

A Rural Perspective/Commentary Regarding
(Description of Policy Options)
“Expanding Health Care Coverage:
Proposals to Provide Affordable Coverage to All Americans”
Senate Finance Committee
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Commentary provided by
RUPRI (Rural Policy Research Institute) Health Panel

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This document includes commentary from the Rural Health Panel on proposed options we feel have special, significant meaning for rural areas. An appendix describes proposed options for which we are not offering commentary at this time.

SECTION I: INSURANCE MARKET REFORM

I.1: Non-Group and Micro-Group Market Reforms

Proposed Options

- Federal rules for the non-group and micro-group (2-10 employees) market
 - Guaranteed issue and guaranteed renewal on all coverage
 - Prohibit exclusion for pre-existing conditions
 - Rates based on tobacco use (up to 1.5:1), age (up to 5:1), and family composition (up to 3:1)
 - Premiums could vary to reflect geography
- Total variation in premiums could not exceed 7.5:1
- Secretary would implement system for risk adjustment comparable to what Medicare uses for private plans; new market plans and grandfathered plans subject to “collective system of risk adjustment for a combined pool”
- Secretary could administer risk adjustment or require states to do so

Rural Commentary

- Many individuals in rural areas are self-employed, so market reforms of the non-group market are critically important. Because it is difficult to anticipate the effect of the proposed regulations in rural areas, it would be beneficial to include a demonstration during the phase-in period, to ensure that policies work as intended.

I.2: Small Group Market Reforms

Proposed Options

- Currently HIPAA requires coverage sold to firms with 2-50 employees be sold on guaranteed issue basis and requires renewal; limits duration of pre-existing conditions
- All states now require issuers to offer to firms with 2-50 workers on guaranteed issue basis with reduced time for excluding pre-existing conditions
- *Proposed option:* same federal rating rules that apply to non-group and micro-group markets would apply to remainder of small group market (as defined by states)
- *State option:* States would merge pooling and rating rules for non-group and small-group markets

Rural Commentary

- The final impact of regulations on the small group and individual markets, including actuarial limits, should be that persons with similar health profiles and demographic characteristics should be able to obtain comparable coverage with comparable cost in large employer groups and in the small group and individual market by using health insurance exchanges. Because of the structure of the rural economy and disproportionately high rates of chronic illness in rural areas, this should be a particular focus.

- The actuarial value of plans offered in rural and urban areas should be comparable. This is currently not the case: the overall actuarial value of plans offered in nonmetropolitan counties is 79.9%, compared with a value of 83.9% in metropolitan counties.¹

I.3: Health Insurance Exchange (HIE)

Proposed Options

- All state-licensed private insurers and the public health insurance option if applicable would be required to participate in the HIE
- Private insurers would also be permitted to sell directly to purchasers
- Micro-groups (2-10 employees) could purchase through the HIE immediately
- Other small employers could purchase through HIE once federal rating rules are fully in by their state; would have to pick only one of the four benefit levels
- Tax exclusion under current law would apply when small business opts to purchase through HIE
- Secretary to establish HIE that enables individual to receive state-specific information; could contract with private entity to operate HIE
- Functions performed by Secretary:
 - Develop standard enrollment application for individuals and small businesses
 - Provide standardized format for presenting insurance options, including benefits, premiums and provider networks (sortable by ZIP code or providers)
 - Develop standardized marketing requirements modeled after MA
 - Maintain call center support including multilingual assistance
 - Enable consumer to enroll on site in hospitals, schools, departments of motor vehicles, local Social Security offices, emergency rooms and other offices designated by the state
 - Establish rate schedules for broker commissions
 - Establish web portal
 - Establish plan for publicizing existence of HIE
 - Establish procedures for enrollment, eligibility determinations for low-income credits, etc.
- State Insurance Commissioners establish procedures for review of plans and plan to decertify plans
- *Option:* multiple competing exchanges, with a national exchange that enables review of state-specific information; could have multiple HIEs in same geographic area; carriers could not operate as HIE or selective participate in one or multiple HIEs

Rural Commentary

- State insurance commissioners should establish procedures to compel plans to assure access to services, defined as maintaining historical patterns of access to primary care and other local services such as emergency care and basic hospital services.
- Practices used to market and sell insurance policies, both through exchanges and in direct contact between insurance agents and consumers, will need to be monitored in rural areas to

¹Gabel J, McDevitt R, Gandolfo L, et al. (2006). Generosity and adjusted premiums in job-based insurance: Hawaii is up, Wyoming is down. *Health Affairs*, 25(3), 832–843.

assure rural residents receive relevant information in an unbiased manner, including using local groups similar to the CMS practice of enrolling “partners” to help with Medicare Part D, and regulating insurance activities similar to how that is done in Medicare Part D.

I.4: Transition: See appendix.

I.5: Role of State Insurance Commissioners

Proposed Option

- State insurance commissioners continue plan oversight with regard to consumer protections, rate reviews, solvency, reserve requirements, and premium taxes
- Federal fallback if states do not adopt federal rating rules
- Rating areas defined by State Insurance Commissioners and reviewed by the Secretary
- Rating areas would allow for exceptions, be required to allow for pooling of similar cost people, and be risk adjusted across the areas

Rural Commentary

- Rating areas should not repeat the Medicare managed care experience of wide variation and volatility in rates because of using a county basis for rating. A more appropriate model would be that used by at least some insurers, creating very large regions that smooth out those differences. Analysis should precede final setting of policy to strengthen evidence-based expectations of effects on affordability of coverage in rural areas.

SECTION II: MAKING COVERAGE AFFORDABLE

II.1: Benefit Options

Proposed Options

- All plans in non-group and small group market required to provide a broad range of benefits including but not limited to:
 - Preventive and primary care
 - Emergency services
 - Hospitalization
 - Physician series
 - Outpatient services
 - Day surgery and related anesthesia
 - Diagnostic imaging and screenings, including x-rays
 - Maternity and newborn care
 - Medical/surgical care
 - Prescription drugs
 - Radiation and chemotherapy
 - Mental health and substance abuse services
- Plans could not include lifetime limits on coverage or annual limits on any benefits and cannot charge cost-sharing for preventive care services
- Insurers required to offer all four options:
 - High option with actuarial value (percentage of health care expenses paid by plan) of 93%

- Medium at 87% (approximately equal to FEHBP Blue Cross/Blue Shield standard option, as estimated by the Congressional Research Service)
- Low at 82%
- Lowest at 76%
- Plan design required to apply parity for cost-sharing conditions within these categories of benefits:
 - Inpatient hospital
 - Outpatient hospital
 - Physician services
 - Other items and services, including mental health
- Each plan design required to meet the class and category of drug coverage requirements specified in Medicare Part D
 - Insurers in the HIE required to charge the same price for the same products in entire service area as defined by the state regardless of how an individual purchases the policy

Rural Commentary

- Exclusion of a dental benefit from the basic package could exacerbate access problems in rural areas. Given the strong evidence linking oral health and medical conditions, dental benefits should be included in any comprehensive health care reform.
- Definition of the service area is an important rural consideration and requires assessment to be sure there is not an adverse affect on affordability.

II.2: Low-Income Tax Credits

Proposed Options

- Tax credit for low income taxpayers who purchase through HIE, refundable and paid in advance in form of premium subsidy
- Level of coverage: high benefit between 100 and 200 percent of federal poverty level; medium between 200 and 300 percent; low benefit option between 300 and 400 percent
- *Option:* calculate premium credit based on enrollment-weighted average premium of qualified low coverage option offered in service area, with cost sharing assistance up to valuation of high coverage option for lowest income, medium coverage between 200 and 300 percent of poverty

Rural Commentary

- Low-income tax credits are important for access to insurance in rural because of higher presence of low-income households in rural and higher likelihood of purchasing insurance through individual plans.
- Congress should consider prohibiting cost sharing for certain services based on income level of the insured to encourage prevention and not discourage utilization of needed services; for example many plans using health savings accounts have discontinued cost sharing for preventive services.
- A sliding scale should be considered as income increases so there is no sudden loss of subsidy.

II.3: Small Business Tax Credits

Proposed Option

- Tax credit for certain small employers for each full time (30 hours) employee covered, equal to 50% of the average total premium
- Full amount of the credit would be available to employer with 10 or fewer full time employees with average annual wages from employer of less than \$20,000; phase out above 10 employees to 25; and for incomes between \$20,000 and \$40,000
- Credit not payable in advance

Rural Commentary

- Will need to include seasonal employees for maximum impact in rural areas.

SECTION III: PUBLIC HEALTH INSURANCE OPTION

Proposed Option A

Issues to be resolved

- How providers will be reimbursed for services
- Whether or not public option will be required to establish provider networks or be able to compel providers to participate
- Whether public option required to have reserve funds
- Whether or not premiums collected by public option will be required to cover costs or if shortfall will be subsidized
- Administration by federal agency or by third party

Rural Commentary

- Many rural areas have persistent provider shortages. Adequate provider reimbursement and provider participation/contracting issues under a public plan need to be carefully considered so as not to exacerbate current workforce shortages.
- The answers to critical rural questions about private plans will determine whether there is a need for a public plan option:
 - Will rural areas be included within the service area of at least one private plan? Currently there are rural areas in which one carrier dominates the market. Should that carrier decide to reduce its service area access to insurance, coverage could suffer. Presence of affordable coverage is more than access to nationally advertised plans in the individual market; equity concerns would demand that there be active agents for the plan.
 - Will private plans marketed in rural areas contract with local primary care providers? Evidence from the Federal Employee Health Benefits Program indicates that plans may be available that do not use local providers.²

² McBride T, Mueller K, Andrews C, Xu L, Fraser R. (2003). *Enrollment in FEHBP plans in rural America: what are the implications for Medicare reform?*(Rural Policy Brief 8). Omaha, NE: RUPRI Center for Rural Health Policy Analysis. Available at www.unmc.edu/ruprihealth.

- Will private plans remain active in rural areas, or will there be market turnover that threatens access to affordable plans?
- Will there be a minimum number of plans (using local providers) available in rural areas to assure benefits of competition among plans?
- Critical issues related to the interaction of choice among plan options (including a public plan option) and access to medical services in rural areas:
 - Consider implementing payment policies and incentives to attract and retain health care professionals in rural areas (e.g., bonus payments, loan repayment policies, guaranteed minimum salaries).
 - Consider a payment system that differentially pays providers a sliding bonus based on societal needs for geographic provider distribution and specialty availability.
 - Reimbursement for alternative delivery modalities such as telemedicine.
- Continue special payment policies as a requirement for all plans to assure access to essential services, including cost-based reimbursement for Critical Access Hospitals, payment policies for Sole Community Hospitals and Rural Referral Centers, bonus payments for physicians, and cost-based reimbursement for rural health clinics.

Approach 1: Medicare-Like Plan

- Administered by new agency within DHHS
- Eligibility rules, markets and income-related tax credits mirror those for all other plans
- Medicare providers required to participate and be paid Medicare rates plus 1-10%
- Rating rules apply to public option same way they apply to all plans in the non-group and small group markets
- Risk adjustment apply in same way that it applies to plans offered through HIE in non-group and small group markets
- Public option incorporate any medical delivery system reforms adopted from the overall reform effort
- Would not have solvency requirements

Rural Commentary

- Payment using Medicare rates has to very clearly include all current special payment categories, including bonuses, in Medicare payment policy.
- Basing new payments on current Medicare methodology reinforces current Medicare inequities.
- Public plan solvency guaranteed by the government potentially increases taxpayer burden or threatens provider payment.
- Research is needed to determine minimum payment requirements of providers such that payments include a reasonable margin for all providers; without this evidence there is a risk that a dominant public plan option could threaten access to services because providers cannot meet their costs.
- Not clear if providers will not accept Medicare if they have to accept the public plan; if payment only marginally higher than Medicare may risk having places where providers accept neither.

- The public plan would be operating under different circumstance from private plans, which may require legislative consideration regarding where and under what circumstances to make the public plan available. Those considerations could include places where a very limited number of private plans (e.g., 0 – 3) offer options using local providers, places where there is a history of very limited or no access to affordable health plans using local providers, and places where particular populations have difficulty accessing affordable coverage.

Approach 2: Third Party Administrator

- Similar to proposal 1 with differences as follows
- Administered through multiple regional third-party administrators (TPAs) required to report to the Secretary
- Separate from agency overseeing completion among other private plans
- TPA required to establish networks of participating medical providers
- Payments for participating providers negotiated by TPAs
- Public option required to have reserve funds the plan, not the TPA, would maintain this reserve

Rural Commentary

- Given use of provider networks, should include access standards, based on historical patterns of utilization by community residents (standard applied to MA plans).
- Given a public option, negotiated payment should not be less than providers now receive from Medicare, protecting special payment categories.
- If this option is designed to create a competing public plan in markets where there are a limited number of private plans, the following elements of plans would need to be comparable across public and private options (assured by legislative requirements applying to *both* types of plans):
 - Payment to providers
 - Requirements to form provider networks
 - Standards for access to essential services
 - Reserve requirements
 - Rating used to determine premiums
 - Expectations for marketing
 - Support, or lack thereof, for innovation in the plans such as new methods for managing chronic illness

Approach 3: State-Run Public Option

- Either mandatory or optional for States with details of administration left to the States
- An option for States might be to allow individuals to purchase coverage through the State-employee plans

Rural Commentary

- Would need to enforce federal access standards in each state.
- Purchase through state-employee plans requires assurance that those plans contract with local providers throughout the state (current contracts could be concentrated in areas of the state)

with critical mass of employees) and that plans truly are accessible across the state, and are actuarially equivalent.

Proposed Option B

No public option and rely on private options in a reformed and well regulated private market

Rural Commentary

- Access standards would be critical, especially for primary care, public health services, and emergency services.
- Could severely restrict access to competing plans in remote rural areas.

SECTION IV: ROLE OF PUBLIC PROGRAMS

IV. 1: Medicaid Coverage

Rural impact of any Medicaid provisions:

Since Medicaid represents a higher percentage of coverage in rural than in urban areas and is one reason for a smaller difference in uninsurance rates as of 2008, any provisions expanding Medicaid coverage will likely have a slightly greater impact in rural areas.

IV.1a: Eligibility Standards and Methodologies: See appendix.

IV.1b: Medicare Program Payments: See appendix.

IV.1c: Options for Medicaid Coverage: See appendix.

IV.1d: Treatment of Territories: See appendix.

IV.2: Children’s Health Insurance Program (CHIP)

Proposed Option

- No federal changes to structure of CHIP prior to end of current reauthorization period (September 30, 2013) or to when HIE fully operational, whichever is later
- After that point CHIP income eligibility increased to 275% of FPL and CHIP programs not able to use low income disregards and income based on MAGI
- CHIP coverage would include Medicaid EPSDT benefit
- When HIE fully operational, CHIP enrollees obtain primary coverage through the HIE with CHIP as secondary payer
- HIE plans would have to contract with state to provide services to CHIP beneficiaries
- *Variations:* allow states to create or act as an HIE plan, allow Medicaid-only plans to participate in HIE, limit premium reimbursement of services covered by Medicaid that are not in HIE plan

Rural Commentary

- Including EPSDT benefits is important to rural given the importance of CHIP in covering rural children.

IV.3: Quality of Care in Medicaid and CHIP: See appendix.

IV.4: Other Improvements to Medicaid

IV.4a: Enrollment and Retention Simplification

Proposed Options

- Eliminate state option to rely on face-to-face interviews to determine eligibility and ability to apply an assets test for eligibility for acute care services
- States required to implement 12 month continuous eligibility, establish enrollment website, permit states to enroll and redetermine eligibility for all beneficiaries at DSH Hospitals, FQHCs and State DMVs, and extend administrative automatic renewal and Express Lane renewal to all Medicaid beneficiaries

Rural Commentary

- Eliminating the assets test could benefit rural residents owning farm/ranch properties that are not yielding current income above the eligibility threshold.
- Many rural areas do not have the proposed enrollment sites (such as DSH hospitals and, in some states, FQHCs). Consider including other sites for enrollment and determining eligibility in rural areas, such as Rural Health Clinics and Critical Access Hospitals.

IV.4b: Family Planning Services and Supplies: See appendix.

IV.4c: Treatment of Selected Option Benefits: See appendix.

IV.4d: Interstate Coordination Requirements for Child Medicaid Beneficiaries: See appendix.

IV.4e: Mandatory Coverage for Prescription Drugs

Proposed Options

- Make prescription drugs a mandatory benefit for categorically and medically needy

Rural Commentary

- Should be combined with meaningful access standards for pharmacy services. The current Medicare Part D access standards should not be used as a model, as they do not apply to many rural areas.

IV.4f: Change the Status of Some Excludable Drugs: See appendix.

IV.4.g: Changes to Medicaid Payment for Prescription Drugs

Proposed Option

- Increase the federal upper payment limits (FUPL) percentage from 250% to 300% of weighted average of the most recent average manufacturer price (AMP) for pharmaceutically and therapeutically equivalent multiple sources drugs available nationally through commercial pharmacies
- Clarify what discounts and other price adjustments were included in the definition of AMP (no detail provided)

- Change definition of multiple source drug from at least one other drug product to two or more drug products
- New prior authorization requirement would prevent more expensive drugs from being dispensed when generic equivalents are available absent medical necessity justifications

Rural Commentary

- Increasing the FUPL will help rural pharmacies struggling to maintain sufficient revenue from sales of prescription medication to remain in business by increasing their income from prescription medications, which for independent pharmacies that are the only retail service in their community typically represents over 80% of their income.
- Include a request to GAO or MedPAC to study the effects of treating certain rural pharmacies as critical points of access to pharmacy services and thereby establishing a special payment classification for those pharmacies.

IV.4h: Transparency in Medicaid and CHIP Section 1115 Waivers: See appendix.

IV.4i: Medicaid State Plan Amendments and Covered Benefits: See appendix.

IV.4j: Changes to the FMAP Formula

Proposed Option

- Incorporates state poverty level as well as state per capita income
- Base on two year average rather than current three-year average
- One third based on poverty rate and remove the squaring factor
- Year-to-year FMAP fluctuations capped at +/- two percentage points

Rural Commentary

- May increase federal share in states with high poverty in rural areas and statewide.

IV.4k: Automatic Countercyclical Stabilizer: See appendix.

IV.5: Medicaid Disproportionate Share (DSH) Hospital Payments : See appendix.

IV.6: Dual Eligibles

IV.6a: Waiver Authority for Dual Eligible Demonstrations

Proposed Option

- Congress would establish a new Medicaid demonstration authority of five years to explore alternative approaches to coordinating care for dual eligibles

Rural Commentary

- No less than 20% of the authorized demonstration sites should be rural.

IV.6b: Cost-Effectiveness Test: See appendix.

IV.6c: Office of Coordination for Dually Eligible Beneficiaries: See appendix.

IV.7: Medicare Coverage

IV.7a: Reduce or Phase-Out the Medicare Disability Waiting Period: See appendix.

IV.7b: Temporary Medicare Buy-In: See appendix.

SECTION V: SHARED RESPONSIBILITY

V.1: Personal Responsibility Coverage Requirement: See appendix.

V.2: Employer Requirement: See appendix.

SECTION VI: PREVENTION AND WELLNESS

VI.1: Promotion of Prevention and Wellness in Medicare

VI.1a: Personalized Prevention Plan and Routine Wellness Visit: See appendix.

VI.1b: Incentives to Utilize Preventive Services and Engage in Healthy Behaviors: See appendix

VI.2: Promotion of Prevention and Wellness in Medicaid

VI.2a: Access to Preventive Services for Eligible Adults: See appendix.

VI.2b: Incentives to Utilize Preventive Services and encourage Healthy Behaviors: See appendix.

VI.3: Options to Prevent Chronic Disease and Encourage Healthy Lifestyles

Proposed Options

- Annual capped grants to states for three or five years, or until options available through HIE, to provide access to evidence-based primary preventive services such as tobacco use screening, influenza immunization, counseling on daily aspirin use, hypertension screening, or obesity screening of uninsured adults and children
- Competitive grant program to promote health and human service program integration, improve care coordination and access to preventive services and treatments, and better integrate delivery of health care services to improve health and wellness; and require DHHS to review and improve administration of its low income programs
- States submit application to create locally integrated delivery systems including establishing multidisciplinary care teams
- Community health teams required to provide: comprehensive care management and patient and family support in conjunction with primary care providers; care coordination and health promotion activities (includes behavioral services and nutritional counseling), coordination with local public health offices; social and economic support to facilitator patient and family assistance with social support services (includes coordination with and referral to community based programs); comprehensive transitional care from inpatient to institutional care settings or care provided in community-settings

- Allow states to implement service integration and delivery reform activities, including individualized plan
- States allowed to submit proposal meeting goals and objectives of this grant
- DHHS would study best practices to improve wellness outcomes for low-income families and issue best practices on how to establish well integrated model of care for health maintenance, reducing chronic disease, promoting patient care and facilitating coordination between health and human service systems
- Within 2 years of DHHS disseminating best practices states required to submit plan to better integrate services for low-income families

Rural Commentary

- Integrated delivery systems should be encouraged to include local providers.
- Grants should be available for establishing rural community and/or regional health teams, recognizing that not all services will be available locally.

VI.4: Employer Wellness Credits: See appendix.

SECTION VII: LONG TERM CARE SERVICES AND SUPPORTS

VII.1: Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid HCBS State Plan Option: See appendix.

VII.2: Eligibility for HCBS Services: See appendix.

VII.3: Increase Access to Medicaid HCBS: See appendix.

VII.4: Medicaid Spousal Impoverishment Rules: See appendix.

VII.5: Medicaid Resources/Asset Test: See appendix.

VII.6: Long Term Care Grants Program: See appendix.

VII.7: Functional Assessment Tool for Post-Acute LTC: See appendix.

VII.8: Money Follows the Person Rebalancing Demonstrations: See appendix.

SECTION VIII: OPTIONS TO ADDRESS HEALTH DISPARITIES

VIII.1: Required Collection of Data: See appendix.

VIII.2: Data Collection Methods

Proposed Option

- Require federally funded population surveys to collect sufficient data on racial/ethnic subgroups to generate statistically reliable estimates in studies comparing health disparities populations

- Ensure quality reporting requirements include proposals to collect data on patients by race, ethnicity, and primary language and extend MIPAA provisions regarding collection of health disparities data to the Medicaid and CHIP populations

Rural Commentary

- Require that surveys include sufficient sample to allow for rural disparities to be examined.

VIII.3: Standardized Categories for Data: See appendix.

VIII.4: Public Reporting, Transparency, and Education: See appendix.

VIII.5: Language Access

Proposed Option

- Extend 75% matching rate for translation services to all Medicaid beneficiaries for whom English not primary language
- Establish grants for outreach and enrollment efforts to fund, for example, multi-lingual help lines and for data collection efforts

Rural Commentary

- These provisions will be helpful in many rural areas experiencing increasing immigration of Hispanics.
- Help lines would be a particularly important strategy for rural providers that might not have either the available workforce or a reasonable volume to support in-person translation services.

VIII.6: Elimination of Five-year Waiting Period for Non-Pregnant Adults: See appendix.

VIII.7: Reduction in Infant Mortality and Improved Maternal Well-Being: See appendix.

APPENDIX

This appendix describes proposed options for which we are not offering commentary at this time.

SECTION I: INSURANCE MARKET REFORM

I.4: Transition

Proposed Option

- Grandfather current coverage; issuers continue to provide coverage under grandfathered plan only to those who are currently enrolled or to new employees hired by employer offering the coverage; any change means meeting new federal benefit requirements
- Federal rating rules for non-group and micro-group markets (other than grandfathered plans) effective on January 1, 2013; for remainder of small group market, phased in over 3 to 10 year period, determined by each state with approval from the Secretary

SECTION IV: ROLE OF PUBLIC PROGRAMS

IV.1a: Eligibility Standards and Methodologies

Proposed Option

- Soon after enactment all state Medicaid programs required to raise income eligibility for pregnant women, children, and parents up to 150% of FPL
- States required to maintain income eligibility for all previously eligible populations, to expire when HIE full operational
- No income disregards would be permitted for any Medicaid eligible population; income measured using modified adjusted gross income (MAGI), same definition used by exchange to determine eligibility for tax credit

IV.1b: Medicare Program Payments

Proposed Option

- Through 2015 federal government full finance all expenditures for benefits provided to individuals newly eligible for Medicaid as result of increases in income eligibility; state share phased in over next five year period
- After phase-in state share equal to proportion established under FMAP formula
- *Option:* federal government could pay increased share for benefits provided to all populations for a certain duration
- Could require that payments to all providers not fall below a given percent (e.g., 80) of Medicare reimbursement rates for similar services.

IV.1c: Options for Medicaid Coverage

Approach 1: Increased Coverage through the Current Medicaid Structure

- Individuals eligible for Medicaid deemed ineligible for tax credits
- For persons eligible for Medicaid receiving coverage through ESI, state Medicaid could provide premium assistance (could be required to do so)

Approach 2: Increased Coverage Through the Exchange

- Medicaid continues for all populations currently eligible
- Medicaid program would be required to cover children, pregnant women, parents and childless adults through insurance plans in the Exchange
- State could provide premium assistance for ESI, but not a requirement
- Medicaid provide eligible enrollees with choice of Exchange Low Option plans
- State Medicaid program arrange coverage for services outside limits of Exchange coverage, such as education setting services, transportation, and eEPSDT
- *Variations:* increasing reimbursement under FMAP, provide eligible populations with choice of High Option plans, allow state to limit populations that would be required to receive coverage to non-pregnant, childless adults, allow states to create or act as a HIE plan, allow states to create Medicaid-only plans to participate in HIE

Approach 3: Increased Coverage through Both the Current Medicaid Structure and the HIE

- Expand coverage for children, pregnant women, and parents
- Childless adults would not become eligible for Medicaid; below 115% of FPL would be eligible for federal tax credits to purchase coverage, either private through the HIE or public coverage through state's Medicaid program
- Could apply Medicaid limits on cost-sharing and require private plans to include safety net providers (like public hospitals and CHCs) in networks
- *Variations:* making a subset of childless adults Medicaid eligible, giving states option to accept "vouchers" (tax credits) for buying into Medicaid, making Medicaid accessible to mandatory populations through the HIE

IV.1d: Treatment of Territories

Proposed Options

- Medicaid eligibility categories same as for states
- Removes existing funding caps for the territories

IV.3: Quality of Care in Medicaid and CHIP

Proposed Option

- Apply quality measures established in Children's Health Insurance Program Reauthorization Act (CHIPRA) to all Medicaid eligible populations (includes developing, testing, updating and disseminating evidence-based measures, demonstrations to improve quality of children's health care, demonstration to develop comprehensive and systematic model for reducing child obesity, program to encourage creation and dissemination of model electronic health record for children)
- Appropriate \$10 million for Medicaid and CHIP Payment and Access Commission (update payment policies including methodologies and impact on access and quality, interaction of Medicaid and CHIP payment policies with health care delivery generally, other policies including those relating to transportation and language barriers)

IV.4b: Family Planning Services and Supplies

Proposed Option

- Add new optional categorically needy eligibility group to Medicaid of non-pregnant individuals with income up to highest level applicable to pregnant women and at state option, individuals eligible for existing section 1115 waivers that provide family planning services and supplies
- Benefits limited to family planning services and supplies and include medical diagnosis and treatment services
- Allow presumptive eligibility

IV.4c: Treatment of Selected Option Benefits

Proposed Option

- Podiatrists, optometrists, and free-standing birth centers would be given provider status

IV.4d: Interstate Coordination Requirements for Child Medicaid Beneficiaries

Proposed Option

- Require coordination to ensure home-state Medicaid program covers child when he or she is out of state

IV.4f: Change the Status of Some Excludable Drugs

Proposed Option

- Eliminate smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excluded drug list

IV.4h: Transparency in Medicaid and CHIP Section 1115 Waivers

Proposed Options

- Transparency in development, implementation, and evaluation of waivers; for states and DHHS

IV.4i: Medicaid State Plan Amendments and Covered Benefits

Proposed Option

- Add transparency-related statutory requirements with the approval process for proposals that limit benefits

IV.4k: Automatic Countercyclical Stabilizer

Proposed Option

- Automatic increase in FMAP during periods of national economic downturn occurring after January 1, 2012
- Downturn is at least 23 states show a 10% increase in rolling average unemployment rate for that quarter compared to corresponding quarter two years prior
- State eligibility for increase based on rolling average unemployment rate for any quarter during downturn has increased as compared to corresponding quarter two years prior
- Increase amount based on increased Medicaid cost attributable to unemployment rate relative to state's total Medicaid spending
- Would exclude disproportionate share hospital payments, CHIP, and title IV-E
- Temporary VMAP increase phased-out to avoid sudden drop in federal financial participation

IV.5: Medicaid Disproportionate Share (DSH) Hospital Payments

Proposed Option

- Funds from state allotments dispersed directly by Secretary to qualifying hospitals
- Hospitals would submit claims data to CMS for uncompensated care
- Secretary would designate specific services as eligible for DSH payments
- *Variation:* reallocate DSH funds among states

IV.6b: cost-Effectiveness Test

Proposed Option

- Modify 195(b) waiver authority to permit states to use Medicare savings from coordinating care in waiver applications

IV.6c: Office of Coordination for Dually Eligible Beneficiaries

Proposed Option

- New office within CMS: Office of Coordination for Dually Eligible Beneficiaries (OCDEB)
- OCDEB responsible for identify and leading efforts to align financing, administration, oversight rules, and policies for dual eligibles
- OCDEB would develop outreach and training to improve coordination, propose policy changes, identify issues that need legislative solutions and develop strategies to ensure good outcomes for duals during care transitions and develop procedures to assist “attainers,” beneficiaries who are turning 65

IV.7a: Reduce or Phase-Out the Medicare Disability Waiting Period

Proposed Options

- *Approach 1:* reduce 24-month waiting period to 12 months beginning October 2009
- *Approach 2:* reduce 24-month waiting period by one month every quarter beginning in October 2009 until reaches zero in July 2015
- *Approach 3:* phase-out waiting period based on date of individual’s disability
- *Approach 4:* retain 24-month waiting period for persons with access to private health insurance coverage (not COBRA) which meets or exceeds specified actuarial standard

IV.7b: Temporary Medicare Buy-In

Proposed Options

- *Approach 1:* people ages 55 through 64 without ESI or Medicaid could voluntarily enroll in Medicare beginning January 1, 2011; after initial enrollment period allow persons in the age group who lose ESI to enroll; end once HIE is operating, allowing people already in Medicare to stay in Medicare; premium equal to expected average cost of benefits plus administrative fee of 5%; if costs exceed Medicare pay an additional premium once reach normal Medicare eligibility age until turn 85; if costs less than premiums collected, rebate on Medicare premiums once reach normal eligibility age
- *Approach 2:* committee seeking input from members on alternative ways to meet needs of near-elderly before insurance market reforms take effect

SECTION V: SHARED RESPONSIBILITY

V.1: Personal Responsibility Coverage Requirement

Proposed Options

- All individuals “have a personal responsibility requirement to obtain health insurance coverage”
- Initial open enrollment of approximately 3 months; annually thereafter
- *Option:* during an initial 45-day open enrollment, all coverage would be guaranteed issue with no limits on pre-existing conditions and for those who don’t enroll then carriers could exclude pre-existing conditions up to 9 months and charge higher premiums
- All individuals required to purchase coverage of at least lowest cost option
- Taxpayers required to report months for which they have required minimum coverage for selves and family members on federal income tax returns
- Insurer required to report months of qualified health coverage to individual covered and to the IRS
- Consequence for not being insured would be excise tax equal to percentage of premium for lowest cost option available through HIE for area where individual resides; phased in and would equal 25% of premium for first year to 75% third and subsequent years

V.2: Employer Requirement

Proposed Option A

- All employers with more than \$500,000 in total tax year payroll will either offer full time employees health insurance or pay an assessment
- Coverage has to be equal to lowest coverage option that includes first dollar coverage for prevention services
- Worker will receive tax exclusion for employer-provided insurance but cannot receive income-based tax credit
- Assessment is excise tax calculated as amount per employee per month based on employer’s gross receipts for taxable year
- States required to offer current-law Medicaid premium assistance to individuals eligible for Medicaid who are offered employer-sponsored coverage

Proposed Option B

- Would not require employers to play or pay, but would have coverage requirement for individuals
- Medicaid eligible individuals offered employer-sponsored coverage could enroll in individual policy using premium and cost-sharing assistance provided through Medicaid and the low-income tax credits offered under this legislation

SECTION VI: PREVENTION AND WELLNESS

VI.1a: Personalized Prevention Plan and Routine Wellness Visit

Proposed Option

- Authorize personalized prevention plan once every 5 years unless deemed inappropriate for all Medicare beneficiaries
- Beneficiaries first receive comprehensive health risk assessment (HRA) including at least complete medical and family history, age-, gender and risk appropriate measurements
- Assessment would identify chronic diseases, modifiable risk factors and emergency or urgent health needs
- No co-payment or deductible applied to HRA
- Within 6 months of HRA Medicare payment authorized for visit to qualified health professional to create a personalized prevention plan

VI.1b: Incentives to Utilize Preventive Services and Engage in Healthy Behaviors

Proposed Option

- Secretary has authority to withdraw Medicare coverage for prevent services rated “D” by US Preventive Services Task Force (PSTF) unless deemed medically necessary by physician

VI.2a: Access to Preventive Services for Eligible Adults

Proposed Option

- Clarify definition of screening and preventive services in Medicaid for adults as including those rated “A” or “B” by USPSTF and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- If state opts to provide all approved preventive services and immunizations it would receive a 1% increase in federal share of FMAP for those services

VI.2b: Incentives to Utilize Preventive Services and encourage Healthy Behaviors

Proposed Option

- Remove or limit cost-sharing for preventive series rated “A” or “B” by USPSTF
- Permit states to design proposal and apply for funds to explore mechanisms to provide refunds or other incentives to Medicaid enrollees who complete behavior modification programs

VI.4: Employer Wellness Credits

Proposed Option

- Tax credit for 50% of the costs paid by employer providing a “qualified wellness program” during a taxable year, limited to \$2300 for each employee not exceeding 200 employers, plus \$100 for each additional employee in excess of 200
- All employers must be required to be eligible to participate in program that includes four components: health awareness, employee engagement, behavioral change, and supportive environment
- Program required to be consistent with evidence-based research and best practices

SECTION VII: LONG TERM CARE SERVICES AND SUPPORTS

VII.1: Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid HCBS State Plan Option

Proposed Option

- Allow states to seek approval from Secretary to offer additional services under Section 1915(1) and allow individuals to simultaneously enroll in more than one Medicaid waiver

VII.2: Eligibility for HCBS Services

Proposed Option

- Eliminate existing institutional level-of-care requirement for eligibility for section 1915© waivers and require states to replace with less stringent criteria
- Eliminate prohibition against providing section 1915(i) services to persons with income above 150% FPL

VII.3: Increase Access to Medicaid HCBS

Proposed Options

- *Approach 1:* increase number of persons under the cap that states would be required to enroll in either or both 1915(c) and 1915 (i)
- *Approach 2:* prohibit states from using waiting lists to prevent eligible beneficiaries from accessing HCBS
- *Approach 3:* committee seeking input from members on alternative ways to ensure beneficiary access

VII.4: Medicaid Spousal Impoverishment Rules

Proposed Option

- Require states to apply spousal impoverishment rules to HCBS applicants and apply to persons applying through medically needy eligibility pathway

VII.5: Medicaid Resources / Asset Test

Proposed Option

- Allow states to treat Medicaid applicants for HCBS differently by allowing them to retain higher levels of assets

VII.6: Long Term Care Grants Program

Proposed Option

- Additional grant authority for Secretary to facilitate the delivery of HCBS by creating Consumer Task Force to assist in development of choice systems change initiatives, providing support for informal caregivers, expanding prevention and health promotion education activities, expanding the Green House Model, implementing approved section 1915 amendments , and other activity to facilitate use of HCBS

VII.7: Functional Assessment Tool for Post-Acute LTC

Proposed Option

- Provide time frame for CMS to implement this assessment tool

VII.8: Money Follows the Person Rebalancing Demonstrations

Proposed Option

- Extend through September 30, 2016

SECTION VIII: OPTIONS TO ADDRESS HEALTH DISPARITIES

VIII.1: Required Collection of Data

Proposed Option

- Require SSA to collect race, ethnicity, and language data on Medicare enrollees, provide funding to upgrade SSA databases so they communicate with one another

VIII.3: Standardized Categories for Data

Proposed Option

- Uniform categories for collecting data on race and ethnicity, require use of OMB Directive 15 standards and OMB policy for aggregation and allocation of subgroups
- Funding provided to states for technology upgrades needed to adopt OMB categories
- CMS required to determine where people with disability access primary care and number of providers with accessible facilities and q2equipment to meet needs of disabled

VIII.4: Public Reporting, Transparency, and Education

Proposed Option

- Require health care quality data to be published by race, ethnicity and gender

VIII.6: Elimination of Five-year Waiting Period for Non-Pregnant Adults

Proposed Option

- Add non-pregnant adults to list of Medicaid beneficiaries for whom states permitted to waive five-year bar to extend Medicaid coverage

VIII.7: Reduction in Infant Mortality and Improved Maternal Well-Being

Proposed Option

- Funding to states, tribes, and territories to develop and implement targeted approaches to reduce infant mortality; grant funding authorized through Title V – Maternal and Child Health Services Block Grant and may require coordination with other operating divisions of HHS

RUPRI Health Panel

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