

Working Group of State Legislators for Health Reform
Suggestions for Strengthening Health Care Legislation from State Legislators

EXECUTIVE SUMMARY

12-11-09

The White House Working Group of State Legislators for Health Reform was established in June and includes state legislators from across the nation interested in passing comprehensive federal health reform. Our group has been working with Progressive States Network (PSN) to address issues related to health care reform and the role of the states. Over 1,000 state legislators from 50 states and several territories have signed onto our position papers and statement of principles.

States will be required to take on a major role in implementing health care reform, just as they already administer Medicaid and numerous state-sponsored health care programs today. Collectively, we have identified a list of issues we believe are of immediate concern as the final legislation is voted upon in the Senate and the differences between the House and Senate bills are resolved:

- Public option and an evaluation of its alternative proposals under consideration;
- The insurance exchange;
- Regulation and enforcement of insurance policies;
- Funding and affordability, including transition funding options;
- Medicaid eligibility and coverage; and
- Cost containment opportunities.

1. Public option and alternative proposals under consideration: The legislation should contain a national public option that each state must participate in, similar to the language passed in the House legislation. In the alternative, the OPM/Medicare expansion could achieve many of the goals of the public option if it is (1) national in scope, (2) subsidies follow those in the House bill; (3) the plan is open to businesses as well as individuals; (4) it is open to all and not only those who have no other options; and (5) the back-up plan is real and operates as a hammer if the private insurer comes up short.

In evaluating alternatives to the public option, their effectiveness should be measured by the extent to which they: inject true competition in the insurance marketplace; lower costs; simplify the complexities of securing health insurance; guarantee portability should an individual change jobs, move, or their health gets worse; cover a sufficient population to be a true insurance plan, not a high-risk pool that simply covers those patients no private insurer wants because they are sick and expensive; set a baseline for consumer and small business needs; and achieve transparency and public accountability.

2. Insurance Exchange. The insurance exchange must include a sufficient number of participating insurers and covered lives to present multiple options to individuals and small businesses for quality, affordable coverage. We support the Exchange language in the House bill, which would create a national Exchange with the option for states to administer a state Exchange, if they

can perform the provisions and requirements of the national exchange. We support extending insurance consumer protections and non-discrimination provisions to all insurance plans and providers, and providing transitional support to all states, regardless of whether they have a high risk pool, to provide access to uninsured individuals with pre-existing conditions.

- 3. Other Insurance Reforms.** Both House and Senate bills include language authorizing “Health Care Choice Compacts.” These provisions should be removed in their entirety from the final bill, as they do nothing to encourage real competition but instead they create a “race to the bottom” and undermine state enforcement of existing consumer protection provisions as well as new federal protections provided in the health care reform bills.
- 4. Funding.** States must be adequately funded, both in the short and long term, to assure the success of comprehensive health care reform. Bridge financing during the transition to the new system will jump start reform and avoid financial penalties to states that have already moved ahead to insure low income persons. Bridge financing is particularly needed during economic downturns. Recommended policies include continuing additional Medicaid match with stimulus or TARP funds, providing temporary funding for state public plans, using high risk pool funds for low income subsidies and early Medicaid expansions, and using a set rate for state funding.
- 5. Affordability.** We have significant concerns about the affordability of the Senate bill, which falls short in helping low income people afford access to health coverage. While we support mandating the purchase of insurance by individuals, this mandate is only feasible if the subsidies are pegged at a level that recognizes fiscal reality, with exceptions if there is significant hardship. We recommend adoption of most of the cost sharing protections in the House bill, including the subsidy structure and out of pocket caps for people with income below 250% and the actuarial values for all populations with incomes below 400% FPL. The subsidies and out of pocket limits for families with incomes at 300% and 400% FPL are stronger in the Senate bill than the House bill and should be retained.
- 6. Medicaid Payment & Coverage.** We support the provisions of the House bill extending Medicaid eligibility for people under age 65 to 150% FPL, and maintenance of effort language that will require states to maintain existing levels of eligibility in their Medicaid programs, combined with bridge funding for those states so they are not penalized for moving ahead with state programs to cover the uninsured. Medicaid members should have access to a “full” benefit package, not a “slimmed down” plan which will result in worse health outcomes and more acute need.
- 7. Cost Containment.** States are clear that any reform must be sustainable, and failure to implement aggressive measures to contain costs now will merely postpone the day when health care will be unaffordable for most Americans. We recommend a series of cost containment measures including payment reform with an emphasis on primary care; incentivizing coordinated care, including medical home models; using data to promote evidence-based medicine with strict conflict of interest standards; administrative simplification

and electronic records; restricting the promotion of unnecessary and sometimes dangerous medicines and medical equipment by re-establishing the historical ban on marketing to the public would reduce the practice of patients demanding the newest drug and banning prescription drug and medical equipment manufacturers from providing gifts of any kind to providers.

Pharmaceutical cost containment measures we support include (1) negotiating Medicare Part D drug prices; (2) closing the “donut hole” coverage gap immediately through industry price roll-backs; (3) amending the provisions for an FDA-approved pathway for generic biologic drugs to reduce the 12 years of data exclusivity offered to new products to a maximum of five years; (4) removing the “evergreening” loophole that will allow brand-name companies to make minor modifications to existing biologics and obtain a brand new 12-year market monopoly ; and (5) banning collusion and sweetheart deals that prevent or delay conventional generic drugs from being brought to market.