



H.R. 3962, “Affordable Health Care for America Act”
Passed November 7, 2009 – 220 to 215

Insurers

- Beginning in 2010, grants the Secretary of Health and Human Services the authority to annually review health plan rate filings jointly with states (Section 104)
 - The process will require insurers to submit a justification for any premium increase prior to implementation of the increase
- Directs the Secretary of Health and Human Services to compensate doctors under the public health insurance option plan with innovative payment mechanisms (Section 323 and Section 324)
 - This will require insurers to raise premiums to meet the requirement
- Starting in 2013, health insurance plans are required to guarantee coverage for all applicants, and cannot exclude any individual based on a preexisting condition (Section 211)
 - Insurers can use an adjusted community rating standard to vary premiums by age (maximum ratio of 2:1), geography, and family size
- Any health plan participating in the Exchange must provide an essential benefits package, which includes coverage for minimum services (Section 203 and Section 222) as determined by the new Health Choices Commissioner
 - Minimum services include hospitalization, outpatient services, professional services, prescription drugs, rehabilitative services, and mental health / substance abuse services
- Individuals are allowed to maintain the same insurance coverage they held prior to the effective date of the bill, thus “grandfathered” into the new exchange system. After five years, individuals must purchase individual policies through the Exchange. (Section 202)
 - Insurers cannot vary a premium percentage increase for a risk group of enrollees who were grandfathered in without changing the premium for all enrollees in the same risk group at the same rate
 - Existing group health plans will be grandfathered in and will have 5 years from enactment to meet the quality health benefits plan requirements