Health Care Reform: Chapter Three

The U.S. Senate and America's Healthy Future Act

Southern Early Childhood Association

SECA Policy Brief

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The Senate Finance Committee Chairman Introduces Legislation

On September 16, 2009, the Chairman of the Senate Finance Committee, Senator Max Baucus, (D-Montana) introduced *America's Healthy Future Act*, the long-awaited Senate version of the health care reform legislation. The Senate Finance Committee began hearings on the proposed legislation on Tuesday, September 22, 2009 and the media reports that there are already over 500 proposed amendments to the bill.

This proposal is the outcome of several months of deliberation, during which the Senate Finance Committee attempted to find a bi-partisan compromise that would be supported by all Committee members. The compromise was not found, and the Chairman chose to move forward with a proposal to initiate the debate.

During the last few weeks, President Obama has stepped up his campaign to ensure the passage of health care legislation in 2009. The proposals listed in the Act are meeting with fierce resistance, both from industry and citizen groups.

As with the House bill, the Senate bill addresses three major issues:

- Quality of services
- Access
- Cost

All information provided in this brief is resourced from the Committee on Finance News Release, September 16, 2009, that announced the *America's Healthy Future Act*. The news release is an 18 page summary of the bill and was produced by the Senate Finance Committee staff. *Direct quotes from the news release are in italics.*

What Would the Bill Do?

Ensure Quality, Affordable Health Care Coverage

The bill would:

- *Create a health care affordability tax credit to help low and middle income families purchase insurance in the private market.*

- *Provide tax credits for small businesses to help them offer insurance to their employees.*

- *Allow people who like the coverage they have today the choice to keep it.*
- *Reform the insurance market to end discrimination based on pre-existing conditions and health status.*
- *Eliminate yearly and lifetime limits on the amount of coverage plans provide.*
- *Create web-based insurance exchanges that would standardize health plan premiums and coverage information to make purchasing insurance easier.*
- *Give consumers the choice of non-profit, consumer owned and oriented plans (CO-OP).*
- *Standardize Medicaid coverage for everyone under 133 percent of the federal poverty level.*

Improve the Quality of Care, Increasing Efficiency within the Health Care System and Lowering Health Care Costs

The bill would:

- *Shift incentives in Medicare to reward better care, not just more care.*
- *Increase the number of primary care doctors in the system.*
- *Aggressively fight fraud, waste and abuse in Medicare.*
- *Encourage all of a patient's doctors to coordinate care and reduce duplication and waste.*
- *Create incentives for health care providers to improve quality by using safe, more cost effective health technology like electronic medical records.*
- *Increase health care research so doctors know what care works best for which patients.*

Promote Preventive Health Care and Wellness

The bill would:

- *Provide annual "wellness visits" for Medicare participants and their doctors to focus on prevention.*
- *Eliminate out-of-pocket costs for screening and prevention services in Medicare.*
- *Create incentives in Medicare and Medicaid for completing healthy lifestyle programs.*
- *Increase federal Medicaid funding for states that cover recommended preventive services and immunizations for enrollees at no extra cost.*
- *Provide free tobacco cessation services for pregnant women in Medicaid.*

What's New?

The Senate bill includes several proposed programs and ways to purchase health insurance that will be new to the market.

- **Health Insurance Exchanges** will be created that will use the Internet to allow consumers to purchase health insurance. The exchanges would offer:
  - *Standardized health insurance enrollment applications.*
  - *A standard format that insurance companies would use to present their insurance plans.*
  - *Standardized marketing materials.*
  - *A call center for customer support.*
  - *Information on whether a person is eligible for health care affordability tax credits or public programs and access to those credits.*
  - *The ability to enroll through the mail or in person in a variety of locations for consumers without access to the Internet.*
- **Small Business Health Options Programs** (SHOP Exchanges) that are state-based and offer health insurance options through Web based portals.

- **Reform of the Individual Health Market, including:**
  - *Issuance of coverage regardless of health status.*
  - *No denial of pre-existing conditions.*
  - *Limited variation in premium rates based on tobacco use, age and family composition.*
  - *Limit on premium rating within a geographic area.*

- **Creation of Four Benefit Categories for the Reformed Health Insurance Market.**
  - *Categories are bronze, silver, gold and platinum*
  - *All policies must comply with one of the four categories.*
  - *All plans would be required to offer primary care and first dollar coverage for preventive services, emergency services, medical and surgical care, physician services, hospitalization, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, including x-rays, maternity and new born care, pediatric services (including dental and vision care), prescription drugs, radiation and chemotherapy and mental health and substance abuse plans*.

- **No Lifetime Limits on Coverage or Annual Limits on Any Benefits.**

- **Health Care Affordability Tax Credits**
  - *A new **advanceable, refundable** tax credit for low and middle-income individuals to subsidize the purchase of health insurance.*
  - *Beginning in 2013, the tax credits would be available on a sliding scale for individuals and families between 134-300 percent of the federal poverty level.*
  - The limits on amount of income that individuals would pay in premium would be limited to *3% of income for individuals at 100% of poverty up to 13% of income for individuals at 300% of poverty and above.*
  - *Undocumented immigrants would be prohibited from benefiting from the credit.*

- **Consumer Owned and Oriented Plan (CO-OP)**
  - *New plans that can operate at the state, regional or national level to serve as non-profit, member-run health plans to compete in the reformed non-group and small group markets.*
  - *Will offer consumer-focused alternatives to existing insurance plans.*
  - *The federal government will provide $6 billion in seed money for start-up costs and to meet solvency requirements*.

New Requirements for Individuals and Businesses

The proposed bill includes some significant new requirements for individuals and businesses to participate in the health insurance market.

- **Personal Responsibility**
  - *Individuals will be required to purchase health insurance.*
  - *Exemptions will be provided to individuals on the basis of religious beliefs (defined in Medicare) and for undocumented workers.*
  - *A financial penalty will be assessed if individuals fail to or choose not to purchase health insurance. The initial proposal includes a penalty of $750 per person or $1500 per family if the income is between 100% and 300% of poverty. If the income is above 300% of poverty, the penalty is $950 per person or $3800 per family.*
- **Employer Responsibility**
  - *Employers will not be required to offer health insurance.*
  - *Effective January 1, 2013, any employer with more than 50 employees who does not offer health insurance will have to reimburse the government for each full-time employee receiving a health care affordability tax credit in the exchange.*
  - *If the employee is Medicaid eligible, he/she can choose to leave the employer's health insurance plan. In this case, the employer is not required to pay a fee.*
  - *The employee's annual W-2 form will now include a statement of the value of a health benefit provided by the employer.*

Strengthening Coverage of Preventive Services in Medicaid and Medicare

The bill includes strategies and policies that are designed to *promote healthy living and help prevent costly chronic conditions like diabetes, cancer, heart disease, obesity and mental illness.*

The bill establishes an initiative that will reward Medicare and Medicaid participants for healthier choices. Funding will be available to provide participants with incentives for completing evidence-based, healthy lifestyle programs and improving their health status. Programs will focus on lowering certain risk factors linked to chronic disease such as blood pressure, cholesterol and obesity.

Changes Affecting Children

- *The Children's Health Insurance Program (CHIP) would continue to operate as it currently exists in states until after September 30, 2013 when the current reauthorization period ends.*

- Beginning October 1, 2013, children who are currently covered under the CHIP program would now *receive coverage under the Health Insurance Exchanges*.

- *At that point, states would be required to provide children between Medicaid eligibility levels and at least 250 percent of the Federal poverty level, a new program that would provide wraparound coverage to supplement the core benefit package available through the exchange.* (A term that has been used for this supplement is CHIP-WRAP. We assume that it would be similar in effect to the Medicare supplements that are currently available.)

- *The wraparound coverage would include the services available under the EPSDT (Early Prevention, Screening, Diagnosis and Treatment) program that is currently provided to children who are eligible for Medicaid.*

- *CHIP cost-sharing protections would continue to apply.*

- *The bill would provide funding to states, tribes and territories to develop and implement one or more evidence-based Maternal, Infant and Early Childhood Home Visitation Programs. Program options would provide training and consultation aimed at reducing infant and maternal mortality and its related causes by producing improvement in prenatal, maternal and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency and family economic self-sufficiency.*

Rural Health Care Protections

Because of the rural nature of the Southern region, how health care reform impacts access and affordability in rural areas has been a major point of discussion. Current policies and reimbursement strategies have made the continued operation of small rural hospitals

uncertain. *The bill proposes several provisions to ensure rural health care facilities and providers have the resources they need to continue delivering quality care in their communities.*

- The FLEX Grant program will be extended through 2012. This program provides federal grant funds that rural health care providers can use to improve the quality of health care and to strengthen health care networks. A new component would allow these funds to be used to support efforts to implement delivery system reform programs.

- The bill would ensure that small rural hospitals receive Medicare payments that would not be less than payments received in previous years.

- The bill would reinstate reasonable cost reimbursement for laboratory services, a policy ended in 2008.

- The bill extends a demonstration program to test the feasibility of reasonable cost reimbursement for small rural hospitals.

- The assistance for Medicare Dependent Hospitals will be extended until September 2013. This program has provided additional reimbursement to small rural hospitals with large numbers of Medicare beneficiaries.

- A temporary increase for certain low-volume hospitals is included.

Where's the Money?

The original cost estimate to implement *America's Healthy Future Act* was placed at $856 billion dollars over 10 years. The Act is designed to be deficit neutral.

According to a preliminary analysis released by the Congressional Budget Office on September 16, 2009, the proposal would result in a net reduction in federal budget deficits of $49 billion over the 2010-2019 period. This is based on the following:

- A proposed net cost of $500 billion over 10 years for the proposed expansions in insurance coverage.

- This includes a gross total of $776 billion in credits and subsidies provided through the exchanges, net outlays for Medicaid and the Children's Health Insurance Program, and tax credits for small employers.

- An estimated $215 billion in revenue from the excise tax on health insurance plans and $59 billion in revenue from other sources would offset the estimated costs of $776 billion, for a net cost of $500 billion.

Source: Congressional Budget Office, Letter to Chairman Baucus, September 16, 2009

In order to raise the revenue needed to offset the cost of the insurance expansion, the bill proposes a series of financing strategies.

- Beginning in 2013, a non-deductible excise tax of 35% would be levied on insurance companies and plan administrators for any health insurance plan that is above the threshold of $8,000 for singles and $21,000 for family plans.

- A lower limit on the amount of tax deductible contributions to a Health Flexible Spending Account (FSA) would be established in 2013. That limit would be $2,000.

- The employer tax deduction for the prescription drug plan subsidy for Medicare Part D eligible retirees that some employers maintain will be eliminated, effective 2011.

- The definition of qualified medical expenses would be modified to limit the tax deductibility of some items.

- The penalty for use of Health Savings Account funds for non-qualified medical expense would increase from 10 to 20 percent.

- An annual flat fee of $2.3 billion on the pharmaceutical manufacturing sector would be imposed, beginning in 2010. The fee would be non-deductible for federal tax purposes.

- An annual flat fee of $6 billion on the health insurance sector would be imposed, beginning in 2010. The fee would be non-deductible for federal tax purposes.

- An annual flat fee of $0.75 billion on clinical laboratories would be imposed, beginning in 2010. The fee would be non-deductible for federal tax purposes.

Some Questions to Ask

1. How will an "**affordability credit"** be administered? We have had limited success with credits such as the Earned Income Tax Credit over the years. Will this new credit be accessed by the families who need it?

2. If there is a **penalty assessed for uninsured persons**, what will this mean in terms of access to care? Will an uninsured person be denied treatment until they pay the penalty? Who will monitor and enforce this? Will it be a new requirement for health care providers?

3. With the significant amount of rural territory in the South, **access to care** is a major issue. What type of incentives will realistically encourage physicians to locate in rural areas? How will health care providers such as hospitals find a market base in those areas?

4. Insurance companies pay a **premium tax** to states in order to operate in that state. What is that money used for in your state? What would be impacted if that tax is no longer collected?

5. What **capacity** currently exists at the state and federal level to implement these enhanced and expanded programs? The **enhanced use of technology** is being proposed; however, in the South, many families who need these services and supports do not have access to technology. How will that be addressed?

The debate has just begun and it's obviously a difficult and complicated issue with many opinions and strategies to be discussed. The proposed Senate Finance Committee bill includes many more provisions around Medicare and reform within the health industry sectors that have not been addressed in this brief. If you would like to see a copy of the bill summary, the CBO letter and the full text of the bill, go to

www.finance.senate.gov

For a discussion of the "basics", go to our ***Policy Brief, Health Care Reform, June 2009***

For a discussion of the competing proposal from the U.S. House of Representatives go to our ***Policy Brief, Health Care Reform: Chapter 2, July 2009***

October 2009 Finance Committee Update

On October 13, 2009, the Senate Finance Committee passed the bill out of committee and Senate leaders will begin the task of developing a final bill for Senate consideration. (The bill passed with a vote of 14-9. The only Republican to vote to send the bill from Committee was Senator Olympia Snowe of Maine.) The final bill will be based on consolidating the competing bills that have come out of Senate Committees and the differences must now be discussed and resolved. Additionally, the Senate version of the bill must be coordinated with the bill from the House of Representatives before final passage can be achieved.

Some provisions to note in the final bill:

- The **CHIP program** will remain as is until 2019. Beginning in 2014 and continuing for six years, states would receive a 23 percentage point increase in their CHIP match rate, subject to a cap of 100%.

- The availability of **Health Care Affordability Tax Credits** would be extended in 2013 to include individuals and families between 134-400% (previously 134-300%) of poverty and the cap on the percentage of income that an individual or family would pay in premiums is lowered from 3%-13% of income to 2%-12% of income.

- The **requirement for individuals to buy health insurance** remains but the penalty for failure to do so has been changed. The new penalty phases in over a four-year period beginning in 2014, when the penalty is $200 per adult, rising to $400 in 2015, $600 in 2016 and $750 in 2017. The penalty would be deducted from any federal payment due to the individual or family (for example, an income tax refund).

- **If you itemize your taxes**, you will now have to meet the threshold of 10% of adjusted gross income to deduct medical expenses. The current deduction has a threshold of 7% of adjusted gross income.

Source: www.senatefinance.gov

You will find both a 22 page summary of the act as amended and a link to a copy of the full text of the proposed act on this site. In the full copy of the amended act, the language that has been deleted is in red and the language that has been added is in blue.