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Max Baucus, Chairman
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BAUCUS, GRASSLEY RELEASE POLICY OPTIONS FOR EXPANDING HEALTH CARE COVERAGE

Options are the second of three papers in Finance leaders' health reform effort

Washington, DC – Senate Finance Committee Chairman Max Baucus (D-Mont.) and Ranking Member Chuck Grassley (R-Iowa) today released policy options for expanding health care coverage to the 46 million Americans who are currently uninsured. The Finance leaders will "walk through" the options at a Committee meeting on Thursday and solicit thoughts and ideas from Members on the options for expanding coverage. The options being released today are the second of three papers that Members will discuss before a Finance Committee mark-up of comprehensive health reform legislation in June.

"Expanding health care coverage is not just a moral imperative – it's an economic necessity," said Baucus. **"Today 46 million uninsured Americans have few places to turn for health care besides a hospital emergency room. And the cost of that care is paid by every American with insurance in the form of a hidden tax of more than $1,000 a year in increased premiums. These policy options propose a uniquely American approach to provide affordable, quality coverage to all Americans through a mix of public and private solutions, and drive down health care costs for every American.**

"Millions of Americans have no health insurance and millions more fear losing what they have," said Grassley. **"Even people with insurance might be under-insured. Congress has an obligation to make insurance more available and more affordable and still give people the option to keep what they have if they like it."**

The policy options released today aim to reform the individual and small group health insurance markets to end discrimination against sicker individuals. They would instead create a competitive insurance market where health plans compete on price and quality rather than the ability to segment risk and discriminate against individuals with pre-existing health conditions. The options also include an expansion of public health insurance programs to cover the poorest Americans and make coverage more affordable by providing tax credits to low income individuals and small businesses. The policy options make purchasing coverage easier and more understandable for all consumers.

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The policy options for expanding health coverage follow the release of policy options to reduce costs and improve patient care in the health care delivery system. The final policy options paper on financing health care reform will be released before the Members meeting on that topic scheduled for May 20. A summary of the policy options for expanding health care coverage released today follows. The complete text of the policy options on expanding health care coverage can be found on the Finance Committee website at http://www.finance.senate.gov/sitepages/leg/LEG%202009/051109%20Health%20Care%20Description%20of%20Policy%20Options.pdf. Public comments should be directed to Health_Reform@finance-dem.senate.gov. The deadline for public comments on the coverage policy options is May 22, 2009.

POLICY OPTIONS FOR EXPANDING HEALTH CARE COVERAGE

Insurance Market Reforms –Americans who like the insurance they have will be able to keep it in a reformed health care system. But for millions of other Americans who don't have or can't afford employer-provided coverage, the insurance market is broken. These individuals and families can't purchase coverage because they have a pre-existing health condition, or they can't afford coverage. The policy options would regulate the individual and small group markets so that coverage is affordable and accessible for all Americans purchasing coverage.

Individual and Micro-group (2-10 employees) Market Reforms - Under the policy options, insurance companies would have to issue coverage to all individuals and would no longer be allowed to bar individuals with pre-existing conditions from qualifying for a policy. Limited variation in premium rates would be permitted for tobacco use, age, and family composition. Geographic variation in rating would be allowed between rating areas, but would not differ within a rating area.

Small Group Market Reforms – Under the policy options, the rating rules for the individual and micro-group markets would apply to the remainder of small groups as defined by states. This would include groups of 11 to 50 people, but could also include self-employed and/or groups up to 100 people depending on current state law.

Health Insurance Exchange – The policy options would make purchasing health insurance coverage easier and more understandable by using the internet to present consumers with available plans. The policy options would create a web portal, or Health Insurance Exchange – or multiple exchanges – that would direct consumers to every health coverage option available in their zip code. The web portal would standardize the health insurance enrollment application, the format companies use to present their insurance plans, and the marketing rules. The new web portal would be publicized and would have a call center for customer support. The web portal will enable users to determine if they are eligible for health insurance subsidies or public programs. The exchange would also allow consumers without access to the internet to enroll through the mail or in person in a variety of locations.

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Eligibility for the Health Insurance Exchange - Under the policy options, individuals and micro-groups would be able to purchase insurance through the Exchange immediately following its creation. The remainder of the small group market (11-50 employees or as defined by states) would be able to purchase insurance through the Exchange once rating rules are fully phased in by that state.

Transitioning to a Reformed Insurance Market – Once the insurance market reforms take effect, people who want to keep the insurance they have today will be able to do so. Plans will be allowed to continue to offer the coverage they offer today, but these grandfathered plans will only be available to those people who are enrolled today. People who qualify for tax credits in the reformed market will not be able to use them to purchase these grandfathered plans. Tax credits will be offered only to purchase plans created in the reformed market that meet the new, benefit standards.

Transitioning for Rating Requirements - Federal rating rules for non-group and micro-group markets (other than for grandfathered plans) will take effect by January 1, 2013, perhaps sooner. Federal rating rules for the remainder of the small group market (as defined by the state) would be phased in over a three-to-ten year period, as determined by each state, with approval from the Secretary of HHS.

Making Coverage Affordable – The cost of health insurance has increased five times faster than wages over the last eight years. And estimates show that just seven years from now, most Americans will spend nearly half their income on health insurance. American businesses pay nearly three times more than our major trading partners for health care benefits. Unaffordable coverage prevents these companies from competing in the global market. The policy options make coverage more affordable by creating tax credits for low income individuals and small businesses and strengthening public programs.

Options for Standard Benefits – The policy options would create four benefit categories which would be permissible in the reformed market: lowest, low, medium, and high. No policies (except grandfathered policies) would be issued that do not comply with one of the four categories. And all insurers would have to offer coverage in each of the four categories. All plans would be required to provide 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 newborn care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services. Plans would not be allowed to set lifetime limits on coverage or annual limits on any benefits.

Individual Health Insurance Tax Credits – Under the proposal, tax credits would be provided for people with incomes under 400 percent of poverty to help offset the cost of health insurance premiums. Eligible low-income individuals – including employees of small and large businesses – would be able to use the credit to purchase health coverage through the Exchange. The subsidy would phase-out, providing a smaller credit as income increases.

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Small business health insurance tax credits – The policy options would base the small business tax credit on a firm's size and average employee earnings. Firms at or below 10 full-time employees with average employee earnings below $20,000 would get a credit equal to 50 percent of the average total premium cost paid by the employer for employer-sponsored insurance in that firm's state. Under that option, a full time employee would be one that worked 30 or more hours per week. The credit would phase out as a firm's size and average wages increased and would be completely phased out for firms with more than 25 workers and average employee earnings of $40,000.

Public health insurance option – The policy options present three alternatives for a public health insurance option. One alternative is a Medicare-like option that would be administered by the Department of HHS. The Federal government would sets payment rates for that plan. Medicare providers would participate in the plan. This public health insurance option would not have solvency requirements. Another alternative is a public health insurance option that would be administered through multiple, regional, third-party administrators (TPA). These TPAs would be required to report to the Secretary of HHS. The TPAs would establish networks of participating medical providers and would negotiate payments for providers participating in the option. This public option would be required to adhere to solvency requirements. A third alternative would be a state-run public health insurance option. The policy paper also presents the option of not creating a public health insurance option, but expanding coverage through a reformed and better regulated private market.

Medicaid – The policy options would standardize Medicaid eligibility for all parents, children, and pregnant women below 150 percent of the Federal Poverty Level (FPL) or $33,000 a year for a family of four. The policy options present three alternatives for these qualified individuals to access this Medicaid coverage. The first is Medicaid in its current structure. Under this alternative, Medicaid would be expanded to cover all individuals with incomes at or below 115 percent of the FPL. The federal government would provide short-term full funding for newly-eligible Medicaid beneficiaries. Then standard FMAP rates would be phased-in over time. A second alternative would be for people eligible for Medicaid to access the program through the Exchange. This alternative would also expand Medicaid to cover all individuals with incomes at or below 115 percent of the FPL. And it would also provide short-term full federal funding for newly-eligible Medicaid beneficiaries and then phase-in standard FMAP. The third alternative is to provide access to coverage through Medicaid and through the Exchange. In this alternative, parents, children, and pregnant women would access Medicaid through the current structure. All other individuals at or below 115 percent of the FPL would not become Medicaid eligible, but instead would get a subsidy to purchase health care coverage. The policy options would also make improvements to the Medicaid program that would simplify and streamline enrollment and retention in the program, expand access to home and community-based services, and create an automatic countercyclical stabilizer to sustain the program during economic downturns when more people qualify for the program, but states have less tax revenue to sustain it.

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Additional Options for Public Health Insurance Programs – The paper also addresses creating options for people ages 55 to 64 years old and for changing the Medicare 24-month disability waiting period. The policy options would not make changes to the Children's Health Insurance Program (CHIP) until after September 30, 2013. After that date, CHIP would be offered through the Exchange and would provide additional benefits for low-income children not eligible for Medicaid.

Eliminating Health Care Disparities – The policy options propose collecting uniform data on race, ethnicity, gender, and disability that could help researchers work to end disparities among those groups. States would also have the option of covering non-pregnant, legal immigrant adults during their first five years in the U.S. The options also propose policies to promote maternal and child health.

Fair share responsibility for individuals – The policy options would create an individual fair share responsibility to have health care coverage. At the same time, the policy option would establish exemptions from the requirement. These exemptions would include religious exemption (as defined in Medicare) and an exemption for undocumented aliens.

Fair share responsibility for employers – The policies set out two options for the employer fair share responsibility. The first is that employers must offer qualified coverage to full-time employees. The coverage must be actuarially equivalent to the lowest coverage option and it must include first dollar coverage for prevention services. Under this alternative, the employer would have to contribute 50 percent of the premium costs and that requirement would be enforced through the tax code. Employers with total annual payroll of less than $250,000 would be exempt from offering coverage. The second option the policies set out is to not create an employer fair share responsibility.

Strengthening Coverage of Preventive Services in Medicare – The policy options would make a wellness visit available to Medicare beneficiaries once every five years and provide a personalized prevention plan. The options would also provide incentives for Medicare beneficiaries to utilize preventive services. Examples of these incentives include reducing or eliminating cost sharing for screenings and offering rebates for completion of health promotion programs like tobacco cessation. The policy options would also align Medicare coverage for preventive services with scientific evidence to ensure patients receive appropriate screenings.

Strengthening Coverage of Preventive Services in Medicaid – The policy options would clarify preventive services covered at the state's option for adults under Medicaid. These optional benefits would be defined as all services rated "A" and "B" by the U.S. Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunizations. States that OPT to cover all "A" and "B" rated services and immunizations would receive a one percent increase in the federal share of the FMAP reimbursement rate. The options would provide incentives for Medicaid beneficiaries to utilize preventive services. Examples of these incentives include reducing or eliminating cost-sharing for screenings and allowing states to apply for funding to reward Medicaid enrollees for completing health promotion programs like tobacco cessation.

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Options to Prevent Chronic Disease and Encourage Healthy Lifestyles– An additional option to promote prevention and wellness in the short-term is make capped grants available to states until the Exchange is operational. The grants could be used to provide primary preventive services such as tobacco use screening, influenza immunization, counseling on daily aspirin use, hypertension screening, or obesity screening. Another option is to provide states with options to improve the coordination and integration of health and human service systems. For example, states might create an individualized plan for low income individuals or create multidisciplinary care teams to better manage and coordinate care, transition individuals from inpatient facilities to other settings and, refer individuals to social support and community resources. A third option would be to create tax incentives for qualified comprehensive workplace wellness programs.

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