



AMERICAN BENEFITS COUNCIL

June 8, 2009

SUMMARY OF THE JUNE 5, 2009
PRELIMINARY DRAFT OF THE AMERICAN HEALTH CHOICES ACT
FROM THE SENATE HELP COMMITTEE
(NOT INCLUDING PROVISIONS RELATED TO HEALTH IT
OR DISABILITY/LONG-TERM CARE COVERAGE)

IMPLICATIONS FOR COUNCIL PRIORITY ISSUES

▪ ERISA

- Retains state regulation of insured health plans and federal regulation of self-insured plans.
- Prohibits employers from self-insuring groups with 250 or fewer employees.
- Adds numerous new federal requirements under ERISA on employer-sponsored health coverage, whether insured or self-insured.

▪ Mandated Coverage

- Includes an individual mandate to obtain qualified health coverage and an employer “pay or play” mandate, applicable to full-time and part-time employees.
- Employers subject to a “pay or play” penalty if they fail to offer qualifying coverage and do not meet a minimum premium contribution requirement.
- In addition to the “pay or play” penalty, employers who do not offer qualified coverage to their employees are subject to a “free rider” penalty, defined as equal to an (as yet unspecified) portion of the cost of the health coverage obtained by an employee that is paid by the federal government, for example, if the employee qualifies for federal premium subsidies for health coverage.
- If an employee opts-out of health coverage offered by an employer and obtains coverage through a health plan offered through a state-based health insurance Gateway (i.e., an insurance exchange or connector), employer must

pay the federal government an amount it would have paid to cover a full-time employee under its employer plan.

▪ **Public Health Insurance Plan Option**

- Establishes Affordable Access Plans (i.e., a public health insurance plan option) which would be available alongside private health insurance plan options offered through the new state-based Gateways.
- Affordable Access Plans would be deemed to meet all state licensure standards and to be “in good standing” in every state.
- Affordable Access Plans would reimburse health care providers at Medicare payment rates plus 10 percent (rather than establishing reimbursement rates as private health plans would, based on negotiations with participating health providers).
- Requires health providers under Medicare to accept payment amounts from Affordable Access Plans.

▪ **Tax Policy and Financing**

- Does not include changes in current tax policy for employer-sponsored health coverage. (Note: Senate HELP Committee does not have jurisdiction in this area.)
- Establishes extensive new premium subsidies for lower-income individuals who elect coverage through the state-based insurance Gateway. Eligible individuals and families are those with incomes between 150% and 500% of the federal poverty level. Individuals with incomes up to 150% of the poverty level would be eligible in all states for coverage under Medicaid.

ADDITIONAL HIGHLIGHTS

- Includes a Declaration of Rights relating to patients choosing doctors, the doctor-patient relationship and health professionals’ determination of “what is best” for their patients.
- Provides for reform of the individual and group insurance markets, including rating limits, guarantee issue and renewal requirements, elimination of annual and lifetime benefit limits.
- Establishes new state-based insurance “Gateways” (i.e., exchanges or connectors) to facilitate the purchase of insurance plans by individuals and groups, with either national or state requirements applied to participating health plans.
- Establishes a Medical Advisory Council (“MAC”) with authority to determine “essential benefits” and determine “affordable, available coverage” for purposes of the individual and employer mandates; MAC recommendations become effective automatically unless disapproved by Congress within a specified number of days.

- Establishes a new federal disability/long-term care plan with automatic enrollment and voluntary opt-out.

SUMMARY OF KEY PROVISIONS

Declaration of Rights

- Right 1: “It is the right of patients to select the doctor of their choice.”
- Right 2: “Patients have a right to an effective doctor-patient relationship.”
- Right 3: “Doctors, nurses and other health professionals have the right to judge what is best for their patients.”

Individual and Group Insurance Market Reforms

- Eliminates the use of preexisting condition exclusions in the individual and group markets, including by self-insured group health plans.
- Requires modified community rating for individual and group insurance coverage, permitting rates to vary only by family structure, community rating area, actuarial value of the benefit and age; precludes insurance rating based on health status, gender, class of business, claims experience, or other factors.
- Requires guaranteed issue and renewability of insurance coverage to individuals and employer groups.
- Requires reporting by insurers on expenditures for clinical services, quality improvement and all other non-claims costs.
- Requires an annual rebate by health insurers to each enrollee if non-claims expenses exceed 20 percent for group coverage or 25 percent for individual coverage.
- Prohibits the establishment of eligibility rules based on health status, medical condition, medical history or other health-related factors.
- Requires all insurers and self-insured group health plans to develop and implement reimbursement structures that provide incentives for:
 - the provision of high quality care, case management,
 - care coordination and chronic care management,
 - reduction in preventable hospital readmissions through discharge planning,
 - improvements in patient safety and reduction in medical errors through the appropriate use of best clinical practices, evidenced based medicine and health information technology,
 - wellness and health promotion activities,
 - child health measures, as defined under the Social Security Act,
 - culturally and linguistically appropriate care, as defined by the Secretary of HHS, and
 - generally reflects Medicare and Children’s Health Insurance Program (CHIP) payment policies with respect to any “generally implemented” payment incentives to promote high quality health care.

- Requires first dollar coverage (i.e., no cost sharing) by insurers and self-insured group health plans for preventive health services included in the recommendations of the U.S. Preventive Services Task Force, immunizations recommended by the Centers for Disease Control and preventive care and screenings for children based on guidelines issued by the Health Resources and Services Administration.
- Requires insurers and self-insured group health plans that cover child dependents to make coverage available until the child dependent reaches age 26.
- Prohibits the establishment of lifetime or annual benefit limits by insurers or self-insured group health plans.
- Prohibits the establishment of eligibility rules for health coverage in employer group plans (both insured and self-insured) for any full-time employee based on total hourly or annual salary of the employee. Clarifies that lower dollar contributions by lower compensated employees are not prohibited.
- Permits individuals to remain enrolled in health coverage that was in effect prior to the effective date of the legislation without the application of the new requirements and permits family members of these individuals to enroll in “grandfathered” coverage which is renewed after the effective date.
- Effective date of reforms generally would be based on the earlier of the date determined by the States as they conform their laws to the new federal requirements or an as yet unspecified number of years after the date of enactment of the legislation.
- Provides for a transition rule for health coverage subject to a collective bargaining agreement which was in effect prior to the date of enactment to apply to plan years beginning after the later of the expiration of the last of the agreements or a date which is 12 months after the date of enactment.

Limit on Self-Insurance by Employers

- Prohibits the use of self-insurance by group health plans with 250 or fewer members.
- Directs the Secretary of Health and Human Services (hereinafter “Secretary”) to establish guidelines for determining the number of group members.

Establishment of Insurance Gateways

- Directs the Secretary to provide grants to the States to establish health insurance Gateways to facilitate the purchase of insurance coverage by individuals and employers.
- Makes individual participation in a qualified health plan or a Gateway voluntary.
- Requires Gateways to include at least one “affordable access plan”; i.e., a public health insurance plan option.
- Permits Gateways to offer plans that are required to meet benefit requirements other than federally-required “essential benefits”.

- Defines the required functions of Gateways, including the certification of qualified health plans, development of plan comparison tools, and the utilization of federal administrative simplification measures and standards.
- Permits Gateways to assess health insurers for its administrative and operating expenses.
- Provides for the Secretary to develop a retrospective risk adjustment mechanism (similar to the one for health plans participating in the Medicare Part D program) to adjust payments among high and low average risk plans offered through the Gateways.
- Authorizes certification of health plans offered by a Gateway if it determines that the health plan has met federal requirements and it would be in the interests of individuals and employers in the State or States served by the Gateway. Affordable access plans (i.e., public health insurance plan options) are deemed to have a certification.
- Plans may also be offered outside of the Gateway and nothing prohibits individuals from enrolling in such plans.
- Gateways may operate on a multi-state basis provided it is permitted by each participating state.
- Gateways may establish subsidiary Gateways serving geographically distinct areas.
- Directs the Secretary to issue regulations related to marketing practices, methods to easily compare insurance products and network adequacy for qualified health plans offered through a Gateway. Clarifies that the federal requirements for qualified health plans do not preempt state laws regarding market conduct or consumer protections.
- Beginning by an unspecified date, qualified health plans may only contract with hospitals that meet certain patient safety and quality improvement standards.

Medical Advisory Council

- Establishes a Medical Advisory Council (MAC) to develop recommendations on the amount, duration and scope of items and services required to be included as “essential health care benefits” for each category of services required by the legislation.
- Service categories required to be covered as “essential benefits” would be:
 - Ambulatory care
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Medical and surgical care
 - Mental health and substance abuse
 - Prescription drugs
 - Rehabilitative, habilitative and laboratory services
 - Preventive and wellness services
 - Pediatric services

- The MAC would also determine the criteria that coverage must meet to be considered minimum qualifying coverage for the purposes of the coverage mandate and the conditions under which coverage would be considered “affordable and available” for individuals and families at different income levels.
- Authorizes the MAC’s recommendations to automatically become effective within an unspecified number of days after it makes its report to Congress unless a law or joint resolution is enacted disapproving the MAC’s report in its entirety.
- Directs the MAC not to establish minimum coverage standards for a single disease or condition or an unreasonably limited set of diseases or conditions or to set an out of pocket limit which exceeds the amount required for a federally-qualified high deductible health plan (HDHP).
- Also directs the MAC to establish criteria “in a manner that results in the least practicable disruption of the health care marketplace...”.
- Permits differing criteria for coverage of young adults.

Navigators

- Directs the Secretary to award grants to States to allow them to enter into agreements with public or private entities (called “navigators”) for public education activities, distribution of fair and impartial information, assist in enrollment and provide culturally and linguistically appropriate information for the population served by the Gateways.

Levels of Benefits for Qualified Health Plans

- Establishes three levels of benefits for qualified health plans based on their actuarial value (unspecified) relative to a benchmark benefit level determined by the Secretary and a limit on out-of-pocket expenditures for covered benefits.

Premium Subsidies

- Establishes seven levels of premium subsidies for individuals who enroll in coverage with income between 150 and 500 percent of the federal poverty limit (based on family size). Subsidy amounts would be set relative to a reference premium so that the amount of premium paid by qualified individuals would not exceed a specified percent of their income.
- Requires that the portion of the reference premium that an individual be responsible for paying be indexed by the medical component of the Consumer Price Index.
- Permits states to provide additional subsidy payments or to increase subsidies in order to defray the costs of state benefit mandates in fully-insured plans which exceed those in the federal essential benefits standard.
- Directs the Secretary to develop application, determination and appeals rules for subsidy payments.

- Directs that premium eligibility be determined based on the individual's income from the preceding year "or the most recent period otherwise practicable" or based on an applicant's declaration of estimated income.
- Excludes premium subsidies for income or asset determination purposes for other federal program purposes.
- Prohibits payment of subsidies to individuals who are not lawfully in the United States.

Expansion of Medicaid Eligibility

- Establishes a federal Medicaid eligibility floor for individuals with income up to 150 percent of the federal poverty level.

Small Business Credits

- Directs the Secretary to provide payments to qualified small employers based on a percentage of a base credit amount that increases depending on the percentage of full-time employees who are offered coverage in the preceding year.
- Qualified small employers must have 27 or fewer full time employees and contribute at least 50 percent of the average amount that small employers in the same state contribute to health insurance premiums, as determined by the Secretary.

Individual Coverage Mandate

- Directs the Secretary to establish a penalty for individuals who are not enrolled in qualifying coverage and "seek to establish the minimum practicable amount that can accomplish the goal of enhancing participation in qualifying coverage."
- Exempts from penalty those individuals who did not have coverage for fewer than an unspecified number of days.
- Also waives the penalty for individuals if affordable coverage (as defined by the Medical Advisory Council) is not available or if it would impose exceptional financial hardship.
- Requires reporting, by those who provide qualifying coverage, of information related to enrollees and their duration of coverage.

Employer "Pay or Play" Coverage Mandate

- Requires employers to provide information to all employees on the services available through a health insurance Gateway and how to contact the Gateway for assistance.
- Places a "pay or play" penalty on employers for each employee not offered qualifying coverage and if the employer does not contribute at least an (unspecified) percentage of the monthly premium.

- Penalties would apply with respect to full-time and part-time employees and would be pro rated based on the hours worked by the employee involved based on a 30 hour work week.
- Small employers (size unspecified) would not be subject to the mandate.
- In addition to the “pay or play” penalty, employers who do not offer qualifying coverage would be subject to a “free rider” penalty, defined as equal to an (unspecified) percent of the cost of an employee’s health care coverage which is paid by the federal government (presumably if, for example, a low-income employee receives a federal premium subsidy when enrolled in a qualified health plan offered through a Gateway or enrolls in a public Affordable Access Plan).
- If an employee opts-out of coverage offered by an employer and enrolls in a qualified health plan offered through a Gateway, employers must make payments equal to the amount the employer would have paid for full-time employees enrolled in the employer’s health plan, under procedures determined by the Secretary.
- Employers may elect to make their employees eligible for a qualified health plan offered through a Gateway if they meet criteria established by each state establishing a Gateway (including criteria for the size of the employer) or, in certain cases, as determined by the Secretary.

Affordable Access Plan (Public Health Insurance Plan Option)

- Establishes a payment rate for covered services by an Affordable Access Plan equal to the Medicare reimbursement rate plus 10 percent. For services not offered under Medicare, directs the Secretary to establish a comparable payment amount.
- Deems Affordable Access Plans to meet state licensure standards and “be in good standing in each state”.
- Directs that premiums be based on “an amount necessary to cover the costs under the plan”.

Retire Health Coverage

- Includes a placeholder section in the draft bill, with no substantive provisions currently available, entitled Affordable Health Coverage for Retirees.