



Center for Policy Analysis

Equitable Quality Universal Affordable Health Care (EQUAL)

HR 3200 as amended and passed by the Energy and Commerce Committee **July 31, 2009**

This updates our analysis of the U.S. House of Representative's Tri-Committee health reform legislation. **Bolded text shows amendments adopted by the Energy and Commerce Committee**, chaired by Rep. Henry Waxman. House leaders will consolidate this bill with versions approved by House Committees on Ways & Means, and Education and Labor, and present the combined bill for a vote by the full House in September. Thanks to John Gilman for preparing this update:
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Concerns: These provisions should be changed to strengthen coverage and affordability:

- Delayed Implementation of Health Insurance Exchange, Public Option, and Affordability Credits and limited access once implemented.
 - Exchanges do not go into effect until 2013. In that year the only employers that may insure through the Exchange are those with 10 or fewer employees. Individuals without other coverage may also enroll, but if they have been offered coverage by their employer they will not be eligible for any affordability credits.
 - Beginning in 2014, any employer with 20 or fewer employees may enroll in the Exchange. Individuals without other coverage may also enroll, but if they have been offered coverage by their employer they will be eligible for affordability credits, but only ***if the employee's share of premium exceeds 12% of adjusted gross income*** and the employee's family income does not exceed 400% FPL. [Note: Prior version set threshold at 11%]
 - Beginning in 2015, and beyond, the Health Care Commissioner may, but is not required to, expand employer participation to larger employers.
- There is an individual mandate to have insurance but Affordability Credits are limited. These credits are not available unless you receive coverage through the Exchange, and even then, they ***are not available through the Exchange if you have declined coverage from your employer unless your share of premium under your employer's plan exceeds 12% of your income.*** [Note: Prior version set threshold at 11%]
 - For those that qualify, Affordability Credits provide some protection for those with the lowest incomes, but these credits quickly phase-out and are not available for much of the middle class. Anyone with family income above 400% FPL (\$43,320 for an individual; \$88,200 for a family of four) is not eligible for any subsidy. The following are examples of health care costs for people buying coverage through the Exchange:
 - A single person with \$16,000 annual income would receive a subsidy and pay no more than a \$480 per year premium (3% of income), while having a cost sharing

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burden of 3-5% of medical costs.

- A couple with family income of \$35,000 would receive a subsidy and ***pay no more than a \$2800 per year premium (8% of income)***, while having a cost sharing burden of 15% of medical costs with an out-of-pocket family limit of \$10,000 per year. *[Note: Prior version maximum annual premium was \$2450 (7% of income)]*
 - A family of three, with family income of \$72,000 would receive a subsidy and ***pay no more than an \$8640 per year premium (12% of income)***, while having a cost sharing burden of up to 30% of medical costs with an out-of-pocket family limit of \$10,000 per year. *[Note: Prior version maximum annual premium was \$7920 (11% of income)]*
 - A family of four with family income of \$90,000 would not be eligible for any premium subsidy and in addition could expect to have a cost sharing burden of up to 30% of medical costs with an out-of-pocket family limit of \$10,000 per year. According to the California HealthCare Foundation, in 2008, the average total family premium for an employer sponsored PPO in California \$1251/month (\$15,012/year). This family would be paying over 16% of its income just for the health care premium.
- ***Note: Amendments were adopted by Energy and Commerce Committee that include various provisions designed to generate savings under the bill, which savings would be used to provide for “an appropriate increase” in affordability credits. Progressives introduced those amendments in response to the Blue Dog amendment which reduces affordability credits. [Not in prior bill]***
- The bill permits a basic insurance plan to have high out-of-pocket expenses. Cost sharing under the basic plan can be up to 30% of medical costs, with out-of-pocket limits of \$5000 per individual and \$10,000 per family.
 - Although the bill offers “enhanced” and “premium” plans with reduced cost sharing—it appears that everyone is entitled to the “basic” plan. The enhanced and premium plans have less cost sharing but higher premiums. Low and middle-income workers will likely not be able to buy enhanced and premium plans because they will not be able to afford the higher premiums, so they will be stuck with the basic plan and its high-cost sharing.
 - Play or Pay. Employers must “play” (offer health insurance to employees) or “pay” (pay a fee to the Health Insurance Exchange Trust Fund).
 - If the employer plays, the minimum employer contribution to premium (for full-time employees) is 72.5% of the premium cost for a single employee and 65% for family coverage. That means the employee with family coverage may pay 35% of the premium cost of his or her policy. (According to the California HealthCare Foundation, single employees in California pay on average 12% of premium costs, while employees with family coverage pay 24% of premium costs.)

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- Employers that choose to pay must pay an amount equal to 8% of total wages (***The amount is less for employers with payrolls of up to \$750,000***) [Note: Prior version small employer reduction applied to firms with payrolls of up to \$400,000]. When the employer chooses to pay, none of the amount paid by the employer is credited to his or her employees, who must obtain insurance through the Exchange. Many of these employees will find themselves paying for the full cost of their insurance. See the above discussion for Affordability Credit subsidies available through the Exchange.
- State-based health insurance exchange – States, or groups of states, can form their own health insurance exchange that would operate in lieu of the national Exchange.
- State benefit mandates – to continue these mandates, states will have to pay any additional cost of affordability credits in the Exchange that are due to the mandates. With tight state budgets, states are likely to drop these benefit mandates, which will effectively reduce the scope of coverage for all state residents whether insured in or outside the Exchange.
- ***CO-OPs – Allows for non-profit state based cooperatives to offer insurance through the Exchange. Appropriates \$5 billion for loans and grants to start up the Co-ops. (As a comparison, the start up appropriation for the public option is \$2 billion.) It appears that the public option could still be available from the Exchange even if a co-op were also available. [Note: Co-ops were not included in prior versions]***
- Essential community providers: Only requires that basic plans contract with essential community providers

Positive Reforms: These provisions would improve coverage and affordability. Some were weakened in Energy & Commerce.

- Insurance Reforms
 - Guaranteed issue and renewal
 - Prohibits preexisting condition exclusion or rating (BUT allows adjusted community rating – based on age and geographic variation condition)
- Prohibits cost sharing for preventive benefits
- Establishes a minimum Medical Loss Ratio, BUT leaves exact ratio to be set by the Secretary of HHS, (effective 1/1/2011)
- Limits policy rescissions (effective 10/1/2010)
- Public Option –Includes a public option, in which all Medicare providers become Public Option participating providers unless they opt out, BUT:
 - ***Requires the public option to negotiate rates with providers and requires that the composite reimbursement rate must be no lower than Medicare rates and no higher than the average of the rates of private plans that participate in the Exchange. [Prior version: Linked reimbursement rates to Medicare rates; provided an additional 5% incentive to Medicare providers who also participate in Public Option]***
- Medicaid improvements

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- Expands coverage: Requires state Medicaid programs to cover childless adults, parents, and individuals with disabilities with incomes up to 133% FPL. Requires state Medicaid programs to cover newborns up to the first 60 days of life who do not have other coverage. ***The cost of these expansions will be paid 100% by federal government for two years; thereafter, 90-10 federal-state match.*** [Prior version: 100% federal; no state match] (NOTE: State Governor's have objected to any increase in state funding for Medicaid.)
 - Improves primary care reimbursement: Requires state Medicaid programs to reimburse for primary care services at no less than 80% of Medicare rates in 2010, 90% in 2011, and 100% thereafter. ***The incremental cost of this increased reimbursement will be paid 100% by federal government for two years; thereafter, 90-10 federal-state match.*** [Prior version: 100% federal; no state match]. (NOTE: State Governor's have objected to any increase in state funding for Medicaid.)
 - Establishes a five-year Medicaid Medical Home pilot program, with 90% federal matching funds for community care workers for the first two years and 75% federal matching for next three years.
 - Increases pharmaceutical manufacturer rebates for brand-name drugs purchased by State Medicaid programs from 15.1% of average manufacturers' price to 22.1%.
 - ***Includes a GAO study on adjusting FMAP (federal matching rate for Medicaid) to reflect state's ability to fund Medicaid.*** [Not in prior bill]
- Establishes the Center for Comparative Effectiveness Research
- Pharmaceutical changes
 - Allows Public Option to negotiate prices with drug manufacturers
 - ***Prohibits brand name drug company settlements with generics companies that delay generic drugs from coming to market***
 - ***Prohibits the renewing of patents for minor modifications, such as making a pill long-acting.***
 - ***Allows Medicare to negotiate Part D drug prices***
 - ***Requires the public option to have a limited formulary (as do private insurers)***
 - ***Creates a pathway for generic biologics to come to market, BUT allows originators to have 12 years of exclusivity. (Energy and Commerce Chairman Waxman argued for 5 years)***
 - [Note: Only the first bullet point was in the original bill]
- ***Single Payer Health Care***
 - ***No provision in Energy and Commerce Bill***
 - ***Speaker has agreed to allow debate and vote on single payer after Congress returns in September***
 - ***Education and Labor Bill includes Kucinich amendment that allows states to overcome ERISA preemption in establishing single payer systems***
 - [No single payer references in original bill]
- ***Insurance reforms prior to 2013***

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- *Reduces preexisting condition look back period from current 6 months to 30 days; generally reduces preexisting coverage denial period from current 12 months to 3 months. [Not in original bill]*

Questionable

- Options for certain individuals to enroll in Medicaid or receive insurance through the Exchange (probably good)
- Eliminate SCHIP; transitions SCHIP eligibles into Exchange, but no earlier than 2013.
- 2.5% tax penalty (2.5% of modified AGI) for failure to obtain coverage, but not to exceed average premium cost; hardship exception available. (If you pass the “hardship test” your prize is not having to pay the penalty and not having health insurance.)
- Up to 50% employer tax credit for premiums paid by small employers with low wage workers
 - Phases out beginning at over \$20,000/ year average wage, fully at \$40,000
 - Phases out beginning at 11 employees; fully at 25
 - Does not apply to any employee earning over \$80,000
- Requires state maintenance of effort (MOE) for Medicaid and CHIP eligibility as of June 16, 2009. This assures that eligibility does not contract (good), but how able are states to do this, given their bleak budget picture.
- *Limits premium increases in the Exchange to no more than 150% of annual rate of medical inflation. (From 1999 to 2008 cumulative medical inflation was 45%; 150% of medical inflation would have allowed a 67.5% increase in premiums during that period. According to the Kaiser Family Foundation, premiums for employer sponsored family coverage during that time period increased 119%. According to the Bureau of Labor Statistics, the consumer price index increased 29.2% during that same time.) [Not in original bill]*
- **Abortion coverage**
 - *Allows health plans to choose whether or not to cover abortion services*
 - *Requires the public option to cover abortions for which federal funding is now allowed (restricted to cases involving rape, incest or danger to the health of the mother).*
 - *States that nothing in the bill prevents the public option from providing or prohibiting coverage of services for which federal funding is now prohibited.*
 - *Requires at least one health plan in each premium rating area of the HI Exchange to cover abortion services (including those services for which federal funding is now prohibited.)*
 - *Prohibits abortion services for which federal funding is now prohibited from being paid by any affordability credits; requires such services be paid from premium amounts attributable to the actuarial value of offering such services.*
 - *[Note: Prior versions did not include any abortion provisions]*