

These are ITUP's summaries of the outstanding differences remaining between the House and Senate reform bills.¹ This summary focuses on the uninsured, not on the changes in Medicare and long term care, which are also important features of the reform. We think both bills are strong and it may be possible to meld the stronger elements of each in the final bill to reach the President's desk. There will be many opportunities to fine-tune the legislation as the needs and opportunities arise over ensuing years.

From our perspective, the most important difference is the earliest possible start date for the major reforms since the sooner we can get the uninsured covered and unsustainable health cost increases slowed, the better for all Californians: House (2013), Senate (2014).

INTERIM ASSISTANCE

Many of the proposed interim (2010-2013) measures allow more Californians to maintain coverage until the larger reforms kick in:

- The proposed funding² for state high risk pools for individuals rejected by insurers due to pre-existing medical conditions,
- The restrictions on health plan rescissions of individual and small employer coverage,
- The extension of coverage for young adults under their parent's policies through age 26,
- The reinsurance funding³ for businesses' struggling to maintain coverage for retirees (aged 55-64) with serious illnesses,
- The tax credits for small, low wage businesses (Senate version) and
- COBRA extension to 2013 (House version).

Other interim measures will help put the building blocks for reform in place and assure the safety net programs and providers are able to survive to care for the uninsured over the next three years:

- Six month extension of the enhanced Medicaid match (House version),
- Increased funding for community health centers and
- Enhanced match for states that wish to cover their uninsured Medically Indigent Adults (Senate version) or get a head start on the proposed coverage expansions and Insurance Exchanges for the uninsured (House version).

UNINSURED

The House version of the reform covers more of the uninsured (36 million) than does the Senate version (31 million), and the Senate version assures greater affordability between 300 and 400% of FPL.⁴ The differences include:

- Medicaid expansion for all families and individuals to 150% of FPL (House) as opposed to 133% (Senate)⁵

- Higher subsidies to assure affordability of premiums, copays and deductibles for individuals between Medi-Cal income limits and 300% of FPL (House)
- Higher subsidies to assure affordability of premiums, copays and deductibles for individuals between 300 and 400% of FPL (Senate)
- Stiffer penalties on those individuals who fail to enroll in coverage (House version -- 2.5% of income above the federal income).
- Lower threshold for financial hardship exemptions from the individual mandate (Senate version -- 8% of income).
- The House version covers children above the Medi-Cal income thresholds with their parents through the Exchange while the Senate preserves and funds a separate CHIP (California's Healthy Families) program.⁶

COVERED BENEFITS

The House version of the reform requires individuals to purchase a broader minimum benefits package, and the Senate version requires less coverage and is therefore more affordable for those individuals with incomes in excess of 400% of FPL (\$88,000+ for a family of four) who will receive no subsidies. Both versions eliminate cost sharing on effective preventive services in both public programs and private insurance.

- The House version requires at a minimum coverage of 70% of expected medical costs,⁷ while the Senate version requires minimum coverage of 60% of expected medical costs and permits young adults and individuals with hardship exemptions to purchase a "young invincibles" policy of preventive services and catastrophic coverage.
- Each version allows grandfathering of any existing individual coverage.⁸
- The Senate version allows grandfathering of existing employer coverage, whereas the House version gives employers 5 years to upgrade to the minimum benefits threshold.

INSURANCE REFORMS

The insurance reforms are directed at improving cost, convenience, customer service and availability (a series of practices known as medical underwriting which insurers may use to exclude individuals with serious medical conditions). The House version has tighter restrictions and regulations on medical underwriting by insurance companies. The Senate version requires somewhat less change. Both assure that every American can get coverage by requiring guaranteed issuance and renewal regardless of an individual's medical conditions. Both eliminate pre-existing condition exclusions, annual and lifetime benefit exclusions and simplify and standardize billing, coverage, administration and pricing of coverage.

- The Senate allows age rating of 3:1 between the oldest (higher cost) and youngest age groups while the House allows 2:1 age rating.⁹
- The Senate allows 1.5:1 rating variations between smokers and non-smokers while the House allow no rate variations.¹⁰
- The Senate allows employers to use financial incentives combined with effective treatments for employees to improve their health status.¹¹

- Each uses an Exchange to distribute premium subsidies for individuals and small employers. The Senate has separate pools within an Exchange for individuals and small businesses, while the House combines the pool for both individuals and small employers.¹²
- The House version has a national Exchange, and it is the exclusive source of coverage for individuals while the Senate has state exchanges and individuals can buy coverage both inside and outside the Exchange.¹³
- The House version provides for a nationwide public insurer while the Senate version provides for two nationwide insurers at least one of which must be a non-profit. Both plans include funding to develop non-profit statewide cooperatives to enhance competition.¹⁴
- The House version has tighter minimum loss ratios – the percent of the premium that must be spent on medical care – than does the Senate version.¹⁵
- The House version repeals the anti-trust exemption for insurers while the Senate version does not.

COST CONTAINMENT/VALUE PURCHASING

These reforms are designed to slow the rate of health spending growth so that spending growth will not crowd out most other state and federal government programs and will not stifle wage, job and economic growth in the private sector. They are a series of adjustments in nearly every realm of health spending that taken collectively appear to bend the cost curve to the desired degree. The Senate version is somewhat stronger, taken all together, while the House version has some provisions that are stronger than the Senate. These are some salient differences.

- The Senate version has the 40% “Cadillac benefits” excise tax on group health benefits costing more than \$8,500 for individual employees and \$23,000 for families.¹⁶ The House version has no comparable provision.
- In the Senate version, subsidies to subscribers within the Exchange are tied to the lower cost plans while in the House subsidies are tied to the average cost plan.¹⁷
- The Senate version has the “MedPac with teeth” for fast track approval of Medicare payment revisions.¹⁸
- The House version authorizes the Secretary of Health and Human Services to contract with pharmaceutical manufacturers to secure favorable prices for their products to seniors and the disabled in the Medicare program.¹⁹
- The House version phases down Medicare payments to Medicare Advantage plans over three years, while the Senate version authorizes competitive bidding.²⁰
- The Senate version implements Medicare pay for performance incentives for hospitals and doctors to improve quality while the House version would study these ideas before implementation.
- Both versions include a 10% increase in primary care reimbursement rates to Medicare providers and the House version increases primary care reimbursement under Medicaid to the Medicare level.

FINANCING

Both the Senate and the House rely on a roughly equal measure of cuts in existing federal spending for public programs and increases in taxes. There is a big difference between the House and the Senate in the taxes that would increase. In general, the Senate version keeps the taxes and financing within the health care sector so that the health sector is in some sense reprioritizing existing finances to pay for reform while the House raises taxes outside the health sector.

- The House version relies primarily on taxes on very high-income taxpayers and a series of very minor adjustment in corporate taxes.²¹
- The Senate version relies on the Cadillac benefits tax, a small increase in the Medicare payroll tax for high earners, fees on pharmaceutical manufacturers, an excise tax on tanning salons and an increase in the threshold for deducting medical expenses.²²
- The House version collects significantly more fees from employers that do not offer coverage to their employees than does the Senate version and provides a promising model to finance coverage for the flex workforce.²³
- Both the House and the Senate initially pay for almost all the cost of Medicaid expansions and after several years collect limited matches from state governments.²⁴

Prepared by Lucien Wulsin, ITUP

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¹ See Tri-Committee House Staff, House Senate Comparison of Key Provisions (December 29, 2009) at: <http://www.speaker.gov/pdf/HScomparison.pdf>

² \$5 billion is proposed. The California high-risk pool is funded at \$40 million, a figure frozen since the late 80's and covers less than 8,000 of the 200,000 medically uninsurable uninsured Californians.

³ \$10 billion in reinsurance is proposed to help pay for costs in excess of \$15,000 and up to \$90,000 per retiree. The funds may only be used to lower premiums and cost sharing.

⁴ See Tri-Committee Staff, House Senate Comparison of Key Provisions at: <http://www.speaker.gov/pdf/HScomparison.pdf>; the Appendix has a nice side-by-side summary of the differences in subsidies between the two bills. The Commonwealth Fund had a nice visual of the earlier differences in the subsidies between the two Houses that is reproduced in Adam Dougherty's blog at <http://www.itup.org/blog/index.php/2009/11/20/trend-png>

⁵ Safety net providers and plans will probably prefer the House's higher Medicaid threshold while private doctors, commercial insurers and state Governors will likely prefer the Senate's lower threshold. Coverage through the Exchange is likely to offer greater choice of plans and providers, but at the cost of higher subscriber out of pocket costs.

⁶ The argument for the House version is that it keeps families in the same health plan, same provider network and same program, making coverage far simpler for families. The argument for the Senate version, which retains and expands CHIP for children up to 250% of FPL with an enhanced match, is that it provides a richer

benefits package, more appropriately tailored to children's development. The other perceived advantage of the Senate version is to assure eligibility for US citizen children in mixed status families.

⁷ The bills use a term actuarial values that is probably unfamiliar to many, and it means what percent of the expected medical costs does the plan cover. So 100% means all medical costs are fully covered by the insurance plan. On average, employer plans cover 80% of expected claims costs while individual plans on average cover less -- 60% and declining in the face of rising premiums.

Within the Exchange, individuals with incomes up to 400% of FPL are subsidized for their premium and out of pocket costs on a sliding scale. For the lowest income, the actuarial value (after subsidies) is 97% in the House version and 90% in the Senate version. Individuals at the lowest income levels within the Exchange pay no more than 1.5% of income for premiums in the House version and not more than 2% in the Senate version. At the top end of the subsidized coverage (just under 400% of FPL), under the Senate version, individuals premium share is capped so they do not pay more than 9.8% of income for premiums, under the House version the cap is 12% of income. Individuals can choose any plan and any level of coverage offered within the Exchange, but choosing more expensive plans would cost individuals 100% of the incremental cost difference.

For the highest income (above 400% of FPL or \$88,000+ for a family of four), the minimum actuarial value is 70% in the House version and 60% in the Senate version and the maximum out of pocket is \$5,000 for an individual and \$10,000 for a family in the House version and \$6,150 for an individual and \$12,300 for a family in the Senate version. The Senate version allows individuals with financial hardship and young adults up to age 30 to buy coverage, limited to catastrophic and preventive services.

⁸ As mentioned in the earlier footnote, some individuals buy coverage with less coverage and may be *underinsured*; both the House and Senate allow this to continue. Those with incomes of less than 400% of FPL may find they can get more coverage at lower costs with the subsidies and purchasing power of the Exchange.

⁹ 3:1 is roughly the premium variation between older and younger employees in the California small employer market where age variations in premiums are unregulated. See Fox, 2006 Overview of the Uninsured: California, Section 5 (Insure the Uninsured Project December 2007) at

<http://itup.org/Reports/Statewide/California%20Overview%202006.pdf>, and Reckling, Improving Affordability under Reform (Insure the Uninsured Project, November 13, 2009) at

[http://itup.org/Reports/Health%20Reform/Health Insurance Exchange 11-12-09.pdf](http://itup.org/Reports/Health%20Reform/Health%20Insurance%20Exchange%2011-12-09.pdf). The argument in favor of a 3:1 ratio on age rating is that average wages and incomes typically increase with age and compressing the age band too much is regressive, such that younger lower paid individuals cross-subsidize older higher paid workers. The subsidies within the Exchange assure equitable affordability for all individuals with incomes up to 400% of FPL, which accounts for 85% of California's uninsured. See Reckling, Improving Affordability under Reform at

[http://itup.org/Reports/Health%20Reform/Health Insurance Exchange 11-12-09.pdf](http://itup.org/Reports/Health%20Reform/Health%20Insurance%20Exchange%2011-12-09.pdf)

¹⁰ Smoking clearly adds extra health costs, which may warrant a premium variation; it is unclear whether the over-all goals of reduced smoking are better achieved by an increase in the cigarette tax, which deters smoking at the point of purchase or by premium variations that are experienced for the most part indirectly by the smoker and muted by the intermediaries of employer contributions, pre-tax purchasing and premium subsidies.

¹¹ Pitney Bowes, Safeway and other employers have had success in improving their employee's health status and work productivity with a combination of approaches to improve health status, including financial incentives for employees with chronic illness (such as diabetes and hypertension) who improve their health profiles with the assistance of well-tested health improvement, risk reduction programs, including smoking cessation, better physical fitness and weight loss.

¹² The reasoning behind separate pools for individuals and small employers is that the small employer market does not include individuals with serious illness who are unable to work, whereas some individuals in the individual market (as it exists now and under reform) may have costly disabling illnesses. Massachusetts combined the two pools with positive results.

¹³ The National Exchange has the following drawback -- how does a Washington DC based purchasing pool know and navigate the ins and outs of plans and markets throughout the diverse state of California. The state Exchanges have the drawback of some states with too small populations for a state Exchange to have real negotiating power and other states whose leaders may be dedicated to throwing monkey wrenches as opposed to effective implementation of health reform. The best compromise may be a national Exchange with the option for state Exchanges or regional exchanges for the Plains or Mountain states; we do think that California should opt for a state Exchange, given the large differences between our health plans and safety nets as compared to the rest of the country.

The exclusivity proposed by the House concentrates within the Exchange the requisite efforts to risk-adjust for adverse selection between plans. Under the Senate version, federal or state regulators will need to have ample authority to monitor and risk-adjust for adverse selection both within and outside the Exchange(s). What do we mean by risk adjust and adverse selection, let's assume one plan ends up with all the low risk meditating yoga instructors and the other plan ends up with all the higher risk crop-dusting, forest fire fighting motorcycle riders. Risk adjustment corrects, albeit imperfectly, for disproportionate enrollment of the high-risk subscribers.

¹⁴ As we discussed in earlier memos, a nationwide public plan has greater symbolic than on the ground significance because of CBO's projections that enrollments are few, cost savings are minor, and enrollment in the public plan may be disproportionately high risk. See Wulsin, Jr., Thinking About the End Game (Insure the Uninsured Project, December 4, 2009), at

[http://itup.org/Reports/Health%20Reform/Thinking About the End Game.pdf](http://itup.org/Reports/Health%20Reform/Thinking%20About%20the%20End%20Game.pdf).

While we think the statewide co-ops have greater potential to transform the

delivery system and inject needed competition, CBO rejects that proposition as well. See Dougherty, Summary of CBO Score for America's Healthy Future Act (Insure the Uninsured Project, October 2009), at:

<http://itup.org/Reports/Solutions/CBOSummary101209.pdf>. The nation-wide plans would have the volume necessary to negotiate favorable rates with pharmaceutical manufacturers and medical equipment suppliers; they likely lack the local market knowledge and flexibility to develop cost efficient local delivery systems. We think California's local public managed care plans (with some necessary consolidation) offer a far better alternative for delivery system reform in California. See Tuttle and Wulsin Jr., California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured: Counties, Clinics, Hospitals, and Local Health Plans (Insure the Uninsured Project, October 2008), at http://itup.org/Reports/Statewide/Safetynet_Report_Final.pdf.

¹⁵ The House is at 85% while the Senate is at 80% for the individual market, which does have higher selling costs than coverage for large and medium sized employers. The Exchange is in part an effort to simplify, streamline and make transparent the purchase of individual and small employer health insurance and the return the savings to subscribers as reduced premiums. In the Senate version, the individual market operates both inside and outside the Exchange. In both the Senate and the House versions, the small employer market operates both inside and outside the Exchange.

¹⁶ Employer health insurance is purchased with a pre-tax dollar that is worth on average over 30% of the cost of the premium. Because the value of this benefit increases with the taxpayer's tax bracket, this tax preference can offset up to 50% of the value of coverage for high wage employees in high tax brackets and ends up being very regressive. The Cadillac benefits excise tax applies to the incremental cost of plans in excess of the thresholds and is adjusted annually by CPI (Consumer Price Index) plus 1%, giving incentives for employers and employees some financial disincentives to choosing the "gold plated" plans. As several commentators have pointed out, the tax may hit some Chevy's along with the Cadillac's as the high cost could be due to dangerous occupations such as coal mining or fire fighting or simple old age as the costs of premiums vary more by age, than by benefit design. The Senate version seeks to protect plans whose high costs are driven more by age and occupation than by benefit design from the tax by increasing the Cadillac threshold.

¹⁷ The managed competition approaches favored by Professor Enthoven and many others propose that employers and government offer a broad choice of plans to subscribers and tie the subsidies to the lower cost plans, which will give consumers incentives to price shop for the best combination of price and coverage.

¹⁸ MedPac has been an expert advisory body that makes recommendations on Medicare rate and benefit design to HHS and Congress. The proposal is have a body of experts whose reimbursement recommendations are fast tracked for Congressional approval or rejection.

¹⁹ This was one of the most contentious issues when Congress expanded Medicare to cover prescription drugs several years ago. The House version gives the Secretary the power to negotiate with drug manufacturers but not the ability to exclude those

with whom the agency is unable to negotiate a mutually satisfactory contract. Thus the agency's negotiating leverage is diminished.

²⁰ Medicare Advantage plans are supposed to be paid at no more than the cost of the Medicare program; in fact they are paid 14% more due primarily to some of the risk selection issues discussed earlier. Under the House version, \$170 billion is saved over the next ten years by a three-year phase down to payment equivalency with traditional Medicare. Under the Senate version, the agency negotiates rates with the Medicare Advantage plans and \$120 billion is saved over 10 years.

²¹ The House's proposed 5.4% surcharge on income taxes for those with incomes over \$500,000 a year for single filers and \$1 million for joint returns raises \$460.5 billion over the next ten years. This is over 80% of the \$565 billion in revenues generated in the House bill. See Tri-Committee Staff, House Senate Comparison of Key Provisions at <http://www.speaker.gov/pdf/Hscomparison.pdf>. One of the advantages of the House's proposed revenues is "equity" as high-income individuals have disproportionately benefited in the American economy's growth over the past 40 years. See U.S. Census Bureau Charts at

<http://www.census.gov/hhes/www/income/incineq/p60204/fig1.html>

²² The Senate raises \$460 billion over 10 years: \$149 billion from the Cadillac benefits excise tax, \$87 billion from 0.9% Medicare payroll tax on wages in excess of \$200,000 for individual filers and \$250,000 for joint filers, \$101 billion from fees on drug and medical device manufacturers and insurers, and \$15 billion from the increase from 7.5% to 10% of income on the floor for deductions of catastrophic medical expenses. See Tri-Committee Staff, House Senate Comparison of Key Provisions at <http://www.speaker.gov/pdf/Hscomparison.pdf>. One of the advantages of the Senate approaches is that all the fees are very small percentages and they are nearly all within the health care industry so that anticipated revenues keep pace with the growth in health spending, and some may slow the rise in health spending.

²³ The House version collects \$135 billion while the Senate version collects \$28 billion over the next ten years from employers who not offer coverage for their employees. See Tri-Committee Staff, House Senate Comparison of Key Provisions at <http://www.speaker.gov/pdf/Hscomparison.pdf>. The House version exempts the first \$500,000 in wages and taxes wages in excess of that figure on a sliding fee basis growing from to 8%. Thus a business with wages of \$550,000 annually would pay \$1000. In addition, the House version appears to give employers the ability to bifurcate their workforce paying the tax for part time and other flex workers while buying traditional employment based coverage for their full-time workers. See Wulsin, Open Letter on Coverage for the Flex Workforce (Insure the Uninsured Project, October 12, 2009) at www.itup.org/reports
The Senate version exempts all employers of less than 50 employees and collects \$750 fee per employee if a large employer fails to offer coverage and one or more of its employees uses the premium subsidies through the Exchange. The Senate version might be better during the earlier stages of a still fragile economic recovery while the House version may be a more equitable and durable long term model to resolve the challenges of coverage for low wage workforces.

The House and Senate versions also provide a small employer tax credit for small low wage businesses that do offer coverage. The 50% premium credit phases down and eventually out between ten and twenty-five employees and between \$20,000 and \$40,000 in annual wages. The Senate version of the tax credit also includes a reduced credit for small low wage non-profits.

²⁴ Under the House and Senate versions the federal government would pay 100% of the match for those newly eligible for Medicaid for 2 years. The House version would have the federal government paying a 91% match thereafter. The Senate version has a 32.3% increase in the federal match so that states would be reimbursed between 82% and 95% of the costs of the new expansion eligibles. See Tri-Committee Staff, House Senate Comparison of Key Provisions at <http://www.speaker.gov/pdf/Hscomparison.pdf>.

Why are Governors upset with these generous matching rates? Governors whose states already expanded Medicaid eligibility want the enhanced match on the expansions they already enacted. Other Governors want the enhanced match on any growth in program enrollment. Other Governors (e.g. California) want to redo their federal match to more accurately reflect their states' higher than average rates of poverty and/or the uninsured.

We would urge those interested in this federal/state tug of war to read John Holahan, Alternatives for Financing Medicaid Expansion in Health Reform (Kaiser Commission on Medicaid and the Uninsured, December 2009) at <http://www.kff.org/healthreform/upload/8029.pdf>.

ITUP's views are that there should be an enhanced FMAP that applies to the entire Medicaid program in order to hold states harmless; otherwise there will be incentives to shift eligibles and costs to the component of the program with the most favorable federal match.