AMERICA'S AFFORDABLE HEALTH CHOICES ACT

QUALITY AFFORDABLE HEALTH CARE

SUMMARY

America's Affordable Health Choices Act provides quality affordable health care for all Americans and controls health care cost growth. Key provisions of the bill released today include:

- COVERAGE AND CHOICE
- AFFORDABILITY
- SHARED RESPONSIBILITY
- CONTROLLING COSTS
- PREVENTION AND WELLNESS
- WORKFORCE INVESTMENTS

I. COVERAGE AND CHOICE

The bill builds on what works in today's health care system and fixes the parts that are broken. It protects current coverage – allowing individuals to keep the insurance they have if they like it – and preserves choice of doctors, hospitals, and health plans. It achieves these reforms through:

- **A Health Insurance Exchange.** The new Health Insurance Exchange creates a transparent and functional marketplace for individuals and small employers to comparison shop among private and public insurers. It works with state insurance departments to set and enforce insurance reforms and consumer protections, facilitates enrollment, and administers affordability credits to help low- and middle-income individuals and families purchase insurance. Over time, the Exchange will be opened to additional employers as another choice for covering their employees. States may opt to operate the Exchange in lieu of the national Exchange provided they follow the federal rules.
- **A public health insurance option.** One of the many choices of health insurance within the health insurance Exchange is a public health insurance option. It will be a new choice in many areas of our country dominated by just one or two private insurers today. The public option will operate on a level playing field. It will be subject to the same market reforms and consumer protections as other private plans in the Exchange and it will be self-sustaining – financed only by its premiums.
- **Guaranteed coverage and insurance market reforms.** Insurance companies will no longer be able to engage in discriminatory practices that enable them to refuse to sell or renew policies today due to an individual's health status. In addition, they can no longer exclude coverage of treatments for pre-existing health conditions. The bill also protects consumers by prohibiting lifetime and annual limits on benefits. It also limits the ability of insurance companies to charge higher rates due to health status, gender, or other factors. Under the proposal, premiums can vary based only on age (no more than 2:1), geography and family size.
- **Essential benefits.** A new independent Advisory Committee with practicing providers and other health care experts, chaired by the Surgeon General, will recommend a benefit package based on standards set in the law. This new essential benefit package will serve as the basic benefit package for coverage in the Exchange and over time will become the minimum quality standard for

employer plans. The basic package will include preventive services with no cost-sharing, mental health services, oral health and vision for children, and caps the amount of money a person or family spends on covered services in a year.

II. AFFORDABILITY

To ensure that all Americans have affordable health coverage the bill:

- **Provides sliding scale affordability credits.** The affordability credits will be available to low- and moderate- income individuals and families. The credits are most generous for those who are just above the proposed new Medicaid eligibility levels; the credits decline with income (and so premium and cost-sharing support is more limited as your income increases) and are completely phased out when income reaches 400 percent of the federal poverty level ($43,000 for an individual or $88,000 for a family of four). The affordability credits will not only make insurance premiums affordable, they will also reduce cost-sharing to levels that ensure access to care. The Exchange administers the affordability credits with other federal and state entities, such as local Social Security offices and state Medicaid agencies.
- **Caps annual out-of-pocket spending.** All new policies will cap annual out-of-pocket spending to prevent bankruptcies from medical expenses.
- **Increased competition:** The creation of the Health Insurance Exchange and the inclusion of a public health insurance option will make health insurance more affordable by opening many market areas in our country to new competition, spurring efficiency and transparency.
- **Expands Medicaid.** Individuals and families with incomes at or below 133 percent of the federal poverty level will be eligible for an expanded and improved Medicaid program. Recognizing the budget challenges in many states, this expansion will be fully federally financed. To improve provider participation in this vital safety net – particularly for low-income children, individuals with disabilities and people with mental illnesses – reimbursement rates for primary care services will be increased with new federal funding**.**
- **Improves Medicare.** Senior citizens and people with disabilities will benefit from provisions that fill the donut hole over time in the Part D drug program, eliminate cost-sharing for preventive services, improve the low-income subsidy programs in Medicare, fix physician payments, and make other program improvements. The bill will also address future fiscal challenges by improving payment accuracy, encouraging delivery system reforms and extending solvency of the Medicare Trust Fund.

III. SHARED RESPONSIBILITY

The bill creates shared responsibility among individuals, employers and government to ensure that all Americans have affordable coverage of essential health benefits.

- **Individual responsibility.** Except in cases of hardship, once market reforms and affordability credits are in effect, individuals will be responsible for obtaining and maintaining health insurance coverage. Those who choose to not obtain coverage will pay a penalty of 2.5 percent of modified adjusted gross income above a specified level.
- **Employer responsibility.** The proposal builds on the employer-sponsored coverage that exists today. Employers will have the option of providing health insurance coverage for their workers or contributing funds on their behalf. Employers that choose to contribute will pay an amount based on eight percent of their payroll. Employers that choose to offer coverage must meet minimum benefit and contribution requirements specified in the proposal.
- **Assistance for small employers.** Recognizing the special needs of small businesses, the smallest businesses (payroll that does not exceed $250,000) are exempt from the employer responsibility

requirement. The payroll penalty would then phase in starting at 2% for firms with annual payrolls over $250,000 rising to the full 8 percent penalty for firms with annual payrolls above $400,000. In addition, a new small business tax credit will be available for those firms who want to provide health coverage to their workers. In addition to the targeted assistance, the Exchange and market reforms provide a long-sought opportunity for small businesses to benefit from a more organized, efficient marketplace in which to purchase coverage.

- **Government responsibility.** The government is responsible for ensuring that every American can afford quality health insurance, through the new affordability credits, insurance reforms, consumer protections, and improvements to Medicare and Medicaid.

IV. PREVENTION AND WELLNESS

Prevention and wellness measures of the bill include:

- Expansion of Community Health Centers;
- Prohibition of cost-sharing for preventive services;
- Creation of community-based programs to deliver prevention and wellness services;
- A focus on community-based programs and new data collection efforts to better identify and address racial, ethnic, regional and other health disparities;
- Funds to strengthen state, local, tribal and territorial public health departments and programs.

V. WORKFORCE INVESTMENTS

The bill expands the health care workforce through:

- Increased funding for the National Health Service Corp;
- More training of primary care doctors and an expansion of the pipeline of individuals going into health professions, including primary care, nursing and public health;
- Greater support for workforce diversity;
- Expansion of scholarships and loans for individuals in needed professions and shortage areas;
- Encouragement of training of primary care physicians by taking steps to increase physician training outside the hospital, where most primary care is delivered, and redistributes unfilled graduate medical education residency slots for purposes of training more primary care physicians. The proposal also improves accountability for graduate medical education funding to ensure that physicians are trained with the skills needed to practice health care in the 21st century.

VI. CONTROLLING COSTS

The bill will reduce the growth in health care spending in a numerous ways. Investing in health care through stronger prevention and wellness measures, increasing access to primary care, health care delivery system reform, the Health Insurance Exchange and the public health insurance option, improvements in payment accuracy and reforms to Medicare and Medicaid will all help slow the growth of health care costs over time. These savings will accrue to families, employers, and taxpayers.

- **Modernization and improvement of Medicare.** The bill implements major delivery system reform in Medicare to reward efficient provision of health care, rolling out innovative concepts such as accountable care organizations, medical homes, and bundling of acute and post-acute provider payments. New payment incentives aim to decrease preventable hospital readmissions, expanding this policy over time to recognize that physicians and post-acute providers also play an important role in avoiding readmissions. The bill improves the Medicare Part D program by creating new consumer protections for Medicare Advantage Plans, eliminating the “donut hole” and improving

low-income subsidy programs, so that Medicare is affordable for all seniors and other eligible individuals. A centerpiece of the proposal is a complete reform of the flawed physician payment mechanism in Medicare (the so-called sustainable growth rate or "SGR" formula), with an update that wipes away accumulated deficits, provides for a fresh start, and rewards primary care services, care coordination and efficiency.

- **Innovation and delivery reform through the public health insurance option.** The public health insurance option will be empowered to implement innovative delivery reform initiatives so that it is a nimble purchaser of health care and gets more value for each health care dollar. It will expand upon the experiments put forth in Medicare and be provided the flexibility to implement value-based purchasing, accountable care organizations, medical homes, and bundled payments. These features will ensure the public option is a leader in efficient delivery of quality care, spurring competition with private plans.
- **Improving payment accuracy and eliminating overpayments.** The bill eliminates overpayments to Medicare Advantage plans and improves payment accuracy for numerous other providers, following recommendations by the Medicare Payment Advisory Commission and the President. These steps will extend Medicare Trust Fund solvency, and put Medicare on stronger financial footing for the future.
- **Preventing waste, fraud and abuse.** New tools will be provided to combat waste, fraud and abuse within the entire health care system. Within Medicare, new authorities allow for pre-enrollment screening of providers and suppliers, permit designation of certain areas as being at elevated risk of fraud to implement enhanced oversight, and require compliance programs of providers and suppliers. The new public health insurance option and Health Insurance Exchange will build upon the safeguards and best practices gleaned from experience in other areas.
- **Administrative simplification.** The bill will simplify the paperwork burden that adds tremendous costs and hassles for patients, providers, and businesses today.

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HEALTH REFORM AT A GLANCE:
THE HEALTH INSURANCE EXCHANGE

America's Affordable Health Choices Act will reform the insurance marketplace to ensure that everyone can purchase quality, affordable health insurance coverage. A critical piece is a new Health Insurance Exchange (Exchange) for individuals and businesses to allow them to comparison shop for coverage. This Exchange will revolutionize health care choices and will help reduce the growth in health care spending by encouraging competition on price and quality, not benefit manipulation or efforts to exclude needy patients. Recognizing that many businesses want to continue providing their own health coverage as they do today, business participation in the Exchange is simply a new option for those that are eligible – no business is required to enter.

HEALTH INSURANCE EXCHANGE: ABILITY TO COMPARISON SHOP

- Give people the ability to choose from a variety of plans — including a new public health insurance option.
- Provide standardized benefit packages so that people will be able to comparison shop and make informed choices based on cost and quality.
- Plans compete locally—so small plans and national plans have an equal opportunity to offer coverage.

AFFORDABILITY (SEE FACT SHEET "MAKING COVERAGE AFFORDABLE" FOR MORE DETAILS)

- To ensure that health care is affordable to people of all incomes, new affordability credits will be available for people purchasing through the Exchange. They will assist people with incomes up to 400% of the federal poverty level ($43,000 for individuals or $88,000 for families of four) and phase-out on a sliding scale basis.
- Includes a cap on premiums and out-of-pocket spending. Regardless of income, everyone will be protected, so no one will face bankruptcy due to medical expenses.

TRANSPARENCY

- Bring transparency to the health care marketplace, so that families know what benefits their plan covers and what it will cost them.
- Require plans to explain their coverage in plain language, so that consumers can make informed choices about their medical care.

STANDARDIZED BENEFITS (SEE FACT SHEET "BENEFITS" FOR DETAILS)

- Allow consumers to choose coverage among several standard benefit packages.
- Provide comprehensive health care services with different levels of cost sharing.
- Include a Premium Plus plan through which people will have options to purchase coverage for additional health care benefits that are not included in the core benefit standards.

ADVANTAGES FOR SMALL BUSINESSES

- Health Insurance Exchange is opened to small employers first (those with 10 or fewer employees in the first year, and 20 or fewer in the second year) and to larger employers over time.
- Offers opportunity to small employers through the Exchange to provide their employees with broad choices for coverage and to be able to eliminate the administrative costs of maintaining their own health plan contracts.

PREPARED BY THE HOUSE COMMITTEES ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUCATION AND LABOR
JULY 14, 2009

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HEALTH REFORM AT A GLANCE:
PUBLIC HEALTH INSURANCE OPTION

The goal of health care reform is to provide quality, affordable health care for every American while preserving what works in today's system, expanding choice, and containing costs. America's Affordable Health Choices Act provides a public health insurance option that would compete with private insurers within the Health Insurance Exchange.

PUBLIC HEALTH INSURANCE OPTION:

OVERVIEW
- Available in the new Health Insurance Exchange (Exchange) along with all of the private health insurance plans.

LEVEL PLAYING FIELD
- Require public option to meet the same benefit requirements and comply with the same insurance market reforms as private plans.
- Establish the public option's premiums for the local market areas that are designated by the Exchange, just as other insurers do.
- Individuals with affordability credits can choose among the private carriers and the public option.

SELF-SUFFICIENCY
- Public option must be financially self-sustaining, as private plans are.
- Public option will need to build start-up costs and contingency funds into its rates and adjust premiums annually in order to assure its financial viability, as private plans do.

INNOVATION AND COST CONTAINMENT
- Promote primary care, encourage coordinated care and shared accountability, and improve quality.
- Institute new payment structures and incentives to promote these critical reforms.

PROVIDER PAYMENTS AND PARTICIPATION
- Initially utilizes rates similar to those used in Medicare with greater flexibility to vary payments.
- Allow immediate integration of delivery reforms also contained in the bill.
- Provider participation is voluntary – Medicare providers are presumed to be participating unless they opt out.

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HEALTH REFORM AT A GLANCE:
MAKING COVERAGE AFFORDABLE

America's Affordable Health Choices Act makes insurance premiums more affordable and reduces cost sharing for individuals and families otherwise unable to confront the high cost of health care.

It provides sliding-scale affordability credits for individuals and families with incomes above the Medicaid thresholds but below 400% of poverty. It also protects individuals and families from catastrophic costs with a cap on total out-of-pocket spending. In addition, it broadens Medicaid coverage to include individuals and families with incomes below 133% of poverty.

AFFORDABILITY:
AFFORDABILITY CREDITS

- Effective 2013, sliding scale affordability credits are provided to individuals and families between 133% to 400% of poverty. That means the credits phase out completely for an individual with $43,320 in income and a family of four with $88,200 in income (2009).
- Premiums: The sliding scale credits limit individual family spending on premiums for the essential benefit package to no more than 1.5% of income for those with the lowest income and phasing up to no more than 11% of income for those at 400% of poverty.
- Cost sharing: The affordability credits also subsidize cost sharing on a sliding scale basis, phasing out at 400% of poverty, ensuring that covered benefits are accessible.
- The Health Insurance Exchange administers the affordability credits in relationship with other federal and state entities, such as local Social Security offices and Medicaid agencies.

CAP ON TOTAL OUT-OF-POCKET SPENDING

- The essential benefit package, and all other benefit options, limit exposure to catastrophic costs with a cap on total out of pocket spending for covered benefits.

MEDICAID (SEE SEPARATE MEDICAID FACT SHEET FOR DETAILS)

- Effective 2013, individuals with family income at or below 133% of poverty ($14,400 for an individual in 2009) are eligible for Medicaid.
- State Medicaid programs would continue to cover those individuals with incomes above 133% of poverty, using the eligibility rules states now have in place.

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HEALTH REFORM AT A GLANCE:
SHARED RESPONSIBILITY

America's Affordable Health Choices Act will ensure that all Americans have access to quality, affordable health care coverage through shared responsibility among individuals, businesses and government. Individuals would be responsible for purchasing health insurance coverage and most employers would be responsible for offering coverage. Individuals, employers and the government would be responsible for contributing to the cost of coverage.

SHARED RESPONSIBILITY:
THE GOVERNMENT WOULD ENSURE AFFORDABILITY OF COVERAGE THROUGH AFFORDABILITY CREDITS

True access to quality health care cannot happen if coverage is not affordable. The bill will ensure all Americans can afford health care coverage by providing affordability credits and expanding Medicaid for those below 400 percent of poverty.

- Affordability credits will be available for individuals and families with incomes above Medicaid eligibility ($14,404 for an individual or $29,327 for a family of four) up to 400 percent of poverty level ($43,420 for an individual or $88,200 for a family of four). The amount of credit is reduced as individual and family income increases.
- Only individuals and families who seek health care coverage in the Exchange will receive affordability credits.

ALL AMERICANS WILL BE RESPONSIBLE FOR HAVING HEALTH INSURANCE, EXCEPT IN CASES OF HARDSHIP

The reforms in the bill will make health care coverage more affordable so that all Americans have access to coverage that protects against catastrophic costs.

- Individuals who choose not to obtain basic health coverage will be subject to a modest penalty based on 2.5 percent of income. In no case would the penalty exceed the average cost of a health care policy in the Exchange.
- Hardship waivers will be granted to individuals based on criteria such as affordability or religious objections, among other reasons.

EMPLOYERS MAY CHOOSE BETWEEN PROVIDING COVERAGE FOR THEIR WORKERS OR CONTRIBUTING ON BEHALF OF THEIR WORKERS

Under the bill, employers have a responsibility to help make health insurance available for their employees. Businesses that do not offer health coverage to their workers would pay an 8 percent payroll tax to help subsidize coverage in the Exchange.

- Employers would contribute 72.5 percent of the cost of premiums for all full-time employees' health coverage and 65 percent for a family policy.

- Employers have the option of providing part-time employees with health coverage by contributing a share of the expense, or contributing to the Exchange in order for part-time employees to seek coverage there.
- In the fifth year after the Exchange begins, companies that offer health insurance would have to meet minimum coverage standards like those required of plans in the Exchange.
- If an employer chooses not to offer health coverage to its employees, a penalty will be assessed based on the size of company's payroll. That penalty will help fund the Exchange which is where that company's employees will purchase quality, affordable coverage.

SMALL BUSINESSES WOULD BE PROTECTED THROUGH EXEMPTIONS FOR LOW-WAGE FIRMS AND A NEW SMALL BUSINESS TAX CREDIT WOULD HELP FIRMS PROVIDING HEALTH COVERAGE

- Employers with annual payrolls that do not exceed $250,000 are exempt from the requirement to provide health insurance to their workers. For employers with over $250,000 in annual payroll, the penalty for not offering health insurance is 2 percent, rising up to the full 8 percent penalty for firms with annual payrolls above $400,000.
- Workers in exempt firms would still be eligible to get coverage through the Exchange.
- Many small businesses will also be eligible to receive a tax credit for the health insurance offered to their workers.

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HEALTH REFORM AT A GLANCE:
GUARANTEED BENEFITS

In order to achieve affordable, quality health care for all, America's Affordable Health Choices Act establishes standards to ensure that all plans in the new Health Insurance Exchange cover a comprehensive set of necessary services and offer cost-sharing protections for consumers.

BENEFITS:
GENERAL

- Establishes a standardized benefit package that covers essential health services.
- Eliminates cost-sharing for preventive care (including well baby and well child care) to underscore the importance of preventive health services in making America healthier and lowering the growth of health care costs over time.
- Caps annual out-of-pocket spending for individuals and families so that no one faces bankruptcy from health costs ever again.
- Creates a new independent Benefits Advisory Committee with physicians, other health care providers, business representatives, consumers and other health care experts, chaired by the Surgeon General, to recommend to the Secretary and update the core package of benefits to address the health care needs of Americans.

BENEFIT PACKAGES

The Exchange makes available four tiers of benefit packages from which consumers can choose to best meet their health care needs. Each plan covers the core benefits.

- *Basic Plan:* Includes the core set of covered benefits and cost sharing protections.
- *Enhanced Plan*: Includes the core set of covered benefits with more generous cost sharing protections than the Basic plan.
- *Premium Plan*: Includes the core set of covered benefits with more generous cost sharing protections than the Enhanced plan.
- *Premium Plus Plan*: Includes the core set of covered benefits, the more generous cost sharing protections of the Premium plan, and additional covered benefits (e.g., oral health coverage for adults, gym membership, etc.) that will vary per plan. In this category, insurers must disclose the separate cost of the additional benefits so consumers know what they're paying for and can choose among plans accordingly.

GUARANTEED SET OF BENEFITS

A required core set of benefits provides coverage for essential health care services and items to ensure that consumers will no longer have to worry about being stuck in an inadequate insurance plan if they get sick. The levels of coverage will be defined by the Secretary of Health and Human Services working with the new Benefits Advisory Commission outlined above. Benefits must include:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Equipment and supplies incident to physician services
- Preventive services
- Maternity services
- Prescription drugs
- Rehabilitative and habilitative services
- Well baby and well child visits and oral health, vision, and hearing services for children
- Mental health and substance abuse services

HEALTH REFORM AT A GLANCE:
CONSUMER PROTECTIONS AND INSURANCE MARKET REFORMS

America's Affordable Health Choices Act includes comprehensive reforms to create a transparent, consumer-friendly insurance marketplace that protects consumers and provides them with choices among quality, affordable health care plans.

PROTECTING CONSUMERS

The bill includes strong reforms to the insurance market so that consumers will be more secure in their health coverage.

- Insurers will be prohibited from excluding coverage based on pre-existing conditions.
- Insurers will be prevented from selectively refusing to renew coverage. They will no longer be able to charge people different premiums based on their gender, health status, or occupation; and the percent difference insurers can charge based on age is limited to a rate band of 2:1.
- Requires a standardized annual out-of-pocket spending limit so that no family faces bankruptcy due to medical expenses.
- Medicare beneficiaries enrolled in private plans will no longer be charged cost sharing above traditional Medicare.
- New requirements on plans will ensure that they keep costs down and pass on savings to consumers.

CREATING A MORE USER-FRIENDLY MARKETPLACE

The bill establishes a transparent, consumer-friendly health care marketplace that focuses on quality, affordable choices for all Americans and keeps insurers honest.

- Creates a new Health Insurance Exchange that provides people with a menu of both public and private quality, affordable health care options so they choose the plan that best meets their needs.
- Consumers and employers will have clear information and transparency on plan costs and benefits in the Exchange so they can comparison shop for the best deals and care.
- Consumer Advocacy offices, a website, 1-800 number and other outreach components will help people understand and select plans, ensure that they receive promised benefits and services, and provide additional help.
- Guarantees benefits so that all consumers have plans with high quality, critical and comprehensive health care benefits.
- Streamlines and simplifies all administrative forms, billing codes and other processes so the system is more efficient and less confusing for all plans, providers and consumers.

PREPARED BY THE HOUSE COMMITTEES ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUCATION AND LABOR
JULY 14, 2009

HEALTH REFORM AT A GLANCE:
EMPLOYERS AND HEALTH REFORM

America's Affordable Health Choices Act will continue the principle of shared responsibility. It will also help employers pay for such plans and give them access to more comprehensive and fairer markets and regulations.

EMPLOYER-RELATED PROVISIONS:
FOR SMALL EMPLOYERS

- Provides access to the new Health Insurance Exchange, giving them the benefits of large-group rates normally enjoyed only by large employers, lower administrative costs, greater transparency, and the ability to offer greater choice of plans to their employees.
- Reforms rating rules so that small employers no longer pay higher premiums if they employ a sicker workforce.
- Assures costs of plans for small businesses will be stabilized.
- Provides a tax credit to assist small employers who want to offer coverage.
- Exempts small businesses from the "Pay-or-Play" requirements (see below) and phases in graduated rates as payroll increases.

FOR LARGER EMPLOYERS

- Leave insurance plans offered by larger employers generally unaffected, particularly for the first five years. After that employers can no longer place annual or lifetime caps on coverage.
- Require that larger employers, however, must comply with the "Pay-or-Play" requirements (that is, they must offer insurance to their employees or pay a payroll tax of 8 percent).
- Over time, businesses of all sizes may participate in the Health Insurance Exchange.

FOR ALL EMPLOYERS

- Will benefit as costs for the uninsured are no longer cost shifted onto employers.
- Provide cost control measures designed to increase employers' competitiveness.
- Reform health care delivery system to improve quality, including in employers' health plans.

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HEALTH REFORM AT A GLANCE:
STRENGTHENING MEDICARE

For more than 40 years, Medicare has offered critical health and financial stability for senior citizens, people with disabilities and those with end-stage renal disease, providing coverage for over 45 million individuals this year. America's Affordable Health Choices Act contains substantial payment and delivery system reforms that reward efficient delivery of quality care and change the incentives in today's health care system to encourage value instead of simply volume. It makes investments that will enable beneficiaries to continue to access high-quality, affordable care, while encouraging prevention and care coordination for those with chronic conditions. These efforts will help modernize the program and strengthen Medicare's financial health, protecting both beneficiaries and taxpayers.

IN MEDICARE, THE LEGISLATION INCLUDES THE FOLLOWING PROVISIONS:

PRIMARY CARE, COORDINATED CARE, AND MENTAL HEALTH SERVICES

- Reforms the sustainable growth rate system in Medicare's physician fee schedule to:
  - Eliminate the 21% cut in physician fees planned for 2011 and put physician payments on a sustainable path for the future
  - Reward primary care, coordination, and efficiency
- Increases reimbursement for primary care services and encourage training of primary care physicians
- Expands programs that reward physicians for spending time coordinating care for their patients
- Encourages more collaboration and accountability among providers via bundling of payments and advancing of Accountable Care Organizations
- Extends key protections for rural providers to ensure access to care in rural areas
- Improves access to mental health services

AFFORDABILITY AND QUALITY OF CARE

- Fills the "donut hole" in Medicare Part D (prescription drug benefit) by combining PhRMA's proposal to discount brand-name drugs in the donut hole with additional policy that fully eliminates the "donut hole" over time
- Eliminates cost-sharing for preventive services in Medicare
- Limits cost-sharing requirements in Medicare Advantage plans to the amount charged for the same services in traditional Medicare coverage
- Improves the low-income subsidy programs in Medicare by:
  - Increasing asset limits for programs that help Medicare beneficiaries pay premiums and cost-sharing
  - Improving the Part D benefit for people dually eligible for Medicare and Medicaid
  - Extending the Qualified Individual program for low-income Medicare enrollees
- Enhances access to care for beneficiaries with limited proficiency in the English language
- Enhances nursing home transparency and accountability requirements related to resident protection and quality of care

EXTEND PROGRAM SOLVENCY BY FIVE YEARS OR MORE

- Improves payment accuracy to ensure that the right amount is paid
- Expands funding and authority to fight waste, fraud and abuse
- Eliminates overpayments to private plans

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HEALTH REFORM AT A GLANCE:

IMPROVING THE MEDICARE PART D DRUG PROGRAM

The Medicare Part D program (Part D) was passed into law in 2003, and has been offering drug benefits to Medicare enrollees since January 1, 2006. The program has helped provide access to drug coverage for millions of beneficiaries. However, analysts have identified a number of problems with the program, including difficulties posed by the so-called "donut hole", which causes seniors to lose coverage entirely for a portion of the year; administrative burdens that cause many low-income enrollees to miss out on benefits; and high drug prices that result from the inability of Part D plans to effectively negotiate with drug manufacturers. America's Affordable Health Choices Act has a number of provisions designed to mitigate these problems.

MEDICARE PART D PROVISIONS:

ELIMINATE PART D DONUT HOLE

- Reduce size of the donut hole by $500 in 2011.
- Eliminate donut hole completely (on a phased-in basis) within 15 years, using drug manufacturer rebates to cover the cost.
- Drug manufacturers provide 50 percent discounts on brand-name drugs in the donut hole to reduce costs during the phase-out.

ACCESS FOR LOW-INCOME BENEFICIARIES

- Increase allowable assets for those individuals who qualify for Part D low-income subsidies and require that the allowable asset level rise to take inflation into account.
- Reduce administrative barriers related to eligibility.
- Allow CMS to use "intelligent assignment" for low-income beneficiaries, assuring that the plans in which they are enrolled provide the best access to necessary drugs at the lowest cost to the beneficiary and Part D.
- Change calculation of which plans are eligible to enroll low-income beneficiaries at $0 premium to allow more enrollees to keep their plan each year, rather than be reassigned to a new plan.

PRESCRIPTION DRUG COSTS

- Establish a new program under which drug manufacturers must provide rebates for dually eligible beneficiaries, and use these rebates to pay for the donut hole closure.
- The rebates restore drug rebate levels in effect prior to 2006 when dual eligible beneficiaries received their drugs through Medicaid (not Part D), and manufacturers paid the higher Medicaid rebates.

CONSUMER PROTECTIONS

- Permit beneficiaries to change drug plans if the plan in which they are enrolled makes a formulary change during the middle of the year.
- Provide for enhanced oversight of reimbursements for beneficiaries who retroactively qualify as low-income beneficiaries.
- Establish new penalties for false or misleading marketing by Part D plans.

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HEALTH REFORM AT A GLANCE:
MAINTAINING AND IMPROVING MEDICAID

Medicaid covers health and long-term care services for over 60 million low-income Americans. States have over 40 years of experience operating the program with federal matching funds. America's Affordable Health Choices Act builds upon this existing state-based administrative structure to extend coverage to uninsured Americans who have incomes near or below poverty. It will also improve Medicaid payments to primary care practitioners to address concerns about access to needed services by Medicaid beneficiaries. These services will include preventive services appropriate to low-income children and adults for which there is evidence of effectiveness.

The Children's Health Insurance Program (CHIP) covers over 6 million low-income children who are not eligible for Medicaid. CHIP expires in 2013, the year that the new Health Insurance Exchange would begin operation. The bill ensures that children covered by CHIP at that time could enroll in a plan of their family's choice in the Exchange with no disruption in coverage and with financial assistance to make their new coverage affordable.

MEDICAID:
COVERING LOW-INCOME UNINSURED AMERICANS

- Effective 2013, individuals under age 65, with family incomes at or below 133% of poverty ($14,400 for an individual in 2009) would be eligible for Medicaid. The cost of care for those newly enrolled in Medicaid as a result of this policy would be paid by the federal government, with no state contribution.
- Those individuals with incomes at or below 133% of poverty who lose health insurance coverage within the previous 6 months (e.g., a young college graduate whose coverage under her parents' policy ends) would have the choice of enrolling in Medicaid or enrolling in the Health Insurance Exchange with assistance for their premiums.
- State Medicaid programs would continue to cover those with incomes above 133% of poverty using the eligibility rules that states now have in place.

IMPROVING ACCESS TO SERVICES

- Medicaid payments to primary care physicians and practitioners for primary care services are increased from 80% of Medicare rates in 2010, to 90% in 2011, and 100% in 2012 and thereafter. The costs of raising these rates would be paid by the federal government.

PREPARED BY THE HOUSE COMMITTEES ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUCATION AND LABOR
JULY 14, 2009

AMERICA'S AFFORDABLE HEALTH CHOICES ACT

QUALITY AFFORDABLE HEALTH CARE

HEALTH REFORM AT A GLANCE:

PAYING FOR HEALTH CARE REFORM

The House Committees are committed to enacting health care reform that is fully paid for. The costs of inaction on the budgets of every American, business, and our fiscal future are well known. We are proposing to pay for roughly half of the costs of reforms that will lower those costs by achieving significant efficiencies and savings in Medicare and Medicaid, such as eliminating overpayments that are driving up profits for Medicare Advantage plans. We are proposing to pay for roughly the other half through a surcharge on the wealthiest 1.2% of Americans.

COST SAVINGS

- Roughly half of the cost of the health care reform bill is paid for by achieving significant efficiencies and savings in Medicare and Medicaid – in other words, reallocating U.S. taxpayer dollars already being spent on health care to achieving more efficiency, higher quality, and broader coverage.

- For example, the bill protects the U.S. taxpayer by achieving $156 billion in savings by eliminating overpayments to private Medicare Advantage plans over 10 years. According to the Medicare Payment Advisory Commission, private Medicare Advantage plans are currently paid, on average, 14 percent more than traditional Medicare providers – and overpayments to certain plans exceed 50 percent.

- The bill also achieves $102 billion in savings over 10 years by incorporating productivity adjustments into Medicare payment updates for hospitals. This adjustment will encourage greater efficiency in health care provision, while more accurately aligning Medicare payments with hospital costs.

- The bill also achieves about $110 billion in savings over 10 years by: 1) codifying the recent PhRMA-White House agreement, which provides that Medicare Part D beneficiaries will get a 50 percent reduction in price on any brand-name drugs they need while in the so-called “donut hole” where drug costs are not reimbursed at certain levels; and 2) requiring that drug companies provide rebates for individuals enrolled in both Medicare and Medicaid that are at least as large as the Medicaid rebates that were provided prior to the enactment of Medicare Part D.

- The bill also achieves more than $100 billion in additional savings over 10 years through numerous other provisions, including incorporating productivity adjustments into Medicare payment updates

for home health agencies; and key delivery system reforms such as incentives to reduce readmissions to hospitals and promoting accountable care organizations.

SURCHARGE ON THE WEALTHIEST 1.2% OF AMERICANS

- The House Committees agree with President Obama that middle-class Americans who are already struggling should not be asked to shoulder higher taxes to help pay for critically-needed health care reform.

- This proposal ensures that middle-class Americans will see no tax increases. Specifically, under the proposal, all families with adjusted gross incomes below $350,000 and all individuals with adjusted gross incomes below $280,000 will not see their taxes go up.

- Under this proposal, according to the nonpartisan Joint Committee on Taxation, only the top 1.2% of wealthiest Americans are asked to pay somewhat more to help finance health reform. These top earners received a disproportionate share of the tax cuts over the last decade and also saw a large jump in their income and overall wealth. Indeed, the gap between the income of the top 1% and the rest of us has grown significantly in recent years.

- We are proposing to place a graduated surcharge on the wealthiest Americans. For example, the surcharge would be 1% for families earning between $350,000 and $500,000, and 1.5% for those earning between $500,000 and $1,000,000. The bill includes a trigger that would result in the surcharge only rising somewhat if projected health care savings are not obtained.

- The surcharge only applies to income earned in excess of $350,000. If the health reforms included in the bill achieve projected cost savings, families making between $350,000 and $1,000,000 will need to contribute less than 1% of their annual income to provide access to affordable health care for all Americans. For example:

    - A family earning $400,000 would contribute $500 to provide access to affordable health care for all Americans – 0.13% of their annual income.

    - A family earning $500,000 would contribute $1,500 to provide access to affordable health care for all Americans – 0.3% of their annual income.

- Despite opponents' claims to the contrary, according to the nonpartisan Joint Committee on Taxation, 96% of small businesses would see no tax increases under this proposal. Furthermore, all small businesses will greatly benefit from the insurance market reforms in the bill.