



SISTERS OF MERCY HEALTH SYSTEM

Executive Summary of the House Health Reform Bill the “Affordable Health Care for America Act”

[as passed by the U.S. House of Representatives on November 7, 2009]

Overview

On November 7, by a vote of 220 to 215, the House approved H.R. 3962 with 219 Democrats and one Republican voting “yes” and 176 Republicans and 39 Democrats voting “no.” This legislation would alter how consumers access health insurance coverage by changing insurance market rules, creating an Exchange to negotiate health plan prices, facilitate enrollment, and offering a government-run option.

The bill would allow health insurance plans to continue offering coverage to existing enrollees in grandfathered products and to develop products that conform to new cost-sharing levels and include an essential benefit package. Individuals would be eligible for tax credit subsidies to help meet the new requirement to obtain health insurance coverage. Employers would be required to offer coverage and provide minimum contribution levels to employees or pay up to 8 percent of wages to the Exchange. The Medicare program would be changed to bring more quality to the delivery system and reimburse Medicare Advantage (MA) plans based on fee-for-service rates. Eligibility for Medicaid would be increased to 150 percent of poverty, and enrollees in the Children’s Health Insurance Program would become eligible for other programs and subsidies once this program is terminated in fiscal year 2014. The proposal also aims to strengthen the health care workforce by increasing the number of primary care physicians and nurses, as well as to generally provide incentives for individuals in needed professions and shortage areas.

The information below summarizes the major provisions of the House legislation.

Financing Health Care Reform

The Congressional Budget Office (CBO) projected the House bill to have a net cost of \$891 billion over 10 years with a \$109 billion net reduction in federal budget deficits. Major spending includes \$425 billion in net federal outlays for Medicaid and CHIP and \$605 billion in federal subsidies to purchase coverage through the new insurance exchanges.

Federal revenue is increased by \$574 billion from 1) a surcharge on high-income individuals equal to 5.4% on incomes exceeding \$1 million (married) and \$500,000 (single) that will raise \$460 billion; 2) an excise tax on the sale of medical devices, \$20 billion; and 3) changes to HSAs, FSAs, corporate reporting and other provisions of the tax code, \$94 billion. CBO estimates that cuts in Medicare, Medicaid, and other federal health programs would reduce spending by about \$427 billion over 10 years. Major spending changes to federal programs include: 1) permanent reductions to Medicare FFS rates, \$228 billion; 2) reducing MA funding, \$170 billion; and 3) increasing payment rates to primary care physicians under Medicaid, \$57 billion.

Individual Responsibility

- *Penalty for Failure to Maintain Coverage:* Imposes a tax on individuals who do not maintain “acceptable coverage”, equal to 2.5 percent of the excess of 1) the taxpayer’s modified adjusted gross income for the taxable year, over 2) the specified amount of gross income with respect to the taxpayer. This tax shall not exceed the applicable national average premium for the taxable year (the average premium for self-only coverage under a “basic” plan offered in an Exchange), and shall be prorated for part-year failures to maintain coverage.
- *Income-Based Affordability Credit:* Individuals that maintain coverage through the Exchange may receive an affordability premium credit, based on income, to be applied against the premium for the plan, and an affordability cost-sharing credit to be applied as a reduction of the cost sharing otherwise applicable to the plan.

Exchange

A Health Insurance Exchange would be created through which individuals and employers can purchase qualified health benefits plans (QHBP). The Commissioner of the Health Choices Administration would oversee operation of the Exchange.

- *Eligibility:* All individuals are eligible for coverage through the Exchange, except those covered through Medicare, Medicaid, TRICARE, VA, or other QHBPs. Permits small employers to purchase coverage through the Exchange by allowing businesses with up to 25 employees to access coverage in the first year, businesses with up to 50 employees in the second year, and businesses with 100 or fewer employees in the third and following years.
- *Benefit Categories:* The Commissioner would establish standards for three basic levels of health benefits plans: “basic,” “enhanced,” and “premium”. Additional benefits (e.g., dental and vision) may be offered through a “premium-plus plan.”
- *Standards for QHBP-Offering Entities:* To offer benefits within the Exchange, plans must: be licensed to offer health insurance coverage under state law; provide for the reporting of data; provide for implementing the affordability credits provided to enrollees; accept all enrollments, participate in a risk pooling mechanism; contract for outpatient services provide; and comply with additional requirements, including standards regarding billing and collection practices for premiums and related grace periods.
- *Outreach and Enrollment:* The Commissioner would be required to conduct outreach activities to inform and educate individuals and employers about the Exchange and available health benefit options. These efforts must include outreach to vulnerable populations

Facilitating Employer-Based Coverage

- *Employer Responsibility:* Employers must offer coverage through the Exchange or through a health benefit plan outside of the Exchange, and must contribute at least the minimum employer contribution level. For full-time employees, employers must contribute 72.5 percent for individuals and 65 percent for family coverage of the applicable premium of the lowest cost plan that is a QHBP. For part-time employees, employers must contribute a proportion of the minimum employer contribution with respect to full-time employees. Should an employer not provide coverage, it shall contribute an amount equal to 8 percent of average wages paid by the employer during the time of enrollment to the Health Insurance Exchange Trust Fund. Small employers with annual payrolls between \$500,000 750,000 would be subjected to a graduated percentage contribution ranging from two to six percent; employers with payrolls under \$500,000 are exempt from this employer contribution requirement.
- *Small Business Tax Credit:* Qualified small employers shall receive a health coverage credit equal to 50 percent of the qualified employee health coverage expenses of the employer for the taxable year. For employers whose average annual employee compensation exceeds \$20,000, this percentage shall be reduced by the number of percentage points which bears the same ratio to 50 as such excess bears to \$20,000. The tax credit shall be limited to a two year period per firm.

Workforce Provisions

- *Workforce Evaluation and Assessment:* Requires the Secretary to establish the Advisory Committee on Health Workforce Evaluation and Assessment to make recommendations to the Secretary on classifications of the health care workforce, the demographics of the workforce, and retention. The bill also establishes a Public Health Workforce Corps to address public health workforce shortages.
- *Grant and Loan Programs:* Provides for the establishment and operation of loan repayment, grant, and scholarship programs for students pursuing careers in certain fields of medicine, public health, and nursing.

Medicare

The Medicare physician payment “fix” is removed from the House bill. House leadership is planning to address this issue in a separate freestanding bill. The Institute of Medicine would conduct a study on geographic variation in per capita health care spending among both Medicare and privately-insured populations and recommend to Congress an implementation plan to address variation through the promotion of high-value care. CMS would implement these recommendations within the Medicare payment system unless Congress votes to disapprove. The Center for Medicare and Medicaid Payment Innovation (CMPI) would be established within CMS to test innovative payment models that are focused on improving quality of care while reducing costs.

Medicare Advantage (MA) rates are phased down to eventually equal 100 percent of Medicare FFS costs over a three year period. Bonus payments would be provided to MA plans based upon their performance on quality measures, but these bonuses would be restricted to MA plans that operate in areas with more than 20 percent MA penetration that also rank in the lowest third of per capita fee-for-service expenditures. Such quality bonuses would equal 1.5% of local benchmark rates in 2011, 3% in 2012, and 5% in 2013.

The proposal would include a minimum MLR requirement and organizations with MLRs below 85 percent in at least three consecutive years would be subject to enrollment freezes and eventually termination from the program. The annual enrollment period for MA and Part D plans would be changed, beginning on November 1st and ending on December 15th of each year beginning in 2011. The three month additional open enrollment period that currently runs from January 1st through March 31st would be eliminated. State governments would enforce standardized marketing rule. Drug manufacturers would be required to provide drug rebates for full-benefit dual eligible individuals covered under a Part D prescription drug plan or MA-PDP. The Secretary would be instructed to directly negotiate prescription drug prices with pharmaceutical manufacturers under the Medicare Part D program. The Part D coverage gap would be eliminated over a ten-year period starting in 2010. Medicare beneficiaries would be provided with price discounts while in the coverage gap.

Medicaid and CHIP

Medicaid eligibility would be expanded to include individuals and families with incomes up to 150 percent of the federal poverty level. The bill provides a 100 percent FMAP match through 2014 for individuals who are newly eligible for Medicaid under this provision, falling to a 91 percent FMAP beginning in 2015. The legislation creates a temporary maintenance of effort that prohibits a state from having in effect eligibility standards, methodologies, or procedures under CHIP (including any CHIP waivers) that are more restrictive than those in effect on June 16, 2009. The bill also extends to June 30, 2011 the temporary enhanced federal Medicaid match rate created under the American Recovery and Reinvestment Act of 2009. The House bill requires Medicaid and CHIP health plans to meet minimum MLR standards. The bill ends the funding of CHIP, effective in FY 2014 and subsequently

CLASS Independence Benefit Plan

Requires the Secretary to establish a national voluntary insurance program, the CLASS Independence Benefit Plan, to provide community living assistance services and supports.

Pharmaceutical Reform

The House proposal includes two key provisions affecting the pharmaceutical industry:

- The Food and Drug Administration would provide a pathway for approval of follow-on biologics, with 12 years of market exclusivity for brand name manufacturers.
- Prohibits prescription drug patent infringement claims from being settled through agreements under which the entity filing a new drug application receives anything of value and agrees not to research, develop, manufacture, market, or sell the product in question (“Pay for Delay”).

The House proposal would eliminate the eligibility of over-the-counter drugs as a tax-free expense under an HSA, Archer MSA, FSA, or HRA, and limits the definition of “qualified medical expense” to include prescription drugs and insulin. The House bill would also remove employer tax exclusion for retiree prescription drug plans.

Changes to Administrative Processes

- *Administrative Simplification:* The House legislation requires a qualified health benefits plan (QHBP)-offering entity to comply with standards for electronic financial and administrative transactions. The Secretary would be required to adopt new standards by interim final rule no later than two years after the implementation of the 5010 electronic transaction standards. The Secretary's standards must enable electronic funds transfers, require claim tracking, adjudication, and appeal processing, require the use of standard electronic transactions, and build upon existing and planned standards.
- *Minimum Medical Loss Ratio:* The Secretary would specify a minimum medical loss ratio (MLR) of no less than 85 percent for health insurance coverage under individual health plans and small and large group health plans. Health insurance plans that do not meet the established MLR would be required to issue rebates to consumers in an amount necessary to reach the MLR. The Secretary's MLR standards apply in the individual and group markets for plan years beginning on or after January 1, 2010.

Health Insurance Markets Rules

Health insurance reforms effective in 2010 would:

- Grant the HHS Secretary the authority to review health plan rate filings in an annual review process that would be conducted with the states.
- Creates national high-risk pool that would provide coverage to individuals who were unable to purchase coverage until the establishment of the Exchange.
- Reduce the "look-back" period so that plans would have 30 days instead of the current six months to determine whether a person has pre-existing conditions, and reduce from 12 months to three months the timeframe during which a plan can exclude coverage for the pre-existing conditions of new enrollees.
- Extend COBRA continuation coverage to unemployed workers until they become eligible either for acceptable coverage or coverage offered through the Exchange.
- Allow individuals through age 26 who are not otherwise covered to enroll on their parent's health coverage.
- Prohibit lifetime benefit limits.

Under new market rules effective in 2013, health insurance plans would be:

- Required to guarantee issue coverage to all applicants, and would be prohibited from employing preexisting condition exclusions.
- Required to implement an adjusted community rating standard that would allow premiums to vary by age (limited ratio of 2:1), geography, and family size.
- Allowed to issue individual health insurance *only* through the Exchange and must provide specified levels of benefits.
- Required to take part in a risk pooling mechanism when participating in the Exchange. The House proposal is unclear as to how a health insurance plan may create risk pools or if risk would be subsidized across all market segments and all products.

The new market rules would result in the merging of the individual and small group markets (with the potential to include the large group market) under the architecture of the Exchange.

Public Health Insurance Option

The House proposal would create a public health insurance option that would only be offered through the Exchange and would comply with all requirements of an Exchange participating health benefits plan, including those related to covered benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing. The public option would offer basic, enhanced and premium plans and may offer premium-plus plans. The House legislation appropriates \$2 billion for the establishment of the public option and enough funds to cover 90 days worth of claims reserves based on projected enrollment.

The public option would require the Secretary to negotiate provider and prescription drug payment rates for the public option that are not lower in aggregate than rates under Medicare and not higher in aggregate than the average rates paid by other QHBP-offering entities for services and health care providers. Health care providers participating under Medicare would be participating providers in the public option unless they opt out in a process established by the Secretary.

CO-OP Health Insurance Option

The House proposal would direct the Health Choices Commissioner to establish a CO-OP program that would provide a new coverage option under the Exchange. The Commissioner may make grants and loans (\$5 billion) available for the establishment and initial operation of not-for-profit, member-run co-ops.

Essential Benefits Package

All Exchange-participating health benefits plans would be required to offer the “essential benefits package,” which would include coverage for minimum services, including mental health services and prescription drugs. Health coverage would be required to have no annual or lifetime benefit limits or cost-sharing for preventative services. A new Health Benefits Advisory Committee comprised of medical experts and other representatives in the health care industry would have the authority to recommend to the HHS Secretary essential benefits package items and services, as well as cost-sharing levels for enhanced and premium plans. The House proposal includes an annual out-of-pocket limitation not to exceed \$5,000 for an individual and \$10,000 for a family for a year.