Key Provisions of Call to Action
Health Reform 2009
(The Baucus Plan)

by Government Relations Staff

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Increasing Access to Affordable Health Coverage

Making affordable health coverage available to all Americans is promoted under the Baucus plan (the Plan) to help end the shifting of costs of the uninsured to the insured, allow the insurance market to function effectively, and expand the efforts to address chronic illnesses. The Plan calls for using the tax system or some other government interaction to enforce an individual responsibility to obtain coverage.

The Plan extends employer-sponsored insurance and would make all but the smallest employers offer a plan that allows employees to pay their health insurance premiums through payroll deduction with pre-tax dollars. If a large employer chooses not to provide coverage it would be required to contribute to a fund to help cover the uninsured. The contribution would be based on a percentage of payroll, taking into account the company's size and annual revenues.

Mid-size and small employers would also have the option of providing adequate coverage or paying into the general coverage fund but their contribution would be lower. The Plan does not indicate what constitutes a large, mid-size or small employer.

The Health Insurance Exchange

The Plan would create an independent entity known as the Health Insurance Exchange (Exchange) through which individuals and small businesses could compare private insurance options as well as a public plan. The Exchange would organize affordable health insurance options, create understandable, comparable information about those options, and develop a standard application for enrollment in a chosen plan.

Insurers would have to offer high, medium, and low-benefit options. Benefit packages could differ but would have to be actuarially equivalent within benefit categories to prevent insurers from using benefit design to discourage enrollment by people with health conditions. Differences in premiums between packages could be due to different benefits but not the expected risk. Participating insurers would have to charge the same price for products inside and outside of the Exchange.

Exchange plans would be subject to state oversight regarding consumer protections. The Exchange would also include a new public plan option, similar to Medicare. The public plan would have to offer the same level of benefits and set premiums the same way as the private plans.

An Independent Health Coverage Council (Council) would decide who could run the public plan, determine eligibility for the public plan, and ensure that the public - private insurance competition lowers costs and improves quality.
The Council would serve as the Board of Directors for the Exchange. Members would be appointed by the President with the advice and consent of the Senate for set, staggered terms. Members would be geographically diverse and have expertise in insurance, health benefit design, actuarial science, economics, medicine, business, and consumer protection. The Council would consult with the Institute of Medicine and review state laws to define terms such as “coverage” and “affordability.”

Insurance Market Reforms

Insurance companies could no longer deny coverage to any individual or discriminate against individuals with pre-existing conditions.

Rules for rating insurance policies will be outlined in statute after consultation with the NAIC, consumer advocates, plans and others. The Plan envisions rating rules for the Exchange that would avoid severe adverse selection.

Public Programs

Medicare buy-in: 55 to 64 years olds who lacked insurance would be temporarily able to obtain coverage under Medicare until the Exchange was established. After that, those in this age group already covered by Medicare could continue in the program but others would have to find coverage through the Exchange.

Benefits would be the same as for Medicare beneficiaries. Premiums for those enrolled through the Medicare buy-in would be budget-neutral. Having this age group covered prior to becoming eligible for Medicare would reduce costs to Medicare in the long run.

Phase out of disability waiting period: The Plan would phase out the 24-month waiting period before people with disabilities may be covered by Medicare. Once the Exchange is established people with disabilities would no longer need Medicare because they could purchase coverage in the reformed market.

Medicaid: The Plan would extend Medicaid eligibility to every American living in poverty with the national minimum being an income at 100% of the Federal poverty level. No one who is currently eligible would lose access to Medicaid under any new rules.

The Federal Matching Assistance Percentage (FMAP) would be revised but it is unclear just how. The Plan suggests that a trigger be constructed to assess a pre-determined combination of circumstances to measure state economic distress.

S-CHIP: Although no details are given, the document indicates there would be Federal assistance to help states with the costs of increased S-CHIP enrollment.

Indian Health Service: Funding for IHS would be increased. Enrollment in other Federal programs would be encouraged for those who are eligible to reduce the burden on IHS.

Prevention and Wellness

Heart disease, stroke, cancer and diabetes are cited in the Plan as the most prevalent, preventable, and costly chronic diseases, based on language taken directly from a document issued by the Centers for Disease Control. The Plan also cites the need to address obesity through prevention and treatment. There are no references to mental health in this section on Prevention and Wellness.

The Plan envisions the creation of a temporary program entitled Right Choices to provide the uninsured with immediate access to a set of proven preventive services such as a health risk assessment, physical examination, age and gender appropriate cancer screenings, and immunizations. Right Choices would also provide referrals to community services such as smoking cessation and nutrition programs.

If an uninsured individual receives preventive services through Right Choices and the screening detects one or more costly, chronic conditions, that individual would receive treatment for the condition(s) on a temporary basis until coverage was available under the Exchange. There would be no cost for the treatment if an individual’s income was below 200% of the Federal poverty level.
The Exchange would require participating plans to include certain preventive services in the benefits package. Grants would be given to states and communities to implement prevention and wellness programs.

Prevention in Federal programs and private insurance options: Under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Congress gave HHS the authority to identify new preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) for coverage under Medicare. First convened by the U.S. Public Health Service in 1984, and sponsored by the Agency for Healthcare Research and Quality (AHRQ) since 1998, USPSTF is an independent panel of private-sector experts in prevention and primary care. It conducts assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. USPSTF includes mental health and substance abuse among the clinical categories that it evaluates. In 2002 it recommended screening for depression in adults but found insufficient evidence to justify screening children and adolescents. It also found insufficient evidence to justify screenings for dementia in 2003 and suicide risk in 2004.

The Plan would reduce or eliminate co-payments for recommended preventive services in Medicare. Medicaid and CHIP would have their copayments for recommended preventive services eliminated.

The Exchange would require private plans to include certain preventive services in their benefit packages. Coverage would be based on recommendations from a variety of sources including USPSTF, the Advisory Committee on Immunization Practices, NIH, IOM, and the Task Force on Community Preventive Services.

Four goals for improving value by reforming the health care delivery system

I. Strengthening the role of primary care and chronic case management.

This includes increasing the supply of primary care practitioners and redefining their role by using Federal reimbursement systems and other means to improve the value placed on their work. Primary care practitioners should furnish preventive care, help patients make informed medical decisions, and serve a critical care management and coordination role.

The Plan suggests increasing Medicare payments for primary care services. Such payments must be well-targeted, starting with identification of the services that qualify as primary care - mainly evaluation and management visits. The Plan proposes to identify physician and non-physician Medicare providers who truly focus on delivering primary care by using claims history.

The Plan also advocates providing an add-on bonus payment for primary care services. Bonus payments should allow for the complexity of the practitioner’s patient panel, with CMS setting the threshold after collaboration with stakeholders.

Budget neutrality: The Plan states that in order to be budget neutral any increases to primary care practitioners will require corresponding cuts to specialist services. Because of the potential controversy, such reforms must be crafted in collaboration with the entire physician community and other practitioners to ensure the appropriate valuation of, and access to, primary care services.

Patient-centered medical home. The Plan would expand Medicare’s role in testing the medical home model with the focus only on providers who are committed to ensuring that patients truly receive the primary care and case management services that the medical home is designed to deliver.

Providers asking to participate in a Medicare medical home expansion program should meet a set of stringent service and capacity criteria. The Plan cites the criteria proposed by MedPAC which at a minimum would require:

- Provision of primary care services
- Active care management
- Use of health information technology for active clinical decision support
- Implementation of a formal quality improvement program

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• Implementation of a rapid access, 24-hour patient communication system

• Maintaining up-to-date records of beneficiaries’ advance directives

• Maintaining a written understanding with each beneficiary designating the provider as a medical home

The Plan states that careful consideration should be given to the role of non-physician providers in the medical home model but only makes reference to nurse practitioners and home health aides. It also calls for expanding the medical home model to target patients in need of comprehensive care management and coordination but does not specify any particular chronic conditions.

The Plan estimates that 36 percent of all physicians who work in solo or group practices would find it difficult to meet the criteria for being a medical home and suggests other options such as community health teams that would include nurses, nutritionists, mental health and social workers. The Plan cites the North Carolina Medicaid program as an example of a community health team model.

The medical home and other care management concepts are described as works in progress with the involvement of patient groups viewed as critical. The Plan suggests reducing or eliminating copayments for services provided in medical homes to encourage patient participation.

Community Health Centers and Rural Health Centers. A prospective payment system would be established for Federally Qualified Health Centers. Compensation for Rural Health Clinics is cited as deficient and in need of improvement.

II. Refocusing payment incentives towards quality.

The Medicare pay for reporting program, PQRI, would transition to a value-based purchasing program. Incentives for PQRI participation should be matched by payment penalties for those who do not report. In order to receive a full bonus, providers may also be required to report the results of patient experience surveys.

The Plan discusses the need for Congress to reform the SGR formula but does not say how. It also suggests that Medicare establish a process to identify high-growth services and impose modest reductions if it appears prices are distorting physician behaviors.

III. Promote provider collaboration and accountability.

The Plan recommends Medicare use payment incentives to achieve more collaboration among physicians, hospitals, and other health care providers. The Plan suggests using bundled payments for all services provided to a patient during hospitalization and for some amount of time after discharge. Geisinger Health Service is noted for using bundled payments to cover diagnosis, surgical / procedural, and all post-operative costs.

IV. Improving the health care infrastructure.

Comparative Effectiveness Research. The Plan calls for the creation of a new private, non-profit institute to identify the most pressing gaps in clinical knowledge. It would assess the full spectrum of clinical interventions, including drugs, medical devices, procedures, services, and other therapies, which have the greatest gaps in evidence and variations in practice pattern.

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Health Care Workforce

The Plan asks Congress to re-examine graduate medical education (GME) funding and the number of medical residency slots currently allowed. Specific questions raised are:

• Whether the GME program should emphasize training in critical areas such as primary care, geriatrics, and preventive services

• Whether GME funds should be allocated for nurse practitioners and physician assistants who play a role in managing patients’ primary care needs

• If GME funding should be used to train residents outside traditional hospital settings, such as in community-based primary care offices

The Plan also calls for expanding loan assistance and forgiveness programs for those who choose to practice in underserved areas.