



Comments to the Honorable Senator Benjamin Cardin on H.R. 3962 - Affordable Health Care for America Act

Thank you for the opportunity to comment on this landmark health care legislation. We are pleased to be a part of the discussion on health care reform, one of the most pressing issues facing our country today. We have comments on several aspects of the bill including Affordability, Benefits, and Community Outreach.

Recommendations

Affordability

It is generally recommended that any affordability scale used to set subsidy amounts and out-of-pocket caps be conservative for low to moderate income families to prevent financial hardship and to account for cost of living variations in the United States.

- Increase subsidy eligibility from 400% of the Federal Poverty Level (FPL) up to 600% FPL and cap this group's out-of-pocket expenses at 8.5% for the highest earners.

Massachusetts, the first state in the union to attempt near universal coverage, did considerable research on affordability to plan subsidies for their low to moderate income residents. Their research, done in conjunction with Community Catalyst, indicated that, "At 600% FPL, people can afford unsubsidized, non-group health plans, at 8.5% income after meeting other basic needs".¹

A recent Ohio study on affordability noted that families with incomes between 300% and 500% of the FPL have limited ability to pay for health care coverage and often are in a negative cash flow situation.²

- Exempt families earning at or below 200% of FPL from premium payments and cap their out-of-pocket co-payments.

Families earning up to 200 percent FPL (\$44,100 for a family of four) should be exempted from premiums – Most families at this income level are exempt from Medicaid premiums and often rely on fuel assistance,

¹ **Defining Affordability for Massachusetts**, Community Catalyst, April, 2007

² **Making Ends Meet: What Can Franklin County Residents Afford to Pay for Health Care?**, UHCAN Ohio, January, 2009

food stamps and EITC assistance to meet their basic needs. Any other cost-sharing for this group should be very limited.³

- Consider combining the premium and out-of-pocket expenses caps for the maximum out-of-pocket expenses for a total of no more than 8.5% of yearly income up to 600% of FPL.

The basic benefit plan for the health exchange or public option may be attractive to lower income households because of the reduced cost but could be unaffordable should there be a significant illness or accident. This plan pays only 70% of the benefit leaving families with 30% of the costs of health care services. Families in such situations could quickly reach their \$10,000 out of pocket and would have already paid up to 11% of their income for premiums. The examples below outline possible scenarios.

Family of Four Example

	200% of FPL	350% of FPL
Yearly Income before taxes	\$44,300	\$77,525
Yearly Premiums for Basic Plan	\$ 2,436	\$ 8,528
Yearly Maximum Out-of Pocket Expenses	\$ 6,000	\$10,000
Yearly Total Health Care Expenses	\$ 8,436	\$18,528

In both these scenarios the actual out of pocket expenses represent a substantial portion of the family budget. Combining the premium and out-of-pocket expenses for a total of no more than 8.5% of income on a sliding scale would be more reasonable and affordable for lower income families.

Benefits

Adult Dental Coverage

- The essential benefit plan should include adult dental care.

Currently the bill calls only for a study on whether adult oral health care should be included in the health exchange essential benefit package. According to the most recent information from the Agency for Healthcare Research and Quality, in 2004 54 percent of Americans had private dental coverage, 12 percent had coverage through government programs such as Medicaid and 35 percent had no

³ **Voices from the Field: The Case for a Commonsense Affordability Standard**, PICO National Network and Community Catalyst, June 2009

dental coverage. Dental industry estimates suggest that the number of insured has increased only slightly since then.⁴

The case of Deamonte Driver illustrates the medical dangers of untreated dental problems. These dangers exist for not just for children but for adults as well. An article in *Clinical Microbiology Reviews*⁵ outlined the very serious medical consequences of untreated dental problems resulting in oral infection including coronary heart disease: atherosclerosis and myocardial infarction, stroke, infective endocarditis, bacterial pneumonia, low birth weight, and diabetes mellitus.

A recent Kaiser Family Foundation report highlighted the problems of adults without dental coverage⁶ including vast unmet oral health needs and untreated dental problems with serious health, employment, and social consequences.

These are not new findings. Multiple studies and case examples from the past decade all have similar conclusions. Dental care is important to good overall health and should be included in any essential benefit package.

Early and Periodic Screening Diagnosis and Treatment

- Clarify the language surrounding the inclusion of Early and Period Screening Diagnosis and Treatment (EPSDT) in the essential benefit package. Use language that clearly states that the essential benefit plan must include EPSDT equivalent benefits.

The bill calls for the following in section 222 (b)10:

Well-baby and well-child care and oral health, vision, and hearing services, equipment, and supplies for children under 21 years of age.

The above language is ambiguous. Section 1905. [42 U.S.C. 1396d] describes EPSDT in much clearer language. The following is an excerpt from Section 1905. [42 U.S.C. 1396d]:

Screening services "to detect physical and mental conditions must be covered at established, periodic intervals (periodic screens) and whenever a problem is suspected (inter-periodic screens). Screening includes a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests, and health education.

⁴ **Health Reform Proposals Enhance Children's Dental Care**, Jessica Marcy, Kaiser Health Network, October 13, 2009

⁵ **Systemic Diseases Caused by Oral Infection**, *Clinical Microbiology Reviews*, October 2000, p. 547-558, Vol. 13, No. 4

⁶ **Oral Histories Report from a Dental Fair for Uninsured Adults**, September 2009, Lake Research Partners, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation

In addition, dental, vision, and hearing services are required, including appropriate screening, diagnostic, and treatment. The treatment component of EPSDT is broadly defined. Federal law states that treatment must include any "necessary health care, diagnostic services, treatment, and other measures" that fall within the federal definition of medical assistance (as described in Section 1905(a) of the Social Security Act that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services."

It is recommended that the above language or equivalency verbiage be added to the bill.

- Consider eliminating the 70% coverage plan.

This plan could cause undue hardship to low-income populations who have unexpected medical costs. Please see the chart and explanation on page one under "Affordability".

Enrollment, Outreach, and Ombudsman Services

- The bill should include strong community based enrollment, outreach, and advocacy services to assist families, especially the newly insured, to enroll and navigate the new health exchange managed care plans.

Although the health exchange plans call for internal and external appeal and grievance procedures, we know these "remedies are often under-utilized for many reasons, namely because consumers are unaware of their rights, are uncertain how to exercise their rights, or do not have confidence in the process. Further, consumers face an array of issues, beyond health plan appeals and grievances, while navigating our confusing, complex, and ever-changing health care system".⁷

Section 244 HEALTH INSURANCE OMBUDSMAN of H.R. 3962, outlines the specific duties of an ombudsman to the new Health Choices program. Stronger language needs to be established in the bill to specifically outline the duties of an ombudsman office. Further the bill should stipulate that States would create and operate their own consumer assistance programs with matching federal dollars. Because States, their services and community resources are so varied it makes sense to for each State to design and implement a program that will work for their residents.

⁷ **Consumer Health Assistance Programs: A Model Act for Legislators and Advocates**, Health Assistance Partnership Families USA, April 2005.

S. 1052 from the 107th Congress outlined a comprehensive consumer assistance program the components of which should be included in any health care reform bill including:

- Operating a toll-free telephone hotline to respond to consumer requests;
- Disseminating educational materials about available health insurance options, access to health care, and the rights and responsibilities of health care consumers;
- Educating consumers on how to resolve questions, problems, and grievances;
- Coordinating education and outreach efforts with health plans, health care providers, payers, and government agencies;
- Assisting consumers, provide them with information, and provide representation in internal, external, and administrative grievances and appeals concerning the denial, termination, or reduction of health care services or the refusal of a health insurer to pay for such services.

Thank you again for the opportunity to comment on H.R 3962. Please do not hesitate to contact either Kathleen Westcoat, Baltimore HealthCare Access President, or Therese McIntyre, Director of Communications and Legislative Affairs at 410-649-0521 or by email at kwestcoat@bhca.org or tmcintyre@bhca.org respectively with any questions you may have.