



Working Group of State Legislators for Health Reform

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To: Director Nancy Ann DeParle, Secretary Sebelius, Speaker Pelosi and Leader Reid
Fm: State Legislators for Health Reform (members listed at end of memo)
Dt: January 11, 2010
Re: Final recommendations on integrating House and Senate Health Care Reform bills

As you finalize the remaining concerns in reconciling the House and Senate Health Care Reform bills, our group has identified the following topics that we suggest you review during your final deliberations.

Medicaid and Affordability - We continue to advocate for Medicaid to 150% and comprehensive coverage and affordability. The House bill's subsidy for those under 250% FPL is far superior to the Senate bill.

FMAP - The importance of keeping and passing an extension for the enhanced FMAP provided by ARRA cannot be stressed enough. The ideal place for this extension is attached to a jobs bill, but if that isn't likely to pass, then the next best place for it is the health care bill. While there is concern that the offset for the enhanced FMAP could result in less money available for subsidies, without immediate enhanced Medicaid funding states will simply cut Medicaid waiver programs, adding to the rolls of the uninsured.

Other State Funding – States that have already moved ahead with innovations including basic health plans, public options, public-private partnerships, expansions of state employee pools and other subsidized health insurance programs should be supported, not penalized. These programs are the building blocks for a more robust public plan as health reform is implemented over the next few years and they currently provide needed insurance to many. To that end (1) the final bill should retain the “basic health plan” (Cantwell) provisions; (2) the Senate bill language that would provide additional funding to states with high risk pools but no funding to states that have already started down the path of health care reform should be replaced with the House language, which makes funding available to states with public/private partnerships for health care coverage; (3) pilot project and waiver funding should encourage and support these innovations; and (4) Medicaid funding rates should not penalize these “early adopter” states in order to favor states that have lagged behind.

Source of Funding - The so-called “Cadillac plan” tax is problematic; it hurts unionized workers in particular, and is set at a level that sweeps within its ambit the kind of comprehensive policies that should be encouraged. We prefer the more progressive House funding mechanism. At the very least, if the health plan tax is retained in some form, it shouldn't kick in at the present level which is closer to a Ford Taurus than a Cadillac. If additional funding is needed to close the gap (and pay for the improved subsidies above), we recommend requiring negotiation and supplemental rebates in the Medicare Part D prescription drug program as is currently required in Medicaid. This change is easily quantifiable and would save billions.

Exchange - We definitely support the Exchange outlined in the House bill since it would be a federal Exchange (taking advantage of economies of scale) that states could run if they met certain standards. More importantly, the provision in the House bill that would merge the individual and small group markets, spreading the risk over a greater number of people in the Exchange plans, is the preferred mechanism. An addition that might prove helpful to the bill is to enable the Exchange oversight agency



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to negotiate rates for the Exchange plans (as the Senate bill does). Perhaps this would soften the loss of the public option for the progressives in the House.

Relationship of Insurance Provisions to State Law – There are a number of provisions in the Senate bill that undermine existing state consumer protections and the enforcement authority of insurance regulators. These provisions should be a floor, not a ceiling and should not preempt existing stronger state standards. Insurance provisions about which we have concerns include:

Choice Compacts –§ 1333(a) (at Page 219) establishes a consumer protection and litigation nightmare under which coverage can be sold in one state subject to the laws of another state with lower standards. *Preferred solution: Eliminate this provision and use the Multi-State Plan program (§ 1334) as the exclusive Senate vehicle for interstate sales. At minimum, adopt House language.*

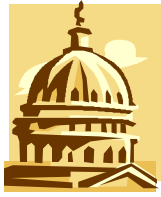
Preemption of community rating laws – Pursuant to § 1312(c)(4) (Page 154 lines 16-18), states are prohibited from requiring insurers to include grandfathered plans in the same risk pool as non-grandfathered plans. *Preferred solution: Eliminate this provision. At a minimum, it should be revised to protect state risk pooling requirements that were in place on the date of enactment. The purpose of grandfathering should protect the status quo, not to establish new rating privileges that insurers don't have now.*

Pre-Existing Conditions – Pursuant to § 1101 (at Page 44), there's a program of transitional support for "Immediate Access to Insurance for Uninsured Individuals with a Preexisting Condition." Unlike the House bill, this support is only available for state high-risk pools, which freezes out states that have chosen other ways to provide access. *Solution: Include, at a minimum, language like the House language that includes public-private partnerships.*

"Level Playing Field" – The stated goal of § 1324 (at Page 200) is a sound one – to ensure that private insurers aren't subject to discriminatory application of state and federal laws vis-à-vis the Community Option, CO-OP plans, and Nationwide Plans. However, the solution offered by this section – to exempt all private insurers from all laws that don't apply to these plans, is dangerous. It is even more dangerous than it might appear because many state laws classify insurance entities in various ways, so all laws that apply to classes that these plans don't belong to are arguably preempted. *Solution: Rephrase the level playing field requirement to raise the bar for the public and quasi-public plans rather than lowering it for private insurers.*

Adverse selection for grandfathered plans – The trigger for grandfathering under § 1251(a)(1) (Page 97, lines 15-16) is enrollment in the coverage on the date of enactment, so companies can go out there and hustle people into new substandard plans, with the assurance that they can freely move into qualifying plans as soon as they need comprehensive coverage. *Solution: Make the grandfathering date January 1, 2009 or July 1, 2009 (so that people can keep coverage they already had but can't be sold "newly issued grandfathered coverage," which is a contradiction in terms.)*

Family Coverage – In PHSA § 2701(1)(A)(i) (Page 80, lines 16-17), the bill allows rating to vary based on "whether such plan or coverage covers an individual or family," but sets no standards for family coverage rating. *Preferred solution: Include the ratios to one-adult coverage that were in the Finance bill (Individual = 1 to 1; Adult with child, 1.8 to 1; Two adults, 2 to 1; Family, 3 to 1) and add a child(ren)-only*



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factor of 0.8 to 1. *Alternative solution: Use the House version, which leaves the issue to state law and rulemaking, but add a category for child(ren) only.*

Wellness – Proposed PHSA § 2705(j)(3) (at page 87) perpetuates the existing loophole under which so-called “employee wellness programs” can provide financial incentives to employees and their families for being good underwriting risks. The maximum rebate, discount, or reward based on health status is increased to 30% from the current 20% of premium (or its self-insured equivalent), and the Secretary is given the authority to increase it to as much as 50%. Furthermore, § 2705(l) (at page 91) provides for a 10-state demonstration program for the individual market. *Preferred solution: Eliminate wellness programs based on health status. Second choice: Preserve the status quo, removing that type of program from the individual market demonstration project and limiting the maximum incentive in the group market to 20% of premium.*

Waivers – § 1332 (at page 212) allows states to apply for a “waiver for state innovation” from all or any requirements of Section 1402 and Parts I and II of Subtitle D. These provisions are important consumer protections including the minimum coverage requirements, the Exchanges, and the subsidies for reduced cost-sharing. *Solution: Eliminate. In the alternative, limit waivers to other provisions like CO-OPs, Nationwide plans, etc.*

Self-insurance – There is no prohibition against self-insurance in the modified-community-rated sector of the market, which creates an unlevel playing field. *Solution: Clarify that risk adjustment applies to self-insured plans.*

Association coverage: Senate Bill (page 385, line 25) repeals current PHSA § 2711(f) [42 U.S.C. § 300gg-11(f)]. This gets rid of the existing exception for bona-fide associations to guaranteed issue requirements under HIPAA. There is no counterpart in the House bill. *Preference: Senate approach.*

Risk pooling/risk adjustment: Subsection 1343(c) of the Senate bill, at page 237 line 22, makes risk adjustment apply outside the Exchange as well as within it. The risk pooling mechanism in the House bill applies only within the Exchange. *Preference: Senate approach.*

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