

What is the Status of the Health Reform Bills?

On November 7, the House of Representatives approved H.R. 3962, the Affordable Health Care for America Act, putting major health reform legislation much further along the legislative obstacle course than ever before in the history of such efforts, dating back to the presidency of Franklin Roosevelt (see below). The House bill passed by a vote of 220 to 215, and it reflects the work of the three House committees with principal jurisdiction for healthcare. The “no” votes of 39 mostly conservative Democrats as well as all but one Republican signaled the challenge ahead for President Obama and the Democratic leadership in overcoming the remaining legislative obstacles to enactment of health reform. The Senate is looking to begin debate on a “melded” version of the Finance Committee and Health, Education, Labor and Pensions (HELP) Committee proposals after Thanksgiving. It remains unclear, however, whether the Democratic leaders can muster 60 votes to close off debate. If not, using reconciliation procedures, which requires only 51 votes to limit debate, then becomes more likely. Assuming passage in both the House and Senate, a joint conference will then be needed to resolve the differences between the bills. The conference agreement will have to be passed by both chambers. Alternatively, either the House- or Senate-passed bill could be “pingponged” between the two chambers until all differences are resolved. In either case, enactment will need the president’s signature.

Status of Health Reform Bills Moving Through Congress

Senate	Senate HELP	Kennedy bill approved, as amended, 13-10 on 7/15/09. Introduced in the Senate by Harkin as S.1679.
	Senate Finance Committee	An amended version of the Baucus proposal (S.1796) was approved 14-9 on 10/19/09.
	Melding of HELP and Finance bills	Senator Reid and key committee Democrats are melding S. 1679 and S. 1796 into a new bill for consideration by full Senate.
	Full Senate	Debate may start in late November. Democrats may have to use the budget reconciliation procedures to avoid a GOP filibuster.
House	House Education and Labor Committee	H.R. 3200, as amended, approved 26-22 on 7/17/09.
	House Energy and Commerce Committee	H.R. 3200, as amended, approved 31-28 on 7/31/09. Additional amendments approved 9/23/09.
	House Ways and Means Committee	H.R. 3200, as amended, approved 23-18 on 7/17/09.
	House Rules Committee	House Democratic Leadership worked with committee chairs to produce H.R. 3962 from the 3 versions of HR 3200 along with additional changes. Rule allowed for floor amendment on a Republican substitute and on an amendment sponsored by Rep. Stupak (D. MI) to prohibit use of federal subsidies to pay for abortions.
	Full House	H.R. 392 as amended to include the Stupak provision, was approved by a vote of 220 to 215 on 11/7/09 after Republican substitute defeated by a vote of 176-258.
Joint	Conference Committee of the Senate and House	Probably no earlier than late December. In lieu of a conference committee, Democratic leaders could elect to “ping pong” either the House or Senate-passed bill until all differences are resolved.
	House/Senate chambers vote approval of conference report/final bill	In time for House and Senate adjournment in late- December. Could spill over into January.
President	Presidential signature	White House is working with the Congress and will be influential in conference; expectation that a conference agreement /final bill will be signed by the President and enacted into law.

What Do the Bills Do?

For the Uninsured

The primary focus of all bills under congressional consideration is improving access, affordability, and stability of health insurance for individuals, small business workers, and part-time workers for whom health insurance is currently difficult to obtain.

Targeted to the uninsured and those who could easily become uninsured as a result of an illness, job loss or other change in life status, the bills set insurance standards that:

1. require insurers to offer health insurance to anyone seeking health insurance;
2. limit the price (i.e. premium) variations health plans can charge among sick versus healthy for the same benefit packages;
3. eliminate current insurance practices that seek to discourage enrollment of older and less healthy individuals or those with above-average risk factors by:
 - a. prohibiting exclusions or waiting periods based on pre-existing conditions,
 - b. prohibiting rescissions of coverage for reasons other than non-payment of premiums or fraud, and
 - c. requiring insurers to provide a minimum level of benefit adequacy.

A new requirement that all Americans have health insurance is a feature of the bills under consideration. Exceptions are included for certain religious objections and financial hardship and unaffordability of coverage (specifically defined). Individuals who fail to obtain coverage once the insurance reforms are implemented will be subject to financial penalties, which vary in the different bills. The Senate Finance Committee would gradually phase in the penalties. Federal subsidies (for those with incomes up to 400% of the federal poverty line) will be made available to low-income Americans requiring assistance to purchase insurance.

Medicaid coverage will become available to all individuals (including adults without dependent children as well as children, pregnant women and parents) below certain income levels. These are 133% of the federal poverty line in the Senate Finance bill, and 150% in H.R. 3962.

Estimated coverage rates at full implementation range from 96% of eligible individuals for the House bill (H.R. 3962) to 94% for the Senate Finance Committee bill (Baucus, S. 1796), not 100% coverage but a vast improvement over the current rate of 83%. These figures exclude undocumented persons, who would be ineligible for Medicaid or subsidies under any of the bills being considered.

Documented persons are eligible for assistance under the bills being considered, with limitations on Medicaid eligibility. Neither H.R. 3962 nor S. 1976 would change current law with respect to Medicaid coverage for documented persons. Such eligibility is generally at the option of the states, but some documented persons are ineligible for the first 5 years. (The 5-year wait has been eliminated for pregnant women and children.) Under both of these bills, documented persons would not be prohibited from buying private coverage in the exchanges, and they could receive subsidized exchange coverage if they meet the eligibility requirements.

For Seniors

The bills do not reduce any traditional fee-for-service Medicare benefits or raise out-of-pocket spending requirements for seniors under Medicare Parts A or B. One exception is that S. 1796 would reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple and also freeze the income thresholds for the income-related Part B premium, which would increase the number of beneficiaries who must pay a higher premium.

Some Medicare benefits are expanded. Under H.R. 3962, the Part D coverage gap (donut hole) would be eliminated by 2019, beginning with a \$500 reduction in 2010. In both H.R.3962 and S. 1796, beneficiaries would get additional help in paying for drugs to the extent that they do fall in the coverage gap. Deductibles and coinsurance on preventive benefits are eliminated, and under S. 1796, a new annual wellness visit would be covered. H.R. 3962 includes a benefit, made available on a voluntary basis only, that would pay physicians to counsel seniors seeking assistance in advance care planning, including preparing advance directives. Changes to the provision were made from an earlier controversial version. This proposed benefit is not in the Senate bills.

For the Currently Insured Population Under 65 Years of Age

The bills grandfather in existing health plan coverage so that the currently insured can keep the plans and benefit packages they have chosen.

For Businesses

In H.R. 3962 and the Senate HELP bill (S. 1679), employers are required to offer health insurance meeting certain minimum benefit standards to employees and to pay at least a specified portion of the health plan costs. (These percentages range from 60% to 72.5% for worker-only coverage, depending on the bill.) Financial penalties apply to companies that do not do so. The bills exempt smaller companies with low payrolls from this requirement. Smaller employers that elect to offer coverage to their employees may qualify for new small business health insurance premium subsidies. Generally, existing self-insured employer plans remain unaffected by legislation for at least five years.

S. 1796 does not include an employer mandate but instead imposes a “free rider tax” (up to \$400 per worker in 2013) on employers that do not provide coverage to their workers but whose low-income workers enroll in state exchanges and get federal premium subsidies. Employers with fewer than 50 workers are exempt. Collections from this tax will be used to help finance the subsidies.

For Healthcare Providers

Hospitals, skilled nursing facilities, home health agencies and physician groups are directly affected by the spending and savings provisions of the reform bills. The House Democratic leadership decided to remove the Medicare physician fee fix from H.R. 3962 and consider it under a separate initiative (H.R. 3961). This bill, with a 10-year cost of \$210 billion, would eliminate the physician payment reduction that will otherwise go into

effect in 2010 and provide a permanent fix to the Sustainable Growth Rate (SGR) problem. By contrast, under S. 1796, the SGR is fixed only for one year. Senate Majority Leader Harry Reid attempted to get a separate bill with a long term fix passed on the Senate floor but failed to get sufficient votes to close off debate. No one expects the scheduled 21% cut in 2010 to go into effect, but exactly how Congress gets to a fix (and finances it) remains unsettled.

Additionally, H.R. 3962 and S. 1796 include several new Medicare payment sources for both physicians and hospitals:

1. New dollars for primary care services;
2. New dollars (and required benefits) to cover prevention services;
3. New reimbursement for doctors who provide counsel on advance care planning (triggered only by voluntary request of a Medicare patient; not required for patients to utilize);
4. New dollars for physicians practicing in efficient areas;
5. Incentive payments for physicians, and potentially for hospitals, from the Accountable Care Organizations (ACO) pilot program; and
6. Extensions and expansions of rural health initiatives.

S. 1796 would also implement “value-based” purchasing (VBP) for inpatient hospital services, plan VBP for home health agencies and skilled nursing facilities, and improve quality reporting by other providers, including physicians. The House bill does not include VBP, although bonuses for physician quality reporting are extended.

For the Government

The role of the federal government is affected in the bills under consideration in a number of ways:

1. New clearinghouses (an “insurance exchange” or “gateway”) for information on available health plans will be set up. The exchanges will facilitate enrollment, help to administer premium subsidies, provide comparative plan information, and generally oversee the competition among qualified insurance plans. The government will set guidelines for the exchanges, but either a new governing entity or the states will operate them.
2. The government, possibly with the input of a new federal entity, will define the minimum benefit (including cost-sharing) standards and parameters for coverage that is needed to meet the federal requirement on individuals to obtain coverage or on employers to provide coverage.
3. The government will provide premium subsidies to qualified lower-income individuals and small businesses to help them purchase qualified health insurance.
4. The government will apply any new taxes or tax penalties to enforce health reform requirements.
5. Whether a “public health plan option” will be offered to Americans is unresolved, but it is included in H.R. 3962 and Senate Majority Leader Reid has announced that the Senate Democratic bill will include one with a provision enabling a state to opt out. If a public option is included, the federal government will play a role in how this plan is structured, assure solvency guarantees, and likely negotiate

provider payment amounts. Alternatively, the development of new private, nonprofit insurance cooperatives may be encouraged through federal grants and loans (grants for such cooperatives are in both H.R. 3962 and S. 1796).

State governments will be required to maintain current Medicaid eligibility levels and bear some of the costs for the Medicaid expansion, with the federal government financing most of the new costs. Under H.R. 3962, the Children's Health Insurance Program (CHIP) will end in 2014, and at that time CHIP-eligible children will be eligible for subsidized private coverage. Under S. 1796, CHIP would continue through 2019.

Impact on Taxes

Several tax provisions are under consideration:

1. A tax penalty for individuals who do not comply with the new federal requirement for all Americans to have health insurance, which varies in the different bills, but all bills include defined financial hardship and religious exemptions;
2. A possible tax on health insurers for their policies that exceed a certain dollar value. For example, S. 1796 includes an excise tax of 40% of coverage in excess of \$8,000 for an individual/\$21,000 for a family, indexed for inflation. Higher-value plans would be allowed for people in high-cost states or for plans with older enrollees or enrollees in high-risk occupations.
3. A tax penalty on businesses that do not comply with the requirement to offer and pay a portion of their employees' health plans. Some small businesses will be exempt from this penalty. Alternatively, a free rider tax will be assessed on larger employers that do not provide coverage to low-income workers.
4. New fees to be paid by pharmaceutical manufacturers, medical device manufacturers and health insurers.
5. A possible 5.4% surtax on the adjusted gross incomes of taxpayers with incomes over \$500,000 in the case of a single filer and \$1 million in the case of joint filers. This provision, included in H.R. 3962, would affect 0.3% of all households, according to the Congressional Joint Committee on Taxation.
6. A possible increase in the Medicare health insurance tax paid by taxpayers with incomes in excess of \$250,000.

Impact on the Federal Budget

President Obama has indicated that he will not sign a health reform bill unless it is "budget neutral" (i.e., does not add to the federal deficit), and the scoring of the Congressional Budget Office (CBO) will be important to the shaping of the final legislation, as it has been during the committee work. CBO has estimated that the coverage expansions in S. 1796 would cost \$829 billion (\$802 billion when the penalties for not adhering to mandates are counted), with the bill's savings and revenue more than covering this amount so that the bill would reduce the federal deficit. Similarly, CBO has estimated that the coverage expansions H.R. 3962 would cost \$1.055 trillion over 10 years (\$894 billion including penalties), but offsetting savings and revenues would lead to a net reduction in federal budget deficits over that period. Most of the expanded coverage provisions do not go into effect until 2013 or later in order to assure the Medicare savings, additional revenue and other changes that offset the costs of the

coverage expansions and investments in healthcare delivery system improvements are under way first.

Catholic Social Teachings and Health Reform

In his speech before Congress, President Obama said that “*no federal dollars will be used to fund abortions, and federal conscience laws will remain in place.*” The House-passed version of H.R. 3962 includes an amendment sponsored by Rep. Stupak (D. MI) that preserves Hyde amendment restrictions on the use of federal funds for abortion for public or privately purchased coverage, including coverage sold through the exchange. The Senate Finance bill (S. 1796) would prohibit abortion coverage from being required as part of the minimum benefits package; require segregation of public subsidy funds from private premium payments for plans that choose to cover abortion services beyond Hyde (which allows coverage for abortion services to save the life of the woman and in cases of rape or incest); and require there be no effect on state or federal laws on abortions. The Stupak amendment is expected to be offered in the Senate as an amendment.

H.R. 3962 would allow Medicare coverage of voluntary advanced care planning consultations for a beneficiary every five years. More frequent consultations would be permitted if there is a significant change in the health of an individual. Changes were made from earlier controversial Committee versions. For example, physician quality measures are not created regarding advance care planning. In addition, the new provision clarifies that beneficiaries are not required to engage in advance care planning or required to consent to restrictions on their medical benefits, and that the provision does not promote suicide or assisted suicide. The Senate bill does not include any provisions on advanced care planning. The Senate bill prohibits federal funds from being used to pay for assisted suicide and offers conscience protections to providers or plans refusing to offer assisted suicide services.