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Finance Committee 'Framework for Health Reform'
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The Senate Finance Committee will begin their mark up of a reform bill in the coming weeks based on a recently released paper entitled "Framework for Comprehensive Health Reform." We at ITUP feel this bipartisan Framework contains many elements that will likely be preserved in the final legislation. Though the paper stresses that this framework is not yet a complete proposal, many of the fundamental pieces will have a significant impact in California's private and public sectors. The full text of the Finance Committee "Framework for Comprehensive Health Reform" can be accessed at *http://finance.senate.gov/press/Bpress/2009press/prb090909.pdf*

Insurance Market Reform

The Framework contains market reforms that are consistent with the other bills as well as the President's overarching goals. These commonalities include guaranteed issue and renewal, prohibition of coverage exclusion based on pre-existing conditions, removal of annual/lifetime caps, and barring of rescissions. The Framework goes further by explicitly attaching ratios of insurance premium variance for tobacco use (1.5:1), family composition (maximum 3:1) and geographic differences. In all, premiums cannot vary by more than 7.5:1. These provisions will be of great benefit for California's high-risk individuals in the non-group market, but may be wider than now prevailing for California's small employers.

Minimum benefit requirements will also be established and made up of four benefit categories with corresponding actuarial values: Bronze (65%), Silver (73%), Gold (81%) and Platinum (90%). Explicitly included in these benefits are prevention and primary care, physician services, emergency services, hospitalizations, diagnostic imaging and screening, labs and x-rays, maternity and new born care, prescriptions, radiation and chemotherapy, pediatric dental and vision, mental health services, and substance abuse services. Cost sharing for preventive care would be eliminated in most but not all categories. Existing plans would be grandfathered, and the subsidized "Exchange" plans in the non-group and small-group market would cover the Silver category. These requirements would assist many who are currently underinsured by inadequate plans and incentivize the use of preventive services by for the most part eliminating co-pay barriers to the consumer/patient.

The Framework contains an additional policy for 'young invincibles' that combines lower-cost catastrophic coverage with preventive benefits. This unique clause may prove more affordable for young adults. Federal premium subsidies to this population would be reduced as affordability increases, thus lowering overall reform cost. Catastrophic coverage may prove inadequate in the advent of less than catastrophic injuries or illnesses.

Health Insurance Exchanges are state-based under the Framework, and will provide standardized enrollment procedures, plan comparisons, and customer service. The proposal enacts the Exchanges comparatively earlier than other proposals (2010), which could yield significantly faster enrollment rates. Additionally, states would immediately be required to establish an ombudsman to advocate for consumers facing difficulty with insurers in the individual and small group markets. Additional funding would also be available to state high risk pools in 2010, though California's MRMIP may not be eligible as the Framework states that funds can not go to high risk pools with a waiting list. The Framework includes language for risk sharing mechanisms (presumably for plans in the Exchange) including risk adjustment, reinsurance, and risk corridors though their operational aspects have not yet been explained.

The Framework establishes separate Exchanges for the small group and individual markets. By sub-dividing the non-group market, it is more difficult to spread risk and control inter-plan adverse selection and adverse selection against the Exchange.

The Framework also allows the interstate sale of health insurance in 2015, through 'health care choice compacts' agreed upon between two or more states. This could result in a slippery slope race to the bottom of state regulations. It is likely to be imperative that the federal floors are adequate, clear and enforceable in order to protect against states that may seek to nullify the federal reforms.

Ensuring Affordability

Individuals

The Framework contains an individual mandate, in order to achieve universal coverage outside of a single-payer system. The mandate has exemptions consistent with other proposals, and includes penalties up to $950/$1500 for individuals/families failing to obtain coverage. Tax credits will be available to individuals and families in 2013 through the Exchange (coinciding with the mandate), and will be sliding scale for those between 134-300% of poverty. Refundable credits will be issued to reduce premium costs to 3% of income for those at 100% of poverty, rising to 13% of income for those at 300% poverty.

Cost sharing assistance will also be available on a sliding fee basis tied to corresponding income brackets: 100-150% (tied to Platinum-level coverage), 150-200% (tied to Gold-level), 200-300% (tied to Silver-level). Out-of-pocket maximums would be tied to current Health Savings Account (HSA) standards. Individuals between 300-400% of poverty would be eligible for credits at a flat percent of income (13% of income for the purchase of Silver Coverage), with no subsidies for cost sharing in this income bracket. Almost half of all Californians have incomes of less than 300% of FPL and 3/4ths of uninsured Californians.

Employer

Businesses with more than 200 employees are required to enroll employees in health coverage. Businesses with more than 50 full-time employees that do not offer coverage may be subject to a fee capped at $400/employee if their employees use subsidized coverage within the Exchange. Individuals offered affordable insurance through an employer would be ineligible for the tax credit unless their unaffordability level for their employment based coverage exceeds 13% of income. 90% of employees accept offered coverage in California. Most of those who do not accept offered coverage are covered by their spouse's coverage.

Small businesses (firms with less than 25 employees, average wage under $40,000) would immediately be eligible for tax credits through the exchange in 2011 with a maximum credit of 35%. After 2013 the maximum credit would increase to 50%. This immediate relief for California small businesses could facilitate increases in employer-sponsored coverage throughout the state.

Health Care Cooperatives

This piece of the Framework has received much focus as a non-governmental alternative to a public plan option. In the proposal, federal loans would be provided to establish non-profit, non-government member-run insurance companies in all 50 states in order to compete in the reformed non-group and small-group markets. Grants and loans will be awarded in 2012 based on a bipartisan Congressional advisory board's recommendations, and priority will be given to statewide proposals with private support and integrated care models. Multiple awards would be allowed per state, and states would be allowed to merge plans. California is well positioned to take advantage of the cooperative alternative, with multiple managed care models and a large population needed to make co-ops effective. However under the framework, the coops must be brand-new entities and the local health plans established by local governments in California are excluded.

Medicaid Reform

Major reform to the Medicaid program is present in the Framework, including eligibility expansion for *all individuals* below 133% poverty in 2014. The benchmark benefit package must comply with the Silver-level plan. Non-elderly, non-pregnant individuals between 100-133% of poverty would be able to choose between Medicaid and subsidized coverage through the Exchange. States, like California, can cover the Medically Indigent Adults with a federal match as early as 2011.

Talks this week surround the concern of state contributions in Medicaid expansion, which are especially relevant as cash-strapped states like California have no

additional funds. Current projections put state contributions at 10% of expansion costs, though an FMAP increase from 50 to 55%, savings from changes to CHIP and Medicaid drug rebate should offset (and even reduce) overall state costs.

Under the Framework, CHIP would transform in 2013 to a supplementary benefit program as beneficiaries would enroll in Exchange plans, and drug rebates amounts would increase and be applied to Medicaid managed care organizations.

Section 1115 demonstration programs would also be subject to new transparency requirements in order to highlight the most successful initiatives. DSH payments will be reduced by 50% once the number of insured in a state is reduced by 50%.

Several quality initiatives are also present in the Framework. A new Office of Coordination for Dual Eligible Beneficiaries will be created to coordinate care for dual-eligibles, with additional funding for bundled payment pilot programs. A new Medicaid state option would be created where beneficiaries with chronic conditions could designate a medical home, and additional funds would available to incentivize enrollment in health lifestyle programs.

Medicare Reform

The Framework immediately addresses the Medicare doughnut hole in 2010, where drug manufacturers are required to provide a 50% discount off the negotiated price of brand name drugs when beneficiaries enter the coverage gap.

Medicare would take the lead in payment reform in order to facilitate better system-wide ”value”, and foster its own sustainability. Cost-containment in Medicare Advantage would begin in 2011, where benchmarks would be lowered by 3%. In 2012 and 2013, the weighted average of plan bids would be included into new 2014 benchmarks with additional reimbursement incentives for quality improvement. Part D subsidies would also be reduced for those beneficiaries at or above the Part B threshold, and this threshold would freeze until 2019.

Other sustainability reforms include a reduced annual market “basket of services” update by an estimate of increased productivity and new Medicare Commission that would also be established to facilitate Medicare solvency and improve quality by submitting proposals to Congress. Additional incentive programs would be established in 2011 to facilitate value-based purchasing, quality reporting, accountable care organizations, payment bundling, and reductions in hospital infections and readmissions. A novel Innovation Center would also be established at CMS in order to test, evaluate, and disseminate these payment models.

Under the Framework, coverage would be expanded to include a Personalized Prevention and Wellness Plan, include incentive programs to target specific risk

factors, and remove of cost sharing for services recommended by the U.S. Preventive Services Task Force.

Primary care would receive a 10% payment bonus in Medicare, and the 2010 21% scheduled reduction in payment rates would be replaced by a 0.5% increase. Other service payments including imaging, power wheelchairs, and durable medical equipment would be reassessed.

Other Cost-Containment and Quality Reform

Comparative effectiveness research is included in the Framework, where a non-profit institute would be funded by a $600 million annual grant from mandatory appropriations, Medicare trust funds, and a fee on health plans. The institute's multi-stakeholder board appointed by the Controller General would establish a research agenda, provide research grants, and act to assess evidence gaps.

New HIPAA-standardized operating rules would also be accelerated to simplify health administration transactions for eligibility verification, claims status, electronic fund transfer, and remittance. Plans would be required to abide by the standards on 2014 or face a penalty.

Finally, fraud and waste in Medicare and Medicaid would be more actively investigated through new provider enrollment procedures, data matching and sharing, and increased penalties.

Tort reform language will also be included that provides fund for demonstration projects on liability lawsuit reduction and may even include a 'certificate of merit' requirement for all lawsuits.

Financing

The Framework provides multiple revenue sources to pay for federal expenditures in addition to the savings from public programs. A new excise tax would be levied on insurance companies for any 'Cadillac' plans above $8,000/$21,000 for individuals/families. The tax would be 35% of the premium in excess of these thresholds and would be indexed for inflation. Increased transparency in employer W-2 reporting of health benefits, limits on annual HSA contributions and qualifying HSA medical expenses, and elimination of the employer exclusion from the Part D subsidy will also generate revenue. Additionally, $13 billion in annual fees will be collected from pharmaceutical companies, medical device manufacturers, health insurers, and clinical laboratories.