

**To: Interested Parties**  
**From: The Glover Park Group**  
**Re: Federal Health Reform Update**  
**Date: July 7, 2009**

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## Report to the California HealthCare Foundation and California Policy Staff

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### A LOOK FORWARD TO JULY

Activity surrounding healthcare reform legislation will increase in intensity this month as the bills move through the Senate Health, Education, Labor and Pension (HELP) and Finance Committees and the House Ways and Means, Energy and Commerce and Education and Labor Committees. The ultimate goal for this Congressional work period is to achieve successful floor votes in both the House and Senate before the August recess (recess begins August 3<sup>rd</sup> in the House of Representatives and August 10<sup>th</sup> in the Senate).

The House "Tri-Committee" bill introduced in the House by the committees with jurisdiction over health care – Energy and Commerce, Ways and Means, and Education and Labor – is likely to be marked up in all three full committees during the week of July 13<sup>th</sup>. During this time the bill will be open to Democratic and Republican amendments. Once the markups are complete, the three committees will merge the three versions of the bill with the goal of bringing the bill to the House floor for debate and a vote the week of July 27<sup>th</sup>.

The Senate continues to work along two tracks. The HELP Committee, chaired by Senator Kennedy (with Senator Chris Dodd (D-CT) acting as his proxy), will continue its

mark up of the Affordable Health Choices Act on July 7<sup>th</sup>. The focus of the third week of the Committee's work will likely be on provisions that were finalized during the July 4<sup>th</sup> recess, which include language on the public option and the employer mandate. As written, the public option would be run by the federal government, which would have the power to negotiate rates and premiums, with healthcare providers not required to participate in the program. The employer mandate would require firms to share in the responsibility of providing coverage. Firms with 26 or more employees that do not offer insurance would be required to pay an annual fee of \$750 per full-time worker, or \$375 per part-time worker, to help pay for their employee's health insurance coverage.

The HELP bill, which the Congressional Budget Office (CBO) had initially projected to cost over \$1 trillion over 10 years, received a big boost on Thursday, when the CBO revised its estimates to \$611 billion over 10 years due to the stringent design of the employer mandate. This estimate is not deficit-neutral nor does it include a likely Medicaid expansion, which is the jurisdiction of the Finance Committee.

The Senate Finance Committee continued its bipartisan negotiations through the July 4<sup>th</sup> recess. According to key staff, significant progress has been made on a package that will cost approximately \$1 trillion over ten years that could garner support from both sides of the aisle on the Committee. The timing on action in the Finance Committee is still up in the air but a chairman's mark could be released this week with a 3-4 day mark up commencing the week of July 13<sup>th</sup>. One issue of contention is the design of an employer responsibility requirement to encourage employers to continue to provide health insurance to their employees. One option under consideration is a "free-rider" provision that would require employers who do not offer affordable coverage to pay half of the average cost of Medicaid for each low-income employee enrolled in it as well as all of the average cost of subsidies for lower-income employees who purchase coverage through a health insurance exchange. In a letter distributed last week, the SEIU and the Center for American Progress joined forces with Wal-Mart to express opposition to a free-rider proposal that would create disincentives for employers to hire

lower-income workers. This could carry significant weight as this issue continues to be debated.

Once action is complete in the HELP Committee and the Senate Finance Committee, both bills will be merged in order to proceed with a full Senate debate and a vote before the August recess.

The emphasis on a House and Senate vote before the August recess is significant because it is a month-long period of time in which members will spend the majority of their time focused on garnering or diluting support for the bills in their states and districts. During this time, it is expected that key staff for the House and Senate will meet to work out differences between both bills in an effort to produce a conference agreement that President Obama hopes to sign this year.

## KEY POLICY SNAPSHOT

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### MEDICAID

One of the most important and least fleshed out issues in the Health reform debate to date is the status of the Medicaid program. There appears to be general consensus among Congressional Democrats and the White House that the program should be expanded to some degree and that income eligibility standards be liberalized for childless adults and parents in particular. To date, only the House bill has weighed in on the treatment of Medicaid and other publicly financed insurance programs. In the initial House proposal, Medicaid eligibility is raised to 133.3 percent of poverty. The new Medicaid population can either receive coverage through traditional Medicaid or the exchange. It appears that the current Medicaid population could opt to enter into the exchange in the 5<sup>th</sup> year of reform being enacted (with states providing wrap around services). It is unclear how the state wrap would be constructed. Under the House approach, the new population will initially be financed at 100% FMAP but would eventually be phased down to traditional FMAP. New FMAP-based incentives would be

put in place to reward states for adoption of best practices and enrollment efforts. It also appears that the CHIP program would be rolled into the exchange – though few details are available in this particular policy area (there is no discussion regarding benefit design, financing mechanisms etc. in this draft). A more in depth analysis and discussion is forthcoming.

As noted above, the HELP Committee remained silent on the issue of Medicaid, though Senator Kennedy has long been an advocate of expanding the program to people at or below 150 percent of poverty. The Finance Committee had expressed initial support for expansion to 150 percent of poverty, but due to budgetary constraints as well as lukewarm support for any programmatic expansion on the Republican side (save Senator Olympia Snowe (R-ME)) it is unlikely that the Finance proposal will go beyond the House's 133.3 percent FPL expansion. It is rumored the Finance Committee may not give states or beneficiaries the option of putting Medicaid beneficiaries into the exchange (while providing wrap around services). The House and likely the Senate Finance bills do/will include language to align eligibility standards for dual eligibles through the Medicare Savings Program and Low Income Subsidy program in Medicare Part D, which currently have different income eligibility standards and asset tests. Overall, the bill will likely remain mostly silent on the issue of Long Term Care.

## **OTHER POTENTIAL CHANGES TO THE SAFETY NET**

While a myriad of changes are being considered with regard to Medicaid eligibility and associated financing, issues regarding coverage of immigrants (both legal and undocumented), hospital and provider payments, and shifting certain waiver-based programs to state options are also in the mix.

While the HELP and House bills (and most likely the Finance Committee product) ban subsidies to undocumented immigrants through the exchange, the treatment of individuals in mixed status families remains uncertain. The House bill appears to try to address the issue, but it is unclear that it goes as far as necessary to ensure eligibility for subsidies to children in such families. More work is required to make sense of current proposals as they relate to undocumented immigrants in Medicaid, the exchange and beyond.

Hospital payment issues under Medicaid are also in flux. Initially, there was talk about the complete elimination of Medicaid DSH over time, anticipating that the exchange would cover most of that population. However, growing appreciation for the impact such a policy change would have for hospitals that serve immigrant populations and others that might not be eligible for subsidies may impact future proposals on this issue. A deal between policy makers and hospitals has apparently been struck, which may slightly affect Medicaid DSH (if at all) and will more likely impact hospital market basket updates and Medicare DSH reimbursement issues. The House bill also seeks to increase Medicaid provider rates to that of Medicare over time.

## **INSURANCE MARKET REFORMS**

Given the three tracks working on healthcare reform, there are different options on the table with respect to reforming the insurance market. This short section briefly outlines where each bill appears to be headed on this issue.

The Senate Finance Committee has included in its draft proposal a number of elements regarding structural changes in the small and non-group markets have been outlined. Such changes include guarantee issue and prohibiting the use of health status rating and pre-existing conditions. Overall premium variation would be capped at a 7.5:1 ratio. Sub-categories, such as age, family composition and tobacco use would also be

capped. The effective date for these changes would be designed to allow states enough time to enact legislation and for plans to develop offerings. States would also have the option of merging the pooling and rating rules for the small and non-group markets.

As introduced, the HELP Committee proposal includes a number of market reforms including guaranteed issue and renewal, a ban on imposing preexisting condition exclusions, and a prohibition on rate variance based on health status, gender, claims experience, and class of business. There would be a cap on premium variance based on age of 2:1, with variation allowed for subgroups of family structure, community rating area, and actuarial value of the benefit. Market rules would apply no later than 4 years after enactment of federal legislation.

Similar to the HELP Committee bill, the House Tri-Committee bill requires guaranteed issue and renewal and no exclusions for preexisting conditions. There would be a cap on premiums based on age of 2:1, with variation based on geographic area (as defined by state insurance regulators) and family size as permitted by state insurance commissioners and the federal Health Choices Commissioner.