



## Summary of Revised Senate Finance Committee Chairman's Mark

Sept. 24, 2009

Senate Finance Committee Chairman Max Baucus released a revised version of the America's Healthy Future Act on Sept. 22. Thanks to an outpouring of grassroots activism, the revised mark contains a number of improvements especially related to regulating insurers and making insurance more affordable. Changes in our summary based on the revision are indicated in **red** below.

Mark-up by the Senate Finance Committee began yesterday and is scheduled to conclude 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 still 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](#). The changes to the Mark are 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 **4:1 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 for individual, small-group, and all Exchange plans. It also prohibits "unreasonable" annual or lifetime limits in large-group plans.**
- 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. **Other adults could enroll in these plans, if they were previously enrolled in a similar plan or are exempt from the individual mandate because their premiums would exceed 10 percent of their income.**
- **Allow states to prohibit the sale of national plans with limited benefits.**

*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 four 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. In addition, charging

smokers more for their insurance punishes them for their addiction without any evidence that it deters smoking. 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 **with up to 100 employees.**
- Offer subsidies to make coverage more affordable only through Exchanges.
- Require all private insurers licensed in the state’s individual and small group markets to offer plans in the Exchange. All Exchange plans must meet minimum benefit and out-of-pocket cost requirements and offer benefits consistent with one of four benefit standards.
- **Require the development of a rating system for Exchange plans, based on quality and value, to aid consumers in choosing plans.**

*Comment:* Overall, details about the Exchanges seem positive. However, because all insurers meeting minimum requirements will participate in state Exchanges and the Exchange is not allowed to bargain with insurers over rates, the Exchange will not do all it could to maximize value and reduce costs. In addition, consumers may still find it difficult to sort out appropriate options among all the plans. The rating system may improve this. Finally, 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.
- **Require states to report on their progress in enrolling Medicaid-eligible individuals.**
- **Provide additional federal financial assistance to “high-need states” that have Medicaid enrollment below the national average and unemployment rates of 12 percent or higher in August 2009. This would provide full federal funding for new Medicaid expansions in these states for five years.**

*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 allows states to tie benefits for these low-income enrollees to the “bronze” benefit package in the Exchange, which is a much skimpier benefit package than Medicaid typically provides and will leave people with significant coverage limitations. In addition, the proposal does not remove the discriminatory five-year waiting period for legal immigrants to obtain Medicaid.

## 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.
- **Require the Secretary of HHS to certify that children transferring from CHIP to the Exchange have access to a level of benefits and out-of-pocket expense protections comparable to the state's CHIP plan. If not, the state must maintain its Medicaid/CHIP plans until the Exchange plans measure up.**
- 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.

## 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 **10 percent** of their income. Premiums would start at **2 percent of income for those earning 100 percent FPL and rise to 12 percent for those between 300 and 400 percent FPL.**
- Reduce out-of-pocket maximums for people below **400 percent FPL** and offer 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:

- Subsidies are too low. In particular, low income families earning up to 200 percent FPL may be unable to meet their premium obligations under the SFC proposal.
- Low-income individuals who are offered expensive insurance through their employers could 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 pose barriers to care for low-income families and put low- and moderate-income families at risk of underinsurance if they face a catastrophic illness.
- 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 with undocumented parents to get coverage.
- The value of the premium subsidy does not keep pace with rising health care costs, so every year families would have to pay more and more for their insurance.

## 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 (**\$1,900 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 cause further financial hardship.

### For employers:

Starting in **July** 2013, employers that do not offer coverage that meets minimum requirements will be required to pay a flat dollar amount for each full-time employee who receives premium subsidies through the Exchange. The flat dollar amount will be equal to the national average tax credit up to a cap. 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 workers that employers assume would be more likely to access subsidies, including minorities and single parents.

## Small business tax-credits

Small businesses **and non-profits** 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 small business employer's contribution and **25 percent of the non-profit's contribution**. Starting in 2013, the credit would be available only for the first two years that a business or non-profit provides coverage to its employees through the state Exchange, but it would offset up to 50 percent of the employer's contribution, or **35 percent of the non-profit's contribution**.

## 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. The state would have to implement all insurance reforms in the law before a CO-OP could operate. 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.

*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 and global 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.
- Foster participation in workplace wellness programs.

- Incorporate the Physician Payment Sunshine Act, requiring drug and device makers to disclose payments to doctors or teaching hospitals.
- Create a new Medicaid state plan option for enrollees with multiple chronic conditions to designate a provider as their health home.

*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.
- **Allow Medicare Part D plans to waive co-payment for the first fill of generic drugs.**

*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 **40 percent excise tax** on insurance companies for employer-sponsored plans that cost \$8,000 or more for most individuals or \$21,000 or more for most families. **However, plans that cover people who are retired and over age 55, or who work in high-risk professions, would be taxed on plans that cost more than \$8,750 for individuals or \$23,000 for families.** 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 **\$6.7 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 Medicare 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 low-income patients, many of whom would still face high out-of-pocket costs under this plan. In addition, although initially only a small percentage of policies would be affected by the excise tax on insurance, over time a growing percentage would become subject to the tax because the amount of the exemption does not keep pace with the growth in health care inflation.