



U.S. Senate Finance Committee Coverage Policy Options Detailed Section by Section Summary – May 18, 2009

This document outlines the 61-page report, “Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans,” that was issued by the Senate Finance Committee on May 14, 2009. In many sections, the committee report did not spell out the full details of proposals.

Section I: Insurance Market Reforms

This section proposes changes in insurance rules and the creation of a Health Insurance Exchange.

Private market rules:

A new set of national rules would apply to all insurers selling to individuals, micro-groups (businesses with 2-10 employees) and small groups nationwide. States would have until 2013 to change their rules to the national standards. The paper does not indicate if states would be allowed to set higher standards.

The rules include:

- Guaranteed issue and guaranteed renewal
- Limits or prohibition of exclusions for pre-existing conditions
- Rating allowed only on tobacco use, age, family composition, and geographic location; not on health status
- Maximum range in rates:
 - Tobacco use: 1.5:1
 - Age: 5:1
 - Family composition: single 1:1; family 3:1
- Total variation in premiums, based on all rating factors, can not exceed 7.5:1

States have the option to merge their individual and small group markets.

Health Insurance Exchange:

A national exchange, or possibly multiple competing exchanges, would be established to sell insurance directly to individuals and small businesses.

Other specifications include:

- All insurers in the individual and small group markets would be required to offer plans through the Exchange, but could offer the same plans to individuals and groups outside the Exchange.
- A public plan, if established, would also be marketed through the Exchange.
- State insurance commissioners would review and certify plans.

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- U.S. Department of Health and Human Services would determine a standard application, marketing rules, procedures for enrollment, and format for presenting insurance options through a website.
- Each insurer would be required to offer four levels of coverage (see Benefits section below).
- The Exchange would be self-sustaining, funded by assessments on insurance premiums.
- The Exchange would be run by a private entity.
- Individual and micro-group coverage would be available as soon as the Exchange begins operating.
- Small-group coverage (as defined by each state) would be phased in, and employers required to pick one benefit level.

Section II: Making Coverage Affordable

This section defines benefits that would be required in all insurance plans, and establishes tax credits for individuals and small businesses to help them pay for insurance.

Benefits:

All insurance plans in the individual and small group markets would be required to cover a broad range of benefits, including preventive and primary care, emergency services, hospitalization, doctors, outpatient care, day surgery and anesthesia, diagnostic imaging, maternity and newborn care, prescription drugs, radiation and chemotherapy and mental health care.

Other new rules:

- No lifetime or annual limits on benefits
- No or low cost-sharing on prevention
- Premiums the same in or outside the Exchange
- All insurers would be required to offer four options, defined by the percentage of health care expenses covered for the average person
 - High (most comprehensive) = insurer would pay 93 percent of expenses
 - Medium = insurer would pay 87 percent
 - Low = insurer would pay 82 percent
 - Lowest (least comprehensive) = insurer would pay 76 percent

Plans may also be prohibited from requiring different co-payments or co-insurance for different diagnoses.

Individual Low-Income Tax Credits

The federal government would subsidize premiums for people with incomes between 100 and 400 percent of the federal poverty level (FPL), based on a sliding scale, using “refundable tax credits.” These tax credits would be available to eligible people even if they do not pay taxes. Credits would be available only through the Exchange, and in place no later than January 2013.

Calculating size of tax credits:

- Individuals or families would pay a premium capped at a percentage of their modified adjusted gross income. (The details are not spelled out.) They would get a refundable tax credit to cover any cost above that cap.
- The sliding scale would be designed to allow lower income families to buy more comprehensive insurance.
- An alternative plan would base tax credits on average premiums for the low benefit option (See Section II), and would limit cost-sharing for people between 100 and 300 percent FPL.

Small Business Tax Credits

Businesses providing insurance could claim a credit on their tax returns for every full-time employee they cover. To qualify businesses must cover at least 50 percent of the cost of their states' average employer-based premium.

The rules businesses would be required to follow to receive the tax credit:

- Full tax credit to businesses with 10 or fewer full-time employees making less than \$20,000
- Partial tax credit to businesses with 25 or fewer full-time employees making less than \$40,000
- Full-time employment defined as 30 hours or more a week

Section III: Public Plan

The proposal offers four options, but provides few details.

Option 1: Medicare-like plan offered through Exchange

- Administered by HHS agency
- Medicare providers required to participate; get Medicare rates plus up to an additional 10 percent
- Required to meet same rating and benefit rules as private plans (identified in Sections I and II)
- Includes delivery system reforms
- Doesn't have to be self-sustaining

Option 2: Multiple regional plans administered by a third party

- Must establish provider networks
- Provider payments negotiated by administrators
- Must have financial reserves

Option 3: State-run plan that would be optional or mandatory

- States would decide how to administer
- Could allow buy-in to state employee plans

Option 4: No public plan

Section IV: Role of Public Programs

This section defines changes in Medicaid, the Children's Health Insurance Program, Medicare, and the ways those programs interact.

Medicaid

The proposal expands Medicaid eligibility and offers three options for how it would operate.

These changes apply to all of the options:

- Increase eligibility to 150 percent FPL for parents, pregnant women and children, based on modified adjusted gross income
- Require maintenance of effort until Exchange is fully operational
- Base eligibility decisions on modified adjusted gross income with no income allowed to be disregarded
- Fund expansion with federal money through 2015, followed by a phased return to Federal Medical Assistance Percentages over five years OR federal government pays higher share for period to be determined
- Set a floor so that provider payments cannot be lower than an unspecified percent of Medicare rates (80 percent suggested for illustration)

The document is unclear about expanded coverage for childless adults. It implies, but doesn't state, that they would be covered up to 115 percent FPL, either through traditional Medicaid or through subsidies to buy insurance through the Exchange.

Option 1: Retain current Medicaid structure and benefits

- Enrollees would not be eligible for refundable tax credit (See Section II)
- Enrollees could get premium assistance for job-based insurance

Option 2: Move most Medicaid enrollees to subsidized public and private plans offered through the Exchange

- People who are disabled, people also eligible for Medicare (dual eligibles), and special needs groups would continue in regular Medicaid program
- All others would get choice of fully subsidized "low-option plans" through the Exchange, with Medicaid providing additional "wrap-around" benefits and cost-sharing
- Insurers would be required to meet Medicaid managed care organization rules
- Payment through state Medicaid programs, with match, would be based on Federal Medical Assistance Percentages

Option 3: Keep most Medicaid enrollees in the program, but provide childless adults with tax credits to buy coverage through the Exchange or to buy into Medicaid

- Children, parents and pregnant women would get care through Medicaid
- Childless adults under 115 percent FPL would get refundable tax credits to buy insurance or voucher to buy into Medicaid
- Federal government would reimburse state Medicaid programs for services used by the childless adults in excess of the voucher
- Safety net providers would be included in care networks

Children's Health Insurance Program (CHIP)

Primary coverage would be provided through Exchange, once it is fully operational; CHIP would then become a secondary payer.

- No changes in structure or decrease in eligibility allowed until 2013 or when the Exchange is fully operational, whichever comes later.
- After the Exchange is operating, CHIP would provide EPSDT services and help to cover premiums and cost-sharing through wrap-around coverage.
- States would be required to cover children in families with income up to 275 percent FPL, but based on modified adjusted gross income with no income exceptions; this might actually reduce eligibility in some states.
- Children's premiums would be fully subsidized.
- Cost-sharing would be limited to Medicaid rules, which cap total cost-sharing at 5 percent of family income.

Quality of Care in Medicaid and CHIP

- Apply quality measures laid out in CHIP reauthorization legislation to all Medicaid populations, including standardized reporting, grants, demonstration projects.
- Appropriate \$10 million for Medicaid and CHIP Payment and Access Commission.

Other Improvements to Medicaid would:

- Simplify enrollment by eliminating face-to-face eligibility interviews, requiring 12-month continuous eligibility, etc., and offer state bonuses for compliance.
- Add new optional category of non-pregnant individuals for family planning services only.
- Provide mandatory coverage of services by podiatrists, optometrists and free-standing birth centers.
- Require a child's home state to cover when child is traveling.
- Mandate prescription drug coverage for categorically needy and medically needy (would expand services to medically needy in 27 states).
- Add smoking cessation drugs, barbiturates and benzodiazepines to Medicaid drug list (which currently exclude them).
- Change how Medicaid pays manufacturers for prescription drugs.
- Create transparency in development and evaluation of waivers and state plan amendments.
- Make a budget-neutral change in FMAP formula to include state poverty level in addition to current per capital income. Year-to-year changes capped at plus or minus 2 percentage points.
- Automatically increase FMAP during economic downturns, starting in 2012. The rate would be triggered by change in unemployment rate, and calculated based on increased Medicaid cost relative to total Medicaid spending.

Medicaid Disproportionate Share Hospital Payments (DSH)

The Centers for Medicare & Medicaid Services (CMS) would take over distribution of Medicaid DSH money within each state. This money, now distributed by each state, is designed to support hospitals that provide large amounts of uncompensated care to the uninsured or underinsured.

- HHS secretary would designate services eligible for DSH payment.
- Hospitals would submit claims data for uncompensated care to CMS, rather than to state governments.

Dual Eligibles

Proposals designed to improve coordination of care for people eligible for both Medicaid and Medicare (duals):

- Establish a five-year Medicaid demonstration authority to coordinate care for duals.
- Modify Medicaid 1915(b) waiver authority to allow states to incorporate savings that accrue to Medicare from coordinating duals' care in cost calculations.
- Create an Office of Coordination for Dually Eligible Beneficiaries to initiate and lead improved coordination of the Medicare/Medicaid programs.

Medicare Coverage

Two major changes included would:

- Phase-out the two-year waiting period for people with disabilities to qualify for Medicare. Approaches include eliminating the waiting period entirely, limiting it to one year, or limiting it to those with access to private insurance.
- Allow temporary Medicare buy-in for individuals ages 55 to 64 without access to employer-sponsored insurance or public insurance until the Health Insurance Exchange is operating. The committee is seeking advice on other ways to cover this age group.

Section V: Shared Responsibility

This section lays out options for both an individual mandate and employer mandate. It does not spell out possible effective dates.

Individual Mandate

All individuals would be required to get insurance or pay a penalty, unless their income is less than 100 percent FPL, or the lowest-tier plan costs more than 10 percent of their income, or they face a hardship (not defined). Undocumented immigrants and people with religious objections would be exempted from the mandate.

The following rules are proposed:

- Individuals must get insurance within a specified time after the individual mandate is imposed.
- Those who get insurance late may be subject to temporary exclusion of pre-existing conditions.
- All coverage must be at least as comprehensive as the lowest-benefit plan, or must be an approved grandfathered plan.
- The penalty would be based on the lowest-premium plan available through the Exchange in an individual's geographic area. It is unclear whether the premium cost would be the same for all age groups.
- The penalty would be phased in, beginning at 25 percent of premium in the first year, and rising to 75 percent over the next two years.

Employer Mandate

The committee has not decided whether or not to require employers to offer insurance to their employees. If insurance is required, the following rules would apply:

- Only employers with payrolls greater than \$500,000 per year would be affected.
- Insurance offered would need to have the same value as lowest coverage option in the Exchange.
- Employer would be required offer to contribute 50 percent of the premium cost to all full-time employees or face a penalty.
- Two penalty options are proposed:
 1. \$100/month/employee for firms with payrolls \$500,000-\$1,000,000;
\$250/month/employee for firms with payrolls \$1,000,000- \$1,500,000
\$500/month/employee for firms with payrolls \$1,500,000 or more
 2. 2 percent of payroll for firms with payrolls \$500,000-\$1,000,000;
4 percent of payroll for firms with payrolls \$1,000,000-\$1,500,000;
6 percent of payroll for firms with payrolls \$1,500,000 or more
- Employees who accept insurance through their employer would not be eligible for the refundable tax credit through the Exchange. Employees who opt out of insurance through work would be potentially eligible for the tax credit to buy insurance through the Exchange, if they met income guidelines.

Section VI: Prevention and Wellness

This section outlines options for increasing preventive services in Medicare, Medicaid, and other insurance programs.

Medicare:

- Every five years, each enrollee would have a free comprehensive health assessment by a physician, and develop a personalized prevention plan.
- No cost-sharing for any preventive services covered by Medicare Parts A and B. Incentives for enrollees to participate in smoking cessation and other wellness programs would be established.

Medicaid:

- Limits cost-sharing for preventive services deemed effective by the U.S. Preventive Services Task Force. Also provide incentives for enrollees to participate in smoking cessation and other wellness programs.

Other Insurance:

- Award annual state grants for developing preventive services through the Exchange.
- Award grants to improve integration, care coordination and prevention, including the use of multidisciplinary care teams.
- Award business tax credits equivalent to 50 percent of the cost of providing access to a qualified wellness program, as certified by the federal government and consistent with evidence-based research.

Section VII: Long Term Care Services and Supports

This section outlines proposals for improving access to home and community-based services for people getting long term care through Medicaid.

- Allows states to offer more services under home and community-based waivers for long term care
- Eases “medical need” requirement for long term care; allows states greater flexibility in income, assets and other requirements for home and community-based care both in their state plans and in waivers
- Increases federal matching percentage for home and community-based care by 1 percent
- Changes rules on how much a spouse can retain in assets when the other spouse is getting long term care under Medicaid
- Expands grant-funded programs
- Extends “Money Follows the Person Demonstration” project through 2016

Section VIII: Options to Address Health Disparities

This section includes a range of proposals on collecting data and improving access to care.

- Allows states to waive five-year wait for Medicaid for legal immigrant adults
- Requires Social Security Administration to collect data on the race, ethnicity and language of Medicare enrollees, and funds upgrade of SSA databases
- Requires that reports on quality of care include data on race, ethnicity, primary language, and gender
- Standardizes data categories using Office of Management and Budget (OMB) rules
- Requires reporting of disparities in Medicaid and CHIP, based on Medicare rules
- Requires CMS to collect primary language data on CHIP enrollees
- Expands efforts to collect data on access to care by people with disabilities
- Establishes CLAS (culturally and linguistically appropriate services) standards for private insurers in the Exchange
- Extends 75 percent Medicaid matching rate for translation services to all enrollees whose primary language is not English
- Awards grants for enrollment and outreach, including multi-lingual help lines
- Establishes block grants to reduce infant mortality