The Healthy Americans Act Section by Section

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TITLE I: HEALTHY AMERICANS PRIVATE INSURANCE PLANS

Subtitle A – GUARANTEED PRIVATE COVERAGE

Section 101: **Guarantee of Healthy Americans Private Insurance Coverage**: Within 2 years of enactment States must create a system as outlined in the bill to provide individuals the opportunity to purchase a Healthy Americans Private Insurance (HAPI) plan that meets the requirements of the Act.

Section 102: **Individual Responsibility to Enroll**: Adults (over age 19, U.S. citizens, not incarcerated) must enroll themselves and dependent children in a plan offered through the state-wide Health Help Agency (HHA) unless they provide evidence of enrollment or coverage through Medicare, a health insurance plan offered by the Department of Defense, an employee benefit plan through a former employer (i.e. retiree health plans), a qualified collective bargaining agreement, the Department of Veterans Affairs, or the Indian Health Service.

Religious Exemption: If a person opposes for religious reasons to purchasing health insurance the requirement may be waived.

Dependent Children: Each adult has the responsibility to enroll each child in a plan. Dependent children include individuals up to age 24 claimed by their parents for deductions in the tax code.

Penalty for Failure to Purchase Coverage: If an individual fails to purchase coverage and does not meet the exceptions or the religious exemption, then a financial penalty will be assessed. The penalty is calculated by multiplying the number of uncovered months times the weighted average of the monthly premium for a plan in the person's coverage class and coverage area, plus 15 percent. Payments will be made to the HHA of the State in which the person resides. That agency also may establish a procedure to waive the penalty if the penalty poses a hardship. Each State shall determine appropriate mechanisms to enforce the requirement that individuals be enrolled, but the enforcement cannot be the revocation or ineligibility of coverage.

Subtitle B – STANDARDS FOR HEALTHY AMERICANS PRIVATE INSURANCE COVERAGE

Section 111: **Healthy Americans Private Insurance Plans**: At least two plans that meet the requirements of the Act must be offered through the Health Help Agency in each State. The offerings permitted through Health Help include several options: (1) a plan similar to the Blue Cross Blue Shield Standard Plan provided under the Federal Employees Health Benefit Program as of January 1, 2007; (2) plans with additional benefits added to the standard plan so long as those benefits are priced and displayed separately; and (3) actuarial equivalent plans to the standard plan. In addition, plans must provide benefits for wellness programs; incentives to promote wellness; provide coverage for catastrophic medical events resulting in the exhaustion of lifetime limits; create a health home for the covered individual or family; ensure that as part of a first visit with a primary care physician, a care plan is developed to maximize the health of the individual through wellness and prevention activities; provide for comprehensive disease prevention, early detection and management; and provide for personal responsibility contributions at the time services are administered except for preventive items or services for early detection.

Family Planning: A health insurance issuer must make available supplemental coverage for abortion services that may be purchased in conjunction with a HAPI plan or an actuarially equivalent HAPI.

Actuarial Equivalent Plans: Actuarial equivalent plans have to have a set of core benefits that include preventive items and services; inpatient and outpatient hospital services; physicians' surgical and medical services; and laboratory and X ray services. Like the other HAPI plans, actuarial equivalent plans cannot charge copays for prevention and chronic disease management items or services.

Coverage Classes: There will be the following coverage classes: (1) individual; (2) married couple or domestic partnership (as determined by a State) without dependent children; (3) coverage of an adult individual with 1 or more dependent children; (4) coverage of a married couple or domestic partnership as determined by a State with one or more dependent children.

Premium Determinations: Community rating or adjusted community rating principles established by the State will be used. States may permit premium variations based only on geography, smoking status, and family size. States may determine to have no variations.

A State shall permit a health insurance issuer to provide premium discounts and other incentives to enrollees based on participation in wellness, chronic disease management, and other programs designed to improve the health of participants.

Limitations: Age, gender, industry, health status or claims experience may not be used to determine premiums.

Section 112: **Specific Coverage Requirements**: This section requires existing provisions of law currently applied to group health markets to be applied to the plans offered through Health Help Agencies including: protections for coverage of pre-existing conditions; guaranteed availability of coverage; guaranteed renewability of coverage; prohibition of discrimination based on health status; coverage protections for mothers and newborns, mental heath parity, and reconstructive surgery following a mastectomy; and prohibition of discrimination on the basis of genetic information.

This section also states that a HAPI plan shall not establish rules for eligibility for enrollment based on genetic information, and premiums and personal responsibility payments cannot be adjusted based on genetic information. A plan cannot request or require an individual to have a genetic test.

Section 113: **Updating Healthy Americans Private Insurance Plan Requirements**: The Secretary of Health and Human Services (HHS) shall create a 15-person advisory committee that will report annually to Congress and the Secretary concerning modifications to benefits, items and services. The committee members will include a health economist; an ethicist; health care providers including nurses and other non-physician providers; health insurance issuers; health care consumers; a member of the U.S. Preventive Services Task Force; and an actuary.

Subtitle C – ELIGIBILITY FOR PREMIUM AND PERSONAL RESPONSIBILITY CONTRIBUTION SUBSIDIES

Section 121: **Eligibility for Premium Subsidies**: Individuals and families with modified adjusted gross incomes of 100% of poverty ($9,800 individual, $20,000 for a family of four) and below will be eligible for a full subsidy with which to purchase health insurance. For individuals and families with income between 100% of poverty and 400% of poverty ($39,200 for an individual, $52,800 for a couple and $80,000 for a family of four), subsidies will be provided on a sliding scale.

[Note: To calculate the subsidy level, the individual or family would first subtract the health deductions and a deduction for children in the family to determine the modified adjusted gross income. See deductions in Section 664.]

Individuals have 60 days to notify the HHA that there has been a change in income which may make them eligible or ineligible for the subsidy. States may also develop other mechanisms to ensure individuals do not have a break in coverage due to a catastrophic financial event.

Section 122: **Eligibility for Personal Responsibility Contribution Subsidies**:

Full subsidy: Individuals who have a modified adjusted gross income below 100 percent of poverty will receive a subsidy amount equal to the full amount of any personal responsibility contributions.

Partial subsidy: For individuals with modified adjusted gross incomes at or above 100 percent of poverty an HHA may provide a subsidy equal to the amount of any personal responsibility contributions the person incurs.

Section 123: **Definitions and Special Rules:**

The term modified adjusted gross income means adjusted gross income as defined in the Internal Revenue Code increased by the amount of interest received during the year and the amount of any Social Security benefits received during the taxable year.

Taxable year to be used to determine modified adjusted gross income is determined by the individual's most recent income tax return and other information the Secretary may require.

Poverty Line is the meaning given in the Community Health Services Block Grant.

The Secretary shall promulgate regulations to be used by the HHAs to calculate premium subsides and personal responsibility subsidies for individuals whose modified adjusted gross income is significantly lower than for the previous year being used to calculate the premium subsidy.

Special Rule for Unlawfully Present Aliens: Subsidies may not go to adult illegal aliens.

Special Rule for Aliens: If an alien owes either a premium payment or a penalty, the alien's visa may not be renewed or adjusted.

Bankruptcy: Debts created by failing to pay premiums are not dischargeable through bankruptcy.

Subtitle D – WELLNESS PROGRAMS

Section 131: **Requirements for Wellness Programs**:

Defining Wellness: Wellness programs must consist of a combination of activities designed to increase awareness, assess risks, educate and promote voluntary behavior change to improve the health of an individual, modify his or her consumer health behavior, enhance his or her personal well-being and productivity, and prevent illness and injury.

Discounts on premiums: Individuals who participate successfully in approved wellness programs are eligible for a discounted premium, including rewarding parents if their child participates in an approved wellness program. Determinations concerning successful participation by an individual in a wellness program shall be made by the plan based on a

retrospective review of the activities the individual participated in and the plan may require a minimum level of successful participation.

A plan may choose to provide discounts on personal responsibility contributions.

Wellness programs approved by the insurer must be offered to all enrollees and permit enrollees an opportunity to meet a reasonable alternative participation standard if it is medically inadvisable to attempt to meet the initial program standard. Participation in wellness programs cannot be used as a proxy for health status.

To be an approved wellness program, the program must be designed to promote good health and prevent disease, is approved by the HAPI plan, and is offered to all enrollees.

Employers may deduct the costs of offering wellness programs or worksite health centers.

TITLE II: HEALTHY START FOR CHILDREN

Subtitle A – BENEFITS AND ELIGIBILITY

Section 201: **General Goal and Authorization of Appropriations for HAPI Plan Coverage for Children**: The general goal of Healthy Start is to ensure all children receive health coverage that is good quality, affordable and includes prevention-oriented benefits.

Funds needed for this section are to be appropriated.

If a child is in a family with an income of 300% or below and the child does not have coverage, Healthy Start shall ensure the child is enrolled in a plan. The States and insurers shall create a separate class of coverage for children not enrolled in a plan by an adult. A child is defined as those under the age of 18 or in the case of foster care, under the age of 21.

Section 202: **Coordination of Supplemental Coverage under the Medicaid Program to HAPI Plan Coverage for Children**: If a child was receiving services through Medicaid that are not offered through the private coverage offered through Health Help, Medicaid will continue to provide that assistance. This includes Early Periodic Screening Diagnosis and Treatment (EPSDT) services.

Subtitle B – SERVICE PROVIDERS

Section 211: **Inclusion of Providers under HAPI Plans**: Children receiving care though school based health centers, other centers funded through Public Health Service Act, rural health clinics or an Indian Health Service facility will be provided services at no cost or HAPI plans will reimburse the providers for the services.

Section 212: **Use of, and Grants for, School Based Health Centers**: Creates and defines school based health centers and provides for grants to develop more school based health centers.

School based health centers must be located in elementary or secondary schools, operated in collaboration with the school in which the center is located; administered by a community-based organization including a hospital, public health department, community health center, or nonprofit health care agency. The school based health center must provide primary health care services including health assessments, diagnosis and treatment of minor acute or chronic conditions and Healthy Start benefits; and mental health services. Services must be available when the school is open and through on call coverage. Services are to be provided by appropriately credentialed individuals including nurse practitioner, physician assistant, a mental health professional, physician or an assistant. Centers must use electronic medical records by January 1, 2010. In addition, the centers may also provide preventive dental services consistent with State licensure law through dental hygienists or dental assistants.

School based health centers may provide services to students in more than one school if it is determined to be appropriate.

A parent must give permission for the child to receive care in a school based health center. Centers may seek reimbursement from a third party payer including HAPI plans. Fund received from third party payer reimbursement shall be allocated to the center in which the care was provided.

Development Grants: The Secretary shall provide grants to local school districts and communities for the establishment and operation of school based health centers. The Secretary shall give priority to applicants who will establish a school based health center in a medically underserved areas or areas for which there are extended distances between the school involved and appropriate providers of care for children; services students with the highest incidence of unmet medical and psycho social needs; and can demonstrate that funding state, local or community partners have provided at least 50 percent of the funding for the center to ensure the ongoing operation of the center.

Federal Tort Claims Act: A health care provider shall have malpractice coverage through the Federal Tort Claims Act for services provided through a school based health center.

TITLE III: BETTER HEALTH FOR OLDER AND DISABLED AMERICANS

Subtitle A – ASSURANCE OF SUPPLEMENTAL MEDICAID COVERAGE

Section 301: **Coordination of Supplemental Coverage under the Medicaid Program for Elderly and Disabled Individuals**: The Secretary shall provide guidance to States and insurers that takes into account the specific health care needs of elderly and disabled

individuals who receive Medicaid benefits so that Medicaid may provide services not provided by HAPI plans.

Subtitle B – EMPOWERING INDIVIDUALS AND STATES TO IMPROVE LONG-TERM CARE CHOICES

Section 311: **New, Automatic Medicaid Option for State Choices for Long-Term Care**: If a State decides to do a waiver similar to the Vermont waiver which allows individuals to have access to home and community based services, so long as the State meets criteria specified, the State may automatically implement the program.

Section 312: **Simpler and more Affordable Long-Term Care Insurance Coverage**: This section creates Medigap-like models for tax qualified long term care policies and adds additional consumer protections.

A Qualified Long Term Care Plan is a plan that meets the standards and requirements developed by either the National Association of Insurance Commissioners (NAIC) or by federal regulations.

Development of Standards and Requirements: Within 9 months after the date of enactment, the NAIC should adopt a model regulation to regulate limitations on the groups or packages of benefits that may be offered under a long term care insurance policy; uniform language and definitions; uniform format to be used in the policy with respect to benefits; and other standards required by the Secretary of HHS.

If NAIC does not adopt a model regulation with the 9-month period, the Secretary shall promulgate regulations within 9 months that do the same as the above section. In developing standards and requirements, the Secretary shall consult with a working group of representatives of long term care insurers, beneficiaries and consumer groups, and other individuals.

Limitations on Groups and Packages of Benefits: The model regulation or federal regulation shall provide for the identification of a core group of basic benefits common to all policies and the total number of different benefit packages and combination of benefits that maybe offered as a separate benefit package may not exceed 10.

The objectives that need to be balanced in developing the packages are: to simplify the market to facilitate comparisons among policies; avoiding adverse selection; provide consumer choice; provide market stability and promote competition.

The requirements would go into effect no later than one year after the date NAIC or the Secretary adopts the standards.

Required State Legislation: State legislatures would adopt the standards.

Additional Consumer Protections: This section amends the 1993 NAIC model regulation and model Act to require additional consumer protections for qualified long term care policies concerning, guaranteed renewal or noncancelability; prohibitions on limitations and exclusions, continuation or conversion of coverage, unintentional lapse, probationary periods, preexisting conditions, and other issues.

Any person selling a long term care insurance policy shall make available to dale a policy with only the core group of basic benefits.

TITLE IV: HEALTHIER MEDICARE

Subtitle A – AUTHORITY TO ADJUST AMOUNT OF PART B PREMIUM TO REWARD POSITIVE HEALTH BEHAVIOR

Section 401: **Authority to Adjust Amount of Medicare Part B Premium to Reward Positive Health Behavior**: The Secretary may adjust Part B premiums for an individual based on whether or not the individual participates in healthy behaviors, including weight management, exercise, nutrition counseling, refraining from tobacco use, designating a health home, and other behaviors determined appropriate by the Secretary. In adjusting the Part B premium, the Secretary must ensure budget neutrality and the aggregate must be equal to 25% of premium paid (as in current law).

Subtitle B – PROMOTING PRIMARY CARE FOR MEDICARE BENEFICIARIES

Section 411: **Primary Care Services Management Payment**: This section requires the Secretary to create a primary care management fee for providers who are designated the health home of a Medicare beneficiary and who provide continuous medical care, including prevention and treatment, and referrals to specialists. This section is cross referenced in the chronic care disease management section so that primary care physicians providing chronic disease management may receive the primary care services management fee for those services. The amount of the payment will be determined by the Secretary in consultation with MedPAC.

Requirement for Designation as a Health Home: The management fee shall be provided if the beneficiary has designated the provider as a health home. A health home is a provider that a Medicare beneficiary has designated to monitor the health and health care of the senior.

Subtitle C – CHRONIC CARE DISEASE MANAGEMENT

Section 421: **Chronic Care Disease Management**: This section requires Medicare to have a chronic disease management program available to all Medicare beneficiaries no later than January 1, 2008. The program must cover the 5 most prevalent diseases. Physicians who are not primary care providers, but do provide chronic disease management may receive an additional payment for providing chronic disease management. The fee will be determined by the Secretary in consultation with MedPAC.

The Secretary shall establish procedures for identifying and enrolling Medicare beneficiaries who may benefit form participation in the program.

Section 422: **Chronic Care Education Centers**: This section creates Chronic Care Education Centers to serve as clearinghouses for information on health care providers who have expertise in the management of chronic disease.

Subtitle D – PART D IMPROVEMENTS
CHAPTER 1

Section 431: **Negotiating Fair Prices for Medicare Prescription Drugs** (based on Snowe-Wyden MEND bill): This section provides the Secretary with authority to negotiate prices with manufacturers of prescription drugs. The Secretary must negotiate for fall back plans and if a plan requests assistance. However, the authority to negotiate is not limited to these two scenarios. Specifies no uniform formulary or price setting is permitted. Savings are to go towards filling the coverage gap or deficit reduction.

Section 432: **Process for Individuals Entering the Medicare Coverage Gap to Switch to a Plan that Provides Coverage in the Gap** (based on Snowe-Wyden Lifeline Act to permit people to change plans if they hit the donut hole): Permits individuals to change plans if they hit the coverage gap. In addition, the section requires the Secretary to notify individuals they are getting close to the coverage gap and what their options are. This provision would sunset five years after enactment.

Subtitle E – IMPROVING QUALITY IN HOSPITALS FOR ALL PATIENTS

Section 441: **Improving Quality in Hospitals for All Patients**: Within two years after enactment, hospitals must demonstrate to accrediting bodies improvements in quality control that include: rapid response teams; heart attack treatments; procedures that reduce medication errors; infection prevention; procedures that reduce the incidence of ventilator-related illnesses; and other elements the Secretary wishes to add.

Within two years after enactment, the Secretary shall convene a panel of independent experts to ensure hospitals have state of the art quality control that is updated on an annual basis.

Subtitle F: END-OF-LIFE CARE IMPROVEMENTS

Section 451: **Patient Empowerment and Following a Patient's Health Care Wishes:** Within two year after enactment, health care facilities receiving Medicare funds must provide each patient with a document designed to promote patient autonomy by documenting the patient's treatment preferences and coordinating these preferences with physician orders. The document must transfer with the patient from one setting to another; provide a summary of treatment preferences in multiple scenarios by the patient or the patient's guardian and a physician or other practitioner's order for care; is easy to read in an emergency situation; reduces repetitive activities in complying with the Patient

Self Determination Act; ensures that the use of the document is voluntary by the patient or the patient's guardian; is easily accessible in the patient's medical chart and does not supplant State health care proxy, living wills or other end of life care forms.

Section 452: **Permitting Hospice Beneficiaries to Receive Curative Care**: Changes the current Medicare requirement that to choose hospice an individual must give up curative care. Instead, an individual may continue curative care while receiving hospice.

Section 453: **Providing Beneficiaries with Information Regarding End-of-Life Care Clearinghouse**: When signing up for Medicare, the Secretary shall refer people to the clearinghouse described in this Act.

Section 454: **Clearinghouse**: The Secretary shall establish a national toll-free information clearing house that the public may access to find out State-specific information regarding advance directives and end-of-life care decisions. If such a clearinghouse exists and is administered by a not-for-profit organization the Secretary must support that clearing house instead of creating a new one.

Subtitle G: Additional Provisions

Section 461: Additional Cost Information: The Secretary of HHS shall require Medicare Advantage Organizations to aggregate claims information into episodes of care and to provide the information to the Secretary so costs for specific hospitals and physicians may be measured and compared. The Secretary shall make the information public on an annual basis.

Section 462: Reducing Medicare Paperwork and Regulatory Burdens: Not later than 18 months after the date of enactment, the Secretary shall provide to Congress a plan for reducing regulations and paperwork in the Medicare program. The plan shall focus initially on regulations that do not directly enhance the quality of patient care provided under Medicare.

TITLE V: STATE HEALTH HELP AGENCIES

Section 501: **Establishment**: Each state will establish a Health Help Agency to administer HAPI plans. States must establish an HHA in order to get transition payments to develop them.

Section 502: **Responsibilities and Authorities**: Health Help Agencies shall promote prevention and wellness through education; distribution of information about wellness programs; making available to the public the number of individuals in each plan that have chosen a health home; and promoting the use and understanding of health information technology.

Enrollment Oversight: Each HHA shall oversee enrollment in plans by: providing standardized unbiased information on plans available; administering open enrollment

periods; assisting changes required by birth, divorce, marriage, adoption or other circumstances that may affect the plan a person chooses; establishing a default enrollment process; establishing procedures for hospitals and other providers to report individuals not enrolled in a plan; ensuring enrollment of all individuals; developing standardized language for plan terms and conditions to be used; providing enrollees with a comparative document of HAPI plans; and assisting consumers in choosing a plan by publishing loss ratios, outcome data regarding wellness programs, and disease detection and chronic care management programs categorized by health insurer.

The HHA will determine and administer subsidies to eligible individuals and collect premium payments made by or on behalf of individuals and send the payments to the plans.

HHAs shall empower individuals to make health care decisions by providing State-specific information concerning the right to refuse treatment and laws relating to end-of-life care decisions; and by providing access to State forms.

Each HHA will establish plan coverage areas for the State.

States that share one or more metropolitan statistical areas may enter into agreements to share responsibilities for administration.

States will have to work with the Secretary of HHS to ensure transition from Medicaid and SCHIP is orderly and that individuals receiving other benefits from Medicaid continue to do so.

Section 503: **Appropriations for Transition to State Health Help Agencies**: States will receive federal funds to establish HHAs for two full fiscal years. States may assess insurers for administrative costs of running their HHAs.

TITLE VI – SHARED RESPONSIBILITIES

Subtitle A – INDIVIDUAL RESPONSIBILITIES

Section 601: **Individual Responsibility to Ensure HAPI Plan Coverage**: Individuals must enroll themselves and their children in a plan during open enrollment periods; submit documentation to the HHA to determine premium and personal responsibility contribution subsidies; pay the required premium and personal responsibility contributions; and inform the HHA of any changes that affect family status or residence.

Subtitle B – EMPLOYER RESPONSIBILITIES

Section 611: **Health Care Responsibility Payments**: Reorders and changes the IRS code.

Subchapter A: **Employer Shared Responsibility Payments:**
Section 3411: **Payment Requirement**: **Employer Shared Responsibility Payments:**
Every Employer must make an employer shared responsibility payment (ESR) for each calendar year in the amount equal to the number of full time equivalent employees employed by the employer during the previous year multiplied by a percentage of the average HAPI plan premium amount. The percentage used is determined by size and revenue per employer.

Once in effect, the percentages employers would pay are:

Large employers:

0-20th percentile	17%
21st - 40th percentile	19%
41st - 60th percentile	21%
61st-80th percentile	23%
81st-99th percentile	25%

Small employers:

0-20th percentile	2%
21st - 40th percentile	4%
41st - 60th percentile	6%
61st-80th percentile	8%
81st-99th percentile	10%

At the beginning of each calendar year, the Secretary in consultation with the Secretary of Labor shall publish a table based on a sampling of employers to be used in determining the national percentile for revenue per employee amounts.

Transition Rates: Employers who offered health insurance prior to enactment will contribute "make good" payments to their employees. The payments will be equal to the cash value of the health insurance provided and the amount will be added to the employee's wages. These employers will not be required to make any other payments in the first two years.

If an employer did not provide health insurance to employees prior to this legislation, the employer shared responsibility payment for the first year will be equal to one-third of the amount otherwise required and the payment for the second year will be two thirds of the amount required.

Employer Shared Responsibility Credit: The Secretary may provide a credit to private employers who provided health insurance benefits greater than the 80th percentile of the national average in the 2 years prior to enactment, can demonstrate the benefits provided encouraged prevention and wellness activities and continue to provide wellness programs.

Section 3412: Instrumentalities of the United States: State and local governments must make employer shared responsibility payments.

Subchapter B: **Individual Shared Responsibility Payments**

Section 3421: **Amount of Payment**: Every individual shall pay an amount equal to the premium amount they owe.

Section 3422: **Deduction of Individual Shared Responsibility Payment from Wages**: Employers may deduct the amount of the payment for premiums from their employees' wages.

Subchapter C: **General Provisions**
Section 3431: **Definitions and Special Rules**: Provides definitions

The average HAPI plan premium used to compute employer responsibility payments will be a simple average of all four premium classes (individuals, married, head of household and family)

All individuals who perform work for an employer for more than three months in the previous calendar year and who meet the definition of common law employee, either full or part time, will be counted toward the employer's total employees when determining the employer shared responsibility payments.

Section 3431: **Definitions and Special Rules**: Provides definitions

Section 3432: **Labor Contracts**: In general these provisions do not apply to collective bargaining agreements until the earlier of 7 years after the date of enactment or the date the collective bargaining agreement expires.

Section 612: **Distribution of Individual Responsibility Payments to HHAs**: The Treasury will provide to each HHA an amount equal to the amount of individual shared responsibility payments made through the tax code by each eligible individual.

Subtitle C – INSURER RESPONSIBILITIES

Section 621: **Insurer Responsibilities**: To offer a HAPI plan through an HHA, insurers will be required to: implement and emphasize prevention, early detection and chronic disease management; ensure wellness programs are available; demonstrate how provider

reimbursement methodology achieves quality and cost efficiency; ensure a physical and a care plan are available to the individual; ensure enrollees have the opportunity to designate a health home and make public how many enrollees have designated a health home; create a medical record if the patient wants one; comply with loss ratios established; use common claims form and billing practices; make administrative payments the State requires for the operation of its HHA; provide discounts and incentives for the parent if the child participates in a wellness program; report outcome data on wellness programs, disease detection and chronic care management, and loss ratio information; send large hospital bills to patients with a contact name so the patient can contact a person to discuss questions or complaints; and provide HHA with information concerning the plans offered.

Insurers must use standardized common claim forms prescribed by the State HHA chronic care programs offered must help provide early identification and management. Each program will use a uniform set of clinical performance standards.

Insurers must report performance and outcomes of chronic care management programs and loss ratios. Loss ratios will be defined by the Secretary in consultation with NAIC, consumers, and insurers.

Defines administrative expenses as including all taxes, reinsurance premiums, medical and dental consultants used in the adjudication process, concurrent or managed care review when not billed by a health provider and other forms of utilization review, the cost of maintaining eligibility files, legal expenses incurred in the litigation of benefit payments and bank charges for letters of credit.

The cost of personnel, equipment and facilities directly used in the delivery of health care services, payments to HHAs and the cost of overseeing chronic disease management programs and wellness programs are not included in the definition of administrative costs.

Subtitle D – STATE RESPONSIBILITIES

Section 631: **State Responsibilities**: States must: designate or create a Health Help Agency; ensure HAPI plans are sold through the HHA and comply with requirements (there must be at least two HAPI plans offered); develop mechanisms for enrollment and the collection of premiums; ensure enrollment and develop methods to check on enrollment status; implement mechanisms to enforce the individual responsibility to purchase coverage (but this may not include revocation of insurance); and implement a way to automatically enroll individuals who are not covered and seek care in emergency departments.

States will continue to apply State law on consumer protections and licensure.

States must continue a maintenance of effort so they are required to contribute 100 percent of what they spent on health services prior to enactment.

Section 632: **Empowering States to Innovate through Waivers**: A State may be granted a waiver if the legislature enacts legislation or the State approves through ballot initiative a plan to provide heath care coverage that is at least as comprehensive as required under a HAPI plan. If the State submits a waiver to the Secretary, the Secretary must respond no later than 180 days and if the Secretary refuses to grant a waiver, the Secretary must notify the State and Congress about why the waiver was not granted.

Subtitle E –FEDERAL FALLBACK GUARANTEE RESPONSIBILITY

Section 641: **Federal Guarantee of Access to Coverage**: If a State does not establish an HHA and have a system up within two years, the Secretary shall establish a fallback plan so individuals can still receive a HAPI plan.

Subtitle F – FEDERAL FINANCING RESPONSIBILITIES

Section 561: **Appropriation for Subsidy Payments**: Appropriations will be made each year to fund the insurance premium subsides.

Section 652: **Recapture of Medicare and 90 Percent of Medicaid Federal DSH Funds to Strengthen Medicare and Ensure Continued Support for Public Health Programs**: All of Medicare DSH stops and remains in the Part A Trust Fund.

Medicaid DSH continues at 10 percent of current levels. The amount not spent is put into a new trust fund, the "Healthy Americans Public Health Trust Fund."

Section 9511: **Healthy Americans Public Health Trust Fund**: The Treasury shall establish a trust fund in which the funds that would have been spent on Medicaid DSH will now go. This trust fund will be used only for premium and personal responsibility payment subsidies and to States for a bonus payment if they adopt certain medical malpractice reforms. Any additional amounts will go toward reducing the federal budget deficit.

Subtitle G – TAX TREATMENT OF HEALTH CARE COVERAGE UNDER HEALTHY AMERICANS PROGRAM; TERMINATION OF COVERAGE UNDER OTHER GOVERNMENTAL PROGRAMS AND TRANSITION RULES FOR MEDICAID AND SCHIP

PART 1: Tax Treatment of Health Care Coverage Under Healthy Americans Program

Section 661: **Limited Employee Income and Payroll Tax Exclusion for Employer Shared Responsibility Payments, Historic Retiree Health Contributions, and Transitional Coverage Contributions**: The following payments made by employers are not taxable as income to their employees: 1) shared responsibility payments by employers; 2) payments for coverage of retirees under existing retiree health plans; 3) payments for continuing employer-provided health plans under existing collective

bargaining agreements; and 4) payments for employer-provided coverage for long-term care.

Section 662: **Exclusion for Limited Employer-Provided Health Care Fringe Benefits**: The value of employer-provided wellness programs and on-site first aid coverage for employees is not taxable as income to the employees.

Section 663: **Limited Employer Deduction for Employer Shared Responsibility Payments, Retiree Health Contributions and other Health Care Expenses**: Limits the current employer deduction for the costs of employee health care coverage to the following: 1) shared responsibility payments made by employers; 2) coverage of retirees under existing retiree health plans; 3) continuing employer-provided health plans under existing collective bargaining agreements; 4) employer-provided wellness programs; and 5) on-site first aid coverage for employees.

Section 664: **Health Care Standard Deduction**: Creates a new Health Care Standard Deduction. Taxpayers can claim this deduction and reduce the amount they pay in taxes whether they file an itemized tax return or take the standard deduction. The amount of the deduction a taxpayer can claim depends on the class of health care coverage the taxpayer has. The deduction is indexed to the consumer price index with the deduction amounts initially set as follows:

> Individual coverage - $6,025
> Married couple or domestic partnership coverage - $12,050
> Unmarried individual with dependent children - $8, 610 plus $2,000 for each dependent child
> Married couple or domestic partnership (as determined by a State) with dependent children - $15,210 plus $2,000 for each dependent child

The deduction can be claimed by individuals and families with incomes greater than the poverty line. Both the health care and the healthy child deduction are phased in starting from 100-400 percent of poverty. The deduction begins phasing out starting at $62,500 ($125,000 in the case of a joint return) and is fully phased out at $125,000 ($250,000 in the case of a joint return). The deduction will be adjusted for inflation

Section 665: **Modification of Other Tax Incentives to Complement Healthy Americans Program**: Sunsets the following tax breaks for health care: tax credit for health insurance costs of individuals; coverage of health care benefits under "cafeteria plans"; and Archer Medical Savings Accounts. This section also allows Health Savings Accounts in conjunction with high deductible Healthy Americans Private Insurance plans and long-term care benefits to be provided tax-free to workers through cafeteria plans.

Section 666: **Termination of Certain Employer Incentives When Replaced by Lower Health Care Costs**: Beginning 2 years after enactment, terminates tax provisions relating to income attributable to domestic production activities, relating to tax-exempt status of voluntary employees' beneficiary associations, and relating to inventory

property sales source rule exception, and the deferral of active income of controlled foreign corporations.

Part II: Termination of Group Coverage under other Governmental Programs and Transition Rules for Medicaid and SCHIP

Sections 671-673: eliminates group coverage, FEHBP, Medicaid (except for its wrap around and long term care functions) and SCHIP.

TITLE VII: OTHER PROVISIONS

Subtitle A – EFFECTIVE HEALTH SERVICES AND PRODUCTS

Section 701: **One Time Disallowance of Deduction for Advertising and Promotional Expenses for Certain Prescription Pharmaceuticals**: If a drug is new and on the market, there is no tax deduction for advertising unless it is being studied for comparison effectiveness. If the drug is already on the market it must inform consumers that a generic will be on the market if the drug is coming off patent.

Section 702: **Enhanced New Drug and Device Approval**: Drugs and devices get additional exclusivity or additional patent protection if they submit comparison effectiveness as part of their application to the Food and Drug Administration.

Section 703: **Medical Schools and Finding What Works in Health Care**: Medical schools and other researchers may post on a website run by Agency Healthcare Research and Quality (AHRQ) evidence-informed best practices. AHRQ will run a pilot program to find ways to get that information into the curricula of medical schools.

Section 704: **Finding Affordable Health Care Providers Nearby**: Creates a website so individuals can find affordable high quality providers by zip code. The website can begin with the providers who report under pay for performance efforts and then be broadened out to include all providers using uniform care standards developed in consultation with Quality Improvement Organizations (QIOs).

The affordability standard would be developed by the Secretary in consultation with insurers.

Subtitle B – OTHER PROVISIONS TO IMPROVE HEALTH CARE SERVICES AND QUALITY

Section 711: **Individual Medical Records**: Individuals own their medical records.

Section 712: **Bonus Payment for Medical Malpractice Reform**: If a State adopts certain reforms the State may get additional funds. Those reforms are: (1) require an individual who files a malpractice action in state court have the facts of their case

reviewed by a panel with not less than one qualified medical expert chosen in consultation with the State Medicare quality improvement organization or physician specialty whose expertise is appropriate for the case; not less than one legal expert and not less than one community representative to verify that a malpractice claim exists; (2) permit an individual to engage in voluntary non-binding mediation with respect to the malpractice claim prior to filing an action in court; (3) impose sanctions against plaintiffs and attorneys who file frivolous medial malpractice claims in courts; (4) prohibit attorneys who file three or more medical malpractice actions in states courts from filing others in state courts for a period of 10 years; and provides for the application of presumption of reasonableness if the defendant establishes that he or she followed accepted clinical practice guidelines established by the specialty or listed in the National Guideline clearinghouse.

The bonus payments must be used to carry out activities related to disease and illness prevention and for children's health care services.

TITLE VIII: CONTAINING MEDICAL COSTS

Section 801: **Cost-Containment Results of the Healthy Americans Act**: Summarizes what in the bill contains costs.

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