



H.R. 3962, The Affordable Health Care For America Act

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The House Democratic leadership released H.R. 3962, The Affordable Health Care For America Act on October 29, 2009 with the final Manager's Amendment released on November 3rd. This single bill replaces the three Committee versions of H.R. 3200, and is projected to extend coverage to 96% of American citizens while reducing the federal deficit. Though structurally similar to its predecessor, many elements of the bill are unique or have been augmented compared to previous drafts. Below are summaries of the major sections of H.R. 3962, with descriptions of the most pertinent changes found in the bill.

Insurance Market Reform

The Affordable Health Care For America Act contains many identical provisions from the three previous House drafts, including guaranteed issue and renewal, prohibition of pre-existing condition coverage exclusions and rescissions, and removal of lifetime/annual caps on medical spending. The bill continues to limit age rating of premiums to 2:1, establishes a 85% medical loss ratio, and now allows young people to remain on their parents' insurance plans to an extended 27 years old. These market reforms notably apply to the entire market, both inside and outside the Exchange, which is an important additional provision to protect the Exchange from adverse selection.

The proposed Exchange continues to operate as a national model (compared to state-based Exchanges in the Senate proposal) and sets an essential benefits package, though states and territories now have the option of running their own Exchange as long as it meets federal standards. The new Health Benefits Advisory Council chaired by the Surgeon General will determine specific services in the benefits package. The Exchange sets four insurance plan tiers for cost-sharing based on actuarial value: basic (70%), standard (85%), premium (95%), and premium plus which contains additional benefits like dental and vision. Plans wishing to offer coverage in the Exchange market must adhere to data reporting requirements, contract with essential community providers, and participate in risk adjustment/pooling. The Manager's Amendment contains language that excludes insurers from the Exchange who 'put profits over patients.' While the initiation of the Exchange in 2013 opens to uninsured individuals and small employers with up to 25 employees, the bill further extends Exchange eligibility to firms with at least 100 employees by the 2015. The bill now also provides seed money for the establishment of cooperative health plans that can compete with private insurers and the public option through the Exchange.

The new bill adds two additional provisions in order to promote insurance market competition. Also seen in the Senate version, the Act now allows for the creation of State Health Insurance Compacts that would permit state legislatures to enter into agreements to allow for the sale of insurance across state lines. A new provision, strengthened by the Manager's Amendment, explicitly repeals the Antitrust Exemption on health insurers and malpractice insurers, making companies liable for price fixing, dividing up territories, and monopolizing markets.

The Public Option

Several changes have taken place regarding the public option, though its national structure has been preserved. The option will be administered by the Secretary of Health and Human Services, operate through the Exchange and be fully financed by the revenue it collects. After extensive debate, the Secretary will now negotiate provider rates through the public option, capping reimbursement at the average rates paid by other plans. All health care providers participating in Medicare are now considered as participating in the public option unless they opt out. The plan will adhere to the same requirements as private plans for benefit levels, consumer protections, and cost-sharing. It will also be allowed to develop innovative payment mechanisms to encourage value-based purchases.

Ensuring Affordability

Individuals

HR 3962 preserves the individual mandate provision; instead of a flat fee as seen in the Senate, the bill penalizes individuals who don't obtain qualifying insurance at 2.5% of their adjusted income above the filing threshold (\$9,350), up to the cost of the average national premium. Exemptions will be available for religious objections and financial hardship. To make coverage affordable under the mandate, premium credits will be available to individuals and families up to 400% FPL to purchase insurance through the Exchange. The subsidies are less generous compared to the previous House drafts in order to reduce the overall cost of the bill. The credits will be issued on a sliding scale so that an individual's premiums will not exceed 1.5% of income for those at 133% FPL, scaling up to 12% of income for those at 400% FPL.

Sliding scale cost-sharing credits will also be available and will be based on actuarial values of at least 70% for those at 400% FPL, up to 97% for those at 133% FPL. Out-of-pocket limits are further specified in the bill scaling from \$500/\$1,000 for individuals/families at 133% FPL up to \$5,000/\$10,000 for individuals/families at 400% FPL. A new provision in the bill now allows employees to obtain premium and

cost sharing credits if their employer-based coverage exceeds 12% of income. Illegal immigrants are ineligible for all public subsidies, and a verification mechanism will be established to determine citizenship.

Several new programs were added to HR 3962 in order to protect individuals beginning in 2010. Newly added to the bill is an immediate temporary insurance program that will provide financial assistance for those who have been uninsured and denied a policy because of a pre-existing condition. This interim high-risk pool will remain until the Exchange is fully set in place. Individuals insured under COBRA will now also be able to keep their coverage until the Exchange is up and running. A voluntary, public long-term care insurance will be created (financed by voluntary payroll deductions) to purchase community living assistance services and supports (dubbed the CLASS program) for adults who become functionally disabled.

Employers

The House bill requires employers to offer coverage to their employees, contributing premium costs of 72.5%/65% for individuals/families for the minimum package or pay 8% of payroll to the Health Insurance Exchange Trust Fund. The bill expands the small business exemption to payrolls below \$500,000 (86% of all businesses) and now graduates the penalty from 2% to 6% of payroll for firms with payrolls between \$500,000 and \$750,000. In order to make coverage affordable for small businesses, the bill provides tax credits for firms with fewer than 25 employees and average wages under \$40,000 for the first two years that the employer offers coverage.

The bill also creates a \$10 billion fund to finance a temporary reinsurance program to help offset expensive health claims for employers covering retirees age 55-64. Employers will be prohibited from reducing retirees' health benefits unless the reductions are also made to active employees.

Medicaid

In order to reduce the overall cost of the bill, a significantly larger portion of the population will now be eligible for Medicaid as opposed to being offered premium credits for purchase through the Exchange. All individuals up to 150% FPL will now be eligible for the Medicaid. The bill preserves the 100% federal matching rate until 2015, 91% thereafter, and deletes the provision allowing childless adults between 133% and 155% to choose between Medicaid and the Exchange. Particularly important for California, the bill also extends the current Recovery Act (ARRA) federal assistance to states with high unemployment. Medicaid reimbursement rates will increase to 100% of Medicare rates for primary care providers by 2012. The bill preserves the prohibition of cost-sharing on recommended preventive services.

Under the bill, the Children's Health Insurance Program (CHIP) will be repealed beginning in 2014, with children above 150% FPL being transitioned into the Exchange. A coordinated investigation and report will be undertaken before this date to assure that children's coverage is not interrupted and comparable to existing CHIP plans.

Medicaid DSH payments will be reduced by \$10B in order to partially offset the bills costs, and the reductions will vary by state based on the comparative reduction in their uninsurance rates over time.

Medicare

Numerous provisions are preserved and expanded in the bill in order to extend the sustainability of Medicare and partially offset the costs of reform. The Medicare donut hole is tackled more expeditiously in HR 3962. Effective January 1, 2010, the Part D gap will be closed by \$500 and a 50% discount will be instituted on brand name drugs in the donut hole. The gap will now be entirely phased out by 2019. The Secretary of HHS will now also be required to negotiate drug prices on behalf of Medicare beneficiaries, and drug manufacturers will be required to provide rebates for dual eligibles. New efforts to better coordinate care for dual eligibles will be instituted, in addition to an expansion of the eligibility threshold for low-income subsidies in Part D to \$17,000/\$34,000 for individuals/couples.

Medicare Advantage (MA) payments will begin to be phased down in 2011, and be equal to traditional rates by 2014. MA plans will be subject to an 85% medical loss ratio by 2014, and high-quality plans will be provided with targeted bonuses.

Numerous pilot programs will be instituted with specific benchmarks, including accountable care organizations, medical homes, telehealth, and payment bundling. Provisions to deny payment for hospital readmissions and hospital-acquired infections are also preserved in the bill. HHS will also be required to assess high-cost diseases in order to target prevention and coordination efforts, and the Secretary will be directed to expand successful programs on a large-scale bases. A new provision to establish a CMS Innovation Center to assist in these efforts was also added. The bill now additionally instructs the Institute of Medicine to investigate geographic variations in Medicare payments as well as make recommendations on how to change the system to reward value and quality.

Other Cost-Containment Strategies

HR 3962 contains other provisions to address long-term cost growth. The bill will now attempt to discourage excessive price increases by insurance companies through a transparent review of any increases in rates. The Manager's Amendment provides an additional \$1 billion to states to rein in price gouging. A new provision will address medical malpractice reform by establishing a voluntary state incentive grant program to implement "certificate of merit" and "early offer" alternatives to traditional litigation. Increased funding of \$100 million annually will be provided to the Healthcare Fraud and Abuse Control Fund to fight fraud in Medicare and Medicaid, with higher penalties for fraudulent activities.

The bill preserves the establishment of a Center for Comparative Effectiveness within AHRQ, directed by an independent Council, in addition to a Center for Quality Improvement and a Community-based Collaborative Care Network Program to promote best practices in care coordination, management, and delivery. Standards will also be developed for the collection of data on race, ethnicity, and health disparities particularly in low-income and underserved populations.

The proposed Prevention and Wellness Trust Fund is preserved in the bill, providing \$34 billion over 10 years for community-based programs, employer wellness programs, and child obesity programs. Increased funding for community health centers and the establishment of school-based health centers are preserved. The bill now also reauthorizes the Indian Health Care Improvement Act (expired in 2001), and requires chain restaurants and vending machines to display nutrition information on menus and displays.

Several provisions addressing graduate medical education are also preserved in HR 3962, including increased funding for the National Health Service Corps, community-based outpatient residency programs, and investment in public health and nursing education programs. A multi-stakeholder Advisory Committee on Health Workforce Evaluation and Assessment will be established to address shortages and national strategies, in addition to a new public health workforce corps.

Revenue and Fiscal Aspects

Numerous amendments were included to improve the overall cost of the bill, and the CBO has scored the net cost of the bill at \$894 billion over 10 years and is fully paid for by the revenue enhancements and cost reductions. HR 3962 further reduces the deficit compared to its predecessor, with a reduction of \$30 billion over the first 10 years and additional reductions over the second decade. This reduction increases to \$103 billion with inclusion of the CLASS Act (see Affordability section). The

overhaul of the Medicare physician payment formula (SGR) was removed to improve the overall costs. Total saving from Medicare and Medicaid are estimated to be \$426 billion over 10 years.

The high-income threshold surcharge was also increased, where a 5.4% tax will now be levied on incomes above \$500,000/\$1 million for an individual/couple, and is estimated to raise \$461 billion. Additional revenue provisions (generating \$97 billion over 10 years) include requiring corporate payment information reporting, limits on HSAs and FSAs, a 2.5% excise tax on medical device sales, and eliminating the double tax deduction for employers receiving a government subsidy for providing retiree prescription drug coverage. The bill also ensures tax parity for domestic partners and non-dependents under employer-sponsored coverage, and clarifies that only employer-provided coverage premiums can be paid on a pre-tax basis through a cafeteria plan in the Exchange.

Sources

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