

Summary of Senate HELP Committee Draft Bill

Insurance Market Reforms: Individual and Group

(from Title I Subtitle A, “Effective Coverage for All Americans” of draft bill, pp 2-19.)

Pre-existing conditions. Plans may not impose preexisting condition exclusions.

Premium Variance. Premium rates may vary only by: (a) family structure; (b) community rating area; (c) actuarial value of the benefit; and (d) age – but not by more than 2 to 1. Premium rates may not vary by health status-related factors, gender, class of business, claims experience, or other factors not listed above.

Guaranteed Issue & Renewal. Plans must accept every individual and employer that applies for coverage, except that plans can have open or special enrollment periods and must have special enrollment periods for “qualifying life events.”

Accounting for Costs. Plans must report to the Secretary on the percentage of total premium revenue spent on reimbursement for clinical services, activities that improve quality, and all other non-claims costs.

Rebates. Plans must provide annual, pro-rata rebates to enrollees when “non-claims” costs exceed specified thresholds (20% in the group market; 25% in the individual market).

Prohibition on Discrimination Based on Health Status. Plans may not discriminate based on the following health-status related factors in relation to an individual or a dependent of the individual: health status; medical condition (physical and mental); claims experience; receipt of health care; medical history; genetic information; evidence of insurability; and disability.

Incentives for Quality. Plans must develop and implement a reimbursement structure that offers incentives for quality, through:

- implementation of case management, care coordination and chronic disease management;
- activities to reduce preventable hospital admissions;
- activities to reduce medical errors and improve patient safety through use of best practices, EBM and health IT;
- implementation of wellness and health promotion, child health measures, and culturally and linguistically appropriate care; and

that reflects the payment policy of Medicare and CHIP to promote high quality care.

Coverage of Preventive Health. Plans must provide coverage for (with no more than minimal cost sharing) items and services that have an A or B rating in the current recommendations of the U.S. Preventive Services Task Force as well as immunizations

recommended by the Advisory Committee on Immunization Practices of the CDC. Plans must also cover preventive care and screenings for infants, children and adolescents included in guidelines supported by HRSA.

Extension of Dependent Coverage. Plans that provide dependent coverage of children must do so for children up to 26 years of age.

Annual & Lifetime Limits. Plans may not establish annual or lifetime limits on benefits.

Prohibition on Discrimination Based on Salary. With respect to the group market, plans may not establish coverage eligibility rules for any full-time employee that are based on the total hourly or annual salary of the employee. Plans may still establish contribution requirements that differ based on hourly or annual compensation.

Effect on Existing Policies. This subtitle (Subtitle A: Effective Coverage for All Americans) does not apply to coverage in which an individual was enrolled prior to the title's effective date. Family members are also permitted to enroll in plan coverage in which an individual was already enrolled prior to the effective date.

Limitation on Self-Insuring. Group health plans that have 250 or fewer group members are not permitted to self-insure.

American Health Benefit Gateways

(from Title XXXI Subtitle A, "Affordable Choices" of draft bill, pp 20-60.)

Establishment of Gateways. Federal grants would be provided to states to establish American Health Benefit Gateways. The HHS Secretary would establish Gateways in states that do not establish them within a specified timeframe (not stated in draft bill). Gateways may operate in more than one state. The Gateways are designed to facilitate the purchase of health insurance (qualified health plans, including at least 1 government-sponsored "affordable access plan") at an affordable price by qualified individuals and qualified employers (self-employed individuals are deemed to be a qualified employer unless the individual elects to be considered as a qualified individual). Participation in a Gateway and enrollment in a qualified health plan is voluntary.

Function of Gateways. Gateways would establish procedures for the certification of qualified plans. Gateways would also make tools available to help consumers obtain accurate information about their expected premiums, out of pocket expenses and other costs, as well as the availability of in-network and out-of-network providers. Gateways would utilize administrative simplification measures, enter into agreements with navigators (see below), facilitate the purchase of long-term care services, and collect and respond to complaints and concerns.

Navigators. The Secretary shall award grants to enable Gateways to contract with private and public entities to: (a) conduct public education activities to raise awareness of the program; (b) distribute fair and impartial information concerning enrollment in and the availability of credits for qualified health plans; (c) assist with enrollment; and (d) provide information that is culturally and linguistically appropriate. A navigator may not be a health insurance issuer.

Enrollment Facilitation. Gateways will identify individuals who lack qualifying coverage and assist these individuals in enrolling in a qualified health plan, Medicaid, CHIP, or other federal health programs for which the individual may qualify. Individuals eligible for CHIP may choose to enroll in CHIP or a qualified health plan. Gateways will also help individuals enroll in other public programs, such as TANF. The Secretary will develop interoperable and secure standards to facilitate enrollment, including electronic matching against existing federal and state data and online application capabilities. [There is additional language regarding the Secretary's role in facilitating enrollment that parallels the above language. Wording in the draft bill implies that more discussion is ongoing regarding state and federal roles in this area. Also, see section below on Health Information Technology]

Surcharges. Gateways may assess a surcharge (not to exceed an unspecified percent of premiums collected) on all issuers offering quality health plans through the Gateway to pay for the administrative and operational expenses of the Gateway.

Risk-Adjusted Payment. Each state shall assess a charge on plans whose enrollees' actuarial risk for a year is less than the average actuarial risk of all enrollees in all plans in the state (excluding self-insured group health plans) for the same year. Each state shall provide a payment to plans whose enrollees' actuarial risk for a year is greater than the average actuarial risk of all enrollees in all plans in the state (excluding self-insured group health plans) for the same year. Payments will be calculated on a retrospective basis.

State Requirements. State benefit mandates are still in effect with respect to non-qualified health plans. Additionally, nothing in this title preempts any state law regarding market conduct or related consumer protections. (Bill language indicates that discussions are still ongoing regarding state and federal roles with respect to market conduct and related consumer protections.)

HHS Regulations. The Secretary will issue regulations regarding, at the very least, marketing practices, methods to ensure that products are simple and comparable, and network adequacy.

Patient Safety. Qualified health plans may contract with hospitals of unspecified size only if the hospitals utilize a patient safety evaluation system and implement mechanisms to ensure that patients receive counseling and comprehensive discharge planning.

Financial Integrity. States must annually report to the Secretary on Gateway expenditures. Secretary may conduct investigations and audits and implement fraud and

abuse reduction measures. The GAO shall conduct an ongoing study of Gateway activities as well.

Medical Advisory Council. The Secretary shall establish a Medical Advisory Council – or contract with the IOM to establish the Council – to make recommendations on at least the following:

- the schedule of items and services that constitute the essential health care benefits eligible for premium credits (see below), including those in the following general categories:
 - ambulatory patient services
 - emergency services
 - hospitalization
 - maternity and newborn care
 - medical and surgical care
 - mental health and substance abuse services
 - prescription drugs
 - rehabilitative, habilitative, and laboratory services
 - preventive and wellness services
 - pediatric services
- the criteria that coverage must meet to be considered minimum qualifying coverage; and
- the conditions under which the coverage is considered affordable and available for individuals and families at different income levels.

The Council must ensure that the recommendations reflect an appropriate balance among the categories and take into account the health care needs of diverse populations. In considering what constitutes minimum qualifying coverage, the Council must exclude from its criteria any coverage that provides reimbursement for the treatment of (a) a single disease or condition; or (b) an unreasonably limited set of diseases or conditions -- or any coverage that has an out of pocket limit that exceeds the allowable contribution to a Health Savings Account for the year involved.

The Council may hold hearings and shall submit a report to the Secretary containing its recommendations (time not specified in bill). The Secretary will review the report for scientific and medical validity and may request revisions. The Secretary shall submit the report to Congress and, unless a joint resolution disapproving the recommendations is enacted, the recommendations shall be implemented.

Affordability

(from Subtitle B, “Making Coverage Affordable” of draft bill, pp 61-85.)

Levels of Cost Sharing. The Secretary shall establish three different levels (yet unspecified) of cost-sharing applicable to qualified health plans. The levels will specify that the cost-sharing is within a certain percentage range of the value of the benefit and that there is a limit on out of pocket expenditures that is also within a certain percentage

range of the individual's income that exceeds the Federal poverty line. To be a qualified health plan, the issuer must offer a plan at each level of cost sharing.

Payment of Credits. The Secretary shall pay a premium credit to the Gateway on behalf of an eligible individual enrolled in a qualified health plan. These credits would be provided, on a sliding scale, to individuals and families with incomes up to 500 percent of the federal poverty level.

Eligibility Determinations. The Secretary shall establish rules and procedures for applying for premium credits, making eligibility determinations, resolving appeals of these determinations, redetermining eligibility on a periodic basis, and making payments.

Medicaid Expansion. Medicaid eligibility would be expanded to 150 percent of the federal poverty level.

Small Business Credit. The Secretary shall make a payment to each qualified small employer that request a credit and that provides the materials needed for the calculation of the credit. The credit amount is the product of the base credit, the number of full time employees, and, in the case of an employer that offered coverage to at least a certain percent (unspecified) of full time employees, 0.5. In the case of an employer that did not offer coverage to a certain percent of full time employees, the credit amount would be a product of the base credit, the number of full-time employees and 1.25. Additional language is included that specifies how the base credit amount is calculated. A qualified small employer is defined as (a) an employer that employed an average of 27 or fewer full time employees or (b) a self-employed individual that had not less than \$5,000 in net earnings or not less than \$15,000 in gross earnings.

Shared Responsibility

(from Subtitle D, "Shared Responsibility for Health Care" of draft bill, pp 85-98.)

Individual Responsibility. "Shared responsibility payments" – with the amount to be determined by the Secretary – would be imposed on individuals who do not have qualifying coverage for any month during the taxable year. An exemption would be provided for those who do not have access to affordable coverage and for those for whom the payment would represent an "exceptional financial hardship."

Reporting of Health Insurance Coverage. Every person who provides qualifying health coverage must submit a "return" specifying the name, address and taxpayer identification number of each individual who is covered under health insurance that is qualifying coverage provided by such person, and the number of months during which each individual was covered.

Notification of Nonenrollment. Through the IRS, each individual who files an individual income tax return and is not enrolled in qualifying coverage will be sent a notification on services available through the appropriate Gateway.

Shared Responsibility of Employer. Employers that do not contribute a certain

percentage toward the cost of employee health coverage (threshold not specified) would be required to make payments (amount not specified) to the HHS Secretary. Payments would be required for each full time employee and pro-rated payments would be required for part time employees. These payments would be made quarterly. Small employers (not defined) would be exempted. In addition, a “free rider” penalty (amount not specified) would apply to employers for each employee who is not offered qualifying coverage. These payments would be made monthly.

Notice to Employees. Employers shall provide employees at the time of hiring written notice informing them of the existence of the Gateway and the services provided.

Government-Sponsored Plan

(from “Miscellaneous Provisions” of draft bill, pp 99-106.)

Affordable Access Plan. The Secretary will offer a qualified health plan. Provider reimbursement would be set at Medicare rates plus 10 percent. The government plan would be deemed to be licensed in each state. Premiums must be sufficient to cover the costs of the government plan.

Health Information Technology

(from Subtitle C, “Other Provisions Related to Health Information Technology” of draft bill, pp 107-112.)

Enrollment Standards and Protocols. The Secretary would be required (in consultation with the HIT Policy Committee and the HIT Standards Committee) to develop interoperable and secure standards and protocols that facilitate electronic enrollment of individuals in federal and state health and human services programs

Standards and protocols for enrollment would allow for: electronic matching against existing federal and state data to serve as evidence for eligibility; simplification and submission of electronic documentation; reuse of stored eligibility information; capability for individuals to apply, recertify and manage their eligibility information online; ability to expand the enrollment system to integrate new programs, rules and functionalities; and notification of eligibility, recertification, and other needed communication regarding eligibility.

Grants for Implementation of Appropriate Enrollment HIT. The Secretary would award grants (amount not specified) to eligible entities (state or local government) to develop new and adapt existing technology systems to implement the HIT enrollment standards and protocols. Appropriate enrollment HIT adopted under these grants shall be made available to other eligible entities and qualified entities (to be determined by the Secretary).

Long-Term Care Services and Supports

(from Subtitle E, “Long-Term Services and Supports” of draft bill, pp 112-171.)

Community Living Assistance Services and Supports Act (CLASS). A national voluntary LTC insurance program – the CLASS program – would be established to provide cash benefits, advocacy services, and counseling to meet the needs of individuals who have functional limitations expected to last for a continuous period of more than 90 days.

Premiums. The CLASS program would be funded with beneficiary premiums. The Secretary shall annually establish the monthly premium for enrollment and may factor in administrative expenses, not to exceed 3 percent of premiums paid in the first 5 years of the program and 5 percent of total expenditures in subsequent years. In general, the amount of an individual’s monthly premium would remain the same for as long as an individual remains an active enrollee in the program. Exceptions include if recalculated premiums are required to ensure program solvency, if an individual re-enrolls after a 3-month lapse, and if an individual ceases to hold full-time student status. Premiums for long-term care insurance could be paid on a pre-tax basis through section 125 cafeteria plans.

CLASS Independence Fund. Premiums would be paid into a CLASS Independence Fund, with the Secretary of Treasury serving as the Managing Trustee of the Fund. There would be a Board of Trustees composed of the Social Security Commissioner, the Secretaries of Labor and HHS and two members of the public nominated by the President and confirmed by the Senate for 4 year terms.. The Fund would have “off-budget status” so that any amounts derived from payments into the fund would not be counted as new budget authority, outlays, receipts, deficit or surplus. The Fund would also have “lock-box protection” so that use of moneys in the Fund could not be used for any unauthorized purpose without a 3/5 majority vote in the Senate.

Automatic Enrollment. The Secretary shall establish procedures for the automatic enrollment of individuals by employers in the CLASS program. Premiums for enrollment in the CLASS program can be deducted from an individual’s wages in accordance with procedures the Secretary shall establish for employers who elect to deduct such premiums on behalf of enrolled employees. Employers who automatically enroll employees and withhold CLASS premiums from wages will receive a tax credit in the amount equal to 25 percent of the cost of the automatic enrollment and premium withhold.

Benefits. The cash benefit amount would provide an eligible beneficiary with not less than an average of \$50 per day and would vary based on a scale of functional ability. The benefit would not be subject to any lifetime or aggregate limit. Payment of the cash benefit would go into a Life Independence Account for the purchase of nonmedical services and supports. Upon application for receipt of benefits, an eligibility assessment shall take place. The Secretary shall enter into agreements with the Disability Determination Service for each state to provide for eligibility assessments; the Protection and Advocacy System for each state to provide advocacy services; and public and private entities to provide advice and assistance counseling. There would be a five-year vesting

period for eligibility for benefits.

Benefit Plan. A CLASS Independence Advisory Council, comprised of not more than 15 individuals appointed by the President, will evaluate alternative benefit plans and recommend to the Secretary that the benefit plan that best balances price and benefits to meet enrollees' needs in an actuarially sound manner be designated as the CLASS Independence Benefit Plan. Taking this recommendation into consideration, the Secretary shall designate and publish in an interim final rule, the CLASS Independence Benefit Plan.

Interaction with Medicaid. In the case of an eligible beneficiary who is enrolled in Medicaid, the following payment rules would apply:

- For institutionalized beneficiaries, the beneficiary would retain 5 percent of the daily or weekly cash benefit and the remainder would be applied towards the institution's cost of providing care. Medicaid would provide secondary coverage for such care.
- For beneficiaries receiving home and community-based services, the beneficiary would retain 50 percent of the daily or weekly cash benefit and the remainder would be applied toward the cost to the state of provide such assistance. Medicaid would provide secondary coverage for the remainder of any costs incurred.

Personal Care Attendant Workers – Infrastructure and Workforce. Not later than 2 years after enactment, each state shall assess the extent to which entities such as providers of home and community services are serving as fiscal agents for/employers of personal care attendant workers and designate or create such entities to ensure an adequate supply of personal care attendant workers. In addition, the Secretary shall establish a Personal Care Attendants Workforce Advisory Panel to examine and advise on workforce issues related to personal care attendant workers.