

November 7, 2009

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

Order of Business: The bill will be considered on Saturday, November 7, 2009, under a modified closed rule, allowing one Republican substitute and one Democrat amendment relating to abortion. The rule self-executes (i.e. automatically adopts) the manager's amendment (made available this past Tuesday), as modified by a five-page amendment (made available late last night – so much for the 72-hour rule). The rule also allows for separate consideration of H.R. 3961 (“doc fix”) under a closed rule with one hour of general debate. Once the “doc fix” passes on the House floor (possibly this weekend, but more likely during the week of November 16th), statutory PAY-GO (H.R. 2920) would be automatically engrossed into H.R. 3961. H.R. 3961 (“doc fix”) would NOT be added onto H.R. 3962 (the underlying government healthcare takeover bill).

Stupak Abortion Amendment: The rule provides for consideration of an amendment offered by Reps. Bart Stupak (D-MI), Brad Ellsworth (D-IN), Joe Pitts (R-PA), Marcy Kaptur (D-OH), Kathy Dahlkemper (D-PA), Dan Lipinski (D-IL), and Chris Smith (R-NJ) that would preserve current law prohibiting federal funds from being used to cover elective abortions. The amendment states that “No funds...may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion...” and contains exclusions for rape, incest, and to save the life of the mother. The amendment also contains language that clarifies that those private plans which do not receive government funds may still offer elective abortions. It further clarifies that an individual may purchase a plan that includes abortion, as long as “such coverage or plan is paid for entirely using only funds not authorized or appropriated by this Act,” and that nothing “shall restrict any nonfederal QHBP (Qualified Health Benefits Plan)...from offering separate supplemental coverage for abortions for which funding is prohibited so long as premiums for such separate supplemental coverage or plan are paid for entirely with funds not authorized or appropriated by this Act.” (20 minutes of total debate)

Groups scoring a “yes” vote: Democrats for Life, National Right to Life, Americans United for Life, Family Research Council, and Concerned Women for America

Republican Amendment in the Nature of a Substitute: The rule provides for the consideration of an amendment in the nature of a substitute by Rep. Boehner, which would create “Universal Access Programs” (expanded and reformed high-risk/reinsurance pools) that would to guarantee access to affordable care for all Americans, regardless of pre-existing conditions or past illnesses. The Republican Substitute would eliminate annual or lifetime caps on insurance, prevent rescission of insurance policies (except in the cause of fraud), and allow young dependent adults to stay on their parent's health care plan until the age of 26.

The Republican substitute amendment enacts real medical liability reforms by allowing caps on non-economic damages, encourages greater competition by allowing individuals to shop for insurance across state lines, and creates Associated Health Plans (AHPs) allowing small businesses to pool together to gain greater market power and offer health care at lower prices. The amendment also provides new incentive payments for states that are able reduce premiums and the number of uninsured and expands HSAs. Finally, the legislation codifies the Hyde amendment so that it explicitly prohibits all Federal funds from being used to pay for abortion. According to CBO, the amendment would cost \$61 billion, yet reduce the deficit by \$68 billion over the ten year budget window. (*60 minutes of total debate*)

“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, so that the cost of the doc fix would not count against the cost of the underlying government healthcare takeover bill for the purposes of PAYGO. CBO determined Wednesday, that H.R. 3961, 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.**

PAY-GO: H.R. 2920 passed the House by a vote of [265 to 166](#) on July 22, 2009. The legislation applies a PAYGO requirement to the 53% of the federal budget that consists of entitlement spending and to *most* changes to tax law. Violations of PAYGO would not be judged on a per-bill basis (as under the current House PAYGO rule), but instead would be judged at the end of each year by two separate standards: the average annual impact on the deficit over five years, and the average annual impact over ten years. To the extent that this scoring system shows bills passed by Congress (again, counting only the types of budget decisions that H.R. 2920 subjects to the PAYGO requirement) led to a *net* deficit impact over either period, OMB would be required to issue a sequester order to get rid of the violation. CBO scoring would be used to measure the “cost” of legislation, except where a CBO score is unavailable (in which case OMB could supply the score). *Note:* OMB is a partisan entity, while CBO is non-partisan. For the RSC Legislative Bulletin of H.R. 2920 see [here](#).

Manager’s Amendment (Dingell (D-MI))

The Manger’s Amendment makes the bill worse, not better; it adds several new grant programs, further restricts businesses and insurers, and pays lip-service to immigration and fiscal restraint while centralizing more power in the federal government. The amendment appears to be trying to head off predicted insurance premium increases by increasing the states’ and the FTC’s regulatory power. Below are the modifications and highlights for a full summary click [here](#).

Modifications to the Manager’s Amendment from Last Night:

- Narrows the exclusion for unprocessed fuels from the cellulosic biofuel.
- Creates grants for non-profit organizations or institutions developing medical school in federally –designated health professional shortage areas (\$500,000).
- Modifies the FTC’s enforcement authority for Patent cases.
- Creates a National Health Services Corps Demonstration project on incentive payments to workers in a health professional shortage area with extreme need (“such sums”).

Highlights of the Manager’s Amendment

- **Coverage:**

- Adds individuals on retiree health coverage whose annual increase in premiums exceed “such excessive percentage as the Secretary shall specify” to the list of people who qualify for the interim high risk pool.
- Adds citizen verification language for high risk pools (same verification language as other provisions in the bill)
- **Insurance Regulation:**
 - Beginning in 2010, it 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). 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. 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.
 - Removes a provision under the section repealing the insurance anti-trust exemption that continued to allow for “information gathering and rate setting activities of a state insurance commission or other state regulatory entity with the authority to set insurance rates”. Gives the Federal Trade Commission (FTC) more authority over for-profit and not-for-profit insurers as a whole vs. just authority over the business of insurance.
 - Weakens the role of the National Association of Insurance Commissioners (NAIC) in setting model guidelines for the creation of interstate compacts and instead requires the Secretary to develop them.
- **Tax-related portions:**
 - The effective date of the provision denying the tax deduction for employer health plans coordinating with Medicare Part D would be delayed for two years, beginning after 2012.
 - Changes the provision delaying the implementation of the worldwide interest allocation by nine years to a complete repeal.
 - Makes modifications to the current-law cellulosic biofuel producer credit, excludes certain fuels from eligibility for this credit, while making certain other fuels eligible.
- **Specialty Hospital Carve outs:** Creates a narrow carve out or special rule for certain “high Medicaid facilities” in relation to the new “conditions for approval” that existing specialty hospitals must abide by in order to grow their facilities under the bill. The amendment allows these certain hospitals to grow if they:
 - Have an annual percent of Medicaid admissions that (as determined by the Secretary) is greater than such a percent with respect to admissions for any other hospital in the country;
 - Do not discriminate against beneficiaries covered under Federal programs (Medicaid, Medicare, etc); and,
 - Meet other conditions set forth by the Secretary. This is four fewer conditions than placed on all other specialty hospitals.
- **Grants and Programs:**
 - Clarifies that a state can still receive a grant for allowed medical liability reforms even if they have enacted a separate reform that establishes caps or reduces lawyers’ fees – as long as it is not combined with the reforms they will pay for. The bottom line however, is that the bill will still not pay for any law that enacts caps or reduces attorney fees.

- Another grant program (\$30 million for 2011 and “such sums” for 2012) for mental health and substance abuse screening in primary care settings.
- Creates 5 new Offices of Minority Health in other agencies including in the Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, Health Resources and Services Administration, and the Food and Drug Administration.
- Creates a diabetes screening, awareness and outreach program.
- Makes improvements to vital statistics collection by the “education and training” of doctors on the importance of birth and death certificate data and how to properly fill them out.
- Adds a scaled down version of an amendment offered by Rep. Sullivan in Energy and Commerce that would have eliminated duplicate programs under the bill. The bill now 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;
- **Other:**
 - Establishes a 90-day waiting period for first time DME provider claims (to reduce fraud).
 - Requires a Medicare fraud and abuse hotline number to be displayed prominently on any statement or notice containing an explanation of benefits.
 - Includes a provision similar to Sen. Cantwell’s amendment from Senate Finance that would allow for coverage in qualified “direct primary care medical home plans” (DPM), provided that the plan meets all requirements applicable and the services covered are coordinated with the QHBP offering entity. DPM practices offer patients comprehensive primary care coverage outside of traditional insurance and include preventive, primary care and chronic disease management.

RSC Staff Contact: Emily Murry, emily.murry@mail.house.gov, (202) 225-9286