

Initial Summary of the “Framework for Comprehensive Health Reform”

On September 8, Senate Finance Committee Chairman Max Baucus released the Framework for Comprehensive Health Reform, which details a plan for consideration by the Senate Finance Committee ‘Gang of 6’. Senator Baucus has stated that this document is not meant to serve as a Chairman’s Mark (or draft bill). The Finance Committee Mark may include provisions not included in the Framework. The following information is the National Council’s initial summary of provisions of interest to community mental health and addiction provider agencies. Questions? Please [contact](#) Chuck Ingolia at the National Council.

IMMEDIATE RELIEF FOR FAMILIES AND SMALL BUSINESSES

Part D Drug Discount Program

Beginning in 2010, drug manufacturers must provide a 50% discount off the negotiated brand-name drug covered on formularies when beneficiaries enter the coverage gap or ‘donut hole’.

ENSURING AFFORDABLE HEALTH COVERAGE

Insurance Market Reforms

Insurance plans will be prohibited from 1) excluding coverage for pre-existing conditions, 2) rescinding coverage, and 3) establishing lifetime limits. Effective date for the individual market is January 1, 2013; for the small group market, these changes can be phased in over a period of up to 5 years, beginning January 1, 2013.

Parity: The mandatory benefit package for individual and small group market insurance plans include “mental health and substance abuse services that meet minimum standards set by federal and state laws”, preventive and primary care, emergency services, hospitalization, and prescription drugs.

Commercial Insurance: Coverage offered by an employer of any size (including self-insured and fully insured plans) does not have to comply with the above mentioned mandatory benefit package. Employers must provide first dollar coverage for prevention services and cannot have a maximum out-of-pocket limit greater than that provided by the standards established for Health Savings Accounts (HSAs).

Multi-State Insurance Provisions: Beginning in 2015, states may create “health care choice compacts” to allow for the purchase of individual insurance across state lines. Insurers selling plans through these compacts would only be subject to the laws of the state in which the policy is written/issued.

State Health Insurance Exchanges: State exchanges for the individual and small group markets will facilitate enrollment through 1) a standardized enrollment application, format for describing insurance options, and marketing; 2) the creation of call center support and customer service. Exchanges must be self-sustaining after the first year.

Ensuring Affordable Coverage

Tax Credits: Tax credits to offset the cost of premiums would be based on the % of income the cost of premiums represents. So, these credits would range from 3% of income for individuals/families at 100% of FPL to 13% of income for those at 300% of FPL. These tax credits apply as of 2013 for individuals/families between 134-300% of FPL and in 2014 for individuals/families between 100-133% of FPL.

Shared Responsibility

Individual Responsibility, Exemptions, & Penalties: Beginning in 2013, all U.S. citizens and legal residents will be required to have some form of insurance, unless they are eligible for exemption due to religious reasons, hardship, are Native American, or are at or below 100% of FPL. For 2013, individuals at or below 133% of FPL will be exempt. A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid (Note: If employee chooses this option, the employer is not required to pay an assessment. See Employer Pay or Play below)

For taxpayers between 100-300% of FPL, the penalty for not having insurance is \$750/year with a maximum/family of \$1500. For those with incomes above 300% of FPL, the penalty is \$950/year with a max/family of \$3800.

Employer Pay or Play: Employers are not mandated to provide coverage; however, if firms with more than 50 employees do not, they must pay an assessment/employee. The assessment is based on the amount of the tax credit received by the employees, but would be capped at \$400/employee.

Health Care Co-Ops

The Framework authorizes federal grant funding for the creation of health care Co-ops that would compete in the reformed individual and small group markets. Federal loans will be provided to assist with start-up costs. These Co-Ops would be permitted to enter into collective purchasing arrangements for services and items that increase administrative and other cost efficiencies. Any profit must be used to lower premiums, improve benefits, or for other programs intended to improve the quality of services delivered.

Federal grant and loan funding will be awarded by the Secretary of HHS and will be given to statewide proposals, integrated care models, and applications with significant support. Multiple awards/state are allowed; distribution of funds will begin by January 1, 2012. In the event that Co-Ops are not established in every state, the Secretary is authorized to use planning grants to encourage Co-Op formation/expansion from other states.

Role of Public Programs

Individual Medicaid Eligibility: As of January 1, 2014, Medicaid income eligibility will be expanded nationwide as follows: 1) Parents increased to 133% of FPL; 2) Kids aged 6 and older increased to 133% of FPL; 3) Childless adults otherwise ineligible for Medicaid would receive coverage if at or below 133% of FPL (individuals meeting the criteria for this new eligibility category would be guaranteed a benchmark benefit package). Coverage for pregnant women would not change.

Medicaid Maintenance of Effort (MOE): Upon enactment, states would be required to maintain existing income eligibility levels for all populations. This MOE requirement would expire when the state-based exchanges become fully operational (expected Jan. 1, 2013), except as it applies to coverage at income levels of 133% of FPL or below, for which it would continue until January 1, 2014.

Increased Federal Medicaid Match: In an effort to defray the cost of covering childless adults at or below 133% of FPL, additional federal assistance will be provided to the states. Greater assistance will initially be given to states that do not currently cover this population, compared to states that currently cover at least some non-elderly non-pregnant individuals. By 2019, all states will receive the same level of additional assistance.

CHIP: States are required to maintain their current CHIP eligibility levels through 2012. Beginning 2013, CHIP beneficiaries would enroll in exchange plans and states provide a “CHIP-wrap” to provide supplementary benefits (inc. EPSDT). A federal floor for CHIP income eligibility for kids and pregnant women is set at 250% of FPL.

Prescription Drug Coverage: Prescription drugs would become a mandatory Medicaid benefit. Medicaid prescription drug rebates will be increased, with the minimum rebate percentage for single-source and innovator multiple source drugs increasing from 15.1% to 23.1% and from 11% to 13% for generic drugs.

Addressing Health Disparities: Racial and ethnic data collection will be standardized across all federal health care programs and new standards will be established for access and treatment for individuals with disabilities.

PROMOTING DISEASE PREVENTION AND WELLNESS

Medicaid

Incentive for States: States will receive 1% increase in their FMAP if they choose to provide Medicaid coverage for all recommended preventive services without cost-sharing for these services.

Incentives for Individuals: \$100M is authorized to the Secretary to grant funds to states who wish to provide incentives to Medicaid enrollees who improve their health status and complete scientifically-based healthy lifestyle programs that target specific conditions, including depression.

Medical Home State Option: A new Medicaid state plan option for Medicaid beneficiaries with chronic conditions (note: specific conditions are not identified) will be established. Qualifying providers (note: not defined) would have to demonstrate 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.

IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Encouraging Development of New Patient Care Models

Accountable Care Organizations: Groups of providers could work together to improve quality of care they provide to Medicare beneficiaries and can keep half of the savings they achieve over a three-year period.

Reducing Avoidable Hospital Readmissions: Directs CMS to track national and hospital-specific data on the readmission rates for Medicare participating hospitals for certain high-cost conditions that have high rates of potentially avoidable hospital readmissions. Starting in 2011, hospitals with readmission rates above a certain threshold will receive reduced payments for the original hospitalization (by 20%) if a patient with a selected condition is re-hospitalized with a preventable readmission within 7 days or by 10% if re-hospitalized within 15 days.

Transitional Care Program: Funds eligible hospitals and community-based partnership organizations that provide patient-centered, evidence-based transitional care services to Medicare beneficiaries at the highest risk of preventable re-hospitalization.

Ensuring Beneficiary Access to Physician Care and Other Services

Medicare Sustainable Growth Rate: The scheduled 21% reduction in Medicare physician payment rates in 2010 would be replaced with a .5% increase.

Medicare Advantage

Special Needs Plans (SNPs): SNPs would be extended through 2013, along with some policy changes to the SNP program (note: no further detail).

Medicare Part D

Six-Protected Classes: The existing Part D six-protected classes will be codified.

FRAUD, WASTE, AND ABUSE

Fraud, waste and abuse in Medicare and Medicaid would be reduced by a series of provisions to prevent and deter wasteful or fraudulent activity including a new enrollment process for providers and suppliers (including an application fee), data matching and sharing across federal health care programs, new procedures to disclose and repay overpayments, and more.

REVENUE PROVISIONS

The Framework identifies several ways in which this reform proposal will be funded, including:

Excise Tax: To be levied on insurance companies/administrators for any insurance plan that is above \$8,000 for singles and \$21,000 for family plans. This tax only applies to self-insured plans and plans sold in the group market (i.e. not individual plans).

Health Insurance Provider Fee: Beginning 2010, an annual fee of \$6 billion will be imposed on the health insurance sector. The fee would be allocated by market share.