

COMPARISON OF HEALTH CARE REFORM BILLS– November 23, 2009

Below is a summary of some of the major topics of interest addressed in the health care reform bill passed by the House of Representatives and in Senate leadership bill combining two committee-approved versions.

Status of Health Care Reform Legislation:

The House passed the “Affordable Health Care for America Act” (H.R. 3962) by a close vote of 220 to 215 late on Saturday, November 7th. On November 18th, the Senate leaders introduced a bill reconciling differences between the Finance and HELP Committee bills entitled “The Patient Protection and Affordable Care Act”.

Health Care Coverage for the Uninsured:

All bills focus on expanding coverage to the uninsured -- including by creating a mandate that all individuals have to have insurance (with tax penalties for those who do not comply and exceptions for financial hardship and religious objections).

The House -passed bill includes an explicit mandate requiring employers to offer coverage to employees. The Senate bill would impose fees on large employers that do not provide coverage to employees who qualify for health care coverage subsidies.

All the bills include exemptions for small employers, but the bills differ in how they define small employers: the Senate exempts those with up to 50 employees; House exempts employers with less than \$750,000 in annual payroll.

Both bills also would establish tax credits to help encourage small businesses to offer coverage. Only employers with less than 25 employees would qualify.

Both bills include provisions to make coverage affordable through various means --

- 1) By establishing health plan “exchanges” (similar to the “Connector” established in Massachusetts) through which individuals and small businesses could purchase coverage with pooled risk and thus lower premiums.
 - Senate bill directs states to establish exchanges by 2014; House bill would establish a national Exchange by 2013.
 - In the House bill, small businesses with up to 25 employees could join in the first year of the Exchange, those with up to 50 employees could join in year two, and those with up to 100 employees could join in year three along with larger employers if permitted by the commissioner overseeing the exchange.

- Senate bill allows employers with up to 100 employees to participate in state-based exchanges and permits states to allow (but not require) large group plans to be offered in the exchanges beginning in 2017.
- 2) By providing premium subsidies for families with incomes up to 400% of poverty (\$43,000 for individuals and \$88,000 for family of four).
 - 3) And Placing caps on cost-sharing
 - The House bill would cap yearly out-of-pocket medical expenses for individuals at \$5,000 and families at \$10,000. Those who earn less than 400 percent of the poverty level would have lower caps, on a sliding scale.
 - The Senate bill caps out-of-pocket costs at \$5,950 for individuals and \$11,900 for families. These limits would be reduced by from one-third to two-thirds on a sliding scale for those between 100 and 400 percent of poverty.
 - 4) Both bills include a government-run public plan option to create competition for the private plans. The Senate bill would allow states to opt out of including the public plan in their exchanges and would also provide federal support for non-profit, member-run insurance cooperatives.

Medicaid Expansion:

Another fundamental component for covering the uninsured included in the bills is an expansion of Medicaid. The Senate bill would expand Medicaid to individuals up to 133% of poverty (\$14,404 for individuals and \$29,327 for families of four) (including childless adults who were not previously eligible) beginning in 2014 (with a state option to expand up to this level starting in 2011). The House would expand Medicaid to 150% of poverty (\$16,245 for individuals and \$33,075 for families of four) beginning in 2013.

The House bill would direct the Secretary of HHS to issue guidance on outreach efforts targeted to informing vulnerable populations about their eligibility for Medicaid including individuals with mental health or substance use disorders. The Senate bill directs the states to conduct outreach regarding Medicaid and the Children's Health Insurance Program to vulnerable populations including individuals with mental health or substance use conditions.

The House bill would provide full federal funding for those newly covered in 2013 and 2014, then 91% federal funding. The Senate bill would cover the full cost from 2014 through 2016 and then phase down to a 32.3% increase in the federal matching rate for this expansion population.

There are also state maintenance of effort requirements, but they only address eligibility not levels of benefits. And, the Senate bill only applies these requirements until the exchanges are operational with a target date of 2014 and through 2019 for children in Medicaid and CHIP.

The House bill would extend regular Medicaid coverage to those newly eligible, but the Senate bill would provide a lesser level of coverage modeled after private insurance plans (as allowed in the CHIP program). However, this Medicaid package would have to meet the standards established for plans offered in the exchanges and those would have to include mental health and substance abuse services. In addition, an explicit parity requirement was included to apply to this group of Medicaid enrollees.

The House bill would also extend the increase in federal Medicaid payments put in place under the Recovery Act to states with high unemployment rates if they maintained access to Medicaid services during the recession.

The House bill would repeal the CHIP program and require CHIP enrollees above 150% of poverty to obtain coverage through the Exchange. CHIP enrollees between 100% and 150% of poverty would transition into Medicaid and states would receive the CHIP enhanced match rate. (The House would also require continued Medicaid coverage of those previously covered through a CHIP/Medicaid expansion program and provide the CHIP matching rate.) The Secretary of Health and Human Services is directed to report to Congress on how to ensure the coverage in the Exchange is comparable to the average CHIP plan. The Senate bill would maintain the CHIP program through 2019 (but it must be reauthorized in 2013) and beginning in 2014 states would receive a 23 percentage point increase in their CHIP matching rate (up to 100 percent).

Mental Health and Substance Use Coverage in Essential Benefit Package:

Both bills would require all newly issued plans offered through the “Exchanges” to offer at least an essential benefits package that would be required to include mental health and substance abuse services – as well as rehabilitative services and preventive services (in addition to the usual outpatient, emergency, hospitalization, prescription drugs, lab services, maternity, and pediatric services, etc.). Further details regarding required coverage would be established by an independent health benefits advisory committee or commission.

In the Senate bill, the prescription drug coverage in the essential benefits package is supposed to meet the class and coverage requirements under Part D (which presumably would include the policy requiring coverage of substantially all anti-depressants, anti-psychotics, and anti-convulsants).

Essential benefit package requirements would apply to other plans, including large employer plans in the House bill. The Senate bill exempts large employer plans from having to comply with the essential benefit package requirements, but applies these standards to individual and small group markets. Moreover, states may allow large employers to participate in the exchanges (where plans would be subject to these requirements) beginning in 2017.

Parity:

The House bill provision would explicitly apply a parity requirement to all plans in individual, small and large group markets including those purchased by small businesses. The Senate bill would extend parity to qualified health plans “in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.” There is a concern that this provision may continue the current law exemption of small businesses.

A further concern is that the Senate bill would allow the creation of new national plans that would be exempt from state mandated benefit and parity laws.

Consumer Protections:

Both bills would apply consumer protections to the broader insurance market– requiring all plans to offer and renew coverage for all who apply (guaranteed issue). Pre-existing condition exclusions would be prohibited. Premiums could only be based on family structure, geography and age (as well as tobacco use in Senate at a ratio of 1.5 to 1). Annual and lifetime limits on coverage would also be prohibited.

Health Care Delivery System and Quality Improvements:

Medical Homes/Care Coordination:

Both bills include provisions to encourage development of medical homes and community health teams to improve care coordination. The Senate would create a Medicaid state plan option to establish medical or health homes and specifies that individuals with serious mental health conditions qualify to receive services through this option. (Mental illness and substance abuse are included on a list of chronic conditions in this new section 1945 of the Medicaid statute and behavioral health providers and community mental health centers are on the list of providers.) And States are directed to consult with SAMHSA regarding prevention and treatment of mental illness and substance abuse among the eligible individuals with chronic conditions. The Senate bill also includes funding to support co-location of primary care in community-based mental and behavioral health settings and would create a program to fund community health teams including primary care and specialists as well as other health professionals and community resources.

The House bill would establish pilot programs in Medicare and Medicaid to encourage development of medical homes. It does not specify the behavioral health specialists must be included on the treatment teams or that mental health or addiction treatment facilities should be allowed to serve as medical homes. The House bill would also redefine community mental health centers as Federally Qualified Behavioral Health Centers similar to the Federally Qualified Health Centers.

In addition, the House would establish an innovations in interdisciplinary care training program to develop and evaluate training programs including models integrating physical, mental and oral health services.

Comparative Effectiveness Research:

In addition, both bills would establish new programs to fund and oversee comparative effectiveness research (CER). The House bill would establish a new center for CER within the Agency for Healthcare Research and Quality to conduct CER. Under the House bill, the Center would appoint expert advisory panels for research priorities that would consult with patients and other stakeholders. In the House bill, an independent stakeholder commission would make recommendations to the Center on research priorities, study methods and dissemination techniques. A majority of the Commission would be health care practitioners, consumers or patients. This Commission would also support forums to increase stakeholder awareness and gather feedback on the Center's activities. A provision was included to prevent the Center or Commission from mandating payment, coverage or reimbursement policies. In addition, the Commission would have to include a researcher with expertise in racial and ethnic minorities.

The Senate bill calls for establishment of an independent Patient-Centered Outcomes Research Institute to identify research priorities and conduct research on comparative effectiveness. The Institute would be overseen by a Board that would have to include three consumer/patient representatives and would be assisted by expert advisory panels that would also have to include consumers/patients. In addition, the Finance bill would include a provision requiring that consumer/patient representatives must be adequately supported to help them more effectively engage on complex research topics.

Quality Measures:

Both bills would provide direction and funding for additional quality measure development and best practices research and implementation. The House bill would direct the Secretary of HHS to establish national priorities for quality improvement taking into account among other factors those chronic conditions that impose a high burden of disease and health disparities and provide \$10 million for this purpose. In addition, this bill would provide \$125 million to fund quality measure development in areas identified as priorities and are directed to include measures of patient experience and engagement.

The Senate bill would direct the Secretary to establish a national quality improvement strategy setting priorities including how to address the health care needs of those with high cost chronic disease and how to address disparities across populations and geographic areas. In addition, the Secretary would be charged with developing quality measures to fill identified gaps or where preexisting quality measures need improvement. The bill would provide \$75 million over five years for this purpose and another \$20 million to promote endorsement and use of these measures in reporting and payment under federal health programs.

The House would establish a shared decision-making demonstration program under Medicare for thirty eligible providers including specialists. (The HELP bill would give grants to the National Quality Forum to develop and test shared decision-making tools and to develop quality measures related to the use of these tools. – not yet found in Senate bill)

Prevention:

There are a number of provisions in both bills to improve access to prevention and wellness services.

The Senate bill would establish a national prevention and public health council to coordinate the work of a number of federal agencies and a prevention and public health investment fund to create a stable funding stream for prevention, wellness and public health activities.

This bill would also improve coordination of the two federal preventive services task forces and establish calls for a public/private partnership to develop an education and outreach campaign regarding preventive benefits (mainly focused on physical activity, nutrition, and smoking cessation).

A temporary program to cover preventive services for the uninsured would be provided until full coverage could be offered through the new Gateways. And, all insurance policies would be required to include incentives for preventive services.

The Senate bill would also support additional research on public health and prevention delivery and the CDC is directed to evaluate employer wellness programs.

The Senate bill would require Medicare to cover preventive services approved by the US Preventive Services Task Force (USPSTF) with no cost-sharing and would increase federal Medicaid funding by one percentage point for states that elect to cover all preventive services approved by the USPSTF with no cost-sharing. The Finance bill would also establish healthy lifestyle incentives in Medicare and Medicaid to provide incentives to enrollees who successfully complete healthy lifestyle programs.

The Senate bill would establish a new Medicare benefit covering an annual wellness visit including a health risk assessment and development of a personalized prevention plan with mental health included.

The House bill would also require coverage of preventive services under Medicare and Medicaid with no cost-sharing. The House bill also establishes a prevention trust fund and calls for development of a national prevention and wellness strategy about which SAMHSA must be consulted. The House would strengthen the two Preventive Services Task Forces and rename them the Task Force on Clinical Preventive Services (which would be required to include an expert on clinical counseling and behavioral services for primary care patients) and the Task Force on Community Preventive Services - both of which would have to establish stakeholder advisory groups to include health care consumers and patients and federal agencies. The House also would fund community prevention research and services grants.

Both bills would include preventive services in the essential benefits package “including” those recommended by the Preventive Services Task Force and Centers for Disease Control (and the Health Resources and Services Administration guidelines for children and adolescents in the Senate) and would prohibit cost sharing for those services.

The House bill would create a state option for nurse home visitation services under Medicaid and a grant program for home visitation programs. And, the Senate bill would establish a new state grant program for early childhood home visitation funded at \$1.5 billion over five years.

Both bills would provide additional grant funding for school-based health clinics and explicitly direct these clinics to include mental health and substance use assessments, treatment and referrals. Funding to be appropriated.

The Senate bill would establish community transformation grants to fund primary community-based prevention initiatives that would assess changes in mental health as the prevalence of other chronic diseases. In addition, the Senate bill would establish Healthy Aging grants for state or local health departments and mental health and substance use are among the conditions targeted for reduction.

The House bill does not include an amendment sponsored by Representatives Patrick Kennedy (D-RI) that was adopted by the Education and Labor Committee. This amendment would have required that mental health and substance use disorder services including screening, brief intervention, and referral to treatment services (SBIRT) would be covered as reimbursable preventive services. Instead, the House bill includes a provision establishing a grant program to fund mental health and substance abuse screening, brief intervention, referral, and recovery services for individuals in primary health care settings.

The Senate bills include provisions to give employers more flexibility to vary premiums for employees who participate in wellness programs by 30 percent (and possibly up to 50 percent if approved by federal agencies). There is a concern that this will drive up premiums for individuals unable to participate in these programs or meet the health status goals set by these programs and is a back door to premium rating based on health status. The House bill includes a less problematic provision that calls for research into providing financial incentives of this kind to promote wellness and would fund grants to small businesses to cover 50 percent of the cost of qualified wellness programs which would include components to address behavioral health issues.

Workforce Development:

Both bills include a number of helpful workforce development programs specific to mental health.

The Senate bill includes loan repayment programs that would include child and adolescent behavioral health providers and education and training grants specifically directed to mental and behavioral health, as well as programs to educate primary care providers about the integration of mental health and physical health, chronic disease management, and treating vulnerable populations including those with mental health or substance use conditions.

The House bill includes a grant program to support interdisciplinary mental and behavioral health training programs including providing financial assistance to persons attending accredited programs. The House bill also would authorize reimbursement of marriage and family therapists and mental health counselors under Medicare. In addition, the House bill would expand the National Health Service Corps which includes behavioral health professionals.

The Senate bill would establish a National Health Care Workforce Commission to assess workforce needs and the high priority list includes mental and behavioral health workforce capacity. The Senate bill would also establish “Teaching Health Centers” to increase training and improve access to primary care services and could include community mental health centers.

Additional Provisions with Mental Health Implications:

The House and Senate bills include provisions to support research on postpartum depression and Finance would also provide support services to women with this condition.

The House and Senate bills also include many other provisions affecting Medicare including a provision to provide a 50 percent discount on brand name medications to beneficiaries when they hit the coverage gap (i.e., “doughnut hole”) in Part D. The House bill would close the doughnut hole by 2019. The House bill would also direct the Secretary of HHS to negotiate drug prices for Medicare Part D. The Senate bill also includes a provision to strengthen the policy ensuring Part D coverage of mental health medications.

The House and Senate bills include a three-year demonstration program to allow Medicaid coverage of private inpatient psychiatric facilities (i.e., IMDs). House would also include public facilities.

The House bill would prohibit states from terminating Medicaid coverage when a youth is incarcerated in a public institution to ease transition upon release from the institution.

The House bill also include provisions to strengthen Medicaid coverage of therapeutic foster care services by defining this benefit and stating that nothing in the bill limits a state from covering such services in out-of-home placements. (This was left out of the leadership Senate bill.)

In addition, the Senate bill includes a provision to remove barbiturates and benzodiazepines from Medicaid’s excluded drug list as of 2014.

The House bill includes a large section entitled Indian Health Care Improvement that includes many provisions to improve access to behavioral health services.

State Responsibilities:

The Senate bill would require the states to establish the health insurance exchanges or gateways and provide oversight with regard to new insurance market regulations and consumer protections. Under both bills, the states would be responsible for implementing the Medicaid

eligibility expansions. The Senate bill would also give grants to the states to establish or fund pre-established ombudsman or health insurance consumer assistance offices to help people with complaints about private insurance plans. Under the House bill the states would be charged with helping to coordinate enrollment of individuals into the national exchange plans. In addition, with the repeal of the CHIP program in 2013, the states would undoubtedly be involved in transferring individuals into Medicaid and the Exchange plans.

Ensuring parity is fully implemented in state-based exchanges will be an important issue.

Another critical aspect of implementation will be monitoring the benefits that will be available to Medicaid expansion populations. Under the Senate bill, states could choose to offer these new enrollees a lower level of coverage modeled after private insurance plans. But, the Senate bill also states that these benefit packages would be subject to the minimum coverage requirements that would apply to plans in the state-based exchanges – presumably including the requirement to provide mental health and substance abuse services as well as the parity requirement. State advocates will have to be vigilant to ensure that mental health and substance abuse services are included in the benefits offered to these new enrollees and that parity applies.

State advocates should also be aware that the Senate bill would allow for national plans that would be exempt from state parity and benefit mandates and other consumer protection laws, but states may be able to opt out of these national plans.

Another area of concern is the lack of an adequate maintenance of effort requirement regarding benefits covered under Medicaid which could lead to benefit cuts and eligibility cuts later on.