Summary of the Senate Finance Committee's Health Care Coverage Options Paper

Proposed Market Reforms

- Combine individual and micro-group markets (two-10).
- Remainder of small group defined by state.
- Modified community rating for individual, micro-groups and small groups with variations allowed for age (5:1 bands), family composition, geography and tobacco use with the total variation not to exceed 7:5:1.
- Risk adjustment for the individual market to be determined by DHHS. May be state-based or based on the Medicare risk-adjustment model.
- All coverage would be guaranteed-issue and there would be no pre-existing condition look-back/exclusionary periods allowed.
- Annual and lifetime benefit limitations would be prohibited.
- No cost-sharing or limited cost sharing for preventive care.
- Phase-in of reform requirements by 2013.

Proposed Exchange

Option One

- National exchange with state-specific information. Not a bricks-and-mortar institution, but a primarily electronic portal.
- All carriers selling to individuals and small groups would be required to participate. Individuals and micro-groups would be able to participate immediately, and small groups after the market reforms became effective.
- Plans would have to charge the same premium regardless of the method of purchase used (i.e., no discounts if an agent/broker is not used).
- Agents and brokers would be able to sell exchange products.
- DHHS would operate the exchange or could contract with a private entity for operation.
- Initial federal funding and then would be funded through premium assessments.
- Secretary of DHHS would:
    - Develop a standard application and a standard format for presenting insurance options.
    - Develop standardized marketing requirements modeled after the MA requirements and a standardized commission schedule modeled after MA.
    - Maintain a customer service call-support center.
    - Enable individuals to enroll in certain public places like hospitals and schools, DMVs and other offices specified by the state.
    - Establish a Web portal to direct individuals and small businesses to coverage options in their state, inform them of eligibility in public assistance and subsidies, and provide quality information.
    - Establish a publicity plan.
    - Establish procedures for enrollment, eligibility determinations, appeals procedures and certification that an individual with coverage through the exchange meets the criteria for the individual mandate.

Option Two

Multiple competing private national/regional exchanges in addition to the federally established exchange.

Proposed Public Plan Option

Option One

- Outlines three potential structures for a government-run public plan to compete with the private market through the exchange.
- First structure would be a Medicare-like plan that would compel Medicare provider participation, use Medicare rates plus 0-10% with no solvency requirements.
- Second structure would use regional TPAs to manage the plans, build networks and negotiate provider rates. This option would be required to have a reserve fund as well.
- Third public plan alternative proposed would be a state-run public plan option that could either be mandatory or optional for states. An option could be to open up the state employees plan to state residents.

Option Two

- No public plan option.

Benefit Options

- Require all small-group and non-group plans to provide a minimum level of coverage including, but not limited to, preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screening, maternity and newborn care, medical/surgical care, prescription drugs, radiation and chemotherapy, mental health and substance abuse services. Would have to meet other minimum standards set by federal law.
- All insurers would have to offer four of the following benefit options:
    - High option (actuarial value of 93%)
    - Medium option (actuarial value of 87%)
    - Low option (actuarial value of 82%)
    - Lowest option (actuarial value of 76%)
- Parity would be required in cost sharing across four categories of benefits: inpatient hospital, outpatient hospital, physician services and others including mental health and substance abuse.
- Plans would have to meet class and category of drug coverage requirements specified in Medicare Part D.

Individual Tax Credits

- Refundable and advanceable tax credit for taxpayers who purchase coverage through the exchange with incomes between 100% and 400% of FPL. There are several complicated options presented for phasing out the credit as income increase that tie the value of the tax credit to income and premium costs based coverage options in the exchange.

Small Business Tax Credits

- Proposes tax credit for qualified businesses of one-25 with payrolls where the average salary is 40,000 or less. The credit would be equal to 50% of the average total premium costs paid by the employer and would phase out based on both on business size and the average employee income.

Medicaid

- Potential requirement that state Medicaid payments to all providers not fall below a given percent of Medicare reimbursement for the same or similar services and suggests 80% as an option.
- Outlines potential expansions of Medicaid (possibly up to 150% FPL) as a coverage option to the lowest-income Americans through three options.
    - Using the current Medicaid for those who do not have ESI and using premium assistance for ESI when available and cost effective.
    - Covering Medicaid-eligible individuals through the exchange in a complex subsidy formula with various state population coverage options.
    - Keeping traditional Medicaid recipients in the Medicaid program but requiring childless adults to purchase subsidized coverage through the exchange in the form of a voucher, with Medicaid serving as wraparound coverage.
- Outlines a number of other proposed changes to Medicaid including the FMAP matching rate, changes to DSH payments, quality issues, changes to covered benefits, particularly prescription drugs, territorial issues, the treatment of dual eligibles and increased transparency of the federal waiver process, among others.

CHIP

- CHIP would be phased out after the current appropriation period expires.
- CHIP-eligible beneficiaries (up to 275% of FPL) would get subsidized coverage through the exchange with a potential federal wraparound if exchange plan did not meet benefit standards.

Medicare

- Proposes various options to eliminate the Medicare disability waiting period.
- Proposes temporarily allowing individuals 55+ who meet certain criteria to buy into Medicare until the market reforms and exchange are functional. Individuals would be charged an actuarial-based premium to represent the total cost of their coverage plus a five-percent administrative fee. If an individual's claims exceeded his premiums during the temporary expansion, the individual would be charged greater part B premiums through age 85. If they were less, he/she would receive a rebate.
- Asks for additional ideas as to how to handle the early retiree population until the exchange and market reforms are operational.

Individual Mandate

- Individuals would be required by January 2013 to obtain health insurance coverage either through government assistance program (Medicaid) or the individual or employer markets. Coverage would have to be either the lowest plan

option offered through the private individual market or employer coverage that was actuarially equivalent.

- Several options were presented for open enrollment in coverage, with additional enrollment opportunities for federal qualifying events, similar to the way that group coverage works now. There would be an annual open-enrollment period for plan changes, and if individuals took no action, they would maintain their current coverage.
- A possibility would be that all policies would be guaranteed-issue/no pre-existing condition exclusions during an open-enrollment window, but pre-existing condition exclusions for up to nine months and higher premiums could apply.
- Insurers and individuals would have to report coverage status to the IRS.
- Penalties for noncompliance would be a phased in excise tax equal to a percentage of the premium (75% when fully phased in) for the lowest option plan available through the exchange.
- There would be an application process for exemptions due to income or hardship.

Employer Mandate

Option One

- Restrictive employer mandate to provide all employees working more than 30 hours with coverage actuarially equivalent to the lowest plan option in the exchange that includes first-dollar coverage for preventive services. A 50% employer contribution rate for the entire premium would be required.
- Small business coverage can be provided through the exchange.
- Strict excise tax penalties that would apply to businesses with payrolls that exceed $500,000. Tax penalties would increase based on payroll size up to $1,500,000.

Option Two

- No employer mandate.

Wellness Initiatives

- Increased wellness, disease management and preventive care coverage in Medicare and Medicaid and provisions to ensure the use of evidence-based medicine.
- State grants for wellness promotion, preventive care and disease management.
- Allows for the development of premium incentives for Medicaid and Medicare recipients who meet wellness goals
- Tax credit for businesses that create wellness programs for employees, similar to the provisions in the Healthy Workforce Act.

Long-Term Care through Medicaid

- Proposes options for changes to Medicaid asset tests and the home and community-based care services and waivers to improve access to home and community-based living and services.

Health Disparities

- Proposals for Medicare to collect data on race, ethnicity and language, as well as a national population survey on race, ethnicity and language to allow for reliable health disparities research.
- Require the collection and federal dissemination of health quality transparency data based on race, ethnicity and gender.
- Grants to reduce infant mortality.