What is the Status of the Health Reform Bills?

Major health reform legislation is now 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.) All five congressional committees with principal jurisdiction for healthcare have approved proposals, and it is now the task of the committee chairs, along with congressional leadership and the White House, to come up with "melded" versions to bring to the full House and Senate. Floor consideration will likely take some time, especially in the Senate where scores of amendments may be offered and 60 votes are needed to close off debate. Assuming passage in both the House and Senate, a joint conference must then resolve the differences between the bills. The conference agreement must then be passed by both chambers and signed by the president to become law.

Status of Health Reform Bills Moving Through Congress		
Senate	Senate HELP (Health, Education, Labor and Pensions) Committee	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 was approved 14-9 on 10/2/09.
	Melding of HELP and Finance bills	Senator Reid and key committee Democrats will meld S. 1679 and Finance committee proposal into a new bill for consideration by full Senate.
	Full Senate	Debate may start in early November. Democrats may have to use the budget reconciliation procedures to avoid a GOP filibuster.
House	House Education and Labor Committee	HR 3200, as amended, approved 26-22 on 7/17/09.
	House Energy and Commerce Committee	HR 3200, as amended, approved 31-28 on 7/31/09. Additional amendments approved 9/23/09.
	House Ways and Means Committee	HR 3200, as amended, approved 23-18 on 7/17/09.
	House Rules Committee	Will work with committee chairs and Democratic leadership to produce a melded version of HR 3200 for a floor vote.
	Full House	Debate and vote possible in mid- to late-November.
Joint	Conference Committee of the Senate and House	Probably no earlier than December.
	House/Senate chambers vote approval of conference report	In time for House and Senate adjournment in late- December.

Presi-dent	**Presidential signature**	**???**

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 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 all 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 (children, pregnant women, parents, and adults without dependent children) below 133% or 150% of the federal poverty line, depending on the particular bill.

Coverage rates at full implementation range from 97% of eligible individuals for the House bills to 94% for the Senate Finance Committee proposal.

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 the Senate Finance Committee 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 the House proposals, the Part D coverage gap (donut hole) would be gradually eliminated. In both the House and Senate Finance Committee proposals, 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 the Senate Finance Committee approach a new annual wellness visit would be covered. The House bills include a benefit, made available on a voluntary basis only, that would pay physicians to counsel seniors seeking assistance in preparing advance directives. This proposed benefit is not in the Senate Finance Committee proposal, and is expected to be dropped before the floor vote on the House bill.

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 the House and Senate HELP bills, 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.

The proposal approved by the Senate Finance Committee 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 bills include provisions to fix the Medicare physician payment reduction that will otherwise go into effect in 2010, and also fixes the Sustainable Growth Rate (SGR) problem long term. In the Senate Finance Committee version,

however, the SGR is fixed only for one year. Reportedly, the House and the Senate are considering dropping these provisions from health reform and moving a permanent SGR fix in separate legislation. Success of this effort is likely to depend on coming up with a source of financing for the physician payment fix, which is not an easy task given the bill's $240 billion price tag.

Additionally, the House bills and the Senate Finance Committee proposal 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 directives (triggered only by voluntary request of a Medicare patient; not required for patients to utilize), which is expected to be dropped from the final House bill;**
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.**

The Senate Finance Committee 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. None of the House committee bills include VBP, although bonuses for physician quality reporting are extended. Some speculate that VBP for hospitals may be added in the final House package by conservative Blue Dog Democrats.

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 several bills under consideration. If 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.**

State governments will be required to maintain current Medicaid eligibility levels and bear some of the costs for the Medicaid expansion to 133% or 150% of the federal poverty line. However, the federal government will finance most of the cost of this expansion. In the House, the Children's Health Insurance Program (CHIP) will end when the insurance exchanges begin, when CHIP-eligible children would receive subsidized private coverage. In the Senate Finance Committee proposal, 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, the Senate Finance Committee is considering 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, including tax-exempt and self-insured plans.**

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. The proposal agreed to by the Senate Finance Committee was given a preliminary cost of $829 billion, with the savings and revenue more than covering this amount so that the bill would reduce the federal deficit. As first introduced, the House bill had a higher cost ($1 trillion), which was fully financed by the savings and revenue provisions in the bill (other than the cost of the SGR fix). 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 Healthcare 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 Senate Finance bill includes language similar to an amendment adopted by the House Energy and Commerce Committee that 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 House bill would allow Medicare coverage of consultations for advanced care planning for a beneficiary every five years. More frequent consultations would be permitted if there is a significant change in the health of an individual. The House bill also requires the Secretary to include measures on end-of-life care and advanced care planning in the Physician's Quality Reporting Initiative, to the extent measures have been endorsed or adopted by a consensus based organization. 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.