



DETAILED SUMMARY

INSURANCE REFORMS:

- **Insurance reforms.** Prohibits insurance rating based on health status or pre-existing conditions, and limits age rating to 2:1. Prohibits annual or lifetime limits on medical spending. Grandfathers current individual policies. Applies these reforms to the entire market (inside and outside the Exchange), although employers have a five-year grace period to come into compliance. Establishes important consumer protections, including internal and external appeal requirements, provider network adequacy requirements, and greater transparency by insurance companies.
- **Exchange.** Creates a new marketplace called the national “Health Insurance Exchange”, with an option for states that agree to meet federal standards to run their own exchange. U.S. Territories will also have the option of operating an exchange if they meet all of the insurance reforms and requirements as established by this Act.
- **Eligibility.** People are eligible to enter the Exchange and purchase health insurance on their own as long as they are not enrolled in employer sponsored insurance, Medicare or Medicaid. The Exchange is also open to businesses, starting with small firms and growing over time. Firms with twenty-five or fewer employees are permitted to buy in the Exchange in 2013, firms with fifty or fewer employees in 2014, and firms with at least one hundred employees in 2015 with discretion to the Commissioner to open the Exchange to larger businesses in that year and the future.
- **Benefits.** Outlines broad categories of covered services in the law, and creates a Health Benefits Advisory Commission, with physicians and other expert members, to help the Secretary of HHS define the essential benefit package. Cost-sharing varies by four tiers ranging in actuarial value (AV) from 70 percent to 95 percent (“basic,” “standard,” “premium,” and “premium plus”). In other words, in a 70 percent plan, the plan pays 70 percent of the costs and an individual would pay the other 30 percent of expenses on average. The fourth tier plan (“premium plus”) will offer additional benefits such as adult dental or vision, gym memberships, or private hospital rooms. All plans will limit annual out-of-pocket expenses for enrollees at a maximum of \$5,000 for an individual and \$10,000 for a family, with lower levels for lower- and middle-income families.
- **Public health insurance option.** The bill establishes a public health insurance option available within the Exchange to ensure choice, competition and accountability. Like other private plans, the public option must survive on its premiums. The Secretary of Health and Human Services will administer the public option and negotiate rates for providers that participate in the public option. The public health insurance option is provided startup administrative funding, but it is required to amortize these costs into future premiums to ensure it operates on a level playing field with private insurers.
- **New health insurance options.** The legislation authorizes start-up loans to assist states with the creation of health insurance co-operatives as an additional option. It also permits states to enter into agreements to allow for the sale of health insurance across state lines when the state legislatures agree to such compacts. Grants are also awarded to help states with this endeavor.

- **Repealing the antitrust exemption for insurers.** The bill promotes competition among health insurers and medical malpractice insurers by removing the antitrust exemption so that it no longer shields these insurers from liability for fixing prices, dividing up territories, or monopolizing their market.
- **Help for early retirees (temporary reinsurance program).** Creates a \$10 billion fund to finance a temporary reinsurance program to help offset the costs of expensive health claims for employers that provide health benefits for retirees age 55-64.
- **Limitation on post-retirement reductions of retiree healthcare benefits.** Prohibits employers from reducing retirees' health benefits after those retirees have retired, unless the reduction is also made to benefits for active participants.

SHARED RESPONSIBILITY:

- **Employers.** Employers must either provide health insurance to their employees or make a contribution to help fund affordable health insurance. Employers that choose to offer coverage contribute at least 72.5 percent of premium for workers, 65 percent for families. However, if the coverage is unaffordable for low-wage workers, that worker can choose subsidized coverage in the Exchange and the employer makes a contribution to the Exchange. Employers who do not offer qualified coverage contribute 8 percent of their payroll to help cover expenses of employees who seek coverage through the Exchange.
- **Small business protections.** Small businesses with annual payrolls below \$500,000 are exempt from requirements to offer or contribute to coverage, including the 8 percent payroll contribution for failure to provide health benefits to their workers. As a result of this exemption, 86 percent of America's businesses are exempt from any requirement to provide coverage to their employees. The 8 percent requirement is phased in for small businesses with an annual payroll between \$500,000 and \$750,000. There is also a tax credit program to help low-wage small businesses offer coverage to their employees.
- **Small business tax credits.** Small business tax credits are available for businesses with 10 or fewer employees and \$20,000 or less in average wages. The credits phase-out if the employer has 25 or more employees or if average wages are \$40,000 or more. The credits are available on rolling basis for the first two years that an employer offers qualified coverage.
- **Individuals.** Individuals are required to obtain health insurance coverage or pay a fee equal to lower of 2.5 percent of their adjusted income above the filing threshold or the average premium on the Exchange. Individuals and families below the income tax filing are exempt. *(NOTE: In 2009, the threshold for taxpayers under age 65 is \$9,350 for singles and \$18,700 for couples).* Individuals may apply for a hardship waiver if coverage is unaffordable and selected exemptions from the mandate are provided in the statute. Those with coverage through the VA or who are eligible for government-sponsored healthcare because they are a member of a tribe are considered to have fulfilled the requirement to obtain coverage.
- **Government responsibility.** It is the responsibility of the federal government to ensure that essential health coverage is affordable and available to all Americans by establishing consumer protections and insurance reforms, affordability credits and overseeing a fair marketplace for people to choose among options.

MAKING COVERAGE MORE AFFORDABLE:

- **Affordability credits.** Provides financial assistance for premiums and cost sharing for individuals and families with incomes up to 400 percent of the federal poverty level (FPL). Affordability credits are offered on a sliding scale such that premiums range from 1.5 percent of income at the lowest tier to 12 percent at

400 percent FPL. Provides additional assistance for households with incomes up to 400 percent FPL by limiting cost-sharing to 3 percent of plan costs at the lowest tier rising to 30 percent of plan costs at 350-400 percent of FPL. Specific out-of-pocket maximums are added to protect individuals at each income tier.

Income	Premium Limit as Percent of Income	Percent of Plan Costs Paid by Families	Annual Out-of-Pocket Cap Individual/Family
Under 133 - 150% FPL	1.5 – 3%	3%	\$500/\$1000
150 - 200% FPL	3 – 5.5%	7%	\$1,000/\$2,000
200 - 250% FPL	5.5 – 8%	15%	\$2,000/\$4,000
250 - 300% FPL	8 – 10%	22%	\$4,000/\$8,000
300 - 350% FPL	10 – 11%	28%	\$4,500/\$9,000
350 - 400% FPL	11 – 12%	30%	\$5,000/\$10,000

- **Eligibility.** Affordability credits are available to American citizens and legal residents whose employers do not offer coverage or whose share of employer-sponsored health insurance costs more than 12 percent of their family income. Those eligible for other government health care programs, such as Medicare or Medicaid, cannot receive affordability credits. Establishes a mechanism by which the Commissioner must verify that individuals are citizens or legal immigrants in order to receive affordability credits.
- **Caps out-of-pocket spending and limits.** Helps prevent medical bankruptcy by limiting out-of-pocket costs to no more than \$5,000 for individuals and \$10,000 for families; these levels are indexed to inflation. Those receiving affordability credits have lower out-of-pocket caps.
- **Medicaid and CHIP.** Expands Medicaid coverage to everyone within income at or below 150 percent FPL (\$33,100 per year for a family of 4) who is not eligible for Medicare. Eliminates assets tests for eligibility groups other than for long-term care. Requires States that now cover those above 150 percent FPL to maintain eligibility. States receive full federal funding for costs of expansion populations in 2013 and 2014. Thereafter, States pay 9 percent and the federal government pays 91 percent. CHIP-eligible children move to the Exchange or Medicaid in 2014.

FINANCING:

- **Revenue.** The bill would impose a surcharge on taxpayers with adjusted gross income in excess of \$1 million (married filing a joint return) and \$500,000 (single) at a rate of 5.4 percent. The bill also: delays implementation of worldwide interest allocation until 2020; limits eligibility for reduced treaty withholding rates; codifies economic substance doctrine; information reporting for payments made to corporations; eliminates nontaxable reimbursements of over the counter medications from HSAs, HRAs, and health FSAs; limits contributions to health FSAs to \$2,500; increases the penalty for non-health related distributions from HSAs (from 10 percent to 20 percent); eliminates the tax deduction for employers who receive a government subsidy for providing retiree prescription drug coverage; impose an excise tax of 2.5 percent on medical devices used in the United States; and ensures tax parity for employer-provided coverage for domestic partners and other non-dependents. The bill also clarifies that an employee's share of premiums for employer-provided coverage offered through the Exchange may be paid on a pre-tax basis through a cafeteria plan, but Exchange coverage that is not employer-offered is not eligible to be offered through a cafeteria plan.

MEDICARE

The Affordable Health Care for America Act proposes major improvements and investments in the Medicare program. It closes the donut hole while providing discounted drugs to beneficiaries; protects the doctor-patient relationship for Medicare patients by promoting primary care, care coordination and other payment reforms; and promotes wellness by eliminating cost-sharing for preventive services and increasing access to vaccines. In addition, Affordable Health Care for America Act strengthens Medicare by extending solvency of the Trust Fund for five years through its provisions that attack waste, fraud and abuse and reform the payment and delivery systems.

PART A:

- **Hospitals.** Substantial delivery and payment system reforms, including productivity adjustments and reductions in market basket updates for most providers, per recommendations from MedPAC, OIG, GAO and others.
- **Skilled nursing facilities.** Follows recommendations from MedPAC and others to encourage payment accuracy that more accurately reflects the costs of services provided. Nursing home transparency provisions provide regulators and families additional information on nursing home ownership and control and more information on nursing home staffing and quality through Nursing Home Compare. Tougher penalties on nursing homes that fail to provide adequate care to their residents and improved training for nursing home staff to increase quality of care. See Medicaid section for additional nursing facility-related policies.
- **Medicare DSH payments.** Directs the Secretary of HHS to study Medicare DSH payments and report to Congress with recommendations on how best to ensure that DSH is properly targeted to adequately reflect the higher costs of care associated with treating low-income patients. Reduces Medicare DSH payments starting in 2017 if the uninsured rate drops by a certain number of percentage points between 2012 and 2014.
- **Graduate medical education.** Provides incentives for the training of primary care physicians. Encourages medical residency training in non-hospital settings so that the future physicians of America will be able to provide coordinated care across the spectrum of provider settings.
- **Hospice moratorium.** Extends a one year moratorium on regulatory changes that would phase out the budget neutrality adjustment factor for Hospice providers to ensure that hospices continue to receive the same reimbursement rate for wages for fiscal year 2010.

PARTS A & B:

- **Reducing potentially preventable hospital readmissions.** Changes payment incentives to hospitals and post-acute care providers to discourage preventable hospital readmissions.
- **Post-acute care bundling.** Promotes bundled payments that encourage providers to coordinate a patient's care across the entire spectrum, from the doctor's office, to the hospital, through a rehabilitative or nursing facility stay, and back to home.
- **Center for Medicare & Medicaid Innovation.** Establishes a Center for Medicare & Medicaid Innovation to empower CMS to pursue additional payment and delivery system reforms.
- **Healthcare-associated infections.** Requires hospitals and ambulatory surgical centers to report public health information on healthcare-associated infections to the Centers for Disease Control and Prevention.

- **IOM study of the appropriateness of Medicare payment rates based on geography.** Within one year of enactment, the Institute of Medicine is required to report to CMS on the validity of the geographic adjusters that apply to Medicare physician and hospital payments and include any recommendations for improvements. CMS is instructed to respond to such recommendations and may spend up to \$4 billion per year, for two years, to increase payment rates as appropriate.
- **IOM study of the extent of geographic variation in health spending.** Instructs the IOM to study the extent and cause of geographic variation in spending on health care (including all payers). The study will focus on major contributors to that variation such as input prices, health status, socioeconomic factors, and access to services. The IOM will make recommendations for addressing such variation in Medicare, which will take into account the need to maintain beneficiary access to services. CMS will implement changes to Medicare payment systems unless Congress votes to disapprove the planned changes.
- **Home health study.** Requires MedPAC to undertake a study to examine the significant variation in Medicare margins among home health agencies. Factors considered will include patient characteristics (including health and socioeconomic factors), agency characteristics, and the types of services provided by different agencies.

PART B:

- **Productivity adjustments.** Expands productivity adjustments to Medicare providers who receive CPI updates in addition to those that receive market basket updates. These providers are: ambulatory surgical centers, ambulances, clinical laboratories, and durable medical equipment not competitively bid.
- **Hospital outpatient department updates.** Expands productivity adjustments to hospital outpatient departments.
- **Accountable Care Organization program.** Establishes a new program that allows providers to share in Medicare savings they help create through care coordination and quality improvement initiatives. Ensures that doctors can join with hospitals and others when forming these organizations.
- **Telehealth.** Expands Medicare’s telehealth benefit to beneficiaries who are receiving care at freestanding dialysis centers. Also establishes a Telehealth Advisory Committee to provide HHS with additional expertise on the telehealth program.
- **Quality measures.** Creates a timely process to allow for a multi-stakeholder group to provide the Secretary with input into the selection of quality measures and provides for consultation by the Secretary of a consensus-based entity in the use of quality measures.
- **Demonstration program on shared decision making.** Uses decision aids and other technologies to help patients and consumers improve their understanding of the risks and benefits of treatment options and make informed decisions about medical care.
- **Medical home pilot program.** Creates a pilot program to reward providers who agree to provide services necessary to make their practice a “medical home” by ensuring full access to patients and providing for coordinated and comprehensive care.
- **Cost sharing for preventive services.** Eliminates deductibles and co-payments for all preventive services covered by the Medicare program.

- **Improved access to vaccines.** Makes it easier for Medicare beneficiaries to get access to needed vaccinations by covering all vaccines under Part B of the program rather than Part D.
- **Extend Qualified Individuals (QI) program.** Extends the QI program two years to help low-income beneficiaries pay their Part B premiums.
- **Extends months of coverage of immunosuppressive drugs for kidney transplant patients.** Lifts the current 36-month limitation on Medicare coverage of immunosuppressive drugs for kidney transplant patients who would otherwise lose this coverage on or after January 1, 2012.
- **Part B premium clarification.** Allows capital gains from the sale of a primary residence to count as a life-changing event for purposes of using a more recent tax year for determination of the Part B income-related premium so that the use of a nest egg doesn't increase the Part B premium owed.
- **Durable medical equipment in Medicare.** Provides protections for beneficiaries receiving oxygen therapy in the event an oxygen supplier goes out of business. Exempts certain pharmacies from the surety bond requirement and the need to be accredited to sell diabetic testing supplies and certain other items.
- **Payment for imaging services.** Instructs CMS to pay more accurately for imaging services in Medicare. Excludes low-tech imaging devices (such as ultrasound, mammograms, EKGs, and x-rays) from the adjustment in payment.

PARTS C & D:

- **Medicare Advantage payment.** Beginning in 2011, reduces MA payments over three years to achieve parity with 100 percent FFS rates; provides targeted bonuses to high-quality plans in high-enrollment areas where reductions likely to be most disruptive.
- **Medicare Advantage reforms.** Changes the annual enrollment period for beneficiaries to enroll in Medicare Advantage to November 1 – December 15.
- **Medicare Advantage administrative costs and consumer protections.** Beginning in 2014, requires MA plans to maintain medical loss ratios of at least 85 percent, ensuring that payments to plans are predominantly spent on providing healthcare, not overhead and profit. Limits Medicare Advantage cost-sharing to no greater than cost-sharing in traditional Medicare.
- **Medicare drug benefit.** Eliminates Part D donut hole over time and provides 50 percent discount in donut hole for Part D enrollees. Restores manufacturer rebate for Part D drugs used by dual eligibles, as well as low-income subsidy eligibles after 2015. Funds raised by this provision are used to close the Part D donut hole.
- **Medicare low-income subsidy.** Increases eligibility limits by raising assets test and clarifying what counts toward the asset test. Eliminates cost-sharing for certain non-institutionalized dual eligibles.
- **Encourage accurate dispensing of drugs.** Requires that Part D and MA-PD plans develop methods to reduce waste of drugs in the long-term care setting.
- **Increase use of generics.** Increases generic drug utilization by eliminating current requirements that prevent Part D and MA-PD plans from creating incentives for seniors to use lower-cost generic drugs.

OTHER:

- **Follow-on biologics.** Creates an FDA licensure pathway for "biosimilar" generic biological products, allowing these products to come to market and compete with brand name biologics. The biosimilar product must have no clinically meaningful differences in safety, purity or potency from the reference product, and may not be licensed until at least 12 years after the date that the brand-name product was licensed.
- **Physician Payment Sunshine.** Requires manufacturers or distributors to electronically report to the HHS OIG any payments or other transfers of value above a \$5 de minimis made to a "covered recipient" (physician, physician group practice, other prescribers, pharmacy or pharmacist, health insurance issuer, group health plan, pharmacy benefit manager, hospital, medical school, sponsor of a continuing medical education program, patient advocacy or disease specific group, organization of health care professionals, biomedical researcher, group purchasing organization.) Requires hospitals, manufacturers and group purchasing organizations to report the nature of ownership arrangements by physicians. Failure to report is subject to civil monetary penalties from \$1000 to \$10,000 (max \$150,000 per year) per payment, transfer of value, or investment interest not disclosed; penalties for knowing failure to report range from \$10,000 to \$100,000 per payment, not to exceed \$1,000,000 in one year or .1% of revenues for that year.
- **Comparative Effectiveness Research (CER).** Creates a new Center at the Agency for Healthcare Research and Quality, supported by a combination of public and private funding that will conduct, support and synthesize CER. An independent stakeholder Commission makes recommendations to the Center on research priorities, study methods, and ways to disseminate research. The Commission has its own source of funding and is responsible for evaluating the processes of the Center and is authorized to make reports directly to Congress. A majority of the Commission members would be required to be physicians, other health care practitioners, consumers or patients. The blended bill contains improved protections to ensure that subpopulations are appropriately accounted for in research study design and dissemination. The bill contains protections to prevent the Center and Commission from mandating payment, coverage or reimbursement policies. In addition, the bill contains protections to ensure that research findings are not construed to mandate coverage, reimbursement or other policies to any public or private payer, and clarify that federal officers and employees will not interfere in the practice of medicine.

REDUCING WASTE, FRAUD, AND ABUSE

Increases funding by \$100 million annually for the Healthcare Fraud and Abuse Control Fund to fight Medicare and Medicaid fraud; improves provider and payment screening to prevent fraud and abuse before it occurs; creates enhanced oversight for Medicare and Medicaid programs at risk of fraud and abuse; creates new penalties for providers and suppliers that defraud federal health care programs; partners with the private sector to reduce waste and abuse by requiring that all Medicare and Medicaid providers establish compliance programs to reduce waste, fraud, and abuse.

PREVENTION & WELLNESS

Creates a grant program to help small and mid-sized employers begin or strengthen workplace wellness programs. These grants will assist in improving the health of our nation's workforce and will reduce employer

health care costs. Participating employers must offer the programs to all employees and cannot mandate participation nor use participation as a condition to receive any financial incentive.

MEDICAID

(provisions relating to Health Care Reform are above)

- **Preventive services.** Requires State Medicaid programs to cover recommended preventive services without cost-sharing. States will receive their regular federal matching rate for the cost of these services.
- **Payments for primary care services.** Requires that physicians and other practitioners are paid for primary care services they provide to Medicaid patients at 100 percent of Medicare rates beginning in 2012. The federal government will pay 100 percent of the increased costs in 2012 through 2014, 90 percent thereafter.
- **Additional federal funds to states with high unemployment.** Assists States in maintaining access to Medicaid services during the recession by extending the current Recovery Act increase in federal Medicaid payments to states with high unemployment rates.
- **Coverage for HIV-positive individuals.** Allows State Medicaid programs to cover low-income individuals who are HIV positive through December 31, 2013, after which coverage will be available through the Health Insurance Exchange or, for those with incomes at or below 133 percent of poverty, Medicaid. States would receive the enhanced federal matching rate for these costs.
- **Nurse home visitation.** Allows State Medicaid programs to cover nurse home visitation services for first-time pregnant women and mothers with children under 2. The federal government would match these costs at the state's regular rate.
- **Increasing prescription drug rebates.** Increases the minimum percentage rebate on brand-name drugs to 23.1 percent of average manufacturer price; extends rebates to new formulations of brand-name drugs; and extends rebate requirement to drugs prescribed by Medicaid managed care organizations.
- **Reductions in Medicaid DSH payments.** Directs the Secretary of HHS to reduce Medicaid DSH payments to States by a total of \$10 billion (\$1.5 billion in FY 2017, \$2.5 billion in FY 2018, and \$6.0 billion in FY 2019) using a methodology that imposes the largest reductions on states with the lowest percentages of uninsured individuals or the least effective targeting of funds on DSH hospitals.
- **Payments to pharmacists.** Increases the ceiling on payments for generic drugs to 130 percent of the weighted average of monthly average manufacturer prices.
- **Medical home pilot program.** Establishes a 5-year pilot program to evaluate medical home models for beneficiaries including medically fragile children. A total of \$1.235 billion is made available for increased federal matching for administrative costs.
- **Managed care organizations.** Requires that Medicaid MCOs meet a medical loss ratio standard set by the Secretary of HHS at not less than 85 percent.
- **Territories.** Raises federal payment ceilings and matching rates for Puerto Rico, Virgin Islands, Guam, Northern Mariana Islands, and American Samoa by a total of \$10.35 billion from FY 2011 through 2019.
- **Supplemental payments to certain nursing facilities.** Directs the Secretary to make supplemental payments to nursing facilities with high percentages of Medicare and Medicaid residents that are

efficiently and transparently operated and that provide quality care. Provides a total of \$6 billion over the period 2010 through 2013 (\$1.5 billion each year) for this purpose. Directs the Medicaid and CHIP Payment and Access Commission (“MACPAC”) to study the adequacy of Medicaid payments to nursing facilities and to provide recommendations to the Congress by December 31, 2011.

- **Prohibitions on Medicaid and CHIP payment for undocumented immigrants.** Provides that the Medicaid title does not change current prohibitions against Federal Medicaid or CHIP payments for persons not lawfully present in the U.S.

PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

- **Funding for public health and workforce development.** Provides funds for years FY 2015 through FY 2019.
- **Community health centers.** Provides significant increases in funding for community health centers.
- **Primary care residencies in community health centers.** Establishes a new grant program to support the development and operation of primary care residency programs in community-based settings such as community health centers.
- **Health workforce.** Provides new and increased investments in training programs designed to increase the number of primary care physicians, nurses, and public health professionals.
- **Treatment of teaching as obligated service.** Provides discretionary authority to the Secretary to allow up to 20 percent of teaching time to count toward meeting obligated service requirements under the National Health Service Corps program. Provides increases in support for Corps scholarship and loan repayment programs.
- **Data collection and analysis on health disparities.** Directs a new Assistant Secretary for Health Information to set standards for the collection of data on a broad set of population and subpopulation categories and to facilitate and coordinate analyses of health disparities within HHS and in collaboration with other departments.
- **Community preventive services grants.** Establishes new grants program for states to provide prevention and wellness services to communities, with a special emphasis on health disparities.
- **Research and requirements for healthy behaviors and community wellness.** Provides for the research and inclusion of proven healthy behaviors in the essential benefits package and in community wellness programs.
- **School-Based health clinics.** Establishes a new grants program to support school-based health clinics that provide health services to children and adolescents.
- **Public health infrastructure.** Provides new investments in state, local, and tribal health departments to build their capacity to address public health epidemics such as tobacco use and obesity, and to be prepared for public health emergencies such as the H1N1 flu epidemic or breakouts of foodborne diseases.

- **National medical device registry.** Establishes a national directory for class III medical devices and class II devices that are permanently implantable, life-supporting, or life-sustaining. Device information in the registry would be linked with patient safety and outcomes data from various public and private databases to facilitate analyses of post-market device safety and effectiveness.
- **Expanded Participation in 340B Program.** Extends the section 340B outpatient drug discounts to certain rural and other hospitals, including Critical Access Hospitals.
- **IHS reauthorization.** A new division is added to provide for the reauthorization of the Indian Health Care Improvement Act (IHCIA). IHCIA provides the main legal authority for the provision of health care to American Indians and Alaskan Natives. The main provisions of this new division address: improvements in workforce development and recruitment; facilities construction, maintenance and improvements, access to and financing of health services; provision of health services for urban Indians; organization improvements within the Indian Health Service (IHS); and the provision of behavioral health services.