



Summary of Initial Draft of Health Reform Bill From House “Tri-Committee” June 25, 2009

The three House Committees with jurisdiction over health reform (dubbed the “tri-committee”) issued its joint initial proposal late last week. The bill reflects the strong progressive vision of the Democratic majority in the House, and includes provisions addressing coverage, affordability, shared responsibility, cost control, prevention and wellness, and workforce investments. The bill does not address financing issues, which will be added at a later time.

The House has issued a number of fact sheets on the bill, which can be accessed [here](#).

The bill would:

- Require all individuals to have health insurance, and require all employers to offer comprehensive coverage.
- Make sliding-scale subsidized coverage available to low- and moderate-income people, and provide assistance for small businesses that offer coverage to their employees.
- Expand Medicaid to cover people up to 133 percent of the Federal Poverty Level (FPL).
- Establish comprehensive private insurance reforms.
- Create a national Health Insurance Exchange that would offer a public option.
- Build programs to improve the quality and value of health care, including a number of provisions focused on expanding primary care and reducing racial and ethnic disparities in care.
- Improve the Medicare program, including eliminating the Part D drug benefits “donut hole.”

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 all policies.
- Prohibit exclusions for pre-existing conditions.
- Bar insurers from basing premiums on health status. Premiums could vary based on age, but the spread is constrained to a 2:1 ratio. They could also vary by location and family size.

- Require insurers to devote 85 percent of their premiums to medical benefits, and provide rebates to consumers if the insurer spends less than this level.

Discussion: These strong protections would remake the individual and group insurance markets 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. 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:

- Expand Medicaid to 133 percent FPL, fully paid for by the federal government.
- Provide new “affordability credits,” sliding-scale subsidies to people earning up to 400 percent FPL. Premiums would start at 1 percent of income for those at the lowest income, rising to 10 percent of income for those at 400 percent FPL.
- Limit the out-of-pocket costs of subsidized plans on a sliding scale. For those below 133 percent FPL, the annual out-of-pocket maximum would be \$250 for an individual, or \$500 for a family; at 400 percent FPL: the annual out-of-pocket maximum will be \$5,000 for an individual or \$10,000 for a family.
- Require that benefits in subsidized plans be comprehensive. Annual or lifetime limits on benefits would not be allowed. Plans for children must include dental and vision care.
- Eliminate cost-sharing for recommended preventive services for people in Medicare, Medicaid and insurance available through the Exchange.
- Offer credits for small businesses.

Discussion: Expanding Medicaid and providing subsidies up to 400 percent FPL is an important first step in assuring everyone can afford coverage. We are concerned, however, that the subsidy levels outlined in this draft would leave some families vulnerable to unaffordable health care costs. This draft requires everyone who would get coverage through the Exchange to pay at least 1 percent of their income toward premiums no matter how little they earn, and requires a higher (as of yet unspecified) contribution for the next poorest families—those between 133 percent and 200 percent FPL. This contribution level will be unaffordable for families below 200 percent FPL who often go into debt just to pay for basic necessities like housing and food. We suggest exempting people below 200 percent or at least 150 percent FPL from premiums.

Shared Responsibility

The bill would require individuals to obtain health insurance, and require most businesses to offer coverage to workers. For individuals, the bill would:

- Mandate everyone to purchase a health plan that meets minimum standards.
- Impose a penalty for noncompliance totaling 2 percent of the individual’s income (minus some exemption amount), up to a maximum of the national average premium for basic coverage.

- Allow hardship waivers to be granted.

For employers, the bill would:

- Mandate that they offer all of their employees comprehensive coverage. For full-time employees, employers must offer to pay at least 72.5 percent of the lowest cost premium for individual coverage, or 65 percent of the premium for family coverage.
- Require a proportional minimum contribution for part-time employees.
- Assess a payment equal to 8 percent of payroll if they fail to meet the requirements. Employers may choose to meet the requirements for full-time employees, and to pay the fine only for their part-time employees.
- Exempt small businesses (not yet defined) from the requirements.

Discussion: The employer “pay or play” requirement appropriately recognizes the need for employers to pay for the value they get when taxpayers pay for their employees’ health insurance coverage. The individual mandate structure has no affordability exemption for those who earn too much to qualify for subsidies, but who cannot find affordable coverage. Under the current structure, individuals above 400 percent FPL would be required to buy coverage, no matter how high the cost. We recommend that an “affordability standard,” a sliding-scale percentage of income that would exempt those who cannot find comprehensive affordable coverage, be added to the bill.

Insurance Exchanges and the Public Option

The bill would establish a “Health Insurance Exchange” to help individuals and businesses compare plans and make informed choices based on cost and quality. One choice would be a new public plan. A national Exchange would be created, but states or groups of states may set up their own Exchange. Participation in the Exchange would be voluntary for employers and providers. The Exchanges would:

- Facilitate comparison of premiums, out-of-pocket costs, and other features of plans.
- Allow choices of plans with standardized benefits, including an option to purchase benefits not included in standard plans.
- Establish a public plan that would be financed through premiums. The public plan would have to meet the same benefit requirements, and comply with the same insurance market reforms, as private plans. It would initially pay most providers Medicare rates plus 5 percent. The public plan would use innovative payment mechanisms to promote health, improve quality, reduce disparities and manage chronic illness.
- Sponsor an ombudsman to assist consumers with enrollment and resolve problems.

Discussion: The Exchange, like the Connector established in Massachusetts, would offer a variety of plans and allow consumers to make comparisons of the choices available. Like Massachusetts, plans in the Exchange must meet an “actuarial value standard” which still allows substantial differences in how cost-sharing is structured. Massachusetts has learned that a very robust community-based assistance program is required to help people understand and enroll in coverage. We support language to have non-profit community-based organizations work with the ombudsman’s office to set up help-lines and electronic enrollment assistance.

Health Disparities

The House bill includes a number of provisions to reduce racial and ethnic disparities. The bill would:

- Expand the National Health Service Corps and set up new scholarships, loans, and loan repayment programs for primary care providers and public health workers who agree to work in underserved areas. It also includes grants to training programs that have a track record of graduating underrepresented minorities, and grants to encourage training that promotes cultural and linguistic competence among health care workers.
- Promote culturally and linguistically appropriate communications and health services, including a demonstration project within Medicare to improve language access.
- Use payment methods in the public plan that encourage reduction of disparities.
- Authorize a new assistant secretary for health information, whose duties would include developing standards for reporting and collecting data on reducing disparities.
- Provide grants to promote community-based public health services.

Discussion: The bill is very strong on diversifying the health care workforce, and expanding public health and prevention initiatives to address disparities. It makes reducing disparities one of the national quality priorities, sets standards for collecting data on disparities, and requires Exchange plans to offer culturally and linguistically competent services. But it does not go far enough. The bill leaves in place the five-year waiting period for legally present immigrants to qualify for Medicaid. It explicitly excludes the undocumented from subsidies. It includes little increase in funding for the safety net, and does not strengthen hospital community benefit standards. We recommend elimination of the five-year waiting period. We also recommend the inclusion of provisions that require hospitals to identify and respond to the unmet health needs of the communities they serve as a condition for receiving Disproportionate Share Hospital payments and tax-exempt status.

Improving Quality

The bill includes a myriad of provisions to promote better coordination and improve the quality of health care in America. Among many provisions, the bill would:

- Establish national priorities and performance measures for quality improvement, with a focus on chronic care and improving patient-centeredness of care.
- Set up an independent commission to coordinate comparative effectiveness research to recommend the most effective clinical treatments.
- Reduce hospital readmissions by changing payment incentives and encouraging services to assist transitions from hospital to home, including translators, discharge planning and ensuring patients receive a summary of care/discharge orders.
- Promote community-based medical homes that employ community health workers to help primary care clinicians teach patients how to manage chronic illness and access community resources.

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, both 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.

Strengthening Medicare

The bill contains a number of provisions to strengthen the Medicare program. The provisions include a number of sections changing payment rates for various services. The bill fixes a long-standing issue around physician payments. Among the provisions, the bill would:

- Fill the “donut hole” in Medicare Part D (prescription drug benefit) by providing an additional \$500 in coverage in 2011, and increasing that amount over time to eliminate “donut hole” within 15 years.
- Improve the low-income subsidy programs in Medicare by increasing asset limits for Medicare assistance programs and facilitating enrollment in subsidy programs.
- Provide enhanced coordinated coverage options for low-income seniors and disabled people who are eligible for both Medicare and Medicaid.
- Limit cost-sharing requirements in Medicare Advantage plans to the amount charged for the same services in traditional Medicare coverage

Discussion: The Medicare provisions would promote more coordinated care by rewarding primary care and health promotion. The payment reforms strengthen Medicare’s financial health while significantly improving benefits in the program. Filling in the “donut hole” would allow seniors and disabled people to afford the prescription drugs they need.