

HEALTH REFORM AT A GLANCE: MAKING COVERAGE AFFORDABLE

The draft proposal 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. The proposal 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 Provisions in the Discussion Draft

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% of income for those with the lowest income and phasing up to no more than 10% 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.

HEALTH REFORM AT A GLANCE: BENEFITS

In order to improve access to affordable and quality health care for all, the discussion draft 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 Provisions in the Discussion Draft:

General

- Establish a core benefits package that will protect people from financial hardship when they get sick.
- Underscore the importance of preventive health services in making America healthier and lowering the growth of health care costs over time by requiring there be no cost sharing to access those benefits.
- Establish a new independent advisory committee with providers and other healthcare experts, chaired by the Surgeon General, to recommend and update the core package of benefits to address the health care needs of Americans.

Benefit Packages

- The Exchange makes available four different tiers of benefit packages from which consumers can choose the best one that meets their health care needs.
 - *Basic Package:* Includes the core set of covered benefits and cost sharing protections
 - *Enhanced Package:* Includes the core set of covered benefits with more generous cost sharing protections than the Basic Package
 - *Premium Package:* Includes the core set of covered benefits with more generous cost sharing protections than the Enhanced Package
 - *Premium Plus Package:* Includes the core set of covered benefits, the more generous cost sharing protections in the Premium Package, and additional covered benefits (e.g., dental coverage for adults; gym membership, etc.)
- 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 having chosen an inadequate insurance plan if they get sick. These 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

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- Well baby and well child visits and dental, vision, and hearing services for children

HEALTH REFORM AT A GLANCE: ADDRESSING HEALTH AND HEALTH CARE DISPARITIES

Within the United States, racial and ethnic minorities and other populations experience a broad range of disparities in disease burden, health outcomes, and access to quality health care. Expanding health insurance coverage will help to alleviate some of these disparities but they must be accompanied by targeted strategies in both clinical and community-based health. The discussion draft contains a comprehensive set of provisions designed to ensure that health reform will meaningfully reduce or eliminate health and health care disparities.

Health Disparities Provisions in the Discussion Draft:

- Strengthen and expand programs that promote diversity in the health workforce.
- Require HHS Secretary to identify key health and health care disparities as part of a National Prevention and Wellness Strategy initiative.
- Direct the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services to take relevant health and health care disparities into account as they develop and disseminate evidence-based recommendations on the use of preventive services.
- Target at least half of the funding in a new grants program for the delivery of preventive health services at the community level to proposals with the primary purpose of addressing health or health care disparities. Eligible grantees include “health empowerment zones,” areas in which a community partnership provides multiple preventive health services.
- Establish a new Assistant Secretary for Health Information who will coordinate and develop standards for the collection of key health information, including information that can be used to measure, study, and reduce health and health care disparities.

HEALTH REFORM AT A GLANCE: THE HEALTH INSURANCE EXCHANGE

This discussion draft 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) that would lay out choices 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 Provisions in the Discussion Draft:

Ability to Comparison Shop

- Give people the ability to choose from a variety of plans — including a new public health insurance option — in the Exchange.
- Provide standardized benefit packages so that people will be able to comparison shop and make informed choices based on cost and quality.

Affordability (see separate fact sheet “Making Coverage Affordable” for details)

- Ensure that health care is accessible even to low and moderate-income individuals and families. New affordability credits will be available for people purchasing through the Health Insurance Exchange. They will reduce as income rises, with a complete phase-out at 400% of the federal poverty level.
- Includes a cap on premiums as well as out-of-pocket spending. Regardless of income, every plan will have an annual cap on out-of-pocket expenses so no family will again 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 separate 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.

Impact on Small Businesses

- Open Health Insurance Exchange to small employers first and to larger employers over time.

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- Offer 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.

**HEALTH REFORM AT A GLANCE:
PROTECTING PROGRAM INTEGRITY BY PREVENTING WASTE, FRAUD AND ABUSE**

Reducing waste, fraud, and abuse saves taxpayer dollars and protects the health care investments made by individuals, businesses, and government. Under the draft proposal, existing compliance and enforcement tools are strengthened for Medicare and Medicaid. In addition, the new public health insurance option and Health Insurance Exchange contain protections against waste and abuse that build upon the safeguards and best practices gleaned from experience in other areas.

Program Integrity Provisions in the Discussion Draft:

Improve Medicare and Medicaid Program Requirements for Providers, Suppliers, and Contractors

- Require providers and suppliers to adopt compliance programs as a condition for participating in Medicare and Medicaid.
- Require Medicare and Medicaid integrity contractors that carry out audits and payment review, to provide annual reports and conduct regular evaluations of effectiveness.

Adequately Fund Efforts to Fight Fraud and Aggressively Monitor Medicare and Medicaid for Evidence of Fraud, Waste, and Abuse

- Increase funding for the Health Care Fraud and Abuse Control Fund to fight Medicare and Medicaid fraud. CBO has estimated that every \$1 invested to fight fraud results in approximately \$1.75 in savings.
- Create a comprehensive “Medicare and Medicaid Provider/Supplier” Data Bank, to enable oversight of suspect utilization and prescribing patterns and complex business arrangements that may conceal fraudulent activity.
- Narrow the window for submitting Medicare claims for payment in order to decrease the opportunities for “gaming” the system.

Improve Screening of Providers and Suppliers

- Create a national pre-enrollment screening program to determine whether potential providers or suppliers have been excluded from other federal or state programs or have a revoked license in any state.
- Allow enhanced oversight periods, or enrollment moratoria in program areas determined to pose a significant risk of fraudulent activity.
- Require that only Medicare-participating physicians can order durable medical equipment (DME) or home health services paid for by Medicare, and allow the Administrator of the Centers for Medicare and Medicaid Services to adopt similar requirements for other “at-risk” programs.

New Penalties to Deter Fraud and Abuse

- Create new penalties for submitting false data or for obstructing audits or investigations related to Medicare or Medicaid.
- Establish new penalties for Medicare Advantage and Part D plans that violate marketing requirements or submit false bids, rebate reports, or other submissions to CMS.

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. The discussion draft builds upon this existing state-based administrative structure to extend coverage to uninsured Americans who have incomes near or below poverty. The discussion draft would also improve Medicaid payments to primary care practitioners to address concerns about access to needed services by current Medicaid beneficiaries as well as those who will be newly enrolled. After the new Health Insurance Exchange has been running for several years and built up enough capacity, low-income individuals and families would have the choice of enrolling in Medicaid or in a health insurance plan offered through the exchange.

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 discussion draft ensures that children covered by CHIP at that time could enroll in a plan of their family's choice in the Health Insurance Exchange with no disruption in coverage and with financial assistance to make their new coverage affordable.

Medicaid Provisions in the Discussion Draft:

Covering Low-income Uninsured Americans

- Effective 2013, individuals 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.
- After the Exchange has been in operation for 4 years, all individuals eligible for Medicaid could choose to enroll in the Health Insurance Exchange rather than stay in Medicaid.

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.

HEALTH REFORM AT A GLANCE: THE 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. A public health insurance option is vital to meeting those goals.

Public Health Insurance Option Provisions in the Discussion Draft:

Expands Choice

- Introduces choice and improves choices in communities across the country.
- Requires private plans to compete on quality and cost.

Promotes Innovation & Cutting Costs:

- Promotes primary care, encourages coordinated care and shared accountability, and improves quality.
- Institutes new payment structures and incentives to promote these critical reforms.
- Helps expand these reforms across the health care system.

Level Playing Field

- Plays by the same rules as private insurers, and operated by HHS and not the entity running the Health Insurance Exchange.
- Will be an equal participant in the Health Exchange – people will not be automatically enrolled in the plan.
- Will be eligible for the same subsidies, be required to meet the identical benefit requirements, and comply with the same insurance market reforms as private plans.

Self-Sufficiency:

- Will be required to be financially self-sustaining, as private plans are.
- Will need to build contingency funds into its rates and adjust premiums annually in order to assure its financial viability, as private plans do.

Provider Network:

- Will temporarily require providers electing to participate in Medicare to participate in the public health insurance option.
- Will use this link to create a provider network (which the private plans already have) and then disconnect after five years.

Provider Payments:

- Will use rates similar to Medicare at first, then sever these ties after three years as a unique and more flexible payment system is developed.
- Will immediately be able to integrate important delivery reforms into the payment system, to

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improve efficiency and quality.

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**HEALTH REFORM AT A GLANCE:
PREVENTING DISEASE/ IMPROVING THE PUBLIC'S HEALTH**

Increased access to treatment, while vitally necessary for fixing our broken health system, is only part of the answer. True reform requires prevention investments to reduce the strain that disease and poor health exert on our health care system. These investments are extremely cost-effective and beneficial, particularly as compared with treatment.

Preventive services can be divided into two general groups. Clinical preventive services are delivered to one patient at a time by a doctor or other health worker in a standard health setting. Community preventive services are delivered outside of this traditional clinical structure, and are frequently implemented across targeted groups.

Examples of Preventive Services	
Clinical Preventive Services	Community Preventive Services
<ul style="list-style-type: none"> • Cancer screenings (breast, cervical, colorectal, etc.) • Daily aspirin use to prevent heart disease • Adult and child immunizations • Adult vision screening • Hypertension treatment 	<ul style="list-style-type: none"> • Telephone “quit” lines to help smokers kick the habit • Distribution of child safety seats • Improving healthy food availability at worksites to reduce obesity • Educating diabetics about blood sugar (control at churches, libraries, etc.)

The discussion draft Prevention and Wellness provisions present a comprehensive policy designed to ensure that all Americans will receive the state-of-the-art in both clinical and community preventive services, undertaking a coordinated effort to make comprehensive prevention research, evaluation, and delivery a permanent part of the national landscape.

Prevention and Wellness Provisions in the Discussion Draft:

- Expand the capacity of two independent, advisory task forces — the U.S. Preventive Services Task Force (USPSTF) and the Task Force on Community Preventive Services (TFCPS) — to undertake rigorous, systematic reviews of existing science to recommend the adoption of proven and effective services.
- Provide new investments in the science of prevention to further expand the base of information available for evaluation by the task forces.
- Deliver clinical preventive services by including USPSTF-recommended services in Medicaid and insurance available in the Health Insurance Exchange.
- Eliminate cost-sharing on recommended preventive services delivered by Medicare, Medicaid, and insurance available in the Health Insurance Exchange.
- Deliver community preventive services by investing in state, territorial, and local public health infrastructure and by providing grants to implement TFCPS-recommended services.

HEALTH REFORM AT A GLANCE: MEETING WOMEN'S HEALTH CARE NEEDS

In our current health care system, women often face higher health costs than men and multiple barriers to health insurance. Fewer women are eligible for employer-based coverage, and comprehensive coverage in the individual health care market is often costly or unavailable. As a result, many women are under- or uninsured, and simply can't afford the services they need. In a recent study, more than half of women — compared with 39% of men — reported delaying needed medical care due to cost.

Women's Health Provisions in the Discussion Draft:

- Make key preventive care more affordable by eliminating cost-sharing on recommended preventive services (e.g., breast cancer screening) delivered by Medicare, Medicaid, and insurance available in the new Health Insurance Exchange.
- Require employers to offer adequate insurance coverage to their employees or pay into the system.
- Offer subsidies to make insurance available in the Exchange affordable for women and others at low-income levels.
- Include coverage of maternity services as a benefit category for plans in the Exchange.
- Prohibit plans in the Exchange from charging women more than men by banning gender rating.
- Ban the insurance industry practice of rejecting applicants with pre-existing conditions, which has kept women with histories of health problems — even survivors of domestic violence — from accessing individual coverage.

HEALTH REFORM AT A GLANCE: STRENGTHENING THE NATION'S HEALTH WORKFORCE

Expansions in coverage will strain an already stressed health workforce. Under this draft proposal, existing scholarship, loan repayment, and training grant programs are strengthened to address the need for primary care, nursing, and public health professionals. The primary care workforce is also enhanced by expanding the National Health Service Corps and creating a new primary care loan program. Nursing workforce expansions are focused on advanced practice nurses who can deliver primary care services and train the next generation of nurses. A new generation of public health workers will be trained through a new loan repayment and scholarship program modeled on the National Health Service Corps. Finally, improved data and advisory systems, coupled with improved diversity and interdisciplinary programs, will provide ongoing surveillance and flexibility to ensure that workforce policies address the needs of a modern U.S. health system.

Workforce Provisions in the Discussion Draft:

Primary Care Workforce (including physician assistants and dental workforce)

- Increase funding for National Health Service Corps to address workforce shortages in high need areas. Allow flexibility for part-time service.
- Create a new scholarship and loan repayment program for health care providers in areas of need.
- Enhance student loan and faculty loan repayment programs for primary care providers.
- Strengthen grant programs for primary care training institutions.
- Expand general and pediatric dentistry, dental hygienists, and dental health programs.
- Expand training for primary care physicians, encourage training outside the hospital setting where most primary care is practiced, and ensure that physicians are trained with the skills needed to practice health care in the 21st century.

Nursing Workforce (including primary care nursing)

- Expand education, practice, and retention programs for nurses.
- Enhance existing student loan, scholarship, and loan repayment programs.
- Enhance development of advanced practice nurses, including those who deliver primary care services.
- Expand existing loan repayment programs to increase number of nursing faculty.

Public Health Workforce

- Create a scholarship and loan repayment program for public health workers, modeled after the National Health Service Corps.
- Strengthen programs for recruitment, training, and retention.
- Strengthen existing preventive medicine programs.

Adapting Workforce to Evolving System Needs

- Strengthen existing programs to promote diversity in the health workforce.
- Authorize grants to promote interdisciplinary and community-based training.
- Establish broad interdisciplinary commission to examine workforce issues.

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- Establish a study center to gather better data on workforce needs.