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BAUCUS INTRODUCES LANDMARK PLAN TO LOWER HEALTH CARE COSTS, PROVIDE QUALITY, AFFORDABLE COVERAGE

*Congressional Budget Office estimates the fully paid-for-package
will increase quality health coverage and reduce federal deficit within ten years*

Washington, DC – Senate Finance Committee Chairman Max Baucus (D-Mont.) today introduced the America’s Health Future Act, landmark health care reform legislation to lower costs and provide quality, affordable health care coverage. The Chairman’s Mark will make it easier for families and small businesses to buy health care coverage, ensure Americans can choose to keep the health care coverage they have if they like it and slow the growth of health care costs over time. It will bar insurance companies from discriminating against people based on health status, denying coverage because of pre-existing conditions, or imposing annual caps or lifetime limits on coverage. The bill would improve the way the health care system delivers care by improving efficiency, quality, and coordination. The \$856 billion dollar package will not add to the federal deficit. The Finance Committee will meet to begin voting on the Chairman’s Mark next week.

“The cost of America’s broken health care system has stretched families, businesses and the economy too far for too long. For too many, quality, affordable health care is simply out of reach,” said Baucus. **“This is a unique moment in history where we can finally reach an objective so many of us have sought for so long. The Finance Committee has carefully worked through the details of health care reform to ensure this package works for patients, for health care providers and for our economy. We worked to build a balanced, common-sense package that ensures quality, affordable coverage and doesn’t add a dime to the deficit. Now we can finally pass legislation that will rein in health care costs and deliver quality, affordable care to the American people.”**

Provisions included in the legislation to ensure **Americans** have quality, affordable, health care **coverage** would:

- – Create health care affordability tax credits to help low and middle income families purchase insurance in the private market;
- – Provide tax credits for small businesses to help them offer insurance to their employees;
- – Allow people who like the coverage they have today the choice to keep it;
- – Reform the insurance market to end discrimination based on pre-existing conditions and health status ;
- – Eliminate yearly and lifetime limits on the amount of coverage plans provide;
- – Create web-based insurance exchanges that would standardize health plan premiums and coverage information to make purchasing insurance easier;
- – Give consumers the choice of non-profit, consumer owned and oriented plans (CO-OP);
- – Standardize Medicaid coverage for everyone under 133 percent of the federal poverty level.

Provisions included in the legislation to improve the **quality** of care, increase **efficiency** within the health care system, and **lower health care costs** would:

- – Shift incentives in Medicare to reward better care, not just more care;
- – Increase the number of primary care doctors in the system;
- – Aggressively fight fraud, waste, and abuse in Medicare;
- – Encourage all of a patient’s doctors to coordinate care and reduce duplication and waste;
- – Create incentives for health care providers to improve quality by using safer, more cost effective health technology like electronic medical records; and
- – Increase health care research so doctors know what care works best for which patients.

Provisions included in the legislation to promote **preventive health care** and **wellness** would:

- – Provide annual “wellness visits” for Medicare participants and their doctors to focus on prevention;
- – Eliminate out-of-pocket costs for screening and prevention services in Medicare;
- – Create incentives in Medicare and Medicaid for completing healthy lifestyle programs;
- – Increase federal Medicaid funding for states that cover recommended preventive services and immunizations for enrollees at no extra cost; and
- – Provide free tobacco cessation services for pregnant women in Medicaid.

The Congressional Budget Office estimates the Chairman’s Mark would make a \$856 billion investment in the health care system over ten years. That investment would be fully paid for mostly through increased focus on quality, efficiency, prevention and adjustments in federal health program payments, without adding to the federal deficit.

A summary of the Chairman's Mark follows below. The full text of the America's Health Future Act is available at: http://finance.senate.gov/sitepages/leg/LEG_2009/091609_Americas_Healthy_Future_Act.pdf.

“The America’s Health Future Act”

Providing Quality Coverage to All Americans

Americans who like their health insurance and want to keep it can do so. For the millions of Americans who don't have or can't afford employer-provided coverage, or who are being denied coverage due to a pre-existing condition, the Chairman's Mark reforms the individual and small-group markets, making coverage affordable and accessible.

Individual Market Reforms – The Mark would require insurance companies to issue coverage to all individuals regardless of health status; insurers would no longer be allowed to limit coverage based on pre-existing conditions. Limited variation in premium rates would be permitted for tobacco use, age, and family composition. Variation in rating would be allowed between geographic areas, but would not differ within a geographic area.

Small Group Market Reforms – Rating rules for the individual market would also apply to the small group market, as defined by states. This would include groups of one to 50 employees, but could include companies with up to 100 employees, depending on current state law.

Health Insurance Exchanges – The Mark would make purchasing health insurance coverage easier and more understandable by using the Internet to present consumers with available plans. The Mark would create state-based web portals, or “exchanges” that would direct consumers purchasing plans on the individual market to every health coverage option available in their zip code. The exchanges would offer standardized health insurance enrollment applications, a standard format companies would use to present their insurance plans, and standardized marketing materials. The exchanges would have a call center for customer support. The exchanges would also enable users to determine whether they are eligible for health care affordability tax credits or public programs and would enable consumers without access to the Internet to enroll through the mail or in person in a variety of locations.

Small Group Purchasing Through SHOP Exchanges – Under the Chairman's Mark, small businesses would have access to state-based Small Business Health Options Program (SHOP) exchanges. These exchanges – like the individual market exchanges – would be

web portals that make comparing and purchasing health care coverage easier for small businesses.

Transitioning to a Reformed Insurance Market – Once the insurance market reforms take effect, people who want to keep the insurance they have today can do so. Plans would be allowed to continue to offer the coverage they offer today and this coverage would be grandfathered. These grandfathered plans would only be available to those people who are enrolled today or, in the case of a small employer, to new employees and their dependents. People who qualify for the health care affordability tax credits in the reformed market would not be able to use the credits to purchase grandfathered plans. Tax credits would be offered only to purchase plans created in the reformed market that meet the new benefit standards.

Transitioning for Rating Requirements – Federal rating rules for the individual market (other than for grandfathered plans) would take effect by January 1, 2013. Federal rating rules for the small group market would be phased in over a period of up to five years, as determined by each state, with approval from the Secretary of HHS.

Medicaid – The Chairman’s Mark would standardize Medicaid eligibility for all parents, children, pregnant women and childless adults at or below 133 percent of the Federal Poverty Level (FPL), or \$30,000 a year for a family of four (\$14,400 for an individual), beginning in 2014. Individuals between 100 percent of FPL and 133 percent of FPL would be given the choice of enrolling in either Medicaid or in a private health insurance plan offered through a health insurance exchange. The federal government would provide additional funding to states for services for newly eligible Medicaid beneficiaries. The Chairman’s Mark would also guarantee prescription drug benefits to all Medicaid beneficiaries.

Prescription Drug Benefits – Medicare beneficiaries who enroll in the Medicare Part D prescription drug program will receive significant help purchasing prescription drugs when they hit the coverage gap portion, or “donut hole” of the benefit. Instead of paying 100 percent of their drug costs in the gap, Part D beneficiaries with low to moderate incomes will receive a 50 percent discount on the price of brand-name drugs covered by their plan. The discount makes expensive medicines more affordable and helps beneficiaries stay on treatments that their doctors prescribe.

Children’s Health Insurance Program – The Chairman’s Mark would not make changes to the Children’s Health Insurance Program (CHIP) until after September 30, 2013, when the current reauthorization period ends. Then, states would be required to provide children between Medicaid eligibility levels and at least 250 percent of FPL with wraparound coverage to supplement the core benefit package available through the exchange. These additional services would be the early and periodic screening, diagnosis and treatment (EPSDT) services available to children in Medicaid. Current

CHIP cost-sharing protections would continue to apply. CHIP benefits under this new form of delivery would be equally as or more generous than the current structure.

Addressing Health Care Disparities – The Chairman’s Mark would require federal health programs to collect uniform data on race, ethnicity, gender and disability to help program administrators and researchers work to end disparities among these groups.

Promoting Maternal and Child Health – The Chairman’s Mark would provide funding to states, tribes and territories to develop and implement one or more evidence-based Maternal, Infant and Early Childhood Visitation programs. Program options would provide training and consultation aimed at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency and family economic self-sufficiency.

Making Coverage Affordable

The cost of health insurance has increased five times faster than wages over the last eight years. Estimates show that just seven years from now, most Americans will spend nearly half their income on health insurance. American businesses pay nearly three times more than our major trading partners for health care benefits. Unaffordable coverage prevents these companies from competing in the global market. The Mark makes coverage more affordable by providing tax credits for low and middle-income individuals and small businesses, and by strengthening public programs.

Options for Standard Benefits – The Mark creates four benefit categories for the reformed health insurance market: bronze, silver, gold and platinum. No policies (except grandfathered policies) would be issued in the individual or small-employer market that do not comply with one of the four categories. All insurers would have to offer coverage in the silver and gold categories. All plans would be required to provide primary care and first-dollar coverage for preventive services, emergency services, medical and surgical care, physician services, hospitalization, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, including x-rays, maternity and newborn care, pediatric services (including dental and vision care), prescription drugs, radiation and chemotherapy, and mental health and substance abuse services. Plans would not be allowed to set lifetime limits on coverage or annual limits on any benefits. Plans would have out-of-pocket limits at least equal to the limits for Health Savings Accounts (HSAs), which will be \$5,950 for an individual and \$11,900 for a family in 2010.

Health Care Affordability Tax Credits –The Mark would provide an advanceable, refundable tax credit for low and middle-income individuals to subsidize the purchase of health insurance. Beginning in 2013, tax credits would be available on a sliding scale for individuals and families between 134-300 percent of FPL (Federal Poverty Level) to help

offset the cost of private health insurance premiums. Beginning in 2014, the credits are also available to individuals and families between 100-133 percent of FPL. The credits would be based on the percentage of income the cost of premiums represents, rising from three percent of income for those at 100 percent of poverty to 13 percent of income for those at 300 percent of poverty. Individuals between 300-400 percent of FPL would be eligible for a premium credit based on capping an individual's share of the premium at a flat 13 percent of income. A cost-sharing subsidy would be provided to limit the amount of cost-sharing that individuals and families between 100-200 percent of FPL have to pay. Undocumented immigrants are prohibited from benefiting from the credit.

Small Business Health Care Affordability Tax Credits – This proposal would provide a tax credit to small businesses that offer health insurance to their employees. In 2011 and 2012, eligible employers can receive a small business credit for up to 35 percent of their contribution. Once the exchanges are up and running in 2013, qualified small employers purchasing insurance through the exchanges can receive a tax credit for two years that covers up to 50 percent of the employer's contribution. Small businesses with 10 or fewer employees and with average taxable wages of \$20,000 or less will be able to claim the full credit amount. The credit phases out for businesses with more than 10 employees and average taxable wages over \$20,000, with a complete phase out at 25 employees or average taxable wages of \$40,000.

Cafeteria Plan Changes - This proposal creates a Simple Cafeteria Plan – a vehicle through which small businesses can provide tax-free benefits to their employees. This change would ease the participation restrictions and include self-employed individuals as qualified employees. The proposal also exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees. Finally, the proposal allows for qualified long-term care insurance to be provided under a cafeteria plan to the extent the amount of such contributions does not exceed the eligible long-term care premiums for the contract. This proposal is effective beginning on January 1, 2011.

Consumer Owned and Oriented Plan (CO-OP) – The Mark creates authority for the formation of the Consumer Owned and Oriented Plan (CO-OP). These plans can operate at the state, regional or national level to serve as non-profit, member-run health plans to compete in the reformed non-group and small group markets. These plans will offer consumer-focused alternatives to existing insurance plans. Six billion dollars of federal seed money would be provided for start-up costs and to meet solvency requirements.

Personal Responsibility – The Mark would create a personal responsibility requirement for health care coverage, with exceptions provided for a variety of reasons including religious conscience (as defined in Medicare) and an exemption for undocumented workers.

Individuals who fail to meet the requirement are subject to a penalty. If an individual's income is between 100 and 300 percent of poverty, the penalty for failing to obtain health coverage is \$750 per person per year with a maximum of \$1,500 per family. If an individual's income is above 300 percent of poverty, the penalty for failing to obtain coverage is \$950 per person per year with a maximum of \$3,800 per family.

Exemptions from the penalty will be made for individuals where the full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds ten percent of their adjusted gross income (AGI); those below 100 percent of FPL; any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs (e.g., such as those participating in Health Sharing Ministries); those experiencing hardship situations (as determined by the Secretary of Health and Human Services); and an individual who is an Indian as defined in section 4 of the Indian Health Care Improvement Act. Additionally, in 2013, individuals at or below 133 percent of FPL will be exempt from the penalty. When making these determinations, income from individuals not subject to the mandate should not be considered.

Responsibility for Employers – The Mark would not require employers to offer health insurance. However, effective January 1, 2013, all employers with more than 50 employees who do not offer coverage will have to reimburse the government for each full-time employee (defined as those working 30 or more hours a week) receiving a health care affordability tax credit in the exchange equal to 100 percent of the average exchange subsidy up to a cap of \$400 per total number of employees whether they are receiving a tax credit or not.

As a general matter, if an employee is offered employer-provided health insurance coverage, the individual would be ineligible for a health care affordability tax credit for health insurance purchased through a state exchange. An employee who is offered coverage that does not have an actuarial value of at least 65 percent or who is offered unaffordable coverage by their employer, however, can be eligible for the tax credit. Unaffordable is defined as 13 percent of the employee's income. A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid. In this circumstance, the employer is not required to pay a fee.

Strengthening Coverage of Preventive Services in Medicare and Medicaid

For the nearly one in three Americans covered under Medicare or Medicaid, the Chairman's Mark makes critical investments in policies that will promote healthy living and help prevent costly chronic conditions like diabetes, cancer, heart disease, obesity and mental illness. Preventive screenings enable doctors to detect diseases earlier when treatment is most effective averting more serious, costly health problems later.

Providing Personalize Prevention Plan and Wellness Visit - The Chairman's Mark provides Medicare beneficiaries with a free visit to their primary care provider every year to create and update a personalized prevention plan to address health risks and chronic health problems and to design a schedule for regular recommended preventive screenings.

Improving Access to Preventive Services - The Mark eliminates out-of-pocket costs for recommended preventive services for Medicare beneficiaries. Beneficiaries will no longer face financial deterrents for seeking preventive care. The Chairman's Mark also encourages states to cover preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) and immunizations recommended by the Advisory Committee on Immunizations (ACIP) to adults enrolled in Medicaid. States that opt to cover recommended services and immunizations without cost-sharing would receive a one percent increase in the federal share of the FMAP reimbursement rate for those services. All states would be required to provide comprehensive tobacco cessation services to pregnant women enrolled in Medicaid.

Moving Toward Patient-Centered Care - The Chairman's Mark creates a new state option and rewards states for providing chronically ill individuals enrolled in Medicaid with a health home. Participating enrollees will receive comprehensive care coordination and management, transitional care and, if relevant, referral to community-based programs and social services. States that take up this option will receive an enhanced match for two years.

Rewarding Healthy Lifestyles - The Mark establishes an initiative that will reward Medicare and Medicaid participants for healthier choices. Funding will be available to provide participants with incentives for completing evidence-based, healthy lifestyle programs and improving their health status. Programs will focus on lowering certain risk factors linked to chronic disease such as blood pressure, cholesterol and obesity.

Reforming the Health Care Delivery System

Medicare currently reimburses health care providers on the basis of the volume of care they provide. For every test, scan or procedure conducted, providers receive payment – regardless of whether the treatment contributes to helping a patient recover. Medicare must move to a system that reimburses health care providers based on the quality of care they provide. The Chairman's Mark includes various proposals to move the Medicare fee-for-service system towards paying for quality and value. These proposals include the following:

Hospital Value-Based Purchasing - The proposal would establish a value-based purchasing program for hospitals starting in 2012. Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality

measures included in the program (and in all other quality programs in this section) will be developed and chosen in cooperation with external stakeholders.

Physician Value-Based Purchasing - This provision would strengthen and expand the Physician Quality Reporting Initiative (PQRI) program, including requiring all eligible health professionals to participate by 2011. It would also improve the Medicare physician feedback program and penalize physicians who utilize significantly more resources than their peers.

Medicare Home Health Agency and Skilled Nursing Facility Value-Based Purchasing - CMS is currently testing value-based purchasing models for these providers. Building on this effort, this provision would direct the Secretary to submit a plan to Congress by 2011 related to home health providers and 2012 related to skilled nursing facilities outlining how to effectively move these providers into a value-based purchasing payment system.

Quality Reporting for Other Providers - This provision would set providers – long-term care hospitals, inpatient rehabilitation facilities, PPS-exempt cancer hospitals and hospice providers – on a path toward value-based purchasing by requiring the Secretary to implement quality measure reporting programs for certain providers. Providers who do not successfully participate in the program would be subject to a reduction in their annual market basket update.

Encouraging Collaboration Among Health Care Providers

Patients receive the best possible care when doctors collaborate and work together to coordinate care. Current payment systems often discourage such care coordination. When providers in different settings – like doctor’s offices, hospitals, nursing homes and rehabilitation facilities – work together, patients benefit from receiving better care and costs in the system are lower.

Payment for Accountable Care – To encourage providers to improve patient care and reduce costs, the Mark would allow high-quality providers that coordinate care across a range of health care settings to share in savings they achieve to the Medicare program.

CMS Innovation Center - This provision would establish an Innovation Center at the Centers for Medicare & Medicaid Services (CMS) that would have the authority to test new patient-centered payment models that encourage evidence-based, coordinated care. Payment reforms that are shown to improve quality and reduce costs could be expanded throughout the Medicare program.

National Pilot Program on Payment Bundling - The Chairman’s Mark would direct the Secretary to develop a voluntary pilot program encouraging hospitals, doctors and post-acute care providers to achieve savings for the Medicare program through increased collaboration and improved coordination of patient care by allowing the providers to share in such savings.

Reducing Avoidable Hospital Readmissions - To improve quality of care, this provision would direct CMS to track national and hospital-specific data on the readmission rates of Medicare participating hospitals for certain high-cost conditions that have high rates of potentially avoidable hospital readmissions. Starting in 2012, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days or by 10 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days.

Infrastructure Investments: Tools to Reduce Costs and Improve Quality

Efforts to reduce costs and improve quality in the health care delivery system will require equal efforts to modernize the system with new tools that support coordinated quality care. Investments in the health care infrastructure are essential to creating a more effective, efficient delivery system.

Strengthening the Quality Infrastructure - Additional resources would be provided to the Department of Health and Human Services (HHS) to strengthen the quality measure development processes for purposes of improving quality, informing patients and purchasers, and updating payments under federal health programs. Specifically, the Secretary of HHS would be directed to develop a national quality strategy; establish an interagency working group on health care quality; provide additional resources for quality measure development and endorsement; and establish a process for HHS to work with external stakeholders, such as the National Quality Forum, to select quality measures to be included in Medicare value-based purchasing and pay-for-reporting programs.

Research and Information – The Mark would invest in research on what treatments work best for which patients and ensure that information is available and accessible to patients and doctors, such as through the establishment of an independent institute to research the effectiveness of different health care treatments and strategies. These provisions are carefully crafted so that patients would never be denied treatment based on age, disability status or other related factors as a result of the research findings.

Transparency - To increase transparency, the Chairman’s Mark would provide patients with information about physician-industry relationships – so called “physician payment sunshine,” close loopholes in physician self-referral laws that allow conflicts of interest, and provide patients and families with more information about nursing home facilities and hospital charges to help them make better decisions. The Chairman’s Mark would also require drug manufacturers and distributors to report information they already collect regarding the number and type of drug samples given to physicians. The Mark would also require the nation’s hospitals to make their average charge information for commercial payers and self-pay patients available to the public.

Strengthening Primary Care and Other Healthcare Workforce Improvements

Primary care physicians play a critical role in our health care system. They are vital to reducing costs and improving quality in the health care system. Primary care doctors provide preventive care, help patients make informed medical decisions, assist with care management, and help coordinate with a patient’s other care providers. Despite their critical function, primary care doctors receive significantly lower Medicare payments than other doctors, which has played a role in the current shortage of primary care providers.

Promoting Primary Care – To encourage more primary care doctors to be part of the system, the Chairman’s Mark would provide primary care practitioners and targeted general surgeons with a Medicare payment bonus of ten percent for five years.

Health Care Workforce – Ensuring America’s health care system has a sufficient supply of health care professionals to meet the demands of a changing and aging population is essential to maintaining focus on high-quality, cost efficient care. To strengthen the health care workforce, the Mark would increase graduate medical education (GME) training positions through a slot re-distribution program for currently unused training slots and priority would be given to increasing training in primary care and general surgery. The proposal would also encourage additional training in outpatient settings and ensure communities retain vital training slots if a hospital closes. It would establish a Workforce Advisory Committee made up of external stakeholders tasked with working with HHS and other relevant federal agencies to develop and implement a national workforce strategy. The Chairman's Mark establishes competitive demonstration grant programs designed to help low-income individuals obtain the education and training needed for well-paying, high-demand health care jobs. The Mark also includes demonstration grants for up to six states to develop training and certification programs for personal and home care aides.

Ensuring Beneficiary Access and Payment Accuracy in Medicare

The Chairman’s Mark ensures that Medicare beneficiaries will continue to have access to physicians and other critical health care providers. The Mark also improves the accuracy of Medicare payments to providers. Reducing overpayments to providers saves money for seniors and taxpayers without limiting beneficiary access.

Physicians – Due to the flawed Sustainable Growth Rate (SGR) formula, physician payments are scheduled to be reduced by 22 percent in 2010. To ensure that Medicare beneficiaries continue to have access to physician services, the Chairman’s Mark replaces the impending cut with a positive update next year.

Medicare Advantage – Private insurers that participate in Medicare should bring value to the program and to beneficiaries. The Chairman’s Mark would improve the value of Medicare Advantage by reforming payments so that they appropriately reimburse insurers for their costs and promote plans that offer high quality, efficient health care for seniors.

Specifically, the Mark would transition current Medicare Advantage payments which are based on statutory benchmarks to payments based on competitive bids from the insurers. It would eliminate overpayments to Medicare Advantage plans and addresses the inequitable distribution of rebates paid to plans by making any extra payment contingent on plan performance. Under the Mark, plans would be eligible for bonus payments based on their performance on quality measures and the operation of evidence-based care management programs. Plans that provide care at lower costs than traditional Medicare would also be eligible for an efficiency bonus. Rebates and bonuses paid to MA plans would need to be used to provide additional benefits that are not covered under Medicare. The Mark would preserve plans’ ability to offer benefit

packages that differ from or supplement traditional Medicare. The Mark would add important protections and transparency for beneficiaries by limiting cost sharing for certain services, like chemotherapy and skilled nursing care, and by creating more consistency in the extra benefits that plans can offer beneficiaries throughout the country.

Medicare Disproportionate Share Hospital Payments - This provision would require the Secretary to update hospital payments to better account for hospitals' uncompensated care costs. Starting in 2015, hospitals' Medicare Disproportionate Share Hospital (DSH) payments would be reduced to reflect lower uncompensated care costs relative to increases in the number of insured.

Home Health Payment Reform - The Secretary would be directed to improve payment accuracy through rebasing home health payments in 2013 based on an analysis of the current mix of services and intensity of care provided to home health patients. It would also establish a 10 percent cap on the amount of reimbursement a home health provider can receive from outlier payments, which are designed to help providers cover the costs of treating sicker patients. The Chairman's mark would also reinstate an add-on payment for rural home health providers from 2010-2015.

Hospice Reform - Based on recommendations by the Medicare Payment Advisory Commission (MedPAC), this provision would require the Secretary to update Medicare hospice claims forms and cost reports. Based on this information, the Secretary would be required to implement changes to the hospice payment system to improve payment accuracy. The Secretary would also impose certain requirements on hospice providers designed to increase accountability in the Medicare hospice program.

Appropriate Payment for High-cost Imaging Services - Because payment rates for imaging services should reflect the rate by which they are used, the Mark would increase the utilization rate assumption for advanced imaging equipment. In addition, the Mark pays more accurately for multiple imaging services performed during a single patient visit.

Updating Outpatient Payments for PPS-Exempt Cancer Hospitals - The Secretary of Health and Human Services would be directed to update payment rates for outpatient care provided by cancer hospitals that are exempt from the prospective payment system.

Rural Health Care Protections

The Chairman's Mark includes several provisions to ensure rural health care facilities and providers have the resources they need to continue delivering quality care in their communities. Specifically, the Mark would extend and improve many rural access protections, including the following:

FLEX Grants for Health Care in Rural Communities - The Medicare Rural Hospital Flexibility Program provides grants that rural health care providers can use to improve the quality of health care, and to strengthen health care networks. Funds can be used for services ranging from ambulance transport to the development of small local hospitals. The Chairman's Mark will extend the FLEX Grant program through 2012, and will add a new component that Flex grant funding to be used to support rural hospitals' efforts to implement delivery system reform programs, such as value-based purchasing programs, bundling, and other quality programs.

Extend Hospital Outpatient Department Hold Harmless for Small Rural Hospitals - Small rural hospitals that are not sole community hospitals (SCHs) can receive additional Medicare payments if their outpatient payments under a new payment system are less than under the prior reimbursement system. The Chairman's Mark would ensure that small rural hospitals receive 85 percent of the payment difference in 2010 and 2011.

Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals - Certain rural areas with low population densities used to receive reasonable cost reimbursement for laboratory services, but this policy ended in 2008. The Chairman's Mark would reinstate reasonable cost reimbursement, thus improving access to laboratory services for those in rural communities.

Extend Rural Community Hospital Demonstration Program - The Centers for Medicare & Medicaid Services has been conducting a demonstration program to test the feasibility of reasonable cost reimbursement for small rural hospitals. The Chairman's Mark extends the program for two years and expands eligible sites to additional rural states.

Extend Medicare Dependent Hospital Program - Small rural hospitals with a high proportion of patients who are Medicare beneficiaries receive special treatment, including higher payments. This assistance for Medicare dependent hospitals (MDHs) is scheduled to expire in September 2011. In order to protect access to health care in rural communities, the Chairman's Mark will extend crucial support to MDHs for an additional two years.

Temporary Medicare Hospital Payment Improvements - The Chairman's Mark would temporarily increase payment for certain low-volume hospitals, ensuring that rural hospitals are adequately reimbursed for serving their communities.

Community Health Integration Models in Certain Rural Counties - The 2008 demonstration project allowed eligible rural entities to develop and test new models for the delivery of health care services in order to improve access to, and integrate the delivery of, acute care, extended care and other essential health care services to Medicare beneficiaries. The Chairman's Mark will expand the 2008 project to more

eligible counties, and will also allow physicians to participate in the demonstration project.

Transparency and Accountability for Insurance Companies

The provision improves the transparency of insurance products to ensure that individuals know what they are purchasing, the services which are covered and the associated out-of-pocket costs. The Mark creates standards that will ensure that each individual receives an outline of coverage which is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font. The Mark would also require insurance companies to publish the share of their premium revenue that is used for administrative expenses and not medical benefits. In addition, the Mark would impose new requirements on insurers to meet standards for the electronic exchange of payment and other health care information with hospitals, doctors and other providers. By 2014, insurers must comply with standards for certain transactions or face a penalty fee assessed annually by the Secretary of Health and Human Services and collected by the Secretary of the Treasury. The fee would represent the inefficiency cost that an insurer imposes on the health care system when its electronic transactions with providers are not conducted in a standard way.

Combating Fraud, Waste, and Abuse

Reducing fraud, waste, and abuse in Medicare and Medicaid will reduce costs and improve quality throughout the system. The Medicare improper payment rate for 2008 was 3.6 percent, or \$10.4 billion, and the National Health Care Anti-Fraud Association estimates that fraud amounts to at least three percent of total health care spending, or more than \$60 billion per year. The Chairman's Mark will combat fraud, waste, and abuse by requiring the review of health care providers prior to granting billing privileges, leveraging technology to better evaluate claims, educating providers to promote compliance with program requirements, monitoring programs more vigilantly, and penalizing fraudulent activity swiftly and sufficiently.

Ensuring Medicare Sustainability

Sharply rising costs throughout the health system threaten Medicare's sustainability in the long term. If costs are not constrained, the Medicare program will be insolvent by 2017. To ensure the fiscal solvency and sustainability of the Medicare program, the Chairman's mark includes the following provisions.

Revisions to Annual Market-Basket Adjustments for Part A Providers - The provision would reduce annual market basket updates for hospitals, home health providers, nursing homes, hospice providers, long-term care hospitals and inpatient rehabilitation facilities, including adjustments to reflect expected gains in productivity.

Part B Productivity Adjustments - This provision would reduce payment updates for Part B providers by an estimate of increased productivity.

Reduce Part D Premium Subsidy for High-Income Beneficiaries – This provision would reduce the premium subsidy under Part D for beneficiaries with incomes at or above the Part B income thresholds.

Medicare Commission - The Chairman's Mark creates a 15-member, independent Medicare Commission tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Commission's proposals will take effect unless Congress passes an alternative measure. Congress would be allowed to consider an alternative proposal on a fast-track basis. The Commission would be prohibited from making proposals that ration care, raise taxes, or change Medicare benefit or eligibility standards.

Medical Malpractice -- The Chairman's Mark would express the Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. The Mark would further express the Sense of the Senate that states should be encouraged to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court. The Mark would express the Sense of the Senate that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.

Financing an Investment in Quality, Affordable, Health Care

High Cost Insurance Excise Tax - Beginning in 2013, this proposal would levy a non-deductible excise tax of 35 percent on insurance companies and plan administrators for any health insurance plan that is above the threshold of \$8,000 for singles and \$21,000 for family plans. The tax would apply to the amount of the premium in excess of the threshold. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market. The threshold would be indexed for inflation, and a transition rule would increase the threshold for the 17 highest cost states for the first three years.

Increasing Transparency in Employer W-2 Reporting of Value of Health Benefits - This proposal would require employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2. This would be effective beginning in 2010. *This proposal has a negligible revenue impact over ten years.*

Limit Health FSA Contributions - This proposal would limit the amount of contributions to health Flexible Spending Accounts (FSAs) to \$2,000 per year, beginning in 2013.

Eliminate Deduction for Employer Part D Subsidy - This proposal would eliminate the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. This would be effective beginning in 2011.

Standardize the Definition of Qualified Medical Expenses - Beginning in 2011, this proposal would conform the definition of qualified medical expenses for Health Savings Accounts (HSAs), health FSAs, and HRAs to the definition used for the itemized deduction. An exception to this rule would allow amounts paid for over-the-counter medicine with a prescription to still qualify as medical expenses.

Increase the Penalty for Use of HSA Funds for Non-qualified Medical Expenses - This proposal would increase the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 percent to 20 percent, beginning in 2010.

Corporate Information Reporting - This proposal would require businesses that pay any amount greater than \$600 during the year to corporate providers of property and services to file an information report with each provider and with the IRS. Information reporting already is required on payments for services to non-corporate providers. This applies to payments made after December 31, 2011.

Non-profit Hospitals - This proposal would establish new requirements applicable to nonprofit hospitals beginning in 2010. The requirements would include a periodic community needs assessment.

Pharmaceutical Manufacturers Fee - This proposal would impose an annual flat fee of \$2.3 billion on the pharmaceutical manufacturing sector, beginning in 2010. This non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of branded pharmaceuticals of \$5 million or less.

Medical Device Manufacturers Fee - This proposal would impose an annual flat fee of \$4 billion on the medical devices manufacturing sector, beginning in 2010. This non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of medical devices in the U.S. of \$5 million or less. The fee does not apply to sales of Class I products under the FDA product classification system.

Health Insurance Provider Fee - This proposal would impose an annual flat fee of \$6 billion on the health insurance sector, beginning in 2010. This non-deductible fee would be allocated across the industry according to market share.

Clinical Laboratories Fee - This proposal would impose an annual flat fee of \$0.75 billion on clinical laboratories, beginning in 2010. This non-deductible fee would be allocated across the industry according to market share and would not apply to clinical laboratories with revenue of \$500,000 or less.