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on LAW & POLICY

Justice and Economic Security for all Coloradans

CCLP Analysis of Key Health Care Reform Provisions **July 2009**

While different legislation is still being finalized in the House and Senate committees, CCLP has the following concerns on key substantive issues based on the draft bills, proposals and news reports currently available.

Affordability

Affordability is a central issue under any reform scenario, but particularly when a mandate is likely. Almost all families will need to be able to afford health insurance if they are required to purchase. The calculation of what families can afford must be based on actual data about affordability.

Concerns:

- Current House and Senate proposals appear to be reducing the maximum subsidy levels to 300% or 400% FPL. CCLP's data shows that families with incomes up to 500% FPL may require a certain level of subsidy in order for health care to be truly affordable.
- Current House and Senate plans propose to offer subsidies only if **premiums** exceed 12.5% or 15% of income. This is much too high a threshold and will cause families to make undesirable trade offs in areas like education, child care, savings, and many families may not have sufficient funds to pay for health care even without those sacrifices.
- Current House and Senate proposals may require cost sharing to begin at 1% for those living at incomes as low as 100% FPL. This is unacceptable. Health care reform should not penalize the lowest income by adding a new cost sharing requirement. 1% of income for a family living in or just over the poverty level is unacceptable, unless is an absolute cap on spending.
- While House and Senate proposals do deal with cost sharing, it is treated separately from premiums. Thus, on top of paying 15% of income for a premium, families will be responsible for copayments and other cost sharing up to an established maximum. This is an extremely high burden. The affordability of health care costs should be considered as a whole, not as layers upon layers of costs which duplicates the current system. Based upon data, we recommend no premiums or cost sharing for those under 200%FPL, a sliding scale between 200%FPL and 500%FPL, and reasonable caps on total out of pocket spending above 200%FPL. CCLP does not consider the caps in current drafts and proposals to be adequate.
- Affordability as a percentage of income should not be based on gross income, it should be based on an income level that adjusts for necessary expenses.
- Health care should be affordable for all, regardless of coverage mechanism, and not only for those receiving subsidies. Caps on premiums as a percentage of income and caps on cost sharing should be incorporated for everyone as a mechanism for ensuring against financial crises resulting from medical expenses or medical debt.

Public Option

A public program option is the only way to achieve true portability and presents significant opportunities for improved continuity of care, as under such a system people would not have to change providers with every move, job change, or life event. The Public Insurance Option would also offer seamless and efficient administration, features that are extremely important to large numbers of people. Only a strong public health care option, widely available throughout the country, could be a true leader in implementing the innovative delivery system initiatives that will improve the quality of health care and reduce costs. Only by spurring true competition with private plans will Americans get more value for our health care dollar.

Concerns:

- Building the Public Option on a private insurance model, as is discussed in the Senate Finance Report on Coverage Options, does not reflect any new thinking about what a public program could offer to participants. The Senate Finance Committee Options paper proposed that the Public Option use the same rating rules as the new proposed non-group and small group market rules. We believe there are substantial advantages to spreading risk on an equal basis across a large group of people, rather than continuing to single individuals out for differential premiums.
- Limiting enrollment in the Public Option. For example, the current version of the House bill proposes to limit enrollment based on an affordability standard, and defines unaffordable as more than 12.5% of an individual's income.
- We oppose the "coop model" proposed by Senator Conrad for the following reasons:
 - The cooperative proposal, like rural electric co-ops are local. Coops would be designed to serve particular areas or regions. One of the key things we want out of health reform is the ability to have health coverage no matter where we are. A health plan modeled this way would not allow for portability of coverage from one part of the country to another, or from an area served by a coop to an area not served by a coop. Just like in the current system, if you move you have to change plans.
 - A health care co-op would have little bargaining power with physicians, hospitals, and pharmaceutical companies, so premiums would necessarily be very high.
 - The population base of a co-op might be small, thus resulting in higher rates for participating individuals (not a large population for risk sharing).
 - A local health cooperative would not have the ability to drive new cost saving and quality improvement practices widely enough to test their efficacy or to impact the system overall.

Medicaid Reform

Medicaid serves a particular and essential purpose by ensuring that low income children and families, disabled and senior persons have access to the care and services they need. The robust benefits package covering all medically necessary services, and no or nominal cost sharing furthers important public policy goals by recognizing that low income persons cannot contribute to the cost of their care, often times have higher incidences of fair or poor health conditions than their wealthier counterparts, and limited means make it impossible to supplement inadequate benefits packages. The 208 Commission believed that Medicaid was the foundation of any reform effort, and understood that people under 200% FPL needed a robust benefits package and could not afford insurance premiums. The Commission, therefore, recommended a Medicaid/CHP+ expansion to 205% of the FPL.

Concerns:

- There should be no reduction in current eligibility levels to offset costs of raising eligibility or adding new eligibility categories.

- Current proposals do not go far enough in expanding eligibility (133% FPL seems to be the proposal, although 100% FPL is also being discussed. The Colorado Blue Ribbon Commission recommended that Medicaid/CHP+ be expanded to 205% FPL, recognizing that low income people do not have money to pay for health insurance and needed robust benefit packages.)
- Discussions about flexibility may threaten entitlement aspects of the Medicaid program. Medicaid beneficiaries ought not to get radically different access and treatment in public programs from state to state. We urge the NGA not to support any move away from core national standards for the Medicaid program.
- The discussion about the potential for using Medicaid dollars to buy in to private health insurance raises serious issues of cost sharing requirements, benefits adequacy and the inefficiency of increased administrative costs. This is true even if Medicaid were available as a wrap around, since experience demonstrates that such a system inevitably has holes in it and beneficiaries regularly fall through those holes.

Risk Pooling

Most of the core concepts being discussed and debated have to do with risk pooling. Risk pooling is the basis of insurance. Many of the key battles about reform have to do with the degree and extent of risk pooling. In the end, the more people participate on an equal basis the more broadly and equitably we distribute and share risk.

Concerns:

- Senator Conrad's Coop proposal as an alternative to the Public Option reduces risk sharing opportunities.
- Limits on ability to participate in the exchange or public option (see current version of Tri-Committee bill which substantially limits ability to participate in Exchange/Gateway or Public Option).
- 50 state based exchange programs minimizes risk pooling potential of exchanges.
- Continued rating based on age and geography. Rate banding proposals range from a ratio of 7:1 to a ratio of 2:1. President Obama's proposal says people making less than \$250,000 per year will not have an increase in their health care costs, but if the Senate Finance committee proposal passes, many people over 50 years of age will see an increase in costs. Note that rate banding based on age and geography may also disproportionately impact rural residents.
- Senate HELP committees discussions about dollar discounts for healthy behavior. While this has enormous support and there are many appropriate and non-discriminatory ways to incentivize healthy behaviors, dollar discounts only raise the average cost of care for everyone and would substantially increase costs for those not participating. Because actual dollar discounts raise costs for those not participating, they can be used as a means of "cherry picking" by making a policy unaffordable for people who because of poverty, disability, illness cannot take advantage of a wellness plan.