



HEALTH CARE REFORM PROPOSALS

Achieving comprehensive health reform has emerged as a leading priority of the President and Congress. This summary of the Senate HELP Committee Affordable Health Choices Act and the House Tri-Committee America’s Affordable Health Choices Act of 2009 (H.B. 3200) describes the key components of these leading health reform proposals.

	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America’s Affordable Health Choices Act of 2009 (H.B. 3200)
Date plan announced	June 9, 2009	June 19, 2009
Overall approach to expanding access to coverage	Require all individuals to have health insurance. Create state-based American Health Benefit Gateways through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes up to 400% of the federal poverty level. Impose new regulations on the individual and small group insurance markets. Expand Medicaid to all individuals with incomes up to 150% of the poverty level.	Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (or \$73,240 for a family of three in 2009). Require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the Exchange and in the small group insurance market. Expand Medicaid to 133% of the poverty level.
Individual mandate	<ul style="list-style-type: none"> Require all individuals to have qualifying health coverage. Enforced through a tax penalty of no less than 50% of the average annual premium for a basic plan. Exemptions to the individual mandate will be granted to residents of states that do not establish an American Health Benefit Gateway, members of Indian tribes, those for whom affordable coverage is not available, and individuals enrolled in Medicare. 	<ul style="list-style-type: none"> Require all individuals to have “acceptable health coverage”. Those without coverage pay a penalty of 2.5% of modified adjusted gross income up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. Exceptions granted for dependents, religious objections, and financial hardship.

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Employer requirements	<ul style="list-style-type: none"> • Require employers to offer health coverage to their employees and contribute at least 60% of the premium cost or pay \$750 for each full-time employee who is not offered coverage. • Exempt employers with 25 or fewer employees from the requirement to provide coverage. 	<ul style="list-style-type: none"> • Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. • Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than \$400,000: <ul style="list-style-type: none"> – Annual payroll less than \$250,000: exempt; – Annual payroll between \$250,000 and \$300,000: 2% of payroll; – Annual payroll between \$300,000 and \$350,000: 4% of payroll; – Annual payroll between \$350,000 and \$400,000: 6% of payroll. • Require employers that offer coverage to automatically enroll into the lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage.
Expansion of public programs	<ul style="list-style-type: none"> • Expand Medicaid to all individuals with incomes up to 150% FPL. Individuals eligible for Medicaid will be covered through state Medicaid programs and will not be eligible for credits to purchase coverage through American Health Benefit Gateways. • Grant individuals eligible for the Children's Health Insurance Program (CHIP) the option of enrolling in CHIP or enrolling in a qualified health plan through a Gateway. • Create a community health insurance option to be offered through state Gateways that complies with the requirements of being a qualified health plan. Require that the costs of the community health insurance option be financed through revenues from premiums and require the plan to negotiate payment rates with providers. Permit the plan to develop innovative payment policies to promote quality, efficiency, and savings to consumers. Additional requirements for the community health insurance option may be developed in collaboration with the National Association of Insurance Commissioners. 	<ul style="list-style-type: none"> • Expand Medicaid to all individuals (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL. Newly eligible, non-traditional (childless adults) Medicaid beneficiaries may enroll in coverage through the Exchange if they were enrolled in qualified health coverage during the six months before becoming Medicaid eligible. Provide Medicaid coverage for all newborns who lack acceptable coverage and provide optional Medicaid coverage to low-income HIV-infected individuals and for family planning services to certain low-income women. In addition, increase Medicaid payment rates for primary care providers to 100% of Medicare rates. The coverage expansions (except the optional expansions) and the enhanced provider payments will be fully financed with federal funds. • Require CHIP enrollees to obtain coverage through the Health Insurance Exchange (in the first year the Exchange is available) provided the Health Choices Commissioner determines that the Exchange has the capacity to cover these children and that procedures are in place to ensure the timely transition of CHIP enrollees into the Exchange without an interruption of coverage.

Premium subsidies
to individuals

- Provide premium credits on a sliding scale basis to individuals and families with incomes up to 400% FPL to purchase coverage through the Gateway. The premium credits will be determined by the Secretary, but will be such that individuals with incomes less than 400% FPL pay no more than 12.5% of income and individuals with incomes less than 150% FPL pay 1% of income, with additional limits on cost-sharing.
- Individuals are not eligible for premium credits through the Gateway if they have access to employer-based coverage that meets minimum qualifying criteria and affordability standards, or are eligible for Medicare, Medicaid, TRICARE, or FEHBP.

- Provide affordability premium credits to eligible individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income tiers:
 - 133-150% FPL: 1.5 - 3% of income
 - 150-200% FPL: 3 - 5% of income
 - 200-250% FPL: 5 - 7% of income
 - 250-300% FPL: 7 - 9% of income
 - 300-350% FPL: 9 - 10% of income
 - 350-400% FPL: 10 - 11% of income
- Provide affordability cost-sharing credits to eligible individuals and families with incomes up to 400% FPL. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income tier:
 - 133-150% FPL: 97%
 - 150-200% FPL: 93%
 - 200-250% FPL: 85%
 - 250-300% FPL: 78%
 - 300-350% FPL: 72%
 - 350-400% FPL: 70%
- Limit availability of premium and cost-sharing credits to individuals who meet the income limits and are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (except those eligible to enroll in the Exchange), TRICARE, or VA coverage (with some exceptions). Individuals with access to employer-based coverage are eligible for the premium and cost-sharing credits if the cost of the employee premium exceeds 11% of the individuals' income.

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<p>Premium subsidies to employers</p>	<ul style="list-style-type: none"> • Provide qualifying small employers with a health options program credit. To qualify for the credit, employers must have fewer than 50 full-time employees, pay an average wage of less than \$50,000, and must pay at least 60% of employee health expenses. The credit is equal to \$1,000 for each employee with single coverage and \$2,000 for each employee with family coverage, adjusted for firm size (phasing out as firm size increases) and number of months of coverage provided. Bonus payments are given for each additional 10% of employee health expenses above 60% paid by the employer. Employers may not receive the credit for more than three consecutive years. • Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers for 80% of retiree claims between \$15,000 and \$90,000. Program will end when the state Gateway is established. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. 	<ul style="list-style-type: none"> • Provide small employers with fewer than 25 employees and average wages of less than \$40,000 with a health coverage tax credit. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of \$20,000 or less. The credit phases-out as firm size and average wage increases and is not permitted for employees earning more than \$80,000 per year. • Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers for 80% of retiree claims between \$15,000 and \$90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan.
<p>Tax changes related to health insurance</p>	<p>Not specified.</p>	<ul style="list-style-type: none"> • Impose a tax on individuals without acceptable health care coverage of 2.5% of modified adjusted gross income.
<p>Creation of insurance pooling mechanisms</p>	<ul style="list-style-type: none"> • Create state-based American Health Benefit Gateways through which individuals and small employers can purchase qualified coverage. States may form regional Gateways or allow more than one Gateway to operate in a state as long as each Gateway serves a distinct geographic area. • Require the Gateway to certify participating health plans, provide consumers with information allowing them to choose among plans, contract with navigators to conduct outreach and enrollment assistance, and create a single point of entry for enrolling in coverage through the Gateway or through Medicaid, CHIP or other federal programs. • Require states to adjust payments to health plans based on the actuarial risk of plan enrollees using methods established by the Secretary. • Require plans participating in the Gateway to provide incentives to providers to better coordinate care, reduce hospital readmissions and implement wellness and health promotion activities; prohibit plans from contracting with hospitals with greater than 50 beds unless those hospitals adopt patient safety and discharge planning programs. 	<ul style="list-style-type: none"> • Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option. • Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (with some exceptions), TRICARE, or VA coverage (with some exceptions). • Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Finance the costs of the public plan through revenues from premiums. For the first three years, set provider payment rates in the public plan at Medicare rates and allow bonus payments of 5% for providers that participate in both Medicare and the public plan and for pediatricians and other providers that don't typically participate in Medicare. In subsequent years, permit the Secretary to establish a process for setting rates. Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out.

Creation of insurance pooling mechanisms
(continued)

Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, differential payment rates, performance based payments, or partial capitation and modify cost sharing and payment rates to encourage use of high-value services.

- Create four benefit categories of plans to be offered through the Exchange:
 - *Basic plan* includes essential benefits package and covers 70% of the benefit costs of the plan;
 - *Enhanced plan* includes essential benefits package, reduced cost sharing compared to the basic plan, and covers 85% of benefit costs of the plan;
 - *Premium plan* includes essential benefits package with reduced cost sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan;
 - *Premium plus plan* is a premium plan that provides additional benefits, such as oral health and vision care.
- Require guarantee issue and renewability; allow rating variation based only on age (limited to 2 to 1 ratio), premium rating area, and family enrollment; and limit the medical loss ratio to a specified percentage.
- Require plans participating in the Exchange to be state licensed, report data as required, implement affordability credits, meet network adequacy standards, provide culturally and linguistically appropriate services, contract with essential community providers, and participate in risk pooling. Require participating plans to offer one basic plan for each service area and permit them to offer additional plans.
- Require risk adjustment of participating Exchange plans.
- Provide information to consumers to enable them to choose among plans in the Exchange, including establishing a telephone hotline and maintaining a website and provide information on open enrollment periods and how to enroll.
- Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the exchange.

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Benefit design	<ul style="list-style-type: none"> • Create three benefit tiers based on the percentage of allowed benefit costs covered by the plan, ranging from 76% of benefit costs for the lowest tier to 93% of benefit costs for the highest tier. Require plans to provide at least the essential benefits and prohibit inclusion of lifetime or annual limits on the dollar value of benefits. • Specify the essential health benefits to be included in a qualified health plan, criteria for minimum qualifying coverage, and an affordability standard such that coverage is deemed unaffordable if the premium exceeds 12.5% of an individual's adjusted gross income. 	<ul style="list-style-type: none"> • Create an essential benefits package that provides a comprehensive set of services, covers 70% of the actuarial value of the covered benefits, limits annual cost-sharing to \$5,000/individual and \$10,000/family, and does not impose annual or lifetime limits on coverage. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. • All qualified health benefits plans, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package.
Changes to private insurance	<ul style="list-style-type: none"> • Require guarantee issue and renewability of health insurance policies in the individual and small group markets; prohibit pre-existing condition exclusions; and allow rating variation based only on family structure, geography, the actuarial value of the health plan benefit, and age (with only 2 to 1 variation). • Require health insurers to report cost information and to provide incentives to providers to better coordinate care, reduce hospital readmissions and reduce medical errors. • Require insurers to provide coverage for preventive care services without cost sharing. • Provide dependent coverage for children up to age 26. • Require insurers and group plans to notify enrollees if coverage does not meet minimum qualifying coverage standards. 	<ul style="list-style-type: none"> • Prohibit coverage purchased through the individual market from qualifying as acceptable coverage for purposes of the individual mandate unless it is grandfathered coverage. Individuals can purchase a qualifying health benefit plan through the Health Insurance Exchange. • Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing exclusions in the small group market and in the Exchange (see creation of insurance pooling mechanism). • Limit health plans' medical loss ratio to a percentage specified by the Secretary to be enforced through a rebate back to consumers. • Improve consumer protections by establishing uniform marketing standards, requiring fair grievance and appeals mechanisms, and prohibiting insurers from rescinding health insurance coverage except in cases of fraud. • Adopt standards for financial and administrative transactions to promote administrative simplification. • Create the Health Choices Administration to establish the qualifying health benefits standards, establish the Exchange, administer the affordability credits, and enforce the requirements for qualified health benefit plan offering entities, including those participating in the Exchange or outside the Exchange.

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State role	<ul style="list-style-type: none"> • Establish American Health Benefit Gateways meeting federal standards and adopt individual and small group market regulation changes. • Create temporary "RightChoices" programs to provide uninsured individuals with immediate access to preventive care and treatment for identified chronic conditions. States will receive federal grants to finance these programs. 	<ul style="list-style-type: none"> • Require states to enroll newly eligible Medicaid beneficiaries into the state Medicaid programs and to implement the specified changes with respect to provider payment rates, benefit enhancements, quality improvement, and program integrity. • Require states to maintain Medicaid and CHIP eligibility standards, methodologies, or procedures that were in place as of June 16, 2009 as a condition of receiving federal Medicaid or CHIP matching payments. • Require states to enter into a Memorandum of Understanding with the Health Insurance Exchange to coordinate enrollment of individuals in Exchange-participating health plans and under the state's Medicaid program. • May require states to determine eligibility for affordability credits through the Health Insurance Exchange.
Cost containment	<ul style="list-style-type: none"> • Establish a Health Care Program Integrity Coordinating Council and two new federal department positions to oversee policy, program development, and oversight of health care fraud, waste, and abuse in public and private coverage. • Provide grants for improving health system efficiency, including grants to establish community health teams to support a medical home model; to implement medication management services; to design and implement regional emergency care and trauma systems. 	<ul style="list-style-type: none"> • Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions. • Modify provider payments under Medicare including: <ul style="list-style-type: none"> – Modify market basket updates to account for productivity improvements for inpatient hospital, home health, skilled nursing facility, and other Medicare providers; and – Reduce payments for potentially preventable hospital readmissions. • Restructure payments to Medicare Advantage plans, phasing to 100% of fee-for-services payments, with bonus payments for quality. • Increase the Medicaid drug rebate percentage and extend the prescription drug rebate to Medicaid managed care plans. Require drug manufacturers to provide drug rebates for dual eligibles enrolled in Part D plans. • Reduce Medicaid DSH payments by \$6 billion in 2019, imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured rates and those that do not target DSH payments. • Require hospitals and ambulatory surgical centers to report on health care-associated infections to the Centers for Disease Control and Prevention and refuse Medicaid payments for certain health care-associated conditions. • Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

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<p>Cost containment (continued)</p>		<ul style="list-style-type: none"> • Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs.
<p>Improving quality/health system performance</p>	<ul style="list-style-type: none"> • Develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health that includes publishing an annual national health care quality report card. • Develop, through a multi-stakeholder process, quality measures that allow assessments of health outcomes; continuity and coordination of care; safety, effectiveness and timeliness of care; health disparities; and appropriate use of health care resources. Require public reporting on quality measures through a user-friendly website. • Create a Patient Safety Research Center charged with identifying, evaluating, and disseminating information on best practices for improving health care quality. • Develop interoperable standards for using HIT to enroll individuals in public programs and provide grants to states and other governmental entities to adopt and implement enrollment technology. 	<ul style="list-style-type: none"> • Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. • Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers, providing Medicare bonus payments to primary care practitioners (with larger bonuses paid to primary care practitioners serving in health professional shortage areas). • Conduct Medicare pilot programs to test payment incentive models for accountable care organizations and bundling of post-acute care payments, and conduct pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing qualified patient-centered medical homes. • Improve coordination of care for dual eligibles by creating a new office or program within the Centers for Medicare and Medicaid Services. • Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. Develop national priorities for performance improvement and quality measures for the delivery of health care services. • Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services and provide Medicare demonstration grants to reimburse culturally and linguistically appropriate services. • Develop standards for the collection of data on race, ethnicity, and primary language.

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Prevention/wellness	<ul style="list-style-type: none"> • Develop a national prevention and health promotion strategy that sets specific goals for improving health. Create a prevention and public health investment fund to expand and sustain funding for prevention and public health programs. 	<ul style="list-style-type: none"> • Develop a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. • Improve prevention by covering only proven preventive services in Medicare and Medicaid. Eliminate any cost-sharing for preventive services in Medicare and increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates.
Long-term care	<ul style="list-style-type: none"> • Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. 	<ul style="list-style-type: none"> • Improve transparency of information about skilled nursing facilities and nursing facilities.
Other investments	<ul style="list-style-type: none"> • Establish a National Health Care Workforce Commission to make recommendations and disseminate information on health workforce priorities, goals, and policies including education and training, workforce supply and demand, and retention practices. • Reform Graduate Medical Education to increase the supply, education, and training of doctors, nurses, and other health care workers, especially in pediatric, geriatric, and primary care. • Improve access to care by providing additional funding to increase the number of community health centers and school-based health centers. 	<ul style="list-style-type: none"> • Make improvements to the Medicare program: <ul style="list-style-type: none"> – Reform the sustainable growth rate for physicians, with incentive payments for primary care services, and for services in efficient areas; – Eliminate the Medicare Part D coverage gap (phased in over 15 years) and require drug manufacturers to provide a 50% discount on brand-name prescriptions filled in the "coverage gap"; – Increase the asset test for Medicare Savings Program and Part D Low-Income Subsidies to \$17,000/\$34,000; and – Eliminate any cost-sharing for preventive services in Medicare and increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. • Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings and support the development of primary care training programs. • Support training of health professionals, including advanced education nurses, who will practice in underserved areas; establish a public health workforce corps; and promote training of a diverse workforce and provide cultural competence training for health care professionals. • Provide grants to each state health department to address core public health infrastructure needs. • Conduct a study of the feasibility of adjusting the federal poverty level to reflect variations in the cost of living across different areas.

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Financing	Not specified.	The Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be \$1.042 trillion over ten years. Approximately half of the cost of the plan is financed through savings from Medicare and Medicaid, including incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing drug rebate provisions, reducing potentially preventable hospital readmissions, and cutting Medicaid DSH payments. The remaining costs are financed through a surcharge imposed on families with incomes above \$350,000 and individuals with incomes above \$280,000. The surcharge is equal to 1% for families with modified adjusted gross income between \$350,000 and \$500,000; 1.5% for families with modified adjusted gross income between \$500,000 and \$1,000,000; and 5.4% for families with modified adjusted gross income greater than \$1,000,000. These surcharge percentages may be adjusted if federal health reform achieves greater than expected savings.
Sources of information	http://help.senate.gov/	http://edworkforce.house.gov/

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