



# Latest in Health Care



## House Democrats Introduce "American's Affordable Health Care Choices Act of 2009"

*July 15, 2009*

House Democrats introduced their proposal for health care reform yesterday afternoon (July 14, 2009), the "America's Affordable Health Choices Act of 2009 (the "House Bill"). Introduced under the sponsorship of three key House committees -- Energy and Commerce, Ways and Means, and Education and Labor -- the 1018 page House Bill details the sweeping and comprehensive health care reforms touted by House Democrat Leaders as the solution to U.S. health care system problems. A copy of the House Bill as introduced may be reviewed [here](#).

The House Bill proposes sweeping reforms built around the establishment of a public plan option while technically continuing to permit private plans to operate but in a federally regulated form allowing for little meaningful plan design control to private payers, health care providers or the individuals choosing among the plan options. The Congressional Budget Office estimates that the coverage side of the bill will cost \$1 trillion and cover 97% of the legal population within 10 years.

The following is a brief overview of certain key provisions of the House Bill drawn mostly from a series of high level summaries released by House Democrats along with the House Bill. Long on politically comforting phrasing and short on details, you can read these summaries [here](#).

**Public Plan Option.** The House Bill proposes the establishment of a public health insurance option that would compete with allowable private plans, both of which would be subject to sweeping federal controls. Democrat House co-sponsors represent the House Bill:

- Provides a public health insurance option that would compete with private insurers within the Health Insurance Exchange.
- The public health insurance option would be made available in the new Health Insurance Exchange (Exchange) along with private health insurance plans that comply with the design dictates established in the House Bill.
- The public health insurance option and private plan options meet the same benefit requirements and comply with the same insurance market reforms.
- The public option's premiums would be established for the local market areas designated by the Exchange.
- Individuals with affordability credits could choose among the private carriers and the public option.
- Require that the public health plan and private health plan options and private options each must be financially self-sustaining.
- Promote primary care, encourage coordinated care and shared accountability, and improve quality.
- Institute new payment structures and incentives to promote these critical reforms.
- Specify health care provider participation in the plans will be voluntary; Medicare providers are presumed to be participating unless they opt out.

- Provides for provider reimbursements for services from the plans initially will be established using “rates similar to those used in Medicare with greater flexibility to vary payments.
- Speaker of the House, Nancy Pelosi, has announced plans to proceed immediately on mark up on the House Bill with the intention to of scheduling a vote on the House Bill by the end of July. Assuming that House leaders adhere to this schedule, the planned timetable leaves little opportunity for critical evaluation and input by members of Congress or the public who may have questions or concerns about the proposed legislation. Prompt and coordinated action is required for individuals with concerns about any of the proposed reforms.

**Federal Mandates Health Plan Benefits.** In order to achieve affordable, quality health care for all, the House Bill would impose federal standards regulating the benefits that the public health plan and private health plans would be required and permitted to offer. Under these provisions, the House Bill would:

- Establish a standardized benefit package that covers essential health services.
- Vest the power in the Secretary of Health & Human Services to decide the coverage that would be included in this mandated standardize benefit package.
- Eliminate cost-sharing for preventive care (including well baby and well child care).
- Impose caps annual out-of-pocket spending for individuals and families.
- Create a new independent Benefits Advisory to recommend to the Secretary and update the core package of benefits.
- Provide for the public health plan option to offer four tiers of benefit packages from which consumers can choose to best meet their health care needs. Each allowable plan would be required to provide the dictated core benefits.
  - The Basic Plan would include the federally mandated core set of covered benefits and cost sharing protections;
  - The Enhanced Plan would include the federally mandated core set of covered benefits with more generous cost sharing protections than the Basic plan;
  - The Premium Plan would include the federally mandated core set of covered benefits with more generous cost sharing protections than the Enhanced plan; and
  - The Premium Plus Plan would include the federally mandated core set of covered benefits, the more generous cost sharing protections of the Premium plan, and additional covered benefits (e.g., oral health coverage for adults, gym membership, 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.

The House Bill empowers the Secretary of Health & Human Services to decide the federally dictated, required core set of benefits provides coverage with input from a newly created Benefits Advisory Commission. These core benefits are intended to include inpatient hospital services, outpatient hospital services, physician services, equipment and supplies 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 and mental health and substance abuse services. However, the particular, terms and scope of these benefits is left to HHS to define.

**Health Insurance Exchange.** The House Bill also calls for the establishment of a “Health Insurance Exchange” meeting federal mandates through which low income individuals initially, and certain small businesses would be offered the option to purchase health care coverage through federally mandated purchasing groups. In the first year, the House Bill provides for the Health Insurance Exchange to accept those without health insurance, those who are buying health insurance on their own, and small businesses with fewer than 10 people. In the second year, the Health Insurance Exchange could accept small businesses with fewer than 20 people. After that, “larger employers as permitted by the Commissioner.” In other words, expansion is discretionary, not mandated.

**Affordability & Subsidies.** The House Bill provides sliding-scale affordability credits for individuals and families with incomes above the Medicaid thresholds but below 400% of poverty and imposes a cap on total out-of-pocket spending for individuals and families covered under the plans regardless of income. In addition, the House Bill would broaden Medicaid coverage to include individuals and families with incomes below 133% of poverty.

Effective 2013, sliding scale affordability credits would be provided to individuals and families between 133% to 400% of poverty. That means the credits phase out completely for an individual with \$43,320 in income and a family of four with \$88,200 in income (2009).

The sliding scale credits limit individual family spending on premiums for the essential benefit package to no more than 1.5% of income for those with the lowest income and phasing up to no more than 11% of income for those at 400% of poverty.

The affordability credits also subsidize cost sharing on a sliding scale basis, phasing out at 400% of poverty, ensuring that covered benefits are accessible.

The Health Insurance Exchange would administer the affordability credits in relationship with other federal and state entities, such as local Social Security offices and Medicaid agencies.

The essential benefit package, and all other benefit options, limit exposure to catastrophic costs with a cap on total out of pocket spending for covered benefits. Special provisions would apply to Medicaid.

Effective 2013, individuals with family income at or below 133% of poverty (\$14,400 for an individual in 2009) are eligible for Medicaid. State Medicaid programs would continue to cover those individuals with incomes above 133% of poverty, using the eligibility rules states now have in place.

**Paying The Tab.** House Democrats propose to finance approximately half of the estimated \$1 trillion bill for their proposed reforms through projected \$500 billion or so in savings from Medicare and Medicaid achieved by a variety of reimbursement and benefit cutbacks and other reforms. The rest of the financing would come from a combination of revenue expectations from employer and individual mandates (an estimated \$200 billion over 10 years) and a surtax on the richest 1.5 percent of Americans. The surtax is 1% on income between \$350,000 and \$500,000; 1.5% on income between \$500,000 and \$1,000,000; and 5.4% in income above \$1,000,000. The House Bill permits the amount of this surtax to vary if the bill is less or more expensive than initially anticipated.

The author of this article, Curran Tomko Tarski LLP Health Care Practice Chair, Cynthia Marcotte Stamer, has extensive experience advising and assisting health industry clients and others about a diverse range of health care policy, regulatory, compliance, risk management and operational concerns. You can get more information about her health industry experience [here](#).

If you need assistance evaluating or formulating comments on the proposed reforms contained in the House Bill or on other health industry matters, please contact Cynthia Marcotte Stamer, CTT Health Care Practice Group Chair, at [cstamer@cttlegal.com](mailto:cstamer@cttlegal.com), 214.270.2402, or your other favorite Curran Tomko Tarski LLP attorney.

### **Curran Tomko Tarski LLP Attorneys Can Help**

Curran Tomko Tarski LLP Health Care Practice leader and author of this update, Cynthia Marcotte Stamer, has extensive experience advising and assisting health industry clients and other businesses and business leaders to establish, administer, investigate and defend health care fraud and other compliance and internal control policies and practices to reduce risk under federal and state health care and other laws. You can get more information about her health industry experience [here](#). If you need assistance with these or other compliance concerns, wish to inquire about arranging for compliance audit or training,

or need legal representation on other matters please contact Cynthia Marcotte Stamer, at [cstamer@ctllegal.com](mailto:cstamer@ctllegal.com), 214.270.2402 or another Curran Tomko Tarski LLP attorney.

### **Other Helpful Resources & Other Information**

We hope that this information is useful to you. Curran Tomko Tarski LLP offers a variety of updates, publications, training and other resources to assist its business clients and their leaders meet their legal and operational challenges. If you or someone else you know would like to receive future updates about developments on these and other concerns, please be sure that we have your current contact information – including your preferred e-mail – by creating or updating your profile [here](#). You can access other recent updates and other informative publications and resources provided by Curran Tomko Tarski LLP attorneys, get information about their briefings and speeches, and review highlights of their experience and credentials [here](#).

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