



**Executive Summary of the Senate Health Reform Bill,
“The Patient Protection and Affordable Care Act”**
[as approved by Senate on December 24, 2009]

Overview

On December 19, 2009, Senate leadership released its manager’s amendment to the pending health reform bill. This amendment makes a number of changes to the bill released in November, including altering the formula used to compute the individual coverage requirement, deleting the government-run plan, and directing the Office of Personnel Management (OPM) to contract with issuers to offer at least two “multi-state plans” through an Exchange in each state, which would provide both individual and small group coverage.

The information below includes highlights of the major provisions of the Senate legislation as amended by the December 19 manager’s amendment and subsequently approved by the Senate on December 24, 2009.

Changes to Administrative Processes

Administrative Simplification: The Senate bill directs the Secretary, no later than January 1, 2012 and at least every three years thereafter, to solicit input from the National Committee on Vital and Health Statistics, the Health Information Technology Policy and Standards Committees, and standards setting organizations and stakeholders (as defined by the Secretary) on (1) whether greater financial and administrative uniformity in activities and items might be achieved, and (2) whether such activities should be considered. Such activities and items shall include (1) whether the application process might be standardized and made electronic; (2) whether standards and operating rules should be expanded to apply to automobile insurance, worker’s compensation, and other programs; (3) whether standardized forms could be applied to financial audits required by health plans, federal and state agencies (such as the Centers for Medicare and Medicaid Services and the HHS Office of the Inspector General), and other agencies; (4) whether health plan processes to establish claim edits could be made more transparent and consistent; and (5) whether health plans should be required to publish timeliness of payment rules. The Secretary shall task the ICD-9-CM Coordination and Maintenance Committee, no later than January 1, 2011, to receive input from relevant stakeholders (including health plans, providers, and clinicians) regarding the crosswalk to ICD-10, and to make recommendations on appropriate revisions.

Health Insurance Markets Rules

Medical Loss Ratio: Beginning in 2011, plans would be subject to a medical loss ratio (MLR) requirement of 80 percent in the individual and small group markets and 85 percent in the large group market. Plans are required to pay rebates to enrollees if they fail to meet this requirement. States would have discretion to increase these thresholds. Also, with respect to the individual market, the HHS Secretary would be permitted to adjust the MLR threshold for a state if the Secretary determines that its application could destabilize the individual market in that state. This provision applies to grandfathered plans. It excludes

federal and state taxes and fees from the calculation of non-claims costs. This provision is permanent and would not sunset. The NAIC would have primary responsibility for developing uniform definitions for the new federal MLR reporting categories and standardized methodologies for calculating measures of such activities by December 31, 2010. Such methodologies must be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans. Also requires every hospital in the U.S. to publish a list of standard charges for items and services provided by the hospital.

Medical Reimbursement Data Centers: Health insurance reform provisions would grant the HHS Secretary the authority to review health plan rate filings in an annual review process that would be conducted with the states. States are eligible to receive grants to establish Medical Reimbursement Data Centers to support the bill's federal premium review process. The functions of such centers would include developing tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates, and making health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services.

Rescissions: Rescissions would be allowed only when fraud occurs or if the individual makes an intentional misrepresentation of material fact as prohibited by the policy.

External Review: Requires plans in states with existing external review laws -- that meet the minimum consumer protection standards of the National Association of Insurance Commissioners (NAIC) Uniform External Review Model Act (NAIC Model Act), to comply with those state laws. Makes determinations by an external review entity binding on plans. For states without external review laws and self-funded plans (that are not subject to state laws), requires the Secretary to develop an effective external review process that is similar to the NAIC Model Act. Allows the Secretary to deem the external review process of a group health plan or health insurance issuer that is in operation on the date of the enactment to be in compliance with the requirements of this section.

Internal Appeals Process: A health insurer offering individual or group health insurance shall implement an internal claims appeals process. The plan must provide notice to enrollees of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman. Enrollees must be able to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

Dependent Coverage: Health plans that provide dependent coverage of children would extend coverage to unmarried children up until age 26.

Lifetime and Annual Dollar Limits: Prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from establishing lifetime or annual dollar limits on essential health benefits, with the exception that prior to January 2014 plans may establish restricted annual limits on essential health benefits as determined by the Secretary, or on benefits that are not essential health benefits.

Any Willing Provider and Prior Authorization: Requires plans to allow enrollees to select their primary care provider (or pediatrician). Prohibits prior authorization or increased cost-sharing for emergency services, whether provided in-network or out-of-network. Prohibits plans from requiring authorization or referral by the plan for OB-GYN services.

High Risk Pool: A national high-risk pool, established within 90 days after enactment, would provide coverage until the establishment of the Exchange in 2014 to individuals who have preexisting conditions, as determined by the Secretary, and have not had creditable coverage for the six months prior to applying for coverage with the high risk pool. The bill appropriates \$5 billion to subsidize the pool coverage. Within 90 days after enactment, the Secretary would develop a voluntary reinsurance program for employers of early retirees that would end on January 1, 2014. The Secretary, in consultation with the states, would also develop an internet portal by July 1, 2010, that identifies affordable health insurance coverage options in a state.

Guarantee Issue and Rating Requirements: Effective January 1, 2014, would require health insurance plans to guarantee issue coverage to all individuals seeking coverage during open or special enrollment periods and would prohibit the application of preexisting condition exclusions. Adjusted community rating standards would apply to the individual and small group markets (if a state permits large groups to access coverage through the Exchange, the rating provisions would apply to the large group market as well). Rate variation would be allowed for age (limited ratio of 3:1), geography, family size, and tobacco use (1.5:1). Enrollees in employer wellness programs would be eligible for a premium discount or rebate. Small groups would be defined as an employer having between 1-100 workers. A state would be allowed, for plan years beginning before January 1, 2016, to define small group as between 1-50 workers.

Individuals and groups would be permitted to renew coverage of an existing “grandfathered” policy. Health plans could continue to offer coverage of grandfathered products, but only to current enrollees, dependents, or (in the case of an employer) new employees and their dependents. Individuals enrolled in grandfathered plans would be ineligible for premium tax credits.

All individual and group grandfathered products and all new products would be subject to a new risk adjustment mechanism. Reinsurance entities would administer a transitional state-based reinsurance program for individual and small group markets from 2014-2016 that would be funded through contributions from health plans totaling \$25 billion. The Secretary would establish risk corridors over that same period for plans in the individual and small group markets. States would have the option to merge the pooling and rating requirements for the individual and small group markets. A health insurance issuer would be required to create a single individual market risk pool for all enrollees in an individual plan, including individuals who purchase coverage outside of the Exchange, and a single group market risk pool for all enrollees in a small group health plan, including groups who purchase coverage outside of the Exchange. Starting on January 1, 2014, all plans offered in the individual and small group markets, whether through the Exchange or outside of the Exchange, would have to comply with the rating reforms and benefit options detailed under this bill.

Clinical Trials: Prohibits insurers from canceling health care coverage when an individual participates in a clinical trial (that treats cancer or other life-threatening diseases) or from denying coverage for routine care that would otherwise be covered absent an individual’s participation in a clinical trial.

Essential Health Benefits Package

Health plans would be required to cover various categories of services, including among others prescription drugs and mental and behavioral health treatments. The Secretary would define and update no less than annually these categories of covered treatments as well as the items and services within benefit classes through a transparent and public process that allows for public input. The benefit package would be defined so as not to be more extensive than the “typical” employer plan (not defined). The Secretary would update or modify the benefit package to account for changes in medical evidence or scientific advancement or to address any gaps in access or changes in the evidence base.

Beginning in 2014, health plans would need to conform to new product designs and one of five benefit levels: bronze, silver, gold, platinum, and young adult. The bronze coverage would provide coverage that is actuarially equivalent to 60 percent of the full actuarial value of the essential health benefit package. Silver coverage would have a 70 percent actuarial value, gold coverage 80 percent, and platinum coverage 90 percent. Health plans could also offer a young adult policy for those age 30 or younger that would be a catastrophic-only policy in which the catastrophic coverage level would be set at the level for HSA-high deductible health plans (with prevention benefits and three primary care visits exempt from the deductible). The out-of-pocket maximum for all plans would be limited to the level allowed for an HSA-high deductible health plan (\$5,950 for individuals and \$11,900 for families in 2010).

The manager's amendment provides that if a state requires benefits that go beyond the federal essential benefit package, the state must make payments to defray the cost of the additional benefits for individuals enrolled in qualified health plans offered in the state.

Exchange

Federal funding would be provided to assist states in establishing an American Health Benefit Exchange (Exchange) in each state by January 1, 2014. The Exchange would facilitate the purchase of qualified health plans for individuals and establish a Small Business Health Options Program (SHOP Exchange) for small businesses. The bill requires the Secretary (directly or through agreement with a not-for-profit entity) to establish an Exchange should a state fail to establish its own Exchange. Permits an Exchange to operate in more than one state, as approved by the Secretary, and allows the creation of one or more subsidiary Exchanges to serve a geographically distinct area. Permits a state to enter into agreements to carry out Exchange responsibilities to the extent the agreements are with a person who is subject to state laws, has demonstrated experience with individual and small group health insurance markets, and is specifically not a health insurance issuer or a state Medicaid agency.

Requires the Secretary to, among other things, establish certification criteria for qualified health plans, ensure network adequacy, develop a rating system for qualified health plans, develop a model template for an Exchange Internet portal, and determine initial and annual open enrollment periods.

Eligibility: Individuals and small employers are eligible to participate in the Exchange beginning in 2014. Beginning in 2017, states may make a determination as to whether large groups may participate in the Exchange.

Benefit Categories: Requires an Exchange to make a qualified health plan available that contains essential health benefits (described above). Permits states to require additional benefits, however requires a state to assume costs for any additional premium increase for such benefits for individuals receiving a premium tax credit.

Standards for Health Insurance Plans: Requires qualified health plans within the Exchange to be certified as meeting specified marketing and network adequacy requirements, to use uniform enrollment forms, and implement quality improvement strategies. Also requires accreditation of, among other things, clinical quality measures, utilization management, consumer access, provider credentialing, and appeals. Requires account data from the premium review process to be taken into account when making a determination about whether to certify a plan as a qualified health benefit plan.

Outreach and Enrollment: Requires Exchanges to maintain an Internet website to provide standardized

comparative information on qualified health plans. Requires Exchanges to award grants to “Navigators” to educate the public about qualified health plans, distribute information on enrollment and tax credits, facilitate enrollment, and provide referrals to questions and grievances.

Disclosure Requirements: Establishes disclosure requirements (for coverage issued in and out of the Exchange) including: disclosure of claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, data on the number of claims that are denied, data on rating practices, information on cost-sharing and payments with respect to out-of-network coverage, information on enrollee/participant rights, and other information identified by the HHS Secretary. Such information must be provided in “plain language.” Plans that offer coverage through the Exchange would be required to permit consumers to learn about cost-sharing amounts that the individual would be responsible for paying with respect to a specific item/service by a participating provider upon request. This information must be provided through the Internet and other means.

Multi-State Plans

The manager’s amendment strikes the Community Health Insurance Option from the bill but in its place creates requirements for multi-state plans. Directs the Director of the Office of Personnel Management (OPM) to contract (on a competitive bidding basis) with health insurance issuers to offer at least two multi-state qualified health plans within each state Exchange. Requires at least one of the contracting entities to be a non-profit entity. Requires OPM to oversee the program in a manner similar to the Federal Employees Health Benefit Program (FEHBP), including negotiating with each multi-state plan on medical loss ratio, profit margin, premiums, and “other terms and conditions of coverage as are in the interest of enrollees of such plans.” Requires multi-state plans to provide individual coverage and small group coverage to small employers, offer a benefits package uniform in each state and consistent with the essential benefits package, meet all requirements with respect to a “qualified health plan” (including the requirements related to the gold, silver, and bronze levels of coverage, as well as catastrophic coverage), offer the plan in all geographic regions and in all states that have adopted adjusted community rating before the date of enactment, and provide for premium determinations based on specified rating requirements.

A state could require the offering of additional benefits (mandates). An individual enrolled in the multi-state plan would be eligible for tax credits and cost sharing assistance, but a state's requirement to offer additional benefits would not increase the tax credit. States are required to defray the costs of the mandates. If the state has a rating requirement that is more restrictive than 3:1, permits the state to require that the plan comply with the more protective age rating requirements. Establishes a phase-in schedule for the requirement that the plan be offered in all states – 60 percent of states in year one, 70 percent in year two, 85 percent in year three, and all states in year four.

Health Insurance Cooperatives (CO-OP)

Requires the Secretary to establish a Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets. Appropriates \$6 billion for the Secretary to provide loans for start-up costs and grants to meet solvency requirements under the CO-OP program. Prohibits health insurance issuers in existence on July 16, 2009, or governmental organizations from participating in the program. Requires participants to meet all requirements of state law with respect to solvency, licensure, payments to providers, network adequacy, rate and form filing, and any applicable premium assessments; and must meet all insurance market reforms outlined in the Act. Allows program participants to form a

private purchasing council to enter into collective purchasing agreements for items and services that increase efficiencies, including health IT and claims administration.

Specifically prohibits a private purchasing council from setting payment rates for providers and facilities. Provides a tax exemption for qualified nonprofit health insurance issuers receiving a loan or grant under the CO-OP program.

Level Playing Field: Requires qualified health plans offered through the CO-OP, the public option, or a nationwide plan to be subject to all federal and state laws that apply to private health insurers.

State Option for a *Basic Health Plan*

Allows states to provide a basic health program option through negotiated contracts with one or more standard health plans (as defined) to provide at least an essential benefits package (as described above) to residents of a state whose household incomes are between 133 percent and 200 percent of FPL, and who are not eligible for employer coverage. Permits states to negotiate a regional compact with other states to include coverage of eligible individuals in all such states in agreements with standard health plans. Encourages the coordination of this program's administrative functions with the state's Medicaid program. Permits care coordination, managed care techniques, and use of performance measures under this program.

Individual Responsibility

Mandate to Purchase Coverage: Beginning in 2014, all U.S. citizens and legal residents are required to purchase coverage and are subject to a penalty for the failure to maintain coverage. Undocumented aliens, incarcerated individuals, and those with religious objections are exempt from this requirement. In addition, individuals are exempt from the responsibility mandate if they are unable to find affordable coverage that costs less than 8% of household income or the individual's household income does not meet a minimum threshold (100% of FPL). Individuals demonstrate compliance with this requirement through federal tax reporting.

Excise Tax: The manager's amendment revises the penalty amount for the individual responsibility requirement imposing a penalty of the greater of \$95 in 2014, \$495 in 2015, and \$750 in 2016, or up to 2 percent of income by 2016 (up to the lesser of (1) the national average bronze plan premium, or (2) the monthly penalty amount). The calculation of the monthly penalty amount is equal to the greater of (1) a flat dollar amount (based on the lesser of (a) the sum of the applicable dollar amount for the taxpayer and any dependents, or (b) 300 percent of the applicable dollar amount of the taxpayer) or (2) a percentage of the taxpayer's income.

Employer-Based Coverage

The bill requires employers with more than 50 full-time workers that do not offer coverage and have at least one worker who receives the premium assistance tax credit to pay a fee of \$750 for each full-time employee. The manager's amendment requires that a large employer requiring a waiting period to enroll in coverage that is more than 60 days to pay a fine of \$600 per full time employee. Employers with more than 50 employees that offer coverage and have at least one full-time employee receiving the premium assistance tax credit will pay an amount equal to the product of the number of full-time employees for that month and 400 percent of the applicable payment amount; this amount shall not exceed the product of the applicable payment amount and the number of fulltime employees employed for that month. Large employers must report to the Secretary on the coverage they make available to employees.

Employers must provide written notice to their employees at the time of hire (or, for current employees, no later than March 1, 2013) of the existence of an Exchange. If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, the employee may be eligible for a premium assistance tax credit and cost sharing reduction. If the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution to the plan offered by the employer, and all or a portion of such contribution may be excludable from income for federal income tax purposes.

Requires employers that offer coverage and make a contribution to provide free choice vouchers to qualified employees for the purchase of QHBPs through Exchanges. The free choice voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their required contribution under the employer's plan would be between 8 and 9.8 percent of their income. Free choice vouchers are excluded from taxation and voucher recipients are not eligible for tax credits.

Small Employer Tax Credit: Effective January 1, 2011, small employers (those employing less than 25 employees and average annual wages of less than \$40,000, indexed per CPI after 2013) who purchase health insurance for their employees may receive a sliding scale tax credit. Small employers with 10 or fewer workers with an average wage of \$20,000 or less may receive the full value of the credit. To qualify for a tax credit, an employer must contribute at least 50 percent of the total premium cost of a benchmark premium. From 2011-2013, eligible employers may receive a credit for up to 35 percent of their contribution toward the employee's health insurance premium. Tax-exempt small businesses are eligible for a reduced credit of up to 25 percent of their contribution. Beginning in 2014, eligible employers who purchase coverage through the Exchange may receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses would be eligible for a reduced credit of up to 35 percent of their contribution.

Auto-Enrollment: The bill requires employers with 200 or more workers to automatically enroll employees into health insurance plans offered by the employer. Workers may opt-out of this enrollment. Effective January 1, 2015.

Free Choice Vouchers: Employers that offer qualified employer-sponsored coverage would be required to provide "free choice vouchers" to certain employees to allow them to purchase coverage through a Health Insurance Exchange. Employees whose income does not exceed 400 percent of the federal poverty level and whose employer contributes between 8 percent and 9.8 percent of the employee's income to coverage would be eligible for a voucher. The voucher would be equal to the amount of the employer's contribution to employer-sponsored coverage.

Long-term Care Public Plan: The CLASS Program

The Secretary would establish a national voluntary insurance program, the CLASS Independence Benefit Plan, to provide community living assistance services and supports. The Secretary would also set criteria for participation in the program that does not restrict eligibility based on underwriting, establish criteria for eligibility for benefits and benefit levels, and establish mechanisms for collecting and distributing payments and assisting beneficiaries in the use of benefits. The Secretary would promulgate rules as necessary and take actions, including adjusting benefits or premiums, to maintain program solvency and ensure the program remains deficit neutral.

Workforce Provisions

Workforce Evaluation and Assessment: A National Health Care Workforce Commission would be established to disseminate information related to workforce supply issues; coordinate with relevant departments and agencies on related activities; commission evaluations of activities; identify barriers to improved communication between local, state, and federal levels; and encourage innovation to address population needs. The Commission would report to Congress on the application of grants established in this Act, and submit recommendations to Congress and to the Departments of HHS and Labor on improving workplace safety. Additionally, the Secretary would establish the National Center for Health Workforce Analysis, which would collaborate with the Commission to evaluate the effectiveness of programs created by the Act annually, and develop and publish performance benchmarks.

Grant and Loans Programs: The Act would establish grant programs to encourage workforce development in a variety of areas, including family, general internal, and general pediatric medicine; physician assistantship; dentistry; geriatrics; behavioral and mental health education; nursing; and community health. It would also provide grants to support health professionals serving in underserved communities and encourage training in cultural competency, disabilities, prevention, and public health.

Prevention and Wellness

Wellness Programs: The Act allows an employer that offers programs of health promotion or disease prevention to provide discounts or rebates based on an individual or employee satisfying a health factor-related standard. To adhere to HIPAA non-discrimination rules, the programs must cap the reward at 30 percent of the employee only coverage under the plan (allows the Secretaries of HHS, Labor and Treasury to increase to 50 percent), and provide protections for participants that cannot meet the standard due to medical conditions. Wellness programs that reward must be reasonably designed to promote health or prevent disease (and must not be a subterfuge for discriminating based on a health status factor), provide individuals the opportunity to qualify for the reward under the program at least once a year, ensure the reward is available to all “similarly situated” individuals, provide a reasonable alternative standard for individuals with medical conditions or if it is medically inadvisable for them to try and achieve the reward, and disclose the availability of the alternative standard.

Pilot Program: The bill directs the Secretaries of HHS and Treasury to establish a 10-state pilot program in 2014 to apply the above provisions to programs of health promotion and disease prevention offered in the individual market.

National Prevention, Health Promotion, and Public Health Council: The President would establish the Council, comprised of various federal agency representatives, to provide coordination and leadership on prevention and wellness initiatives, advise the President and Congress on the most pressing health issues affecting Americans, and develop a strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable disease. No later than July 1, 2010, and annually thereafter until January 1, 2015, the Council would report to the President and Congress on the activities and efforts to develop a national strategy and the national progress in meeting specific goals.

Increasing Public Awareness: The bill provides for a number of education and outreach initiatives, including a public-private prevention and health promotion outreach and education effort to raise public awareness of health improvement across the life-span, and a national science-based media campaign on health promotion and disease prevention.

CDC and Employer-Based Wellness Programs: The CDC Director would conduct national educational campaigns to inform employers on the benefits of workplace wellness programs and provide employers with assistance in evaluating these programs.

Medicare and Medicaid Programs: The Act would expand the preventive services covered under the Medicaid program and award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. The Act also provides for coverage of an annual wellness visit and personalized prevention plan, free from cost-sharing, under the Medicare program, as well as waives beneficiary coinsurance for most preventive services. In addition, the CDC would provide grants to states or large local health departments to conduct pilot programs to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk in the 55-to-64 year old population. CMS would conduct a comprehensive assessment of community-based disease self-management programs that help control chronic diseases. The Secretary would then develop a plan for improving access to such services for Medicare beneficiaries.

Medicare

Medicare Advantage Payments: The bill transitions the Medicare Advantage (MA) program to competitive bidding over a three year period. In 2011, the current payment methodology would be retained, and the national MA per capita growth percentage would be reduced by three percentage points. In 2012 and 2013, local MA benchmarks under current law would be blended with competitive bidding benchmarks based on the weighted average of plan bids. Beginning in 2014, the MA local benchmarks would be determined by the enrollment weighted average of all MA bids in each payment area. Local benchmarks would not exceed the levels that would have existed under current law. Rebates for local and regional MA plans would be calculated as follows: in 2011, 2012, and 2013, local and regional MA plans would still receive 75 percent of the difference between their bids and the benchmark rates as a rebate payment; beginning 2014, MA plans that bid below the new benchmark rate would receive a rebate amount equal to 100 percent of the difference between their bid and the new benchmark. As required under current law, local and regional MA plans that bid equal to or above the new benchmark rate would be paid the benchmark amount and must charge an enrollee premium equal to the difference between the benchmark and the bid. The legislation would provide quality bonuses to MA plans starting in 2014. Organizations participating in limited areas would be permitted to grandfather beneficiaries enrolled on the date of enactment into plans that are provided additional payments. “Transitional extra benefits” payments would be made available to organizations participating in other specified areas from 2012-2019. Special Needs Plans would be extended through 2013 and Cost Plans would be extended through 2012.

Improving Coverage in the Part D Coverage Gap: The bill establishes a discount program for beneficiaries who enroll in Part D and have drug spending that falls into the coverage gap. Beginning July 1, 2010, eligible beneficiaries would automatically receive a 50 percent discount off the negotiated price for brand-name prescription drugs that are covered under Part D and covered by their plan’s formulary. The legislation also reduces the Part D coverage gap by \$500 in 2010.

Medicare Advisory Board: The legislation establishes a 15-member independent Medicare Advisory Board to make recommendations to Congress to reduce Medicare spending and improve quality. The Board’s recommendations would become law in years that Medicare spending is determined to be unsustainable unless Congress enacts alternative measures to achieve similar savings. The Board would be prohibited from making recommendations that increase beneficiary cost-sharing or eligibility standards, raise taxes, or reduce payments to certain groups of providers including hospitals and physicians.

CMS Innovation Center: The bill directs the Secretary to establish, prior to January 1, 2011, an Innovation Center within CMS authorized to test, evaluate, and expand different payment structures and methodologies that aim to improve quality and slow the rate of Medicare, Medicaid, and CHIP cost growth. The Center would be funded by a transfer of \$10 billion from the Part A and Part B Trust Funds over ten years.

Medicaid and CHIP

Medicaid: The bill creates a new mandatory eligibility category of all non-elderly, non-pregnant individuals at or below 133 percent FPL effective January 1, 2014, and provides states the option of covering such populations beginning April 1, 2010. From 2014 through 2016 the federal government will pay 100 percent of the costs of covering the newly eligible. In 2017 and 2018 states will receive an additional 30.3 to 34.3 percentage points to their regular FMAP to help defray the costs of the newly eligible, and then all states will receive a FMAP increase of 32.3 percentage points in 2019 and thereafter.

A “maintenance of effort” is established, under which states are required to maintain existing income eligibility levels for adults in Medicaid through September 30, 2013, and for all children in Medicaid and CHIP through September 30, 2019. Beginning in 2014 all states would have to use modified gross income for determining Medicaid eligibility. Income disregards and asset tests would no longer apply in Medicaid except for long-term services and supports and for certain populations such as individuals eligible for Medicaid through another program.

States would be required to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered employer sponsored insurance if it is cost-effective as determined under current law requirements. In addition, the bill facilitates enrollment coordination with state exchanges, and requires states to establish a state enrollment website to promote seamless enrollment in Medicaid, CHIP or the exchange should a Medicaid or CHIP eligible individual apply for tax credits through a state exchange website or vice versa.

The bill increases the brand-name drug and generic drug rebate amounts and extends the Medicaid drug rebate to include drugs dispensed to enrollees of Medicaid health plans. The bill includes several provisions that provide incentives for states to increase their coverage of home and community-based services and supports. The Secretary is directed to develop a set of quality measures for Medicaid eligible adults that is similar to the quality measurement program for children enacted in the Children’s Health Insurance Program Reauthorization Act of 2009. States are prohibited from making Medicaid payments for services related to a health care acquired condition. The scope of topics that the Medicaid and CHIP Program Advisory Commission (MACPAC) is to address is expanded to include federal Medicaid and CHIP regulations, and an assessment of adult services in Medicaid.

CHIP: The bill maintains the current CHIP structure, requiring states to maintain income eligibility levels for currently eligible children in Medicaid (up to the CHIP eligibility level) and CHIP. Reauthorizes CHIP through 2015. It allows states to expand their current income eligibility levels at any time. CHIP-eligible children who cannot enroll in CHIP due to federal allotment caps are eligible for tax credits in the state exchange. Provides additional federal allocations of \$17.4 billion in FY 2013, \$19.1 billion in FY 2014, and \$5.7 billion in FY 2015. Beginning in 2014, the legislation provides a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent, through federal FY 2019. Beginning in 2015, states that experience CHIP shortfalls may enroll targeted low-income children into qualified health plans that participate in Exchanges. The qualified health plans must be certified by the Secretary as providing CHIP-comparable coverage.

Cost Containment

The bill requires the Independent Payment Advisory Board (formerly the Independent Medicare Advisory Board) to issue an annual report beginning July 1, 2014 containing standardized information on system-wide health care costs, access to care, utilization, variation and quality of care. The Board is required to submit to Congress and the President, every other year, recommendations to slow the growth in national health expenditures, such as recommendations that could be implemented administratively or legislatively, or that private sector entities could voluntarily implement. Allows partial capitation under the Accountable Care Organization (ACO) program. Permits the HHS Secretary to limit partial capitation to entities that are “capable of bearing risk.” The HHS Secretary would have authority to give preference to ACOs “who are participating in similar arrangements with other payers.” Other cost containment provisions include: payment bundling would be expanded to ten conditions (from eight in the underlying bill); the scope of pay-for-performance would be expanded to include psychiatric, long-term care, and rehabilitation hospitals; value-based purchasing for hospitals would be expanded to include ambulatory surgical centers; and the criteria for programs under the Center for Medicare and Medicaid Innovation would include activities that have effective linkage with other public sector or private sector payers.

Pathway for Biosimilars

Licensure of Biological Products as Biosimilar or Interchangeable: Any person may submit a biologic application, which must include information demonstrating that the biologic is biosimilar to the reference product; that the biologic and reference product utilize the same mechanism(s) of action for the condition(s) of use prescribed; that the conditions of use for the biologic have been previously-approved for the reference; that the route of administration, dosage form, and strength of the biologic are the same as those of the reference; and that the facility in which the biologic is manufactured meets standards designed to ensure safety, potency, and purity. Upon review of the application, the Secretary would issue a license if the biologic meets interchangeability standards and the manufacturer consents to an inspection of its facility. The Secretary would deem a biologic “interchangeable” if it is biosimilar to the reference product and can be expected to achieve the same clinical result as the reference and, if a biologic is administered more than once to an individual, the risk between use of the biologic and reference is no greater than the risk of using the reference without a switch. The bill would impose exclusivity periods on reference products (12 years) and first interchangeable biologics (the earlier of: 1) one year after the first commercial marketing as interchangeable for the reference; 2) 18 months after a final court decision with respect to all patent suits or dismissal of an action against the applicant; or 3) 42 months after approval if the applicant has been sued and such litigation is ongoing within such 42-month period **or** 18 months after approval of the first interchangeable biosimilar biologic if the applicant that submitted the application has not been sued.)

Patents: The Act establishes a process for the resolution of disputes relating to existing patents, including negotiation procedures and infringement actions.

Select Revenue-Raising Provisions

Excise Tax on High-Cost Insurance: The bill would impose an excise tax on insurers, equal to 40 percent of the aggregate value of employer-sponsored health coverage that exceeds the threshold amount of \$8,500 for an individual policy and \$23,000 for a family policy for 2013, indexed to CPI-U plus one percent. For retired individuals over the age of 55 and a plan that covers employees engaged in “high risk professions,” the threshold amount is increased by \$1,350 for individual coverage and \$3,000 for family

coverage, indexed to the CPI-U plus one percent. Effective for taxable years beginning after December 31, 2012.

Annual Fee on Health Insurance Providers: The bill would impose a fee, in the aggregate amount of \$70 billion over ten years, on the health insurance sector beginning in 2011, allocated by market share. The manager's amendment removes the third party administration (TPA) agreement fees from the allocation of the fee to health insurance providers. Establishes a \$2 billion annual fee for 2011, \$4 billion for 2012, \$7 billion for 2013, \$9 billion for years 2014 through 2016, and \$10 billion for years after 2016. Creates a limited exemption from the fee for certain non-profit insurers with a medical loss ratio of 90 percent or more.

Annual Fee on Pharmaceutical Manufacturers and Importers: Impose an annual fee of \$2.3 billion on the pharmaceutical manufacturing sector beginning in 2010 allocated by market share.

Annual Fee on Medical Device Manufacturers: Imposes an annual fee of \$2 billion on the medical device manufacturing sector beginning in 2011 through 2017, and \$3 billion for years after 2017 allocated by market share.

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