OUTLINE OF HEALTH CARE OVERHAUL LEGISLATION

PREPARED FOR AOA MEMBERS BY THE WASHINGTON OFFICE, MARCH 2010

More than 16 months after a far-reaching overhaul of the nation's health care system became the top domestic policy priority in Washington, D.C., Congress has approved and President Obama has signed into law the Patient Protection and Affordable Care Act of 2010 and the accompanying Reconciliation Act of 2010. However, rather than the end of the national health care reform battle, this marks the beginning of a new phase in which the Federal government and every state government will begin to take steps to implement the provisions of this sweeping legislation.

Optometry will need to continue to be fully engaged in the implementation process – both at the Federal level and in the states – in order to solidify patient access gains, address deficiencies and continue the fight for full recognition and fair treatment for ODs.

For more information on the legislation or to join AOA Advocacy as a Federal Keyperson or AOA-PAC Investor, please contact the AOA Washington Office 1-800-365-2219 / ImpactWashingtonDC@aoa.org.

STATUS OF AOA PRIORITY ISSUES

Key AOA-backed elements included in national health care reform legislation approved by Congress and signed in to law by President Obama:

- ✓ Establishment of the first ever Federal standard of provider non-discrimination which would apply to all health benefit plans, including self-insured ERISA plans (AOA-backed Harkin Amendment).

- ✓ No pre-emption of state insurance non-discrimination laws; creation of 50 (one in each state) state-based health insurance exchanges to provide coverage to the uninsured.

- ✓ Designation of children's vision care as an essential health benefit.

- ✓ No disruption of existing health coverage, including through stand-alone vision plans.

- ✓ Recognition of vision care in school-based health clinics.

- ✓ New emphasis on the preferred "health care home" model of patient-centered care, which fully recognizes optometry, and a key rejection of the exclusionary "medical home" scheme.

- ✓ Exemption for eyeglasses and contact lenses from a 2.9% medical device excise tax.

- ✓ Exemption of the cost of vision benefits from the calculation of a new excise tax on high-cost "Cadillac" health plans.

Key AOA-backed provisions that were considered over the last year, <u>but not included in final health care overhaul bill</u>:

- o Full recognition of optometrists in Medicaid (House-passed Schakowsky Amendment based on HR 2697).

- o Statutory inclusion of optometrists in further Federal health programs, such as the National Health Service Corps (Committee-passed Gordon Amendment based on HR 1884).

- o Expansion of Federal eye health efforts targeting infants (Byrd Amendment). This provision is separate from the more than $1 million in Federal funding secured by the AOA in support of InfantSEE.

- o Statutory non-pre-emption of state laws (House-passed Ross Amendment), viewed by AOA as an essential safeguard in the House-passed version of health care reform which sought to establish a single centrally-controlled interstate health insurance exchange, a proposal ultimately rejected by Congress and the Obama Administration. Instead, the final legislation will, in 2014, establish 50 state insurance exchanges to be administered by individual states and subject to state patient access / provider non-discrimination laws.

<u>HEALTH INSURANCE COVERAGE</u>

- Seeks to extend coverage to about 32 million currently uninsured Americans through fifty (one in each state) state-based health insurance exchanges to be established in 2014.

- Requires individuals to obtain qualifying health coverage or face financial penalties beginning in 2014.

- Imposes fines, beginning in 2014, on employers of 50 or more full-time workers if the employer does not provide health insurance coverage.

INSURANCE REFORMS (Effective This Year)

- Bans plans from dropping individuals due to illness.
- Prohibits plans from placing lifetime caps on coverage.
- Prohibits plans from denying coverage to children with pre-existing conditions (would extend to adults as well in 2014).
- Allows those under age 26 to remain on their parent's health plan.
- Requirement for insurers to abide by yearly caps on what they may charge beneficiaries for out-of-pocket expenses.

MEDICAID AND OTHER HEALTH CARE PROGRAM EXPANSIONS

- Expands Medicaid to cover all individuals with incomes under 133% of the Federal poverty level.
- The Federal government will pay all the state costs for the newly eligible Medicaid beneficiaries between 2014 and 2016.
- Funding for community health centers increased by $11 billion over five years.
- Funding to support prevention and wellness care increased by $15 billion.

EXPANSION OF PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI)

- Extends the PQRI program for physicians who successfully report quality data to Medicare, with 1% bonus payment in 2011 and 0.5% bonus payment in 2012, 2013 and 2014.
- Provides a 1.5% reduction penalty for physicians who do not participate in PQRI in 2015, and then increases the penalty to 2% in 2016 and thereafter.
- Provides an additional incentive payment of 0.5% for 2011 through 2014 for physicians who successfully report quality measures through the use of a qualified maintenance of certification program that includes "a formalized, secure examination."
- Establishes an informal appeals process for providers seeking review of a denial for unsatisfactory data submission, a timely feedback process for submitting satisfactory data and encourages coordination of ongoing PQRI and electronic health records (EHR) quality reporting efforts.

- By January 1, 2011, the Secretary must develop a Physician Compare Internet website with information on physicians enrolled in PQRI. The website will include information on (A) measures collected under the Physician Quality Reporting Initiative; (B) an assessment of patient health outcomes and the functional status of patients; (C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use; (D) an assessment of efficiency; (E) an assessment of patient experience and patient, caregiver, and family engagement; (F) an assessment of the safety, effectiveness, and timeliness of care; and (G) other information as determined appropriate by the Secretary.

POWERFUL NEW FEDERAL BOARD TO CONTROL MEDICARE COSTS

- Establishes a 15-member Independent Payment Advisory Board (IPAB) charged with reducing the per capita rate of growth in Medicare spending. If spending exceeds targets, beginning in 2014, IPAB will submit recommendations to the President and Congress to achieve reductions in Medicare spending. CBO estimates IPAB will produce $13.3 billion in savings over the first 10 years.

- In 2015 and annually thereafter, IPAB will propose a plan to reduce Medicare spending to a target amount when program spending is projected to exceed the CPI (through 2017) or GDP (after 2017).

- Congress will have limited opportunities to amend or reject IPAB recommendations.

CRACKDOWN ON FRAUD, WASTE AND ABUSE

- Launches new efforts starting in 2010 to reduce waste, fraud, and abuse in public programs through provider screening which may include site visits, background check, finger printing, database checks, enhanced oversight periods for new providers and suppliers, enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs. Medicare has acknowledged that physicians, including optometrists, are not a major source of fraud and abuse, but doctors will face added administrative burdens.

- Directs the HHS Secretary to develop and implement compliance programs for all Medicare and Medicaid program providers and suppliers.

- Increases penalties for submitting false claims to between 3 and 6 times the amount of damages which the government sustains because of the act of that person.

SUPPORTERS SAY IT'S PAID FOR

- Requires Medicare cuts, including $132 billion funding reduction for Medicare Advantage plans run by private insurers.

- Sets a 40% excise tax, to begin in 2018, on high-value health insurance group coverage ("Cadillac Plans") costing more than $10,200 and $27,500 (with higher amounts for retirees and those in high-risk professions). The cost of vision coverage is exempted from the tax calculation.

- Imposes a 2.9% tax on manufacturers of medical devices. Eyeglasses and contact lenses are exempt.

- Creates an annual fee on large, for-profit health insurers expected to take in between $2 billion in 2011 and $10 billion by 2017.

- Reduces from $5000 to $2500 the maximum contribution to Flexible Spending Accounts (FSAs). Increases the tax penalty, from 10% to 20%, on early or ineligible distributions from Health Savings Accounts (HSAs).

- Imposes a 3.8% tax on investment income of individuals making $200,000 and families earning $250,000.

- Imposes a nearly 1% increase in the Medicare payroll tax of individuals making $200,000 and families earning $250,000.

SMALL BUSINESS ISSUES

- Creates fifty (one in each state) state-based health insurance exchanges, to be launched in 2014, in an effort to make health insurance more affordable for small businesses and the self-employed. Exchanges will serve as a marketplace for insurance coverage where tens of millions of uninsured Americans and small business employees will be able to do one-stop comparison shopping.

- Sets a sliding scale tax credit to small businesses with fewer than 25 employees and average annual wages of $50,000 or less that purchase health insurance for employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of $25,000 or less. To be eligible for a tax credit, the employer must contribute at least 50% of the total premium cost.

- The small business tax credits begin immediately. For 2010 through 2013, eligible employers will receive a small business tax credit for up to 35% of the employee's premium. For 2014 onward, once the Health Insurance Exchanges are established, eligible employers purchasing coverage through the Exchange for their employees can receive a tax credit for two years of up to 50% of the employee's premium.

- Beginning in 2014, employers with 50 or more employees that do not offer health insurance coverage will pay an assessment of $2,000 per full-time worker if any of their employees obtain premium tax credits through their state-based health insurance exchange – this is referred to as the "Shared Responsibility Requirement." Small businesses with fewer than 50 employees are exempt from the shared responsibility requirement.

- The law exempts income earned by Americans running a small, closely-held business (for example, active income earned from shares in an S-Corporation). This avoids the tax-increase on income over $200,000 per individual, $250,000 for married couples.

STUDENT LOAN PROVISIONS

- Included within the final version of health reform legislation were a number of provisions aimed at reforming student aid and making college more affordable for low income families.

- The new law increases the maximum Pell Grant award from $5,500 for 2010 and to $5,975 by 2017. It also spends $750 million nationwide to bolster college access and completion support and makes federal loans more affordable for borrowers to repay. It allows borrowers to cap their monthly federal student loan payments at 15 percent of their discretionary income. The 15 percent cap is lowered to 10 percent for new borrowers after 2014.

- Beginning July 1, all new federal student loans will originate through the Direct Loan program instead of through the Federal Family Education Loan program, which has been dissolved. The Congressional Budget Office anticipates a savings to taxpayers of $61 billion over a 10-year period by switching to the Direct Loan program.

- For students who make their payments on time, the government will forgive the balance after 20 years instead of the current 25 years. Public service workers including those in the military will see their remaining debt forgiven after 10 years of repayment.

AOA REMAINS ACTIVE

- MEDICARE PHYSICIAN PAYMENT SYSTEM STILL BROKEN – Although the AOA and other physician organizations support a new effort to bring fairness and stability to Medicare payments to physicians, there is no consensus in Congress at this time on how to replace the flawed SGR formula. In 2009, Congress and the President chose to separate the need for long-term Medicare physician payment reform from the health care overhaul. Consequently, ODs and other Medicare physicians are again facing a massive 21% Medicare cut as early as April 1. The AOA is urging

Congress to take corrective action to stop this year's cut and to begin to work on a solution to the ongoing Medicare physician payment crisis.

- ODs AND OTHER PROVIDERS EXCLUDED FROM ACOs – The health care overhaul bill authorizes a new medical delivery model starting in 2012 called Accountable Care Organizations (ACOs). ACOs are designed to group otherwise independent providers (physicians, hospitals, nursing homes, etc.) that can share in savings they create collectively for the Medicare program by more efficiently caring for patients. The provision uses restrictive language that would makes optometrists and other non-MD physician level providers ineligible to join an ACO.

- PRIMARY CARE BONUS TIED TO CERTAIN MD PROVIDERS ONLY – The health care bill creates a 10% Medicare bonus payment for certain primary care physicians in underserved areas between 2011 and 2016. Restrictive language used in this provision would limit the bonus to certain MD/DO physicians who perform a high level of primary care services. Similarly, a separate provision would require state Medicaid programs to pay certain MD/DO primary care physicians at the higher Medicare rate for 2013 and 2014. The AOA will continue to urge full recognition for the role of ODs in providing primary care.

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