

The Healthy Americans Act (S. 391)
Introduced by Senator Wyden (D-OR) on February 5, 2009

Summary of Provisions

TITLE I – HEALTHY AMERICANS PRIVATE INSURANCE PLANS

Subtitle A – Guaranteed Private Coverage

Healthy Americans Private Insurance Plans

All adults and their dependent children must enroll in a Healthy Americans Private Insurance (HAPI) plan offered through an employer or a state-wide Health Help Agency. Individuals who fail to enroll will be penalized financially unless they can demonstrate coverage through Medicare or other source (e.g., the Department of Defense or Veterans Affairs). This requirement is waived for individuals who oppose health insurance for religious reasons. Self-insured and employer group health plans must meet the same requirements as HAPI plans and participate in a risk-adjustment mechanism. Furthermore, employers are required to advise their employees of the availability of HAPI plans by distributing standardized, unbiased information regarding HAPI plans and supplemental insurance options provided by the Health Help Agency to their employees.

State Health Help Agencies must offer the option of at least two HAPI plans from the following options: 1) a plan that is similar to the Blue Cross Blue Shield Standard Plan provider under the Federal Employees Health Benefit Program; 2) a plan with additional benefits provided the additional benefits are priced and marked separately; 3) an actuarial equivalent plan; and 4) a plan that includes state mandated benefits. Additionally, HAPI plans must provide: primary care assessment and annual physical examinations; wellness programs and incentives; catastrophic medical events in excess of lifetime limits; designation of a medical professional responsible for the monitoring of an individual's medical care (health home); a care plan (created upon a first visit to primary care physician or health home); management of disease and chronic conditions; and cost-sharing requirements for covered benefits except for preventive services for early detection.

Medicaid

Coverage under a state Medicaid plan is considered to be supplemental to, and cannot supplant HAPI plan coverage for eligible nondisabled, nonelderly, adult, individuals. However, in cases where Medicaid coverage is more comprehensive than the HAPI plan all eligible nondisabled, nonelderly, adult, individuals are entitled to receive all items or services provided under Medicaid. Cost-sharing for non-supplemental coverage under a HAPI plan shall not be greater than the rate under the state Medicaid plan for eligible nondisabled, nonelderly, adult, individuals.

Subtitle B – Standards for Healthy Americans Private Insurance Coverage

Actuarially Equivalent plans

Any actuarially equivalent plan to a HAPI plan must be actuarially equivalent to the Blue Cross Blue Shield Standard Plan under the Federal Employees Health Benefit Program, while providing at least the same level of coverage as a HAPI plan. Similar to other HAPI plans, actuarially equivalent plans cannot charge copays for preventive services and chronic disease management.

Coverage Classes

The following classes of individuals are eligible for coverage: individuals, married couples or domestic partnerships (as determined by a state) without dependent children, and married couples of domestic partnerships (as determined by a state) with dependent children.

Premiums

A health insurance issuer may determine premiums using community rating or adjusted community rating principles (including risk-adjustment). Variation is permitted for geography, tobacco use, and family size. Age, gender, industry, health status, or claims experience may not be considered. However, premium discounts and other incentives may be offered for participation wellness and chronic disease prevention programs.

Access

HAPI plans are subject to existing requirements for the group health market, including: prohibition on pre-existing exclusions for new enrollees with no prior creditable coverage; guaranteed availability and renewability of coverage; prohibition on health status discrimination; coverage protections for mothers and newborns and reconstructive surgery following a mastectomy; prohibition on genetic discrimination; and mental health parity.

Advisory Committee

The Secretary of Health and Human Services (Secretary) must establish a 15-person Healthy America Advisory Committee that will provide annual report and recommendations to the Secretary and Congress concerning modifications to covered benefits, items, and services for HAPI plans. Members of the Committee will include a health economist, an ethicist, health care providers, health insurance issuers, health care consumers, a member of the U.S. Preventive Services Task Force, and an actuary. Members shall be appointed by the Comptroller General and will serve for three years with a reappointment option of one year.

Subtitle C – Eligibility for Premium and Personal Responsibility Contribution Subsidies

Eligibility for Premium Subsidies

Income-based premium subsidies are available to individuals and their families with an adjusted gross income at or below 100% of the poverty line. Individuals or families with an adjusted gross income greater than 100% of the poverty line, but below the applicable percentage (400%) will receive partial basic premium subsidies equal to the basic premium subsidy reduced by a formula amount. Individuals must notify the Health Help Agency within 60 days if they change their state of residence or have a change in income that makes

them either eligible or ineligible for a subsidy. The Health Help Agency will adjust the premium of an individual whose income changes to take effect on the first month after the date the individual notifies the Health Help Agency of the change. A state may develop mechanisms to ensure that covered individuals do not experience a break in coverage due to a catastrophic financial event.

Eligibility for Personal Responsibility Contribution Subsidies

The Health Help Agency will provide individuals with a modified adjusted gross income below 100% of the federal poverty level for the relevant family size a full subsidy for any personal responsibility contributions. Those individuals with incomes above 100% of the federal poverty level will receive a partial subsidy. A health insurance issuer must return any federal government funding received on behalf of an illegal adult alien. The Secretary of Homeland Security may not extend or renew an alien's eligibility for status in the U.S. or adjust the status if the alien owes a HAPI plan premium payment that is past due or a penalty for failing to pay a premium. Penalties will be imposed for failure to pay HAPI plan premiums.

The Secretary must develop regulations to be used by Healthy Help Agencies to calculate premium and personal responsibility subsidies for those individuals whose modified adjusted gross income based on the most recent tax filing is significantly lower than the modified adjusted gross income for the year involved.

Subtitle D – Wellness Programs

Requirements for Wellness Programs

Wellness programs are those that include activities designed to improve an individual's health by modifying consumer behavior, enhancing well-being and productivity, and preventing illness and injury through increased awareness, assessment of risks and education. In order for an enrollee to receive a premium discount from a HAPI plan, the administrator of the wellness program must certify in writing that the program meets certain requirements and that the enrollee is participating or the dependent child of the enrollee is participating. Wellness program participation may not be used to make rate or discount determinations with respect to the health status of the enrollee. A HAPI plan must provide enrollees with an opportunity to participate in a wellness program and qualify for a premium discount at least once a year.

Enrollees may participate in more than one wellness program to get the maximum premium discount allowed by their plan or state law. A HAPI plan may also provide discounts in the amount of the personal responsibility contributions required of enrollees if the enrollee participates in an approved wellness program. As an incentive, the Internal Revenue Service rules for health insurance costs of self-employed individuals apply to employers deducting the costs of offering wellness programs to enrollees.

TITLE II – HEALTHY START FOR CHILDREN

Subtitle A – Benefits and Eligibility

Identification and Enrollment of Eligible Children

The Secretary shall develop policies and procedures for states to identify and enroll eligible children into a HAPI plan. This applies to children who are under age 19 (or under the age of 21 and living in foster care) and live in a family with a modified adjusted gross income that is below 300 percent of the poverty line and are not eligible for coverage as a dependent under a parent's HAPI plan.

Coordination of Supplemental Coverage under Medicaid

When a child is enrolled in a HAPI plan and is also eligible for Medicaid, the Medicaid services shall be coordinated with and supplemental to coverage under a HAPI plan. However, if a HAPI plan excludes or limits services to Medicaid eligible children, those children shall receive all services identified in a Medicaid state plan, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services through Medicaid.

For purposes of coordination with Medicaid, eligible children are Medicaid eligible individuals under age 21, children who are under age 19 who live in a family with a modified adjusted gross income that is below 300 percent of the poverty line and who are not eligible for coverage as a dependent under his/her parent's HAPI plan, and children who are under age 21 and who live in foster care arrangements.

If a child receives services that are not supplemental to HAPI coverage, the premiums, deductibles, or other cost-sharing shall not be greater than permissible under the Medicaid state plan.

Subtitle B – Service Providers

Service Providers

HAPI plans will reimburse providers for services for children receiving care through school-based health centers, health centers funded under Section 330 of the Public Health Services Act, federally qualified health centers, rural health clinics, or Indian health service facilities if the services are not provided at no cost.

School-based health centers must be located in elementary or secondary school facilities, operated in collaboration with the school, and administered by a community-based organization. Students shall be provided an opportunity to enroll in a health center with parental consent. Services may be provided to students in more than one school if the school district determines that it is appropriate based on capacity and geographic location. Each center must provide primary care and mental health services when the school is open and 24-hour coverage through an on-call system. Preventive dental services are optional.

The centers must be staffed by qualified and appropriately credentialed professionals, who shall be considered government employees and protected under the Federal Tort Claims Act if acting within the scope of his or her license.

School-based health centers may seek reimbursement from a third party payer, including HAPI plans. The center must use the funds to provide additional care. By January 1, 2012, all centers must use individual electronic medical records.

A local school district must apply to the Secretary for a grant to establish and operate school-based health centers. At least 50 percent of the funds must be used for the ongoing operation of the center. Priority will be given to centers that will be located in medically underserved areas, including areas where appropriate providers are not located within reasonable proximity to the school, schools that serve students with the highest incidence of unmet medical and psycho-social need, and where the applicant has received at least 50 percent of the necessary funding from state, local, or community partners to ensure the ongoing operation of the center.

TITLE III – BETTER HEALTH FOR OLDER AND DISABLED AMERICANS

Subtitle A – Assurance of Supplemental Medicaid Coverage

Coverage Under Medicaid for the Elderly and Disabled

Any elderly or disabled individual who is covered under a HAPI plan and Medicaid must receive the benefits in a coordinated manner and not be charged premiums, deductibles, or other cost-sharing that is greater than what would have been charged under the state plan.

The Secretary is granted the authority to issue regulations and guidance to states and health insurers that takes into account the special needs of elderly and disabled individuals.

Subtitle B – Empowering Individuals and States to Improve Long-Term Care Choices

Automatic Medicaid Option for State Choices for Long-Term Care Program

Title XIX of the Social Security Act is amended by adding a new section entitled “State Choices for Long-Term Care Program.” This allows states the option to operate a State Choices for Long-Term Care Program that provides individuals with long-term care services tailored to the individual’s needs and preferences. Each enrolled individual will be provided with a personal case manager who will assist in determining the individual’s needs, identify community resources, and address issues related to safety and quality of care.

The state’s long-term care program must include equal access to institutional care and home and community-based services. In addition, the state must create eligibility criteria that will be approved by the Secretary. Finally, a state may not participate in the program unless it agrees to limit federal expenditures, provides a plan for capacity building and skills enhancement, and dedicates program savings for prevention or early intervention services.

Simpler and More Affordable Long-Term Care Insurance Coverage

Section 7702B of the Internal Revenue Code of 1986 (IRC) is amended to related to qualified long-term care plans to provide f. The National Association of Insurance Commissioners is required to adopt a model regulation within nine months. If this does not occur, the Secretary will promulgate a regulation in its place that applies to all states. Also, additional consumer protections are set forth, including guaranteed renewal or non-cancelability and prohibitions on limitations or exclusions. Finally, any person who sells a long-term care insurance policy must make available a policy with only the core group of basic benefits and shall provide before the sale of the policy an outline of coverage that describes these basic benefits.

TITLE IV – HEALTHIER MEDICARE

Subtitle A – Authority to Adjust Amount of Part B Premium to Reward Positive Health Behavior

Adjusting Part B Premiums

The Secretary may adjust Part B premiums to incentivize positive health behaviors such as weight management, exercise, nutrition counseling, refraining from tobacco use, designating a health home, and other similar behaviors.

Subtitle B – Promoting Primary Care for Medicare Beneficiaries

Promoting Primary Care

The Secretary must implement a primary care management fee for providers serving as the health home of a Medicare beneficiary and providing continuous medical care, prevention and treatment, and specialist referrals. The amount of the payment will be determined by the Secretary in consultation with MedPAC.

Subtitle C – Chronic Care Disease Management

Chronic Care Disease Management

Medicare must make available a chronic care disease management program to Medicare beneficiaries no later than January 1, 2010. The program must cover the five most prevalent diseases and providers who are not primary care providers, but cover chronic disease management, may receive an additional payment. The amount of the payment will be determined by the Secretary in consultation with MedPAC. In addition, the Act requires the Secretary to establish procedures for identifying and enrolling Medicare beneficiaries in the program and creates Chronic Care Education Centers as a clearinghouse for chronic disease management information.

Subtitle D – Part D Improvements

Part D Improvements

The Secretary shall develop a process to permit individuals to change prescription drug plans once they hit the donut hole to a plan that provides coverage in the gap.

Subtitle E – Improving Quality in Hospitals for All Patients

Hospital Quality Program

All Medicare participating hospitals must demonstrate improvements in quality control including rapid response teams, health attack treatments, reduction of medication errors, infection prevention, and others initiatives as determined by the Secretary. The Secretary also shall convene an independent panel to ensure hospital quality control within two years of enactment.

Subtitle F – End-of-Life Care Improvements

End-of-Life Care

Medicare participating health care facilities must provide each patient with a document that outlines the patient’s individual treatment preferences, coordinates those preferences with physician orders, and transfers with the patient from setting to setting. The document does not override any state health care proxy, living wills or other end-of-life forms. The Secretary also must create a public, national, toll-free information clearinghouse to provide state-specific information on advance directive and end-of-life care decisions unless one already exists. Upon enrollment in Medicare, the Secretary shall refer new Medicare beneficiaries to the clearinghouse.

Medicare patients may continue to receive curative care while receiving hospice benefits.

Subtitle G – Additional Provisions

Additional Cost Information/Paperwork

The Secretary shall require Medicare Advantage organizations to aggregate claims data into episodes of care and report the information to the Secretary for measurement and comparison. The information also shall be publicly reported. In addition, the Secretary is required to develop a plan to reduce regulations and paperwork focusing on regulations that do not enhance the quality of patient care reimbursed by Medicare.

TITLE V – STATE HEALTH HELP AGENCIES

Each state must establish a Health Help Agency to administer HAPI plans. Each state will receive federal funds for two years following enactment of the law to establish such an agency, so long as the state agrees that the agency will undertake certain responsibilities. These responsibilities include: 1) promotion of prevention and wellness; 2) promotion of the use of health information technology; 3) oversight and facilitation of enrollment in HAPI plans (including the dissemination of information about the private HAPI plans to

individuals); 4) determination of how subsidies will be calculated for low-income enrollees and who is eligible under the subsidy program; 5) collection of a fee from each private insurer offering a HAPI plan to fund the subsidy program; 6) collection of premiums from the covered individuals in HAPI plans and subsequent remittance of such payments to the plans themselves in accordance with the premium rating rules; 7) dissemination of detailed bioethical information including the patient's right to refuse treatment and have control over end-of-life care decisions as permitted under state law.

The state Health Help Agencies also must detail the exact coverage area in which HAPI plans will be available in their state and work with other state governments in managing metropolitan areas that cross state lines. Moreover, the agencies must work with the Secretary to ensure transition from Medicaid and CHIP is orderly and that Medicaid beneficiaries receiving other Medicaid benefits continue to receive those benefits.

TITLE VI – SHARED RESPONSIBILITIES

Subtitle A – Individual Responsibilities

Individual Responsibilities

Under the Act, adult individuals (and on behalf of his/her spouse and/or dependent children) are expected to enroll in a HAPI plan through a state Health Help Agency and submit required monthly premiums or required personal responsibility contributions (the latter being payments in an amount equal to the HAPI plan premium amount).

Subtitle B – Employer Responsibilities

Employer Responsibilities

All employers are required to pay an employer shared responsibility payment for each calendar year, with the amount to be determined based on the number of full-time equivalent employees and the applicable percentage of the average HAPI plan premium amount (applicable percentage amount is determined based on the employer's revenue per employee, size, non-profit [or government] status, and whether the employer was providing health insurance coverage to its employees at the time the Healthy Americans Act was enacted). A credit may be provided to private employers who provided health insurance benefits greater than the 80th percentile of the national average in the two years prior to enactment of the Act, can demonstrate that the benefits provided encouraged prevention and wellness activities, and continue to provide wellness programs. Employers who provided insurance through self-insurance are subject to a special rule using the average HAPI plan premium amount for the first year the section applies, and self-employed individuals shall be treated as both a full-time equivalent employee and as an employer.

Subtitle C – Insurer Responsibilities

Insurer Responsibilities

An insurer that seeks to offer a HAPI plan must: 1) emphasize prevention, early detection, and chronic disease management; ensure that a wellness program is available to all covered

individuals; 2) demonstrate how the provider reimbursement methodology has been adjusted to reward providers for achieving quality and cost efficiency in prevention, early detection of disease, and chronic care management; 3) create and implement an electronic medical record for each covered individual (unless the individual declines); 4) contribute to the financing of the Health Help Agencies by incorporating into the administration component of premiums an additional amount to reimburse Health Help Agencies for administrative costs; 5) use standardized common claims forms and uniform billing practices; 6) provide incentives such as premium discounts for parents (e.g., if a covered child participates in wellness activities and the health of the child improves) and for adults to participate in prevention, wellness, and chronic disease management programs; and other requirements.

Subtitle D – State Responsibilities

State Responsibilities

States must meet certain requirements as conditions before receiving payment under Section 503 of the Healthy Americans Act, including: 1) creation of a Health Help Agency; 2) development of mechanisms to support enrollment and collection of premiums; 3) development of mechanism to ensure enrollment and develop methods to check on enrollment status; and 4) implementation of a mechanism to automatically enroll uninsured individuals who seek care in the an emergency department. Each state is also required to submit an annual maintenance of effort report to the Secretary that details the state’s expenditures with regard to public health programs that are operated in the state.

A state is eligible for a waiver from applicable program requirements if it presents a plan to provide health coverage to its residents that is at least as comprehensive as the coverage required under a HAPI plan. The Secretary is provided with timeframes and instructions for granting such waivers.

Subtitle E – Federal Fallback Guarantee Responsibility

Federal Guarantee of Access to Coverage

If a state does not establish a Health Help Agency two years after the enactment of the Healthy Americans Act, the Secretary shall ensure that each individual in that state has a choice of enrollment between at least two HAPI plans. Parameters are also set for the Secretary to enter into contracts for the offering of fallback HAPI plans in areas in which the guarantee is not met

Subtitle F - Federal Financing Responsibilities

Federal Financing Responsibilities

One hundred percent of Medicare disproportionate share (DSH) funds and 90% of Medicaid DSH payments will be recaptured. Amounts not spent will be used to create a Healthy Americans Public Health Trust Fund. The Trust Fund is authorized to provide for premium and personal responsibility subsidies, bonus payments to states for implementing medical malpractice reform, and transfers for purposes of reducing the federal budget deficit.

Subtitle G – Tax Treatment of Health Care Coverage Under Healthy Americans Program; Termination of Coverage Under Other Governmental Programs and Transition Rules for Medicaid and CHIP

Tax Treatment of Health Care Coverage

Certain payments made by employers are not taxable as income to their employees, namely shared responsibility payments by employers, payments for coverage of former employees under existing retiree health plans, payments for employer provided health care under existing collective bargaining agreements, and payments for employer provided coverage for long term care. The value of wellness programs provided by employers, as well as onsite first aid coverage, is also not taxable as employee income.

Limitations are also placed on deductible employer health care expenditures. No deduction is allowed for any employer contribution to an accident or health plan other than shared responsibility payments by employers, any accident or health plan coverage for former employees under existing retiree health plans, payments for continuing employer-provided health plans under qualified collective bargaining agreements, any accident or health plan which qualifies as a wellness program, any accident or health plan which constitutes on-site first aid coverage for employees, and any accident or health plan which is a qualified long-term care insurance contract.

A new Health Care Standard Deduction is also created and made available to individuals and families falling below the poverty line. The deduction begins to phase out at \$62,500 for individuals and \$125,000 for joint filers, and becomes unavailable to those earning \$125,000 as an individual and \$250,000 as a joint filer.

Certain tax breaks for health care are protected, including tax credits for health insurance costs for individuals, coverage of benefits enjoyed under “cafeteria plans,” and Archer Medical Savings Accounts.

ERISA Applicability to Employer-Sponsored HAPI Plans

ERISA protections are still available to employers who continue to offer their employees group health insurance coverage, so long as the coverage meets the Act’s benefit standard.

Federal Employees Health Benefits Plan, Medicaid and CHIP

Group coverage offered under the Federal Employees Health Benefit Plan, Medicaid and CHIP are all eliminated, with the exception of Medicaid wrap around and long term care functions.

TITLE VII – PURCHASING HEALTH SERVICES AND PRODUCTS THAT ARE MOST EFFECTIVE

Subtitle A – Effective Health Services and Products

The Act amends the IRC to disallow the deduction of advertising and promotion costs for all pharmaceuticals and medical devices (except those for rare diseases and certain others specified in Section 45(c) of the Act) that manufacturers currently enjoy for a specified period after the approval and release of the drug or device. However, for drugs and devices that have been subject to comparative effectiveness research (CER) studies, the deduction for marketing and promotion still applies.

Manufacturers of drugs and devices are permitted to include the results of CER studies in new drug/device applications for approval. If such CER information is included in the new drug/device applications, the Food and Drug Administration will apply the provisions of market exclusivity to the application in the same way the agency does for pediatric drugs, and extend the patent life for devices. If such CER information is not included in the new drug/device application, then all promotional material for that drug/device must contain a disclaimer that CER studies were not undertaken for the product.

The Secretary is required to set up a website that medical schools and other researchers can use to post information about evidence-based best practices, how to implement such practices, and the source of their research funds. Additionally, the Act establishes a pilot program using the information about best practices from the website to update medical school curricula and training to reflect innovations in quality and efficiency in care.

Additionally, a website will be established by the state Health Help Agencies and private insurance companies aimed at assisting beneficiaries in finding quality physicians nearby.

Subtitle B – Other Provisions to Improve Health Care Services and Quality

The Secretary shall establish procedures to ensure that an individual's medical record is considered the property of the individual.

Within three years of enactment, states shall be eligible for a bonus payment for amending their medical malpractice laws in conformance with the Act (including a screening procedure of medical liability claims, voluntary non-binding mediation, sanctions for the filing of frivolous claims, etc). The bonus payment must be used for disease and illness prevention and enhanced health care services for kids.

Health care employment and training activities shall be prioritized by requiring the Secretary of Labor (or whichever federal official is granted power over stimulus or authorization funds to provide services for individuals) to distribute funds with priority status for those seeking employment in, or training for, positions as health care providers.

TITLE VIII – CONTAINING MEDICAL COSTS AND GETTING MORE VALUE FOR THE HEALTH CARE DOLLAR

The cost-saving elements in the Act include: 1) Private insurance companies will be forced to hold down costs and will slow rate of growth when offering standardized Healthy Americans Private Insurance plans; 2) Administrative costs for employers and insurers will be reduced; 3) Private insurance companies will implement uniform billing and common claims forms; 4) Congress will reclaim Medicare and Medicaid disproportionate share hospital payments because previously uninsured individuals will go to providers on an outpatient basis rather than the emergency room; 5) State and local government will spend less on programs for the uninsured will be reduced; 6) Federal government will spend less on federal tax subsidies that reward inefficient care will be reduced; 7) Federal government and private sector will save money if the Food and Drug Administration determines whether products provide new value; 8) Reduced medical errors will accrue savings to government and private sector; 9) Cost savings will accrue from requiring hospitals to send large bills to patients for review that will reduce errors; 10) Insurers will reimburse for quality and cost effective services that will hold down private sector costs; 11) Limiting Medicare's restriction of prescription drug price negotiations will reduce costs for sole source drugs and other medications; 12) Use of electronic medical records will create savings; and 13) Publication of cost and quality data will allow individuals to identify affordable high-quality providers for their care.