

Key Elements of Proposed Health Reform Legislation (as of 9/16/09)

Health Care Financing Reforms

EXPANDING ACCESS to affordable health insurance

1. **Private insurance market reforms** (2013): Guaranteed issue & renewal, banning pre-existing condition exclusions, standard benefits package with 3-5 cost-sharing/additional coverage options, annual out-of-pocket limits, no annual or lifetime benefit limits, no cost-sharing for preventive services
2. **Individual mandate** to obtain health insurance coverage through employer, govt. plan, or on one's own; excise tax penalty for failure to obtain coverage (% AGI vs. fixed amt); exceptions for financial hardship (if lowest cost option >10% AGI), dependents, religious objections
3. **Health insurance exchanges** (2013): State/regional/national web-based purchasing pools for small businesses and individuals (open to only self-employed, unemployed, and people ineligible for current federal insurance options with income up to 300%–400% FPL)
4. **“Play or pay” requirement for employers** (>50 FTEs + average wages <\$40,000) to provide health insurance or pay fee for each employee receiving health insurance through an exchange
5. **Tax credit, premium subsidies** for individuals & families (based on % of income premium cost represents) and small businesses that offer insurance
6. **Expansion of public programs:** *Medicaid* eligibility for everyone \leq 133% FPL (\$14,400 single, \$29,327 family of 4) including children, parents, childless adults (2014). *CHIP* beneficiaries given option/required to enroll in exchange plans (2013); federal eligibility floor raised to 250% FPL with supplementary (EPSDT) benefits.
7. **New public or nonprofit insurance option** through exchanges in areas with limited choice of affordable health plans
8. **Rural health care protections** (Sen. Fin. Mark): extended / new grant funding for rural hospitals and providers

Issues / areas of controversy:

- *Public option* (House + Sen. HELP bills) vs. *nonprofit member-owned co-ops* (Sen. Fin. Mark) vs. *benchmark to trigger implementation of public option* if insurance market reform does not provide affordable private options by the time legislation is fully implemented (possible compromise position)
- Affordability of exchange options for middle class workers (300%–400% FPL)
- Premium subsidies / tax credits and eligibility levels (Sen. Fin. Mark = floor, H.R.3200 = ceiling)
- Coverage of immigrants, abortion services, counseling on end-of-life care options

FINANCING health insurance reforms

1. **Premiums & penalties** paid by individuals for failure to get insurance coverage (amount per person per year based on FPL)
2. **Penalties paid by larger businesses** (>50 employees) that do not offer health insurance to employees
3. **High-cost insurance excise tax** on insurance companies and plan administrators for health insurance plans >\$8,000 individuals, >\$21,000 families
4. **Fees** for insurance companies, drug manufacturers, medical device manufacturers, clinical laboratories (Sen. Fin. Ctte. Mark)
5. **Graduated tax surcharge for high-income taxpayers:** 1%–5.4% on income >\$280,000 for individuals, \$350,000 for families (H.R.3200)
6. **Medicaid program reforms:** States assume responsibility for % of Medicaid expansion costs 5 years after implementation; disproportionate share (DSH) payments to hospitals reduced as more patients become insured
7. **Medicare program reforms:** 50% discount off negotiated price for brand-name drugs on plan formularies when beneficiaries enter coverage gap, paid for by drug manufacturers (Sen. Fin. Mark.) vs. negotiated drug prices for Medicare Part D program (proposed amendment to H.R.3200); strategies to ensure Medicare sustainability (Medicare Commission)

Issues / areas of controversy:

- Governors' concern about State responsibility for portion of Medicaid expansion costs in wake of recession
- Pharmaceutical manufacturers strongly oppose government negotiation of drug prices

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Health Care Delivery Reforms

REDUCING COST of health care

1. **Mandated budget neutrality:** No public deficit; trigger to reduce public expenditures if health care costs continue to rise
2. **Administrative simplification:** Broader implementation of medical information technology, standardized insurance forms
3. **Medicare payment reforms** including: *value-based purchasing* for hospitals, providers, home health agencies & skilled nursing facilities (incentives to move from fee-for-service toward paying for quality & value); *payment for accountable care* (allowing high-quality providers that coordinate care across health care settings to share in savings realized for Medicare program); reduced payments to hospitals for avoidable re-admissions; demonstration project to evaluate use of *bundled payments* for acute & post-acute care/ concurrent physician services; competitive bidding for Medicare Advantage plans (reduced payments to private insurers)
4. **Enhanced focus on preventive care / health promotion:** No cost-sharing for preventive services, annual “wellness” visit under Medicare; incentives for States providing recommended preventive services under Medicaid (1% increase in FMAP); grants to States to provide incentives to Medicaid enrollees for healthy lifestyles
5. **Combating fraud, waste & abuse** in Medicare & Medicaid: better claims evaluation; screening, educating, monitoring & penalizing providers
6. **Medical malpractice (tort) reform:** State demonstration program to evaluate alternatives to current civil litigation system—to improve patient safety, reduce medical errors, encourage efficient resolution of disputes & improve access to liability insurance, while preserving right to seek redress in court
7. **Quality improvements** likely to realize cost savings over the long term (see below)

Issues / areas of controversy:

- Seniors’ fears of increased Medicare costs to enrollees and reduced benefits as possible result of cost-saving measures
- Specialists’ fears of reduced reimbursement
- Physicians’ preference for malpractice reform: Statutory ceiling on liability for non-economic damages

IMPROVING QUALITY of health care

1. **Develop quality measures** for accountable, value-based care; grants to State Medicaid programs to collect and report quality data
2. **Improve coordination of care** through electronic medical information systems, multidisciplinary care teams, use of community health workers
3. **Better chronic disease management:** Medical home / health home State option for Medicare / Medicaid beneficiaries with chronic conditions
4. **Strengthen primary care:** Targeted GME slots for primary care providers and more training in community settings; expansion of community health centers; financial incentives for primary care practitioners and students serving in HPSAs
5. **Foster comparative effectiveness & patient-centered outcomes research:** To identify regional variations in cost and outcomes of particular interventions and reduce provision of unnecessary / ineffective health services

Issues / areas of controversy:

- Some providers skeptical about feasibility / efficacy of comparative effectiveness research
- Many of these initiatives will take years to result in healthier population and reduced medical costs

Sources:

House Tri-Committee America’s Affordable Health Choices Act of 2009 (H.R. 3200) with proposed amendments (6/19/09)

<http://hdl.loc.gov/loc.uscongress/legislation.111hr3200>; <http://www.kff.org/healthreform/sidebyside.cfm>

Senate HELP Committee’s Affordable Health Choices Act (6/9/09) http://help.senate.gov/Maj_press/2009_07_15_b.pdf

Chairman’s Mark Senate Finance Committee (9/16/09) <http://www.kaiserhealthnews.org/Stories/2009/September/16/Baucus-Bill.aspx>

* Implementation dates, (2013 / 2014); AGI, adjusted gross income; FPL, federal poverty level; FTE, full-time equivalent employee; EPSDT, early periodic screening, diagnosis, and treatment; FMAP, federal medical assistance percentage; GME, graduate medical education; HPSA, health provider shortage areas.