Heartland Actuarial Consulting, LLC

H.R. 3200

The following is a summary of H.R. 3200 as it existed in August 2009. The information presented is the personal opinion of William R. Lane, FSA, MAAA as to the implications of the proposed legislation and is not a legal opinion. Neither is this document necessarily the opinion of the Society of Actuaries. This document should not be considered as legal advice in any manner. All legislation is subject to change at any time, and by the time the reader is viewing this document, the proposal will probably have changed in significant ways.

This document is intended to explore the aspects of this legislation that impact providers of health insurance coverage, including self-insured plans. As such details with regard to electronic administration, Medicare, Medicaid, and other aspects of this legislation are not noted in detail. Significant portions of the legislation deals with providers that provide services for Medicare, which generally includes the vast majority of health care providers in the United States.

The legislation creates a new independent administration called the Health Choices Administration, headed by a Commissioner. Some of the specific requirements for offering coverage are spelled out in this legislation and some of the requirements will be specified (or may be modified) by the Commissioner. Hence, it is not possible to determine from the legislative language what the final requirements will comprise. Acceptable plans are referred to as QHBP's. Over time all health care plans will become a QHBP or the plan sponsor will face significant tax penalties.

Some significant changes from the market of today include:

A) Three levels of plans in terms of cost-sharing, and over time, relatively little difference in these three sets of plan benefits between carriers. These plans include adding vision and dental care for children which will add to the cost of these plans for almost everyone.

B) Mandated minimum 85% loss ratio for MA plans and unspecified minimum loss ratios for all other plans, which will likely make it difficult to provide for quality care management and adequate customer service.

C) Standardized eligibility information without allowing any optional fields. This will be difficult for properly identifying enrollees in special circumstances such as hour bank coverage, or will require many fields which are used only in specialized circumstances.

D) Partial funding, through "reinsurance" of employer early retiree coverage by public funds.

E) An exchange for the sale of health insurance.

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F) A "public option" of coverage provided by the Federal government with provider reimbursement at or near Medicare levels making this "option" the least expensive choice on the market. Over time the cost advantage will push the vast majority of people into this plan and will significantly reduce provider reimbursement, possibly to the point of significant hospital bankruptcies.

G) "Affordability credits" for individuals and families under 400% of the poverty level. These credits reduce both the premium and the cost sharing mechanisms. This will cause a significant increase in utilization due to the very low cost sharing.

H) An individual mandate and an employer mandate with required employer contributions of 65% for family and 72.5% for individual coverage.

I) Significant provider requirements, such as a requirement that all providers have available translator services for all languages. How this is even possible is a significant question.

J) Apparent reliance on "quality" measurement and provider payments based in part on the "quality" of the provider. "Quality" programs have been business management fads for some time and have not been widely effective. In this setting, it is even more questionable.

K) Assumes that health care providers will have "productivity improvements" similar to those measured within other industries and automatically reduces governmental provider payments for this increased "productivity". Since the population will be aging and health care services are likely to become more complex due to the increased bureaucratic controls, it is likely that average productivity in the health care area will not occur and these assumed "improvements" are simply on-going payments reductions.

L) Medicare Part D, drug coverage, is significantly enhanced with the removal over time of the so-called donut hole.

The numbering of comments under each sub-title is for this document only and is not according to the sections of the legislation. Page numbers refer to the legislation as of August 25, 3009.

Short title: "America's Affordable Health Choices Act of 2009"

Division A - Title I - Subtitle A

General standards for health insurance (Page 14 and onward)

1. Defines "Employment-based health plan" as all health insurance provided through employers, insured or self-insured, including ERISA plans, governmental plans and church plans.

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2. Defines Y1 as calendar year 2013, Y2 means calendar year 2014, etc.

3. Defines "Qualified Health Benefits Plan" (QHBP) as a health plan that meets the requirements of Title I, including the public option.

4. Defines "QHBP offering entity" as the ERISA plan sponsor, the health insurance company, the Secretary of Health and Human Services (for the public option), or the appropriate governmental official for governmental plans.

5. Considers Individual Health Insurance as a "QHBP" only if it is in force before the first day of Y1, and the issuer of the coverage does not enroll any new individuals on or after the first day of Y1. This means that individual coverage is not grandfathered if the carrier attempts to continue sell the coverage, which is beyond the control or knowledge of the individual policyholder. In addition, the issuer of the individual coverage may not change the terms or conditions of the coverage, including benefits form those in effect as of the first day of Y1. The issuer may not raise rates unless it raises the rates for all individual in the same "risk group" (undefined term).

6. Requires employment based health plans to have a grace period running from Y1 through Y5. After this time, the employer based plan must meet all requirements of Title I including the essential benefit package. Limited benefit plans as described in section 3001 (a) (1) (B) (ii) (IV) of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) are exempted. Coverage under a specified disease or illness policy as defined in section 733(c) of ERISA are also exempted.

7. Requires individual coverage offered on or after the first day of Y1 to be an Exchange-participating health benefits plan.

Division A - Title I - Subtitle B

Access to health insurance (Page 19 and onward)

1. Requires that QHBP's may not apply any pre-existing conditions limitation, nor any coverage waivers for specified conditions.

2. Specifies that HIPAA requirements for guarantee issue and renewability apply to all QHBP's, except that an issuer must provide an enrollee with notice of non-payment and allow a grace period during which the enrollee may correct such non-payment. Rescissions are limited to fraud.

3. Specifies that premium rates for insured QHBP's are limited as follows:
   A) Uni-gender, with a 1 to 2 limit on age rating.
   B) Area rating as "permitted" by State insurance regulators or the Commissioner (defined later).
   C) By family composition enrolled in the coverage "as specified by State insurance

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regulators or the Commissioner.

Strictly read, this section (Sec. 113 - page 21) would not allow for differences in rates for any other reason which would include differences based on benefit plan or effective dates of coverage.

4. Requires that a study, due 18 months after passage of this legislation, is to be conducted by the Commissioner examining the impact of self-insurance by employers of all sizes, considering anti-selection against the exchange, and solvency of the employers.

5. Mental health substance abuse disorders parity will apply to all QHBP's as it currently applies to large employers.

6. Specifies that the Commissioner will establish requirements to ensure the adequacy of provider networks, and to provide for "transparency" in the cost-sharing differentials between in-network coverage and out-of-network coverage.

7. Requires that the Commissioner specify a loss ratio for all QHBP's. Any QHBP which has a lower loss ratio shall provide a rebate to enrollees sufficient to meet such loss ratio. This loss ratio shall be at "the highest medical loss ratio possible that is designed to ensure adequate participation by QHBP offering entities, competition in the health insurance market in and out of the Health Insurance Exchange, and value for consumers so that their premiums are used for services".

Division A - Title I - Subtitle C

Access to essential benefits (Page 25 and onward)

1. Requires a QHBP to offer benefits equal to the essential benefits package. If a QHBP is no-exchange-participating, then it may offer additional benefits as well.

2. Requires a QHBP that is exchange-participating to offer the specified benefits.

3. Specifies that benefits must be in accordance with generally accepted standards of medical or appropriate clinical or professional practice.

4. Requires that benefits must limit cost sharing as detailed.

5. Requires that benefits may not have annual or lifetime limits on coverage of items and services.

6. Requires that benefits must be equivalent to the average prevailing employer-sponsored coverage as certified by the Office of the Actuary of CMS.

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7. Requires that benefits include
    * hospitalization,
    * outpatient hospital and clinical services including emergency room services,
    * services of physicians and other health professionals,
    * services, equipment, and supplies incident to services of physicians and other health professionals,
    * prescription drugs,
    * rehabilitative and habilitative services,
    * mental health and substance abuse disorder services,
    * preventive services,
    * maternity care,
    * well baby care, well child care, and
    * oral health, vision, and hearing services, equipment, and supplies for, at least, all children under 21 years of age.

8. Requires that there can be no cost sharing for preventative services, including well baby and well child care.

9. Requires that cost sharing, in total, may not exceed $5,000 for an individual and $10,000 for a family in Y1. Such limits shall be increased annually by the increase in the Consumer Price Index (all items).

10. Suggests that to the extent possible, cost sharing shall be copayments and not coinsurance.

11. Requires that cost sharing shall be established such that all cost sharing shall be actuarially equivalent to 30% of all benefits without cost sharing.

12. Establishes Health Benefits Advisory Committee to review benefit levels and make recommendations for future changes.

13. Allows that an enhanced benefit plan can be made available such that all cost sharing shall be actuarially equivalent to 15% of all benefits without cost sharing.

14. Allows that a premium benefit plan can be made available such that all cost sharing shall be actuarially equivalent to 5% of all benefits without cost sharing.

Division A - Title I - Subtitle D

Consumer protections (Page 37 and onward)

1. Requires that a QHBP provide timely grievance and appeals mechanisms.

2. Requires the Commissioner to establish an external review process of denied claims. A determination made under the external review process shall be binding on the QHBP.

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3. Requires that all QHBP's shall publically disclose
    * plan documents,
    * plan terms and conditions,
    * claim payment policies and practices,
    * periodic financial disclosures,
    * enrollment data,
    * number of claim denials,
    * rating practices,
    * cost sharing and payments with respect to out-of-network coverage, and
    * other information determined appropriate by the Commissioner.

4. Specifies all such disclosures to be in plan language. "Plain language" means the intended audience, including individuals with limited English proficiency, can readily understand and use.

5. Specifies that changes in QHBP's cannot be made without reasonable advance timely notice to enrollees.

6. Clarifies that these requirements (of Subtitle D) apply to a QHBP that is not exchange-participating only to the extent specified by the Commissioner.

7. Requires a QHBP to comply with section 1857(f) of the Social Security Act (with regard to timely payment of claims) in the same manner as an Medicare Advantage organization is currently required to comply with respect to a Part C Medicare Advantage plan.

8. Requires a QHBP to comply with standards for coordination and subrogation of benefits as established by the Commissioner.

Division A - Title I - Subtitle E
Governance (Page 41 and onward)

1. Establishes a Health Choices Administration headed by the Commissioner. In general this administration oversees all aspects of the requirements of this act with regard to QHBP's.

Division A - Title I - Subtitle F
Miscellaneous (Page 49 and onward)

1. Clarifies that requirements of this act do not supercede requirements of
    * Public Health Service Act (Titles XXII and XXVII),
    * ERISA, or
    * state law.

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2. Clarifies that individual rights and remedies under state laws still apply.

3. Mandates that no employer may discharge or otherwise discriminate against any employee who provides information to the appropriate regulatory authority information which the employee reasonably believes to be a violation of any provision of this Act.

4. Clarifies that requirements of this act shall alter or supercede any statutory or other obligation to engage in collective bargaining over terms and conditions of employment related to health care.

Division A - Title I - Subtitle G
Early Actions (Page 53 and onward)

1. Specifies that requirements with regard to minimum loss ratios shall begin for plan years beginning on or after January 1, 2001.

2. Requires that a health insurance issuer may rescind health insurance coverage only upon clear and convincing evidence of fraud on or after July 1, 2010.

3. Requires the Commissioner to establish standards for electronic administration by QHBP's including real time (or near real-time) determination of an individual's financial responsibilities at point of service including whether the individual is eligible for the service, near real-time adjudication of claims.

   The standards shall describe all data elements, not permit optional fields, and harmonize all common data elements across administrative and clinical transaction standards.

   Not later than 6 months after the date of the enactment of this section, the Secretary shall submit a plan for implementation by not later than 5 years after such date of enactment.

4. Requires the Secretary of Health and Human Services to establish a reinsurance program to reimburse employment-based plans for claims of retirees who are not yet eligible for Medicare, but is at least 55 years old.

   The reimbursement shall be 80% of the portion of a claim that exceeds $15,000, but does not exceed $90,000. The amount of the claim shall include any retiree deductibles, coinsurance or copayments. These dollar limits will be adjusted annually by the increase in the medical component of the CPI.

   Amounts received by the employment-based plan shall be used to reduce premiums and cost-sharing by plan participants, and not to reduce the cost of the employer.

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Annual funding of this reinsurance program shall not exceed $10 Billion.

Division A - Title II - Subtitle A
Health Insurance Exchange (Page 72 and onward)

1. Establishes a Health Insurance Exchange ("Exchange") which will offer a variety of QHBP's to individuals and employers. The Exchange will be under the authority and direction of the Commissioner.

2. Requires, in accordance with this legislation, and the direction of the Commissioner, the Exchange to negotiate with health insurance issuers to offer the essential benefit plan, the enhanced benefit plan, and the premium benefit plan.

3. Specifies that during Y1, only individuals and the "smallest employers", defined as 10 or fewer employees, will be eligible to purchase coverage through the Exchange.

4. Specifies that during Y2, individuals, smallest employers, and "smaller employers", defined as 11 to 20 employees, will be eligible to purchase coverage through the Exchange.

5. Specifies that beginning in Y3 and onward, all individuals and employers will be eligible to purchase coverage through the Exchange. The Commissioner may phase in larger employers over time rather than accept all sizes of employers in Y3.

6. Clarifies that once an employer enrolls in the Exchange, they remain Exchange eligible unless they set up an employment-based QHBP.

7. Specifies that an individual cannot purchase coverage through the Exchange if they have
    * Another QHBP
    * Grandfathered individual coverage
    * Medicare
    * Medicaid (except some non-traditional Medicaid enrollees)
    * Coverage through one of the armed forces
    * Coverage under the Veteran's health care program (if deemed sufficient by the Commissioner)
    * Other coverage deemed sufficient by the Commissioner.

8. Clarifies that once an individual is enrolled through the Exchange, they remain eligible unless they drop their Exchange coverage, or become eligible under Medicare or Medicaid).

9. requires that employers which enroll in the Exchange must meet specific participation and contribution requirements. Employees will be eligible to enroll under any Exchange offered plan.

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10. Requires the Commissioner to conduct a study of access to the Exchange to determine if there are significant groups of employers or individuals who are not Exchange eligible, but who would have improved benefits and affordability if they were eligible for Exchange coverage.

11. Requires the Commissioner to enter into contracts from health coverage issuers for benefit plans consistent with the essential benefit plan, the enhanced benefit plan, and the premium benefit plan described in Title I, Section C.

12. Clarifies that a health coverage issuer may offer only one basic plan (the essential benefit plan).

13. Specifies that a health coverage issuer may offer one and only one enhanced plan, but only if they are offering a basic benefit plan.

14. Specifies that a health coverage issuer may offer only one and only one premium plan, but only if they are offering an enhanced benefit plan.

15. Allows a health coverage issuer to offer premium-plus plans, but only if they are offering a premium benefit plan. This might include adding adult oral health or vision care.

16. Specifies that the benefits of the basic benefit plan will be modified for reduced cost sharing for individuals deemed to be an "affordable credit eligible individual" as defined later in this legislation.

17. Requires the Commissioner to establish plus or minus 10% ranges of acceptable cost sharing for each basic, enhanced, and premium plan.

18. Clarifies that state mandates still apply to Exchange plans, but the respective state must agree to reimburse the Commissioner for claim costs which increase the affordable premium credits as defined later in this legislation.

19. Requires the Commissioner to establish procedures for contracting with Health coverage issuers for Exchange coverage. Such issuers must be licensed by each state in which it is offering coverage. Such issuers must provide sufficient risk pooling information.

20. Requires all health coverage issuers to accept all Exchange applicants, but may subject them to capacity limitations under rules set by the Commissioner. Issuers must participate in a risk pool as defined later in this legislation.

21. Requires all health coverage issuers to contract for outpatient services with covered entities as defined in section 340B(a)(4) of the Public Health Service Act. The Commissioner may modify this requirement for HMO coverage if the HMO provides substantially all benefits.

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22. Requires all health coverage issuers to provide "culturally and linguistically appropriate" communication and health services.

23. Specifies that health coverage issuers will be selected through a bid process determined by the Commissioner.
24. Specifies that if a QHBP uses a network that the Commissioner determines does not meet adequacy standards as set by the Commissioner, then if an individual that receives an item or services from a non-network provider, then that individual shall only have to pay the in-network cost sharing. Note this section does not limit the in-network cost sharing to specific types of items or services that might be inadequate in the network. It simply states that if the network is inadequate, then non-network services will only have in-network cost sharing.

25. Requires the Commissioner to conduct outreach (marketing) activities to inform Exchange eligible individuals and employers of the Exchange and its products.

26. Requires the Commissioner to establish annual open enrollments, but shall also offer enrollment under specified special circumstances such as losing acceptable coverage, changes in marital or dependent status, moving into a different service areas, or having a significant change in income.

27. Requires the Commissioner to automatically select a QHBP and enroll certain people into the Exchange.
    * People who are "affordability credit eligible", but have not selected a QHBP in the Exchange,
    * People who were enrolled in an Exchange QHBP which has terminated, but have not enrolled into another QHBP.

28. Specifies that the Exchange shall not administer premium. Each QHBP shall administer the collection of premium for their enrollees.

29. Specifies that a child who is not enrolled within a QHBP shall automatically be enrolled as a non-traditional Medicaid enrollee.

30. Specifies that a child who is CHIP and who is not Medicaid eligible shall be deemed to be Exchange eligible as of the first day of Y1.

31. Specifies that a person who is a non-traditional Medicaid eligible individual and who does not enroll in an Exchange plan shall be enrolled in Medicaid by the Commissioner.

32. Requires the Commissioner to establish a mechanism whereby the premiums paid to QHBP's are adjusted to take into account the differences in risk characteristics of their respective enrollees. No mention is made of which "risk characteristics" will be included in making this determination nor how much "adjustment" will be made for such risk characteristics.

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33. Specifies that the president shall appoint a Special Inspector General, approved by the Senate, who will conduct audits and evaluations of the Health Insurance Exchange.

34. Specifies that there shall be a Health Insurance Exchange Trust Fund. The fund shall receive the tax on individuals who do not purchase a QHBP, and from employers who do not provide health benefits, as well as the excise tax for failing to meet certain participation requirements. Payments from the fund shall include amounts deemed necessary to operate the Health Insurance Exchange including the affordability credits.

35. Allows the Commissioner to approve a state-based Exchange if the Commissioner deems that the state-based Exchange will operate as the Federal Exchange and for no more expense to the Federal government.

Division A - Title II - Subtitle B

Public Health Insurance Option (Page 116 and onward)

1. Requires the Secretary of Health and Human Services to establish a QHBP to be offered through the Exchange. This "public option" shall comply with all Exchange rules for QHBP's.

2. Allows the administrative functions of the "public option" to be contracted to a non-governmental entity, but no risk may be transferred to a non-governmental entity.

3. Specifies that premiums for the "public option" shall include an appropriate contingency margin.

4. Requires payment rates to providers to be set on the payment rates for similar services and providers under Part A and Part B of Medicare. Payments for services not normally covered by Medicare shall be set on a comparable basis. Payments for prescription drugs shall be negotiated by the Secretary.

5. Requires, for an initial period of three years, the Secretary to pay five percent more than the Medicare rates for practitioners paid under the fee schedule under section 1848 of the Medicare Act.

6. Specifies that health care providers who are participating under Medicare shall be participating providers under the "public option" unless they opt out in a process established by the Secretary.

7. Specifies that the provider reimbursement rates set by these provisions are not to be subject to "administrative or judicial review".

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Division A - Title II - Subtitle C
Individual Affordability Credits (Page 128 and onward)

1. Specifies that individuals with sufficiently low income shall be eligible for an "affordability credit" to be applied against their Exchange premium, and an "affordability credit" to be applied against the cost sharing under their Exchange plan.

2. Requires the individual to apply for such credit and the Commissioner to establish a procedure to determine who is eligible.

3. Specifies that the Commissioner may allow a state Medicaid agency to make such determinations if the Commissioner determines that such agency can do so appropriately.

4. Specifies that in years Y1 and Y2, affordability credits may be applied against basic benefit plans only. In Y3 and onward, the Commissioner shall establish a process to allow affordability credits to be used against enhanced and premium plans.

5. Specifies that to be affordability credit eligible, an individual must not be enrolled in an employer plan and has a family income below 400% of the federal poverty level for the individual's family, and is not medicaid eligible.

6. Requires the Commissioner to establish rules for divorced spouses or separated individuals as to eligibility for affordability credits.

7. Specifies that beginning in Y2, being enrolled in an employer plan does not disqualify an individual for affordability credits if the individual's cost of coverage exceeds 11% of the individual's family income.

8. Sets an "affordable premium" on a monthly basis to be equal to one twelfth of the individual's family annual income times a percentage form a sliding scale ranging from 1.5% for the lowest incomes to
   - 3% at 150% of Federal Poverty Level (FPL),
   - 5% at 200% of the FPL,
   - 7% at 250% of the FPL,
   - 9% at 300% of the FPL,
   - 10% at 350% of the FPL, and up to
   - 11% at 400% of the FPL.

9. Requires the cost sharing for an affordability eligible individual to be reduced from the standard 30% (for a basic benefits plan) to
   - 3% at 150% of Federal Poverty Level (FPL),
   - 7% at 200% of the FPL,
   - 15% at 250% of the FPL,

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22% at 300% of the FPL,
28% at 350% of the FPL, and up to
30% at 400% of the FPL.

10. Specifies that the QHBP that enrolls an affordability credit eligible individual shall receive an increased premium based on the increased value of the plan (without consideration of the impact on utilization when cost sharing is substantially reduced).

Division A - Title III - Subtitle A
Individual Responsibility (Page 143)

1. Adds section 59B of the Internal Revenue Code.

Division A - Title III - Subtitle B
Part 1 Coverage Participation
Employer Responsibility (Page 143 and onward)

1. Requires an employer to either offer QHBP coverage to employees (and their dependents) with an acceptable employer contribution toward the premium, or to make Exchange QHBP's available to employees with an employer contribution paid to the Exchange.

2. Sets the minimum employer contribution toward coverage for individual coverage at 72.5 percent of premium (lowest available QHBP premium if offered through the Exchange).

3. Sets the minimum employer contribution toward coverage for family coverage at 65% of premium (lowest available QHBP premium if offered through the Exchange).

4. Specifies that for employees working less than the minimum number of hours considered to be "full time" (as specified by the Commissioner), the employer contribution will be pro-rated based on actual hours worked versus minimum hours required for full time status.

5. Specifies that salary reduction shall not be considered an employer contribution.

6. Specifies that an employer that makes Exchange QHBP available to employees, but without the appropriate employer contribution, shall make a payment of 8% of wages to the Health Insurance Exchange trust Fund. This payment is not used to provide an employer contribution toward that employer's employees.

7. Specifies the 8% to be scaled down for smaller employers with annual payrolls under $400,000.

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Division A - Title III - Subtitle B
Part 2 Satisfaction of Coverage Participation
Employer Responsibility (Page 152 and onward)

1. "Allows" an employer to elect to be subject to health coverage participation requirements.

2, Requires the Secretary to periodically audit employer plans to ensure compliance.

3. Allows the Secretary to terminate such an election if the Secretary finds substantial noncompliance.

4. Specifies that in the case of noncompliance which is due to reasonable cause and not to willful neglect, the employer is subject to a penalty of the lesser or $500,000 or 10% of the amount the employer paid during the prior one year period for health plans.

5. Mandates that if an employer fails to elect compliance (or does not substantially comply with requirements), then that employer is subject to an excise tax equal to 8% of payroll. This tax is reduced for smaller employers:
   to 6%if annual payroll exceeds $350,000, but is less than $400,000,
   to 4%if annual payroll exceeds $300,000, but is less than $350,000,
   to 2%if annual payroll exceeds $250,000, but is less than $300,000, or
   to 0%if annual payroll is less than $250,000.

6. Defines the health coverage participation requirements as those specified earlier in Part A, Title III, subtitle B, part 1. The more substantial requirements (not including benefit requirements) are as follows:

   * *The minimum employer contribution toward coverage for individual coverage is 72.5 percent of premium (lowest available QHBP premium if offered through the Exchange).*

   * *The minimum employer contribution toward coverage for family coverage is 65% of premium (lowest available QHBP premium if offered through the Exchange).*

   * *For employees working less than the minimum number of hours to be considered "full time" (specified by the Commissioner), the employer contribution will be pro-rated based on actual hours worked versus minimum hours required for full time status.*

   * *Salary reduction shall not be considered an employer contribution.*

Division A - Title IV
Subtitle A - Shared Responsibility
Part 1 Individual Responsibility
(Page 167 and onward)

1. Specifies that individuals who do not have acceptable coverage shall be subject to an

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additional income tax equal to the lesser of the national average annual premium or 2.5% of income in excess of the maximum amount of income allowed without a requirement to file your federal income taxes.

2. Requires the national average annual premium to be calculated by the Secretary as the average premium for self-only coverage under a basic plan.

3. Specifies that if an individual fails to meet coverage requirements for any dependent, then the national average premium as calculated above will be the family premium.

4. Specifies that penalties are pro-rated for periods of non-coverage that are less than twelve months.

5. Allows certain exemptions to apply, such as for residents of U.S. possessions, non-resident aliens, religious exemptions, etc.

6. Specifies that "acceptable coverage" includes a QHBP, grandfathered individual coverage, Medicare, Medicaid, VA coverage, coverage with the armed forces, or other coverage as defined by the Secretary.

7. Specifies that the tax penalty begins with the 2012 tax year.

Division A - Title IV
Subtitle A - Shared Responsibility
Part 2 Employer Responsibility
(Page 179 and onward)

1. Changes to the Internal Revenue Code to make taxes on employer's which don't meet requirements. Details are shown in earlier comments above.

Division A - Title IV
Subtitle B - Credit for Small Business Employee Health Coverage Expenses
(Page 188 and onward)

1. Sets a small business "credit" to be equal to an "applicable percentage" times the employee health coverage expenses of the small employer.

2. Sets the applicable percentage at 50% if the average annual compensation for the small employer is $20,000 or less,. If the average annual compensation for the small employer is $40,000 or greater, then the applicable percentage is 0%. In between these limits, the percentage is prorated.

3. Maintains the above percentage if the small employer employs 10 employees or less. If the

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small employer employs 25 or more employees, then the above percentage drops to 0%. In between these limits, the above percentage is prorated.

4. Specifies that no credit is allowed for any employee paid $80,000 or more.

5. Specifies that partnerships and self-employed individuals shall be treated as small employers and the partners or self-employed individuals are treated as "employees".

6. Specifies that any deduction from the employer's income allowed for the same health coverage expenses is reduced by the amount of the credit.

Division A - Title IV
Subtitle C - Disclosures
(Page 194 and onward)

1. Requires the Secretary to disclose to the Commissioner or the head of any state-based exchange the information needed to determine which individuals are eligible for an affordability credit.

Division A - Title IV
Subtitle D - Other Revenue
(Page 197 and onward)

1. Increases, beginning in tax year 2011, the Federal income tax for high income individuals:

    * Single taxpayer returns - 1% of income from $175,000 to $250,000; 1.5% of income from $250,000 to $500,000; and 5.4% of income above $500,000

    * Joint returns - 1% of income from $350,000 to $500,000; 1.5% of income from $500,000 to $1,000,000; and 5.4% of income above $1,000,000

    * All other returns - 1% of income from $280,000 to $400,000; 1.5% of income from $400,000 to $800,000; and 5.4% of income above $800,000

2. Specifies that these income amounts will be adjusted by a cost of living index.

3. Specifies that for tax years after 2012, the 1% above becomes 2%, and the 1.5% above becomes 3%.

4. Specifies that if "excess Federal health reform savings is more than $150 billion, but not more than $175 billion, then the increases from 1% to 2%, and 1.5% to 3% will not be

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applied.

5. Specifies that if "excess Federal health reform savings is more than $175 billion, then none of these tax increases apply.

6. Defines "Excess" Federal health reform savings as the Federal health reform savings minus $525 billion.

7. Specifies that Federal health reform savings shall be calculated by the Office of Management and Budget "as a result of this act and amendments", without regard to program investments.

8. Sets special rules which apply to nonresident aliens and citizens living abroad.

9. Sets special rules which apply to various types of foreign income.

Division B - Title I - Subtitle A
Medicare Part A
Part 1 Market Basket Updates (Page 223 and onward)

1. Adds or extends an annual assumption of productivity improvements in various Medicare health care providers and thereby reduces the otherwise increase in payments to these providers.

Division B - Title I - Subtitle A
Medicare Part A
Part 1 Other Changes (Page 228 and onward)

1. Changes case mix indices and outlier adjustments, in a budget neutral manner, for Skilled Nursing Facilities.

2. Adjusts Medicare payments to reflect the lower number of uninsureds and therefore the reduced uncompensated care by Medicare providers.

Division B - Title I - Subtitle B
Medicare Part B
Part 1 Physician Services (Page 238 and onward)

1. Adjusts the reimbursement for physician services under Medicare, setting target growth

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rates and allowing for the change in fee schedule amounts for "miscalled codes".

2. Requires the secretary to identify counties or equivalent areas where the utilization rate for services is within the bottom 20% of all counties. The fee schedule is to be increased by 5% in these counties. Since many individuals from more rural areas seek services in more urban areas, in large part due to the larger numbers of service providers, counties with fewer providers will tend to appear more "efficient" if they are located near larger population centers. Hence, these payments are unlikely to be made to more "efficient" providers.

3. Changes the fee schedule areas in California to be based on MSA's, and also makes other miscellaneous changes.

Division B - Title I - Subtitle B
Medicare Part B
Part 2 Market Basket Updates (Page 265 and onward)

1. Makes the reimbursement for various Part B services also subject to "productivity" adjustments.

Division B - Title I - Subtitle B
Medicare Part B
Part 3other Provisions (Page 268 and onward)

1. Covers a number of changes to medicare payments, but nothing that seems material in terms of the total Medicare Part B cost.

Division B - Title I - Subtitle C
Medicare Parts A and B
Part 1 Physician Services (Page 280 and onward)

1. Reduces the payment by Medicare for readmissions to hospitals. The methodology to determine the reduction factor does not consider whether or not the readmission was medically necessary.

2. Reduces the amount payable by Medicare for Home Health services.

3. Requires the Secretary to contract with the Institute of Medicine (of the National Academy of Science) to study the geographic adjustment factors used in the Medicare reimbursement system, and for the Secretary to offer proposed changes to the reimbursement system in a manner consistent with this study.

Division B - Title I - Subtitle D
Medicare Advantage Reforms
Part 1 Payment and Administration (Page 331 and onward)

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1. Changes the formula for blended benchmark amounts.

2. Provides for a "quality bonus" for MA plans that perform well according to rules established by the Secretary based on HEDIS quality measures, CAHPS quality measures, and other measures as the Secretary may specify. Bonuses can range up to 3% by 2013.

Division B - Title I - Subtitle D
Medicare Advantage Reforms
Part 2 Beneficiary Protection (Page 345 and onward)

1. Puts limits on allowable cost-sharing in Medicare Advantage plans.

2. Requires the Secretary to collect and publish loss ratio information for Medicare Advantage plans.

3. requires MA plans to have a loss ratio of at least 85% or give enrollees a rebate of premiums to cause the plan to have an 85% loss ratio.

4. Specifies that if an MA plan does not have an 85% loss ratio for three consecutive years, then the plan may not enroll new members.

5. Specifies that if an MA plan does not have an 85% loss ratio for five consecutive years, then the Secretary may terminate the plan contract.

Division B - Title I - Subtitle D
Medicare Advantage Reforms
Part 3 Treatment of Special Needs Plans (Page 353 and onward)

1. Allows a limitation on enrollment in a special needs plan other than the annual open enrollment period or when an individual is diagnosed with a condition that qualifies them as a special needs individual for that plan.

Division B - Title I - Subtitle E
Improvements to Medicare Part D
(Page 355 and onward)

1. Eliminates over time the gap in coverage within Medicare Part D, beginning in 2011.
2. Requires drug manufacturers to provide drug rebates for full-benefit dual eligible enrollees in a PDP plan or an MA Part C plan.

3. Requires drug manufacturers to discount their drug prices for an enrollee in a PDP plan or

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an MA Part C plan while the individual is within the current gap in coverage. Such discounts are to apply toward the satisfaction of the out of pocket limits even though this portion of the initial cost was not paid by the enrollee.

4. Specifies that drugs provided by AIDS drug assistance programs and Indian Health Service plans shall apply toward the satisfaction of the out of pocket limits even though the costs were not paid by the enrollee.

5. Allows enrollees to switch Medicare Part D plans if the drug formulary changes in mid-year for an enrollee who has been using such drug.

Division B - Title I - Subtitle F
Medicare Rural Access Protections
(Page 379 and onward)

1. Funds various studies or extensions of provisions for rural health services.

Division B - Title II - Subtitle A
Improvements to Financial Assistance
(Page 386 and onward)

1. Increases asset tests for low income subsidy program participants.

2. Eliminates cost sharing under Part D for certain full benefit dual eligible individuals.

3. Allows for self-certification of income and resources for low income subsidy, “except in extraordinary situations as determined by the Commissioner”.

Division B - Title II - Subtitle B
Reducing Health Disparities
(Page 400 and onward)

1. Authorizes a study to determine the feasibility of requiring all medicare providers to have the ability to communicate with patient in the patient’s language for “limited English proficient” patients.

Division B - Title II - Subtitle C
Miscellaneous Improvements
(Page 419 and onward)

1. Provides for extended months of coverage for immunosuppressive drugs for kidney

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transplant patients under specific circumstances.

2. Requires physicians to provide end of life counseling to their elderly patients every five years. Such counseling shall be part of the measurement of the physician's "quality' score. Combined with HIPAA privacy laws, without approval from the patient, nothing discussed in these sessions can be shared with another family member.

Division B - Title III
Promoting Primary Care, Mental Health Services & Coordinated Care
(Page 443 and onward)

1. Authorizes a study to test different payment incentive models designed to reduce the growth in expenditures.

2. Authorizes a pilot program to study the feasibility of home service to targeted high need beneficiaries.

3. Increases primary care physician reimbursement by 5% (or 10% if the physician provides services in a primary care shortage area).

4. Removes the cost sharing for the deductible and coinsurance for various preventive screening services.

5. Adds coverage for marriage and family therapy services and the services of a mental health counselor if they are for the diagnosis and treatment of mental illnesses.

6. Adds coverage for federally recommended vaccines and their administration.

Division B - Title IV - Subtitle A
Comparative Effectiveness Research
(Page 501 and onward)

1. Authorizes comparative effectiveness research.

Division B - Title IV - Subtitle B
Nursing Home Transparency
(Page 524 and onward)

1. Requires the public disclosure of a nursing home's owners, officers, managing employees, and organizational chart.

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2. Requires nursing homes to have a compliance and ethics program that prevents criminal, civil and administrative violations.

3. Requires nursing homes to have quality assurance and performance improvement programs.

4. Adds information to the official internet website "Nursing Home Compare".

5. Requires nursing homes to report more detailed expenses, and staffing information.

6. Requires the Secretary to develop a standardized nursing home complaint form. It also provides for "whistle blower' protection.

7. Proscribes civil monetary penalties for violations of these requirements.

8. Requires the Secretary to establish a pilot program to implement an independent monitor to oversee interstate chains of skilled nursing facilities.

9. Requires the administrator of a nursing home to notify the Secretary of a pending closure of a nursing home and disclose the plan to move residents to other facilities.

Division B - Title IV - Subtitle C
Quality Measurements
(Page 619 and onward)

1. Requires the secretary to establish national priorities for performance improvement in the delivery of health care, and develop quality measures as needed. The GAO shall evaluate the collection of data under this section and whether the standards provide physicians and other providers an opportunity to review and correct findings. Such measures shall be considered by various stakeholders, but need not be endorsed if the Secretary includes a rationale for using the non-endorsed measures.

Division B - Title IV - Subtitle D
Physician Payments Sunshine Provision
(Page 634 and onward)

1. Requires the reporting by any manufacturer of distributor of payments or gifts to physicians or other Medicare providers.

Division B - Title IV - Subtitle E
Public Reporting

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(Page 653 and onward)

1. Requires hospitals and ambulatory surgical centers to report health care associated infections of patients developed while within the facility.

Division B - Title V
Medicare Graduate Medical Education
(Page 659 and onward)

1. Allows the Secretary to provide additional resident physicians at hospitals under specific circumstances with an emphasis on primary care residents.

Division B - Title VI - Subtitle A
Increased Funding To Fight Waste, Fraud & Abuse
(Page 685 and onward)

1. Adds $100 million for fighting fraud and abuse.

Division B - Title VI - Subtitle B
Enhanced penalties For Fraud & Abuse
(Page 686 and onward)

1. Provides increased penalties for providing false information in various Medicare settings, both for providers and carriers under Medicare Advantage and Part D.

Division B - Title VI - Subtitle C
Enhanced Program & Provider Protections
(Page 703 and onward)

1. Specifies that if the Secretary determines that there is a significant risk of fraudulent activity, then the Secretary may enact various requirements such as screenings, oversight periods, and enrollment moratoria. Such "significant risk" includes any current affiliation or affiliation within the past 10 years with a provider of services that has been suspended or excluded from the program.

Division B - Title VI - Subtitle D

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Access To Information Needed
(Page 734 and onward)

1. Allows the Secretary to have access to health care data, subject to existing privacy laws, and to eliminate the Healthcare Integrity And Protection Data Bank

Division B - Title VII - Subtitle A
Medicaid & Health Reform
(Page 739 and onward)

1. Allows eligibility for Medicaid individuals and families up to age 65 who income is at or below 133% of federal poverty level.

2. Requires states to enroll Medicaid eligibles into acceptable coverage including determining the eligibility for affordability credits.

3. Requires the Secretary to reduce the Medicaid disproportionate share hospital payments by $1.5 billion in 2017, $2.5 billion in 2018, and $6 billion in 2019.

Division B - Title VII - Subtitle B
Prevention
(Page 764 and onward)

1. Requires the coverage under Medicaid of preventative services that the Secretary determines are appropriate for individuals entitled to medical assistance, and are either
    * Grade A or B by the Task Force for Clinical Preventive Services, or
    * Vaccines recommended by CDC.

2. Adds a few other services to covered Medicaid services.

Division B - Title VII - Subtitle C
Access
(Page 777 and onward)

1. Increases the payment of primary care services under Medicaid from 80% of title XVIII payment levels in 2010, 90% in 2011, and 100% in 2012.

Division B - Title VII - Subtitle D
Coverage

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(Page 785 and onward)

1. Provides Medicaid coverage for low income HIV infected individuals.

Division B - Title VII - Subtitle E
Financing
(Page 788 and onward)

1. Sets the Medicaid payment for drugs at 30% of the average manufacturer prices, and sets the minimum rebate at 22.1%.

2. Extends the drug discounts to enrollees in Medicaid managed care programs.

Division B - Title VII - Subtitle F
Waste, Fraud & Abuse
(Page 800 and onward)

1. Establishes a minimum loss ratio of 85% for Medicaid managed care programs.

Division B - Title VII - Subtitle G
Puerto Rico & The Territories
(Page 812 and onward)

1. Increases payments to Puerto Rico and the territories by a percentage specified by the Secretary.

Division B - Title VII - Subtitle H
Miscellaneous
(Page 815 and onward)

1. Specifies certain tchnical corrections.

Division B - Title VIII
Revenue Related provisions
(Page 819 and onward)

1. Allows Social Security to obtain the income from federal income tax filings for individuals which Social Security has identified as “likely to be eligible” for the low income prescription drug subsidy.

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2. Establishes a tax, which the Secretary is to compute will collect $375 million per year. The tax is due to each covered "life" under any health insurance policy in the United States and each covered "life" under a self-insured employer plan.

Division B - Title IX
Miscellaneous Provisions
(Page 835 and onward)

1. Repeals trigger provision from Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Title VIII, Subtitle A), and the Comparative Cost Adjustment Program (CCA) as added to the Social Security Act by the same Act.

2. Provides financial support for home visitation programs for families expecting children or with young children.

Division C - Title I
Community Health Centers
(Page 855 and onward)

1. Funds a Public Health Investment Fund and provides additional funding for community health centers out of this fund.

Division C - Title II - Subtitle A
Primary Care Workforce
(Page 864 and onward)

1. Allows for fulfillment of obligated service (under the Scholarship Program or the Loan Repayment Program) by serving half time providing clinical practice.

2.Establishes a program to provide health services in areas designated as "health professional needs areas" in return for loan repayments. Providers to include primary care physicians, family practice, general practice, physician assistants, dentists, and dental hygienists.

Division C - Title II - Subtitle B
Nursing Workforce
(Page 891 and onward)

1. Provides grants and loan repayments for primary care or wellness nurses.

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Division C - Title II - Subtitle C
Public Health Workforce
(Page 897 and onward)

1. Establishes a federal public health workforce with a scholarship and loan repayment program.

Division C - Title II - Subtitle D
Adapting Workforce To Evolving Needs
(Page 912 and onward)

1. Increases funding for scholarships, loan repayments, and fellowships regarding individuals from "disadvantaged backgrounds".

2. Collects data on the health workforce with respect to supply, diversity (race, ethnic background, and gender) and geographic distribution.

Division C - Title III
Prevention & Wellness
(Page 930 and onward)

1. Establishes and funds a "prevention and wellness trust".

2. Requires the Secretary to develop a strategy to promote evidence-based prevention and wellness activities.

3. Requires the Secretary to establish a permanent task force on clinical preventive services.
4. Funds grants for researching priority areas in prevention and wellness.

5. Funds programs for the delivery of prevention and wellness services with an emphasis on achieving a measurable reduction in one or more health disparities.

Division C - Title IV
Quality & Surveillance
(Page 964 and onward)

1. Establishes the Center for Quality Improvement (in the delivery of healthcare). The center

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will fund research into identifying, developing, evaluating, and implementing "best practices".

Division C - Title V - Subtitle A
Drug Discounts For Rural & Other Hospitals
(Page 979 and onward)

1. Expands covered entities to receive discounted drug prices, including inpatient drugs.

Division C - Title V - Subtitle B
School Based Health Clinics
(Page 992 and onward)

1. Establishes a program of school-based health clinics with an emphasis on areas with a high percentage of medically underserved children.

Division C - Title V- Subtitle C
National Medical Device Registry
(Page 1000 and onward)

1. Establishes a national registry for medical devices to facilitate analyses of postmarked safety and patient outcomes for such devices.

Division C - Title V - Subtitle D
Grants To Provide Education For Nurses
(Page 1007 and onward)

1. Authorizes grants for the education of nurses.

Division C - Title V - Subtitle E
States Failing To Adhere To Employment Obligations
(Page 1017)

1. Specifies that any state which does not implement all of these requirements, including its own health care plans, shall lose all Federal funding from the Public Health Services Act.

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