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**Senate Finance Committee Policy Options Paper
Expanding Health Care Coverage**

On May 11, the Senate Finance Committee released the second of three policy options papers entitled, *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*. The following is an outline of a wide variety of options to expand both private and public insurance coverage options. Besides discussing a wide variety of coverage options, the paper also details proposals to expand access to preventive services.

Section I: Insurance Market Reforms

- Non-Group and Micro-Groups:
 - o Guaranteed issue and guaranteed renewal rules would be imposed; prohibit exclusions for pre-existing conditions
 - o Changes would be effective January 1, 2013 or sooner if possible
 - o Implement a system for risk adjustment comparable to that used for Medicare payments for private plans

- Small groups:
 - o Same rating rules would apply as those for the non-group and micro-group markets
 - o States would have the option to merge the pooling and rating rules for the non-group and small group markets

- Health Insurance Exchange:
 - o All state-licensed private insurers in the non-group and small group markets (and the public option if applicable) operating nationally, regionally, statewide or locally would be required to participate in the Exchange
 - o Micro-groups could purchase insurance through the Exchange immediately and the remainder of small employers could purchase insurance through the Exchange once the rating rules are fully phased in by their state
 - o Secretary would establish an Exchange that enables an individual to receive state-specific information; the Secretary could contract with a private entity to operate the Exchange
 - o Secretary would develop a standard enrollment application, provide a standardized format for presenting insurance options, develop standardized marketing requirements, maintain a call center, enable consumers to enroll in plans in various community locations, establish rate schedules for broker commissions, establish a Web portal that directs consumers to available insurance options in their state and establish a plan for publicizing the Exchange.
 - o State Insurance Commissioners would establish procedures for review of plans to be offered through the Exchange
 - o A second option of establishing multiple competing exchanges
 - o Exchange would receive initial federal funding but then would be self-sustaining through premium assessments

- Individuals with existing coverage could maintain that coverage; these plans would be grandfathered into the system.
- State insurance commissioners would continue to provide oversight of plans re: consumer protections, rate reviews, solvency, reserve requirements and premium taxes. There would be a federal fallback that allows the Secretary to enforce federal rating rules in the case they weren't adopted by a state. Rating areas would be defined by State Insurance Commissioners.

Section II: Making Coverage Affordable

- All plans would be required to provide a broad range of medical benefits, which at least meet minimum standards set by federal and state laws. Plans could not include lifetime limits on coverage or annual limits on any benefits and cannot charge cost-sharing for preventive services. Another option would be to allow for nominal cost-sharing for preventive services. All insurers would be required to offer all four benefit options: high, medium, low and lowest. Insurers in the Exchange would be required to charge the same price for the same products in the entire service area.
- Proposed tax credits for low income taxpayers who purchase health insurance through the Exchange; this credit would be refundable and paid in advance. It would be available for individuals with modified adjusted gross income (MAGI) between 100 and 400 percent of the FPL. The amount subsidized would depend on the individual's MAGI.
- Provide tax credits to certain small employers for the purchase of employer provided health insurance; this credit would be provided for each full time employee covered and would be equal to 50 percent of the average total premium cost paid by the employer for employer sponsored coverage. Credit would be available to offset actual tax liability and would be claimed on the employer's tax return.

Section III: Public Health Insurance Option

- Medicare-like plan: To be offered through the Exchange and administered by a new agency within HHS; Medicare providers would be required to participate and would be paid Medicare rates plus 0-10 percent; no solvency requirement.
- Third party administrator (TPA): Similar to the Medicare-like plan except it would be operated through multiple regional TPAs who would report to the Secretary; TPAs would be required to establish networks of participating medical providers and would negotiate payments for providers; would include a solvency requirement.
- State-Run public option: Either mandatory or optional for States who would be responsible for the details of its administration
- No public option, instead relying on private options in a reformed and well regulated market



Section IV: Role of Public Programs

- All Medicaid programs would be required to raise income eligibility for pregnant women, children and parents. States would be required to maintain income eligibility for all previously eligible populations, which would expire when the Secretary determines the Exchange is fully operational.
- Through 2015, the federal government would fully finance all expenditures for newly eligible Medicaid beneficiaries as a result in increase in income eligibility. State share would be phased in over the next 5 years.
- Options for Medicaid Coverage:
 - o Medicaid eligible individuals would be deemed ineligible for tax credits in the Exchange. The Medicaid program would provide premium assistance for employer sponsored insurance for those eligible for Medicaid in order to mitigate the likelihood of this population dropping their employer sponsored coverage.
 - o Provide eligible Medicaid enrollees with a choice of Exchange Low Option plans, fully subsidizing the premiums.
 - o Children, parents and pregnant women would continue to receive Medicaid in its current structure. Childless adults below 115 FPL would not become eligible for Medicaid, but instead would be eligible for tax credits to purchase coverage
- Medicaid eligibility categories would be the same for the territories as they are for states.
- No changes would be made to SCHIP until its current authorization expires on September 30, 2013 or prior to when the Exchange is fully operational, whichever is later. After that point, SCHIP eligibility would be increased to 275 percent FPL. Enrollees would obtain primary coverage through the Exchange and SCHIP would serve as a secondary payer.
- Similar quality measures as established in the recent SCHIP reauthorization would apply to all Medicaid eligible populations.
- Simplify and streamline enrollment and retention for Medicaid.
- Prescription drugs would be a mandatory benefit for the categorically and medically needy.
- Impose statutory requirements regarding transparency in the development, implementation and evaluation of Medicaid and CHIP section 1115 demonstration programs that impact eligibility, enrollment, benefits, cost-sharing or financing.
- The FMAP formula would be changed in a budget neutral manner that would not only rely on a state's per capita income but also incorporate data on the state's poverty level.



- Stabilize Medicaid during economic downturns.
- The level of a state's disproportionate share (DSH) hospital payment allotment and the definition of a DSH hospital would remain the same. State allotments would be designated as a pool for qualified hospitals within each state and funds from this pool would be dispersed directly by the Secretary to qualifying hospitals. Hospitals would submit claims data to CMS for uncompensated care.
- Establish new Medicaid demonstration authority of years for exploring alternative approaches for coordinating the care of dual eligibles.
- Establish a new office within CMS, the Office of Coordination for Dually Eligible Beneficiaries, to identify and lead agency efforts to align Medicaid and Medicaid financing, administration, oversight rules, and policies for dual eligibles..
- Options for changing the Medicare disability waiting period:
 - o Reduce the waiting period from 24 to 12 months
 - o Reduce the 24 month waiting period by one month every quarter beginning in October 2009 until the waiting period reaches zero months in June 2015
 - o Phase-out the waiting period based on the date of the individual's disability
 - o Retain the 24 month waiting period for persons with access to probate health insurance coverage
- Temporary Medicare Buy-In:
 - o Peoples ages 55 through 64 who do not have employer sponsored coverage or Medicaid coverage could voluntarily enroll in Medicare beginning January 1, 2011. This option would end once the Exchange fully operational, though people already enrolled in Medicare could stay in Medicare.
 - o The committee is seeking input on alternate proposals to meet the needs of this population.

Section V: Shared Responsibility

- All individuals would have a personal responsibility to obtain health insurance coverage. They would be required to purchase coverage through (1) the individual market, (2) any grandfathered plan, or (3) in the group market. Exemptions from the coverage requirement would be allowed for religious objections and for undocumented aliens. Taxpayers would be required to report the months for which they have the required minimum coverage on their federal tax returns. The penalty for not being insured would be an excise tax equal to a percentage of the premium for the lowest cost option available through the Exchange.
- Employers would either offer insurance coverage for their full time employees or pay an assessment of an excise tax calculated as a per employee per month based on gross receipts.



Section VI: Options to Improve Access to Preventive Services and Encourage Healthy Lifestyles

- Authorize a personalized prevention plan for all enrolled Medicare beneficiaries once every five years unless deemed inappropriate.
- Provide the Secretary with the option of withdrawing Medicare coverage for preventive services that are rated “D” by the United States Preventive Services Task Force (USPSTF).
- Provide states with a 1 percent increase in the federal share of its FMAP for providing preventive services rated as “A” or “B” by the USPSTF and immunizations recommended by the Advisory Committee on Immunization Practices.
- Remove or limit cost-sharing for clinical preventive services rated “A” or “B” by the USPSTF.
- Provide annual, capped grants to states for three or five years to provide access to certain evidence-based primary preventive services.
- Establish a competitive grant program to promote health and human services program integration, improve care coordination and access to preventive services and treatments and better integrate the delivery of health care services to improve health and wellness outcome.
- Provide a tax credit for 50 percent of the costs paid by an employer for providing a “qualified wellness program” during a taxable year.

Section VII: Long Term Care Services and Supports

- Allow states to seek approval to offer additional services under the Medicaid HCBS State Plan Option.
- Eliminate the institutional level-of-care requirement for eligibility for section 1915(c) waivers and require states to replace it with less stringent criteria.
- Options to Increase Access to Medicaid HCBS:
 - o Increase the number of persons under the cap that states would be required to enroll in either or both of these authorities
 - o Prohibit states from using waiting lists to prevent eligible beneficiaries from accessing HCBS
 - o Alternate ways as suggested by the committee to ensure access to HCBS
- Increase the federal match for HCBS by 1 percent.



- Amend Medicaid law to require states to apply spousal impoverishment rules to applicants who would receive HCBS under specified sections and would allow persons to apply for HCBS through the medically needy eligibility pathway.
- Allow states to treat those applying for Medicaid HCBS differently by allowing them to retain higher levels of assets.

Section VIII: Options to Address Health Disparities

- The Social Security Administration (SSA) would be required to collect race, ethnicity and language data on Medicare enrollees.
- Require that federally funded population surveys collect sufficient data on racial/ethnic groups to generate statistically reliable estimates in studies comparing health disparities populations.
- Establish uniform categories for collecting data on race and ethnicity.
- Health care quality data would be required to be published by race, ethnicity and gender.
- Extend the 75 percent matching rate for translation services to all Medicaid beneficiaries for whom English is not the primary language.
- Add non-pregnant adults to the list of Medicaid beneficiaries for whom states would be permitted to waive the 5 year bar to extend Medicaid coverage.
- Provide funding to states, tribes and territories to develop targeted approaches to reducing infant mortality.

