Comparison of Oregon Health Reform To Senate Health Care Bill and Reconciliation Bill Changes

Based on OHPR staff understanding as of 03/22/2010

Oregon Health Reform (H.B. 2009/H.B. 2116)	The Patient Protection and Affordable Care Act (Senate Bill, H.R. 3590)	Health Care and Education Affordability Reconciliation Bill (H.R. 4872)
	MARKET REFORM	
• ***Insurance Exchange*** – Develop plan for Oregon Health Insurance Exchange by 12-31-10. • ***Public Plan*** – By 12-31-10, assess the feasibility of publicly-owned health benefit plan to operate within Exchange. • ***Health Insurance Coverage*** – Plan to provide and fund access to affordable, quality health care for all Oregonians by 2015. • ***Benefits*** – Develop health benefit package to be used as baseline for all plans offered through the Exchange. Package will encourage use of integrated health home, limit cost sharing for evidence-based care and services, create incentives for active patient participation in care. • ***Other Market Reforms*** o Develop affordable products for small group market. o Benchmark maximum on admin. spending for health insurers, standards for reviewing expenses, and annual reporting on rates and total premiums earned. o Investigate and report on feasibility of insurance market reforms, including individual mandate, health insurance premium assistance.	• ***Insurance Exchange*** – States establish exchanges under federal rules by 2014; exchanges offer qualified plans they select; sell to individuals with incomes above 133% FPL and small groups; individual insurance offered both inside and outside the Exchange; employees with access to employer coverage can purchase through the exchange if that coverage is unaffordable (some employees will receive subsidies and others will be permitted to use employer dollars); state exchanges to offer at least two multi-state plans contracted through the federal Office of Personnel Management. • ***Public Plan*** – Not included. • ***Health Insurance Coverage*** – Provides coverage through Medicaid, employer-sponsored insurance, or subsidized insurance; individual mandate unless affordable coverage unavailable. CBO estimates 24 million will remain uninsured. • ***Benefits*** – Coverage to be offered in the exchange and fulfill individual mandate must pay for 60% of costs for covered services (except current insurance plans that are grandfathered and catastrophic plans for people under 30); no cost sharing for preventive services; cap on out-of-pocket; no unreasonable annual caps or lifetime caps. • ***Other Market Reforms*** o Guaranteed issue, no pre-existing condition limits, no annual or lifetime maximums, 3:1 maximum age rate band in individual and small group market. o Prohibits waiting period of greater than 90 days for ESI coverage. o New insurer reporting requirements. o Authorizes health care cooperatives as nonprofit health insurer subject to state regulation. o Extends dependent coverage to children through age 25 at parent's option.	• ***Insurance Exchange*** – Technical changes only. • ***Public Plan*** – No changes noted. • ***Health Insurance Coverage*** –CBO estimates 2 million more people gain coverage while 22 million remain uninsured. • ***Benefits*** – No changes noted. • ***Other Market Reforms*** o Extends dependent coverage to children through age 26 (rather than 25). o "Grandfathered" plans have more consumer protections added. They must cover adult dependents up through age 26, prohibit rescissions of coverage, and modify appeals processes. When exchanges begin in 2014, they must be guaranteed issue, have no pre-existing condition limits, and no annual or lifetime maximums. In 2018, plans must provide certain preventive services with no cost-sharing.

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MEDICAID & PREMIUM ASSISTANCE		
• ***Medicaid/CHIP Expansion* –** Expands access to coverage for children up to 200% FPL and approximately 50,000 low income adults (>100% FPL) in Oregon. • ***Premium Assistance/Credits* –** Sliding-scale premium assistance for children in families up to 300% FPL; option to purchase coverage at full premium cost for children in families above 300% FPL. Premium assistance to be used for newly created health insurance product for children (Healthy Kids).	• ***Medicaid/CHIP Expansion* –** All individuals up to 133% FPL considered mandatory Medicaid populations; assumes continuation of CHIP. • ***Federal Funding* –** Full federal financing for new eligibles from 2014-2016; on average 90% of costs for expansion population covered by federal government from 2017 on. • ***Premium Assistance/Credits for Private Insurance Coverage through the Exchange* –** CHIP-eligible kids who cannot enroll due to federal allotment caps are eligible for tax credits in state exchange. Sliding scale premium assistance and cost-sharing reductions ensure that premiums do not exceed 2% for families below 133% FPL and 9.8% for families at 300-400% FPL and that cost-sharing levels are reduced for low and moderate income individuals. • ***Disproportionate Share Hospitals* –** Decreases DSH allotments as number of uninsured drops beginning 2012, smaller decreases for low DHS states (like OR) that spent full allotment in past. • ***FPL-*** By 2013 HHS will investigate/report on feasibility, usefulness of establishing geographic adjustments to FPL calculation for eligibility.	• ***Medicaid/CHIP Expansion* –** States may start to expand eligibility beginning in April 2010, rather than in 2011. • ***Federal Funding* –** o Substitute Medicaid funding provision: For non-expansion states (not clear if Oregon is a non-expansion state), 100% federal funding for expansion populations in 2014-16, 95% federal funding in 2017, 94% federal funding in 2018, 93% in 2019, and 90% in 2020. Expansion states will receive a phased-in increase in FMAP so that by 2020, they receive the same 90% federal financing as other states. o Starting in FY2016, states receive a 23 percentage point increase to CHIP match rate. • ***Premium Assistance/Credits* –** Provides greater sliding scale premium assistance: Premiums do not exceed 9.5% (rather than 9.8%) of income for individuals up to 400% FPL. Provides greater cost-sharing reductions so that the plan pays the following percentage of the cost of covered services: 100-150% FPL-94%; 150-200% FPL-85%; 200-250% FPL-73%; 250-400% FPL-70%. • ***Disproportionate Share Hospitals* –** Decreases DSH allotments beginning in 2014; methodology to be created but smaller decreases for low DHS states (like Oregon).
DELIVERY SYSTEM REFORM		
• ***Oregon Health Authority*** – Citizen board to coordinate the State's health care policy, purchasing and investments in health service innovation. • ***Transparency & Simplification* –** Conduct comparative effectiveness research and develop evidence-based health care guidelines. • ***System Innovation & Improvement*** o Align state health care purchasing. o Establish and promote patient-centered	• ***Transparency & Simplification* –** National Patient Outcomes (comparative effectiveness) research center. • ***System Innovation & Improvement*** o Accountable Care Organization demonstrations for seniors (Medicare) and kids (Medicaid). o Medical home demonstrations in Medicare & Medicaid for patients with chronic conditions. o Medicare & Medicaid Innovation Center to test new payment & delivery models. o Several Medicare payment reforms or pilots	• ***Transparency & Simplification* –** No changes noted. • ***System Innovation & Improvement* –** No changes noted.

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primary care homes. o Establish statewide exchange of electronic health record system. o Establish statewide registry of Physician-Ordered Life Sustaining Treatment (POLST) forms. • ***Measurement & Reporting –*** Develop statewide common quality standards; all-payer, all-claims data collection and reporting program; workforce database and reporting program. • ***Healthcare Workforce*** – Creates Health Care Workforce Committee to coordinate efforts to recruit and educate health care professionals.	(e.g. hospital value-based payments). • ***Measurement & Reporting –*** HHS to devise national healthcare quality improvement strategy; new commission to establish Key National Indicators system. • ***Healthcare Workforce*** o National advisory commission. o $9.5M in workforce planning and implementation grants. o Increased funding and loan flexibility for training. • ***Medicare Payment*** o Restructures payments to Medicare Advantage plans, based on the average plan bid in each area, phased in over four years, with bonus payments for quality/improved-quality plans. o Requires study to establish fair and reliable geographic cost adjustment. Recommendations to be implemented (in budget-neutral manner) by 2012. • ***Medicare Benefits*** o Reduces coverage gap in Medicare prescription drug coverage by $500 in 2010 only; o Provides a 50% discount on brand-name drugs in the coverage gap.	• ***Measurement & Reporting –*** No changes noted. • ***Healthcare Workforce –*** No changes noted. • ***Medicare Payment –*** Substitute Medicare Advantage provisions: Restructures payments to Medicare Advantage plans to reduce total payments beginning 2012, especially in high-cost areas. Caps benchmarks at 115% of fee for service costs. Adds bonus payments for quality/improved-quality plans. • ***Medicare Benefits -*** Substitute prescription provisions on the donut hole: Provides $250 rebate to Medicare beneficiaries who reach "donut hole" in prescription drug benefits in 2010, and by 2020 phases down the coinsurance so it is the standard 25% throughout coverage gap • ***Medicaid Payment –*** Payments to primary care physicians for primary care services (evaluation and management, and immunizations) must be at least 100% of Medicare in 2013 and 2014; federal government will cover 100% of incremental cost to state.
POPULATION HEALTH		
• Statewide Health Improvement Program to support evidence-based community efforts to prevent chronic disease.	• National Prevention, Health Promotion, & Public Health Council with $7B for 2010-15. • $34B in grants for operations at Community Health Centers (2010-15) plus $10B for CHCs and National Health Service Corps through 2015 for construction, renovation, operations. • $190M annually through 2013 for epidemiology & lab capacity. • Community-based prevention grant programs • Menu labeling for chain restaurants & vending; preempts OR law but has same basic effect.	• Increased funding (now $11B) over 5 years for Community Health Center Fund, and $1.5 B for the National Health Service Corps in the same time period. • No other significant changes noted.

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<tr><td colspan="3">FINANCING</td></tr>
<tr><td>• Current expansions: Hospital and premium tax to finance coverage for children and low-income adults.
• Employer Responsibility – Report on feasibility of payroll tax to encourage employers to provide coverage.
• Individual Responsibility – Report on feasibility of a requirement for individuals to have coverage.</td><td>• Employer Responsibility – If any full-time employee of a large employer (50+ full-time employees, 5+ in the construction industry) receives a subsidy in the Exchange, a non-offering employer pays $750 per full-time employee per year while an offering employer pays $3000 per subsidized full-time employee or $750 per full-time employee per year, whichever is less.
• Individual Responsibility – Minimum coverage required (tax penalty of greater of $750 or 2% of income per year with 3-yr phase-in).
• Other – Excise tax (40%) on value of employer plans above a cap; increases Medicare tax on high income earners; health care industry taxes; Medicare Advantage payment change; other sources.</td><td>• Employer Responsibility – Substitute penalty provision for non-offering employers; Assessment for non-offering employers with more than 50 full-time equivalent workers is $2,000 (excluding first 30 employees from assessment).
• Individual Responsibility – Lowers phased-in flat dollar assessment to $695 but raises percent of income to 2.5%, whichever is higher; changes payment exemption to individuals with incomes below the tax filling threshold.
• Other –
o Delays effective date for high-cost plan excise tax to 2018, and increases the assessment exemption from $8,500 to $10,200 for singles and from $23,000 to $27,500 for families, indexed to inflation plus 1%, and provides adjustments based on certain criteria.
o Adds 3.8 percent tax on unearned income for taxpayers with income above $200,000 for singles and $250,000 for married couples.
o Increases fees on brand name drugs by $10 billion over 10 years, and delays implementation until 2011.
o Delays assessment of insurer fees until 2014, and provides limited exception for certain plans.
o Converts the medical device fee to an excise tax that starts in 2013.</td></tr>
<tr><td colspan="3">WAIVERS</td></tr>
<tr><td>• Federal waiver amendments required for HB 2116 expansions.</td><td>• Allows states to leave Exchange operation to HHS.
• Allows HHS to waive Exchange, minimum benefit, other requirements in 2017 for states that will cover as many at no greater federal cost.</td><td>• No significant changes noted.</td></tr>
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