

	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.B. 3200)
Date Plan Announced	9-Jun-09	19-Jun-09
Passed out of Committee	15-Jul-09 <ul style="list-style-type: none"> • 13-10, on a party-line vote. 	7/16/2009 <ul style="list-style-type: none"> • Ways & Means, Bill passed with Unanimous Republican opposition AND three Democrats voting against the healthcare bill. They were: Ron Kind (WI-03), Earl Pomeroy (ND-At Large), and John Tanner (TN-08). • The following Democrats voted against reporting out H.R. 3200 in the House Education and Labor Committee: Altmire - (D-PA) Polis - (D-CO) Titus - (D-NV)
Overall approach to expanding access to coverage	<p>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.</p>	<p>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.</p>

<p>Individual Mandate</p>	<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.
<p>Employer Requirements</p>	<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 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.

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%

		<p>300-350% FPL: 72%</p> <p>350-400% FPL: 70%</p> <ul style="list-style-type: none"> 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.
<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 	<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>three consecutive years.</p> <ul style="list-style-type: none"> • 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. 	
Tax Changes Related to Health Insurance	Not specified.	Impose a tax on individuals without acceptable health care coverage of 2.5% of modified adjusted gross income.
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 specified by the Medical Advisory Council and prohibit inclusion of lifetime or annual limits on the dollar value of benefits. • Specify the essential health care benefits to be included in a qualified health plan, criteria for minimum qualifying coverage, and an affordability standard such that 	<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.

	<p>coverage is deemed unaffordable if the premium exceeds 12.5% of an individual's adjusted gross income.</p>	
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Changes to Private Insurance

- 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.
- 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.

Cost Containment

- 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.
- 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:
 - 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

		<p>providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.</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.
Financing	Not specified.	<p>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.</p>

Sources of information	http://help.senate.gov/	http://waysandmeans.house.gov/MoreInfo.asp?section=52
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