



AMERICAN OSTEOPATHIC ASSOCIATION

1090 Vermont Avenue NW, Suite 510, Washington D.C. 20005 ph 202 414 0140 | 800 962 9008

## **FREQUENTLY ASKED QUESTIONS ABOUT HEALTH PROVISIONS IN THE “AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009” (H.R. 1)**

In recent days the House and Senate have approved different versions of the “American Recovery and Reinvestment Act of 2009 (ARRA)” (H.R. 1). The House approved the legislation on January 28 by a vote of 244-188 with no Republican support. Eleven House Democrats joined the Republican’s in voting against the legislation. The Senate approved a modified version of the legislation on February 10 by a vote of 61-37 with 3 Republicans joining 58 Democrats in supporting the bill.

This legislation includes several health care provisions—including some supported by the American Osteopathic Association (AOA). Among them are investments in the training of primary care physicians (House), prevention and wellness (House), health information technology (House and Senate), and the creation of a federal body charged with conducting research on the comparative effectiveness of various health care tests and treatments (House and Senate).

These investments are aimed at improving the quality and efficiency of health care. The AOA is especially supportive of provisions that would make significant investments in the training of primary care physicians, improve funding for wellness and prevention activities, and make an initial down payment on the creation of a national interoperable health information system.

There have been widespread reports and commentaries this week that mischaracterize certain provisions of the legislation pertaining to health information technology and to comparative effectiveness research. This document is designed to clarify the legislation and provide answers to emerging concerns.

### **Access and Coverage**

- Both bills provide COBRA subsidies for workers and their families who have been involuntarily terminated from their jobs for 12 months. The House bill creates a subsidy that amounts to 65 percent of premium costs. The Senate subsidy is 50 percent of premium costs.

- The House bill allows COBRA-eligible workers age 55 and older, and those who have worked for an employer for 10 years or more, to retain COBRA coverage at their own expense beyond the 18 months provided under current law.
- Both bills increase the federal medical assistance percentage (FMAP) for Medicaid. The House increases FMAP to 4.9 percent. The Senate bill increases the FMAP subsidy to 7.6 percent.

### **Primary Care**

- The House bill would increase funding for programs under Title VII of the Public Health Service Act, which are designed to increase the education and training of primary care physicians by \$600 million.
- The original Senate bill included similar funding, but the funding was dropped as part of the Nelson-Collins compromise.
- The AOA will advocate inclusion of this funding in the final package.

### **Prevention**

- The House bill allocated over \$5 billion towards prevention and wellness programs. This included over \$700 million for pandemic flu preparedness.
- The original Senate bill included similar funding, but the funding was dropped as part of the Nelson-Collins compromise.
- The AOA will advocate inclusion of this funding in the final package.

### **Health Information Technology**

- Both bills create incentive payment structures to accelerate the adoption and implementation of health information technology (HIT). The exact provisions differ slightly, but both provide positive payment incentives followed by financial penalties for physician practices, hospitals, and other health care settings.
- The House bill imposes penalties through Medicare payment reductions for those who are not “meaningful users” of HIT beginning in 2015. Penalties under the House bill begin in 2014. The AOA will advocate for the maximum time in the final package. “Meaningful User” is not defined in the legislation, but refers to those that have incorporated HIT in their practices.
- Most policy experts are in agreement that a national interoperable HIT system will reduce medical errors, improve efficiency, and assist physicians in providing the highest quality health care for their patients. Furthermore, an HIT system removes the fragmentation of medical information that exists under the current system.

- Neither bill creates a federal system for electronically tracking patients' medical treatments or for monitoring compliance with federal treatment standards. While the legislation would impose financial penalties for those who do not adopt HIT over the next 6-7 years, those penalties bear no relation to individual treatment decisions made by physicians.
- Both bills codify the National Coordinator of Health Information Technology. The Coordinator will set minimum standards for the technology systems physicians may choose to store and maintain medical records. The Coordinator also is charged with ensuring that HIT systems are configured to maximize patient privacy avoiding unintentional public disclosures of personal health information.
- The Office of the National Coordinator of Health Information Technology is not new. It was originally established through Executive Order by former President George W. Bush. This legislation simply codifies the office and provides direction for its function.
- Neither bill grants the federal government access to electronic medical records. Current laws protecting patient privacy apply whether the health record is electronic or paper.
- Both bills create new disclosure requirements and the AOA continues to express concerns these provisions may have upon the use of health information in a medical practice. Our main goal is to ensure that physicians, in consultation with patients, can continue to use health information for the purposes of providing care and operating a medical practice. Additionally, we are strongly opposing any new penalties or rights of action for the inadvertent disclosure of patient medical records.

### **Comparative Effectiveness Research**

- Comparative effectiveness research is designed to compare clinical outcomes, or the "clinical effectiveness," of therapies for treatments for medical conditions. Such research may produce evidence on the clinical effectiveness which may help patients and doctors make better health care decisions, thus improving the quality of patients' care, improving efficiency, and ultimately saving money throughout the health system.
- Neither bill creates a single new bureaucracy to determine whether treatments are appropriate or cost effective. In fact, both versions of the bill incorporate by reference provisions in current law that prohibit the Secretary of Health and Human Services from including mandates establishing national clinical guidelines or national coverage decisions in clinical comparative effectiveness research.
- Either bill authorizes the government to use the results of clinical effectiveness research to dictate which tests, therapies, or treatments a physician may use in patient care. The Senate bill explicitly prohibits the government from making any coverage decisions based on this research, or even issuing guidelines that would suggest how

to interpret the research results. The House bill is less clear on this provision. The AOA will advocate for inclusion of the Senate language in the final package.

### **Health Czar**

- Neither bill creates a single health care “czar” who would have access to comparative effectiveness research and electronic medical records, thus enabling them to make coverage and treatment determinations. Comparative effectiveness research and HIT are separate in both bills.