Senate Finance Committee Health Care Reform Bill

Below is a review of those measures contained in the Senate Finance Committee’s draft on health care reform that correspond to issues contained in the NLN *Public Policy Agenda*. The Finance Committee will eventually combine its bill with the Senate Health, Education, Labor, and Pension (HELP) Committee’s bill prior to Senate floor debate.

**Status of Health Care Reform**

In the House, the three committees with jurisdiction – Energy & Commerce, Education & Labor, and Ways & Means – passed their health care reform bill in the during the spring and summer. With the exception of some negotiations that still need to occur with members of the Blue Dog Coalition (a group of fiscally conservative House Democrats); the House Tri-Committee bill should be debated on the House floor in October.

The HELP Committee passed its bill out of committee in mid-July. Since then it has been waiting for the Finance Committee to produce its draft in order to incorporate the two bills.

The Senate Finance Committee began its markup the week of September 21. The committee’s intent was to finish its markup, combine the two bills, and bring the combined bill to the Senate floor the week of September 28. Since the Finance Committee did not complete its markup last week, the schedule was pushed back. Right now, we are looking at the potential for a committee vote this week.

Currently, it is unclear if the House and Senate will be able to stay on their self-imposed timelines to get a final bill to the president by the end of October.

**Health Care Workforce Issues**

**Proposal on Development of a National Workforce Strategy**

The secretary of Health and Human Services (HHS) is charged with creating a Workforce Advisory Committee. The committee is composed of external stakeholders and representatives of health professionals, schools of higher education for health care professionals, public health experts, health insurers, business, labor, state or local workforce investment boards, and any other health professional organization or practice the secretary determines appropriate.

These stakeholders will develop and present a national workforce strategy to the secretary and the Congress that sets the nation on a path toward recruiting, training, and retaining a health workforce that meets the nation's current and future health care needs. In developing this strategy, the committee is to consult closely with relevant federal agencies, such as the Health Resources and Services Administration (HRSA) and the Veterans Administration, to avoid duplication of effort and to review government-wide federal workforce policies. It is also to consult with state and local entities. The committee will present biannual reports to Congress, relevant federal agencies, and the public, outlining its findings and policy recommendations. Specifically, the committee will examine the current and projected health care workforce supply; the current and projected demand for health professionals; the health care workforce education training capacity; the implications of new and existing federal policies which will affect the health care workforce; and finally, the health care workforce.
needs of specific populations, including minorities, rural and urban, and medically underserved populations.

In addition, the committee will report on specific high-priority topics including efforts to integrate the health care workforce into a reformed delivery system, the implications for the health care workforce as a result of greater utilization of health information technology, nursing workforce capacity, mental and behavioral health care workforce capacity, and the geographic distribution of health care providers.

**Demonstration Project to Address Health Professions Workforce Needs**
The chairman’s mark provides funding for demonstration grants to address the needs of the health professions workforce. The competitive grants will provide aid and supportive services to low-income individuals with the opportunity to obtain education and training for occupations in a health care field that is experiencing labor shortages or is in high demand. The HHS secretary, in consultation with the secretary of labor, will make these grants to states, Indian tribes, tribal organizations, institutions of higher education, local workforce investment boards, or community-based organizations. At least three grants must be awarded to an Indian tribe, tribal organization, or tribal college or university.

**Insurance Coverage/Reform**

**Benefit Options**
Four benefit categories will be available: bronze, silver, gold and platinum. No policies can be issued in the individual or small group market (other than grandfathered plans) that did not meet the actuarial standards described below. All health insurance plans in the individual and small group market will be required, at a minimum, to offer coverage in the silver and gold categories.

All plans must provide preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by federal and state laws. In addition, plans cannot charge cost sharing (e.g., deductibles, copayments) for preventive care services, except in cases where value-based insurance design is used. Plans also cannot include lifetime limits on coverage or annual limits on any benefits. Any insurer that rates on tobacco use must also provide coverage for comprehensive tobacco cessation programs including counseling and pharmacotherapy (prescription and non-prescription). These provisions will all be within the actuarial value of the appropriate benefit level.

Each plan design for products in the state exchanges will be required to apply parity for cost sharing for treatment of conditions within each of the following categories of benefits: (1) inpatient hospital; (2) outpatient hospital; (3) physician services; and (4) other items and services, except in cases where value-based insurance design is used. Each plan design will also be required to meet the class and category of drug coverage requirements specified in Medicare Part D. (Generally, Part D plans must offer two drugs in each class or category.) States may permit some flexibility in plan design to encourage widely agreed upon cost and quality effective services.

Insurers participating in the state exchanges will be required to charge the same price for the same products in the entire service area as defined by the state regardless of how an individual purchases
the policy (i.e., whether the policy is purchased inside or outside the state exchange from the carrier or an agent).

**Health Care Affordability Tax Credits**
Provides a refundable tax credit for eligible individuals and families who purchase health insurance through the state exchanges. The premium tax credit will subsidize the purchase of certain health insurance plans through the state exchanges and will be refundable and payable in advance directly to the insurer. The tax credit would be available for individuals (single or joint filers) with Modified Adjusted Gross Incomes (MAGI) up to 300 percent of the federal poverty level (FPL).

**Small Business Tax Credit**
Provides a tax credit for a qualified small employer for contributions to purchase health insurance for its employees. A qualified small employer generally would be an employer with no more than 25 fulltime equivalent employees (FTEs) employed during the employer's taxable year, and whose employees have annual fulltime equivalent wages that average no more than $40,000. However, the full amount of the credit would be available only to an employer with ten or fewer FTEs and whose employees have average annual fulltime equivalent wages from the employer of less than $20,000. The credit would not be payable in advance to the taxpayer or refundable. The employer would pay the employees' premiums during the year and claim the credit only at the end of the year on the employer's income tax return.

**Personal Responsibility Requirement**
Beginning in 2013, all US citizens and legal residents would be required to purchase coverage through (1) the individual market, a public program such as Medicare, Medicaid, the Children's Health Insurance Program, Veteran's Health Care Program, or TRICARE or through an employer (or as a dependent of a covered employee) in the small group market, meeting at least the requirements of a bronze plan, or (2) in the large group market, in a plan with first dollar coverage for prevention-related services. Exemptions from the requirement to have health coverage will be allowed for religious objections that are consistent with those allowed under Medicare, and for undocumented aliens. An individual enrolled in a grandfathered plan will be deemed to have met the responsibility requirement.

In order to ensure compliance, individuals would be required to report on their federal income tax return the months for which they maintain the required minimum health coverage for themselves and all dependents under age 18. In addition to this self-attestation by individuals of qualified coverage, insurers (including employers who self-insure and therefore act as insurers) must report information on health insurance coverage information to both the covered individual and to the IRS. A similar reporting requirement would apply to employers with respect to individuals enrolled in group health plans if the reporting is not provided by the insurer (for example in the case of self-insured plans) and for those enrolled in public health insurance plans.

**Children's Health Insurance Program**
The chairman's mark changes the structure of CHIP. Upon enactment, states would be required to maintain income eligibility levels for currently eligible children. This requirement would expire as of September 30, 2013. There would be no other federal changes to CHIP prior to the end of the current reauthorization period (September 30, 2013) or until the secretary of HHS determines that the state exchange is operational, whichever occurs later. After such date, the chairman's mark would establish a federal floor for CHIP eligibility at 250 percent of FPL – requiring states to offer CHIP to all children between 134 percent and 250 percent of FPL. After the above date, CHIP income
eligibility will be based on modified adjusted gross income, the same measurement that would be used in Medicaid and the state ex-changes.

**National Strategy to Improve Health Care Quality**
Directs the HHS secretary to establish a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health through a transparent and collaborative process. In their development, the secretary will consider how the priorities would: address health care needs of those with high-cost chronic diseases; improve strategies and best practices to improve patient safety and reduce medical errors, preventable hospital admissions and readmissions, and health care-associated infections; have the greatest potential for improving the health outcomes, efficiency and patient-centeredness of health care; reduce health care disparities across populations and geographic areas; address gaps in quality, efficiency and outcomes measures and data aggregation techniques; identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care; improve payment policy under federal health programs to emphasize quality and efficiency; and enhance the use of health care data to improve quality, efficiency, transparency, and outcomes.

The national strategy will also include a comprehensive strategic plan to achieve the priorities established. At a minimum, the strategic plan will include provisions for addressing coordination among agencies within HHS; agency specific strategic plans, where appropriate, along with annual benchmarks to achieve the priorities; and strategies to align incentives among public and private payers with regard to quality and patient safety efforts.

In developing the national strategy and priorities, the secretary will take into consideration recommendations submitted by a qualified consensus-based entity as set forth in the *Medicare Improvements for Patients and Providers Act of 2008*. To develop these recommendations, the qualified consensus-based entity will convene a multi-stakeholder group. Stakeholders will include, but will not be limited to, representatives of hospitals, physicians, post-acute providers, quality alliances, nurses and other health care practitioners, health plans, consumer representatives, life sciences industry, employers and public purchasers, labor organizations, licensing, credentialing and accrediting bodies, and relevant government agency representatives.

**Interagency Working Group on Health Care Quality**
The president will convene a working group consisting of relevant federal departments and agencies that will collaborate and consult on fulfilling the national quality improvement strategy and priorities. No later than a date determined appropriate by the secretary and annually thereafter, the working group will submit a report to the secretary on the progress and recommendations of the working group. This report will take into consideration a national quality improvement strategy and related reports to Congress as outlined in previous sections.

**Prevention and Wellness**

**Removing Barriers to Preventative Services**
Encourages Medicare beneficiaries to receive preventive screenings by removing cost sharing (co-payment and deductible) for services covered by Medicare and recommended by the US Preventive Services Task Force (USPSTF).
Evidence-Based Coverage of Preventative Services
The chairman’s mark encourages evidence-based coverage of preventive services by giving the secretary the authority to use the same standards of evidence that apply to any new preventive services to existing preventive services in Medicare. The HHS secretary can modify coverage of existing preventive services to the extent that the modification is consistent with USPSTF recommendations. The mark also allows, but does not require, the secretary to withdraw Medicare coverage for services rated very low or harmful by USPSTF. It provides funding for CMS to improve provider education and patient awareness of covered preventive services and requires a GAO study to determine if any barriers exist that prevent the optimal utilization of covered primary, secondary, and tertiary preventive services.

Incentives for Healthy Lifestyles (Medicare)
Authorizes and appropriates $100 million over five years for the HHS secretary to establish an initiative to provide incentives to Medicare beneficiaries who successfully complete certain healthy lifestyle programs. Programs will target the following risk factors: high blood pressure, high cholesterol, tobacco use, overweight or obesity, diabetes and falls. The secretary will establish a system to monitor beneficiary participation and validate the results, as well as set standards and health status targets for participating beneficiaries. Prior to establishing the initiative, the secretary will review evidence concerning healthy lifestyle programs and providing incentives to individuals for participating in such programs. The initiative will be implemented on January 1, 2011.

Incentives for Healthy Lifestyles (Medicaid)
The HHS secretary will develop criteria for healthy lifestyle programs using relevant, evidence-based resources. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. The secretary will also set targets for measuring health status improvements. After the secretary develops criteria, states could design a proposal and apply for funds to provide incentives to Medicaid enrollees who successfully complete healthy lifestyle programs. States are permitted to collaborate with community-based programs, non-profit organizations, providers, and faith-based groups, among others. The state is required to establish a system to monitor beneficiary participation and validate health outcomes. The mark authorizes $100 million in funding for these grants during a five-year period beginning January 1, 2011.

Improving Access to Preventive Services for Eligible Adults
The chairman’s mark encourage states to improve coverage of and access to recommended preventive services and immunizations in Medicaid. At a minimum, states will be required to provide Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost sharing for such services. Additionally, a state that opts to provide Medicaid coverage for all USPSTF (described in an earlier section) recommended services and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), as well as removes cost sharing for those services, would receive a one-percentage point increase in the federal share of its Federal Medical Assistance Percentage.
Primary Care

Medicaid State Plan Option Promoting Health Homes and Integrated Care
Creates a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home. Qualifying providers will have to meet certain standards established by the HHS secretary, including demonstrating that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. The designated provider or a team of health professionals will offer the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant and as feasible use health information technology to link such services.

Teams of providers could be free-standing, virtual, or based at a hospital, community health center, clinic, physician's office, or physician group practice. Designated providers are required to report to the state on all applicable quality measures in the state Medicaid program. The state will develop a mechanism to pay the health home for services rendered. The state plan amendment will include a plan for tracking avoidable hospital readmissions and for producing savings resulting from improved chronic care coordination and management. The mark provides an enhanced match of 90 percent FMAP for two years for states that take up this option. In addition, small planning grants may be available to help states intending to take up this option.

The mark requires the HHS secretary to survey states and report to Congress on the nature, extent, and use of this option, particularly as it pertains to hospital admission rates, chronic disease management, and coordination of care for the chronically ill. The state option will be available beginning January 1, 2011. After two years, there will be an independent evaluation of the impact of this option on reducing hospital admissions.