H.R. 3590, "The Patient Protection and Affordable Care Act" (PPACA)
H.R. 4872, "The Health Care & Education Affordability Reconciliation Act of 2010"
ASA Post-Reform Key Issues "Watch" List

Health Insurance Reforms – The new law seeks to expand coverage to 26 million Americans through reform of the current health insurance marketplace. Reforms include prohibitions on the establishment of lifetime and annual limits, a prohibition on "rescissions," limits on premium variations, a prohibition on preexisting condition exclusions, the establishment of "qualified health plans" with a defined benefits package and other mandated changes (Sec. 1001- 1313). Consumer access to health plans supported by premium tax credits and subsidies (Sec. 1401-1421). *Various effective dates.*

ASA position: ASA has long advocated for health insurance market reforms that reduce unnecessary costs, expand choice of affordable coverage, increase portability, and eliminate denial or restrictions for pre-existing conditions. Insurance coverage options offered in a health insurance exchange should 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. ASA opposes any proliferation of Medicare payment rates as part of any plan, public option, triggered public option or state-based co-op.

Independent Payment Advisory Commission (IPAB) – A new independent commission is tasked with putting forth proposals to "reduce cost growth" and "improve quality of care for Medicare beneficiaries." The commission will recommend cost-saving initiatives should per capita spending exceed a government determined threshold. The Commission is also authorized to make recommendations to "constrain the rate of growth in the private sector" as well. The Commission's recommendations could become law without congressional action and could not be challenged in court (Sec. 3403 and 10320). *Effective January 1, 2014.*

ASA position: ASA opposes Medicare payment cuts mandated by an unaccountable commission. The commission could create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment SGR system.

Medicaid Expansion –Medicaid is expanded to 15 million individuals through a new Medicaid eligibility category for individuals with incomes at or below 133% of the federal poverty level (Sec. 2001). *Effective January 1, 2014*. Medicaid payments to primary care physicians are increased to 100-percent of Medicare payment levels (Sec. 1201 of H.R. 4872). *Effective January 1, 2013.*

ASA position: Medicaid's payments for physician services are unsustainably low. The intent of the law to expand coverage for more Americans through increased participation in the Medicaid program should be balanced with physician payment levels that adequately reflect the cost of the providing services. Congress recognized the need to improve Medicaid payments for primary care services to ensure patient access to preventive services. Likewise, Medicaid payments to all other physicians should be fairly adjusted upward to ensure access to important surgical and anesthesia services.

Non-Discrimination in Health Care – Prohibits health plans from "discriminating" against non-physician health care providers in plan participation (Sec 2706). *Effective January 1, 2014.*

ASA position: The provision would prohibit health plans from properly and appropriately distinguishing among health care providers with widely varying skills and training in coverage and contracting decisions. It would exacerbate patient confusion over the qualifications of health care professionals. The language inappropriately interjects civil rights concepts into well-established state scope of practice law by setting up a collision course between constitutional and state scope of practice laws. The language also establishes an undesirable barrier to implementing coverage decisions based on effectiveness research.

Mandatory Physician Quality Report Initiative (PQRI) – Extends operation of the PQRI program. Physicians who do not satisfactorily report measures will have Medicare payments reduced by 1.5% to 2% (Sec. 3002). *Payment reductions effective January 1, 2015.*

ASA position: ASA opposes reduced payments for physicians for failing to report quality data when there is evidence of persistent, widespread operational problems that have not been corrected by the Centers for Medicare and Medicaid Services. Any changes made to the current PQRI program should ensure the program remains voluntary, non-punitive, provides access to data in a timely manner, and has a reasonable appeals process.

Repeal of the Sustainable Growth Rate (SGR) Medicare Physician Payment Update Mechanism – The law includes no provisions to prevent the currently scheduled 21-percent payment reduction for 2010 .

ASA position: ASA supports repeal of the current SGR formula immediately and the establishment of a new baseline for the physician payment system. For full-scale health care reform to be successful, Medicare's physician reimbursement system must be set on a path toward comprehensive and permanent reform. Congress must incorporate a realistic budget baseline that provides physicians with positive updates. Failure to do so threatens the providers on whom the newly insured will rely for their care.

Other important and impending issues:

Secretary Authorized to Adjust "Mis-valued" Codes – The Secretary is directed to regularly review Medicare rates for physician services and adjust payments for those services that are "mis-valued" (Sec. 3134).

National Pilot Program on Payment Bundling – The Secretary is directed to develop a national, voluntary pilot program for bundling the payments for services of hospital, physicians and post-acute care providers "in order to improve the coordination, quality, and efficiency of health care services" (Sec. 3023). *Effective January 1, 2013*. The Secretary is authorized to expand the program if the pilot reduces spending and improves the quality of care (Sec. 10308) *Effective January 1, 2016.*

Medicare Shared Saving Program – Accountable Care Organization (ACOs) – Directs the Secretary to establish a shared savings program that promotes "accountability for a patient population and coordinates services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery." Such programs - ACOs - created by hospitals, physicians, and others would be eligible to keep a portion of the savings they generate (Sec. 3022, 10370). *Effective January 1, 2012.*

State Demonstration Programs To Evaluate Alternatives To Current Medical Tort Litigation – The Secretary is authorized to award grants to States for the development, implementation, and evaluation of alternatives to the current liability system (Sec. 10607). *Effective October 1, 2011.*

Quality Improvement Initiatives – Requires the Secretary to pursue various "value-based" programs and initiatives to "improve health care quality" (Sec. 3003, 3007, 3011-3015). *Various effective dates.*

Medicare, Medicaid, and CHIP Program Integrity Provisions – Creates new programs and requirements to reduce fraud and abuse (Sec 6104-6508). *Various effective dates.*