Federal Health Reform Update

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The Game Plan

Hill Players

- House Committees
  - Energy & Commerce
  - Education & Labor
  - **Ways & Means**
- Senate Committees
  - Health, Education, Labor & Pensions
  - **Finance**
- **Congressional Budget Office (CBO)**
  - Determines the costs/savings associated with each provision (**Scores** the provisions)
- White House
  - No legislation
- HHS & Labor

"Stakeholders"

- State and Local Governments
- Providers
- Insurers
- Pharmaceutical Industry
- Employers (Large & Small)
- Senior & Disability Advocates
- Advocates for Children's Health
- Many, many others.....

Is it a different game this time?

- Yes
- No
- Maybe so

The Budget

- Health Reform must be budget neutral
  - All expenditures must be paid for in real time (5 year and ten year budget window)
- CBO determines what each provision costs or saves
- Tension between health policy priorities and budget priorities
- The economy.....

Congressional Mathematics

- Regular Order
  - House (218 votes)
    - 60 Progressive Democrats
    - 50-55 Blue Dog Democrats
  - Senate (60 votes)
- **Reconciliation**
  - Senate needs 51 votes
  - Point of Order on "germaneness" = "Byrd Rule"

What is the reconciliation

- Reconciliation is a procedure under the Congressional Budget Act of 1974 that the Congress uses to implement budget resolution policies. The process primarily affects permanent spending and revenue provisions.
- The principal focus of reconciliation is usually deficit reduction.

What is the "Byrd Rule"

- The "Byrd Rule" is used to extract "extraneous matter" from reconciliation bills.
- Permits a member to raise a point of order to strike extraneous matter or to prevent an amendment that would involve the incorporation of extraneous matter in the bill.
- Once material has been stricken under the "Byrd Rule" if cannot be offered again as an amendment.

General Consensus Issues

- Maintain employer-based system
- Expand Medicaid to include non-traditional group(s) with incomes at or below some percentage of the Federal Poverty Level (FPL)
- Adopt insurance reforms to make insurance more accessible and affordable
- Require individual coverage
- Establish a premium subsidy/tax credit program to make health insurance affordable

What's the Goal?

- Provide health insurance coverage to all/most Americans. Who's not covered now?
  - Low-income individuals/families
  - Individuals with pre-existing medical conditions
  - People who work for employers that don't provide health insurance benefits
  - Retirees, before they are eligible for Medicare
  - Young invincibles
  - People who don't want to spend the money

The Game Plan.....

Game Plan in Brief

- Insurance Reform
- Individual Responsibility
- Employer Responsibility
- Expansion of Medicaid
- Additional System Supports

Overview - Insurance Reforms

- Individual responsibility??? (Hard/soft penalty; exceptions)
- Employers
  - Employer responsibility??? (Hard/soft penalties; exceptions)
- Insurers
  - Insurance Reforms
  - Exchange/Connector program(s)
  - Public plan/Coop/Something else?????
  - Essential Benefits
  - National, State, Regional or Combo

Individual Responsibility

- Requires individuals to have "qualifying coverage" usually at most basic level.
- Failure to comply will result in a penalty enforced through the tax code. May be cap on penalty amount.
- Exceptions/Exemptions (financial hardship, religious objections, dependents, Native Americans.
- Military/Veteran's coverage is "qualifying coverage"

The Carrot----Premium Subsidies

Income by Percentage of FPL	Premium Contributions
133-150%	1.5 - 3% of income
150-200%	3 -5.5% of income
200-250	5.5-8% of income
250-300	8-10% of income
300-350	10-11% of income
350-400	11-12% of income

More Carrots--Cost-Sharing Credits

Income by Percentage of FPL	Actuarial Value
133-150%	97%
150-200%	93%
200-250	85%
250-300	78%
300-350	72%
350-400	70%

The Stick - Penalty

- Failure to comply with requirement to obtain qualified coverage results in a penalty of 2.5% of modified adjusted gross income up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Exchange.
- Provides exceptions for dependents, religious objections and financial hardship.

Employer Responsibility

- Employer contribution: 72.5% of premium for individuals; 65% of premium for family coverage or pay 8% of payroll into the Health Insurance Exchange Trust Fund.
- Provides for a hardship exemption for employers that would be negatively affected by job losses as a result of this requirement.

Small Employers

Aggregate Wages	Penalty
Less than $500,000	Exempt
Between $500,000 - $585,000	2% of payroll
Between $585,000 - $670,000	4% of payroll
Between $670,000 - $750,000	6% of payroll

Insurance Reforms

- Guaranteed Issue
- Prohibition on Pre-existing Condition Exclusion
- Modified Community Rating
- Essential Benefits
- Prohibition on Lifetime/Annual Coverage Caps
- Requires insurers to report medical loss ratio or sets desired loss ratio
- Extend eligibility for dependent coverage to age 26
- Accountability/Transparency requirements

Essential Benefits

- hospitalization;
- outpatient hospital and clinic services, including emergency department services;
- services of physicians and other health professionals;
- services, equipment, and supplies incident to the services of a physician or health professional in appropriate settings;
- prescription drugs;
- rehabilitative and "habilitative" services (i.e., services to maintain the physical, intellectual, emotional, and social functioning of developmentally delayed individuals);

Essential Benefits cont.

- mental health and substance use disorder services;
- certain preventive services (with no cost-sharing permitted) and vaccines;
- maternity care;
- under the Ways and Means version, well baby and well child care *and* oral health, vision, and hearing services, equipment, and supplies for those under age 21;
- under the Education and Labor version, well baby and well child care *and* early and period screening, diagnostic and treatment services (EPSDT, as available under Medicaid) for those under age 21; and
- under the Education and Labor version, durable medical equipment, prosthetics, orthotics, and related supplies.

Essential Benefits cont.

- The annual out-of-pocket limit in 2013 would be $5,000 for an individual and $10,000 for a family, adjusted annually for inflation.
- To the extent possible, urges the Commissioner to establish cost-sharing levels using copayments (a flat dollar fee) and not coinsurance (a percentage fee).

Medicaid Reform

- Establishes minimum eligibility level at 133% of FPL.
- Adds two new mandatory categories:
  - Single, childless adults
  - Parents
- Provides enhanced federal match for new individuals not subject to the maintenance of effort (MOE) provisions.

Medicaid/Enhanced Federal Match

- The federal government will pay 100 percent of the costs for FY 2013 - FY 2015 for individuals with incomes between the state's income standard on June 16, 2009 and 133 percent of FPL. After FY 2015 and for subsequent fiscal years, the federal government will reduce the enhanced match from 100% to 90%.
- If the state's income standard on June 16, 2009 was above the 133% of FPL level, the state will receive the regular Medicaid match for those beneficiaries for FY 2013 and subsequent years.

Medicaid/Asset Test &Income Disregards

- Prohibits states from using an asset or resource test for determining or redetermining Medicaid eligibility for most eligibility categories.
- Eliminates use of income disregards. Income eligibility is based on modified adjusted gross income.

Medicaid/CHIP Maintenance of Effort

- Prohibits states from adopting eligibility standards, methodologies, or procedures in their Medicaid programs and for the Children's Health Insurance Program (CHIP) more restrictive than those in effect as of June 16, 2009.
- The MOE on CHIP expires in 2013 when the CHIP authorization expires and the individuals in CHIP will either be enrolled in Medicaid or in a insurance plan through the exchange.

Medicaid/DSH Report & Reductions

- **Requires the Secretary of HHS to report to Congress by January 1, 2016 on the continuing role of Medicaid Disproportionate Share Hospital (DSH) payments as health reform is implemented.**
- **Directs the Secretary to reduce Medicaid DSH payments to States by a total of $10 billion ($1.5 billion in FY 2017, $2.5 billion in FY 2018, and $6.0 billion in FY 2019).**

Medicaid/Physician Payment

- Requires state Medicaid programs to reimburse for primary care services furnished by physicians and other practitioners at no less than 80% of Medicare rates in 2010, 90% in 2011, and 100 percent in 2012 and after.
- The requirement is also applicable to Medicaid managed care plans.
- Enhanced Federal match applies.