunity to submit corrections to the information made available to the public .</p> <p><u>Ownership Interests and Immediate Family Members</u>: Covered hospitals and other entities that bill Medicare (excluding MA) required to disclose physician and family member ownership interests (other than in a publicly traded security and mutual fund). Sec. 1451</p>	<p>medical practice, a physician group practice, or a hospital with an approved medical residency training program.</p> <p><u>Samples</u>: Would require drug manufacturers and distributors to submit records on drug samples distributed, destroyed, or returned to manufacturer.</p> <p><u>Reportable Transfers</u>: Would require reporting entities to submit reports on the transfer of value to covered entities and with some exceptions would be subject to public disclosure.</p> <p><u>Preemption</u>: Prohibits states from regulating in areas specifically covered by legislation.</p> <p><u>Due Process</u>: Provides physicians (and other covered entities) an opportunity to submit corrections to the information during a 45 day window prior to public disclosure.</p> <p><u>Ownership Interests &amp; Immediate Family Members</u>: Covered manufacturer or group purchasing organization required to report any ownership or investment interest (other than in a publicly traded security and mutual fund) held by a physician (or an immediate family member). Sec. 602</p>		<p>minimis transfers, and in-direct transfers of value; (3) complete federal preemption; (4) due process rights for physicians, including an opportunity to correct reporting prior to public disclosure; and (5) excluding reporting of immediate family member ownership interests. H.R. 3590 more closely tracks with these legislative principles.</p>

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Fraud and Abuse	<p><b>Funding/Staff/Positions:</b> Provides an additional \$100 million annually in funding for the Health Care Fraud and Abuse Control Fund. Allows expanded use of funds by the CMS Medicare Integrity Program. Sec. 1601.</p> <p><b>Face-to-Face:</b> Mandatory face-to-face encounter with patient before physician may certify eligibility for home health services or durable medical equipment. Sec. 1639.</p> <p><b>New Penalties:</b> Would increase penalties for fraud and abuse and establish new conduct constituting violations. Sec. 1611-1620.</p> <p><b>Enrollment:</b> Would expand enrollment screening requirements and criteria, impose longer oversight periods. Sec. 1631.</p> <p><b>Affiliations.</b> Required to disclose fraud and abuse related affiliations and as a result the Secretary authorized to impose additional requirements if such affiliations are believed to pose undue risk of fraud waste and abuse (or if there are multiple affiliations, deny application). Sec. 1632.</p> <p><b>New Intent Standard.</b> New standard for establishing fraud liability in Federal health care programs. Amends the intent requirement for violations of the federal healthcare program Anti-Kickback Statute (AKS). The AKS provides for criminal sanctions against anyone who "knowingly and willfully" offers, pays, solicits, or receives remuneration in connection with inducements for referrals of program-related business. The</p>	<p><b>Funding/Staff/Positions:</b> Health Care Fraud and Abuse Control (HCFAC) program funding would be increased by \$10 million each year for 10 years, and would remain available until expended. Permanently applies the CPI adjustment to HCFAC funding. Sec. 6402.</p> <p><b>Face-to-Face.</b> Mandatory face-to-face encounter with patient before physician may certify eligibility for home health services or durable medical equipment. Sec. 6407.</p> <p><b>New Penalties:</b> Would increase penalties for fraud and abuse and establish new conduct constituting violations. Sec. 6402, 6408.</p> <p><b>Enrollment:</b> Would expand enrollment screening requirements and criteria, impose longer oversight periods. Sec. 6401.</p> <p><b>Affiliations.</b> Required to disclose fraud and abuse related affiliations and as a result the Secretary authorized to impose additional requirements if such affiliations are believed to pose undue risk of fraud waste and abuse (or if there are multiple affiliations, deny application).</p> <p><b>New Intent Standard.</b> New standard for establishing fraud liability in Federal health care programs. Amends the intent requirement for violations of the federal healthcare program Anti-Kickback Statute (AKS). The AKS provides for criminal sanctions against anyone who "knowingly and willfully" offers, pays, solicits, or receives remuneration in connection with inducements for referrals of</p>	<p>The Manager's Amendment would change the existing intent standard for violations of the health care provisions of the mail fraud statute from "knowingly and willfully" to "[w]ith respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section." Also, includes language concerning more stringent sentencing guidelines and expanded subpoena powers.</p> <p>Manager's Amendment strikes provisions in the substitute amendment that would have authorized a significant increase in monetary penalties for violations of the False Claims Act where violations arise in the context of the health insurance exchange.</p> <p>Adds clarification that courts must dismiss health care fraud <i>qui tam</i> actions when the information that is the basis of the claim was publicly disclosed unless dismissal opposed by government.</p> <p>Face-to-Face. Clarifies that the face-to-face encounter required prior to certification for home health services may be performed by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant.</p>	<p>AMA policy supports additional funding of existing fraud and abuse initiatives.</p> <p>Both bills include increased sanctions and additional requirements that would impose substantial regulatory burdens on physicians.</p> <p>AMA policy opposes expansion of payment suspension authority.</p> <p>The AMA does not support using the enrollment process as a fraud and abuse tool given there are existing authorities that would address many of the fraud and abuse challenges.</p> <p>AMA policy opposes the expansion of the RAC as it is currently structured because it imposes a substantial administrative burden on providers as well as costs, and creates a strong financial incentive for RACs to identify appropriate payments as overpayments.</p> <p>AMA policy supports new authorities to curb MA/Part D excesses.</p> <p>AMA policy opposes imposition of civil and criminal liability in instances where physicians have done nothing more than made an honest mistake, but would face liability when they had no intent to commit fraud and did not know their conduct constituted fraud.</p> <p>The NPDB provision in both bills is not consistent with AMA policy. AMA policy calls for sufficient measures and protections to ensure the accuracy, relevancy, and confidentiality of the sensitive physician information contained in</p>

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	<p>standard would now include “a person [who does] not have actual knowledge of this section or specific intent to commit a violation.” AKS violations have also become a common predicate for actions under the civil False Claims Act, both by the government and by qui tam relators, and for civil monetary penalties.. Sec. 1620, 1645</p> <p><u>Self-Referral Voluntary Disclosure Protocol.</u> Requires HHS Secretary to establish a self-referral disclosure protocol to provide a mechanism for health care providers to disclose actual or potential violations of the physician self-referral law. Sec. 1621.</p> <p><u>Mandatory EFT Payments.</u> As of July 1, 2012, all Medicare payments must be made through direct deposit or electronic funds transfer. Sec. 1646.</p> <p><u>Databases.</u> Elimination of duplication between the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB). Directs the Secretary to reduce duplication between the two databases. Allows access to the NPDB by the VA. Sec. 1652.</p> <p><u>Overpayments.</u> Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later. Sec. 1641.</p>	<p>program-related business. The standard would now include “a person [who does] not have actual knowledge of this section or specific intent to commit a violation.” AKS violations have also become a common predicate for actions under the civil False Claims Act, both by the government and by qui tam relators, and for civil monetary penalties. Sec. 6402.</p> <p><u>Self-Referral Voluntary Disclosure Protocol.</u> Requires HHS Secretary to establish a self-referral disclosure protocol to provide a mechanism for health care providers to disclose actual or potential violations of the physician self-referral law. Sec. 6409.</p> <p><u>Recovery Audit Contractors.</u> Expand RAC program to Medicaid, Medicare Advantage, and the Medicare prescription drug benefit programs. Sec. 6411.</p> <p><u>Payment Suspension.</u> Expanded authority to suspend payments to physicians pending a fraud investigation. Sec. 6402.</p> <p><u>Databases:</u> Would mandate data matching and data sharing across federal health care programs. Would require the expansion and consolidation of existing health care provider databases (i.e., Healthcare Integrity and Protection Data Bank (HIPDB), the National Practitioner Data Bank (NPDB)) with a national patient abuse/neglect registry. Allows access to the NPDB by the VA. Sec. 6403.</p> <p><u>Overpayments.</u> Requires that overpayments be reported and returned within 60 days from the</p>		<p>databases like the NPDB. In addition, AMA policy supports physicians being accorded full due process rights to contest, appeal, and respond to all alleged charges reported to the NPDB.</p>

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	<p><u>Public Plan.</u> As specified through regulation, the HHS Secretary would be responsible for identifying Medicare's anti-fraud and abuse protections that would apply to the public health insurance plan including the False Claims Act. Sec. 326.</p> <p><u>Enhanced penalties for Medicare Advantage and Part D marketing violations.</u> Establishes new criteria for determining marketing violations, and provides greater discretion to the Secretary or the CMS Administrator to impose penalties on MA and Part D plans that violate marketing requirements. Sec. 1617.</p> <p><u>Required inclusion of payment modifier for certain evaluation and management services.</u> Establishes a "payment modifier" when service results in ordering additional services, prescription drugs, or durable medical equipment, in order to assist efforts to identify fraud. Sec. 1633.</p> <p><u>Maximum period for submission of Medicare claims reduced to not more than 12 months.</u> Sec. 1636.</p> <p><u>Physicians who order durable medical equipment or home health services required to be Medicare enrolled physicians or eligible professionals.</u> Sec. 1637.</p>	<p>date the overpayment was identified or by the date a corresponding cost report was due, whichever is later. Sec. 6402.</p> <p><u>National Provider Identifier.</u> Mandates all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications. Sec. 6402.</p> <p><u>Enhanced penalties for Medicare Advantage and Part D marketing violations.</u> Specifies conduct that will subject MA plans to penalties including marketing violations, transfers of beneficiaries without their consent or for the purpose solely of earning commission. Sec. 6408.</p> <p><u>Adds new authority: permissive exclusions; testimonial subpoena authority; surety bonds on providers and suppliers considered to be at risk by the Secretary.</u> Sec. 6402.</p> <p><u>Maximum period for submission of Medicare claims reduced to not more than 12 months.</u> Sec. 6404.</p> <p><u>Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals.</u> Sec. 6405.</p>		
Biosimilars	<p><u>New FDA Authority:</u> Confers the FDA with authority to establish an abbreviated pathway to approve biosimilars for market. An abbreviated approval pathway for biosimilars is projected by CBO to reduce direct spending by an estimated \$6.2 billion over the 2010–</p>	<p><u>New FDA Authority:</u> Confers the FDA with authority to establish an abbreviated pathway to approve biosimilars for market. An abbreviated approval pathway for biosimilars is projected by CBO to reduce direct spending by an estimated \$7 billion over the 2010–2019</p>		<p>AMA policy supports providing the FDA with authority to establish an abbreviated pathway for biosimilars, which would generate substantial savings throughout the health care system, reduce costs to physicians and patients, and increase access to life saving medication.</p>

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	<p>2019 period.</p> <p><u>Medicare Part B Payment:</u> Authority to reimburse biosimilars and biologicals at the same rate. Sec. 1149A.</p> <p><u>Exclusivity:</u> Provide 12 years of market exclusivity protection.</p> <p><u>User Fees:</u> User fees to fund the FDA's activity for approval of the biosimilars.</p> <p><u>Labeling:</u> Require the FDA to ensure that the labeling and packaging of each biosimilar product licensed bears a name that uniquely identifies the biosimilar product and distinguishes it from the innovator biological.</p> <p><u>REMS:</u> Rigorous regulatory provisions for approval of biosimilars; apply the Risk Evaluation and Mitigation Strategy requirement to biosimilars in the same manner it is applied to innovators.</p> <p><u>Approval Pathway:</u> Require the FDA to issue guidance documents for approval of biosimilars; require immunogenicity studies (which may be waived after FDA guidance issued that the current state of scientific evidence allows for a determination of immunogenicity safety without the need for a study); and require clinical studies to assess immunogenicity, pharmacokinetics/dynamics (may be waived after FDA guidance issued). Sec. 2575-2577.</p>	<p>period.</p> <p><u>Medicare Part B Payment:</u> Reimburse biosimilars and biologicals at the same rate. Sec. 3139.</p> <p><u>Exclusivity:</u> Provide 12 years of market exclusivity protection.</p> <p><u>User Fees:</u> User fees to fund the FDA's activity for approval of the biosimilars.</p> <p><u>Labeling:</u> No longer requires the FDA to ensure that the labeling and packaging of each biosimilar product licensed bears a name that uniquely identifies the biosimilar product and distinguishes it from the innovator biological.</p> <p><u>REMS:</u> Rigorous regulatory provisions for approval of biosimilars; apply the Risk Evaluation and Mitigation Strategy requirement to biosimilars in the same manner it is applied to innovators.</p> <p><u>Approval Pathway:</u> Require the FDA to issue guidance documents for approval of biosimilars; require immunogenicity studies which may be waived after FDA guidance issued that the current state of scientific evidence allows for a determination of immunogenicity safety. Sec. 7001-7003.</p>		<p>AMA policy does not support reimbursing brand biologicals and biosimilars at the same rate.</p> <p>AMA policy supports unique naming/labeling to distinguish biosimilar from innovator in light of the significant safety risks and adverse reporting needs.</p>
Medicare Advantage	<u>Fiscal Neutrality:</u> Phases-in fiscal neutrality between MA and Medicare fee-for-service.	<u>Fiscal Neutrality:</u> Phases-in fiscal neutrality between MA and regular Medicare fee-for-		AMA policy supports fiscal neutrality between regular Medicare fee for service and MA. AMA

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	<p>Reduces MA benchmarks to fee-for-service levels over three years, reaching equality of payment rates in 2013. Transitioning payment rates in the MA program on the basis of Medicare fee for service yields savings of an estimated \$170 billion over the 2010–2019 period. Sec. 1161.</p> <p><u>Strengthening audit authority.</u> Strengthens the ability of CMS to recover overpayments to plans discovered by audits. Sec. 1174.</p> <p><u>Quality Bonus.</u> Creates an incentive system to increase payments to high-quality plans in low-cost areas, phased-in over 2011-2013. Sec. 1161.</p> <p><u>MA Stabilization Fund:</u> Would eliminate the MA Regional Plan Stabilization Fund by transferring remaining funds to the Federal Supplementary Medical Insurance Trust Fund. Sec. 1167.</p> <p><u>Authority to deny plan bids.</u> Clarifies that CMS is not obligated to accept any or every bid submitted by a MA or Part D plan. Sec. 1175.</p> <p><u>Benefit Protection and Simplification.</u> Prohibits MA plans from charging beneficiaries higher cost-sharing than they would face in regular fee-for-service. Ensures that beneficiaries dually eligible for Medicare and Medicaid are not subject to higher cost-</p>	<p>service. Sets MA payment based on the average of the bids from MA plans in each market. Provides a four-year transition to new benchmarks beginning in 2011. Setting payment rates in the MA program on the basis of the average of the bids submitted by MA plans in each market, yielding savings of an estimated \$118 billion (before interactions) over the 2010–2019 period. Sec. 3201.</p> <p><u>Grandfather Clause.</u> Allowed to grandfather in certain benefits offered to enrollees in certain geographic areas that are paid at rates competitive with regular Medicare, but would bar eligibility for bonus payments. Sec. 3201.</p> <p><u>Quality Bonus.</u> Creates performance bonus payments based on a plan's level of care coordination and care management and achievement on quality rankings. Sec. 3201.</p> <p><u>Authority to deny plan bids.</u> Authorizes the HHS Secretary to deny bids submitted by MA and prescription plans. Sec. 3209.</p> <p><u>Benefit Protection and Simplification.</u> Prohibits MA plans from charging beneficiaries higher cost sharing than they would face in regular fee-for-service. Requires plans that provide extra benefits to give priority to cost sharing reductions,</p>		<p>policy also provides support for reforms to address marketing abuses and delivery of services.</p>

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	<p>sharing than they would face under Medicaid were they not enrolled in Medicare. Sec. 1171.</p> <p><u>Extension of Secretarial coding intensity adjustment authority.</u> Extends HHS authority to adjust risk scores in MA for observed differences in coding patterns relative to fee-for-service. Sec. 1162.</p> <p><u>Simplification of annual beneficiary election periods.</u> Provides extra time for CMS and health plans to process enrollment paperwork during annual enrollment periods and eliminates a duplicative open enrollment period for MA plans. Sec. 1163.</p> <p><u>Extension of reasonable cost contracts.</u> Extends the period of time for which cost plans may operate in areas that have other health plan options. Sec. 1164.</p> <p><u>Limitation of waiver authority for employer group plans.</u> Restricts the ability of MA plans to offer coverage outside their service area and grandfathers current contracts. Sec. 1165.</p> <p><u>Extension for specialized MA plans for special needs individuals.</u> Extends the SNP program through 2012, and extends certain fully integrated dual eligible SNPs through 2015. Extends the moratorium on service area expansions for dual eligible SNPs that do not meet certain requirements. Sec. 1177.</p> <p><u>Extension of Medicare senior housing plans.</u></p>	<p>wellness and preventive care, and then benefits not covered under Medicare. Sec. 3202.</p> <p><u>Extension of Secretarial coding intensity adjustment authority.</u> Extends HHS authority to adjust risk scores in MA for observed differences in coding patterns relative to traditional fee-for-service. Sec. 3203.</p> <p><u>Simplification of annual beneficiary election periods.</u> Provides extra time for CMS, MA plans and prescription drug plans to process enrollment paperwork during annual enrollment periods and eliminates a duplicative open enrollment period for MA plans. Allows beneficiaries to disenroll from a MA plan and return to the traditional fee-for-service program from January 1 to March 15 of each year. Sec. 3204.</p> <p><u>Extension of reasonable cost contracts.</u> Extends the period of time for which cost plans may operate in areas that have other health plan options. Sec. 3206.</p> <p><u>Expanding waiver authority for employer group plans.</u> Allows employer-sponsored MA private fee-for-service plans with current enrollment to use, beginning 2011, a CMS service area waiver available to employer and union group health plans that are coordinated care plans. Sec. 3207.</p> <p><u>Extension for specialized MA plans for special needs individuals.</u> Extends the SNP program through 2013 and requires SNPs to be NCQA approved. Allows HHS to apply a frailty</p>		

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	<p>Extends MA SNPs that serve residents in continuing care retirement communities. Sec. 1178.</p> <p><u>State authority to enforce standardized marketing requirements.</u> Permits states to impose civil monetary penalties and provides for Federal-state coordination of intermediate sanctions against Part D and MA plans found violating marketing rules. Ensures that plans will not face double State and Federal jeopardy for the same violation. Sec. 1175A.</p> <p><u>Continuous open enrollment.</u> Allows beneficiaries in MA plans facing sanctions for failure to meet program rules to opt out of the plan at any time for another plan or fee-for-service Medicare. Sec. 1172.</p> <p><u>Information for beneficiaries on MA plan administrative costs.</u> Requires CMS to publish standardized information on medical loss ratios and other plan information to beneficiaries and the public. For plans with medical loss ratios below 85%, the provision requires rebates and increasing penalties over time, including eventual termination of contracts. Sec. 1173.</p>	<p>payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations. Requires HHS to transition beneficiaries enrolled in SNPs that do not meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning 2013. Requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations. Sec. 3205.</p> <p><u>Making senior housing facility demonstration permanent.</u> Allows demonstration plans that serve residents in continuing care retirement communities to operate under the MA program. Sec. 3208.</p>		
Medicare Part D	<p><u>Donut Hole:</u> Eliminates prescription drug coverage gap, beginning with a \$500 reduction in 2010, and completing phase-out by 2019. Pays for the elimination of the gap with funds raised by requiring drug manufacturers to provide Medicaid rebates for drugs used by full dual eligibles. Sec. 1181.</p> <p><u>Discount for Part D Drugs.</u> Requires drug</p>	<p><u>Donut Hole:</u> Immediate one year reduction in coverage gap for 2010 only by increasing the initial coverage limit in the standard Part D benefit by \$500. Sec. 3315.</p> <p><u>Discount for Part D drugs:</u> Requires drug</p>	<p>Manager's Amendment adds new section that requires Part D plan sponsors to offer medication treatment management (MTM) services to targeted beneficiaries as well as regular assessment of beneficiaries at risk, but not enrolled in MTM. Requires auto-enrollment for eligible beneficiaries with an opt out provision. Sec. 10328.</p>	<p>AMA policy provides support for pluralism in the selection of Medicare prescription drug benefits. AMA policy also provides support for the option of covering costs through the doughnut hole. The AMA supports efforts to enhance access to beneficiaries and streamline information and overall processes in the Part D program.</p>

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	<p>manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning in 2010. Sec. 1182.</p> <p><u>Part D Negotiations:</u> Requires HHS Secretary to negotiate Part D drugs directly with manufacturers without establishing national formulary. Would allow plans to negotiate additional discounts or reductions in the price negotiated by the Secretary. Sec. 1186.</p> <p><u>Including costs incurred by AIDS Drug Assistance Programs and Indian Health Service</u> in providing prescription drugs towards the annual out-of-pocket threshold under Part D. Sec. 1184.</p> <p><u>Accurate dispensing in long-term care facilities.</u> Requires Part D plans to develop utilization management techniques to reduce prescription drug waste in long-term care facilities. Sec. 1187.</p> <p><u>Prohibits mid-year formulary changes.</u> Prevents Part D plans from making any formulary change that increase cost-sharing or otherwise reduce coverage once the plan marketing period begins. Sec. 1185.</p> <p><u>Free generic refill.</u> Clarifies that Part D plans may offer generic drugs to enrollees with zero copayment to encourage use of lower-cost generic drugs. Sec. 1188.</p>	<p>manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. Sec. 3301.</p> <p><u>Including costs incurred by AIDS drug assistance programs and Indian Health Service</u> in providing prescription drugs toward the annual out-of-pocket threshold under part D. Sec. 3314.</p> <p><u>Accurate dispensing in long-term care facilities.</u> Requires Part D plans to develop drug dispensing techniques to reduce prescription drug waste in long-term care facilities. Sec. 3310.</p> <p><u>Improved Medicare prescription drug plan and MA-PD plan complaint system.</u> HHS to develop and maintain a plan complaint system to handle complaints regarding MA and Part D plans or their sponsors. Sec. 3311.</p> <p><u>Uniform exceptions and appeals process for prescription drug plans and MA-PD plans.</u> Requires Part D plans to use a single, uniform exceptions and appeals process. Sec. 3312.</p> <p><u>Reducing part D premium subsidy for high-</u></p>		

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		<p><u>income beneficiaries</u>. Reduces the Part D premium subsidy for beneficiaries with incomes above the Part B income thresholds. Sec. 3308.</p> <p><u>Improving formulary requirements for prescription drug plans and MA-PD plans</u> with respect to certain categories or classes of drugs. Codifies the current six classes of clinical concern, removes the criteria specified in section 176 of MIPPA that would have been used by HHS to identify protected classes of drugs and gives the Secretary authority to identify classes of clinical concern through rulemaking. Sec. 3307.</p> <p><u>Elimination of cost sharing for certain dual-eligible individuals</u>. Eliminates cost sharing for beneficiaries receiving care under a home and community-based waiver program who would otherwise require institutional care. Sec. 3309.</p>		
Self-Referral Exception for Imaging	Requires HHS to conduct a study to evaluate the extent of physician self-referral arrangements and the effects of such arrangements on the cost of providing advanced diagnostic imaging and radiation oncology services to Medicare beneficiaries.	Referring physicians are required to notify patients in writing that in-office ancillary services for specified imaging services may be obtained from a person other than the referring physician. Sec. 6003.		AMA policy supports the in-office exception to the prohibition on self-referral.
Physician Data	Requires HHS Secretary to study the use of physician prescribing information in sales and marketing practices of manufacturers and make recommendations to Congress and HHS Secretary for action. Sec. 239	None		AMA policy supports the licensing for legitimate business purposes of physician prescribing data where physicians are provided the opportunity to opt-out of use.
Medicare Payment/SGR	SGR provisions moved to separate bill, H.R. 3961: repeals SGR; provides MEI update in 2010 to replace a 21% cut; for 2011, two new	Medicare update is 0.5% in 2010, with cliff financing, in lieu of a 21% cut in January. Sec. 3101	One-year SGR temporary fix eliminated in the manager's amendment.	The AMA supports the SGR provision in H.R. 3961.

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	<p>targets: (i) E&amp;M and preventive services (GDP +2); and (ii) all other services (GDP +1). Excludes cost of physician-administered drugs and lab services from new targets; re-sets new targets after five years to help reduce the likelihood of future steep cuts. (H.R. 3961)</p>			<p>AMA policy directs that health system reform legislation replace the SGR with a system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula.</p> <p>The AMA does not support a one or two year temporary SGR patch. Thus, we support the Senate elimination of the one-year SGR fix so that the funds that had been set aside for this provision could be used to finance elimination of other provisions, such as the budget-neutrality aspect of the primary care bonus, Medicare enrollment fees, and the cosmetic surgery tax. The Senate leadership has committed to addressing a long-term solution to the SGR in early 2011. Congress has passed a 60-day SGR freeze (through February 2010) to allow Congress time to address a long-term solution.</p>
Medicare Commission	None	<p>Establishes Independent Medicare Advisory Board (IMAB) to reduce Medicare payment updates for physicians and other providers under a new spending target system and fast track legislative approval process. The new Senate bill modifies the procedures for consideration of the Medicare Advisory Board recommendations, including provisions that would make it difficult for Congress to repeal or otherwise change Board recommendations or the process for Congressional consideration of Board recommendations via separate legislation. The bill also clarifies that the physician fee schedule would not qualify for an exemption from the Board's payment recommendations. Sec. 3403</p>	<p>Expands the authority of the Medicare Board: requires the Board to: take into account in its recommendations system-wide costs, patient access, utilization and quality of care that allows for comparison by region, types of services and providers, and both private payers and Medicare; make recommendations to slow growth in national health spending, including recommendations that the Secretary or other federal agencies can implement administratively, that may require legislation to be enacted at the federal, state or local government, or that the private sector can voluntarily implement. Changes the name of the Board to the "Independent Payment Advisory Board.</p>	<p>AMA policy opposes an independent Medicare commission under the current construct in H.R. 3590. This provision could subject physicians to another spending target, which could produce multiple payment cuts per year. In addition, for the first 4 years, it would wall off significant portions of the Medicare program from savings.</p>

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Medicare Enrollment	None	An enrollment application fee of \$200 for individual practitioners and \$500 for institutional providers and suppliers would be imposed to cover the costs of screening each time they re-verify their enrollment (every five years). Sec. 6401.	The Manager's Amendment excludes all health care professionals required to undergo state licensure processes such as physicians from the mandatory Medicare, Medicaid, and CHIP \$200 enrollment fee.	AMA policy does not support enrollment fees.
Geographic Adjustment	<p>Requires Institute of Medicine study on Medicare GPCI accuracy; adds new funding to revise GPICs (\$4 billion for each of 2012 and 2103).</p> <p>Requires IOM geographic variation study, with recommendations on modifying physician/hospital payments based on quality/cost value index. Payment recommendations would be implemented unless disapproved by Congress before May 31, 2012., and would have to be budget neutral over 10-years. The new payment system likely would begin for physicians in 2014. Sec. 1157-1160</p>	<p>Modifies physician payments based on quality/cost index and on budget neutral basis – begins 2015 (based on 2014 performance.) By 2017, all physician payments must be subject to quality/cost payment modifications. Sec. 3007</p> <p>Provides new money for 2010/2011 practice expense GPCI adjustments to help payment areas with PE GPICs less than 1.0. Based on the results of an HHS PE GPCI study, PE GPICs adjustments would be implemented by 2012 in a budget neutral manner. Sec. 3102</p>	Adds new money to provide a practice expense GPCI floor of 1.0 for frontier states.	<p>AMA policy opposes redistributing Medicare payments among providers based on outcomes, quality, and risk adjustment measurements that are not scientifically valid, verifiable, and accurate.</p> <p>AMA policy supports GPCI revisions with new money. In lieu of the Senate provision and self-implementation provision in the House bill, the AMA would prefer a geographic variation study as well as funding for the transparent development and testing of measures that recognize necessary components of agreed upon risk adjustment and attribution models that would be most useful for addressing geographic and quality of care variations.</p>
Physician Resource Use	Expands current physician resource use program by requiring physician resource use reports to be disseminated to increasing numbers of physicians “in a significant manner in the regions and cities of the country with the highest utilization” of Medicare services beginning in 2012, so that “during 2014 and subsequent years, reports are disseminated at least to physicians with utilization rates among the highest 5 percent” nationally. Details of the nature of the reports to be publicly available (it seems as of January 1, 2012). Sec. 1121	<p>Expands the Medicare physician feedback program based on episode-grouper methodology developed by 2012. Secretary must make methodology publicly available and seek endorsement of methodology through NQF. Beginning in 2012, Secretary to provide reports to physicians comparing physicians’ patterns of resource use to other physicians. Public reporting of aggregate reports for MDs and DOs.</p> <p>As a result of AMA advocacy efforts, the new Senate bill removes the 5% outlier penalty that was in the SFC bill. (The penalty would have applied to outlier physicians at/above 90<sup>th</sup></p>		<p>AMA policy supports removal of the 5% outlier penalty in the Senate bill. The AMA recommends that appropriate funding be allocated to CMS to help construct a fair and workable system while expanding the physician feedback program, as required under both bills.</p> <p>The House provision should clarify: (i) that public reports should not contain details about individual physicians’ resource use; and (ii) whether utilization is “per capita” and “per episode.”</p>

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		percentile of national utilization beginning in 2014.)		
Physician Quality Reporting Initiative (PQRI)	Requires timely feedback and appeals process regarding successful PQRI participation; PQRI bonuses (2%) extended through 2012. Sec. 1124	<p>PQRI provisions in the Senate Finance Committee bill (SFC) and new Senate bill that are the same include: timely feedback requirement, with informal appeals process by 2011. Also, beginning in 2012, Secretary would develop a plan to integrate quality measure reporting with EHR meaningful use reporting requirements.</p> <p>Senate Finance Committee (SFC) bill provided PQRI bonus for 2011 (1%) and 2012 (0.5%); under new Senate bill, PQRI bonuses are extended an additional 2 years (0.5% for 2013 and 2014), totaling 4 years of PQRI bonuses.</p> <p>SFC bill provided PQRI penalties for unsuccessful participation beginning in 2013 (1.5%) and thereafter (2%). Under new Senate bill, these penalties are delayed 2 years and will begin to apply in 2015 (1.5%) and thereafter (2%);</p> <p>SFC bill provided a new PQRI option beginning in 2011 -- physicians can qualify for maintenance of certification (MOC) or equivalent program and complete MOC practice assessment. Under the new Senate bill, beginning in 2011, physicians could submit data to the HHS Secretary through an MOC program, but the new Senate bill modifies this provision slightly by giving the Secretary more discretion in establishing the</p>	Provides additional 0.5% PQRI bonus for 3 years (2011-2014) if physicians and other eligible professionals report quality data to the PQRI through a maintenance of certification (MOC) process, and after 2014, the Secretary could require participation in an MOC as part of the physician cost/quality index under section 3007.	The PQRI improvements in both bills are those recommended by the AMA. The AMA also supports the bonus payments, which are consistent with AMA policy. AMA policy opposes the penalties in H.R. 3590.

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		MOC program. Sec. 3002		
Quality Improvement Initiatives/ CMS Innovation Center	<p>Provides additional resources for development of national priorities for performance improvement and quality measures, development/dissemination of “best practices, evaluation of data collection processes, and Medicare shared decision making demonstration.</p> <p>Creates a Center for Medicare &amp; Medicaid Payment Innovation (CMI) within CMS not later than 2011 to test and expand new innovative payment and service delivery models that encourage higher quality and lower cost. Initially, in testing a model, the design would not have to ensure that the model is budget neutral with respect to program spending. The Secretary could expand the duration and scope of a model, including nationwide if the model meets certain criteria set forth in the bill. Sec. 1441-1445 and 2401</p>	<p>Provides additional resources for development of national strategy and priorities for performance improvement and development/dissemination of quality measures, development/dissemination of best practices, data aggregation. The new Senate bill also extends these provisions to include public reporting of performance for quality measures that is “provider-specific and sufficiently disaggregated and specific to meet the needs of patients.” This provision is based on provisions in the Senate HELP Committee bill, which would have required public reporting within 5 years of enactment. The provisions in the Senate bill do not have an effective date and thus the Secretary has the discretion to determine the timeline for public reporting. The new Senate bill also provides additional resources for grants for shared decision making programs in federal programs. Sec. 3011-3015 and Sec. 3501</p> <p>Establishes CMS Innovation Center by 2011 to test care models that improve quality and slow Medicare cost growth rate, including programs that promote greater efficiencies and timely access to outpatient services (such as physical therapy) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care. The Secretary can expand the duration and scope of a model, including nationwide. Secretary to make public</p>	<p>Adds a new subsection to section 3011 of H.R. 3590 requiring the Secretary to develop and update outcomes measures for physicians, hospitals and other providers. Measures must address acute and chronic diseases within 2 years of enactment and primary and preventative care within 3 years of enactment, with at least 10 measures for each of these categories.</p> <p>Under the CMS Innovation Center, allows the Secretary to limit testing of a model to certain geographic areas.</p> <p>Adds new provision 10331 that would require public reporting of physician Medicare and private payer (if available) performance information regarding such matters as PQRI measures and other factors, such as health outcomes, care coordination, resource use, efficiency and patient experience. Data would have to meet certain safeguards (valid, reliable, risk-adjusted) and physicians would have prior opportunity to review data. There would also be appropriate attribution, timely feedback, and CMS computer systems that support valid, reliable and accurate public reporting. Public reporting would begin January 1, 2013 regarding reporting periods that begin no earlier than January 1, 2012.</p> <p>Includes a new provision that would direct HHS Secretary to contract with the IOM to regarding</p>	<p>The AMA is generally supportive of provisions in both bills that add resources for quality improvement processes. The AMA is working with the Stand for Quality group to ensure provisions reflect appropriate Secretarial discretion, public/private cooperation, and public reporting protections. The AMA is concerned about the public reporting provisions in the Senate bill given problems with the existing PQRI. The AMA supports public reporting when implemented with appropriate safeguards, especially regarding appropriate risk-adjustment, correctly attributing care to those involved in the care, and ensuring accurate, user-friendly, and relevant information that is helpful to consumer/patients, physicians and other stakeholders.</p> <p>The CMS Innovation Center can work for or against physicians, depending on what models the Secretary develops and how they are implemented. It could also lead to scope of practice issues, and AMA policy does not support expansion of scope of practice for non-physician practitioners.</p> <p>The clinical practice guidelines in the manager’s amendment could provide additional resources for assisting in the identification and development of clinical practice guidelines, but raises the possibility of reducing the discretion of groups that currently identify and develop such guidelines.</p>

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		evaluation of each model, including quality of care furnished under the model. Sec. 3021	best methods for identifying existing and new clinical practice guidelines that were developed using best practices and methods. Would highlight best practices for developing guidelines as well as the guidelines. HHS Secretary would be required to consult with professional societies, voluntary health care organizations, and expert panels.	
Medicare Claims Data	No provision	No provision	Effective January 1, 2012, the Secretary would provide Medicare claims data to qualified entities for purposes of public provider performance reports subject to certain conditions. Entities would meet certain safeguards regarding ensuring validity and reliability of the data. Physicians and other providers would have prior review of the data before publicly reported with an opportunity to appeal and correct errors. Data cannot be subject to discovery or admitted as evidence in legal proceedings without consent of provider/supplier.	The AMA has successfully advocated to include important safeguards in this provision, and we will continue to work to include additional changes in the House-Senate conference committee.
Primary Care Bonus	As of 2011, 5% bonus for primary care if 50% of billings are for certain primary care services (bonus is 10% if the practitioner predominantly provides services in a primary care health professional shortage area). Sec. 1303	For 5 years (2011 through 2015), provides 10% bonus for primary care practitioners if the primary care services account for at least 60% of allowed Medicare charges (and general surgeons in health professional shortage areas); 1/2 of bonuses funded by 0.5% reduction in Medicare payments for all other services. Sec. 5501	Removes the 0.5% reduction in Medicare payments that would partially offset the costs of the primary care and general surgery bonuses.	The AMA supports primary care/general surgery bonus payments treated as a funded workforce investment that is not offset through a reduction in payments to other physicians. AMA policy opposes budget neutrality offsets.
Payment Bonus for Efficient Areas	For 2011 through 2013, provides 5% percent bonus for counties (or equivalent areas) in 5 <sup>th</sup> lowest percentile of utilization based on per capita Parts A and B spending (as standardized to eliminate GPCI payment adjustments). Sec. 1123	None		The AMA supports the House provision.

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Payment for Imaging Services	Effective January 2011, for purposes of practice expense RVUs, increases utilization rate assumption from 50% to 75% for advanced diagnostic imaging equipment (i.e., nuclear medicine, including PET; MRI, CT, and others as specified by the Secretary in consultation with physician specialty organizations and other stakeholders); increases technical multiple imaging procedure payment reduction from 25% to 50%. Sec. 1146	Increases utilization rate assumption for advanced imaging equipment from 50% to 65% for 2010 through 2012, 70% in 2013, and 75% in 2014 and thereafter; advanced diagnostic imaging includes (i) diagnostic MRI, CT, and nuclear medicine (including PET); and (ii) such other diagnostic imaging services (excluding X-ray, ultrasound, and fluoroscopy), as specified by the Secretary in consultation with physician specialty organizations and other stakeholders. (Under the SFC bill, the 75% assumption was effective for 2013 and thereafter). Beginning July 1, 2010 increases technical multiple imaging procedure payment reduction from 25% to 50%. (Under the SFC bill, this provision would have been effective January 1, 2010.) Sec. 3135		The AMA believes the provisions in both bills are too broad, and should allow medical specialties that represent users of the various imaging modalities to submit data to CMS to determine an appropriate assumption for utilization. This provision should override recent regulatory changes to the utilization rate announced under the final physician fee schedule rule for 2010. AMA policy does not support the multiple procedure payment reduction.
Accountable Care Organization	Establishes 3-5 year Medicare ACO pilot program for physicians and other providers to share in cost savings. ACOs could be a group of physicians and may, but are not required to, include a hospital. The Secretary could extend and permanently implement certain ACO models on a large scale basis. Sec. 1301	Beginning in 2012, the Secretary would establish Medicare shared savings programs (ACOs) for various providers, including groups of physicians, to share in savings. ACOs would have to be formed for at least 3 years and shall have at least 5,000 beneficiaries assigned to it. Sec. 3022		The AMA generally supports ACOs that provide for voluntary participation, but have expressed some structural concerns, including physician financial risk for ACO patients that seek care from other physicians and providers. AMA policy supports implementing successful models under the pilot program on a broad-scale basis, as provided in the House bill.
Medical Home Pilot Program	Establishes a voluntary medical home pilot program, led by primary care physicians, principal physicians, or nurse practitioners. The Secretary could extend and permanently implement certain medical home models on a large scale basis. Sec. 1302  Also establishes an "independence at home pilot program" to bring primary care services to high cost Medicare beneficiaries with multiple chronic conditions in their home.	Establishes an independence at home demonstration program to bring primary care services to the highest cost Medicare beneficiaries with multiple chronic conditions in their home. Health teams could be eligible for shared savings if they achieve quality outcomes, patient satisfaction, and cost savings. NPs and PAs could lead the home-based primary care team as part of an independence at home medical practice. Sec. 3024		AMA policy supports testing medical home models and implementing beneficial models on a broad-scale basis upon a thorough evaluation, as provided for in the House bill. Consistent with AMA scope of practice policy, the AMA does not support any provision in the bill that would expand the scope of practice for non-physician practitioners, and believes that medical homes should be led by physicians.  The AMA generally supports testing

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	Health teams could be eligible for shared savings if they achieve quality outcomes and cost savings. Sec. 1312			independence at home medical models, as provided for in the Senate bill, but have some structural concerns, including that the demonstration program should be led by physicians.
Misvalued Codes Under Physician Fee Schedule	Requires Secretary to identify/adjust RVUs for potentially misvalued CPT codes, and the Secretary may use existing processes for recommendations on review/adjustment. The Secretary would also establish a process to validate RVUs, and may use exiting processes to do so. Sec. 1122	Requires Secretary to identify/adjust RVUs for potentially misvalued CPT codes, and the Secretary may use existing processes for recommendations on review/adjustment. The Secretary would also establish a process to validate RVUs, and may use exiting processes to do so, and shall make adjustments to work RVUs. Sec. 3134		This provision is unnecessary since it likely would duplicate ongoing efforts already undertaken by the AMA/Specialty Society RVS Update Committee (RUC) to review and adjust potentially over-valued codes.  The AMA is concerned about repeal of Section 4505(d) of the Balanced Budget Act of 1997. While this provision includes obsolete requirements that could be repealed, it also includes important requirements specifying that actual and valid data are used in determining practice expense relative value units and specifying that physician organizations are consulted about methodology and data to be used in developing these relative values. This provision should be retained in law.
Physician-Owned Hospitals	Ban on new physician-owned hospital in Medicare. For current hospitals, level of physician ownership and investment in the aggregate could not increase, and there are limits on operating rooms, procedure rooms, expansion of beds, and new disclosure requirements.  Manager's amendment would allow existing physician owned hospitals with high inpatient Medicaid admissions to apply for permission to grow. Sec. 1156	Ban on new physician-owned hospitals in Medicare. For current hospitals, level of physician ownership and investment in the aggregate could not increase, and there are limits on expansions of beds, operating rooms, procedure rooms, and new disclosure requirements. Under the new Senate bill, current hospitals must have a provider agreement in effect as of February 1, 2010 (this date was November 1, 2009 under the SFC bill). Sec. 6001	Extends the date by which current hospitals must have a provider agreement in effect (from February 1, 2010 to August 1, 2010).	AMA policy supports the disclosure of physician ownership and investment information.  AMA policy opposes the proposal to eliminate the whole hospital exception to the Stark self-referral law.
Preventive Services	As of January 1, 2011, Medicare would eliminate co-insurance for covered preventive services. Sec. 1305	Provides incentives for use of preventive services; eliminates co-insurance; provides annual Medicare coverage of risk assessment		AMA policy supports the preventive services provisions.

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		and wellness visit and personalized prevention plan, with incentives for healthy lifestyles; no co-insurance. Sec. 4103, 4104		
Work GPCI	Extends work GPCI floor through 2011. Sec. 1194	Extends the work GPCI floor through 2010 (the SFC bill would have extended it through 2012). Sec. 3102		AMA policy supports the GPCI provisions.
Nurse Midwives	Increases Medicare payment rates for nurse-midwives from 65% to 100% of the Medicare physician fee schedule. Sec. 1304	Increases Medicare payment rates for nurse-midwives from 65% to 100% of the Medicare physician fee schedule. Sec. 3114		The AMA has strong concerns about this provision.
Medical Liability Reform (MLR)	<p>Establishes a grant program for States that have enacted and implemented certificate of merit and/or early offer alternative medical liability reform programs (alternative programs must be enacted after H.R. 3962 is signed into law). In addition, the bill indicates that these alternative programs may not include provisions that limit attorneys' fees or impose caps on damages. Also, includes a provision clarifying that this incentive program does not override existing or future state liability reform laws on caps or on limiting attorneys' fees. Sec. 2531</p> <p>Extends medical liability protection under the Federal Tort Claims Act (FTCA) to volunteer practitioners providing uncompensated services at federally qualified health centers. Sec. 2586</p> <p>Clarifies that certain provisions in the bill, relating to payment initiatives and delivery system reform such as, reducing hospital readmissions, nonpayment for certain health care acquired conditions (HACs), prevention and wellness guidelines, and the Center for Quality Improvement, can not be used to establish the standard or duty of care owed by</p>	Sense of the Senate to encourage states through demonstration programs to evaluate alternatives to the current medical liability system. Sec. 6801	<p>Authorizes a GAO study and report on whether the development, recognition, or implementation of guidelines, standards, or payment adjustments (i.e., health care acquired conditions) specified in multiple sections of the bill would result in new causes of actions or claims. Sec. 3512</p> <p>Authorizes the Secretary of HHS to provide grants to states to pursue demonstration programs on alternative liability reforms, but there is a provision that would allow patients to opt-out of these alternatives at any time and pursue their liability claim in court. Sec. 10607</p> <p>Extends medical liability protections under the Federal Tort Claims Act (FTCA) to officers, employees, board members, employees, and contractors of free clinics. Sec. 10608</p>	<p>Consistent with AMA policy, H.R. 3962 would authorize federal grants for states to pursue alternative liability programs, and would provide medical liability protections to those physicians who provide volunteer medical services at federally qualified health centers.</p> <p>The provision in H.R. 3962 that clarifies that certain provisions in the bill (i.e., payment initiatives associated with hospital readmissions or health care acquired conditions, best practice guidelines) cannot be used to establish the standard of care owed in any medical liability action or claim is consistent with AMA policy. The savings clause in H.R. 3962 requires further clarification.</p> <p>As a result of AMA advocacy, the Agency for Healthcare Quality and Research has established a grant program to fund pilots of alternative medical liability reforms that is open to a broader array of initiatives than permitted in H.R. 3962.</p> <p>AMA policy supports effective medical liability reforms, including federal grants for states to pursue alternative liability reforms, to reduce the cost of defensive medicine and eliminate</p>

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	a physician (or a health care provider) to his/her patients in a medical liability claim or action. Includes a savings clause indicating that nothing in the bill is intended to override existing state laws governing legal standards or procedures used in medical liability cases or the ability of a state to enact or implement such state liability laws. Sec. 261			unnecessary litigation from the system. AMA policy also supports pursuing clarifying language for protecting existing and future state liability reform laws.
Graduate Medical Education (GME)	<p>GME provisions would authorize: the re-distribution of unused GME positions to qualifying hospitals, with preference to hospitals that emphasize primary care training; more flexibility in the GME program; and preservation of resident cap positions from closed hospitals.</p> <p>Includes a provision that would require the Government Accountability Office (GAO) to assess and report on medical residency training programs, including curriculum requirements, and assessment of faculty expertise and the accreditation processes. Sec. 1501-1505</p>	<p>GME proposal would authorize re-distribution of current unused GME residency slots to qualifying hospitals to address physician shortages in rural and other underserved areas, especially in the areas of primary care and general surgery. Also includes provisions that would provide more flexibility in the GME program to allow for training in outpatient settings and would preserve GME positions from closed hospitals based on certain criteria. Also authorizes qualified teaching hospitals to be eligible for GME payments and would allow for teaching health centers development grants to enable newly accredited or to expand primary care medical residency programs meeting certain criteria. Sec. 5503-5506 and 5508</p> <p>Also would establish a graduate nurse education demonstration program in Medicare. Sec. 5509</p>		<p>To address physician shortages, AMA policy supports advocating for adequate funding for graduate medical education (GME) and increasing GME positions for undersupplied specialties and underserved areas.</p> <p>Consistent with AMA policy, both bills include provisions that would re-distribute unused GME positions to qualifying hospitals to address physician shortages. Both bills would also provide more flexibility in the GME program to allow for training in outpatient settings, and would preserve GME positions from closed hospitals based on certain criteria.</p> <p>To address physician shortages, AMA policy supports lifting the cap on Medicare supported GME positions in undersupplied specialties and underserved areas to increase residency positions, which is absent from both bills.</p> <p>The provision in H.R. 3962 that would require a Government Accountability Office (GAO) study and report on medical residency training programs, including curriculum requirements, is inconsistent with AMA policy.</p>
Health Care Workforce	Workforce provisions authorize: funding for the National Health Service Corps (NHSC) to address workforce shortages in high need	Workforce provisions authorize: the establishment of a National Health Care Workforce Commission to provide	Authorizes the National Health Care Workforce Commission to examine the barriers of entering and remaining in primary care careers, including	Consistent with AMA policy, provisions in both bills would authorize funding for existing scholarship, loan repayment, and training

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	<p>areas; the creation of a Frontline loan repayment program for eligible primary care physicians and other health professionals who do not qualify to participate in the NHSC; part-time service to qualify towards the NHSC service requirement; increasing of the annual NHSC loan repayment amount from \$35,000 to \$50,000; funding for Title VII health professions and diversity programs; establishment of a public health workforce corps similar to the NHSC to address public health workforce shortages; funding for nurse education and training programs; funding for nurse-managed health centers; grants for promoting interdisciplinary and community-based training; and the establishment of an advisory committee and study center to assess health care workforce needs. Also requires the Government Accountability Office (GAO) to conduct a study on the effectiveness of scholarships and loan repayments offered through both the NHSC and the Frontline Health Provider Loan Repayment Program. Sec. 2201-2281 and 2512</p>	<p>recommendations to Congress on health care workforce needs; authorization for state workforce development grants; increased funding for the National Health Service Corps (NHSC) scholarship and loan repayment program (up to \$1.15 billion in FY 2015), funding for Title VII health professions and diversity programs and Title VIII nurse education and training programs; easing of current criteria for schools and students to qualify for primary care student loans; the establishment of a loan repayment program for pediatric subspecialists and mental and behavioral health service providers working in underserved areas; the creation of a Ready Reserve Corps for service in times of national emergency; authorization of funding for new training opportunities for direct care workers providing long-term care services; expansion of the geriatric academic career awards under Title VII to advanced practice nurses and other health care professionals; the creation of a grant program to support nurse-managed health clinics; authorization for mental and behavioral health education and training grants; reauthorization and expansion of programs to support model curricula for cultural competency, prevention, and public health proficiency; grants to promote the community health workforce; addressing of workforce shortages in state and local health departments in applied public health epidemiology and public health science; and the establishment of a primary care extension program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive</p>	<p>provider compensation, and to provide recommendations for overcoming such barriers. Sec. 10501</p> <p>Enables part-time service to qualify towards the NHSC service requirement as well as teaching to count for up to 20 percent of service commitment; also would increase the annual NHSC loan repayment amount from \$35,000 to \$50,000. Sec. 10501</p> <p>Authorizes grants for medical schools to establish programs that recruit students from underserved rural areas. Programs would provide medical students with specialized training in rural health issues. Sec. 10501</p> <p>Authorizes funding under Title VII for grants for eligible entities to provide training to graduate medical residents in preventive medicine and public health residency programs. Sec. 10501</p> <p>Requires the Secretary to study the appropriateness of the level of diabetes education in medical schools and report on recommendations for what level of diabetes education should be required in medical education. Sec. 10501</p> <p>Authorizes HHS to establish a training demonstration program for family nurse practitioners for careers as primary care providers in Federally qualified health centers and nurse-managed health clinics, in order to increase access to primary care in underserved communities. Sec. 10501</p>	<p>programs like the National Health Service Corps (NHSC) and Title VII health professions and diversity programs in order to address the need for more physicians and other health care professionals.</p> <p>Consistent with AMA policy, provisions in H.R. 3962 and the manager's amendment to H.R. 3590, would provide more flexibility in the NHSC by allowing for part-time service and would increase the annual NHSC loan repayment amount from \$35,000 to \$50,000.</p> <p>The AMA does not support imposing limits on the number of physicians and health educational professionals to be appointed to the national health care workforce commissions.</p> <p>AMA policy supports fully integrated multidisciplinary health care teams that are comprised of nurses and other health care professionals, which are led by physicians to ensure that patients get the best possible care.</p> <p>The AMA supports the expansion of Title VII geriatric career incentive and academic career awards program being extended to other relevant physician specialists, and that all expansions occur with additional, not existing, funding.</p> <p>Requiring a study and report on medical school curriculum requirements is inconsistent with AMA policy.</p> <p>AMA policy supports the restoration of the economic hardship student loan deferment program known as the 20/220 pathway that a</p>

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		<p>medicine, health promotion, chronic disease management, and mental health. Sec. 5001-5405</p> <p>The Senate bill would also provide funding to support pilot projects that design, implement, and evaluate models of regionalized emergency care and trauma systems. In addition, would authorize grants to trauma centers in underserved areas. Sec. 3504-3505</p>	<p>Authorizes the establishment of a Community Health Centers and National Health Service Corps Fund. Sec. 10503</p> <p>Authorizes student loan repayment tax relief by exempting certain state funded loan repayment programs from federal income taxation. Sec. 10908</p>	<p>majority of medical residents could qualify for, which was included in the Senate HELP Committee bill, S. 1679.</p>
Administrative Simplification	<p>Authorizes funding for the Secretary of HHS to adopt certain HIPAA transaction and code set standards such as claims attachments and electronic funds transfers (EFT), and to adopt operating rules for using and processing electronic health care transactions.</p> <p>In addition, requires the Secretary of HHS to adopt a single, binding, uniform companion guide, including operating rules, for each of the standards for version 5010 (version 5010 is the updated version of the HIPAA electronic transactions required for use by physicians and others on January 1, 2012). Also requires the adoption of uniform claim edits, uniform reason and remark denial codes, unique health plan identifier, standards for first report of injury, and an electronic funds transfer (EFT) standard which must be adopted and implemented prior to mandating the use of EFTs by January 1, 2015 under Medicare. Authorizes the Secretary of HHS to establish an annual audit and certification process to ensure that health plans are compliant with all the standard transactions. Sec. 115</p>	<p>Requires the Secretary to adopt a single set of operating rules, recommended by a qualifying non-profit entity, for electronic transactions like eligibility verification, claims status, claims remittance/payment, claims attachments, as well as a rule to establish an electronic funds transfers (EFT) standard, within specified periods of time. Also requires the Secretary to adopt the development of a unique health plan identifier and the mandated use of EFT under Medicare by January 1, 2014. Health plans are required to certify compliance with standards and operating rules and would be subject to penalties for noncompliance. Sec. 1104</p>	<p>Requires the Secretary to consult with stakeholders and the National Committee on Vital and Health Statistics to identify additional administrative simplification standards, and would authorize the Secretary to convene stakeholders to establish and make recommendations on an ICD-9 to ICD-10 crosswalk and subsequent revisions. Sec. 10109</p>	<p>AMA policy supports streamlining and standardizing insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.</p> <p>While the administrative simplification provision in H.R. 3590 attempts to achieve this goal, the AMA supports additional essential elements, including the adoption of a single, binding, uniform companion guide (not just operating rules), for each of the standards for version 5010 (version 5010 is the updated version of the HIPAA electronic transactions required for use by physicians and others on January 1, 2012).</p> <p>The administrative simplification provisions in H.R. 3962 are consistent with AMA's recommendations, especially: (1) the requirement that the Secretary of HHS adopt a single, binding, uniform companion guide, including operating rules, for each of the standards for version 5010, and the requirement to consult with a nonprofit entity that meets the requirements specified in H.R. 3962; (2) the requirement for the adoption of additional standards such as uniform claim edits, uniform</p>

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				<p>reason and remark denial codes, unique health plan identifier, standards for first report of injury, and clarification that an electronic funds transfer (EFT) standard must be adopted and implemented prior to mandating the use of EFTs by January 1, 2015 under Medicare; (3) defined terms such as “code set” and “operating rules” in accordance with AMA’s recommendations, and (4) the authorization for the Secretary of HHS to establish an annual audit and certification process to ensure that health plans are compliant with all the standard transactions and authorization of concurrent State enforcement jurisdiction.</p> <p>In order to fully realize the cost savings associated with administrative simplification, the AMA supports these additional administrative simplification requirements: (1) the adoption and use of a single, mandated ICD-9 CM to ICD-10 CM and ICD-10 PCS cross walk, which must be effective October 1, 2013, and which must be available publicly without charge; (2) the adoption and use of binding operational guidelines and instructions for each of the standards code sets; (3) the adoption and use of uniform payment rules; and (4) definitions for other critical terms such as “companion guide” and “standard” in accordance with AMA’s recommended language to avoid multiple interpretations.</p>
Antitrust Reform	Eliminates the federal antitrust exemption under the McCarran-Ferguson Act for health insurers and medical liability carriers. Sec. 262	No provision.		AMA policy supports the inclusion of provisions that would provide antitrust relief for physicians: reforms that provide relief from legal and regulatory impediments to physician collaboration; allow for groups of physicians to effectively reengineer their practices to improve

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				care coordination and quality; allow greater clinical integration of physician practices to enable care coordination and quality improvements for all patients.
Cosmetic Surgery Excise Tax	None	Imposes five percent excise tax on elective cosmetic surgical and medical procedures performed by a licensed medical professional collected at point of service which is estimated to generate \$ 5 billion. Excluded are elective cosmetic surgical and medical procedures that are "necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease." Every person receiving a payment for procedures on which a tax is imposed must collect the amount of the tax from the individual on whom the procedure is performed and remit such tax quarterly to the Secretary at such time and in such manner as provided by the Secretary. However, where any tax is not paid at the time payments for cosmetic surgery and medical procedures are made, then the tax must be paid by the person who performs the procedure. Sec. 9017	The Manager's Amendment strikes the five percent excise tax on voluntary cosmetic surgical and medical procedures performed by a licensed medical professional. Imposes an excise tax on indoor tanning services equal to 10 percent of the amount paid for such services. It excludes phototherapy service performed by a licensed medical professional.	AMA policy opposes the imposition of a selective revenue tax on physicians and other health care providers.