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The Consumer Connection
... linking consumers with health care news and information

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The Consumer Connection is a publication of the Michigan Consumer Health Care Coalition with the Michigan League for Human Services

Update on the Nation's Health Care Reform

The source for the information provided below is The Kaiser Family Foundation's *Side-by-Side Comparison of Major Health Care Reform Proposals.* This bill comparison can be found online at http://www.kff.org/healthreform/sidebyside.cfm. Some of the key points of the bill are summarized below; a more detailed exploration of key provisions resulting from the House-Senate conference committee will be included in the next edition of the *Consumer Connection.*

	House Leadership Bill	Senate Leadership Bill
DATE ANNOUNCEMENT	**November 7, 2009**	**November 18, 2009**
	On Saturday, November 7, 2009, the United States House of Representatives passed the ''Affordable Health Care for America Act'' (H.R. 3962) by a vote of 220-215.[1]	On November 18, 2009, the United States Senate combined two original bills, created by the Senate Finance Committee and the Senate Health, Education, Labor, and Pension (HELP) Committee, in H.R. 3590, the *Patient Protection and Affordable Care Act*. Additional sources for the information provided below are the U.S. Senate's website (http://democrats.senate.gov/reform), and Health Affairs (http://healthaffairs.org/blog/2009).
INDIVIDUAL MANDATE	**effective January 1, 2013**	**effective 2014**
	• The bill requires that all individuals have ''acceptable health coverage'' either through their employers or by purchasing a basic plan within a Health Insurance Exchange (see below for more information regarding the creation of this exchange). There would be a penalty of 2.5 percent of an individual's adjusted gross income for those who choose not to get insurance coverage. Individuals with income below $9,350 annually and couples with income below $18,700 annually, the current tax filing threshold, those who have religious objections, American Indians, and those who pay	• The Senate bill requires most individuals to have ''minimum essential'' health insurance coverage through any of the following avenues: public insurance, health insurance exchange, employment-based coverage, or continuation of current coverage. A penalty up to a $750 (by 2016) per year for adults (with a maximum of $2,250 per family) who do not have insurance is proposed. Exceptions to this mandate would be those with religious objections; financial hardship (defined as the lowest cost plan exceeding 8% of income for coverage or having an income under 100% of the FPL); persons incarcerated or those living in the United States illegally; and members of Indian tribes.

[1] The Families USA website (http://www.familiesusa.org/standupforhealthcare/how-they-voted.html#MI) provides information on how Michigan representatives voted.

	House Leadership Bill	Senate Leadership Bill
INDIVIDUAL MANDATE	**effective January 1, 2013**	**effective 2014**
	more than 2.5 percent of their income for health insurance are the exceptions to this mandate. • This bill would provide subsidies for individuals and/or families whose income is up to 400 percent of the federal poverty level (FPL), currently $88,224 for a family of 4. The first is a ''premium credit'' that is based on the cost of the three lowest tiers of a basic health plan. Depending on an individual or family's income, they would be able to receive a premium credit of 1.5 percent—12 percent of their income. The ''cost-sharing credit'' allows an individual or family to receive a credit to offset in part, out-of-pocket expenses.	• Premium credits would be available to individuals and families whose income is between 100-400 percent of the federal poverty level. The credits would limit premium contributions to a range of 2 percent (if income is under 133% FPL) to 9.8 percent (if income is between 300% and 400% FPL) of family incomes. Cost-sharing subsidies would also be available for individuals and families with incomes between 100 and 200 percent of the FPL. The cost-sharing subsidies allow for an individual or family to receive a credit to partially offset out-of-pocket expenses.
EMPLOYER MANDATE	**effective January 1, 2013**	**effective January 1, 2014**
	• Employers with annual payrolls of $500,000 or more would be required to offer insurance coverage to their employees and contribute to the employee's premium (72.5% for single coverage and 65% for family coverage) or pay up to 8 percent of their payroll into the Health Insurance Exchange Trust Fund. Lesser assessments would be levied (ranging from 2% to 6% of payroll, depending on the amount of the employer's payroll) for those employers whose payroll is more than $500,000 and less than $750,000 annually. Employers will be required to automatically enroll employees in the lowest cost plan that they have available unless the employee opts out of this coverage (for example, gets insurance through spouse's employer or opts out of coverage all together). • Employers with fewer than 25 employees (with an average wage of less than $40,000 per year) would be eligible to receive a tax credit for up to 2 years. Depending on the size of the business, the number of employees, and the employees' wages, an employer could receive a tax credit of up to 50 percent of the cost of the premiums paid by the employer. • Also available to employers is a reinsurance program that provides up to 80 percent reimbursement for retiree claims between $15,000 and $90,000 for those employers who are providing health insurance to any retirees over the age of 55 and Medicare ineligible.	• Employers with 50 or fewer employees are not required to offer health insurance to their employees. • Employers with more than 50 employees would be penalized if they do not offer health insurance to their employees. Employers who offer coverage and who have at least one full-time employee receiving the federal assistance tax credit would pay $750 per full-time employee. Employers who do not offer coverage who have at least one full-time employee receiving the federal assistance tax credit would pay $3,000 per employee receiving the tax credit or $750 for each full-time employee, whichever is less. (The federal assistance tax credit is a subsidy for citizens and legal immigrants with incomes up to 400% of the FPL, the uninsured, and people whose current health care premiums exceed 9.8% of their incomes.) • Employers with fewer than 25 employees (with an average wage of less than $40,000 per year) would be eligible to receive tax credits for up to 2 years.

	House Leadership Bill	Senate Leadership Bill
PUBLIC PROGRAM EXPANSIONS	**effective January 1, 2013**	**effective 2014**
	• Medicaid would be expanded to include everyone under the age of 65 (children, pregnant women, parents, and adults without dependent children) who has an annual income up to 150 percent of the federal poverty level, currently $16,248 for an individual, or $21,864 for a two member household. The expansion includes coverage through 2013 for all newborns that otherwise wouldn't have coverage through their parents and low-income HIV-infected persons with enhanced federal matching funds. Also included within this public program expansion are family planning services for certain qualifying low-income women and increased payment rates, to 100 percent of Medicare, for primary care providers. Children's Health Insurance Program (CHIP) enrollees with household income above 150 percent of the FPL would be required to obtain insurance coverage through the Health Insurance Exchange (see more information regarding the exchange below) beginning in 2014.	• Like the House bill, the Senate bill includes an expansion of Medicaid services to children, pregnant women, parents, and adults without dependent children. The Senate bill would expand coverage for individuals with incomes up to 133 percent of the FPL and mandate current eligibility for children be continued until 2019. This bill also increases community-based services to disabled individuals with Medicaid in lieu of institutional care. Other services to be included within this expansion include freestanding birth center services, prevention services (including tobacco cessation), and medical homes for Medicaid recipients who have chronic health conditions.
NEW PUBLIC OPTION	**effective January 1, 2013, with exceptions**	**available by 2017**
	• The House bill creates a new public health insurance option to be offered through the national exchange (see below) that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost sharing. The public option must offer basic and enhanced plans and must negotiate rates with providers that are no lower than Medicare rates and no higher than average rates paid by private health plans.	• The Senate bill creates a new public health insurance option (''Community Health Insurance Option'') to be offered through state-based exchanges (see below) that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost sharing. The public option must negotiate rates with providers that are no higher than average rates paid by private health plans. States may opt out of offering the public plan by passing a law to that effect.
CREATION OF HEALTH INSURANCE EXCHANGE (HIE)	**National Exchange** **effective January 1, 2013**	**State-Based Exchange** **effective January 1, 2014**
	• Individuals and small employers would be able to purchase either private insurance or the public insurance option through a pool of insurance providers as part of a Health Insurance Exchange. Four benefit categories	• The Senate bill includes a state-based health insurance exchange that is initially designed for the individual and small group markets. The exchange would allow individuals and small businesses to purchase insurance

	House Leadership Bill	Senate Leadership Bill
Creation of Health Insurance Exchange (HIE)	**National Exchange** **effective January 1, 2013**	**State-Based Exchange** **effective January 1, 2014**
	would be available for purchase: a basic plan, an enhanced plan, a premium plan, and a premium plus plan. Guaranteed issuance and renewal would be required. States would be allowed to operate state-based exchanges if they can demonstrate the capacity to meet the requirements and operate the exchanges.	through the exchange beginning in 2015; larger businesses (more than 100 employees) could begin to purchase insurance through the exchange two years later. This bill also would create a plan to foster creation of member-run, nonprofit health insur-ance cooperatives in all fifty states. The exchange would be required to offer four benefit plan categories plus a catastrophic plan with guaranteed issue and renewal.
Private insurance regulations	**effective dates ranging from January 1, 2010 to January 1, 2013**	**effective dates vary**
	• A number of private insurance regulations would be implemented under the bill including the following: — establishing a temporary high-risk pool that would provide coverage to individuals with pre-existing medical conditions, individuals denied coverage, individuals offered unaffordable coverage, or individuals uninsured for 6 months; — limiting pre-existing condition exclusions; — prohibiting establishment of life-time limits; — extension of dependent coverage for children to age 27; — improving consumer protections; — prohibiting reductions to retiree benefits unless reductions are also applicable to current employees; — limiting variations in premium rating; and — prohibiting insurers from rescinding coverage except for fraud.	• Like the House bill, the Senate bill includes: — establishing a temporary high-risk pool that would provide coverage to individuals with pre-existing medical conditions, individuals denied coverage, individuals offered unaffordable coverage, or individuals uninsured for 6 months; — limiting pre-existing condition exclusions; — prohibiting establishment of life-time limits; — extension of dependent coverage for children to age 26; — prohibiting reductions to retiree benefits unless reductions are also applicable to current employees; — limiting variations in premium rating; and — prohibiting insurers from rescinding coverage except for fraud. • Allow states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact.

	House Leadership Bill	Senate Leadership Bill
COSST CONTAINMENT	**various effective dates ranging from January 1, 2010 to October 1, 2016**	**effective dates vary**
	• To contain the costs of health care, the bill would require actions such as simplifying health insurance administration through standardization (including electronic transactions); strengthening oversight of public programs; reducing Medicare payments to hospitals for preventable hospital readmissions; and lowering payments to Medicare Advantage plans to 100 percent of the fee-for-service levels with bonuses for improved quality. The requirement for negotiation of drug prices between the Secretary of Health and Human Services and pharmaceutical manufacturers for Medicare Part D plans, as well as the requirement that drug manufacturers expand Medicaid drug rebates are included in the bill. Reductions in the Medicaid and Medicare Disproportionate Share Hospital payments are also included due to the projected reduction in the number of uninsured.	• To contain the costs of health care, the Senate bill calls for: simplified health insurance administration through standardization of operating rules, including eligibility verification and claims processing; lower payments to the Medicare Advantage plans but provide bonuses for quality, performance improvement, and care coordination in future years; reduced Medicare and Medicaid Disproportionate Share Hospital payments due to the reduction in the number of uninsured; changes in Medicare Part D subsidies; and increases in Medicaid drug rebates. It would also create a Medicare Advisory Board to recommend ways to reduce excess cost; allow Accountable Care Organizations to share in cost savings; and reduce Medicare payments for preventable hospital readmissions.
IMPROVEMENTS IN HEALTH CARE QUALITY	**various effective dates ranging from 2010 to January 1, 2012**	**various dates from 2010 through 2015**
	• This bill endeavors to improve the quality of health care delivery by increasing care coordination. This would be achieved by offering Medicaid payments to primary care providers that reflect Medicare rates and by providing Medicare bonus payments to primary care providers who use care coordination models. The bill also establishes a number of collaborative efforts to identify evidence-based best practices to increase the efficiency and quality of health care delivery. These efforts include the establishments of the Center for Medicare and Medicaid Innovation, the Center for Quality Improvement, and the Community-based Collaborative Care Network Program.	• The bill strives to improve health care delivery (including patient health outcomes and population health) by simplifying health insurance administrative duties; creating a Patient-Centered Outcomes Research Institute to conduct comparative effectiveness research; requiring quality reports from hospitals and physicians; creating a value-based payment system for hospitals and physicians; creating a pilot project to test bundled payment methods for acute and post-acute care; and encouraging the development of new patient-care models.
FINANCING	**various dates**	**various dates**
	• The House bill is estimated to cost $894 billion over a ten year period. This amount is expected to be financed by an estimated $426 billion savings in Medicare and Medicaid spending (see cost containment above) and new revenues from individual and employer	• The Patient Protection and Affordable Care Act is estimated to cost $848 billion over ten years. As with the House bill, provisions of the bill are expected to be paid for by Medicare and Medicaid savings, new taxes, and various fees. It is estimated that there

	House Leadership Bill	Senate Leadership Bill
FINANCING	**various dates**	**various dates**
	assessments and taxes (most significantly, a 5.4 percent levy on individuals with incomes exceeding $500,000 and families with incomes exceeding $1 million, and a 2.5 percent tax on medical device sales). The Congressional Budget Office projects the proposals will reduce the deficit by $104 billion over 10 years.	would be a $491 billion savings in Medicare and Medicaid over this ten-year period. There would also be $149 billion in revenue from an excise tax on high-cost insurance policies; an increase in Medicare payroll tax (from 1.45% to 1.95%) for individuals with incomes of more than $200,000; and a new 5 percent tax for cosmetic surgical/medical procedures. There would also be new fees on pharmaceutical and medical device manufacturers and health insurance companies that would increase revenue by $11 billion.
OTHER PROVISIONS AND INVESTMENTS	**various effective dates**	**various effective dates**
	• This bill includes numerous other provisions such as: improving the nation's health through prevention and wellness initiatives; establishing a national, voluntary insurance program for purchasing community living assistance services and supports to improve long-term care options; workforce training and development; strengthening public health; and improving access to care.	• The Senate bill includes numerous other provisions, similar to the House, including: improving the nation's health through prevention and wellness initiatives; establishing a national, voluntary insurance program for purchasing community living assistance services and supports to improve long-term care options; workforce training and development; strengthening public health; and improving access to care.
CURRENT STATUS		
	The bill passed the House on November 7, 2009, and is waiting conference committee action.	The Senate began deliberations on December 1st and hopes to complete its task by the end of the year. However, Senate Majority Leader Harry Reid (D-Nev) has stated in recent interviews with the press that he is not sure whether the Senate will be able to meet the end-of-the-year deadline requested by President Obama.

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From the consumers' perspective...

Not A Road Map: Just Signs That Say "Bump Ahead"

Public Option

Originally created as an alternative, or fall-back, to a Single Payer System, the public option would be a public nonprofit insurance program sponsored by the federal government where people who can't get coverage from an employer can go as well as small businesses to buy a basic benefit package of health care services; the most disturbing and furiously challenged provision by the private insurance industry. *Key issue here: whether rates in this option will be set as in Medicare or "negotiated" as in the private insurance industry.*

Trigger

The public option wouldn't kick in for a couple of years after health reform is implemented, in a wait to see how high private insurance companies raise their rates. *Key issue here: the industry will have time to temporarily moderate rate increases to ward off the public option, but still build up the cost base, thereby giving the industry enough time to blunt some of the effectiveness of the public option as a cost control measure.*

Pre-existing Condition Exclusions

No insuring entity would be allowed to keep someone who is sick from purchasing their coverage, or charge them more because of their disease or illness, as is done currently. *Key issue: whether domestic violence victims will be considered to have a "pre-existing condition" and excluded as they are now by many insurance companies.*

Insurance Rescissions

This provision would prevent the practice of ending coverage when the insured person gets sick, usually through the insurer going back through the records to find something (anything) to indicate that once the insured was sick and didn't tell them so coverage was obtained fraudulently. *Key issue: whether domestic violence victims will be considered to have a "pre-existing condition" and excluded as they are now by many insurance companies.*

Guaranteed Issue

Come one, come all and you will be insured by the company with ''guaranteed issue,'' now the practice of mostly Blues plans under state regulation. *Key issue: when "buying insurance across state lines" is discussed, it mostly is an effort to get around state regulation of insurance practices.*

The Exchange

A state-level array of the private insurance companies and the public insurance company (option) where people and businesses can go to see their choices, compare prices, review coverage options and select their coverage. *Key issue: why "negotiated rates" are sought in the public option, so that rate differences are not so stark between the public option and the private insurance industry.*

Benefit Packages

As of this writing, it looks like all carriers will have to offer a Gold, Silver, Platinum and ''Young Invincibles'' plan, at roughly the same price (they are expected to compete on quality). Persons under 133 percent (or 150% depending which plan advances) of the poverty level will be assigned to the Medicaid program, a problematic approach in Michigan where a very small number of doctors currently take Medicaid patients, and the state will struggle with whatever share of costs are assigned to them. *Key issue: why "negotiated rates" are sought in the public option, so that rate differences are not so stark between the public option and the private insurance industry.*

Insurance Costs and Subsidies

Persons of low and modest income will receive subsidies to assist them to purchase insurance. Those outside of the current system will be assisted with subsidies on a sliding scale which they can take into the Exchange to offset the unaffordable part of their cost-sharing for coverage. The size of the subsidy will likely relate to household income, size of family, a ceiling on the percentage of income devoted to insurance coverage. *Note: using the designs currently under consideration, a family can open a subsidy calculator, plug in their numbers and obtain a sense of whether a subsidy and the size of it will*

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cont'd.

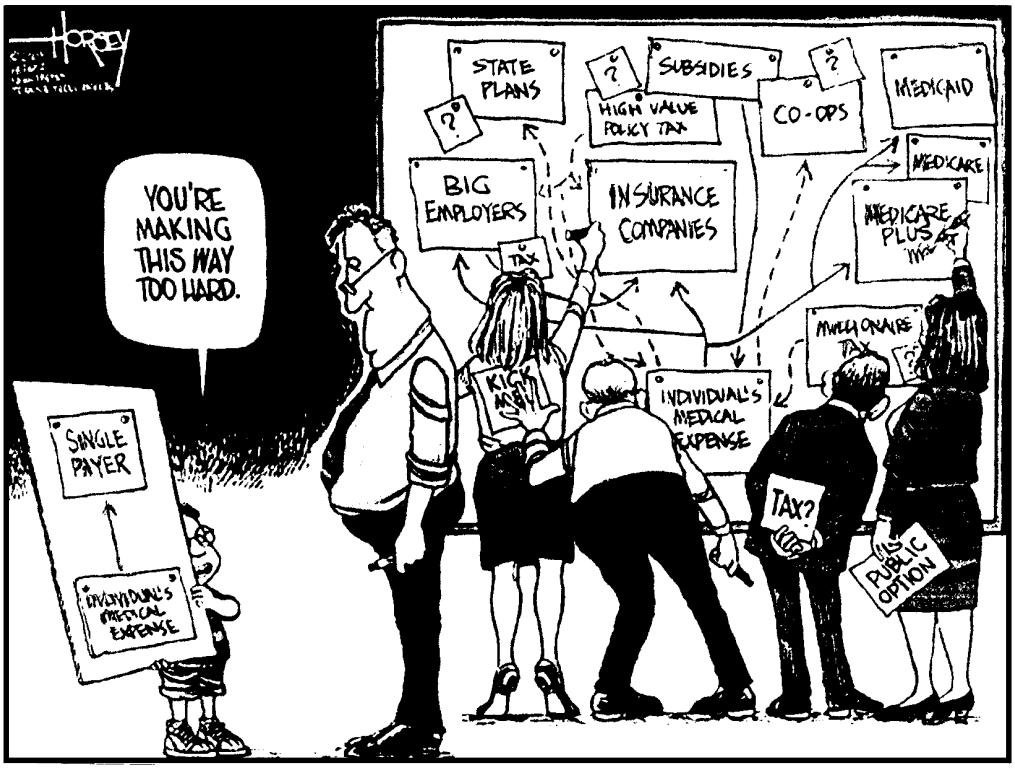
From the consumers' perspective...

be available to the family. The calculator is available at http://healthreform.kff.org/SubsidyCalculator.aspx.

Conflicts of Interest/Sunshine Provisions

Senate and House proposals contain provisions to shed light on the financial relationships between the medical industry and doctors, taking aim at common business practices like drug company payments to doctors for speeches and consulting services promoting their products. *Key issue: an attempt to control the practice of steering drug use towards the company from which a physician is drawing additional benefits. With the rapidly escalating use and costs of drug therapies in patient care, the cost of these "business" practices is not insignificant. When a handful of device makers were required as a result of a federal government settlement to publicly disclose their payments to doctors for promoting their products, the payments dropped 61 percent from $272 million in 2007 to $105 million in 2008.*

Beverley McDonald, Chair
Michigan Consumer Health Care Coalition



FY2010 Department of Community Health Budget Summary

The fiscal year 2010 Department of Community Health (DCH) budget includes a number of harmful program reductions and eliminations, impacting a broad array of residents, from Medicaid recipients to those seeking mental health and public health services, to those needing critical disease treatment and prevention programs. These reductions, based on a ''cuts only'' approach by the Legislature, do not represent a balanced approach which would have included new revenues to protect services needed by Michigan families to survive during these unprecedented economic times.

The cuts are also short-sighted and will lead to higher costs now and in the future as critical services are not provided to those in need. In addition, the Medicaid reductions make little fiscal sense because of Michigan's high federal matching rate (73.27%). In FY2010, for every dollar in Medicaid spending, the federal government will provide 73 cents, while the state has to contribute only 27 cents. Conversely, for every $1 of state funding cut, $3.73 of health care services must be cut.

The following list of service eliminations/reductions is not all-inclusive. Additional detail can be found on the House Fiscal Agency Website at http://www.house.mi.gov/hfa/dch.asp.

Program Eliminations/Reductions:

- Continued elimination of federally-defined optional Medicaid services for adults, including dental, vision, podiatric, chiropractic, and hearing aid services originally terminated on July 1, 2009;
- Provider rate reductions totaling 8 percent including an earlier 4 percent cut effective July 1, 2009;
- Continued savings ($40 million) from reductions in funding of non-Medicaid mental health services;
- Elimination of mental health initiatives for older persons and respite services for families of children with severe emotional disturbances;
- Elimination of funding for 16 of 27 Healthy Michigan Fund programs for prevention, education, and key services;
- Other public health program funding is also reduced (family planning local agreements) or eliminated (such as AIDS/tobacco media campaign, African American male health initiative);
- Local public health operations funding was reduced by $500,000
- Reduction of funding for senior citizen community services, including community programs, nutrition services and meals, and senior volunteer programs and
- elimination of the Social Services to the Physically Disabled program;
- A modest savings through implementation of a preferred provider list for behavioral health drugs requiring a law change to implement;
- Closure of the Mount Pleasant Facility for the Developmentally Disabled;
- Increased parent participation fees in the Children's Special Health Care Services program;
- Elimination of the Offices of Long Term Care Supports and Services and the Office of Drug Control Policy and Services with their functions reintegrated into the Department;
- Budgeted savings (again) for implementation of an Estate Recovery Program for Medicaid-funded long term care services, an initiative yet to be approved by the legislature and the federal government.

It is important to note, however, that more than $1 billion of federal recovery funds were appropriated in the FY2010 Community Health budget, saving programs from even deeper cuts. In addition, requirements of the federal recovery funds precluded reductions in Medicaid eligibility.

There were are very few program enhancements included in the budget, beyond the required increases for actuarially sound rates for pre-paid health plan services, and caseload and utilization changes within the Department's programs.

Program Enhancements:

- A 50 cents/hour wage increase for Adult Home Help workers;
- Expansion to full Medicaid coverage of children in the Children's Special Health Care Services Program with family incomes between 200% and 300% of the federal poverty level, an initiative using only new federal funding;
- Restoration of the 25 cents pharmacy dispensing fee reduced earlier through an Executive Order.

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The Governor vetoed funding for several DCH programs including 0 – 3 Secondary Prevention; Prenatal Care Outreach and Service Delivery Support, which included funding for the Nurse Family Partnership Program; and the $5 million Medicaid Hospital Disproportionate Share Pool that goes to low level participating hospitals receiving less that $900,000 from the $45 million pool.

The Department of Community Health appropriations act, Public Act 131 of 2009 is available at http://www.legislature.mi.gov/documents/2009-2010/publicact/pdf/2009-PA-0131.pdf.

Medical Costs Pushing up America's Credit Card Debt

44 The percent of ''medically indebted'' households with credit card balances of more than $10,000*

11,623 Average dollars of credit card debt among low and middle income households with a major medical expense in the three months prior to the survey

64 Percent of credit card debt among low and middle income Hispanic households *higher* than their counterparts in other groups

* ''Medical indebtedness'' relates to medical expenses which contribute to current credit card debt

Source: Cindy Zeldin and Mark Rukavina: *Borrowing to Stay Healthy: How Credit Card Debt Is Related to Medical Expenses*, Demos A NETWORK FOR IDEAS & ACTION, New York, NY 2007