After hosting a second healthcare reform roundtable discussion on May 5, Senate Finance Committee leaders released policy options for improvements in healthcare coverage on Monday, May 11. The document is the second of a series of healthcare reform options papers that provide insight into how the committee plans to tackle coverage, delivery system changes, and financing issues as part of larger efforts to pass healthcare legislation this Congress, perhaps this year. The Committee is soliciting written comments to the coverage reform document by May 22nd.

Last week, the Committee released its policy options for reform of the delivery system which focused in large measure on Medicare reforms. Comments on those options are due today, Friday, May 15. The Senate Finance Committee held the final roundtable discussion on the all-important topic of financing on Tuesday, May 12.

The healthcare coverage policy options are divided into eight categories: insurance market reforms; minimum benefit package, subsidies and tax credits; public health insurance options; entitlement programs; individual and employer mandates; prevention and wellness; long term care services and supports; and health disparities.

I. Individual and small group market reform options include:
   o Imposing guaranteed issue and guaranteed renewal rules on coverage in the individual and small group markets (p. 2)
Prohibiting pre-existing health condition exclusions in these same markets (p.2)

Restricting premium rating practices in these markets so that only tobacco use, age and family composition could be used to set different premiums (p. 2)

Subjecting new market plans and grandfathered plans to a collective system of risk adjustment (p. 2)

Establishing a single “Health Insurance Exchange” for all insurers in the small and individual market; or establishing multiple competing exchanges in addition to the national exchange (p. 4)

NOTE: These insurance market reforms, if enacted as is, would constitute the single most significant set of improvements to the insurance market for people with significant health conditions. Of course, to avoid “adverse selection,” where people purchase insurance only when they need it, many believe that some sort of mandate to maintain health insurance coverage is a necessity.

II. Minimum benefit package, subsidy and tax credit options include:

- For individual and small group markets, establishment of a minimum benefit requirement that covers:
  - Preventive and primary care, emergency services, hospitalization, physicians services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services.
  - A requirement that each plan apply “parity” for cost-sharing treatment of conditions within each of the following categories: inpatient hospital, outpatient hospital, physician services and other items and services, including mental health services (p. 8)

- A tax credit for low income taxpayers purchasing insurance through the Exchange (p. 10)

- A tax credit to certain small employers for the purchase of employer provided health insurance (p. 12)

III. Public health insurance options include:

- Three approaches to a “public plan” for non-disabled individuals under 65 (p. 13)
  - A Medicare like-plan, administered by a new agency within HHS, which would have most of the same rules as the other plans in the exchange. Medicare providers would be required to participate in the plan and would be paid Medicare rates plus 0-10 percent.
  - A Medicare like-plan administered by regional third party administrators (TPAs) that would report to the HHS Secretary. TPAs would be required to establish networks of participating medical providers and negotiate payments for providers.
  - A State-run mandatory or optional public option, with administration details left to the states

- Proceeding with healthcare reform without a public plan option (p. 14)
NOTE: Whether the final healthcare reform package will contain a public plan option has quickly become the flash point in the healthcare debate. Proponents say a public plan is necessary to act as a competing plan to all private health plans in the Exchange, thereby putting pressure on private insurers to offer attractive benefit packages with reasonable premiums. Opponents say the public plan would give the government too much power over healthcare and that providers would suffer as reimbursement rates decrease due to unfair government competition.

IV. Entitlement program options include:

- For Medicaid and SCHIP
  - Requiring states to raise Medicaid eligibility for pregnant women, children and parents; the federal government could temporarily fully finance all expenditures as a result of this expansion (p. 14)
  - Three approaches for defining the relationship between the Exchange and Medicaid (p. 16):
    - Requiring state Medicaid programs to provide premium assistance to Medicaid eligible individuals with employer-sponsored insurance, mitigating the likelihood of Medicaid-eligible individuals dropping their employer health plans;
    - Requiring state Medicaid programs to provide coverage for children, pregnant women, parents and childless adults through insurance plans in the Exchange. Medicaid enrollees with disabilities and dual eligibles would continue to receive coverage through the Medicaid structure. A state could, but would not be required to, provide premium assistance for employer-sponsored insurance; and
    - Requiring state Medicaid programs to expand coverage for children, pregnant women and parents. Childless adults below 115 percent of the Federal Poverty level would be eligible for tax credits to purchase coverage through the Exchange or through Medicaid.
  - Increasing SCHIP eligibility to 275 percent of the Federal Poverty Level. Once the Exchange is fully operational, SCHIP enrollees would obtain primary coverage through the Exchange and secondary coverage through SCHIP (p. 19)
  - Implementing a number of policies to simplify Medicaid enrollment and retention (p. 23)
  - Eliminating smoking cessation drugs, barbiturates and benzodiazepines from Medicaid’s excluded drug list (p. 26)
  - Updating the state plan amendment process to provide more transparency and to give greater opportunity for public involvement (p. 27)
  - Altering the FMAP formula to provide an automatic increase during periods of national economic downturn, thereby moderating the negative
state budget impact whenever a recession or other economic problem in a state creates added costs to Medicaid (p. 31)

- **For dual eligibles (beneficiaries eligible for both Medicare and Medicaid)**
  - Creating new Medicaid demonstration authority of five years for exploring alternative approaches to coordinating care for dual eligibles (p. 34)
  - Allowing states to use savings from coordinating care for dual eligibles between Medicare and Medicaid in waiver applications (p. 35)
  - Establishing a new CMS office for leading efforts to align Medicare and Medicaid financing, administration, oversight rules and policies (p. 36)

- **NOTE:** Taken together, this section of the document implements policies that would enhance existing public programs to cover more Americans. The problem is that a Health Insurance Exchange with federal subsidies available to low income persons will inevitably tempt states to no longer cover optional populations (in which they are required to contribute to the cost of Medicaid).

- **For Medicare**
  - Offering a temporary Medicare buy-in for people ages 55 through 64 that lose employer sponsored insurance (p. 38)
  - Four possible options to address the 2 year disability waiting period (p. 37):
    - Reducing the waiting period to one year;
    - Reducing the waiting period by one month every quarter until it is eliminated;
    - Reducing the waiting period by six months each half year until it is eliminated;
    - Retain the 2 year waiting period for those with private insurance, excluding COBRA, and phase out the waiting period for those without private insurance.

V. **Individual and employer mandates**

- **For an individual mandate (p. 39):**
  - Requiring all individuals to obtain health insurance coverage during a specified enrollment period, and with an annual open enrollment period
  - Allowing for a 45-day open enrollment period during which all coverage would be guaranteed issue, with no limits on pre-existing conditions. After that time, carriers could exclude pre-existing conditions for up to 9 months and charge higher premiums. There would be the potential for an annual open enrollment period.

- **For an employer mandate (p. 42):**
  - Requiring all employers with more than $500,000 in total payroll for a taxable year to offer full time employees health insurance coverage or pay
an assessment. States would be required to offer Medicaid premium assistance to individuals eligible for Medicaid who are offered employer-sponsored insurance.

- Forgoing an employer mandate and allowing Medicaid eligible individuals offered employer-sponsored insurance to enroll in an individual policy using Medicaid assistance.

  - NOTE: This section of the document, coupled with the insurance reforms in the first section of the document, have the potential to completely transform the health insurance market and healthcare in this country and ultimately lead to universal coverage of health insurance for all Americans. Many suspect that while these provisions are the very policies that many have publicly endorsed, they will become more and more controversial once people realize exactly what they will be required to do, and how much this will cost them and the federal government, over time.

VI. Preventive Services

- Authorizing a personalized prevention plan for Medicare beneficiaries once every five years (p. 43)
- Removing or limiting beneficiary cost-sharing for Medicare and Medicaid preventive services and providing incentives for behavior modification programs (p. 44 and 46)
- Providing a 1 percent increase in FMAP to states that provide coverage for all approved preventive services and immunizations (p. 46)
- Funding annual state grants to provide access to specified evidence-based services to help prevent chronic disease (p. 47)
- Establishing a competitive grant program to promote health and human services program integration and improve care coordination and access to preventive services and treatments (p. 47)

VII. Long Term Care Services and Supports

- Allowing states to seek approval from the HHS Secretary to offer additional home and community based services in addition to the currently approved services; and allowing individuals to simultaneously enroll in more than one Medicaid waiver (p. 49)
- Replacing the existing Medicaid institutional level-of-care requirement for eligibility for home and community based services with a less stringent requirement (p. 51)
- Increase FMAP by one percent for Medicaid home and community based services
- Allowing states to apply spousal impoverishment rules to applicants for all home and community based services (p. 52)
- Allowing applicants for Medicaid home and community based services to retain a higher level of assets than applicants for institutional care (p. 53)
o Boosting grant money available for state home and community based services programs (p. 54)

o Providing a time frame for CMS to implement an assessment tool to measure the health and functional status of Medicare acute care discharges and outcomes for post acute care Medicare patients, including those in long term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home health agencies (p. 55)

o Extend the money follows the person rebalancing demonstration through September 30, 2016 (p. 56)

o NOTE: These changes appear to be significant advances for those in favor of eventually eliminating the institutional bias under Medicaid. If enacted as is, these provisions will be a meaningful step forward toward the home and community based Medicaid policies espoused by the Community Choice Act sponsored by Senator Harking (D-IA).

VIII. Health Disparities and Public Reporting

o Establishing uniform categories for collecting data on race and ethnicity, requiring the use of Office of Management and Budget policy for aggregation and allocation of subgroups (p. 59)

o Adding disability as a health disparity category alongside race, ethnicity, gender, and rural status. Requiring the collection of access and treatment data for people with disabilities; CMS would be required to determine where people with disabilities access primary care and the number of providers with accessible facilities and equipment to meet the needs of the disabled (p. 59)

o Requiring health care quality data to be published by race, ethnicity and gender (p. 60)

o NOTE: The addition of “disability” as a category for purposes of tracking health disparities is a significant advance for the chronic illness and disability population as ongoing monitoring and reporting will raise the awareness level on the disability population’s unequal access to quality health care services.