



Summary of House Health Reform Bill updated November 9, 2009

On Oct. 29, House Speaker Nancy Pelosi and the House leadership unveiled their health reform proposal, the Affordable Health Care for America Act (H.R. 3962). The bill assures access to quality, stable, affordable health care; promotes competition; slows the growth in health care costs; and improves the quality of care. This bill, possibly with minor changes, will be considered on the House floor in the next few days. The bill's full text, detailed fact sheets and summaries are available on the [Speaker's website](#).

Community Catalyst is strongly supportive of the House bill, which goes beyond earlier drafts in a number of respects. For example, this bill increases Medicaid coverage to 150 percent of the poverty line, compared to 133 percent in earlier versions, adds a long-term care insurance program for disabled adults, requires health plans to allow young people through age 26 to remain on their parents' policy, and eliminates the Medicare donut hole by 2019, rather than 2024.

The summary below details many of the advances proposed by the House.

Insurance Reform

The bill makes significant improvements to the private insurance system. Unlike earlier versions of the House bill, a number of those improvements go into effect immediately, including provisions to:

- Create a national high risk pool plan for people denied coverage because of medical conditions. This pool is temporary, until the Exchange is up and running.
- Require that insurers devote at least 85 percent of their premiums to medical benefits, and provide rebates to consumers if an insurer spends less than this level.
- Prohibit rescissions, when insurance is retroactively cancelled.
- Extend dependent coverage in all plans up to age 27.
- Prohibit lifetime benefit limits in all plans.
- Limit pre-existing condition exclusions to three months.

Additional private insurance reforms to begin by 2013 include provisions that will:

- Require insurers for small groups and individuals to offer coverage to everyone and to renew all policies.
- Prohibit exclusions for pre-existing conditions.
- Bar insurers from basing premiums on health status. Premiums could vary based on age, but the spread is constrained to a 2:1 ratio. Premiums may vary by geographic area and family size.
- Require all health plans to include essential benefits, which include hospital and outpatient services, prescription drugs, mental health services, maternity care, durable medical equipment, but not abortion services.
- Limit out-of-pocket cost-sharing to \$5,000/individual and \$10,000/family.
- Apply anti-trust regulations to health insurers.
- Starting in 2015, allow the sale of insurance across state lines if both states approve.

Discussion: These strong protections will ensure equal access to coverage for everyone in the private insurance markets. The reforms that will take effect immediately provide some relief for people who currently cannot access coverage. One concern is the proposal to allow insurers to sell health policies across state lines. While the bill creates standards for the interstate sale of insurance, this policy could still undermine consumer protections and state oversight of health plans.

Ensuring Affordability

The bill expands Medicaid, establish a sliding-scale subsidy program for low- and moderate-income people, and provides assistance for small businesses. The bill:

- Expands Medicaid to 150 percent of the federal poverty level (FPL) (or \$27,465 for a family of three).
- Provides new “affordability credits,” sliding-scale subsidies to people earning up to 400 percent FPL (or \$73,240 for a family of three) that do not get affordable coverage from their employer. Premiums would start at 1.5 percent of income for those at the lowest income, rising to 12 percent of income for those at 400 percent FPL.
- Limits the out-of-pocket costs of subsidized plans on a sliding scale. For those below 150 percent FPL who do not qualify for Medicaid, the annual out-of-pocket maximum would be \$500 for an individual or \$1,000 for a family; at 400 percent FPL, the annual out-of-pocket maximum will be \$5,000 for an individual or \$10,000 for a family.
- Offers credits to small businesses to offset up to half of the costs of providing coverage to employees for up to two years.

Discussion: Expanding Medicaid and providing subsidies up to 400 percent FPL is an important first step in assuring everyone can afford coverage. The subsidies offered in this bill will make coverage substantially much more affordable for low- and moderate-income families than the subsidies offered in the Senate Finance Committee bill.

However, low-income families who are offered expensive coverage through their employer may still be left with no affordable option; the bill restricts eligibility for subsidies so that individuals cannot qualify unless their employer coverage would cost more than 12 percent of their income. The House should, at a minimum, exempt workers from the mandate if their premiums would cost more than what someone at the same income level who qualifies for subsidies would pay.

Public Health Insurance Option

The bill provides for a public health insurance option which will only be available through the Exchange (see below). The plan negotiates rates with providers, and provider participation is voluntary. The public option is authorized to use innovative payment methods and policies, and the plan is subject to all of the requirements of Exchange-participating plans. The federal government will provide start-up funding and funding for initial reserves, which must be paid back over ten years. The plan must be financially self-sustaining and maintain its operations using premium revenue.

Discussion: This public option increases choice and competition and provides an accountable alternative to private plans. The plan will operate throughout the country and could provide savings through lower administrative costs and innovative care management. The House proposal falls short of the most robust model, in that it is not based on Medicare rates, and is not available to everyone.

Health Insurance Exchange

The bill creates a National Health Insurance Exchange to help individuals and employers compare health plans, make informed choices and facilitate enrollment. States (or multiple states in a region) will have the option of operating their own Exchanges in lieu of the national Exchange. The Exchange has the power to negotiate rates and contract with insurers. Subsidies and the public option plan will be available through the Exchange, in which participation is voluntary.

Eligibility for the Exchange starts in 2013 for individuals without an available health care option and small employers with up to 25 workers. In 2014, the Exchange opens to businesses with up to 50 employees, and in 2015, businesses up to 100 employees. The Commissioner may allow all employers to participate. Exchange plans must provide transparent information on benefits, cost-sharing, payment policies, and claims denials.

Benefits and cost-sharing for Exchange plans will be determined by a Health Benefits Advisory Committee. Four tiers of plans will be offered in the Exchange, starting with a Basic Plan that includes essential benefits and meets 70 percent of average health costs (actuarial value), up to a Premium Plan which covers 95 percent actuarial value. A Premium-Plus Plan will offer additional benefits, such as dental and vision coverage.

Discussion: The Exchange will offer a variety of plans and allow consumers to make comparisons of the choices available. With the power to contract and negotiate with plans, the Exchange will be able to provide high quality benefits that are affordable for consumers. In addition, the patient representative on the Health Benefits Advisory Committee will help to ensure benefits and cost-sharing for Exchange plans are adequate. While the Commissioner has the authority to pool risk *within* the Exchange plans, this pooling should also extend to plans offered outside of the Exchange, to reduce adverse selection and prevent the Exchange plans from having higher premiums.

Shared Responsibility

The bill requires individuals to obtain health insurance, and require most businesses to offer coverage to workers. For individuals, the bill will:

- Starting in 2013, mandate everyone to purchase a health plan that meets minimum standards.
- Impose a penalty for noncompliance totaling 2.5 percent of the individual's income above the income tax standard deduction amount, up to a maximum of the national average premium for basic coverage.
- Create a "hardship exemption" from the penalties for the mandate.

For employers, the bill will:

- Mandate that they offer all of their employees comprehensive coverage. For full-time employees, employers must offer to pay at least 72.5 percent of the lowest cost premium for individual coverage, or 65 percent of the premium for family coverage.
- Require a proportional minimum contribution for part-time employees.
- Assess a payment equal to 8 percent of payroll if they fail to meet the requirements. Employers may choose to meet the requirements for full-time employees, and to pay the fine only for their part-time employees.
- Exempt small businesses with annual payrolls of less than \$500,000 from the requirements, and require penalties of less than 8 percent from businesses with annual payrolls of less than \$750,000.

Discussion: The employer “pay or play” requirement is an important component of ensuring that everyone has access to adequate coverage. The individual mandate structure has no affordability exemption for those who earn too much to qualify for subsidies, but cannot find affordable coverage. Under the current structure, individuals above 400 percent FPL would be required to buy coverage, no matter how high the cost. We recommend that an “affordability standard,” a sliding-scale percentage of income that would exempt those who cannot find comprehensive affordable coverage, be added to the bill.

Children’s Health

The bill makes Medicaid more accessible to larger groups of children than previous bills, yet it does less to protect children moving into the Exchange after CHIP sunsets in 2013. The bill:

- Expands access to the Medicaid program for children by providing coverage with the EPSDT package of preventive and screening services for those at or below 150 percent FPL and automatically enrolling newborns up to the first 60 days of life who would otherwise be uninsured.
- Continues the requirement that states not weaken eligibility in their Medicaid and CHIP programs.
- Establishes initiatives for implementing pediatric medical homes and obesity prevention programs.

Discussion: The expansion of Medicaid up to 150 percent FPL guarantees access to critical EPSDT services designed for children. The increase in Medicaid provider rates for primary care physicians will improve access to care for children. We are concerned about the failure of the bill to include the provision permitting children to stay in CHIP past 2013 if Exchange coverage is not comparable. The transition period must be better planned, and sufficient time must be allotted, to make this go smoothly. We believe children should not move into the Exchange until these plans are evaluated and it is clear that their care is at least comparable to what they receive currently through CHIP.

Reducing Disparities

The bill contains numerous provisions aimed at reducing racial and ethnic health disparities. These include provisions to:

- Develop quality improvement measures and require data collection on key health indicators and health care system performance including standards for appropriate collection of data on race, ethnicity, primary language, and diversity of workforce.
- Establish grants and scholarships to diversify the health care workforce.
- Develop a national prevention and wellness strategy with goals to reduce health disparities, including grants to promote wellness for high-risk populations and the reduction of health disparities through community health workers.
- Establish cultural and linguistic competency training programs for health professionals.
- Set up a demonstration project within Medicare to improve culturally- and linguistically-appropriate communications.
- Allow legal immigrants to receive affordability tax credits, although legal immigrants will continue to be ineligible for Medicaid during their first five years of legal status.

Discussion: The bill is very strong in supporting public health and wellness efforts, with a focus on health disparities. Quality improvement initiatives identify disparities reduction as a priority, and standardized race, ethnicity, language data collection is also included. Workforce development grants will help to diversify the health care professions and build cultural competence among health

professionals. We are disappointed that the bill does not address the “Five-year bar” policy that excludes legal immigrants from Medicaid for five years after attaining legal residency.

Consumer Voice

The bill includes several mechanisms to make sure consumers get the assistance they need to enroll in coverage that meets their needs. A provision creates a national ombudsman office to document complaints and to help consumers gain access to care. The bill directs the Exchange to conduct outreach, education, and enrollment assistance in a culturally- and linguistically-appropriate manner, and allows the Exchange to work with other entities to perform outreach and enrollment assistance.

Discussion: We support provisions to provide consumers with the information, support, and trouble-shooting they need to enroll in the right coverage and navigate the health system. In addition, these services should be provided by non-profit, community-based organizations that have experience supporting consumers. A function of this assistance and support is also to provide feedback to public agencies about any problems with implementation of health reforms. We continue to encourage stronger language that directs the Exchange to work through community-based nonprofits to develop this assistance.

Strengthening Medicare

The bill contains a number of provisions to strengthen Medicare’s stability and improve beneficiaries’ access to care. Among the provisions, the bill will:

- Eliminate the Medicare Part D “doughnut hole” by 2019 by progressively increasing coverage limits and decreasing out-of-pocket spending. The federal government will also negotiate for lower drug prices for Medicare Part D.
- Require manufacturer drug rebates to be paid to Medicare for beneficiaries dually eligible for Medicaid and Medicare D.
- Limit cost-sharing requirements in Medicare Advantage plans to the amount charged for the same services in traditional Medicare coverage.
- Extend the Special Needs Plan program for Medicare beneficiaries with multiple chronic conditions and those that are dually eligible. A new Office within CMS will promote policies and assist states in better integrating care for dually eligible Medicare beneficiaries.
- Create a demonstration program for Medicare beneficiaries with multiple chronic illnesses, using a combination of teams led by primary care providers, a shared savings incentive program, and home- and community-based services to improve health care outcomes.

Discussion: Seniors, particularly low-income seniors, win in many of the House provisions dealing with Medicare. We are particularly pleased to see limitations on cost-sharing for seniors enrolled in Medicare Advantage and the new Office dedicated to improving policies for dually eligible beneficiaries.

Prescription Drugs

The bill promotes the use of the safest, most effective drugs, increase transparency in financial transactions related to prescription drugs, and reduce the cost of drugs for private and public payers.

- The Physician Payments Sunshine provision will require pharmaceutical and medical device companies to report all payments over \$5 to health professionals and organizations, which will be posted to a searchable website accessible to the public.

- The Pharmacy Benefits Manager (PBM) transparency requirement will provide health plans operating in the Exchange information about the rebates that their PBMs receive from drug manufacturers, as well as the amount a PBM pays pharmacies to dispense the drugs.
- A ban on “Pay-for-Delay” settlements will prevent pharmaceutical manufacturers from paying their generics competitors to delay bringing a generic drug to market.
- The minimum manufacturer rebate provided to Medicaid programs for brand name drugs will be increased from 15.1 percent of average manufacturer price to 23.1 percent of average manufacturer price. Manufacturer rebates will now be paid to states for Medicaid beneficiaries in managed care plans.

Discussion: Requiring transparency in payments by the drug and device industry to prescribers and other providers will help reduce industry influence over prescribing, improving quality and reducing costs. PBM transparency will encourage the industry to work in the best interest of consumers and payers, and the generics section will result in savings to consumers by making cheaper generics available more quickly. Savings for Medicaid will result from enhanced rebates by drug manufacturers.

Improving Quality

The bill includes numerous provisions to promote access to primary and preventive care, strengthen care coordination, and improve the quality of health care in America. Among these provisions, the bill will:

- Increase Medicare payments to primary care providers (PCPs) and require state Medicaid programs to pay PCPs at the full Medicare rate by 2012. States will begin phasing in higher payments in 2010, with the federal government paying 100 percent of increased costs till 2015 and 90 percent thereafter.
- Establish a Center for Comparative Effectiveness Research to conduct, support, and synthesize research with respect to outcomes, effectiveness, and appropriateness of health care services and procedures.
- Reduce Medicare payments for preventable hospital readmissions.
- Require public reporting on healthcare-associated infections.
- Establish pilot programs in Medicare and Medicaid to test new models of paying for and delivering care, *e.g.*, bundling, patient-centered medical homes, accountable care organizations, and provide pathways for successful models to be brought to scale nationally.
- Build an in-house innovation center within CMS to research, develop, and expand payment and delivery models that improve quality and reduce costs for Medicare, Medicaid, and dually eligible beneficiaries.
- Support new research and programs to improve prevention and wellness activities.
- Establish a voluntary long-term care insurance program (CLASS) to provide community services and supports to people with functional limitations.

Discussion: We are pleased to see that many of the provisions in the House bill recognize the need to improve overall value within our health care system. The House provisions make significant investments in primary care and focus on improving quality and patient-centeredness as a means to reduce costs. The proposed bill takes important steps to build infrastructure within the federal government, in particular, to test and expand promising models of care and payment. As expected, most of these new initiatives leave it to the HHS Secretary to build out and develop programs, and advocates will need to pay close attention to how these programs unfold during implementation.

Strengthen Safety Net Services

Several of the bill's provisions improve or build the infrastructure necessary to improve access to care for low-income and other vulnerable populations. The bill will:

- Provide a 75 percent federal match rate for translation or interpretation services to Medicaid beneficiaries for whom English is not their primary language.
- Establish a grant program to create “community-based collaborative networks” of safety net service providers and others who serve low-income and underserved communities, including those that may not be eligible for adequate coverage under health reform.
- Provide grant funding to test whether medical-legal partnerships can effectively increase access, reduce health disparities, and improve health outcomes for low-income populations.

Discussion: Many of these reforms represent positive, necessary improvements to the safety net infrastructure. We are pleased to see increased attention paid to reducing health disparities and improving access to care for vulnerable populations, especially for those that are likely to remain un- or underinsured, even after reform passes. We do, however, question the impact of some of these new initiatives, particularly since several of them lack specific funding or require matching funds from states. The bill also imposes significant automatic reductions in funding to Disproportionate Share Hospitals (DSH) and other safety net providers that could threaten access to care in some communities.

Financing

The House bill is financed largely by a 5.4 percent surtax on high-income individuals, affecting income over \$500,000 per year for individuals and income over \$1,000,000 per year for families. This is a more progressive form of taxation than the excise tax in the Senate Finance Committee proposal. Overall, according to the non-partisan Congressional Budget Office, the bill would result in a reduction in federal budget deficits of \$104 billion over the 2010–2019 period. Budget deficits would continue to decline after 2019. Under the House bill, about 96 percent of legal residents would have coverage by 2019.

Floor amendments

An amendment was added on the House floor, restricting the availability of abortion coverage in plans offered by the Exchange. The amendment goes beyond long-standing prohibitions against public funding for abortions, limiting abortion coverage even for women paying for it without government subsidies. The amendment would allow plans to offer separate supplemental coverage that covers abortion only, though most observers doubt such plans would be viable.