



## **Summary of Initial Draft of Health Reform Bill from Senate Health, Education, Labor and Pensions Committee Updated 6-15-09**

The Senate Health, Education, Labor and Pensions (HELP) Committee, chaired by Sen. Edward M. Kennedy, released an initial draft of its health reform bill on June 9.

The “*Affordable Health Choices Act*” proposes fundamental changes to every aspect of our health care system, including affordable coverage programs, insurance reforms, quality improvements, disparities reduction and financing. The bill is a working draft, with a number of issues left undecided, and others needing further clarification. We expect many changes in the text before the HELP Committee finishes its work on the bill next week.

### **The bill would:**

- Require all individuals to have health insurance if an affordable plan is available.
- Make sliding-scale subsidized coverage available to low- and moderate-income people, and provide assistance for small businesses that offer coverage to their employees. The draft assumes the final bill will expand Medicaid to 150 percent of the Federal Poverty Line (FPL).
- Establish comprehensive private insurance reforms.
- Create state and regional “Gateways” – insurance Exchanges that facilitate the comparison and purchase of coverage.
- Build programs to improve the quality and value of health care, including a number of the provisions focused on reducing racial and ethnic disparities in care.

As drafted, the bill does not set out details on several issues still being worked on by the Committee, including the public plan option and a requirement that all employers offer coverage to their employees.

Below is our summary of a number of the main provisions of the bill, along with some initial comments.

### **Insurance Reform**

The bill would overhaul the individual and group health insurance markets to ensure that everyone can buy insurance on the same level. The bill would:

- Require insurers to offer coverage to everyone and to renew policies.
- Prohibit exclusions for pre-existing conditions.

- Bar insurers from basing premiums on health status, gender, genetic information, disability, type of work, or claims history. Premiums could vary based on age, but the spread is constrained to a 2:1 ratio.
- Require insurers to disclose how much they spend for patient care, and how much goes for administration, advertising, and profit. Regulations would set a maximum level of expenses that go for non-patient care.
- Mandate that insurers develop quality measures, such as care coordination, reduction of preventable hospital readmissions, use of evidence-based medicine, discharge planning and error reduction.
- Restrict co-pays and deductibles for preventive care to minimal amounts.
- Include dependents through age 26 in family coverage.
- Prohibit caps on lifetime or annual benefits.

*Discussion:* These strong protections would remake the individual and group insurance market to assure equal access to coverage for everyone. In most states, insurers charge much more to older and sicker people, making coverage unaffordable for those who need it the most. The provisions would also guarantee that all insurers include comprehensive preventive care benefits. While premium differentials based on age are limited to a 2:1 ratio, there is no limit placed on the different premiums insurers could charge based on geography. This loophole could be exploited, and ought to be limited, perhaps to a 1.5:1 ratio.

### **Affordability**

The bill would expand Medicaid, establish a sliding scale subsidy program for low- and moderate-income people, and provide assistance for small businesses. The bill would:

- Operate under an assumption that the final bill will expand Medicaid to 150 percent FPL.. This would initially be fully paid for by the federal government, with the state share phasing in between 2015 and 2020. States that are already covering up to this level would receive additional federal support.
- Make available new sliding-scale subsidies to people earning up to 500 percent FPL, or about \$54,000 annual income for a single person. Individuals will have the choice of three levels of plan options, and subsidies for lower-income families will be tied to the cost of more generous plans.
- Put limits on the out-of-pocket costs of subsidized plans. For those in the 300-500 percent FPL income range, the maximum would be \$5,800 for individuals and \$11,600 for family coverage a year. At the low end, individuals with incomes up to 200 percent FPL could face out-of-pocket costs of up to \$870.
- Require that benefits in subsidized plans be comprehensive. Plans for children must include dental and vision care.
- Prohibit benefits from going to people unlawfully present in the U.S.
- Offer subsidies for small businesses with up to 50 full-time employees who cover at least 60 percent of their employees' premiums. Businesses providing a higher contribution, paying lower wages, or having fewer employees would get a larger credit per employee under the formula. Firms could get assistance for up to three years.
- Offer a public plan option, though the bill provides no language.

*Discussion:* Expanding Medicaid and providing subsidies up to 500 percent FPL would provide critical assistance to people needing help affording insurance premiums. We are concerned, however, that the subsidized plans will have cost sharing requirements that make them unaffordable for many, particularly people with chronic illness.

### **Shared Responsibility**

The bill would require individuals to obtain health insurance if an affordable plan is available. The committee also intends to require employers to offer coverage to their workers, though the details on employer responsibility are not included in this draft.

The individual mandate would require people with access to affordable coverage who do not enroll to make a “shared responsibility payment” on their taxes. The payment may be waived in cases of financial hardship. The amount of the payment and the determination of affordability would be set by regulation. An expert council would set the benefits required to meet the individual mandate.

*Discussion:* We hope the committee will recommend a strong employer responsibility provision that recognizes the need for employers to pay for the value they get when taxpayers pay for their employees’ health insurance coverage. The bill appropriately directs the individual mandate penalty to be set at the lowest level needed to achieve the goal of encouraging enrollment. We are concerned that there is no “circuit breaker” that sets a maximum percentage of income people not eligible for subsidies would be expected to contribute to health insurance.

### **Insurance Exchanges**

The bill would establish “Health Benefit Gateways,” state or regional agencies that would facilitate the purchase of insurance by individuals and businesses. Participation in the Gateways would be voluntary. The bill would:

- Facilitate comparison of premiums, out-of-pocket costs, and other features of plans, and will support electronic enrollment.
- Assess insurers with healthier-than-average members to help support insurers with sicker-than-average members, in order to spread the risk of covering sicker patients both within and outside the Gateway.
- Encourage states to set up “Navigators,” or consumer education and assistance centers, and award grants for states to establish help lines and public education campaigns.
- Establish a board of experts, called the Medical Advisory Council, that would set benefit levels, which must be broad and include emergency services, hospitalization, medical and surgical care, mental health care, prescription drugs, rehabilitative care and prevention.

*Discussion:* These Gateways, like the Connector established in Massachusetts, would offer a variety of plans and allow consumers to make fair apples-to-apples comparisons of the choices available. Massachusetts has learned that a very robust community-based assistance program is required to help people understand and enroll in coverage. Currently, the proposed Navigators are oriented towards business and industry groups. We support language prioritizing mission-driven, non-profit community-based organizations in the navigator role. It appears that plans in the Gateway could have very different cost-sharing levels, as long as they met some broad

benefit criteria and an overall “actuarial value” test. Experience in Massachusetts suggests that greater standardization in plan cost-sharing would help consumers make better informed comparisons.

## **Health Disparities**

The Committee proposed a number of steps that would reduce racial and ethnic disparities and help ensure that people get the right care at the right time and right place, regardless of income, race, ethnicity or primary language. The bill includes public health initiatives to address social determinants of health, establishing a national quality improvement initiative with reducing disparities as one of its goals, and requiring more extensive collection, analysis and reporting of disparities data. The bill adds a new program called Right Choices that would assess the health needs of the uninsured under 350 percent FPL and link them with safety net services until Gateways are established.

*Discussion:* We believe that the Committee could go further on all of these fronts and take some additional steps, such as setting benchmarks to reduce disparities, with financial benefits for providers that meet the standards. We are particularly concerned that certain language and provisions in the bill might have the unintended consequence of reducing access to quality care, rather than expanding access. In particular, we fear that the wording, “Nothing in this Act shall allow federal payments for individuals who are not lawfully present in the United States,” could preclude undocumented individuals from getting emergency care or critical public health services, underscoring the need for continuing support of the health care safety net.

## **Improving Quality**

The bill includes a myriad of provisions to improve the quality of health care in America. Many of these provisions have a strong public health focus. Among many provisions, the bill would:

- Increase support for immunizations, school-based clinics, employer wellness programs, chronic disease medication management, trauma care, community health centers and other programs.
- Require nutrition labeling of standard menu items at chain restaurants and food sold from vending machines.
- Create a Health Aging program, which would provide grants for community-based public health activities for people 55-64 years old to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles.
- Establish a Primary Care Extension program to support community health workers to assist primary care providers with preventive medicine, health promotion, chronic disease management, and mental health services.
- Support an oral health prevention and education campaign.
- Establish a program to develop and encourage use of patient decision aids, which help patients decide with their provider what treatments are best for them based on their beliefs and preferences, options, scientific evidence, and other circumstances.
- Establish, via grants, community health teams to support a medical home model.
- Build a broad workforce program, including increased grants for a nursing student loan program, a loan repayment program for pediatric sub-specialists and providers of mental

health services in under-served areas, a public health and allied health recruitment and retention programs, and a grant program to support nurse-managed health clinics.

- Establish standards to allow diagnostic equipment to be accessible for people with disabilities.

*Discussion:* We're very pleased that the committee included these initiatives, which will help move our health system toward a more patient-centered primary care model, improving quality and lowering costs. We applaud the committee for understanding the vital role public health plays in keeping people healthy and productive. We suggest adding a provision to require all public and private insurers and providers to meet the established standards for culturally and linguistically appropriate services.

### **Prescription Drugs**

The bill includes several provisions to improve the affordability of prescription drugs. One issue, how to regulate "follow-on biologics," which are generic drugs that are similar to approved biotech drugs, was deferred in the draft. The bill provisions include:

- Expand 340B drug discount program, allowing more hospitals to gain access to substantial discounts.
- Strengthen the Medicaid rebate program, reducing drug costs for state Medicaid programs.
- Allow FDA to require drug companies to use a standard summary of the benefits and risks of drugs in an easy-to-understand drug facts box format on labels.
- Create a comparative effectiveness program to support and synthesize comparative health outcomes and effectiveness research on drugs, devices, medical and surgical procedures, screening and diagnostics, behavioral health care, and other health interventions.

*Discussion:* These provisions would improve the affordability and value of prescription drugs, which play a crucial role in our medical care. We also suggest including programs to provide unbiased information directly to doctors to counter drug industry marketing, and public disclosure of drug industry marketing payments to doctors.

### **Insurance for Care at Home**

The bill would set up the Community Living Assistance Services and Supports (CLASS) program, a national voluntary insurance program to help cover services and supports for disabled people living at home or in a residential setting. People would be automatically enrolled through their employer, unless they opt out, and would pay fixed premiums throughout their life. Participants in the program who become disabled would receive cash benefits (averaging \$50 per day) for non-medical services, such as personal care attendants, counseling and other supports to help them maintain independence. The benefits would supplement, not supplant, other benefits for which the enrollee is eligible (such as Medicaid or other federal programs). The bill would allow participants to use the program to pay family caregivers who are providing covered services and supports.

*Discussion:* This program fills an important hole in our support system for people with disabilities, allowing them to stay in their communities. We support this effort to promote independence for people with disabilities.