# AFFORDABLE HEALTH CARE FOR AMERICA ACT

## TOP 14 PROVISIONS THAT TAKE EFFECT IMMEDIATELY

1. **BEGINS TO CLOSE THE MEDICARE PART D DONUT HOLE** — Reduces the donut hole by $500 and institutes a 50% discount on brand-name drugs, effective January 1, 2010.

2. **IMMEDIATE HELP FOR THE UNINSURED UNTIL EXCHANGE IS AVAILABLE (INTERIM HIGH-RISK POOL)** — Creates a temporary insurance program until the Exchange is available for individuals who have been uninsured for several months or have been denied a policy because of pre-existing conditions.

3. **BANS LIFETIME LIMITS ON COVERAGE**—Prohibits health insurance companies from placing lifetime caps on coverage.

4. **ENDS RESCISSIONS**—Prohibits insurers from nullifying or rescinding a patient's policy when they file a claim for benefits, except in the case of fraud.

5. **EXTENDS COVERAGE FOR YOUNG PEOPLE UP TO 27TH BIRTHDAY THROUGH PARENTS' INSURANCE**— Requires health plans to allow young people through age 26 to remain on their parents' insurance policy, at the parents' choice.

6. **ELIMINATES COST-SHARING FOR PREVENTIVE SERVICES IN MEDICARE**—Eliminates co-payments for preventive services and exempts preventive services from deductibles under the Medicare program.

7. **IMPROVES HELP FOR LOW-INCOME MEDICARE BENEFICIARIES**—Improves the low-income protection programs in Medicare to assure more individuals are able to access this vital help.

8. **PROVIDES NEW CONSUMER PROTECTIONS IN MEDICARE ADVANTAGE**— Prohibits Medicare Advantage plans from charging enrollees higher cost-sharing for services in their private plan than what is charged in traditional Medicare.

9. **IMMEDIATE SUNSHINE ON PRICE GOUGING**—Discourages excessive price increases by insurance companies through review and disclosure of insurance rate increases.

10. **CONTINUITY FOR DISPLACED WORKERS**—Allows Americans to keep their COBRA coverage until the Exchange is in place and they can access affordable coverage.

11. **CREATES NEW, VOLUNTARY, PUBLIC LONG-TERM CARE INSURANCE PROGRAM**—Creates a long-term care insurance program to be financed by voluntary payroll deductions to provide benefits to adults who become functionally disabled.

12. **HELP FOR EARLY RETIREES**—Creates a $10 billon 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.

13. **COMMUNITY HEALTH CENTERS**—Increases funding for Community Health Centers to allow for a doubling of the number of patients seen by the centers over the next 5 years.

14. **INCREASING NUMBER OF PRIMARY CARE DOCTORS** — Provides new investment in training programs to increase the number of primary care doctors, nurses, and public health professionals.

PREPARED BY OFFICE OF SPEAKER PELOSI – OCTOBER 29, 2009


# IMPLEMENTATION TIMELINE

## 2010

### INSURANCE MARKET REFORMS

**ENDS HEALTH INSURANCE RESCISSIONS:** Prohibits abusive practices whereby health insurance companies rescind existing health insurance policies when a person gets sick as a way of avoiding covering the costs of enrollees' health care needs.

**NEW LIMITS ON PRE-EXISTING CONDITION EXCLUSIONS:** Prior to the bill's complete prohibition on pre-existing condition exclusions beginning in 2013, reduces the window that plans can look back for pre-existing conditions from 6 months to 30 days and shortens the period that plans may exclude coverage of certain benefits. It also prohibits insurers from limiting or denying coverage based on acts stemming from domestic violence.

**BAN ON LIFETIME LIMITS:** Prohibits insurance companies from placing lifetime caps on coverage.

**IMMEDIATE SUNSHINE AGAINST INSURER PRICE GOUGING (RATE REVIEW):** Discourages excessive price increases by insurance companies through review and disclosure of insurance rate increases.

**ENACTS ADMINISTRATIVE SIMPLIFICATION:** Begins adopting and implementing administrative simplification requirements to reduce paperwork, standardize transactions, and greatly diminish the administrative burdens and associated costs in today's health care system.

**ENSURING VALUE (MEDICAL LOSS RATIO):** Specifies that health plans spend a minimum of 85 percent of premium dollars on medical care, while making sure that such a change doesn't further destabilize the current individual health insurance market.

**INCREASE DEPENDENT AGE FOR POLICIES THROUGH AGE 26:** Allows those through age 26 not otherwise covered to remain on their parents' policies at their parents' discretion.

**COBRA EXTENSION:** Allows individuals to keep their COBRA coverage until the Exchange is up and running. *[NOTE: This is separate from the Recovery Act provisions that provide premium assistance for selected groups.]*

**ENSURING RECONSTRUCTIVE SURGERY FOR CHILDREN:** Requires plans to pay for reconstructive surgery for children with deformities.

**LIMITATION ON POST-RETIREMENT REDUCTIONS OF RETIREE HEALTH BENEFITS:** Prohibits employers from reducing retirees' health benefits after those retirees have retired, unless the reduction is also made to benefits for active participants.

**GRANTS TO STATES FOR IMMEDIATE HEALTH REFORM INITITATIVES:** Builds on an existing grant program to enhance incentives for states to move forward with a variety of health reform initiatives prior to 2013.

## IMPROVED BENEFITS

**CREATES REINSURANCE FOR EARLY RETIREES:** Creates a new temporary reinsurance program to help offset the cost of coverage for companies that provide early retiree health benefits for those ages 55-64.

**IMMEDIATE HELP FOR THE UNINSURED (INTERIM HIGH-RISK POOL):** Creates a $5 billion fund, modeled after the President's plan, to finance an immediate, temporary insurance program for those who are uninsurable because of pre-existing conditions.

**NEW LONG-TERM CARE PROGRAM (CLASS ACT):** Creates a new, voluntary, public long-term care insurance program to help purchase services and supports for people who have functional limitations. Benefits are a daily or weekly cash benefit to help people with functional limitations purchase the services and supports needed to maintain personal and financial independence. CLASS would supplement, not supplant, traditional payers of long-term care (e.g. Medicaid and/or private long term care insurance).

**ESTABLISHES THE HEALTH BENEFITS ADVISORY COMMITTEE:** Establishes within 60 days of enactment the Health Benefits Advisory Committee—led by the Surgeon General and made up of health care experts, health care providers and patients—provides recommendations on the essential benefits package to the Secretary of HHS for approval.

## PUBLIC HEALTH IMPROVEMENTS

**INCREASES FUNDING FOR COMMUNITY HEALTH CENTERS:** Provides increased funding for community health centers that will allow them to double the number of patients served over the next five years.

**IMPLEMENTS NEW PREVENTIVE HEALTH SERVICES PROGRAM IN COMMUNITIES**: Provides immediate funding for preventive services at the community and local level to address public health problems such as obesity, tobacco use, and diabetes.

**EXPANDS PRIMARY CARE, NURSING AND PUBLIC HEALTH WORKFORCE:** Increases access to primary care by sustaining the current efforts to increase the size of the National Health Service Corps. Primary care and nurse training programs are also immediately expanded to increase the size of the primary care and nursing workforce. Ensures that public health challenges are adequately addressed.

**EMPLOYER WELLNESS PROGRAMS:** Establishes a grant program for employers to promote healthy behaviors among their employees.

## MEDICARE AND MEDICAID IMPROVEMENTS

**BEGINS TO FILL IN THE MEDICARE PART D DRUG DONUT HOLE:** Provides for a 50% discount on brand-name drugs in the Part D donut hole, and immediately shrinks the size of the donut hole by $500 in 2010. The donut hole continues to be narrowed over the coming years until it is fully eliminated by 2019.

**IMPROVES PREVENTIVE HEALTH COVERAGE IN MEDICARE & MEDICAID:** Eliminates cost sharing for preventive services to encourage wider use of preventive care for Medicare beneficiaries. Requires State Medicaid programs to cover preventive services recommended to the Secretary of HHS based on evidence, such as tobacco cessation counseling for pregnant women.

**ALLOWS STATES TO COVER LOW-INCOME INDIVIDUALS WITH HIV:** Gives States the option of extending Medicaid coverage to HIV-positive individuals and provides enhanced federal matching payments for the costs of care.

**INCREASES REIMBURSEMENT FOR PRIMARY CARE IN MEDICAID:** Brings reimbursement for primary care services in Medicaid up to Medicare levels with 100% federal funding (phased in over several years).

**PROVIDES FOR 12-MONTH CONTINUOUS ELIGIBILITY IN CHIP:** Provides continuity of care for children by requiring that states provide 12-month continuous eligibility for children in the CHIP program

**CREATES MEDICARE ACCOUNTABLE CARE ORGANIZATIONS AND MEDICAL HOME PILOT PROGRAMS:** Requires the Secretary to set specific benchmarks for expansion of these programs and to test them in a variety of settings and geographic regions. If the initial pilots prove successful, the Secretary is directed to continue expanding them on a large-scale basis.

## 2011

**ELIMINATES BARRIERS TO ENROLLMENT IN MEDICARE LOW-INCOME SUBSIDY FOR PART D DRUG PROGRAM:** Eases burdens on enrollment so more low-income beneficiaries can get the financial help they need to make health care affordable.

**NEW PROTECTIONS IN MEDICARE ADVANTAGE:** Limits cost-sharing for services in Medicare Advantage plans to no more than cost-sharing in traditional Medicare, and provides for bonus payments to high-quality plans.

**ESSENTIAL BENEFITS:** In preparation for reform, the Health Benefits Advisory Committee reports their recommended essential benefits package to the Secretary of HHS for adoption.

**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.

## 2012

**IMPROVES LOW-INCOME PROTECTIONS IN MEDICARE:** Increases the assets test limits in the Part D drug program and Medicare Savings Programs to ensure that more low-income beneficiaries get the financial help they need to make their health care affordable.

**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.

# 2013

**HEALTH INSURANCE REFORMS:** Implements comprehensive health insurance reforms that prohibit insurance companies from engaging in discriminatory practices that enable them to refuse to sell or renew policies due to an individual's health status. In addition, insurance companies can no longer exclude coverage for treatments based on pre-existing health conditions. The legislation also limits their ability to charge higher rates due to health status, gender, or other factors, and permits premiums to vary only by age (no more than 2:1), geography and family size.

**HEALTH INSURANCE EXCHANGE:** Opens the Health Insurance Exchange to individuals without other coverage and to small employers with 25 or fewer employees. This new venue will enable people to comparison shop for standardized health packages. It facilitates enrollment and administers affordability credits so that people of all incomes can obtain affordable coverage.

**PUBLIC HEALTH INSURANCE OPTION:** Creates a new public health insurance plan option that is available only within the Health Insurance Exchange. It competes on a level playing field against private health plans and will inject competition into the many parts of our country without a competitive health insurance market. Because it doesn't operate at the behest of investors, it will be able to offer stiff competition to private insurers—forcing them to compete on cost and quality for the first time.

**AFFORDABILITY CREDITS:** Makes Health Insurance Affordability Credits available through the Exchange to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400% of poverty who are not eligible for or offered other acceptable coverage. They apply to both premiums and cost sharing to ensure that no families face bankruptcy due to medical expenses.

**INDIVIDUAL RESPONSIBILITY:** Requires individuals to obtain acceptable health insurance coverage or pay a penalty of 2.5% of their income that is capped at the cost of the average cost of qualified coverage.

**EMPLOYER RESPONSIBILITY:** Employers are required to offer coverage to their workers and their workers' families with minimum contributions and meet standards for that coverage or pay a penalty of 8% of their payroll to help offset the cost of their workers obtaining coverage through the Exchange. Employers have a grace period and are not required to meet the benefit standards until 2018.

**PROTECTS SMALL BUSINESS:** Small businesses with annual payrolls below $500,000 are exempt from requirements to offer or contribute to coverage, including the 8% payroll contribution for failure to provide health benefits to their workers. The 8% requirement is phased in for small businesses with an annual payroll between $500,000 and $750,000.

**SMALL BUSINESS TAX CREDITS:** Provides certain lower-wage small businesses that choose to provide health coverage with a new tax credit worth up to 50% of the amount paid by a small employer for employee health coverage. The credits are available on a rolling basis for the first two years that an employer offers qualified coverage.

**EXPANDS MEDICAID ELIGIBILITY:** Expands Medicaid to 150% of poverty to ensure that people obtain affordable health care in the most efficient and appropriate manner. The expansion is fully federally funded in 2013 and 2014; thereafter states pay 9% and the federal government pays 91%.

**PROTECTS THE HEALTH OF NEWBORN BABIES:** Provides temporary Medicaid coverage for up to 60 days for babies who are born without proof of other health coverage.

## 2014

**INITIATES AN AFFORDABILITY TEST FOR EMPLOYER-SPONSORED COVERAGE:** Opens the Health Insurance Exchange to individuals who have an offer of employer-sponsored coverage, but for whom that coverage would be unaffordable because the premium would absorb more than 12% of their family income. People who meet this test will be able to enter the Exchange and are eligible for affordability credits based on their incomes.

**HEALTH INSURANCE EXCHANGE EXPANDS:** Opens the Health Insurance Exchange to small businesses with 50 or fewer employees.

**ENSURING VALUE IN MEDICARE ADVANTAGE (MEDICAL LOSS RATIO):** Requires Medicare Advantage plans to spend a minimum of 85 percent of premium dollars on medical care.

## 2015

**EXPANDS HEALTH INSURANCE EXCHANGE:** Opens the Health Insurance Exchange to small businesses with 100 or fewer employees and provides the Health Choices Commissioner the authority, from 2015 forward, to continue expanding the Exchange to larger employers as the system is ready to handle increased capacity.

## 2018

**EMPLOYERS OUTSIDE THE EXCHANGE ARE REQUIRED TO MEET ESSENTIAL BENEFITS PACKAGE:** The grace period ends for employer-sponsored plans to meet the health insurance standards. All employer-sponsored coverage and health insurance offered within the Exchange is required to meet benefit and contribution standards.


# GUARANTEED BENEFITS

In order to achieve affordable, quality health care for all, the Affordable Health Care for America Act establishes standards to ensure that all plans in the new Health Insurance Exchange cover a comprehensive set of necessary services and offer protections for consumers.

## GENERAL

- Establishes a standardized benefit package that covers essential health services.
- Eliminates out-of-pocket expenses for preventive care (including well baby and well child care) to underscore the importance of preventive health services in making America healthier and lowering the growth of health care costs over time.
- Caps annual out-of-pocket spending for individuals and families so that no one faces bankruptcy from health costs ever again.
- Creates a new independent Benefits Advisory Committee to make recommendations to the Secretary of Health and Human Services and to update the core package of benefits to address the health care needs of Americans. The committee will be chaired by the Surgeon General and will consist of physicians, other health care providers, business representatives, consumers, and other health care experts.
- Prohibits annual and lifetime limits by insurance companies on coverage.

## BENEFIT PACKAGES

The Exchange makes available four tiers of benefit packages that will be offered by private plans and the public health insurance option from which consumers can choose to best meet their health care needs. Each plan covers the essential benefits.

- *Basic Plan:* Includes the essential benefits and minimum cost-sharing protections.
- *Enhanced Plan*: Includes the essential benefits with more generous cost-sharing protections than the Basic plan.
- *Premium Plan*: Includes the essential benefits with more generous cost-sharing protections than the Enhanced plan.
- *Premium Plus Plan*: Includes essential benefits, the more generous cost-sharing protections of the Premium plan, and additional covered benefits (e.g., oral health coverage for adults, gym membership, private rooms, etc.) that will vary per plan. In this category, insurers must disclose the separate cost of the additional benefits so consumers know what they're paying for and can choose among plans accordingly.

## GUARANTEED SET OF BENEFITS

A required core set of benefits provides coverage for essential health care services and items to ensure that consumers will no longer have to worry about being stuck in an inadequate insurance plan. The levels of coverage will be defined by the Secretary of Health and Human Services working with the new Benefits Advisory Commission outlined above. Benefits must include:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Equipment and supplies provided incident to physician services
- Preventive services
- Maternity services
- Prescription drugs
- Rehabilitative and habilitative services
- Well baby and well child visits and oral health, vision, and hearing services for children
- Durable medical equipment, prosthetics, orthotics and related supplies
- Mental health and substance abuse services, including behavioral health treatments

In defining the essential benefits package, abortion services may not be made a required benefit (except in cases of rape, incest, or to save the life of the woman). Each plan may decide whether or not to cover abortion services, and, if it does, it may use only private premium dollars to pay for them. No federal funds may be used to pay for abortion services (except in cases of rape, incest, or to save the life of the woman).