

Key Changes in the Senate Finance Committee Amended Mark

After eight days, the Senate Finance Committee finished its markup. This is the fifth and final Congressional Committee to complete a markup on a comprehensive bill to overhaul our nation's health care system. Key amendments to the Senate Finance bill are outlined below.

Medicaid and CHIP

Medicaid income eligibility: Income determinations for Medicaid eligibility for parents, childless adults, and children will be based on modified gross income (MGI) rather than on modified adjusted gross income (MAGI). This means that “above the line” (think of your federal income tax form) deductions that reduce total reportable income won't be taken into account. Therefore, the income level for some people will be higher under MGI than MAGI. This change is unlikely to significantly change the number of people eligible for Medicaid.

Medicaid eligibility levels: States will be required to maintain their existing Medicaid eligibility levels until exchanges are in place (July 1, 2013). However, states that cover parents or childless adults with incomes over 133% of the federal poverty level in their Medicaid programs will be allowed to roll back that coverage to 133% of the federal poverty level starting in January 2011 (after the maintenance-of-effort provision in the stimulus act expires) if they are experiencing, or are projecting, a budget shortfall.

State option for a Basic Health Plan: States will be allowed to establish a new health insurance program for people with incomes between 133% and 200% of the federal poverty level. Similar to the CHIP structure, states would receive a capped amount of federal funding to contract directly with provider networks and managed care organizations to provide a package of covered services. The benefits package, as well as premium and cost-sharing assistance to individuals, would be equivalent to that available in state exchanges.

To fund these new programs, states would receive funds from the federal government equivalent to 85 percent of the amount that would have otherwise been made available to individuals in that state through the tax credit and cost-sharing subsidies.

Cost-sharing protections for certain children in the exchanges: Children with family incomes between 100 and 133% of the federal poverty level who receive coverage in the exchange (because their parents choose exchange coverage over Medicaid coverage), will retain the Medicaid cost-sharing protections and out-of-pocket limit (five percent of family income) they would have received in Medicaid. They will also continue to get EPSDT.

CHIP: The CHIP program will be maintained in its current form. States would be required to maintain their CHIP eligibility levels and income methodologies through September 30, 2019. The current-law benefit package and cost-sharing rules would also continue to apply. States would receive their current-law allotments and matching rates through September 30, 2013.

Starting October 1, 2013, the federal matching rate for CHIP would increase by 23 percentage points in every state (but no state will receive more than 100 percent match for CHIP). States would also get a .15 percentage point increase in their Medicaid matching rate. CHIP-eligible children who could not enroll in CHIP due to federal funding allotment caps, would be eligible for tax credits in the exchange. Although the amendment has provisions that apply after 2013, language in the amendment “calls for the reauthorization of CHIP by September 30, 2013.”

Outreach and enrollment simplifications: A simple, one-stop application process will be established for the exchange tax credits, Medicaid, and CHIP. It would allow families to submit one form to apply for any of these programs, via phone, Internet, mail, or in-person.

Affordability

Who qualifies for the tax credit: Income determinations for the tax credits will be based on modified gross income (MGI) rather than on modified adjusted gross income (MAGI). This means that “above the line” (think of your federal income tax form) deductions that reduce total reportable income won’t be taken into account. Therefore, the income level for some people will be higher under MGI than MAGI. These changes in income determination could have broad impact on moderate-income families who might otherwise qualify for the tax credit.

Affordability credits: The revised mark improves the income-based premium credits for exchange coverage, setting a scale of 2% of income spent on premiums at 100% of the federal poverty level to 12% of incomes spent on premiums at 300 to 400% of the federal poverty level. The scale in the original Mark was set from 3% to 13% of income spent on premiums.

The revised mark also includes a "failsafe" provision that could significantly reduce subsidies in the future instead of making other adjustments. Beginning in 2012, if the Office of Management and Budget (OMB) determines that provisions in the bill will increase the deficit, the OMB will notify Congress and the amount of subsidies in the exchange will be automatically adjusted commensurate with the deficit increase.

Cost-sharing protections: There will be a reduced annual out-of-pocket cap on health care expenditures for people earning incomes between 300 and 400% of the federal poverty level who purchase coverage through the Exchange, in addition to the caps in the original bill for people with lower incomes. The new cap equals two-thirds of the Health Savings Account limit, or \$3,867 for an individual and \$7,965 for a family in 2009.

“Wellness” plans: The revised mark changes current rules about so-called wellness plans to allow employees to be charged up to 30 percent more (instead of the currently allowed 20 percent) for their health insurance premiums if they fail to meet health goals (i.e. lowering cholesterol or quitting smoking). In addition, the mark allows the cost differential to eventually go up to 50 percent, instead of 30 percent, at the discretion of the Secretary of Health and Human Services. These provisions would also apply to the Federal Employee Health Benefit Plans and eventually to the individual market under a pilot program that would start in 2014.

Insurance Market Reforms

Individual mandate: The revised mark changes the value of the excise tax for not meeting individual mandate requirements. It phases in a per-adult penalty of \$750 for not meeting the requirement in 2017, starting with a \$200 penalty in 2014. In addition, it allows people who have

to spend more than eight percent (instead of the original ten percent) of their income on health costs to be exempt from the individual mandate. These exempted individuals would be able to buy a “young invincible” health insurance policy, regardless of their age, under the revised mark.

Age-rating: Age-rating will be limited to 4:1 instead of the limit of 5:1 proposed initially. This means that an older person may not be charged more than four times as much as a younger person for the same plan.

Benefits package: The US Department of Health and Human Services (HHS) will be required to annually update the exchange benefits package through a transparent and public process at least once a year. Exchange plans must provide mental health parity and they must cover behavioral health treatment. Also, Federally Qualified Health Centers (FQHCs) will be added to the list of providers that enrollees can use with their exchange coverage.

Emergency care protections: All plans in the exchange will be required to provide emergency room services without prior authorization, regardless of whether the emergency facility is in an enrollee’s network. Enrollees would not have to pay higher copayments or cost-sharing for emergency room services at an out-of-network facility.

Child-only and dental coverage: The revised mark clarifies that child-only and stand-alone dental plans (including pediatric dental plans) may be sold through exchanges, as long as they comply with required consumer protections. People would get help paying for pediatric dental plans through tax credits (just as they get help when pediatric dental care is part of a comprehensive plan in the exchange), and a formula would be devised for the stand-alone plans.

Small employer exchange coverage: Exchange eligibility will be extended to employers with up to 100 workers in 2015 and allows even larger employers, at a state’s discretion, to enter the exchange in 2017. In addition, the revised mark requires small employers purchasing coverage through the exchange to offer a plan with a deductible that does not exceed \$2,000 for an individual or \$4,000 for a family.

Tax credits for non-profit employers: Non-profits will be able to receive small employer tax credits, although the value of their credits is less than for other small employers.

Multiple exchanges: The revised mark removes an earlier provision that would have allowed multiple exchanges to operate in each state.

State waiver of federal requirements: If states provide access to quality, affordable coverage for all residents that is at least as comprehensive as required under an exchange plan, they may apply for a waiver from certain federal health reform requirements. To be approved, state plans must lower health care spending growth, improve delivery system performance, provide affordable choices for all citizens, expand protections against excessive out-of-pocket spending, provide coverage to the same number of uninsured as would federal reform, and not increase the federal deficit. “Waivers are not intended to thwart or affect the intent of the (federal) reforms.”

Ombudsman and consumer assistance: State-based ombudsmen offices must assist with internal appeals that have not been resolved after three months or are life threatening, and assist in resolving problems with premium credits and cost sharing subsidies. Additionally, the bill authorizes a \$30 million grant program for consumer assistance in states. Organizations capable of conducting outreach and enrollment for hard-to-reach populations are among those eligible.

State consumer protections: The revised proposal ensures that the protections included in federal reform become a floor, not a ceiling for consumer protections. State legislatures will also have more authority to determine whether their states participate in the interstate sale of insurance or the sale of “national” plans (private plans sold across state lines). This will allow states to better protect their consumer-friendly insurance laws.

Medicare

Improvements for low-income beneficiaries: Effective 2011, Part D cost-sharing provisions will be eliminated for full dual eligibles who receive home and community-based care under a section 1915, 1932, or 1115 waiver and who would otherwise receive institutional care.

AIDS Drug Assistance Programs (ADAPs) and Indian Health Service (IHS): Effective 2011, the value of drugs provided through ADAPs and the IHS will count toward Part D beneficiaries’ out-of-pocket maximum.

Medicare Advantage grandfathering: Medicare Advantage plans will be allowed to grandfather extra benefits for current enrollees in regions of the country where average plan bids are at or below 75 percent of traditional Medicare.

Medicare Commission: The Medicare Commission will have the authority to reduce federal premium subsidies for Part D and Medicare Advantage plans. The amended mark establishes a Medicare target growth rate of GDP plus one percent for 2019 and later. The Commission will also continue to operate after 2019 unless Congress votes affirmatively to terminate it.

Long Term Services and Supports

Incentives to increase access to home and community-based services: Two programs will give states incentives to expand home and community-based services (HCBS). The first, Community First Choice Option, would create a state plan option to provide community-based attendant supports and services to individuals with disabilities who are Medicaid eligible and require an institutional level of care. States that take up this option would get an enhanced Federal Medical Assistance Percentage (FMAP) of six percentage points for program expenses.

The second optional program would provide an increased FMAP to states that make Medicaid program structural changes that have been proven to increase nursing home diversion and expand use of HCBS. The amount of the FMAP increase would be tied to the percent of a state's long-term services that are currently provided through HCBS, with states that have lower HCBS use getting a higher increase. Both programs would sunset after five years.

Improved spousal impoverishment protection: States would be required to apply their existing Medicaid spousal impoverishment rules for nursing home residents to home and community-based services programs. This would also sunset after five years.