



HR 3200 (July 14, 2009 version)
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Concerns

- State benefit mandates – to continue these mandates, state 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.
- 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 11% of adjusted gross income and the employee's family income does not exceed 400% FPL.
 - 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 11% of your income.
 - 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 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 \$2450 per year premium (7% 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.
 - A family of three, with family income of \$72,000 would receive a subsidy and pay no more than a \$7920 per year premium (11% 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.
 - 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.

- 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.)
 - 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 \$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. However, it appears that such an exchange would NOT be required to offer a public option. (See Section 208)
- State benefit mandates – to continue these mandates, state 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.
- Essential community providers: The bill requires that only basic plans contract with essential community providers? [Page 90 - Sec 204 (b)(6)]

Good:

- 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 –Provides incentives for Medicare providers to be public option providers (assures broad, diverse panel of providers)

- Medicaid improvements
 - 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. These expansions will be paid 100% by federal government. BUT, these expansions do not go into effect until 2013.
 - 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.
 - 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%.

- Establishes the Center for Comparative Effectiveness Research

Uncertain effect

- 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.