

Legislative Bulletin.....November 7, 2009

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H.R. 3962 – Affordable Health Care for America Act

**Key Conservative Concerns**

*Take-Away Points*

- **Constitutionality:** The U.S. Constitution and the principle of limited government are tested as never before by forcing Americans to purchase “acceptable” health care coverage or face a tax of 2.5% of modified adjusted gross income. The definition provided in the bill for “acceptable” coverage will surely force some Americans to purchase plans that include coverage they cannot afford, or don’t want or need.
- **Illegal Immigrants:** The bill fails to adequately address citizen verification for individuals applying for low-income affordability subsidies, or enrolling in Medicaid/CHIP, or enrolling in high risk pools.
- **Funds Abortions:** The permits federal funds to be spent on abortion services
- **Lack of Medical Liability Reform:** Trial lawyers get off scot-free as Democrats pay lip service to real medical malpractice reform, opting to hand over money for lawyer-friendly “alternatives” instead of limiting attorneys’ fees or capping damages.
- **Forced out of Current Plans:** Government-run plan will force tens of millions out of the coverage they currently have while Members of Congress are not subject to the same health care system Americans will have to live by.
- **Increases Premiums:** The Democrats’ health care plan will increase premiums. As JCT, CBO and six other studies have shown, imposing new taxes on insurance policies, health care products, and various new insurance regulations will be drive up the cost for patients of all ages in the form of higher premiums. Industry reports found that the youngest 30% of the population will see a 69% increase under the 2:1 age band included in the Pelosi Government Healthcare Takeover Bill.
- **Increases Personal Health Expenditures:** CMS Actuaries predicts overall national health expenditures under the bill due to various regulations will jump by 2.1 percent, or \$750.3 billion.
- **Bends the Curve in the Wrong Direction:** According to CBO “On balance, during the decade following the 10-year budget window, the bill would increase both federal outlays for health care and the federal budgetary commitment to health care, relative to the amounts under current law.”

- **Raises Taxes:** The bill increases taxes by \$766.6 billion over ten years. The bill also includes billions in cuts to Medicare and Medicaid, cutting benefits and raising premiums on seniors. These cuts are not used to reduce the deficit, but instead to create new entitlement programs.
  - **Costs:** The total cost of is nearly \$1.3 trillion (not including the \$210 billion “Doc Fix”) when including the cost to states for mandated Medicaid expansion (\$34 billion) and authorized discretionary spending for grants, public programs, changes and funding for a variety of agencies that would be responsible for implementing H.R. 3962.
  - **Government Takeover:** Many conservatives may believe that the bill is a step away from personal, private coverage and choice, to a Washington-controlled healthcare system that rations care, limits choice, and reduces quality, innovation and competition.
- For more details on these concerns, see below.*

## **H.R. 3962 — Affordable Health Care for America Act (*Dingell, D-MI*)**

**Order of Business:** The bill is scheduled to be considered on Saturday November 7, 2009 (or later), under a modified closed rule, allowing one Republican substitute. More information will be forthcoming when the Rules Committee reports out a rule for the bill.

### **Cost to Taxpayers:**

**Spending.** The legislation does not meet President Obama’s demand that the cost of health care legislation not exceed \$900 billion. The legislation would explicitly cause **\$1.052 trillion** of new entitlement spending over the ten-year budget window, according to CBO. In addition, the bill implicitly will lead to another \$209 billion of entitlement spending because the bill fails to provide the promised “SGR fix,” which brings the bills true cost to **\$1.3 trillion**. Finally, the legislation will require more than \$200 billion worth of discretionary spending, which brings the total cost of the legislation to just over **\$1.5 trillion**.

But even this understates the cost of this legislation since the vast majority of the cost of the bill falls outside of the first few years. The first ten years after implementation (2014-2023), the bill will cost **\$2.4 trillion**.

**Taxes:** The legislation increases the federal tax burden by **\$766.6** billion over ten years according to the Joint Committee on Taxation and CBO.

**Impact on Ten-Year Budget Deficit.** Proponents of the legislation will claim that CBO states that the legislation will reduce the deficit by \$129 billion. But this is not accurate. Indeed, CBO makes it very clear that the bill will very likely lead to substantial increases to the national debt, since the assumptions that lead to that figure almost certainly will not occur. As CBO puts it:

These longer-term projections assume that the provisions of H.R. 3962 are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the SGR mechanism governing Medicare’s payments to physicians has frequently been modified to avoid reductions in those payments, and legislation to do so again is currently under consideration in the Congress. **The bill would put into effect (or leave in effect) a number of procedures that might be difficult to maintain over a long period of time. It would leave in**

**place the 21 percent reduction in the payment rates for physicians currently scheduled for 2010. At the same time, the bill includes a number of provisions that would constrain payment rates for other providers of Medicare services. In particular, increases in payment rates for many providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care).** Based on the extrapolation described above, CBO expects that Medicare spending under the bill would increase at an average annual rate of roughly 6 percent during the next two decades—well below the roughly 8 percent annual growth rate of the past two decades, despite a growing number of Medicare beneficiaries as the baby-boom generation retires.

**The long-term budgetary impact of H.R. 3962 could be quite different if those provisions generating savings were ultimately changed or not fully implemented.** If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.

In other words, to claim that the legislation will lead to \$129 billion in deficit reduction is to advocate allowing the SGR cuts to take place as currently scheduled, and to advocate a host of new reductions to provider payments (according to CBO many providers would have payments held to increases below inflation). Beyond that, to claim that that the bill reduces the deficit by \$129 billion is to advocate that Congress appropriate not one penny of the billions of dollars CBO says will be required to implement the legislation. And it is to advocate that Congress appropriate not one penny for the many new programs created by the bill (that will be subject to the appropriations process).

**Major Changes Since H.R. 3200 Unveiled:** While H.R. 3962 contains minor tweaks in premium rates, surtaxes, penalties for not complying with mandates, and “negotiated” rates in the government-run plan, the bill largely leaves intact the egregious provisions from H.R. 3200. Also of note, the bill moves a step further away from the façade of bipartisanship as H.R. 3962 only includes [5 Republican amendments of the 20](#) that were previously accepted in the Committees on Education and Labor and Energy and Commerce. The bill includes various provisions meant to appease moderate Democrat Members but a closer inspection reveals that the following provisions merely pay lip service to these issues:

**Removal of the Sustainable Growth Rate (SGR) “Fix”:** The Pelosi Government Healthcare Takeover bill uses a budget trick to avoid offsetting the \$210 billion cost of enacting a permanent repeal of the Sustainable Growth Rate (SGR), or “Doc Fix”. The Democrats detached the permanent “doc fix” provision from the larger bill, H.R. 3962, and introduced it separately (without it being paid for), as H.R. 3961, with the intention of bringing it up at the same time as H.R. 3962, using a procedural maneuver (likely a “self-executing rule”) that will cause the SGR fix to be incorporated into the larger bill without technically adding to the score. CBO determined Wednesday, that H.R. 3961, the House’s physician payment fix will cost \$210 billion over 10 years. CBO reduced its cost estimate from a previous \$245 billion due to the Obama administration’s, acting through HHS, retroactive removal of the cost of physician-administered drugs from the formula. **Some conservatives may be concerned that the Democrats are not being honest with the American people concerning the cost of this legislation**

**Medical Liability Reform:** Not surprisingly, the Democrats have played lip-service to medical liability reform while including language that protects trial lawyers. The bill gives money (authorized at “such sums”) to states that enact “certificate of merit” (a document signed by a medical professional that says there is a probability that the standard of care was violated) and / or a certificate of “early offer” (an early, confidential apology) laws, but will not pay for state reforms that limit attorneys’ fees or impose caps on damages.

**Interstate Health Insurance Compacts:** Unlike Republican proposals for shopping across state lines, this bill would only provide for regional compacts that states can enter into if their state legislatures approve it. The Secretary would consult with the NAIC when developing model guidelines for the creation of such compacts, states would retain the authority over consumer protections and the ability to bring claims to the court in the state the resident resides, and would revive up to \$1 million per year to regulate coverage sold in secondary states. **However, these compacts can only exist after the federal government has established stringent national rules** for minimum benefits and what constitutes a “qualified plan,” virtually eliminated the individual market, and created a national exchange, causing many to wonder how any real increase in competition would even be possible.

**Health Insurance Cooperatives:** H.R. 3962 requires that the Commissioner to establish a “CO-OP Program” to help organizations and fund (\$5 billion for FY 2010-2014) the creation of even more not-for-profit insurance companies **alongside the government-run plan**. The CO-OPs would only have to pay back the loans or grants plus interest if they violate the terms of the program. Otherwise they, like the government-run insurance plan, are financed on the back of the taxpayer with **no prohibition on the CO-OP from receiving a bail-out if it fails**.

**Repeal of Anti-Trust Exemption for Health and Medical Liability Insurers:** The bill includes partial repeal of the insurance anti-trust exemption in the McCarran-Ferguson Act for *only* health insurance and medical malpractice insurance to prohibit “price fixing, market allocation, or monopolization,” which is already regulated by states. This appears to be a political move to intimidate insurers – as contrary to Democrats claim that a repeal will increase competition and bring down costs, [CBO](#) has found that it may actually increase premium costs due to being subject to additional (federal) litigation, but more than likely would have no effect as “state laws already bar the activities that would be prohibited under federal law if this bill was enacted.” The repeal may in fact have a negative effect on competition by prohibiting smaller insurance businesses from gaining access to enough information to accurately trend, forecast, or rate and potentially keeping new entrants to the market from being able to accurately rate or price. The National Association for Insurance Commissioners (NAIC) also stated in a [Letter](#) to the House and Senate Judiciary Chairmen that “the notion that McCarran-Ferguson in any way encourages collusion or is the cause of high health insurance and medical malpractice premiums **is not supported by the facts.**”

The bill would also expand the FTC’s oversight authority over health insurance whether or not the insurer is for profit or not for profit (current FTC authority applies only to for-profit). Many conservatives may believe that the inclusion of this provision is duplicative and merely a political move to intimidate insurers while attempting to get at the perceived problem of markets in which one insurer has a very large market share. However, as the NAIC points out, “We know there are persuasive arguments that there is a lack of competition in some states, with few insurance companies competing against one another. Such a situation normally raises serious anti-trust concerns. However, insurance companies are different than other businesses in terms of current state oversight.” Rates, among other issues, are currently reviewed by state insurance commissioners, who do not permit a rate if it is not justified by claims experience. Other reasons for high market share that have nothing to do with anti-trust violations may be the result of that plan offering the most competitive rates, highest beneficiary satisfaction or longest market history in that state or other factors such as aggressive state regulations and benefit mandates that keep insurers from entering the market. **Some conservatives may believe that a more reasonable approach to increase insurance competition would be to allow for individuals to shop across state lines.**

**Interim High Risk Pool:** H.R. 3962 would establish a *national* interim high risk pool of sorts (costing \$5 billion) beginning January 1, 2010 through December 31, 2012 for people without coverage for at least 6 months, that were turned down by private insurers due to pre-existing conditions, that were offered coverage with pre-existing limitations but the offered rate was above the rate for the high risk pool coverage, that are on retiree health coverage whose annual increase in premiums exceed “such excessive

percentage,” or that had an eligible medical condition determined by the Secretary. The inclusion of this provision is interesting, considering that when RSC offered such a proposal, House Majority Leader Hoyer criticized it. Click here for a [must read](#).

The bill also establishes sanctions on insurers who the Secretary determines have encouraged beneficiaries to disenroll from their current health benefits coverage (as a means to improve their own risk pool) prior to enrolling in the national high-risk pool. Premiums in the pool can vary by age on a 2:1 ratio, can't be higher than 125% of standard rate for comparable coverage in individual market, and will be adjusted for geographic variations. The pool must cover benefits defined in the essential benefits package, have caps on deductible and cost sharing, have no preexisting condition exclusion period, and have an appeals' process related to an individuals eligibility and claims submission. The state, as a condition of the benefits must do a maintenance of efforts for their current high-risk pool made in as of July 1, 2009 and maintain insurers contributions to pool already in place. The bill states that if the \$5 billion appropriated isn't enough, the Secretary may make adjustments to eliminate the deficit including reducing benefits, increasing premiums or establishing waiting lists. However, without an explicit ban, **some conservatives may be concerned that a pool would be able to receive a bail-out if it runs out of money, even after the Secretary makes changes.**

**Extends Health Benefits Applicable to Spouses and Dependents to Domestic Partners:** This provision expands the definition of an eligible beneficiary to include “any individual who is eligible to receive benefits or coverage under an accident or health plan.” Currently domestic partners do not qualify for dependant status under the tax code and the Defense of Marriage Act (P.L. 104-199) prohibits their classification as spouses. The bill would change their status for tax exempt purposes relating to insurance at a cost of \$4 billion over 19 years.

**COBRA Extension:** Extends COBRA eligibility (extended post-employment health care coverage) to permit individuals to remain in their COBRA policy until the Health Insurance Exchange is up and running. This would force employers to spend more time and money to administer COBRA to former employees, while increasing premiums for current employees.

**Repeals the Medicare Trigger:** Repeals Subtitle A of Title VIII of the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*, commonly referred to as the “45% trigger,” a cost-containment measure inserted into law by the Republican Study Committee.

**Nutrition Labels for Menus and Vending Machines:** Includes the requirement for nutrition labeling of standard menu items at chain restaurants and of articles of food sold from vending machines.

**Federal Funds for Indian Sexual Predators and Does Not Include a Permanent Ban on Abortion Services for Indian Health:** The Indian Health Service reauthorization was added to the back of the health care bill without a provision that would permanently prevent the Indian Health Service from funding abortions. The reauthorization would also create a grant program that would support Indian child abusers.

**Creates a Long Term Care Entitlement Program, The CLASS Act:** The Community Living Services and Support (CLASS Act), which is part of H.R. 3962, would create a government-sponsored long term care insurance program that would automatically enroll individuals unless they actively opt-out. This amounts to a federal take-over of the private long-term health insurance system.

Individuals would pay premium levels set by the federal government (estimated to be \$123/month on average) in exchange for a \$50-a-day benefits to cover the cost of care. However, an individual must first pay into the program through premiums for 5 years before they can receive any benefits - meaning that

the program wouldn't pay anything out until 2016. Furthermore, the \$50-a-day allocation for long-term care insurance is only a portion of the actual cost of long-term care for senior. The CLASS Act would only add to the confusion about Medicare coverage of long-term care without covering the true cost of care. The Act could cause seniors to drop their current coverage.

The CLASS Act is another unsustainable program being used to disguise the short-term costs of the broader bill through a budget gimmick. According to the CBO, the CLASS Act would raise \$72 billion over the first ten years (while paying out \$0 in benefits for half of that time), but will begin to increase the deficit following FY2029. A group of 7 Democrat Senators stated in a letter to Senate Majority Leader Reid, "We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues. This is especially the case if savings from the first decade of the program are spent on other health reform priorities."

Numerous organizations have raised concerns with the CLASS Act, including CBO, the Concord Coalition, as well as the American Academy of Actuaries, who found that due to its program design, the program would require massive premium increases and benefit decreases by 2019 to remain solvent.

**Some conservatives may be concerned that this is another unsustainable program being used to disguise the short-term costs of the broader bill through a budget gimmick.**

**Government-Run Health Insurance Plan:** The introduction of a government-run plan is nothing more than a back door path to a government takeover of health care. Because the government-plan would be subsidized by taxpayers, private insurance would be priced out of the market, leaving patients with only a government plan. The bill allows the Secretary to "negotiate" rates for providers who will be auto-enrolled in the plan with an opt-out process largely determined by the Secretary. While it "allows" providers to opt-out in the first year, the provision is silent on the process for reenrollment – meaning that providers may face other penalties if / when they decide to opt back in. Furthermore, the bill contains no definition of "negotiate," thus causing some conservatives to be concerned that the Secretary will simply tell providers – who cannot under current law band together to negotiate – that they are paid Medicare rates.

**Institute of Medicine Study (IOM):** The bill adds two studies by the Institute of Medicine, one on the accuracy, validity, and effects of the Medicare geographic adjusters used for provider payments and another on geographic spending variation in health care for both private and public payers. The IOM shall issue recommendations after a study on Medicare payments, after which CMS is instructed to spend \$4 billion in response to increase payments and "hold harmless" to those who the study found payment inaccuracies for only 2 years. The Secretary will then develop a plan for changing the Medicare payment system based on the recommendations. These changes will automatically become law in 2013 unless Congress votes to disapprove it. Some conservatives may have concerns with the massive power given to IOM, CMS and HHS without clarifying that the payment system cannot delay, deny, or ration care by not covering certain treatments or services.

**Vast Medicaid Expansion:** Increases Medicaid eligibility up to 150% of the Federal Poverty Level (FPL), up from 133% in the previous version of the bill, and up from 100% under current law, hurting already thinly stretched state budgets (a \$34 billion unfunded mandate) while dumping 15 million more people onto an already unsustainable entitlement program with poor patient access and care.

**Citizenship and Legal Immigration Verification:** The bill adds a provision that **still fails to adequately address citizen verification** for individuals applying for low-income affordability subsidies, or enrolling in Medicaid, or enrolling in high risk pools. Instead the bill simply extends sub-par standards enacted under SCHIP.

**Second Generation Bio-fuel Producer Credit:** The bill prohibits the so-called “black liquor” – a wood pulp byproduct that can be used as an alternative bio-fuel – from becoming eligible to receive a \$1.01 per gallon tax credit for cellulosic bio-fuel production that was established in the 2008 farm bill. Recently, the IRS determined that paper companies that produce “black liquor” could become eligible to receive the nonrefundable credit if the EPA registered it as a qualifying fuel for the cellulosic credit. The amendment would extend the credit to “cultivated algae, cyanobacteria, or lemna,” but not allow “black liquor” to be eligible for it. This provision is expected to help offset the cost of the bill by raising taxes on the paper and bio-fuel industries by \$24 billion by ensuring black liquor will not qualify for the tax credit. However, according to the American Forest & Paper Association, they do not even believe “black liquor” would qualify under an EPA ruling, so the “revenue raiser” is questionable and the potential for unintended consequences on the paper industry could affect current tax incentives for paper production in the United States.

**Immediate Reforms:** The bill implements “Immediate Reforms” (effective January 1, 2010) many of which sunset on date of coverage offered through the Exchange as they are also included under the new insurance standards, regulation, and mandates, beginning in 2013, the first year of the Exchange.

- Gives the Secretary the authority to set medical loss ratios - as long as they are less than 85% in the group market as well as in the individual market.
- Prohibits recession of insurance unless clear and convincing proof of fraud.
- Requires yearly submission of private insurance premium increases with justification prior to implementing.
- Allows “young adults” to stay on their parents’ insurance plan until age 27, if the individual who (but for age) would be treated as a dependent child of the participant under such plan or coverage and doesn’t have other coverage.
- Places new limitation on pre-ex coverage and look back (with union exception) before the prohibition occurs in 2013.
- Prohibits domestic violence from being treated as a preexisting condition.
- Eliminates lifetime dollar limits imposed by health plans.
- Prohibits post retirement reductions (benefits which are currently voluntary).
- Requires coverage for treatment of children (up to age 21) with deformities.
- Creates wellness program grants of up to 50% (or \$50,000 a year) of costs incurred by small businesses for specific qualified programs certified by the Department of Labor, HHS or the CDC. However, an employer cannot receive a credit for programs that provide financial rewards tied to the premium or cost-sharing of the individual under the health benefits plan.
- Creates State Health Access Program grants.
- Requires the Secretary to adopt a plan for administrative simplification and standards for electronic administrative transactions that enable electronic funds transfers, claims management processes, and verification of eligibility among other items. Applies HIPAA privacy protections and annual audits to ensue compliance.

**Summary:** H.R. 3962 closely follows H.R. 3200, which passed out of the Committees on Energy and Commerce, Ways and Means, and Education and Labor in July. *Highlights* of the bill are described below.

## **Division A - Affordable Health Care Choices**

Division A focuses on coverage expansion, insurance regulations, and tax increases. Some *highlights* include:

**Tax Increases:** The bill would increase taxes by a staggering *\$766.6 billion* over ten years. These taxes would fall on the backs of small and large businesses, individuals, medical devices (like wheelchairs) and various other non-health care related items.

**Health Insurance Taxes:** The bill includes limitations on Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), medical devices, health plans and other items including:

- *\$5 billion* in taxes from non-prescription medications from being purchased pre-tax using these accounts, beginning on December 31, 2010.
- *\$13.3 billion* in taxes from an annual cap of \$2,500 on FSAs, which are currently uncapped due to the “use-it-or-loose-it rule” whereby at the end of a plan year money remaining in an FSA must be forfeited by the employee beginning on December 31, 2012.
- *\$1.3 billion* in taxes from subjecting non-qualified distributions from HSAs to a tax of 20% on the disbursed amount (current law is 10%) beginning on December 31, 2012.
- *\$2.2 billion* in taxes from eliminating the exclusion for subsidies employer plans receive in connection with offering qualified retiree prescription drug coverage under the Part D retiree drug subsidy program (RDS) beginning on December 31, 2012. Under current law, this government subsidy is not subject to corporate income tax. Some conservatives may be concerned that eliminating this favorable tax treatment will lead to employers dropping drug benefits for retirees.
- *\$2 billion* tax on health plans from a new “fee” is imposed on insurance policies to fund the Comparative Effectiveness Research Trust Fund based on a “fair share” calculation beginning on October 1, 2012.
- *\$20 billion* tax on medical devices (hospital beds, wheelchairs) from a 2.5% tax on sales beginning December 31, 2012
- *\$14 billion* in other indirect tax revenues from Medicare, Medicaid, etc. (fraud, waste and abuse, administrative simplification, and Effect on Revenues of Provisions Involving Comparative Effectiveness, Access to Generic Drugs, and Follow-On Biologics)

**Other Non-Health Related Taxes:**

- *\$26.1 billion* from the complete repeal of the implementation of the Worldwide Allocation of Interest, a corporate tax relief provision from the American Jobs Creation Act.
- *\$23.9 billion* from modifications to the current-law cellulosic biofuel producer credit by excluding certain fuels (“black liquor”) from eligibility for this credit.
- *\$17.1 billion* from expanding of 1099-MISC information reporting to corporations.
- *\$7.5 billion* to override U.S. treaties for certain payments such that it increases taxes on U.S. employers with overseas operations.
- *\$5.7 billion* in taxes from codifying the “Economic Substance Doctrine,” which allows the IRS to disallow a tax deduction or other tax relief simply because the IRS deems that the motive of the taxpayer was not primarily business-related (as opposed to tax-related).
- *\$460.5 billion* in taxes from a 5.4% surtax on “wealthy” individuals and small businesses with income over \$500,000 (\$1 million for married filing jointly). Although Democrats argue that the surtax on the “wealthy” only affects 1.2% of small businesses, JCT found that 1/3 of the \$460.5 billion raised will be from business income. Also of note, the income thresholds for this tax is not indexed for inflation which means the tax will eventually hit the middle-class

**Penalty Payment from Not Complying with Insurance Mandates:**

- *\$135 billion* in new taxes for failure to comply with the “pay-or-play” employer mandate.
- *\$33 billion* in new taxes for failure to comply with the individual mandate.

**Immediate Reforms:**

**Prohibition Against Reductions in Retiree Health Benefits:** Upon date of enactment, employers offering voluntary retiree benefits cannot reduce these benefits or increase share of premium unless they also reduce current employees benefits. Business leaders sent a letter in July to Pelosi stating that: “Mandating benefits in this manner significantly increases both the cost and risk to the employer of voluntarily providing retiree health plans at all. These costs and risks will have to be paid for by reduced benefits, wages, or jobs. The unintended consequence of [this section] would be a drastic reduction in the number of employers offering retiree benefits.” Some conservatives may be concerned that this provision, once again proves that under the Democrat bill, if you like what you have there is little chance you will keep it.

**“Reinsurance” Subsidy Program for Retirees:** 90 days after enactment, the Secretary of HHS will establish a temporary program to reimburse employment-based plans for 80% of claims that exceed \$15,000 but are less than \$90,000 (CPI annual adjustment), for health benefits provided to 55-64 year old retirees and their dependents. During the Pelosi rewrite, unions and state agencies or political subdivisions were included in the definition of “eligible employment-based plan.” Some conservatives may be concerned that this was added in to buy off states and unions whose rich benefits are costly but must be maintained due to contracts or law.

**State Health Access Program Grants:** The Secretary will provide grants (“such sums”) to establish programs to expand access to affordable health care coverage for the uninsured populations in that state as long as they are consistent with other reforms under Division A. The grants must be spent on a limited set of reforms before 2013, with states contributing 20% of the monies awarded (unless they receive a hardship waiver). Grants can go to: state insurance exchanges, community coverage programs, reinsurance plans, a transparent marketplace (such as a Web exchange or portal) for the sale of insurance products, statewide or automated enrollment systems for public assistance programs, innovative strategies to insure low-income childless adults, and not-for-profit / consumer purchasing collaborative.

**Regulation over Health Insurance Price Increases:** Beginning in 2010, the Secretary in conjunction with the states shall set up an annual review process for monitoring increases in health insurance premiums. Insurers must submit justification for any premium increase prior to implementation. Provides grants to the states (\$1 billion) for giving information to the Commissioner relating to trends in premium increases. It further increases states’ power in determining whether an insurer should not be allowed to participate in the Exchange due to “excess or unjustified premium increases” (i.e. price gouging). The Commissioner is to take these factors into consideration when making determinations about offering contracts to “qualified health benefit plans” (QHBP). The Commissioner is also given the ability to monitor and keep track of these items starting in 2014, both inside and outside of the Exchange. When considering whether to include larger employees in the Exchange the Commissioner should take into account excess of premium growth outside the Exchange compared to inside.

### **Mandates:**

**Individual Mandates:** When the federal government requires individuals to purchase health insurance, it then must also define what qualifies as health insurance. The definition provided in the bill will surely force some Americans to purchase plans that include coverage they cannot afford, or don’t want or need. Individuals who don’t purchase “acceptable health care coverage” will be forced to pay a tax of 2.5% of modified adjusted gross income (MAGI), not to exceed the national average premium in the Exchange. According to CBO, in H.R. 3962, the share of income that enrollees would have to contribute toward premiums was **increased** from the previous version and indexed so that federal subsidies would grow more slowly over time. Some conservatives may be concerned that this breaks President Obama’s pledge not raise taxes on individuals making less than \$250,000.

**Employer Mandates:** The cost of the mandate may force businesses to hire fewer workers, cut workers' hours, reduce the growth of wages or other benefits, and layoff current employees or pass along the costs to consumers. Under the "Pay-or-Play" mandate, companies with a payroll of \$500,000 or more must offer health coverage to employees (regardless of whether they can afford to or not), or pay a penalty of at least 2% of payroll. If an employer with a payroll greater than \$750,000 does not pay 72.5% of a single employee's health premium (65% of a family employee's), then the employer must pay an excise tax equal to 8% of average wages. **Like the individual mandate, the payroll exemption is not indexed and thus over time fewer small businesses will qualify for an exemption.** While the bill does provide a small business tax credit, it is far from sufficient, as it is only available for two years and phases out for firms with more than 10 employees (while excluding individuals with incomes over \$80,000 for purposes of calculating the credit).

This bill amends Employee Retirement Income Security Act (ERISA) to require the Secretary of Labor to "conduct investigations" and audits "to discover non-compliance" with the mandate. The bill provides a further penalty of \$100 per employee per day for non-compliance with the "pay-or-play" mandate—subject only to a limit of \$500,000 per year for unintentional failures on the part of the employer. Allows the new Commissioner to conduct audits of health benefits plans (paid for by the benefit plans).

**Conservatives may be concerned that the bill encourages employers to drop coverage and dump people into the Exchange rather than pay the increased rates associated with the costly mandates. According to estimates based on findings from the Council of Economic Advisors (CER) Chair, the mandate will result in 5.5 million lost jobs.**

**Exchange:** Effective 2013, the bill creates a national health insurance exchange and implements health insurance reforms. The Exchange is limited to those who don't have access to employer-based coverage, those who are not eligible for existing public programs and small businesses through 2014. In 2013, firms with up to 25 employees can enter the Exchange; in 2014, firms with up to 50 employees; in 2015, firms with up to 100 employees (unions are also allowed in at this time); in 2015 and beyond the Commissioner can allow larger employers "as appropriate." The Exchange will offer 4 highly structured types of plans starting off with a "basic" level with the highest cost-sharing and moving towards a richer benefit with lower cost sharing. This provision may cause some conservatives to be concerned that innovative plans will cease to exist.

**Health Choices Administration:** The new Agency will be governed by a Commissioner who will oversee the Exchange; establish standards for, accept bids from, and negotiate and enter into contracts with, QHBP offering entities; facilitate outreach and enrollment in such plans of Exchange-eligible individuals and employers and establish a risk pooling mechanism and consumer protections. The Commissioner also defines who is and is not a full-time and part-time employee, and what is the minimum employer contribution. The Commissioner has the power to continuously change thresholds, thus leaving small business owners in constant fear of ever-changing compliance requirements. Some conservatives may be concerned at the creation of another large bureaucracy with consolidated power. Some conservatives may be concerned that community organizations like **ACORN** may assist the Health Choices Commissioner in enrolling individuals in the Health Insurance Exchange.

**Health Benefits Advisory Committee:** The bill creates yet another federal board of unelected bureaucrats to make minimum benefits standards and cost-sharing requirements for all health care plans. The bill omits language to protect individuals from government rationing. Speaker Pelosi's bill no longer contains a provision that states that the Health Benefits Advisory Committee - created to establish minimum benefit standards - should "ensure that essential benefits coverage does not lead to rationing of health care."

**Premium and Cost sharing Subsidies:** Subsidies will be available for “low-income” individuals and families with income between 150% and 400% Federal Poverty Level (FPL). The subsidies are based on a sliding scale such that individuals at 400% FPL must pay 12% of their income before they receive any subsidy amount. The bill also establishes specific out-of-pocket maximum levels of cost sharing at each income tier. However, as CBO noted, these costs are going to rise for individuals because the subsidy is indexed to maintain a constant rate for government’s share of the premium.

**Government-Run Health Insurance Plan:** Beginning in 2013, the bill creates a “public plan”, run by government bureaucrats, paid for on the backs of taxpayers (\$2 billion in “start-up funds”) to “compete” in the Exchange. The Lewin Group estimates that the uneven playing field will cause as many as 114 million people to be dumped into the government plan due to lower provider payments and cost shifting onto private plans. According to CBO, under the initially negotiated rates, the plan “would typically have premiums that are somewhat higher than the average premiums for the private plans in the exchanges... The public plan would have lower administrative costs than those private plans but would probably engage in less management of utilization by its enrollees and attract a less healthy pool of enrollees.” However, as we have seen with Medicare and Medicaid, there is nothing to prohibit the government to change the rules and tilt the field in their direction through price fixing, cut in payments or rationing care.

### **Insurance Regulations:**

**De Facto Elimination of The Private Individual Market:** Despite the claim that current health care plans are “grandfathered” in, if an individual’s current insurance company makes any additions to its plan (such as including more people or adding a newly found cure for cancer), it would trigger the mandate to have a government approved plan.

**“Qualified Health Benefit Plan” (QHBP):** Beginning in 2013, all Exchange plans must abide by the rules regulating insurance set forth in the bill. After five years, all plans (including employer sponsored plans) must then meet a new federal definition for a “qualified” health care plan. According to the National Federation of Independent Business (NFIB), 86% of small businesses who offer coverage only offer one plan, but the new bill will make it even harder for them to offer anything. The bill requires small employers to offer certain services that are currently exempt from under federal law.

**“Essential Benefits Package”:** The bill states that as of 2013, all plans must abide by a minimum benefit standard, cost-sharing restrictions, and cap on out-of-pocket expenses. The out-of-pocket cap on medical expenses is *\$5,000 for an individual/\$10,000 for a family*, while there can be no co-payment for preventative services. The bill also provides for a de facto elimination of HSAs, since the minimum cost-sharing actuarial equivalence for health plans being set at 70%. HSAs cost sharing structures, however, are anywhere from 55%-65%, thus essentially outlawing HSAs as a “qualified plan.” Other insurance requirements include guarantee issue, ban on annual and lifetime limits, and a 2:1 community rating based on age, family structure, and geography.

The minimum covered benefits include: prescription drug coverage; hospitalization; outpatient hospital and clinic services; professional services; physician-administered supplies and equipment; rehabilitative and habilitative services; mental health services; preventive services; maternity benefits; well child care “for children under 21 years of age;” and durable medical equipment.

### **Other Issues:**

**Treatment of Territories:** It should be noted that although territories are included in titles I through III relating to insurance market reforms; thus they are exempted from the employer and individual mandates,

tax penalties associated with non-compliance with the mandates, and other general tax increases.

**State Carve-Outs:** Despite refusing to allow states to opt-out of the bill entirely, Democrats have no problem with carving out special exemptions for the state of Hawaii and an indirect exemption for the state of Massachusetts. Rather than applying the mandates of H.R. 3962 equally, the bill creates special statuses for favored states. Sec. 256 allows Hawaii to be exempt from state penalties imposing greater mandates by making the Hawaii Prepaid Health Care Act a qualified health benefits plan. Sec. 308 allows the “optional operation” of state health insurance exchanges if states can demonstrate that they can fulfill all the functions of an exchange. Furthermore, the bill provides that a state operating an exchange before January 1, 2010 shall be presumed by the Commissioner to meet the standards required by this section. The only state that appears to be eligible for such an exemption is Massachusetts, which enacted health care reform in 2006 that created the Connector, their version of a state health insurance exchange. Additionally, H.R. 3962 provides matching federal grants for states operating their own exchanges. Not only would Massachusetts’s health care system likely be exempt, it would receive federal funding. **Some conservatives may ask, “If the Democrats’ plan is really the prescription for the ailments of the American health care system, then why do certain states require immunity from the provisions of H.R. 3962?”**

**Civil Actions by State Attorneys General.** The bill allows any State Attorney General to bring a civil action in on behalf of a person residing in such State “to secure monetary or equitable relief for violation of any provisions of this title or regulations issued thereunder” This provisions means that 50 different states can now bring suit to enforce any provision of title II, not just for insurance regulation violations.

## **Division B—Medicare and Medicaid Improvements**

Division B makes significant changes to Medicare and Medicaid payments system, provides for a vast expansion of Medicaid, and cuts billions of dollars in Medicare that will result in less access to providers and choice.

**SCHIP Déjà Vu:** Pelosi’s bill (H.R. 3962) extends the sub-par standards enacted under the Children’s Health Insurance Program (commonly known as SCHIP) reauthorization in the beginning of the 111<sup>th</sup> Congress (P.L. 111-3), which weakened laws already in place related to documentation requests. SCHIP removed the requirement that citizens and nationals provide documentation proving their citizenship in order to be covered under Medicaid and SCHIP. Instead, it required that a name and Social Security number be provided as documentation of legal status and that those names and Social Security numbers be submitted to the Secretary to be checked for validity. Conservatives will be concerned that a Social Security number and name are not enough to prove immigration status.

**Ineffective Verification Methods:** According to Section 347 of the underlying bill, illegal immigrants are not eligible to receive affordability credits (government subsidies to purchase “qualified health benefit plans”). *However*, the verification method to determine whether an individual is here legally is unreliable and ineffective. While the bill requires that applicants give a Social Security number, it contains no requirement that an individual show a valid ID in order to match the individual with the Social Security number provided – thus creating a vast opportunity for fraud and abuse. Moreover, the verification provisions allow an individual who self-certifies eligibility presumptively to enroll in federal programs—and remain enrolled for up to 120 days after a records discrepancy is finally discovered.

**Backdoor Eligibility for Illegals with Legal Relatives.** Section 342 of the underlying bill contains a subheading entitled “Treatment of Family,” which implies that if a legal member of the family is eligible for affordability credits, the family will be eligible as well – regardless of immigration status.

**Medicaid Provisions:** Increases primary care payments to bring them up to 100% of Medicare rates by 2012, (allows) establishes a Medicaid Home Pilot program, creates Medicaid Accountable Care Organizations, and allows states to cover various items new programs and certain low-income HIV positive individuals at an enhanced Federal Medical Assistance Percentages (FMAP). The bill extends funding for the Transitional Medical Assistance (TMA) program, a program that provides Medicaid benefits for low-income families transitioning from welfare to work, by 2 years.

**Expansion to Higher Incomes:** Despite an estimated **\$80 billion** in taxpayer dollars lost *every year* due to Medicare and Medicaid fraud, the bill drastically expands the currently unsustainable Medicaid program from 100% of Federal Poverty Level (FPL) to 150%. This expansion will open up the program to an additional 15 million individuals, and by, 2019, 1 in 6 people will be enrolled in the Medicaid and CHIP entitlement programs. Upon enactment, the bill further requires states to do “maintenance of efforts” for current Medicaid and CHIP eligibility. **Some conservatives may be concerned that Congress is passing up an important opportunity to tailor and prioritize Medicaid for the lowest-income individuals.**

**Extends the Additional Federal Medicaid Aid to States (FMAP) Under The ARRA:** The legislation would provide \$23.5 billion to states, increasing by two calendar quarters through the end of FY 2011 the share of Medicaid costs the federal government reimburses all states by 6.2%, with additional relief tied to rates of unemployment. **Some conservatives may be concerned that the federal government is forcing states to expand eligibility when they are struggling to maintain current eligibility.**

**Medicaid Rebates:** The bill requires that in order for drug manufacturers’ drugs to be covered under Medicare Part D, they must expand Medicaid drug rebates under Medicare to dual-eligibles in 2010, and a modified Medicaid rebate to any low-income subsidy individual in 2015. Beginning in 2010, Medicaid rebates are vastly expanded in size from 15.1% to 23.1%, as they are extended to Medicaid managed care organizations (MCOs), and applied to line extensions of certain types of drug.

**Cost to States:** Cost to states would be \$34 billion – although the true cost once fully implemented will be much greater, as the Medicaid program is not expanded until 2013, and the states are not required to share in their 9% of funding until 2015. However, this cost is not included in CBO’s overall ten year cost of the bill. Some conservatives may be concerned that imposing an unfunded mandate on the states to pay for the bill’s Medicaid expansion will shift the burden to state taxpayers, who may experience further tax increases to cover the cost.

#### **Medicare Provisions:**

- **Disproportionate Share Hospital (DSH) Cuts:** The bill requires Medicare and Medicaid DSH reports and payment adjustments in response to coverage expansion.
- Makes payment cuts and Market Basket updates to home health, long term care, nursing homes and hospital payments.
- **Equipment Utilization Rate Assumptions:** Increases the equipment utilization rate assumptions for X such that it would further reduce payments on top of significant cuts stemming from the Physician Fee Schedule Final Rule and the Deficit Reduction Act (DRA).
- Allows for payment reductions for high readmission rates and reporting on hospital based infections.
- Establishes Medical Home and Accountable Care Organizations pilot programs.
- **Prevention and Mental Health Coverage:** Eliminates co-payments and cost-sharing for certain preventive services while covering marriage, family therapist, and mental health counselor services
- **Physician Payment Sunshine:** Beginning on March 31, 2011 the bill requires reporting of payments

and transfers over \$5 in value by manufacturers to “covered” recipients with all information reported online.

- **Fraud, Waste and Abuse Provisions:** Establishes a 90-day waiting period for first time DME provider claims, requires a Medicare fraud and abuse hotline number on explanation of benefits, increases funds for policing and levies various fines and penalties on Medicaid, Medicare Advantage, and Part D for mis-representing facts.
- **Expansion of Electronic Transactions in Medicare by 2015:** Requires Medicare payments to providers be made in electronic form to insured depository institutions.
- **Medicare Payment for Biosimilar Biological Products:** Dictates that an “interchangeable” follow-on product be put in the same billing code as the reference product.

**Medicare Advantage:** If seniors like the Medicare Advantage plan they have now, they won’t be able to keep it. The cuts to Medicare Advantage mean that the 22% of Medicare beneficiaries (11 million American seniors) enrolled in a Medicare Advantage plan will see their benefits cut. According to CBO, the House bill “could lead many plans to limit the benefits they offer, raise their premiums, or withdraw from the program.” The CMS Actuary Report finds that “Medicare Advantage enrollment would decrease by 64% (from a projected level of 13.2 million to 4.7 million under the proposal).” The bill cuts \$170 billion from Medicare Advantage, and \$237.3 billion when including direct cuts and “savings” due to interactions. After drastically slashing the program and requiring MA plans to have the same cost sharing as traditional Medicare, giving the authority to the Secretary to deny MA bids, and numerous other onerous regulations, the bill then allows quality bonus payments in certain areas to soften the blow.

**Medicare Part D:** The Pelosi bill makes various changes to the Part D benefit - for consumers and plans, and drug manufacturers including:

- Beginning in 2011, the bill prohibits Part D plans, once they have begun marketing, from making any mid-year formulary changes that would increase beneficiary cost-sharing or reduce benefits.
- Increases generic drug use through requiring plans to waive or reduce co-pays in Part D “to induce the individual to switch to a generic, bioequivalent drug, or biosimilar” beginning in 2011.
- Starting in 2010, PhRMA will indirectly pay to close the beneficiaries’ Part D “donut hole” by \$500 with a 50% discount for brand-name drugs, with the donut hole completely closed by 2019.
- Starting in 2011, the Secretary of HHS will gain authority to “negotiate” Medicare drug prices by repealing the non-interference clause. The bill repeals a provision so that the Secretary may now set a price set through establishing a reimbursement formulary or price structure.

Despite Speaker Pelosi’s claim that the bill will close the Medicare Part D “donut hole,” what she doesn’t say is that, according to CBO, changes will raise Medicare Part B premiums by \$25 billion and Part D premiums by 20 percent.

**Physician-Owned Hospitals:** The bill would ban new physician-owned hospitals (as of January 1, 2009) from participating in Medicare, and place severe restrictions on the expansion of existing hospitals, ultimately resulting in growth controlled at the federal level. Physician owned hospitals currently in existence will essentially not be able to grow, as they must now jump through extensive hoops. Only a small percentage of such hospitals will even be eligible to ask the Secretary of HHS for an expansion. In addition, it is estimated that about 124 projects under development in 22 states will not be recognized under Medicare or eligible for the self-referral exemption. **Some conservatives may be concerned that the bill is taking legitimate state certified hospitals, and legislating that they cannot grow. Some of the best hospitals in the world, such as the Mayo and the Cleveland Clinic, were started as physician-owned hospitals.**

**CMS Innovation Center:** The bill would establish a Center for Medicare & Medicaid Innovation within CMS that gives the Secretary wide-ranging authority to conduct and expand payment demonstrations in

Medicare and Medicaid. The Center is to be established by January 1, 2011. Some conservatives may be concerned that this Center would grant too much power to make arbitrary cuts.

**Comparative Effectiveness Research:** The bill establishes another unelected bureaucratic board, (members are appointed by the GAO), the Comparative Effectiveness Research advisory committee, within Agency for Healthcare Research and Quality (AHRQ) that would be financed through a tax on health plans. Democrats have once again refused to limit the scope of CER to “clinical” effectiveness. Since Washington bureaucrats view health care in terms of dollars and cents, this will lead to rationing boards that make one-size-fits-all judgments prohibiting treatment options on the basis of cost.

**Quality Measures:** The bill requires the federal government to establish national priorities for performance improvement and create a list of quality measures, allowing stakeholder input only afterward (included stakeholder such as “labor unions”). The bill cedes further medical decision making by giving the GAO the authority to review residency training curricula to determine whether it is meeting certain quality standards. Some conservatives may have concerns about giving the federal government the power to set priorities, create measures, and make recommendations.

## **DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT**

Division C focuses on public health and wellness, and provider workforce issues. This Division proposes a vast expansion of federal programs, grants and regulations. Some *highlights* include:

### **Workforce:**

**Public Health Investment Fund:** The bill establishes a \$34 billion “fund” to finance various public health, prevention, and wellness programs. However, some conservatives may be concerned that the bill uses an accounting gimmick by only funding the “fund” through 2015, leaving the rest of the provision beyond this date “off the books.”

**National Health Service Corps:** Authorizes funds for National Health Services Corps for 5 years through 2015. Increases maximum loan repayment benefits (\$50,000 per year) and allows part-time service and clinical teaching to count towards fulfillment of service (for up to 20% of the period obligated).

**Primary Care and Dentistry:** Establishes a “Frontline” loan repayment program for additional “health professional needs areas” for individuals in the national health services corps, students, and other health professionals, and makes changes to financial eligibility for primary care loans. Establishes various other training programs including:

- Student loans, guidelines, training, grants for a high or significantly improved percentage of health professionals who provide primary care, as well as training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among primary care professionals).
- Training of Medical Residents in Community-Based Settings.

Some medical provider groups have expressed concerns over the emphasis on national workforce policy on primary care, to the exclusion of surgical and other specialty care.

**Public Health Workforce Corps:** The bill expands eligibility for federal grant funding (authorizes \$283 million over 5 years) through scholarship programs and loan forgiveness for students at accredited graduate schools or programs of public health (including veterinary medicine) who commit to at least two years of public health service. While supportive of workforce improvements, some conservatives may take issue with **federal funds being spent on scholarship programs for veterinarians**. Given this time of high deficits and economic uncertainty some may find it fiscally irresponsible to be spending money this way.

Some provider groups have concerns that the bill fails to recognize the looming workforce shortages in areas besides primary care (such as surgery) by requiring that all unused medical residency training slots be allocated to primary care and placing the emphasis on national workforce policy on primary care, to the exclusion of surgical and other specialty care.

**Prevention and Wellness:** The bill establishes a “Prevention and Wellness Trust” funded for 5 years at \$15.4 billion. \$150 million for Prevention Task Forces, \$1.28 billion for Prevention and Wellness Research, \$6.86 for Delivery of Community Preventive and Wellness Services, \$5.37 billion for Core Public Health Infrastructure for State, Local, and Tribal Health Departments, and \$1.7 billion for Core Public Health Infrastructure and Activities for CDC.

H.R. 3962 establishes a National Prevention And Wellness Strategy to “improve the nation’s health” as well as a Task Force on Clinical Preventative Services that is responsible for indentifying clinical preventive services and to “review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of clinical preventive services identified” for the purpose of developing and disseminating recommendations on the use of such services.

### **Other Provisions:**

**Implementation of Best Practices Through the Agency for Healthcare Research and Quality (AHRQ):** The bill establishes a Center for Quality Improvement under AHRQ (funded at \$1.5 billion over FY 2011 – 2015), giving the agency the power to identify, develop, prioritize and implement best practice measures. Of note, this provision does not place a prohibition on other governmental entities from using information to deny or ration care. Some conservatives may be concerned that this provision cedes the definition of quality to the government in place of those who truly know best, providers working with patients. This provision does not place a prohibition on other governmental entities from using information to deny or ration care.

**Creation of a Pathway for Biosimilars (“Follow-on-Biologics”):** The bill would create an FDA pathway for generic drug companies to manufacture “follow-on” biologics. Creates a regulatory framework that would streamline the follow-on approval process and provide a brand-name drug companies a 12-year period of data exclusivity (with an additional 6 months for agreeing to am FDA request for a pediatric study), allowing them to recoup their investments. The provision grants the Secretary the authority to issue guidance documents (after opportunity for public comment) relating to product classifications.

**Expansion of 340B Program:** The bill would vastly expand the 340B Program (which reduces the drug price paid by certain entities) to include outpatient drugs in specified new covered entities including certain children’s hospitals; critical access hospitals; entities that provide maternal and child health; substance abuse, and mental health services; certain rural hospitals; and sole community hospitals, among others. The bill further regulates the program by prohibiting the use of Group Purchasing Organizations (GPOs) for outpatient drugs to certain entities, including new verification and penalties related to applicable ceiling prices, and requirements that manufacturers “must sell” at or below the ceiling price if

such drug is made available to any other purchaser at any price. Some conservatives may be concerned that this provision **further expands the federal government’s price controls over drug manufacturers**. Negative effects from such a policy include reduced incentives for innovation and development of product both in general, and in the U.S., resulting in loss of jobs and life-saving treatments (that have made the United States a leader in the field.)

**Other Grants and Public Health Programs:** States are only eligible for federal funds under the PHSA if the state agrees to abide by all the regulations established in Division A in their capacity as an employer and assures all political subdivisions will do the same. Some of the other programs and grants established in Division C include:

- Scholarships and grants for health professions training for diversity (for individuals from “disadvantaged backgrounds”) and grants for cultural and linguistic competency training for health professionals;
- Grants for certain clinics and centers such as school-based health clinics, nurse-managed health centers, and federally qualified behavioral health centers;
- Grants for telehealth and telemedicine programs, mental health and substance abuse screening in primary care settings, and promotion of positive health behaviors and outcomes;
- Creates a “no child left unimmunized against influenza” demonstration program using elementary and secondary schools as influenza vaccination centers;
- Various new programs to provide education and training to nurses, mental and behavioral health, and initiatives on autism spectrum disorder;
- Provides an extension of the WISEWOMAN Program;
- Creates programs for diabetes screening, awareness and outreach program, infant mortality pilot programs, and programs for postpartum depression;
- Community-based collaborative care networks, and an overweight and obesity prevention program;
- Nationwide demonstration project to award grants to medical-legal partnerships to assist individuals in navigating health programs;
- Establishes the Office of Women’s Health within the Office of the Secretary.

**Other Provisions:**

- Allows for a study on duplication in Division C grant programs. At the Secretary’s discretion, she could integrate the old program into the new and could potentially terminate the duplicative old program. If programs could not be integrated into existing programs, the Secretary is required to publish a rule terminating the duplicative programs. If Congress does not take a vote disapproving of those terminations, the duplicative programs would be eliminated. However, the money would not go away, it would just go to the new or integrated program;
- Increases federal funding for Community Health Centers for FY 2013-2015 (above and beyond the \$13.3 billion reauthorization passed in the 110<sup>th</sup> Congress) and provides for liability protections for volunteer practitioners working at the Centers;
- **Implements medication management services for treatment of chronic diseases:**
- **Establishes Emergency Care-Related Programs** including grants for public, private nonprofit, Indian Health Service, and Indian trauma centers; establishes an Emergency Care Coordination Center; pilot programs to improve emergency care; establishes a grant program to assist veterans who received and completed military emergency medical training while serving in the Armed Forces become, state-licensed or certified emergency medical technicians;

- **Establishes Pain Care and Management Programs** including an Institute of Medicine conference on pain; pain research at National Institutes of Health; and a public awareness campaign on pain management;
- **Food and Drug Administration:** Requires nutrition labeling of standard menu items at chain restaurants and of articles of food sold from vending machines. This bill creates a National Medical Device Registry for analyzing post-market safety and outcomes data for Class III medical devices, as well as and certain Class II devices without regard to liability protections.

## **Division D-Indian Health Care Improvement**

The Indian Health Care Improvement Act is a comprehensive federal program for health-related services, benefits, and facilities for Native Americans last reauthorized in 1992. Historically, specific statutes and treaties provided for the federal care of members of certain Indian tribes under the jurisdiction of the United States, however, Congress has continued to expand coverage over the years. The Indian Health Service (“IHS”) of the Department of Health and Human Services is the primary federal agency responsible for carrying out this Act. The IHS administers a system of 12 area offices and 161 agency and tribally-managed service units. Members of 562 federally recognized Tribes and a total of 1.9 million Native Americans are served.

Division D of the legislation *permanently reauthorizes* the Indian Health Care Act, expands upon health care services offered by the IHS, changes Medicaid reimbursement process, increases the coordination and number of behavioral health programs, authorizes more facility construction, and authorizes the IHS to offer a number of new services. Additionally, the bill establishes a Division of Urban Indian Health in IHS and extends eligibility for its urban Indian health program not only to members of federally recognized tribes but also to persons who are not members of such tribes.

The bill expands upon and creates several new behavior health programs including; new mental health programs beyond alcohol and substance abuse, programs to deal with fetal alcohol spectrum disorders, sexual abuse, and domestic violence prevention.

H.R. 3962 also changes the eligibility requirements to offer health profession scholarships to Native American students and changes the priority status rating for loan repayment programs. The legislation also requires the IHS to develop new programs for tribal health programs to attract and retain Indian health care professionals.

The bill expands upon the number of authorized facility construction projects and would provide ambiguous definitions of the sanitation deficiencies used to identify and prioritize water and sewer projects on reservations. The legislation also establishes demonstration projects for improving facility construction methods. The bill also authorizes “such sums” as necessary to cover the cost for the various existing and new programs.

### **Other Highlights of Division D:**

**Funding for Sexual Predators in Indian Health Service:** Section 713 of the bill would provide funding to help treat “perpetrators of child sexual abuse who are Indian or members of a Indian household.”

**Lack of a Permanent Abortion Ban in Indian Health Service:** The bill reauthorizes the Indian Health Service. While the bill includes a cross-reference to the Hyde Amendment which prohibits funding for abortion, it does not contain a *permanent* ban on abortion funding. Should Hyde not be attached as a rider

in the Labor-HHS Appropriations bill in any given year, abortion will be covered under the Indian Health Service.

**Definition of “Indian”:** The bill defines Indians to include individuals that are not members of federally recognized tribes, those who do not live on or near a reservation, and members of state-recognized tribes. Additionally, Urban Indians are also eligible for benefits under the legislation and some conservatives would argue that Indians living in remote reservations should have priority for receiving federal health benefits than those residing in the cities.

**Davis-Bacon:** The bill requires that construction of new facilities comply with the Davis-Bacon Act which has been shown to increase public construction costs by anywhere from 5 to 38 percent above projected costs for the same project in the private sector.

### **Values Concerns:**

**School-Based Health Clinics:** Section 2511 (page 1354) prohibits school-based health clinics from providing grants for abortion. However, the bill does not contain language prohibiting these clinics from referring individuals to a place that will provide an abortion or facilitating an abortion (by providing transportation, etc.).

**Assisted Suicide:** Section 240 (page 129) requires plans in each state to distribute end-of-life planning materials (“advanced care planning information”). While the bill prohibits the dissemination of materials regarding assisted suicide, states like Oregon and Washington – which do not use the term “assisted suicide,” but instead use “death with dignity” – could be forced to disseminate materials on what is actually assisted suicide.

**Funding for Sexual Predators in Indian Health Service:** Section 713 (page 1925) will provide funding to help treat “perpetrators of child sexual abuse who are Indian or members of an Indian household.” Many conservatives might question whether a healthcare reform bill should create a priority for funding sexual predators, especially since the bill outlines that a federal bureaucrat will be able to determine when the predator is no longer a threat to children and society.

**Lack of a Permanent Abortion Ban in Indian Health Service:** The bill reauthorizes the Indian Health Service. While the bill includes a cross-reference to the Hyde Amendment which prohibits funding for abortion, it does not contain a *permanent* ban on abortion funding. Should Hyde not be attached as a rider in the Labor-HHS Appropriations bill in any given year, abortion will be covered under the Indian Health Service.

**Conscience Protections:** While the bill includes the Stupak amendment, which protects health care professionals from being discriminated against based on their opposition to abortion (codifying the Hyde-Weldon rider in the Labor-HHS Appropriations bill), it does not contain broader language protecting them from other potential discrimination due to deeply held beliefs. Catholic hospitals, for example, will be affected by this omission by being forced to disseminate contraception and/or the morning-after pill, despite their religious objections.

**Same-Sex Health Benefits:** Section 571 (page 359) expands healthcare tax benefits to domestic partners and their children by defining eligible beneficiaries as “any individual who is eligible to receive benefits or coverage under an accident or health plan.”

**Abstinence Education.** The bill establishes a new teen pregnancy prevention program to provide comprehensive sex education designed to replace Title V abstinence grants, which expired on June 30th

of this year. Congressman Lee Terry (R-NE) offered an amendment in committee to reinstate the abstinence grants, but the amendment failed.

**Committee Action:** The original version as introduced, H.R. 3200, was referred to the House Committees on Energy and Commerce, Ways and Means, and Education and Labor and reported out on October 14, 2009. H.R. 3962, is the compilation bill (with numerous substantive changes), introduced on October 29, 2009.

**Does the Bill Expand the Size and Scope of the Federal Government?:** Yes, the bill provides \$1.052 trillion over 10 years in new mandatory spending. In general, the bill expands the number of eligible individuals for government programs, creates new federal grants and programs, and creates federal mandates and benefit levels for insurance among other items. The bill increases taxes by more than \$700 billion over ten years. The bill also includes a back-door to a federal takeover of health care in America.

**Does the Bill Contain Any New State-Government, Local-Government, or Private-Sector Mandates?:** Yes. CBO and JCT have determined that the bill contains several private-sector and intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The total cost to the private sector of those mandates, as estimated by CBO and JCT, would greatly exceed the threshold established in that act for private entities (\$139 million in 2009, adjusted annually for inflation). CBO estimates that the total cost of intergovernmental mandates would not exceed the annual threshold established for state, local, and tribal entities (\$69 million in 2009, adjusted annually for inflation). However, among other things, the legislation would increase the obligations of state budgets by requiring an additional \$34 billion over ten years.

**Does the Bill Comply with House Rules Regarding Earmarks/Limited Tax Benefits/Limited Tariff Benefits?:** There is no committee report citing constitutional authority available on H.R. 3962. However, the committee reports for H.R. 3200 state that the bill does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI of the Rules of the House of Representatives

**Constitutional Authority:** There is no committee report citing constitutional authority available on H.R. 3962. However, the Committee reports for H.R. 3200 state that pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committees found that the constitutional authority for H.R. 3200 is provided in clauses 1, 3, and 18 of Article I, section 8 of the United States Constitution. Many Conservatives would question the constitutionality of numerous provisions in the bill.

**Outside Groups:** A full list of groups opposed to the bill will be provided in a separate document.