APPENDIX B

THE AFFORDABLE HEALTH CHOICES ACT
U.S. SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

I. INSURANCE COVERAGE PROVISIONS

Insurance Market Reforms

The health reform bill passed by the U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP) would require all insurance carriers providing coverage through new state insurance exchanges or through the individual or group insurance markets to be a certified qualifying health plan. The employer and individual mandates would be satisfied only with benefits provided by qualifying health plans. To be considered qualified, a plan would have to accept every individual and employer that applied for coverage (guaranteed issue) and could not allow rating on the basis of health status. Premiums could reflect age (with a maximum rate variance between age bands of 2:1), tobacco use, family structure, the actuarial value of the plan, and the community-rating area. Annual or lifetime limits on benefits would be prohibited.

The individual market would continue operation subject to the same regulations as the exchanges. Insurance carriers would be required to include all individuals enrolled in a plan, or all small groups enrolled in a plan, to be part of a single risk pool, regardless of where the plan is purchased.

Insurers that offer dependent coverage must cover dependents through age 26.

Amendments to the bill outlaw the use rescissions by insurance companies, unless a covered individual has committed fraud or has intentionally misrepresented a material fact prohibited by the terms of coverage.

Health Insurance Exchange

The Senate HELP Committee bill would allow for the creation of state-based exchanges, called American Health Benefit Gateways, subject to strict federal guidelines on insurance market regulations, premium subsidies, benefit standards, the choice of private and public plans, and participation. States would have the option of becoming an "establishing" state in which they would establish and operate a gateway or a "participating" state in which the secretary of health and human services (HHS) would establish and operate the gateway in the state. Groups of states could also jointly operate a gateway. Subregional gateways would be allowed within states or regions so long as each gateway served a geographically distinct area that was at least the size of the minimum community-rating area established by HHS. The federal government would provide grants to states that opted to establish gateways, with the amount determined by the state's population. The gateway may also help finance its activities by assessing a surcharge on all health insurance carriers that offer qualified health plans through the exchange, with the surcharge not to exceed 4 percent of premiums collected by a plan.

Who Is Eligible to Participate?

Under the Senate HELP bill, individuals can purchase coverage through the exchange if they do not have access to employer coverage that is in compliance with the employer shared responsibility requirements or if they are not eligible for Medicaid (i.e., earn less than 150 percent of the federal poverty level). Small businesses with fewer than 50 employees could purchase plans through the exchange. Under an amendment to the bill, the state (for an establishing state) or the secretary of HHS (for a participating state) could increase the threshold above 50 employees.

Standard Benefit Package

Under the Senate HELP bill, the secretary of HHS would define an essential health benefits package that would be equal in scope to typical employer plans, with this confirmed by the chief actuary of the Centers for Medicare and Medicaid Services (CMS). An amendment to the bill would establish the National Independent Commission on Essential Health Care Benefits, a temporary advisory commission comprised of nationally recognized experts in clinical medicine, primary and preventive health care, integrative medicine, and actuarial science and health plan benefit design. Members would also include representatives from key stakeholder groups. The secretary would designate as chair of the commission an expert in actuarial science and health plan benefit design. The commission would:

- Review benefits offered under typical employer-sponsored health plans and state laws requiring coverage of specified items and services in the individual and group insurance markets;
- Hold public hearings, meetings, or other public sessions to take testimony and receive evidence that the commission considers advisable to carry out the activities of the commission;
- Make recommendations to the HHS secretary regarding specific items and services that should be included in the essential health benefits package and eligible for individual premium credits;
- Submit to the HHS secretary, within six months of the bill's enactment, a detailed report of all commission recommendations, findings, and conclusions that received at least 12 votes of approval, with the secretary publishing the report in the *Federal Register*; and
- Consider
  - clinical appropriateness and effectiveness of the benefits covered
  - affordability of the benefits covered;
  - financial protection of enrollees against high health care expenses
  - access to necessary health care service, including primary and preventive health services
  - existing state laws requiring coverage of health care items and services in the individual and group markets
  - the potential of additional or expanded benefits to increase costs, and interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations.

The commission would terminate 30 days after submitting its report to the HHS secretary.

The essential benefit package must include, at a minimum: ambulatory care services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and pediatric services. The secretary would be required to establish at least three cost-sharing tiers for the essential benefits package:

Tier 1: A “basic” plan covering 76 percent of costs, with the out-of-pocket limits not to exceed that which applies to health savings account–qualified high-deductible plans or $5,950 for individual policies and $11,200 for family policies.

Tier 2: Plans covering 84 percent of costs, with out-of-pocket limits set at 50 percent of the first-tier plan.

Tier 3: Plans covering 93 percent of costs, with out-of-pocket limits set at 20 percent of the first-tier plan.

A state may require a qualified health plan offered through the gateway to offer benefits in addition to the essential health benefits package, but the state would have to pay for the costs of the additional benefits for individuals who are eligible for premium credits.

Sliding-Scale Premium Subsidies

The Senate HELP bill would provide premium credits on a sliding scale up to 400 percent of the poverty level for plans purchased through the exchange, such that premiums are no more than 1 percent of income for people with incomes of 150 percent of poverty or less and no more than 12.5 percent of income for those with incomes at 400 percent of poverty. Premium subsidies would be based on the three lowest-cost private plans in the gateway (not including the public plan option). There would be no subsidies for people with employer-based coverage that meets minimum qualifying criteria and affordability standards (premiums must be less than 12.5 percent of income).

Choice of Plan

1. **Private plans.** To be able to participate in the gateways, health plans would have to meet certification standards for a qualified health plan, which would be set by the secretary under consultation with the National Association of Insurance Commissioners. In addition, insurers would have to agree to offer at least one plan in each of two cost-sharing tiers specified in the bill, including the basic plan. Criteria for qualifying health plans sold inside and outside the exchange would include: not designing benefits or pursuing marketing that would discourage applicants with health problems from enrolling in the plan; providing detailed descriptions of benefits and cost-sharing and other plan provisions; and providing at least the essential health benefits plan.

The bill also establishes requirements for qualified health plans aimed at improving the quality and lowering the cost of care. To be certified as a qualified health plan by the HHS secretary (whether the plan is provided by employers or sold through the individual market or gateways), the plan would be required to implement a payment structure that provides increased reimbursement or other market-based incentives to reward quality. The secretary, in consultation with experts in health quality and other stakeholders, would develop guidelines for the activities required by the bill, including activities that would:

- improve health outcomes (such activities must include quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including use of the medical home model to conduct these activities;
- prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement;
- improve patient safety and reduce medical errors through appropriate use of best medical practices, evidence-based medicine, and health information technology; and
- promote health and wellness.

By 2012, qualified health plans would be allowed to enter into contracts only with hospitals that have more than 50 beds, that use a patient safety evaluation system that collects and analyzes information for reporting to, or by, patient safety organizations, and that have implemented a comprehensive program for hospital discharge including patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement. In addition, qualified health plans would be able to contract only with providers that implement activities to improve health quality that the HHS secretary may establish through regulation.

2. **Public plan.** The bill requires the HHS secretary to establish a public plan option called a "community health insurance option," which would be offered through each gateway. The plan would comply with the requirements of the qualified health plans, would set premiums that would sufficiently cover expected costs, and would also be required to provide high value for the premium charged, reduce administrative costs and simplify administration for enrollees, promote high-quality care, provide high-quality customer service, and offer a wide choice of providers. Providers would not be required to participate in the plan. The secretary would be required to negotiate

provider reimbursement rates, which must not be higher than the average reimbursement rates paid by carriers offering health plans through the gateways. The secretary would contract with qualified nonprofit organizations to administer the plan. The bill would establish a health benefit plan start-up fund to provide loans to qualified carriers for the initial operations of a community health insurance option, with repayments of loans required within 10 years. States would be required to establish state advisory councils comprised of members of the public including consumers and providers. The councils would be permitted to develop innovative payment policies that promote quality and efficiency and make recommendations to the secretary concerning policies for integrating quality improvement and cost containment mechanisms into the delivery system, mechanisms for facilitating public awareness of the community heath insurance option, and alternative provider payment structures under the community health insurance option that encourage quality improvement and cost control.

Risk Adjustment

Health plans or health insurance issuers that provide coverage in a state through a gateway to an individual or employer group whose size is less than a threshold to be determined by the state (for establishing states) or the Secretary of HHS (for participating states) would be subject to risk-adjustment payments using the following guidelines:

- If, for a year, the actuarial risk is less than the average actuarial risk of all enrollees in all plans or coverage in the state, then the state would assess a charge on the health plan or health insurance issuer;
- If, for a year, the actuarial risk is more than the average actuarial risk of all enrollees in all plans or coverage in the state, then the state would provide a payment to the health plan or health insurance issuer;
- The HHS secretary, in consultation with the state, would determine criteria and methods for carrying out the risk-adjustment assessments and payments;
- Self-insured group health plans would not be factored into the average actuarial risk calculations (as such plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA)).

Individual Mandate

The Senate HELP bill requires all individuals and their dependents to have insurance that meets the standard of minimum qualifying coverage to be defined by the HHS secretary or pay a penalty determined by the secretary of the treasury in consultation with the HHS

secretary. The penalty would not exceed $750 per year, and the total amount for all dependents for which an individual is responsible would not exceed four times the individual penalty. The penalties would be adjusted for inflation annually beginning in 2011. Penalties would not apply to individuals who: have an adjusted gross income of less than 150 percent of the federal poverty level; have to pay a premium for coverage that is more than 12.5 percent of his or her adjusted gross income; are without qualifying coverage for a period of less than 90 days; live in a state that has not yet established a gateway; or are members of Indian tribes or certain religious groups. The gateways would be responsible for identifying people who lack qualifying insurance and help them enroll through the gateway or other federal programs for which they might be eligible.

Medicaid Expansion

Though the Senate HELP Committee does not have jurisdiction over Medicaid, it would expand eligibility for Medicaid to 150 percent of the poverty level, or $31,804 for a family of four. People eligible for Medicaid are not eligible for premium subsidies through the exchange.

Employer Shared Responsibility

The Senate HELP bill requires employers to offer their employees health coverage that meets the federal standard of minimum qualifying coverage and to contribute at least 60 percent of the premium cost. Employers who do not "play" would pay $750 annually for each full-time employee who is not offered coverage, and $375 for each uncovered part-time worker. Similar to the Massachusetts universal coverage law, the bill also requires employers that offer dependent coverage to cover dependents up to age 26. Twenty five other states have passed similar laws for dependent coverage of young adults.[1]

Exemptions for Small Businesses

The Senate HELP bill exempts employers with fewer than 25 employees from the requirement to offer coverage.

Premium Subsidies for Small Businesses

The Senate HELP bill provides program credits for up to three years for firms with 50 workers or fewer and with an average wage of $50,000 or less that offer coverage and pay 60 percent or more of their employees' premiums. As opposed to tax credits, the

[1] J. L. Nicholson, S. R. Collins, B. Mahato, E. Gould, C. Schoen, and S. D. Rustgi, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2009 Update* (New York: The Commonwealth Fund, Aug. 2009).

program credits are essentially direct subsidies, meaning that nonprofit companies that do not pay taxes are eligible to receive the credits. The credit is equal to $1,000 for each employee with single coverage, $1,500 for two adults or an adult and a child, and $2,000 for family coverage. Bonus payments are available for each additional 10-percentage-point increase in premium contributions in the amount of $200 for individual, $300 for two people, or $400 for family policies. Self-employed individuals who do not receive credits for purchasing coverage through the gateway are eligible if their net earnings are between $5,000 and $50,000, or if their gross earnings are between $15,000 and $150,000.

II. DELIVERY SYSTEM REFORM PROVISIONS

Quality Improvement

The HELP bill calls upon the HHS secretary to establish and implement a national quality strategy, designed to reduce variations in care quality and health disparities while improving health care delivery, patient outcomes, and population health. A qualified, consensus-based entity of stakeholders would review the strategy on a triennial basis and recommend priorities for improvement. As part of the strategy, several initiatives would be developed to improve research, coordination of care, and quality of care. Not only would the HELP bill establish a streamlined quality measurement endorsement process, but it would also require public reporting of quality information so that it could be used by providers, patients, consumers, researchers, and policymakers.

The bill requires that the HHS secretary publish an annual national health care quality report card that includes: considerations for national priorities; an analysis of progress in implementing the national strategy; an assessment of the extent to which private sector strategies have informed federal quality improvement efforts; and a summary of consumer and provider feedback regarding quality improvement.

Quality Measurement

In addition to implementing successful federal quality activities and learning from them, the director of the Agency for Healthcare Research and Quality (AHRQ) would provide eligible organizations with grants to develop comprehensive measurements of health care quality. These measurements include assessments of: health outcomes; continuity and coordination of care; experience of patients, caregivers, and involved persons; safety, effectiveness, and timeliness of care; health disparities; appropriate use of health care resources; and use of innovative strategies and methodologies. These measures would be reviewed at least once every three years to ensure they maintain their relevance.

To ensure that lessons learned are shared among all health care sectors and government sectors, the bill requires the president to create an interagency working group to improve health care quality and safety. This group would seek to coordinate, collaborate, and streamline federal quality initiatives under the national strategy. The quality activities would be aligned with the national priorities outlined in the annual national health care quality report card.

To improve research, a patient safety research center would be established within AHRQ. In addition to overseeing research, this organization would offer local health care providers implementation and technical assistance to teach and implement best practices. Local providers would also be eligible for grants to implement medication management services.

The national quality strategy to be established by the HHS secretary aims to reduce geographic variations in care quality and reduce health disparities, while improving the delivery of health care services, patient health outcomes, and population health. As part of the strategy, quality measures would be developed and reported, and best practices would be implemented to address geographic variations in quality of care.

The amended bill provides $90 million annually, from 2010 to 2014, for quality-measure development and endorsement and for collection and analysis of reported data. Other initiatives would reduce medical errors, reduce hospital readmissions, improve patient safety, promote evidence-based medicine, and disseminate best care practices.[2]

Medical Homes

As part of the national quality strategy, the HHS secretary would provide states with grants to fund community health teams, which in turn would support the development of medical homes by increasing access to comprehensive, community-based, coordinated care. The care must be patient-centered and coordinated by an integrated team of providers.

Hospital Readmissions

As part of the comprehensive quality improvement strategy, the HELP bill requires hospitals to report preventable readmission rates. Those hospitals with high readmission rates would be required to work with local patient-safety organizations to improve care transition practices, including effective use of discharge planning and counseling.

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[2] "n Historic Vote, HELP Committee approves the Affordable Health Choices Act," HELP Committee press release, July 15, 2009, http://help.senate.gov/Maj_press/2009_07_15_b.pdf.

Fraud and Abuse

The HELP bill would establish the Health Care Program Integrity Coordinating Council, an expanded and improved organization that builds upon the Health Care Fraud and Abuse Control Program, which was originally established under the Health Insurance Portability and Accountability Act (HIPAA). This new organization would be charged with improving earlier efforts to facilitate coordination of fraud-prevention efforts between federal, state, and local law enforcement groups. In addition, the new organization would recommend measures to estimate the amount of fraud, waste, and abuse in private and public plans, as well as the savings generated by implementation of its guidelines.

Health Information Technology

In addition, the HELP bill requires the HHS secretary to adopt and update, as necessary, new technical standards for the electronic use and exchange of heath information for financial and administrative transactions. The secretary, in consultation with the Office of the National Coordinator for Health Information Technology, would be required to develop interoperable, secure, scalable, and reusable standards and protocols that facilitate enrollment in federal and state health services programs. Specific elements of the program are defined in the bill and include grants to eligible organizations to facilitate both development and implementation. In addition, the HELP bill calls for timely updating of standards to meet evolving administration needs.

Comparative Effectiveness

The HELP bill would establish the Center for Health Outcomes Research and Evaluation within AHRQ. This new center would promote health outcomes research and evaluation to enable patients and providers to identify which therapies work best for most people and to identify where more individualized approaches are required. An advisory commission would oversee the center.

Prevention/Wellness

The bill includes numerous provisions designed to enhance national strategy to prevent disease, promote health and build the public health system. Specifically, the bill calls for creating the National Prevention, Health Promotion and Public Health Council to promote federal health policies and to establish a national prevention and health promotion strategy. In addition, the new Prevention and Public Health Investment Fund would support and expand prevention and public health programs, as well as restrain the rate of health care cost growth. In addition to these national activities, competitive grants

would be awarded to state and local governments and community-based organizations that promote individual and community health and prevent the incidence of chronic diseases, particularly those stemming from obesity, tobacco use, and mental illness.

To alleviate the difficulties that many low-income, uninsured adults face when accessing care, the HELP bill calls on states to implement on a temporary basis the new Right Choices Program, funded by federal grants, to provide preventive services, including a chronic disease health risk assessment, a care plan, and referrals to community-based resources. The program would exist only until the gateways are established, making universal coverage available.

Efficiency

Under the HELP bill, the HHS secretary would 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; and to improve women's health and quality of care.

Workforce

The Senate HELP Committee's bill would establish the National Health Care Workforce Commission to make recommendations and disseminate information regarding the current and projected supply and demand of health care professionals, their education and training, and promising retention practices. In addition, the bill reforms graduate medical education to increase the supply, education, and training of health care workers, especially in pediatric, geriatric, and primary care fields. Loan repayment programs for the National Health Service Corps and eligible pediatric subspecialists, public health officials, allied health professionals, and nursing students would be expanded and/or extended.

SOURCES

The Affordable Health Choices Act, S. 1679, 111th Cong., 1st sess. (Sept. 17, 2009).

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