



Summary of Senate Health Reform Bill Updated December 21, 2009

This updated summary includes (in red) changes made to the Senate's *Patient Protection and Affordable Care Act* by the Manager's amendment introduced December 19. The bill expands access to quality, stable, affordable health care; slows the growth of health care costs; and improves the quality of care. The bill and the Manager's amendment are available online at democrats.senate.gov/reform.

Insurance Reform

The bill makes significant improvements to the private insurance system, overhauling the individual and small-group health insurance markets to expand access to coverage. A number of those improvements go into effect immediately, including provisions to:

- Ban copays or other out-of-pocket expenses for preventive care and immunizations.
- Prohibit all rescissions when insurance is retroactively canceled.
- Extend dependent coverage in all plans up to age 26.
- Prohibit lifetime benefit limits in all plans.
- **Prohibit pre-existing condition exclusions for children.**
- Require insurers to devote at least 85 percent of premiums **in the large group markets and 80 percent in the small and individual markets** to medical benefits or provide consumer rebates if medical benefit spending falls below this percentage.
- Create a national, high-risk pool plan for people denied coverage because of medical conditions. This pool is temporary until the exchange is up and running.

Additional private insurance requirements begin by 2014, including reforms that:

- Require insurers in the small-group and individual markets to offer coverage to everyone and to renew all policies.
- Prohibit exclusions for preexisting conditions.
- **Prohibit annual benefit limits for essential services.**
- Bar insurers from basing premiums on health status, gender and other factors. Premiums may vary based on age, with the spread constrained to a 3:1 ratio, and based on tobacco use up to a 1.5:1 ratio. Premiums may also vary by geographic area and family size.
- Require all health plans to cover essential benefits, which include hospital and outpatient services, prescription drugs, mental health services, maternity care, rehabilitation and preventive care, but not abortion services.
- Direct plans to meet out-of-pocket expense limits of \$5,800/individual and \$11,600/family, indexed to inflation.
- **Create "multi-state plans" to promote competition in the insurance market. (See details in the Public Health Insurance Option and CO-OPs section below.)**

Discussion: Overall, the bill creates strong protections that would assure equal access to coverage for people in the private insurance market. The reforms that take effect immediately provide some relief

for consumers who currently cannot access coverage. While premiums should not be based on tobacco use and the age rate spread should be reduced, these provisions are stronger than in the Senate Finance bill. **The Manager's Amendment also seems to have strengthened oversight of multi-state insurance plans from earlier versions of the bill. However, the Manager's Amendment weakens coverage for abortion services in Exchange plans, and exempts self-insured plans from rules that constrain or prohibit premium rates based on age and other factors.**

Ensuring Affordability

To make coverage affordable, the bill would expand Medicaid, establish a sliding-scale subsidy program for low- and moderate-income people, and provide assistance for small businesses. The bill includes provisions to:

- Expand Medicaid to 133 percent of the federal poverty level (FPL) (\$24,360 per year for a family of three) in 2014 to cover children and non-disabled, childless adults under the age of 65. States could expand Medicaid earlier, starting **April 1, 2010**.
- Provide "premium tax credits," which operate as sliding-scale subsidies, in the exchange for people earning between 100 and 400 percent FPL (\$73,240 for a family of three) and for those below 100 percent FPL only if they are legal U.S. residents who do not qualify for Medicaid. Individuals only qualify for subsidies if they do not have access to employer-sponsored insurance that meets certain minimum standards and costs less than 9.8 percent of their income. Premiums would start at 2 percent of income for those earning 133 percent FPL or less and rise to 9.8 percent for those between 300 and 400 percent FPL
- Reduce out-of-pocket maximums for people below 400 percent FPL in the exchange and offer further out-of-pocket subsidies for people below 200 percent FPL in the exchange
- Give tax credits to small businesses and nonprofits that have 25 or fewer full-time equivalent employees, have an average wage of no more than **\$50,000**, and who contribute at least 50 percent of the premium for employee coverage.

The Senate's expansion of Medicaid will make health insurance affordable to this newly eligible group of people at 133 percent FPL. The House expansion goes further, though, covering people up to 150 percent FPL. Other strengths of the Senate's Medicaid portion of the bill include new quality directives for Medicaid, expansion of medical homes to those with chronic illness, and enrollment simplification measures.

Premium subsidies make coverage substantially more affordable for millions of low- and middle-income families who do not have access to coverage through their employers. However, there are some weaknesses in this provision. Specifically, subsidies remain too low, particularly for low-income families earning up to 200 percent FPL. Also, the out-of-pocket protections continue to pose barriers to care for low-income families, put low- and moderate-income families at risk of underinsurance if they face a catastrophic illness.

Public Health Insurance Option and CO-OPs

The Senate bill eliminates the choice of a public insurance option and instead offers two proposals to promote competition in the insurance market. First, it authorizes the Office of Personnel Management to enter in to contracts with insurers to offer coverage to individuals and small groups through "multi-state" plans. The plans will be offered through each state's Exchange and must meet its benefit and plan requirements. At least two plans will be offered in each state; one must be

through a nonprofit entity. Plans must set premiums using HIPAA rating requirements and must be offered in community rated states. Enrollees are eligible for credits and subsidies.

Second, the bill authorizes funds for at least one nonprofit, member-run health insurance Consumer Operated and Oriented Plan (CO-OP) in each state that would offer coverage to individuals and small businesses. The state would have to implement all insurance reforms in the law before a CO-OP could operate.

Discussion: A public health insurance option would increase choice and competition and provide an accountable alternative to private plans. While national plans overseen by OPM offer some degree of public accountability they are unlikely to be much different from current non-profit insurers. The CO-OP model is untested, has few inherent advantages and is unlikely to be a strong competitor with insurance companies, or to significantly influence provider prices.

Health Insurance Exchange

The bill directs states to create Health Benefit Exchanges to help individuals and employers compare health plans, make informed choices and facilitate enrollment. Exchanges also must develop a rating system to help consumers choose the best plan for them. Subsidies and the multi-state plans would be available through the exchange, and participation in the exchange is voluntary. In addition, the Exchange must consult with consumers about its processes, and provide transparent information about claims, cost sharing, and benefits. Eligibility for the exchange starts in 2014 for individuals and small employers. No undocumented immigrants may enroll through the exchange.

Discussion: Unlike in the Senate Finance bill, the exchange has the authority to certify plans and help consumers make comparisons through a rating system. Pooling risk for plans both inside and outside of the exchange would reduce adverse selection and prevent the exchange plans from having higher premiums. The actuarial benefit levels for plans, however, are lower than in previous bills. This leaves consumers more vulnerable to out-of-pocket costs. The Manager's Amendment improves public oversight and transparency in Exchanges.

Shared Responsibility

For individuals: Starting in 2014, all U.S. citizens and legal residents will be required to obtain coverage for themselves and for their dependents. This coverage must meet minimum requirements, unless the available coverage costs more than 8 percent of their income. Exemptions are allowed for religious objections, financial hardship, undocumented immigrants, Native Americans, people below 100 percent FPL, and for short gaps in coverage. The maximum penalty for not obtaining coverage for any family is the national average premium for a bronze plan. The penalty is calculated as the greater of:

- \$95 per year in 2014, \$495 per year in 2015, \$750 in 2016 (half that amount for children under age 18), up to a maximum of 3 times those penalty amounts per family, or
- 0.5 percent of income in 2014, 1 percent of income in 2015, 2 percent of income in 2016 and beyond.

Discussion: The individual mandate includes some critical consumer protections, including the affordability and hardship exemptions. However, fines for families who do not have insurance are high and may cause further financial hardship.

For employers: Starting in 2014, employers who do not offer coverage that meets minimum requirements to all their full-time employees (and their dependents), and have at least one full-time employee who qualifies for premium tax credits, will be required to pay \$750 per year for each full-time employee they employ.

Also, even employers who offer coverage that meets minimum requirements to all of their full-time employees but still have at least one full-time employee who qualifies for premium tax credits (because the coverage offered by the employer is not affordable to the employee), will be required to pay \$3,000 for each of their employees receiving a tax credit, up to a maximum of \$750 for each full-time employee.

Any employer who offers minimum essential coverage to its employees and pays a portion of the costs of that plan must offer a “free choice voucher” to any employee who earns less than 400 percent FPL and whose required contribution to the plan would be between 8 percent and 9.8 percent of their income. The free choice voucher would be equal to the costs that the employer would have paid towards that employee’s coverage under the employer-sponsored plan. The employee can then apply that free choice voucher towards the cost of any plan offered in the Exchange, but will not be eligible for subsidies. Employers do not have to pay the above free-rider surcharge with respect to employees for whom they offer a “free choice voucher.”

Employers will also have to pay penalties if they impose a 60-day (or longer) waiting period for employees to enroll in coverage.

Employers with fewer than 50 full-time employees are exempt from these requirements.

Discussion: The employer requirements in this bill help raise money for subsidies and encourage employers to continue offering coverage to their employees. The requirements in this bill could be improved by setting minimum contribution requirements for employers toward employee coverage. Such a requirement would ensure that employers pay their fair share, and that low-wage workers have access to affordable coverage.

Children’s Health

The Senate bill increases mandatory Medicaid income eligibility levels for children ages six to 19, though to a lower level than in the House bill. The bill also preserves the CHIP program **past 2013 with full funding until 2015**. The bill includes provisions to:

- Expand children’s access to the Medicaid program by providing coverage with Early Periodic Screening, Diagnosis and Treatment (EPSDT) for every child at or below 133 percent FPL **and every foster child through age 26**.
- Maintain CHIP through at least September 30, **2015, allowing states to provide CHIP coverage to children of state employees eligible for health benefits**. The federal CHIP match rate in will be increased in 2015 by 23 percent.
- Simplify and coordinate enrollment processes for coverage in Medicaid, CHIP and the exchange.
- Provide funding for school-based health centers, oral health education campaigns and pediatric quality improvement programs.
- **Immediately ban insurers from denying coverage to children for preexisting conditions.**

Discussion: The expansion of Medicaid will provide more children access to the comprehensive EPSDT benefits package, but the House bill goes further, expanding coverage for children to 150 percent FPL. With regards to CHIP, we are pleased to see that CHIP-eligible children will not be abruptly transferred into exchange plans **in 2013 and that the program will be funded until 2015**. In the event that some or all children are ultimately moved into exchange plans, **we are pleased that these children will first be screened for Medicaid and that the Secretary of HHS must review and certify which plans in the Exchange provide CHIP-comparable benefits and cost sharing protections. While states will be required to establish procedures to enroll the children in equivalent coverage, we believe that more specific safeguards should be established to guarantee that children receive comparable benefits and protections.**

Racial and Ethnic Health Disparities

The Senate bill aims to reduce racial and ethnic health disparities with provisions to:

- **Guarantee \$8.5 billion more in funding for community health centers.**
- Require all federal health programs and surveys to collect data on the race, ethnicity and primary language of participants; and require the federal government to use the data to monitor health disparities.
- Establish a national strategy to improve delivery of care, patient outcomes and population health, including reduction of disparities.
- Provide grants for community health programs and community health workers to promote wellness and address disparities.
- Provide loan repayments and scholarships for students from disadvantaged backgrounds seeking to work in medically underserved areas.
- Support programs that develop cultural competency and health disparities curricula for use in health professions schools and continuing education programs.
- **Reauthorize and expand Indian Health services, with goals of reducing disparities and increasing the ability to meet Indian health needs.**

Discussion: The bill takes steps to reduce racial and ethnic disparities, **and the Manager's Amendment adds some initiatives. But overall the bill** is not as strong as the House bill on this count. The Senate bill promotes community health initiatives and takes steps to diversify the health workforce and make it more culturally sensitive. It strengthens the safety net by boosting funding for community health centers, but would drastically cut funding that supports care for the uninsured at hospitals. Like the House bill, the Senate bill maintains the current policy of excluding legal immigrants from Medicaid for five years and excludes undocumented immigrants from access to new insurance subsidies. However, unlike the House bill, it also excludes undocumented immigrants from buying insurance at full price through the exchange.

Consumer Assistance

The bill makes very positive steps toward institutionalizing consumer support services, by:

- Immediate creation of state consumer assistance offices or state ombudsman programs to help consumers enroll in plans, file complaints and appeals, solve problems with programs and track any problems with implementation of reform.
- Authorizing state exchanges to provide grants to navigators to facilitate enrollment and provide information about plans. Navigators may include community-based nonprofits as well as trade groups.

Discussion: We are very pleased with provisions in the Senate bill to provide consumers with the information, support and troubleshooting they need to enroll in the right coverage and navigate the health care system. In addition, state exchanges should be required, rather than just permitted, to work with community-based nonprofits to provide targeted assistance to consumers.

Prescription Drugs

The bill advances prescription drug reforms by promoting the use of the safest, most effective drugs, and takes significant steps toward reducing the cost of drugs for seniors and all Americans. The bill includes provisions to:

- Require pharmaceutical and medical device companies to report all payments over \$10 to physicians and teaching hospitals. Importantly, this data will be made public on a searchable website.
- Require pharmacy benefit managers (PBMs) to report information on the rebates, discounts or price concessions negotiated by the PBM, as well as the payment difference between health plans and PBMs, and between the PBMs and pharmacies. These confidential reports will be disclosed to HHS and the PBM's health plan clients.
- Reduce by \$500 the threshold at which Medicare Part D beneficiaries enter the coverage gap, or "donut hole." This \$500 of additional coverage is accompanied by a 50 percent discount on the prices of drugs while beneficiaries are in the "donut hole."
- Establishes a nonprofit institute to coordinate federally-supported research on the comparative effectiveness of interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostic tools and pharmaceuticals.

Discussion: The Medicare changes are significant improvements for seniors. We believe Congress should aim to ensure that seniors have continuity of prescription drug coverage by completely eliminating the "donut hole." The provisions on research are an important step toward generating and aggregating needed evidence on the relative utility of treatment options for patients. However, the research institute should have strong conflicts of interest standards for employees and advisory panel members, and investigators' freedom to publish findings should be guaranteed.

Improving Quality

The bill includes numerous provisions that promote access to primary and preventive care; strengthen infrastructure by rewarding care coordination, innovation and efficiency within the delivery system; and improve the quality of health care in America. The bill includes provisions to:

- Develop a National Quality Strategy to improve care delivery, health outcomes and population health. A new Center for Innovation within the Centers for Medicare & Medicaid Services (CMS) would test and evaluate innovative models of care.
- Establishes numerous national pilot programs and demonstration programs to test and evaluate new strategies for improving the quality of care people receive while reducing costs, such as bundled payments, global payments, accountable care organizations and medical homes through multiple payers and settings.
- Establishes new quality measures for Medicaid-eligible adults, including grants to states to provide incentives for Medicaid beneficiaries to participate in healthy lifestyle programs. A state option would enroll Medicaid beneficiaries with chronic illnesses into health homes that offer comprehensive, team-based care, and a new optional Medicaid benefit would allow people with disabilities to receive community-based services and supports.

- Rewards hospitals for providing value-based care and penalizes hospitals that perform poorly on quality measures such as preventable hospital readmissions.
- Establishes a five-year pilot program that would use public health interventions to reduce chronic illnesses and their associated costs for people between age 55 and 64.
- **Provides incentives for states to shift Medicaid beneficiaries away from nursing homes and toward care in the home or community.**

Discussion: The tagline of many of the provisions captured in this section is pretty familiar to most of us by now: “improves quality while reducing costs.” Notably, a number of the key Senate provision, such as those related to the National Quality Strategy, reserve roles for the public and for consumer representation in key efforts, such as establishing new quality measures, determining which models of care to pursue, or evaluating new pilot and demonstration programs. Though much of the hard work here will be left for implementation, we are pleased that the Senate bill hones in on reducing chronic illness, improving patient-centeredness and care coordination, integrating medical care with home- and community-based services, and building capacity at the state and local level to meet many of these objectives.

Strengthening Medicare

The bill includes many provisions that will strengthen Medicare’s stability and improve beneficiary access to care. In addition to the drug provisions mentioned above, the bill:

- Extends the Special Needs Plan program for frail, sick and elderly Medicare beneficiaries. A new office within CMS will promote policies and assist states in better integrating care for dually eligible Medicare beneficiaries.
- Limits cost-sharing requirements for certain services in Medicare Advantage plans to the amount charged for the same services in traditional Medicare coverage.
- Creates an independent Advisory Board to make recommendations to Congress on reducing costs and improving the quality of care **in Medicare and in the private sector.**
- Provides beneficiaries with free, annual wellness visits and personalized prevention plans, including a comprehensive health risk assessment.
- **Creates a “Physician Compare” website for Medicare beneficiaries to compare physician quality and patient experience.**

While not part of Medicare, per se, the bill also begins to address a longstanding gap in the program by creating a voluntary insurance program (CLASS) to provide community-based assistance services and support.

Discussion: Like its House counterpart, the Senate bill includes some significant wins for seniors. We are particularly pleased to see limitations on cost-sharing for seniors enrolled in Medicare Advantage, and the new office dedicated to improving policies for dually eligible beneficiaries.

Changes to Safety Net Services

The bill makes several significant changes to existing safety net programs, including:

- Significant reductions to the amount of funding hospitals and states receive through Medicare and Medicaid Disproportionate Share Hospital (DSH) funding.

- New requirements for private tax-exempt hospitals around financial assistance policies, including transparency in hospital charges, conducting community needs assessments, billing and collection policies, and reporting.

Discussion: We are extremely pleased to see that the Senate bill includes new requirements for private tax-exempt hospitals. These provisions would do much to promote fairness, transparency and accountability for people who need to access hospital safety net services, while creating new energy around hospitals' collaboration on health care planning with the communities they serve. We are concerned, however, that the significant cuts to DSH funding—which, unlike similar cuts in the House bill, do not require hospitals to report on their targeted and appropriate use of DSH funds—will create major distress to many safety net providers who serve populations unlikely to be fully covered by national health care reform.

Financing

The main revenue provision in the Senate bill remains an excise tax on the most expensive health insurance plans. The threshold of plan values above which the tax applies is \$8,500 for individual plans and \$23,000 for non-individual plans, and the tax is still 40 percent of the value above those thresholds. The **compromise** Senate bill also levies an additional **0.9** percent Medicare tax on high-income individuals (individuals earning over \$200,000 and families earning over \$250,000), and imposes a **10** percent excise tax on indoor tanning services.