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The Honorable Nancy Pelosi  
Speaker, US House of Representatives  
H-232, US Capitol  
Washington, DC 20515

The Honorable Steny Hoyer  
Majority Leader, US House of Representatives  
H-107, US Capitol  
Washington D.C. 20515

Dear Speaker Pelosi and Majority Leader Hoyer:

As the debate over passage of health care reform legislation approaches its final phase, during which House and Senate legislation must be merged, we would like to take this opportunity to again express our appreciation for the strong legislation produced by the House of Representatives and to acknowledge the enormous effort on the part of so many that went into producing the bill.

We recognize that time is short and completing legislative work on reform will require compromise, in some cases compromise that is likely to make many passionate advocates for reform – both in and out of the House – uncomfortable. At Community Catalyst we believe that, notwithstanding the inevitable compromises that attend the legislative process, we are on the verge of an historic achievement and that passage of legislation that moves us toward health security for all Americans is of paramount importance.

At the same time, we strongly believe there are important provisions in HR 3962 that should not be compromised in the coming negotiation with the Senate if at all possible. The most important of these provisions make coverage and care affordable for the most economically vulnerable households. Additional areas where we believe every effort must be made to retain House language relate to Medicaid, private insurance regulation, reduction in racial and ethnic health disparities, and accountability of the prescription drug industry. We briefly summarized key House provisions that differ from the current Senate bill that we hope will be retained in the final legislation below.

## Affordability

- **Premium subsidy levels and annual out-of-pocket caps for families earning up to 250 percent of the Federal Poverty Level (FPL) [Section 343(d)(1)].** These low-income families are the least able to bear the brunt of a federal mandate to purchase insurance, yet they could end up paying several thousand dollars more in health care costs under the Senate approach. For example, a family of three earning \$27,465 (or 150 percent FPL) would pay 50 percent more for premiums under the Senate bill than under the House bill. That same family would get a plan that protects them from spending more than \$1,000 (or 4 percent of their income) annually on out-of-pocket costs in the House bill, compared to \$3,867 (or 14 percent of their income) in the Senate bill. The House provisions would help more low-income families afford coverage and have meaningful access to health care.
- **Higher actuarial values for all low- and moderate-income families who qualify for subsidies Section [343 (d)(1)].** Families who qualify for subsidies would face much lower out-of-pocket costs using the House actuarial values rather than the Senate's. For example, a family of three with average medical expenses and income of \$36,620 would pay for about 7 percent of the total costs of the health care they need under the House bill, but 20 percent of those costs under the Senate bill. Unreasonable out-of-pocket expenses can put insured families at increased risk of underinsurance, medical debt, and delayed or forgone medical care.
- **Progressive penalties for individuals who fail to obtain coverage under the individual mandate [Section 501(a)].** The House bill would charge uninsured individuals 2.5 percent of their income above a threshold amount. Under this penalty structure, low-income families would face a much lower penalty than higher-income families, better reflecting what they can actually afford. In contrast, the Senate bill would charge a flat \$750 per person, regardless of income. This regressive penalty structure could lead low-income uninsured families – who are already struggling to make ends meet – to face stiff penalties that force them further into poverty.

## Medicaid

- **Expand Medicaid eligibility to 150 percent FPL [Section 1701].** Increasing the eligibility threshold above the 133 percent FPL in the Senate bill will help more families get the quality health care they need. Providing insurance coverage through Medicaid instead of a private plan (offered through an Exchange) best protects low-income individuals from high out-of-pocket costs and matches them with a program that is best-suited to their health and financial needs. Additionally, Medicaid is the least expensive insurance option, with care costing 26-30 percent less than a private plan (Leighton Ku <http://healthaffairs.org/blog/2009/06/23/expanding-coverage-for-low-income-americans-medicaid-of-health-insurance-exchanges/?source=promo>). Medicaid also has a long history of providing quality care to the sickest and poorest individuals in our country.
- **Increased payments for Medicaid primary care providers [Section 1721].** Raising primary care provider rates to parity with Medicare rates will result in broader provider

participation in Medicaid and ensure greater access for patients to the primary care that is the basis of a quality health care system. This measure addresses a longstanding concern by the physician community. The *Urban Institute* reports that Medicaid payments to primary care providers represent approximately 66 percent of Medicare payments for similar services in 2008 (<http://www.healthaffairs.org/press/marapr0910.htm>).

- **Extend the enhanced FMAP for states beyond the end of American Recovery and Reinvestment Act (ARRA) [Section 1749].** The extension through June 2011 is necessary to help maintain existing Medicaid programs through the economic downturn. Medicaid enrollment is rising with the increase in unemployment, placing increasing financial pressure on states. If ARRA funds are terminated as scheduled, many states will cut their Medicaid programs, creating backward momentum just as health reform begins. It is imperative to preserve the integrity of state programs, particularly when Medicaid will serve as an important building block of health reform.

### **Private Insurance**

- **Rate premiums only by age and constrained to a 2:1 ratio [Section 213].** Limiting the amount that premiums may vary protects people from unaffordable coverage based on their age or other factors.
- **Authority for Health Insurance Exchanges to negotiate and contract with health plans based on their value and quality of benefits [Section 155].** Based on the Massachusetts experience, this authority is critical to guarantee insurers offer consumers cost-effective coverage and consumers are able to navigate a somewhat rational health insurance marketplace.
- **70 percent actuarial value for the basic health plan in the Exchange [Section 167].** Our work on health care reform in Massachusetts highlighted the importance of adequate benefit standards for all consumers. The House standard will ensure that people are buying adequate coverage that will be there when they need it.

### **Health Disparities**

- **Allow undocumented immigrants to purchase insurance at full cost through the Exchange [Section 302].** Allowing everyone in the United States to purchase health insurance at no cost to taxpayers will help ensure that communities across the nation are healthier. It may also reduce uncompensated care costs, as people who would have sought care at emergency rooms are able to visit primary care doctors. In addition, since immigrants are, as a whole, younger and healthier than citizens, including them in the insurance pool could also reduce costs and rates for everyone.
- **Increase federal funding for translation services for adults in Medicaid [Section 1723].** This provision would expand federal funding for translation or interpretation services to adults in Medicaid whose primary language is not English. To enroll and properly care for adults in Medicaid, health providers must be able to communicate

clearly with people who struggle to understand English. Increasing federal funding for these services will help ensure these services are available when needed.

- **Explicit inclusion of community health workers in medical home teams [Sections 1866F (d)(1)(B)(iii) and 1722(c)(2)].** Community health workers focus on prevention and education, and on improving access to the most appropriate care settings. Community health workers improve health outcomes, increase the use of non-emergency health care services, decrease the use of acute care resources, lower the cost of health care and add value to health care teams when integrated.
- **Require the Secretary of HHS to study and recommend ways to improve transparency and accountability of Disproportionate Share Hospital (DSH) funds [Sections 1112 and 1704].** The original intent of the DSH programs has not always been honored by states or hospitals, but in many communities the money supports essential care. Evaluating the impact that national health reform will have on DSH is an important step toward ensuring the proper role and accountability for the funds in the future. While we expect coverage expansions in national health reform will reduce uncompensated care, our experience in Massachusetts has shown that expansion will significantly lessen – not negate – the need for free care and other services hospitals provide without reimbursement.

### **Quality/Delivery System Reform**

- **Create the Center for Medicare and Medicaid Innovation [Section 1907].** This Center will allow CMS to test, evaluate and expand payment and delivery models that improve quality and offer patient-centered care while simultaneously altering the trajectory of health care spending.
- **Pilot a Medical Home program [Section 1302].** Medical home models offer some of the most promising approaches to providing effective, coordinated care that improves patients' health and increases access to the right care in the right place at the right time. Requiring that the pilot programs incorporate patient-centered practices will also help ensure that services are targeted to patient and family needs.
- **Create an Office within CMS to coordinate Medicare and Medicaid. [Section 1905].** This Office will provide enormous benefit to dually eligible beneficiaries by working to eliminate confusion about Medicare and Medicaid while also improving the continuity of medical, behavioral health, and long-term care.

### **Prescription Drugs**

- **Require pharmaceutical or medical device companies to report payments to physicians and other providers [Section 1128H].** The House Physician Payment Sunshine Act contains stronger language than the Senate, including not only physicians but other prescribers, such as nurse practitioners and physician assistants. The House also requires reporting payments made through third parties. Other key sections are a low

threshold for reporting; public reporting on a searchable website; and careful pre-emption of state disclosure laws that preserves the right of states to collect other information. This important transparency initiative, supported by the Institute of Medicine, MedPac and diverse stakeholders, will protect patients and help restore trust in our health care system.

- **Ban pay-for-delay settlements between pharmaceutical manufacturers and generic competitors [Section 2573].** This would prevent drug companies from paying competitors to delay bringing a generic drug to market. This provision would also promote competition in the marketplace and help provide patients affordable access to needed medicines. The Federal Trade Commission estimates it will save \$35 billion over 10 years.

We would also like to bring to your attention some specific provisions in the current version of the Senate bill which we hope you will accept in a combined bill.

- **Immediate funding for states to create consumer assistance offices [Section 1002] as well as authorization for navigators, including community and consumer-focused nonprofit organizations, through state Exchanges to help consumers enroll in coverage [Section 1311(i)].** While the House clearly recognizes that consumers will need help enrolling in and maintaining health coverage, the Senate bill provides more direct support for consumer-focused nonprofits to provide consumer assistance. Consumers, particularly those with low incomes, will need help from organizations they trust to find their way in the new health system. We believe this is critical to the success of health care reform.
- **New accountability standards for private tax-exempt hospitals [Section 9007].** The Senate bill requires private tax-exempt hospitals to establish fair, transparent financial assistance policies for people who are unable to pay for care. It also requires these hospitals to include community members in local and institutional health planning. These measures will help ensure that hospitals granted tax-exempt status serve their communities by providing free or reduced-cost care to the most needy and by working with community members to target fundamental health needs that would otherwise go unaddressed. Past polling shows tremendous public support for this kind of government oversight for tax-exempt hospitals.
- **Premium subsidy levels and annual out-of-pocket caps for families earning more than 250 percent of FPL [Section 1401(a)].** The Senate bill makes premiums more affordable for moderate-income households. For example, a family of three earning \$73,240 (at 400 percent FPL) would pay almost 20 percent less under the Senate bill than under the House. That same family could spend up to 14 percent of their income on out-of-pocket costs in the House bill, compared with only 11 percent in the Senate bill.

- **Exemptions from the individual mandate for families who cannot find affordable coverage and for undocumented immigrants [Section 1501(b)].** Unlike the House bill which has no “circuit breaker” exemption based on affordability, the Senate bill exempts all individuals and families from the individual mandate if the lowest-cost coverage available exceeds 8 percent of their income. The Senate also explicitly exempts all undocumented immigrants (who are not granted access to Medicaid or subsidies under either bill). These critical protections ensure that no family is required to spend more than they can afford to comply with the individual mandate. They are particularly relevant if the final bill includes the weaker employer mandate from the Senate bill, rather than the stronger employer mandate from the House bill, since low-wage workers may be precluded from obtaining subsidies but still find it difficult to afford their employer’s insurance.
- **Gradual phase-in of the penalties for families who fail to obtain coverage under the individual mandate [Section 1501 (b)].** The Senate bill phases in the penalties over three years, so that in the first year families would face a penalty of no more than \$95 per uninsured person. This gradual phase-in is an important consumer protection that enables families to understand and adapt to the individual mandate without facing steep penalties in the first few years.
- **Children’s health care coverage through CHIP (Section 2101).** The Senate bill keeps children in CHIP past 2013 rather than moving them into the Exchange. We believe that this protects children more fully than the House bill’s language to dissolve CHIP, as it better guarantees children a more robust benefits package and stronger out-of-pocket cost protections. Maintaining and building on the CHIP program also provides greater opportunity to understand the Exchange programs before millions of children are moved into them. While maintaining the CHIP program is not the only way to ensure that children are protected in health reform, we think that it is the best proposed option at the current time.

In conclusion, we want to again recognize your personal leadership and also express our appreciation through you to the many members and staff of the House of Representatives who listened attentively to our concerns and those of other consumer advocates. We know people have labored many hours to bring us closer to the goal of affordable health care for all that has long eluded us in the United States. If Community Catalyst can provide you with any additional information on the provisions above or offer any other assistance in the final phase of the legislative process we would be pleased to do so.

Sincerely,



Robert Restuccia  
Executive Director, Community Catalyst