AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009
H.R. 1, as passed by the Senate and House of Representatives

Summary of Major Health Care Provisions (as of 2/10/09)
(Unless otherwise noted, the provisions in the House and Senate versions of the bill are the same)

STATUS

- H.R. 1 passed the House of Representatives on 1/28/09 by a vote of 244-188.
- H.R. 1 was amended and passed by the Senate on 2/10/09 by a vote of 61-37.
- The two versions of the bill must now be reconciled by a House-Senate Conference Committee before a vote on final passage.

COBRA

Both the House and Senate bills include a new temporary subsidy for COBRA premiums.

- Sixty-five percent (**50% in Senate**) COBRA premium subsidy for workers who have been involuntarily terminated between Sept. 1, 2008, and Dec. 31, 2009.
- Subsidy available for up to 12 months.
- Subsidy would not be considered income for purposes of other federal/state program eligibility.
- **House bill** also allows COBRA-eligible workers 55 years or older, or who have worked for an employer for 10 years or more, to retain unsubsidized COBRA coverage to age 65.
- Appropriations: $27 billion House; $21 billion Senate.

MEDICAID

Both bills provide $87 billion in additional federal matching funds (from Oct. 1, 2008-Dec. 31, 2010).

- Increases FMAP for all states by **4.9% House/7.6 % Senate**.
- Holds states harmless against a drop in their FMAPs for FYs 2009, 2010, and first quarter of FY 2011 (e.g., if 2008 FMAP is higher than 2009, the state gets the higher 2008 rate).
- States with large increases in unemployment would receive an additional FMAP increase. (Reportedly, the **Senate bill** would provide increased funds to rural states.)
- FMAP increases would not apply to other parts of state Medicaid programs that are based on enhanced FMAP (e.g., DSH, TANF, SCHIP, child/family services, etc.).
- States cannot use FMAP/high unemployment increases for rainy day/reserve fund.
- States must maintain the same eligibility standards, methodologies, and procedures that were in effect on July 1, 2008, in order to receive FMAP increase.
- States retain flexibility with respect to benefits offered under the Medicaid program.
- **Senate bill** disallows increased FMAP if state does not comply with prompt pay laws.
- **House bill** includes temporary option for states to provide Medicaid coverage to certain additional unemployed individuals without health insurance.
- **House bill** extends through June 30, 2009, the current moratorium on six Medicaid regulations relating to cost limits on public providers, GME payments, provider taxes, rehabilitative services, targeted case management services, and school administration and transportation services.
- Both bills provide for an increase in state DSH allotments but use different formulas: **House bill**, increase would only be for FY 2009 and 2010; **Senate bill**, increase would be for FY 2009-2011.

HEALTH INFORMATION TECHNOLOGY (HIT)

Both bills include funding **(approx. $20 billion House; approx. $21 billion Senate)** for the development/implementation/adoption of a nationwide HIT infrastructure.

- Codifies the Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS.
- Establishes HIT Policy and Standards Committees that are comprised of public and private stakeholders (e.g., physicians) to provide recommendations on implementation, standards, and certification criteria for electronic exchange and use of health information.
- HHS would adopt through the rule-making process standards, implementation specifications, and certification criteria by Dec. 31, 2009.
- ONCHIT would be authorized to make available an HIT system to providers for a nominal fee.
- Provides financial incentives through the Medicare program to encourage physicians and hospitals to adopt and use certified electronic health records (EHR) in a meaningful way (as defined by the Secretary and may include reporting quality measures). Authorizes ONCHIT to provide competitive grants to states for loans to providers.
- Medicare incentive payments would be based on an amount equal to 75% of the Secretary's estimate of allowable charges, up to $15,000 (**House bill**) for the first payment year after initial set of standards are available, as early as 2011. Incentive payments would be reduced in subsequent years: $12,000, $8,000, $4,000, and $2000, ending in 2015. Also provides incentives for eligible physicians, hospitals, rural health clinics, and other providers under Medicaid.
- **Senate bill**: Early adopters, whose first payment year is 2011 or 2012, would be eligible for an initial incentive payment up to $18,000. In 2014, the payment limit would equal $12,000. For eligible professionals in a rural health professional shortage area, the incentive payment amounts would be increased by 25 percent.
- **House bill penalty**: Physicians who do not adopt/use a certified HIT system would face reduction in Medicare fee schedule of -1% in 2016, -2% in 2017, -3% in 2018 and beyond.
- **Senate bill penalty**: The Medicare fee schedule amount would be reduced to -1% in 2015, -2% in 2016, and -3% in 2017 and beyond.
- Both bills allow HHS to increase penalties beginning in 2019, but penalties cannot exceed -5%. Exceptions would be made on a case by case basis for significant hardships (e.g., rural areas without sufficient Internet access).
- Federal privacy and security laws (HIPAA) would be expanded to protect identifiable health information, restrict certain disclosures and sales of protected health information, require an accounting of disclosures, would increase civil monetary penalties for violations, and would authorize state attorneys general to enforce HIPAA privacy and security laws.

COMPARATIVE EFFECTIVENESS RESEARCH (CER)

The House and Senate bills increase funding for CER by $1.1 billion.

- Establishes the Federal Coordinating Council for Comparative Effectiveness Research (FCC-CER), which would be comprised of up to 15 representatives of federal agencies—at least half would have to be physicians or other experts with clinical expertise. The FCC-CER would be an advisory board comprised solely of representatives of federal agencies charged with **coordinating federal research on CER.** The Council is not charged with establishing national clinical standards of care nor with making national coverage determinations. The mission of the Council is to coordinate the resources allocated and used for CER and make recommendations to the HHS Secretary concerning CER infrastructure and resource allocation.

- The FCC-CER would assist federal agencies with coordinating CER and related health services research, and advise the President and Congress on CER infrastructure needs.
- **Senate bill** includes language that specifies that the $1.1 billion is to be used to support and promote the dissemination of comparative ***clinical*** effectiveness research.
- **House bill** simply provides that funds will support CER.
- **Senate bill report** explicitly expresses intent that the research will not contain recommendations establishing national clinical guidelines nor will research contain national coverage recommendations. (The **House** Appropriations Committee report language has been interpreted by some as allowing CER to be used to deny coverage for what could be appropriate and medically necessary care).
- The Agency for Healthcare Research and Quality (AHRQ) would receive $700 million for CER; AHRQ must transfer $400 million to NIH to conduct or support CER.
- The Secretary would have the discretion to allocate $400 million for CER to accelerate the development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies.
- The Secretary would also be obligated to meet several requirements, including: contract with the IOM to produce and submit a report to Congress and the Secretary by June 30, 2009, that includes recommendations on the national priorities for CER; consider any recommendations of the FCC-CER; publish information on grants and contracts awarded with the funds within a reasonable time of the obligation of funds for such grants and contracts and disseminate research findings from such grants and contracts to clinicians, patients, and the general public, as appropriate; ensure that the recipients of the funds offer an opportunity for public comment on the research; and annually report on the research conducted or supported through the funds.

REPEAL OF THE 3 PERCENT WITHHOLDING TAX

The House bill would repeal the 3% withholding tax on government contractors (including Medicare providers) that was enacted under section 511 of the Tax Prevention and Reconciliation Act of 2005. The law, which was intended to ensure that government contractors file their tax returns properly and promptly, would be tremendously burdensome on physician practices with their relatively small operating margins and the AMA has been working actively in a coalition effort to promote its repeal. **The Senate bill** would only delay implementation of the 3% withholding requirement from Dec. 31, 2010, to December 31, 2011.

MEDICARE IMPROVEMENT FUND MODIFICATIONS

The **House bill** clarifies that the Medicare Improvement Fund can be used to increase the physician conversion factor to address any projected shortfall in 2014 relative to the 2008 conversion factor and to adjust Medicare payments for Parts A and B items and services. It would also require, in 2020 and beyond, that any savings from HIT penalties be applied to the Medicare Improvement Fund.

OTHER APPROPRIATIONS

- **Prevention and Wellness**: **House bill** provides $3 billion in funding (0 in **Senate bill**) for wellness and prevention programs.
- **Community Health Centers**: **$1.5 billion in House bill** , including $500 million to increase the number of uninsured Americans who receive quality health care services and $1 billion to renovate clinics and make health information technology improvements; **$1.96 billion in Senate bill,** with $1.87 billion for construction, renovation, and equipment for clinics.
- **Training Primary Care Providers**: $600 million in House bill (0 in Senate bill) to address shortages by training primary health care providers, under Titles VII and VIII of the Public Health Service Act,

including physicians, dentists, and nurses as well as helping pay medical school expenses for students who agree to practice in underserved communities through the National Health Service Corps, and for the patient navigator program.

- **Indian Health Service Facilities**: $550 million in House bill ($495 million in Senate) to modernize aging hospitals and clinics and make health care technology upgrades to improve care.
- **NIH Research and Facilities**: **House bill provides $3.5 billion** in funding for NIH; $2 billion for new research grants and renovations at the NIH's campuses and $1.5 billion for universities conducting NIH-sponsored research for renovation of their laboratories. (**Senate bill $10 billion)**
- **Pandemic Preparedness and Advanced Research and Development**: $900 million in House bill to prepare for and respond to an influenza pandemic (0 in Senate bill).