



NATIONAL ASSOCIATION OF INSURANCE AND FINANCIAL ADVISORS

HEALTH CARE REFORM

	Senate Finance Committee Options	Senate HELP Bill	House Tri-Committee Bill	NAIFA Principles
Date Released	May 2009	June 9, 2009	June 19, 2009	May 2009
Insurance Market Reforms	<p>Require guarantee issue and renewability</p> <p>Rating variation based only on age, tobacco use, family composition, and geography (not health status) in the non-group, micro-group (2-10 employees), and small group markets</p> <p>Risk adjustment in all markets</p>	<p>Bar on exclusions due to pre-existing conditions</p> <p>Premium rate reforms that limit variations to those based on family structure, community rating area, actuarial value of benefits available under the plan, and age (this variance is limited to 2 to 1); prohibits rate variances based on health-status-related factors, gender, class of</p>	<p>Bar on exclusions due to pre-existing conditions</p> <p>Limits rate variances to those based on area, family structure, and age (age variance is limited to 2 to 1)</p> <p>Guaranteed issue and renewability</p> <p>Non-discrimination</p>	<p>No preexisting condition underwriting and guaranteed-issue coverage if balanced with maintained coverage</p> <p>Modified community rating provides the opportunity for those who take the initiative to improve their lifestyle and health status to be rewarded in a premium cost variance</p> <p>Rating based upon individuals who present the same class</p>

	<p>All state-licensed insurers in the non-group and small group markets required to participate in the Health Insurance Exchange</p> <p>Require all insurers to issue policies in each of the four new benefit categories</p> <p>Allow states the option of merging the non-group and small group markets</p>	<p>business, claims experience or any other factor not included in permitted rate variance list</p> <p>Guaranteed issue and renewability</p> <p>Prohibition on co-pays for preventative care</p> <p>Insurer cost reporting to HHS required</p> <p>Rebates to enrollees required if premium revenue exceeds amount plan expended on non-claims costs in the group and individual markets, by percentages to be developed by HHS</p> <p>Bar on lifetime or annual coverage limits</p> <p>Plans must develop reimbursement structure that provides incentives for implementation of measures such as case management and coordination, patient safety, and wellness</p> <p>Mandate that plans offering dependent coverage make such</p>	<p>standards</p> <p>Prohibition on co-pays for preventative care</p> <p>Network provider standards with regard to access and transparency</p> <p>Minimum medical loss ratios of 85% and premium rebates to the extent that a plan does not meet this loss ratio</p> <p>Minimum benefit packages to be offered by all plans, with limits on out-of-pocket costs</p> <p>No limits on coverage unrelated to “clinical appropriateness”</p>	<p>characteristics should not vary more than +/- 30 percent from the modified community rate set because of health status, claim experience or any other factor</p>
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Connector Mechanism	<p>Create one national or multiple regional Health Insurance Exchanges</p> <p>Require all state-licensed insurers in the non-group and small group markets to participate in the Health Insurance Exchange(s)</p> <p>Require the Exchange(s) to develop a standardized format for presenting insurance options</p> <p>Create a web portal to help consumers find insurance</p> <p>Maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax</p>	<p>Establishment of "American Health Benefit Gateways"</p> <p>Funded through grants to each state</p> <p>States are to facilitate the purchase by individuals of "qualified coverage" from "qualified insurers" at an "affordable price"</p> <p>Allow states to contract with private "navigators" to assist in educating the public regarding their Gateway options and assist with enrollment; states would be required to adopt conflict of interest rules prohibiting anyone who receives payment from insurers from serving as a navigator</p>	<p>Creates a new "National Health Insurance Exchange:" to administer market reforms and facilitate comparison shopping among private insurers and a new public insurance option</p> <p>Only "qualified health benefits plans" that meet all market reform requirements will be offered through the Exchange</p> <p>No explicit prohibition on insurance agents and brokers providing services in connection with Exchange plans (although Exchange administration has sufficiently broad authority to adopt limits)</p>	<p>If government-organized exchanges or gateways are created as an alternative method for distributing coverage, consumers will need reliable information from which to make informed decisions</p> <p>It would be a significant mistake to assume that a federal government call center, website or unlicensed "navigators" could perform the many services currently offered by the professional advisor</p>

	credits	<p>Employers permitted to offer employees coverage through the Gateway</p> <p>HHS will establish gateways in any states that fail to do so within a certain time period</p> <p>Establish a Medical Advisory Council to make recommendations on what items constitute health care benefits eligible for premium credits</p>	<p>Phased-in eligibility for Exchange plans, starting with smallest employers and uninsured individuals</p> <p>Allows option of developing a state or regional exchange in lieu of the national exchange, but only with federal approval</p> <p>Establishes an advisory council to make recommendations concerning the components of minimum benefits packages and maximum out of pocket costs</p> <p>Establishes a telephone hotline and website to enable consumers to choose among plans in the exchange</p>	
Benefit Design	<p>Create four benefit categories (lowest, low, medium, and high)</p> <p>Require all plans to provide a comprehensive set of services and prohibit inclusion of lifetime limits on coverage or annual limits on benefits</p> <p>All policies (except certain</p>	<p>Create three benefit tiers based on the percentage of allowed benefit costs covered by the plan, ranging from 76% of benefit costs for the lowest tier to 93% of benefit costs for the highest tier. Require plans to provide at least the essential benefits specified by the Medical Advisory Council and prohibit inclusion of lifetime</p>	<p>Create an essential benefits package that provides a comprehensive set of services as recommended by the Health Benefits Advisory Council</p> <p>The essential benefits package covers 70% of the actuarial value of the covered benefits; limits annual cost-sharing to</p>	<p>Allow insurers to offer low-cost, basic benefit packages which are exempt from costly benefit mandates. Basic benefit policies should be structured to keep premiums low. A basic benefit package can be designed with specific benefits or specific cost coverage</p> <p>Develop consumer choice health plans which encompass a variety of approaches to health care financing designed to improve</p>

	grandfathered employer-sponsored plans) must comply with one of the four benefit categories, including those offered through the Exchange and those offered outside of the Exchange	or annual limits on benefits. Establish a Medical Advisory Council to make recommendations on essential health care benefits, criteria for minimum qualifying coverage, and affordability standards	\$5,000/individual and \$10,000/family; and does not impose annual or lifetime limits on coverage. All policies, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package	consumer awareness of the costs and quality of their care
Individual Subsidies	Refundable tax credits to individuals and families with incomes between 100 and 400% FPL to purchase insurance through the Health Insurance Exchange The level of the premium tax credit could be set as a percentage of income or as a percentage of the premium, with additional limits on cost-sharing	Provide premium credits on a sliding scale basis to individuals and families with incomes up to 500% to purchase coverage through the Gateway. Credits determined by the Secretary, but will be such that individuals with incomes less than 500% FPL pay no more than 10% of income and individuals with incomes less than 150% FPL pay 1% of income, with additional limits on cost sharing Individuals are not eligible for premium credits	Provide affordability premium credits to individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange Credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contribution is no more than 1% of income for individuals with income at or below 133% FPL and no more than 10% of income for individuals with income at 400% FPL	Subsidies should be provided inside and outside the Gateway/Exchange Tax credits, full deductibility of premiums and other incentives should be adopted to encourage more businesses and individuals to purchase coverage. Make refundable, tax credits available for low-income individuals and families for the purchase of health coverage. The credits would be used to purchase employer-sponsored insurance when an employer offers coverage

		through the Gateway if they have access to employer-based coverage that meets minimum qualifying criteria and affordability standards, or are eligible for Medicare, Medicaid, TRICARE, or FEHBP	<p>Provide affordability cost-sharing credits to individuals and families with incomes up to 400% FPL</p> <p>The cost-sharing credits are offered on a sliding scale basis such that the cost-sharing limit for those with income at or below 133% FPL is \$250 per individual and \$500 per family and for those with income at 400% FPL is \$5,000 per individual and \$10,000 per family</p>	
Employer Subsidies	<p>Provide certain small employers that purchase insurance for their employees with a tax credit</p> <p>The full credit of 50% of the average total premium cost paid by the employer would be available to employers with 10 or fewer employees and whose employees have average annual wages of less than \$20,000</p> <p>The tax credit would be phased out as firm size and earnings increase</p> <p>The tax credit would not be payable in advance or</p>	<p>Provide qualifying small employers with a health options program credit for employers with fewer than 50 full-time employees, pay an average wage of less than \$50,000, and must pay at least 60% of employee health expenses</p> <p>The credit is equal to \$1,000 for each employee with single coverage and \$2,000 for each employee with family coverage, adjusted for firm size (phasing out as firm size increases) and number of months of coverage</p>	<p>Provide small employers with fewer than 25 employees and average wages of less than \$40,000 with a health coverage tax credit</p> <p>The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of \$20,000 or less</p> <p>The credit phases-out as firm size and average wage increases</p>	Tax credits, full deductibility of premiums and other incentives should be adopted to encourage more businesses and individuals to purchase coverage

	refundable	<p>provided</p> <p>Bonus payments are given for each additional 10% of employee health expenses above 60% paid by the employer</p> <p>Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64</p> <p>Program will reimburse employers for 80% of retiree claims between \$15,000 and \$90,000</p> <p>Program will end when the state Gateway is established</p>		
Public Program Expansions	<p>Medicaid Expand Medicaid to all individuals with incomes up to 115% FPL, with a possible increase in eligibility for parents, pregnant women, and children to a higher level</p> <p>Children's Health Insurance Program After September 30, 2013, expand CHIP eligibility to 275% FPL</p> <p>Once the Health Insurance</p>	<p>Medicaid eligibility will be expanded to 150% of federal poverty level [note that this provision will likely be part of Senate Finance bill rather than HELP bill]</p>	Expands Medicaid eligibility	<p>Support initiatives to expand access to health care to the 3 million adults and 6 million children who are eligible for, but not enrolled in, the Medicaid or State Children's Health Insurance (SCHIP) programs.</p> <p>Support adequately funding state Medicaid programs. Fully funding Medicaid will ensure that the important safety net that state programs provide will remain viable, and those with low incomes will be able to continue to receive necessary health care</p>

	<p>Exchange is fully operational, CHIP enrollees would obtain coverage through the Exchange and states would be required to continue to provide services not covered by plans in the Exchange, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services</p> <p>Medicare Until the Health Insurance Exchange is underway, allow individuals aged 55-64 without coverage to buy-in to Medicare at full-cost</p> <p>Phase-out or reduce the two-year waiting period for Medicare eligibility for people with disabilities</p>			services
Individual Mandates	Individuals who fail to obtain health coverage will be subject to a tax	Individuals who fail to obtain health coverage will be subject to a tax	Individuals who fail to obtain health coverage will be subject to a tax	A voluntary approach to coverage is preferred. However, a given proposal will not be automatically opposed simply because such proposal includes an individual or employer mandate, so long as it includes appropriate safe-guards designed to protect the vitality of choice, quality and competition, with such safe-guards to include but not be limited to: <ul style="list-style-type: none"> • Appropriate cost sharing between employers and

				<p>employees</p> <ul style="list-style-type: none"> • Establishment of affordable basic benefits packages exempt from mandated benefit laws • Appropriate government subsidies for low-income individuals • Availability of pooling mechanisms to which high risks may be ceded • Real consequences for those that ignore the coverage mandate
Employer Mandates	<p>Option A: require employers with more than \$500K in total payroll per year to offer coverage and contribute at least 50% of the premium or pay an assessment.</p> <p>Option B: No employer “pay or play” requirement</p>	Employers that do not offer health coverage to employees will be required to make payments into a pool	<p>Employers may choose between providing coverage (either through Exchanges, self insuring or offering other coverage) for their workers or contributing funds on behalf of their uncovered workers</p> <p>Self insured plans must meet same requirements as plans eligible for Exchanges, including offering minimum benefit package</p> <p>Employers will be required to make minimum premium payment contributions</p>	<p>A voluntary approach to coverage is preferred. However, a given proposal will not be automatically opposed simply because such proposal includes an individual or employer mandate, so long as it includes appropriate safe-guards designed to protect the vitality of choice, quality and competition, with such safe-guards to include but not be limited to:</p> <ul style="list-style-type: none"> • Appropriate cost sharing between employers and employees • Establishment of affordable basic benefits packages exempt from mandated benefit laws • Appropriate government subsidies for low-income individuals • Availability of pooling mechanisms to which high risks may be ceded • Real consequences for those

				that ignore the coverage mandate
New Public Plan	<p>Option A: create a new public plan to be offered through the Exchange that will be subject to the same rating and risk adjustment rules as the private plans. The public plan could be administered by the federal government, by multiple third-party administrators, or by the states.</p> <p>Option B: Do not create a public plan option.</p>	<p>The “Government Plan” provisions:</p> <p>HHS is directed to develop an “affordable access plan”</p> <p>The plan will pay rates equal to the rates paid by Medicaid plus 10%, or “consistent” rates for services not covered by Medicaid;</p> <p>Premiums will be assessed in “an amount necessary to cover costs” of the plan</p> <p>[note that these are details as they appeared in the June 5 HELP draft]</p>	<p>Creates a new public insurance plan option within the Exchange that will “compete on a level playing field” with private insurers</p> <p>The plan will pay rates equal to the rates paid by Medicaid plus 5 bonus for providers participating in both Medicare and new public plan</p> <p>Premiums will be set by HHS in accordance with the premium rules for plans participating in the Exchange but set at a level to allow the program to fully finance itself plus a contingency margin</p> <p>States will be allowed to impose mandates on public and Exchange plans, but only if states pay for any excess premium cost associated with their mandates</p>	<p>A new government plan should not be created to contend with private insurance. In order to compete on a level playing field, the new government plan would need to comply with the numerous private plan requirements including: state licensure, capital requirements, financial solvency, provider network adequacy standards, rate approval, federal and state taxes and assessments, state privacy protections and marketing requirements. If a government plan met the same requirements as private plans, there would be no reason to justify the enormous cost of creating a new federal government establishment to administer the government plan. Preservation of the private health insurance delivery system is necessary in order to ensure choice, quality and competition.</p>
Limits on Self Insurance	None specified	Limitation to groups of 250 or more reportedly deleted from Senate HELP draft	None specified	Self insurance should be preserved.
Reporting	None specified	Those who provide health	Those who provide health	Additional documentation

<p>and Disclosure Obligations</p>		<p>insurance coverage will be required to file tax returns identifying the individuals they covered and the time periods of coverage; they will also be required to provide statements containing the same information to covered individuals</p> <p>Employers will be required to notify employees regarding the availability of coverage through the Gateways</p>	<p>insurance coverage will be required to provide covered individuals with tax returns describing the coverage and the time periods of coverage;</p> <p>Insurers and employers will be subject to random audits by the federal government to assess compliance with employer mandates</p>	<p>requirements should not be overly burdensome and/or costly for insurers and employers.</p>
<p>Long Term Care Insurance</p>	<p>Improve the availability of long-term care services by increasing access to home and community based services through changes in Medicaid program requirements and through grants to states</p>	<p>Includes the “Community Living Assistance Services and Supports” (CLASS Act):</p> <p>Establishes a voluntary nationwide insurance program for long term care;</p> <p>Program will be self-funded, financed through voluntary payroll deductions;</p> <p>Cash benefits will be payable to those unable to perform two or more activities of daily living; benefits will be designed to cover half the current average cost of long term care, to retain a role for</p>	<p>None specified</p>	<p>Provide tax incentives for the purchase of long-term care insurance coverage including an above-the-line deduction for long term care insurance</p> <p>Permit long term care insurance in cafeteria plans</p>

		<p>private insurance;</p> <p>Employers may receive a tax credit for automatically enrolling employees in this long term care program and withholding premiums from wages</p> <p>Tax credits for employers who automatically enroll employees and withhold CLASS deductions – allows 25% tax credit for automatic enrollment and withholding of CLASS premiums</p> <p>Amends the Internal Revenue Code to make long term care insurance includible in cafeteria plans</p>		
Cost Containment	<p>Encourage adoption and use of health information technology by expanding eligibility for the Medicare HIT incentives in the American Recovery and Reinvestment Act to include additional providers</p> <p>Eliminate fraud, waste, and abuse in public programs through more intensive screening of providers, the development of the “One PI database” to</p>	<p>Establish a Health Care Program Integrity Coordinating Council and two new federal department positions to oversee policy, program development, and oversight of health care fraud, waste, and abuse in public and private coverage.</p> <p>Develop a national prevention and health promotion strategy</p>	<p>Simplify health insurance administration by standardizing health care claims forms, operating rules for using and processing health care transactions, and quality reporting requirements and increasing electronic exchange of administrative and clinical data.</p> <p>Modify provider payments under Medicare to:</p> <ul style="list-style-type: none"> – Reform the sustainable 	<p>Establish comparative effectiveness research while maintaining the strictest patient-doctor privacy standards</p> <p>Expand cost-effective wellness programs and preventive medicine</p> <p>Tax incentives for employers who offer long term wellness and disease prevention programs should be considered</p> <p>Create cost transparency by</p>

	<p>capture and share data across federal and state programs, increased penalties for submitting false claims and violating EMTALA, and increase funding for anti-fraud activities.</p> <p>Restructure payments to Medicare Advantage plans to promote efficiency and quality</p> <p>Require drug or device manufacturers to disclose payments and incentives given to providers and any investment interest held by a physician</p> <p>Improve transparency of information about skilled nursing facilities</p> <p>Allow providers organized as accountable care organizations that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program</p> <p>Improve prevention by covering only proven preventive services in Medicare and Medicaid and providing incentives to</p>	<p>that sets specific goals for improving health. Create a prevention and public health investment fund to expand and sustain funding for prevention and public health programs</p> <p>Provide grants for improving health system efficiency</p>	<p>growth rate for physicians and include incentive payments to physicians practicing in efficient areas</p> <ul style="list-style-type: none"> – Reduce payments to hospitals with excess readmissions and apply the readmissions policy to post acute care providers and physicians – Reform payment for post acute care services to include a bundled payment for post acute care services <p>Restructure payments to Medicare Advantage plans to link to fee-for-services payments and incorporate incentives for quality; require Medicare Advantage plans to have medical loss ratios of at least 85%</p> <p>Increase the Medicaid drug rebate percentage and extend the prescription drug rebate to Medicaid managed care plans</p> <p>Reduce waste, fraud, and abuse in public programs by</p> <ul style="list-style-type: none"> – Refusing Medicaid payments for health care-acquired conditions – Allowing provider 	<p>providing consumers with information about payment rates, the quality of care and services allowing them to make wise decisions about health care</p> <p>Efforts should be made to mitigate cost shifting by federal, state and self-insured programs. Artificially discounting the cost of care for these people not only results in higher costs and premiums to private payers, but also creates incentives for providers to avoid treating public patients</p> <p>Adopt a system of peer approved practice protocols, which would establish guidelines for providers to follow for specific procedures and impose limits on a provider's liability if such guidelines were followed in a non-negligent manner</p> <p>Supports continuation and proper funding of Medicare Advantage Plans</p>
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	<p>Medicare and Medicaid beneficiaries to complete behavior modification programs</p>		<p>screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs</p> <ul style="list-style-type: none"> – Requiring Medicare and Medicaid program providers and suppliers to establish compliance programs – Requiring evaluations and reports under Medicare and Medicaid integrity programs <p>Improve transparency of information about skilled nursing facilities</p> <p>Improve prevention by covering only proven preventive services in Medicare and Medicaid and eliminate any cost-sharing for preventive services</p> <p>Develop a national strategy to improve the nation’s health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop,</p>	
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			update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services	
Additional Information	http://www.finance.senate.gov/sitepages/leg/LEG%202009/051809%20Health%20Care%20Description%20of%20Policy%20Options.pdf	http://help.senate.gov/BAI09A84_xml.pdf	http://edworkforce.house.gov	http://www.ahia.net/advocacy/documents/RXForHealthcare_0609.pdf