



Summary of Senate Finance Committee Chairman's Mark

Senate Finance Committee Chairman Max Baucus released his version of the America's Healthy Future Act on Sept. 16. It is slated for mark-up by the Senate Finance Committee this week. The chairman's version is an important step forward for national health reform. It contains many positive measures, including expansion of Medicaid, improvements to private insurance, strong delivery system reforms, community benefits standards for hospitals, enhancements to Medicare and fairer prescription drug policies. However, there are areas that need to be strengthened, including making coverage more affordable for families, improving access for immigrants, and including a strong public insurance option. The Chairman's Mark is available [here](#).

Insurance Reform

The proposal would overhaul the individual and small group health insurance markets to expand access to coverage. The proposal would:

- Require insurers to offer coverage to everyone.
- Prohibit exclusions for pre-existing conditions.
- Bar insurers from basing premiums on health status. Premiums could vary based on age, constrained to a 5:1 ratio. They could also vary by geography, family size and tobacco use, with the overall spread limited to a 7.5:1 ratio.
- Prohibit caps on lifetime or annual benefits.
- Require all health plans to cover preventive and primary care, physician and outpatient services, emergency care, hospitalization, maternity and newborn care, pediatric care, prescription drugs, and mental health and substance abuse services.
- Eliminate out-of-pocket costs for preventive care.
- Limit annual out-of-pocket costs to \$5,800 for an individual and \$11,600 for families.
- Allow slimmed-down insurance plans for young adults with only catastrophic coverage, plus preventive care.

Comment: Overall, this proposal creates important consumer protections in the private insurance market, which will allow many Americans to get coverage. However, allowing premiums for older people to be up to five times more than premiums for young people will keep coverage unaffordable for some. In the House bills, age rating is limited to a 2:1 ratio and out-of-pocket costs are limited to \$5,000 for individuals and \$10,000 for families. The Senate Finance Committee insurance standards would apply to all health plans in the individual and small group markets, which is stronger than in the House bill, in which benefits and cost sharing limits are only required for plans offered through the Exchange.

Insurance Exchanges

The proposal would:

- Establish an "Exchange" in each state to help individuals and employees of small businesses compare plans and make informed choices. States have an option to create separate Exchanges for individuals and small businesses.
- Offer subsidies to make coverage more affordable only through Exchanges.

- Require all private insurers in the individual and small group markets to offer plans in the Exchange. All Exchange plans must meet minimum benefit and cost-sharing standards.
- Allow state insurance regulators to determine which health plans could be offered in the Exchange in their state.

Comment: Overall, details about the Exchanges seem positive. However, because all insurers are required to participate in state Exchanges, consumers may find it difficult to sort out appropriate options among all the plans. In addition, undocumented immigrants are prohibited from purchasing insurance through the Exchange, even at full price.

Medicaid Expansion

The proposal would:

- Expand Medicaid to 133 percent of the federal poverty level (FPL) for most adults, including people without children, funded in part by expanded federal assistance, effective 2014.
- Allow adults between 100 - 133 percent FPL to choose between Medicaid and insurance coverage through the Exchange. States would pay premiums for adults who choose the Exchange based on the average cost of Medicaid coverage for a similar person.
- Create improvements to Medicaid including presumptive eligibility and greater transparency on application and approval of waivers.
- Make prescription drugs a mandatory benefit for all Medicaid programs by January 2014 and require larger rebates from drug makers.

Comment: The expansion of Medicaid to childless adults and parents up to 133 percent FPL would make coverage affordable for this newly eligible group. However, the proposal does not remove the unfair five-year waiting period for legally present immigrants.

Children's Coverage

This proposal would:

- Phase out the Children's Health Insurance Program (CHIP) by 2013 and allow children in families with incomes between 134 - 250 percent FPL to enroll in subsidized Exchange plans and receive expanded benefits, including Early Periodic Screening, Diagnosis and Treatment.
- Limit out-of-pocket expenses to a maximum of 5 percent of income.
- Keep current levels of federal matching funds to states for CHIP benefits.
- Maintain the quality provisions established in CHIP reauthorization for children in Medicaid and CHIP.

Comment: The quality measures for children are a positive step. However, shifting children from CHIP into the Exchange without more robust safeguards could reduce benefits and increase out-of-pocket expenses. Under the proposal, states would be required to coordinate wrap-around services if Exchange plans did not provide benefits at parity to CHIP. However, the language does not provide details about enforcement

Affordability

The proposal would:

- Provide new “affordability tax credits” or sliding scale subsidies for people earning between 100 - 400 percent FPL (\$73,240 for a family of three) if they do not have access to insurance through their employer that costs less than 13 percent of their income. Premiums would start at 3 percent of income for those earning 100 percent FPL and rise to 13 percent for those at 300 percent FPL or above.
- Reduce out-of-pocket maximums for people below 300 percent FPL and out-of-pocket subsidies for people below 200 percent FPL.

Comment: The subsidies would make coverage substantially more affordable for millions of low- and middle-income families who do not have access to coverage through their employers.

However, there are significant weaknesses. Specifically:

- The subsidies are too low. Families earning up to 150 percent FPL already struggle to pay for basic necessities like housing and shelter, so they should be exempt from premiums. Premiums should be limited to no more than 11 percent of income for those at 400 percent FPL, as in the original House Tri-Committee bill, with lower caps for individuals at lower incomes.
- Low-income individuals who are offered expensive insurance through their employers will be left with no affordable option. Those with expensive employer-sponsored coverage should get aid to lower their premiums to what they would pay in the Exchange
- The out-of-pocket protections are insufficient and would continue to put low- and moderate-income families at risk of underinsurance if they face a catastrophic illness.
- Exchange subsidies are not available to people with income below 100 percent FPL. The language is ambiguous about eligibility for subsidies for legally present immigrants with incomes under 100 percent FPL.
- Verification rules for eligibility may exclude some citizens who do not have birth certificates or other appropriate documents, and make it difficult for children who are citizens but have undocumented parents to get coverage.

Shared Responsibility

For individuals:

All U.S. citizens and legal residents would have to obtain coverage that meets minimum requirements unless the available coverage would cost them more than 10 percent of their income. Exemptions would be allowed for religious objections, financial hardship, undocumented immigrants, Native Americans, and people below 100 percent FPL. The penalty is equal to \$750 per year (\$1,500 maximum per family) for people between 100 - 300 percent FPL, and \$950 per year (\$3,800 maximum per family) for people above 300 percent FPL.

Comment:

The individual mandate includes some critical consumer protections, including the affordability and hardship exemptions. However, fines for families who do not have insurance are high and may be cause further financial hardship.

For employers:

Starting in 2013, employers that do not offer coverage that meets minimum requirements will be required to pay a flat dollar amount for each employee who receives premium subsidies through the Exchange. The flat dollar amount will be equal to the average tax credit in the state Exchanges. Employers with 50 or fewer full-time employees would be exempt.

Comment:

Employers could avoid the fine by offering their workers fairly minimal coverage that would be unaffordable for many low wage workers. Also, because employers would not face a fine for higher-income employees – since they aren't eligible for subsidies – this provision may discourage hiring of low-income workers, including minorities.

Small business tax-credits

Small businesses with 25 or fewer employees, an average wage of no more than \$40,000, and who contribute at least 50 percent of the premium for employee coverage, would qualify for tax credits. In 2011 and 2012, credits would be available to offset up to 35 percent of the employer's contribution. Starting in 2013, the credit would be available only for the first two years that a business provides coverage to its employees through the state Exchange, but it would offset up to 50 percent of the employer's contribution.

Comment: Because the credit would only be available to offset actual tax liability, small non-profit organizations might not be able to take advantage of this tax credit.

CO-OP / Public Plan

The proposal would authorize \$6 billion in loans and grants to fund start-up and reserves for at least one non-profit, member-run health insurance company in each state that would offer coverage to individuals and small businesses. While these Consumer Operated and Oriented Plans (CO-OP) could enter into collective purchasing agreements, they would not be allowed to collaborate in setting rates and are subject to anti-trust laws.

Comment: The Baucus proposal does not include a public option. The CO-OP model is untested, has few advantages, and is unlikely to be a strong competitor with insurance companies or to significantly influence provider prices.

Ombudsman's Office / Consumer Voice

- All states would be required to create an ombudsman's office to serve as a "consumer advocate" by 2010. The ombudsman would help people with individual and small group insurance resolve problems with health claims if they have exhausted other options.
- The proposal also provides \$30 million for consumer assistance organizations in each state to help consumers navigate the health system and provide feedback.

Comment: This section improves consumer assistance and feedback on implementation.

Disparities

The proposal would:

- Require quality reporting to include data on race, ethnicity, primary language, gender and disability and standardize collection of this and other disparities data.
- Establish a national quality improvement strategy that prioritizes reduction of health care disparities.
- Provide bonus payments to Medicare Advantage plans for care coordination and management activities that address health care disparities.
- Establish a health care workforce advisory committee to examine the needs of minority and medically underserved populations.
- Establish demonstration grants to support low-income individuals training in health professions.
- Create a new Medicaid state plan option for enrollees with multiple chronic conditions to designate a provider as their health home.

Comment: These measures would advance efforts to reduce racial and ethnic disparities, but the committee could go further. One important step would be to require insurers and health professionals to provide culturally and linguistically appropriate care. In addition, the proposal does not include the expanded funding for community health centers that is in the House and HELP bills. The proposal also restricts immigrant access to coverage (as noted in Insurance Exchanges, Medicaid Expansion, Shared Responsibility and Affordability sections above).

Improving Quality

The proposal would:

- Authorize the secretary of Health and Human Services to develop a national quality strategy.
- Expand pay-for-performance programs and test new payment models, including bundled payments, to encourage care coordination.
- Establish specific initiatives to reduce avoidable hospital re-admissions and hospital-acquired infections, and improve care transitions.
- Create a center to develop means of improving the quality of Medicare while slowing cost growth and fostering patient-centered care.
- Encourage the development of new patient care models, including accountable care organizations (ACOs).
- Create a non-profit institute to conduct comparative effectiveness research, but bar use of the results to ration care through federal programs.
- Promote an increase in the number of primary care providers.
- Incorporate the Physician Payment Sunshine Act, requiring drug and device makers to disclose payments to doctors or teaching hospitals.

Comment: The proposal would likely improve the quality of health care, particularly for vulnerable populations. Many provisions would move the health care delivery system away from the current fragmented, fee-for-service approach and toward a more coordinated, comprehensive system that encourages prevention and wellness, and rewards improved health outcomes.

Medicare

The proposal would:

- Establish an independent Medicare Commission to investigate reforming the delivery system to improve quality of care for Medicare patients while reducing costs. Commission members would report directly to Congress.
- Establish a new office in the Centers for Medicare & Medicaid Services (CMS) charged with aligning Medicare and Medicaid policies and financing for dually eligible beneficiaries.
- Phase out enhanced payments to private Medicare Advantage (MA) plans starting in 2011. The plans could get bonuses for coordinating care and improving quality, but they would have to use the money to provide additional benefits – such as limiting patients' out-of-pocket costs.
- Extend Special Needs Plans (SNPs) to the end of 2013 and require SNPs serving dually eligible beneficiaries to contract with state Medicaid programs.
- Starting in 2010, pharmaceutical companies participating in Medicare Part D would be required to offer brand name prescription drugs for Medicare Part D enrollees in the donut hole at a 50 percent discount from the negotiated price.

Comment: The proposal takes important steps to preserve Medicare for future generations while reducing seniors' out-of-pocket expenses.

New Requirements for Not-for-Profit Hospitals

The proposal requires:

- Each not-for-profit hospital to conduct a community needs assessment every three years with input from the community, and develop a strategy to meet those needs. Failure to do so would result in a penalty of up to \$50,000 per hospital.
- Each hospital to adopt and publicize a financial assistance policy.
- Hospitals to limit charges to patients who qualify for financial aid to either the Medicare rate, the best commercial rate, or an average of the best three commercial rates. Hospitals cannot use extraordinary collection tactics – lawsuits, liens on homes, arrests – without first making a reasonable attempt to inform patients about financial aid policies.
- The IRS to audit information on hospitals' community benefits every three years.
- The IRS and HHS to report annually to Congress on the levels of bad debt, charity care, and unreimbursed costs incurred by all hospitals, in addition to the costs not-for-profit hospitals incur from community benefits.

Comment: Unlike many other provisions of the House and HELP bills and the Chairman's Mark, these provisions would go into effect for the tax year following the bill's enactment. They could dramatically improve patients' ability to access health care services. They would immediately provide some relief to people who are unable to pay for the full cost of care and currently find themselves at the mercy of their local hospital's collection procedures. However, the proposal would allow hospitals to set their own eligibility and billing standards, which would perpetuate problematic variation from hospital to hospital.

Financing

The proposal would be financed through a variety of new taxes and other revenue-generating provisions, including:

- A 35 percent excise tax on insurance companies for employer-sponsored plans that cost \$8,000 or more for an individual or \$21,000 or more for a family. The tax would apply to the amount of the premium in excess of these amounts.
- New annual fees on health care stakeholders, including a \$2.3 billion fee on pharmaceutical manufacturing companies, a \$4 billion fee on medical device manufacturers, and a \$6 billion fee on health insurers.
- Reductions in Medicaid Disproportionate Share Hospital (DSH) payments, including up to 65 percent of DSH payments in any state, tied to reductions in the number of uninsured.
- Reductions in DSH payments to 25 percent of current levels. However, hospitals with higher uncompensated care costs could get extra money.

Comment: Significant cuts to funding for hospitals that serve the uninsured and underinsured could diminish the safety net for patients.