ADDITIONAL REGULATION UNDER TRI COMMITTEE BILL*

America's Health Insurance Plans

As of July 12, 2009

HEALTH INSURANCE PLANS

- Payment for minimum services
- Limited cost sharing
- No annual/lifetime limits
- Network adequacy requirements
- Other benefits as determined by Health Benefits Committee

ESSENTIAL BENEFITS PACKAGE (EBP)

MINIMUM SERVICES

- Hospitalization
- Outpatient, including ER
- Professional services of doctors and other health professionals
- Services, equipment, supplies
- Prescription drugs
- Rehabilitation
- Mental health/substance abuse
- Preventive services
- Maternity benefits
- Well child care including hearing, vision, and oral care for under 21

PRESIDENT

- Require states prior to 2017 to allow traditional Medicaid eligibles enrolled in the Exchange to also be eligible for additional Medicaid benefits not offered in Exchange

SURGEON GENERAL

GSA COMPTROLLER GENERAL

- Periodic audit of Comparative Effectiveness Research Commission

HEALTH BENEFITS ADVISARY COMMITTEE

- Recommend to Secretary on essential benefits package
- Recommend to Secretaryon cost sharing levels for premium and enhanced plans

SPECIAL INSPECTOR GENERAL FOR HEALTH INSURANCE EXCHANGE

- Conduct audits, evaluations, investigations

CONGRESS

- Increase funding to Health Care Fraud and Abuse Control Account

DEPARTMENT OF JUSTICE

- Access to MA and Part D contract information for audit, evaluation, and enforcement.

GOVERNMENT ACCOUNTABILITY OFFICE

- Access to MA and Part D contract information for audit, evaluation, and enforcement.

MEDICARE ADVANTAGE (MA)

- Payment changes based on fee for service costs
- Eliminates Regional Plan Stabilization Fund
- Additional quality bonus payments to high quality plans.
- Limits cost sharing to no greater than the cost sharing under traditional Medicare.
- Changes dates for enrollment periods and special enrollment period for enrollees in suspended MA plans.
- MA Coding Intensity Adjustment permanently extended.
- MA cost plans extended through 2011.
- Employers granted MA requirement waivers if 90 percent of MA eligible individuals enrolled in a plan reside in a county which offers a local MA plan.
- Plans must submit information on each plan's MLR, per enrollee payment, average risk scores, total medical expenses, non-medical expenses, private reinsurance costs, and gain/loss margin for publishing by Secretary.

CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH (CCER)

- Conduct, support, and synthesize research on comparative effectiveness
- Review of clinical research
- Develop scientific methods for conducting studies
- Submit reports to Congress, Secretary, and Comparative Effectiveness Research Commission.
- Encourage development of clinical registries and clinical effectiveness research data networks.

OMBUDSMAN FOR PUBLIC OPTION

PUBLIC HEALTH INSURANCE OPTION

- HHS Secretary required to establish
- Offered only in Exchange
- Meet requirements of Exchange participating plan for benefits, benefit levels, provider network consumer protedtion and cost sharing
- Must offer basic, enhanced, and premium plans. May offer premium plus.
- Contract to operate similar to Medicare
- Different payment initiatives and delivery system reforms
- Different cost sharing and payment rates
- Varying payment structure based on geography
- Fraud/abuse
- Health care provider or supplier must submit in application any affiliation within last 7 years with a person or entity that has been suspended or excluded from the program.
- Establish provider incentives

REQUIREMENTS

- Licensed in state
- Report all information required by Commissioner
- Provide method to implement affordability credits
- Accept all enrollments
- Reimburse medical for wraparound services
- Pooling mechanism
- Contrast with essential community providers as required by Commissioner
- Culturally / linguistic appropriate communications
- Compliance with Title 2 (billing, grace periods, etc.)
- Contract with Commissioner

HEALTH EXCHANGE

- Meet requirements for Exchange participation
- Only offers QHBP
- Grievance/appeal process
- Standards for disclosure of plan information, reimbursement, plan changes
- Prompt payment equal to Medicare Advantage or Commissioner regulations
- Offer basic plan. May offer enhanced, premium and premium plus plans

ACCEPTABLE COVERAGE

- QHBP
- Grandfathered individual plan
- Medicare
- Medicaid
- Armed Forces (TRICARE)
- Veterans Administration (VA)
- Other coverage recognized by Secretary and Federal Commissioner

INDIVIDUAL RESPONSIBILITY REQUIREMENTS

- Enrolled in acceptable coverage
- Non-compliance tax on individual
- Entity providing coverage must file a return to Secretary on individual's compliance. Information can then be disclosed to Federal Commissioner and State exchange

OUTSIDE THE EXCHANGE

- Excepted benefits
- Individual grandfathered coverage
- QHBP

STATE MANDATES

- Continues in effect if it exceeds EBP
- Must meet rules under Federal Commissioner
- Reimburse Federal Commissioner for increases in individual affordability credits

STATE INSURANCE REGULATORS

- Consult with Federal Commissioner
- Set premium rating area outside Exchange
- QHBP and enforcement

NAIC

- QHBP and enforcement

STATE ATTORNEYS GENERAL

- QHBP and enforcement

OTHER STATE AGENCIES

- Medicaid eligibles
- Individual affordability credits

STATE EXCHANGE

- States get permission from Federal Commissioner to operate a state trust fund and state-based exchange
- Federal Commissioner puts process regulation and approval for state exchange. Only one exchange per state
- Federal Commissioner retains all authority

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

- Any child who qualifies under CHIP is enrolled in Exchange
- Eligibility requirements no more restrictive than those in effect on June 16, 2009
- Requires tobacco cessation counseling as part of benefits for pregnant women
- Nurse home visitation services to families with first time pregnant women or with child under age of two

QUALIFIED HEALTH BENEFIT PLAN (QHBP)

- Guarantee access to plan
- Guarantee coverage
- Guarantee access to essential benefits
- Consumer protections
- Guarantee renewal
- Pre-existing conditions
- Non-discrimination/benefits
- Use provider networks
- 85% MLR or give rebate
- Rating

EMPLOYERS

- Offer employees option to join exchange. Employee chooses specific plan
- To meet requirements for employer responsibility, must offer coverage under QHBP, contribute toward coverage, make timely contributions to exchange if employee refuses coverage and joins exchange
- If no coverage, pay 8% of wages as a fee
- Allowed to keep ERISA plans
- Excise tax for not meeting reqirements
- Small business tax credit

COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND

- Monies from Federal Hospital Insurance Trust Fund, Federal Supplementary Medical Insurance Trust Fund, and Medicare Prescription Drug Account.
- Money from fees on insured and self-insured health plans to be paid by issuer of policy.

INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES

- Review and report on standards of evidence used by Comparative Effectiveness Research Commission and CCER

PATIENT OMBUDSMAN

- Ensure that research of CCER accounts for differences in populations of patients.

DEPARTMENT OF DEFENSE

- Consult with Secretary on prevention/wellness

DEPARTMENT OF VETERANS AFFAIRS

- Consult with Secretary on prevention/wellness

INDIAN TRIBES

QHBP OMBUDSMAN

- Receive complaints and provide assistance
- Provide info on choosing plans and affordability credit

DEPARTMENT OF LABOR

- Claims procedure rule must be met for QHBP
- Coordinate with Secretary, Federal Commissioner and Treasury on Exchange

TREASURY

- Coordinate with Secretary, Federal Commissioner and Labor on Exchange

HEALTH CHOICES ADMINISTRATION COMMISSIONER (FEDERAL COMMISSIONER)

- Rating/age
- Premium rating area in Exchange with consultation with state insurance regulators
- Non-discrimination rules
- Network adequacy requirements
- Minimum loss ratio standards
- Plan transparency standards
- Timely payment of claims
- COB/subrogation rules
- QHBP uniform marketing standards
- Internal and external grievance, claims, and appeals process requirements
- Establish/operate Exchange
- Administer individual affordability credits
- Collect data on quality, value, disparities. Share with Secretary
- QHBP enforcement/penalties
- Accept bid and contract for QHBP
- Facilitate outreach and enrollment
- Risk pools
- Define terms for employer coverage
- Survey Exchange participants
- Rules for transition into Exchange
- EBP and plans specifics
- Auto enrollment of individuals into Exchange
- Disseminate information on Exchange
- Memorandum of understanding with each state for Medicaid eligible enrollees

INDIVIDUAL AFFORDABILITY CREDITS

- Only available through Exchange
- Federal Commissioner pays QHBP entity the aggregate of credits
- Individual applies to be eligible
- Federal Commissioner can grant state Medicaid agency authority to determine eligibility and reimburse state for costs
- y1/y2 basic plan only. Thereafter determined by Federal Commissioner
- Only an individual is eligible—cannot be part of employer plan or if employer offers coverage (y1) or if premium from employer is less than 10% AGI (y2+)
- Must be in U.S. lawfully

HEALTH INSURANCE EXCHANGE TRUST FUND

- Payments to operate exchange
- Payments of individual affordability credits

STATES

- Grants from federal government to develop programs to improve health of children
- Enter into Medicaid memorandum of understanding with Federal Commissioner to coordinate enrollment of individuals into exchange
- Accept any individual determined by Federal Commissioner to be a non-traditional Medicaid eligible individual
- Provide coverage during eligibility period to Traditional Medicaid eligible individual who is referred by Federal Commissioner while the state accesses if the individual is eligible
- Certify to Secretary State has procedure for Medicaid services provided in a school-based health clinic
- Pay for extended rebate on outpatient drugs provided by Medicaid managed care organizations
- Report to Secretary total yearly rebate for prescription drugs
- Report to Secretary on Medicaid GME payments
- Review and Report to Secretary on effectiveness under Medicaid Integrity Program

MEDICAID

- Any child born in U.S. without acceptable coverage
- Any child eligible for CHIP who has not enrolled in Exchange and eligible for Medicaid
- Any non-traditional Medicaid eligible individual eligible for Exchange
- Mandatory coverage for non-traditional and traditional Medicaid eligible individuals under 133 percent federal poverty level
- 100 percent federal FMAP match for traditional and non-traditional Medicaid enrollees under 133 percent federal poverty level
- Medicaid coverage of a child at birth with 100 percent federal match
- Eligibility requirements no more restrictive than those in effect on June 16, 2009
- Mandatory coverage without cost sharing for preventive services recommended by US Preventive Task Force or vaccines by Center for Disease Control and Prevention
- Requires coverage for tobacco cessation drugs if Medicaid plan covers prescription drugs
- Mandatory Medicaid managed care plan payments consistent with new minimum payment rates to primary care physicians
- Option eligibility category for low-income HIV infected individuals at increased FMAP match rate equal to enhanced CHIP rate
- Transitional Medicaid Assistance program extended 2 years
- 90 percent federal FMAP match for creating/updating Electronic Eligibility System and 75 percent for operation
- Eliminates requirement for state to provide for receipt and initial processing of applications for certain Medicaid eligibility categories.
- Medicaid non-payment for hospital treatment of conditions reasonably preventable as determined by HHS

SPECIAL NEEDS PLANS (SNP)

- Prohibited from enrolling new beneficiaries except during open enrollment period or at time of diagnosis of a qualifying disease or condition.
- Extended through 2012

FULLY INTEGRATED DUAL ELIGIBLE SPECIAL NEEDS PLAN (FIDESNP)

- Paid same amounts and same rules as MA plans except under waivers by Secretary
- Provides dual eligibles access to Medicare and Medicaid
- Uses a single managed care organization
- Coordinates care through coordinated community care network methods for high-risk dual eligibles.
- Contracts with a state Medicaid agency that includes primary, acute, long term care benefits and services under risk based financing
- Policies and procedures approved by Secretary and State for enrollment, member materials/communications, grievances/appeals, and quality assurance
- Waiver authority to align Medicare and Medicaid requirements and better coordination for dual eligibles served by plans not fully integrated.

REINSURANCE PROGRAM

- Assist early retirees
- Insurance smart card
- Preventive care visit card

MEDICARE

- Eliminate funding to Medicare Improvement Fund in FY 2014-2017
- Review mechanism for providers on quality measures and appeal process
- Quality Reporting
- Adjustments to Medicare reimbursement and provider payment rates
- Decreased payments to hospitals with excessive readmissions
- Hospital reporting and disclosure requirements for ownership, investment, and compensation
- Drug manufacturer rebate agreements with state Medicaid Agencies must include rebates for covered outpatient drugs dispensed to full premium subsidy Medicare Part D enrollees
- Eliminate Part D coverage gap
- Repeal requirement that Long-Term Care pharmacies submit claim within 30-90 days
- Prescription drug costs under AIDS Drug Assistance Programs and Indian Health Services included in true out-of-pocket costs
- Special enrollment period for Part D beneficiaries whose plan materially changes formula or cost sharing mid-year. every bid by an MA organization
- Special enrollment period for TriCare beneficiaries
- Extends various Medicare provisions for rural areas
- Increases income-related subsidies and Medicare cost-sharing assistance and allows for self-certification of eligibility and automatic re-enrollment
- Guaranteed issue of Medigap for disabled Medicare beneficiaries and MA enrollees who leave their plan
- Permits payment for end of life consultation and requires inclusion of information in *Medicare and You* book
- Rate increase for primary care practitioners
- Expanded coverage for education services under Medicare Covered Preventive Services
- Eliminates cost-sharing and waives application of deductible payments for all Medicare Covered Preventive Services
- New payment modifier for physician fee schedule
- Protection under Medicare and Medicaid Integrity Programs that submit annual reports to Secretary on effectiveness of its activities
- Compliance measures to be determined by Secretary
- 12 month limit on filing claims under parts A/B
- Any claim for durable medical equipment must be submitted by a Medicare participating provider
- Providers must report and return any overpayment within 60 days of discovery
- Repeals provision of Medicare Modernization Act requiring President and Congress to propose Medicare spending reductions when Medicare Trustees issue a Medicare Funding Warning.
- Repeals Comparative Cost Adjustment Program
- Extends Gainsharing Demonstration project
- Pharmacists payment based on federal upper reimbursement limit no less than 130 percent of weighted average of most recent nationwide average manufacturer prices.
- Additional prescription drug rebates and increased minimum rebate percentage.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- New office to improve coordination between Medicare and Medicaid
- Oversight of FIDESNP
- Support states where FIDESNP have been designated or other integration
- Coordination of state and federal contraction and oversight of dual integration
- Align federal rules for Medicaid and MA plans
- Monitor total Medicare and Medicaid program costs for dual eligibles
- Recommendations for optimizing quality, cost performance, access to Medicare and Medicaid.

ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM

- Payment incentive models to reduce growth of expenditure and improve health outcomes of beneficiaries through qualifying accountable care organization.
- Promote accountability for patient populations and coordinate services
- Encourage investment in infrastructure
- Reward high quality, efficient physician practices
- Each accountable care organization agreement can be 3-5 years, can be extended or terminated by Secretary.

MEDICAL HOME PILOT PROGRAM

- Feasibility of reimbursing qualified patient-centered medical homes for furnishing medical home services to high need beneficiaries.
- Operate at least 5 years, extended by Secretary.

HHS SECRETARY (SECRETARY)

- Regulations to require health services (insurance) to be delivered without regard to personal characteristics
- Public health insurance option
- Collect data on public option for premiums/payments
- Increase payments 5% to providers in Medicare and public option
- Provider requirements under public option
- Fine non-compliant employers
- Establish 85% MLR
- Administrative simplification
- Report to Congress on Medicare and other provisions
- Audit authority for risk adjustment data in MA plans
- Not required to accept any or every bid by an MA organization.
- Coordinate with states to establish a common regulatory system, quality measures, and reporting procedures for Medicare and Medicare for FIDESNP
- Expand and enhance Medicare beneficiaries access to telehealth services
- Assign enrollees to Medicare Part D plans to maximize access to individual and minimize cost.
- Study on Medicare service providers utilization of language services for beneficiaries with limited English proficiency.
- Demonstration program/grants to health care providers to improve communication in communities with racial/ethnic minorities.
- At least triennially, establish and update national priorities for performance improvement.
- Consult with CMS and AHRQ to determine areas in need of quality measures for assessing health care services.
- Receive reports by manufacturers and distributors of covered drugs, devices, biological, or medical supplies under Medicare, Medicaid, or CHIP. Reports include information on payments or transfers of value to a covered recipient.
- Screening and oversight, moratorium on enrollment if determines there is a significant risk of fraudulent activity
- Report to Congress on prevention/wellness

COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION

- Oversee CCER
- Identify credible research methods and standards of evidence
- Review methodologies
- Forums to increase awareness and get feedback on the Agency for Healthcare Research and Quality.
- Recommendations for public access to data of reviews.
- Recommendations to CCER for dissemination of research findings.
- Public disclosure of relevant reports.
- Recommendations for periodic reviews of research and studies of CCER.
- Determine national priorities for research though consultation with public/private stakeholders.
- Monitor use of Comparative Effectiveness Research Trust Fund
- Clinical perspective advisory panel for each research priority for CCER.
- Review processes of CCER
- Report to Congress on activities of CCER

BUREAU OF HEALTH INFORMATION

- Ensure collection, collation, reporting, publishing of statistics on key health indicators of national health/health care system
- Identify/resolve gaps in data collection
- Standards for collection of data on health and health care
- Reassess key health indicators every 3 years
- Publish quarterly statistics on key health indicators
- Consistency of key health indicators with national strategy
- Disbursement of data to HHS/other federal agencies
- Public access to datasets
- Work with National Health IT

CENTER FOR QUALITY IMPROVEMENT

- Best practices/quality improvement
- Patient outcomes
- Behavioral changes for quality improvement
- Grants to implement at state/local

INSPECTOR GENERAL

- Access to claims and payment databases to identify fraud and abuse
- Review reports on ownership and compensation between renal dialysis facilities and its medical director or any physician

CLINICAL PREVENTION STAKEHOLDER BOARD

- Recommendations to Task Force on Clinical Preventive Services
- Suggest studies
- Feedback on draft recommendations
- Disseminate recommendations

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

- Enter into agreement with qualified entities to develop quality measures for delivery of health care services

TASK FORCE FOR CLINICAL PREVENTIVE SERVICES

- Evidence Based recommendations on preventive services
- Recommend priority areas for research
- Health disparities in recommendations

COMMUNITY PREVENTION STAKEHOLDERS BOARD

- Recommendations to Task Force on Clinical Preventive Services
- Suggest studies
- Feedback on draft recommendations
- Disseminate recommendations

CENTER FOR DISEASE CONTROL AND PREVENTION (CDC)

- Provide preventive services recommendations
- Determine schedule for Pediatric Vaccine Distribution Program
- Grants for prevention/wellness priority areas
- Grants to states, local and Tribes for health infrastructure
- Review/update/report to Congress on voluntary accreditation of state/local health departments
- Disseminate recommendations

TASK FORCE FOR COMMUNITY PREVENTIVE SERVICES

- Evidence Based recommendations on preventive services
- Recommend priority areas for research
- Health disparities in recommendations

NATIONAL INSTITUTES OF HEALTH (NIH)

- Consult with CDC on prevention/wellness

*This is additional regulation to current system. Use with attached chart.

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