

RSC Info Alert: Summary of Major Changes to Senator Reid's Takeover of Health Care Bill, H.R. 3590 (Patient Protection and Affordable Care Act)

Procedure:

The Senate Republicans are not giving up and will use every procedural tactic available to them in the coming days. As of now the Senate expects to have the final vote on the bill at 7:30 PM on December 24, 2009, in light of the 60-40 cloture vote on the Reid Manager's Amendment earlier this morning. There are three possible scenarios that could play out if the Senate passes H.R. 3590 including:

- **Ping-Pong:** The House may choose to take up the Senate bill, making necessary changes to garner enough votes, and then send it back to the Senate where once again it must achieve a 60 vote threshold. This seems the least likely scenario.
- **Conference Report:** A robust Conference report is less likely at this point, but should that occur, final passage in the Senate will still require 60 votes for passage. Sen. Nelson, during his press conference on [December 19, 2009](#), stated that he reserves the right to vote against the bill if major changes occur in Conference.
- **The House simply accepts the Senate bill through an up-or-down vote:** Although Speaker Pelosi and Leader Hoyer have said they will not simply accept the Senate bill, it remains to be seen whether the progressives and pro-life Democrats will keep their promises or crumble.

Major Issues to be Resolved Between House and Senate:

- Illegal immigrants' ability to purchase coverage in the exchange
- Federal funding of abortion
- The government-run option vs. the federally overseen "Multi-State Plan"
- Financing the expansion of coverage through a surtax on the "wealthy" and small businesses vs. a union opposed tax on "Cadillac plans" and the Medicare payroll increase for the "wealthy"
- Independent Medicare Advisory Board (IMAB), also known as "MedPAC on Steroids"

Main Issues:

- **Costs still go up:** [CBO](#) has said that the net increase in the federal budgetary commitment to health care will go up \$200 billion.
 - Most recently, [CBO](#) revised its long-term estimate to lower their projected savings by 0.25% of GDP or \$500 billion.
- **Premiums still go up:** CBO says the amendment would have little impact on premiums.
- **Hurts access and quality of care:** According to CBO, if the projected **\$470.7 billion** (up from \$464.6 billion) in Medicare cuts are actually allowed to occur, they could still harm beneficiaries' access and quality of care.
- **Real cost once implemented:** Previous estimates place the cost of the bill once fully implemented (FY 2014-2023) at **\$2.5 trillion**.

- **If you like what you, have you can't keep it:** CBO has estimated that 8-9 million people would lose employer coverage under the Reid bill.

Summary:

The nearly [400-page Manager's Amendment](#) (bringing the total bill to 2,733 pages) makes several substantial changes to the underlying bill, H.R. 3590. Some highlights of the changes include:

- **New government-run "Multi-State" plan:** Although the government-run plan with a state-opt out has been removed, the Manager's Amendment still allows for the federal government through the Office of Personnel Management (OPM), to run, oversee and "negotiate" with new "Multi-State" plans offered in State Exchanges and available nationwide.
 - At least one of the plans must be non-profit and at least one plan must not offer coverage of abortions.
 - Individuals who enroll in an OPM run multi-state plan will be placed in a separate risk pool from federal employees enrolled in the FEHBP.
 - Qualified plans must still be licensed in each state and meet all state and federal requirements including newly established standards for medical loss ratios, profit margins, and premiums. OPM-run multi-state plans must cover all essential health benefits and meet all of the requirements of a qualified health plan, and comply with 3:1 age rating.
 - CBO stated that the new plan would have little impact as insurers may not want to or be able to participate and would probably already be participating in the Exchanges.
- **Still allows for the funding of abortion,** and is far from the Stupak language that passed the House with the support of 64 Democrats.
 - Specifically Nelson's "compromise" would mandate that every state provide an insurance plan option that does not cover abortion while giving each state the right to pass a law barring insurance coverage for abortion within state borders (which was already allowed in the underlying bill). However, the provision still allows for state taxes to go toward abortions in other states, and there is no prohibition on abortion coverage in federally-subsidized exchanges. Each state through the new government run plan ("Multi-State Plan") overseen by the Office of Management Personnel (OMP) can provide access to two plans – only one of which must exclude abortions. Currently no plan under the Federal Employee Health Benefits Plan, overseen by OMP, provides for abortion coverage.
 - Additionally, it fails to fix Sen. Mikulski's amendment which gives the Health Resources and Services Administration (HRSA) the power to require private insurance plans include abortion coverage under the title of "preventive care." Finally, the amendment fails to provide adequate conscience clause protection, as it does not prohibit any government entity or program from discriminating against health care providers that do not want to participate in abortions.

- **Increase in individual mandate penalty:** The penalty is now tied to the higher of a flat dollar (up to \$750) amount or 2% of taxable income up to the national average of the “Bronze” (lowest value) plan premium, bringing in \$15 billion - \$7 billion more than the underlying bill.
- **Tighter insurance restrictions on Medical Loss Ratio (MLR):** It requires insurers both before and after the establishment of the Exchanges to have a MLR of 80% in the small group and individual market and 85% in the large group market, forcing insurers to cut down on administrative costs such as Health IT, fraud detection, care management, etc. Plans that exceed this must give a rebate to consumers, and states can determine a higher MLR rate in any market. This is a new federal intrusion into private companies as it dictates how companies can allocate their resources. According to [CBO](#), if the government dictates MLR up to 90% (combined with the bills other regulations) it would essentially make private insurance a government program, dramatically adding to the cost of the bill.
- **Removes the temporary “Doc Fix”(SGR):** The underlying bill provided for an 0.5% increase in Medicare reimbursements to physicians for 2010. The Manager’s Amendment removes this doc fix without addressing the problem. The temporary payment freeze passed in the DOD bill to avoid the 21.2% cut effective January 1, 2010 will expire March 1, 2010 and thus the Senate must enact a separate SGR fix. Some members may be concerned that such an important health priority is omitted from a “health care reform” bill and that this change is simply a budget gimmick to eliminate the \$11.3 billion cost of the patch.
- **Still expands Medicaid with new carve outs:** The bill still contains unfunded mandates to states through the expansion of Medicaid, but this time with new special treatment for the states of Nebraska, Vermont, and Massachusetts (tailored to get the votes from Sens. Nelson and Sanders). These states will receive FMAP bonuses such that:
 - Nebraska will receive 100% FMAP for newly eligibles indefinitely.
 - Vermont will receive a 2.2% FMAP increase for 6 years for their entire program.
 - Massachusetts will receive a 0.5% FMAP increase for three years for the entire program.
 - According to CBO “there would be roughly 15 million more enrollees in Medicaid and CHIP than is projected under current law,” bringing the total in 2019 to 50 million people or 1 in 6 (50 million out of 282 million).
- **Coverage:** Increase coverage by 1 million people – now leaving 23 million vs. 24 million uninsured under the bill.
- **Taxes:** The bill increases taxes by \$518.5 billion – up \$25 billion from the underlying bill and **still raises taxes on middle class families**, breaking President Obama’s pledge not to tax Americans earning less than \$250,000. The major changes to the tax provisions include:
 - *\$86.8 billion* tax increase: **Raises the Medicare payroll tax by 0.9%** (an additional 0.4% increase from the underlying bill which raised it by 0.5%) on individuals making \$200,000 and families making \$250,000 (**thus maintaining the marriage penalty**).

- *\$2.7 billion* tax increase: Replaces the “botax” or excise tax on elective cosmetic surgery with a new excise tax (10% of the amount paid for the service by the customer) on indoor tanning services.
 - *\$19.2 billion* tax increase: Moves the annual tax on medical devices back one year from 2010 to 2011 and increases it to \$3 billion up from the previous \$2 billion beginning in 2018.
 - *\$13.3 billion* tax increase: Indexes Flexible Spending Accounts (FSAs) to CPI-U after 2011
 - *\$59.6 billion* tax increase: Moves the tax on health insurers back one year (from 2010 to 2011) and changes it from a flat tax of \$6.7 billion a year to a phased in tax starting at \$2 billion in 2011, \$4 billion in 2012, \$7 billion in 2013, \$9 billion in 2014 - 2016, and \$10 billion in 2017 and thereafter.
 - *\$2.6 billion* tax increase: Places a “fee” on insurance policies to fund the Patient-Centered Outcomes Research Trust Fund. The amendment provides a new exemption from the health insurer fee for nonprofit insurers that meet certain requirements (only two insurers in the States of Nebraska and Michigan qualify), including a high MLR.
 - *\$148.9 billion* tax increase: Includes additional carve outs for several types of insurance that would be subject to the tax on “Cadillac” or high-cost health care plans such as workers compensation, automobile medical payment insurance, coverage for on-site medical clinics, supplemental liability insurance.
 - Specifically exempts Longshore (Union) workers from the tax on “Cadillac” plans by qualifying them as “high-risk workers”.
- **CLASS Act:** It still contains the new unsustainable long-term care entitlement program – the CLASS Act, which faced major opposition from Senate Democrats, including Senator Conrad, the Chairman of the Budget Committee, who called it a “Ponzi Scheme”. The CLASS Act, 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 would not 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 seniors. The CLASS Act would only add confusion about Medicare coverage of long-term care without covering the true cost of care. This may 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 in the Senate bill (while paying out \$0 in benefits for half of that time), but will begin to increase the deficit following FY2029. A group of seven 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.**
- **Comparative Effectiveness Research:** The bill still establishes the Patient Centered Outcomes Research Institute (PCORI), a nonprofit corporation, to conduct comparative effectiveness research (CER). PCORI will replace the Federal Coordinating Council created in the American Recovery and Reinvestment Act of 2009. Despite repeated attempts by Republicans to prohibit the government from using CER to make coverage decisions, such amendments failed along party lines. There is concern that this unelected, bureaucrat-appointed board will lead to rationing and make one-size-fits-all judgments prohibiting treatment options on the basis of cost.
 - The bill allows the Secretary of HHS to use CER findings to make a determination regarding coverage as long as it is done through an open and transparent process.
 - To pay for these activities, the bill would impose a new “fair share” tax on insurance policies.
- Still contains the **Independent Medicare Advisory Board (IMAB), or “MedPAC on Steroids,”** made up of non-elected government bureaucrats that are empowered to make arbitrary cuts to Medicare providers that will limit access to care for seniors. Congress would be required to consider legislation implementing the proposal or alternative proposals with the same budgetary impact on a fast track basis. The recommendations of the board would go into effect automatically unless blocked by subsequent legislative action.
 - IMAB’s recommendations would be required if the Chief Actuary for the Medicare program projected that the program’s spending per beneficiary would grow faster than the average of the growth rates of the consumer price index for medical services and the overall index for all urban consumers fiscal years 2015 through 2019
 - After 2019, the threshold would be increased and IMAB’s recommendations would be required if Medicare spending growth rose faster than gross domestic product (GDP) per capita plus 1 percentage point.
 - [CBO](#) revised its long-term estimate to take into account this change in 2019, such that it lowered the projected savings by 0.25% of GDP or \$500 billion.
- **Adds State demonstration programs for Medical Liability Reform:** The amendment allows for grants to States to test alternatives to civil tort litigation, which would be evaluated by the Secretary of HHS who would then determine their

effectiveness. These demonstration projects would only allow models that emphasize patient safety, disclosure of health care errors, and the early resolution of disputes with the ability for patients to opt-out at any time. The bill contains no actual medical liability reform.

- **“Free-Choice vouchers”:** The amendment requires employers to provide their share of premiums through a tax-exempt voucher to be used in the Exchange if coverage they offer is unaffordable for employees. Eligible employees are individuals below 400% of the Federal Poverty Level (FPL) whose premiums exceed 8% of income (but not above 9.8%) and are not enrolled in employer coverage. CBO estimates that about 100,000 workers would utilize this option.
- **New carve outs for some physician-owned hospitals:** The amendment pushes back the date from February 1, 2010 to August 1, 2010 by which a physician-owned hospital must have a provider agreement to participate in Medicare. Of the 125 projects projected estimated to be eliminated through the prohibition on physician owned hospitals, 55 are expected to be saved by this carve out (including projects in Nebraska).

Other Provisions:

- **Extends CHIP program:** Continues the current reauthorization period of CHIP for two years, through September 30, 2015.
- **Adds a Second Amendment protection clause:** Clarifies that the Secretary of HHS cannot collect, maintain or use information on the possession or use of firearms. The amendment also prohibits the Secretary from implementing any sort of incentive program (including wellness programs), that could change rates on insurance, simply due to an individual owning, possessing or using a firearm.
- **Expands basic health program eligibility to immigrants:** Allows legal immigrants with incomes less than 133% FPL, who are not eligible for Medicaid due to the five-year waiting period, to be eligible for the new state-run, federally-funded, basic health program that states can establish for “low-income” individuals above 133% FPL.
- **Expansion of the Center for Medicare and Medicaid Innovation:** Adds payment reform models to the list of items the Center may consider and instructs the Secretary of HHS to focus on models expected to reduce program costs while preserving or enhancing quality of care.
- **Health professionals State loan repayment tax relief:** Excludes from gross income for tax purposes, payments for participants in the National Health Service Corps, as well as State loan repayment or loan forgiveness programs, to provide for the increased availability of health care services in underserved or health professional shortage areas.
- **Expands adoption tax credit:** Makes the adoption tax credit refundable, increases it from \$10,000 to \$13,170 and allows for the tax exclusion for employer-provided adoption assistance benefits to be increased by the same amount.
- Adds the Indian Health Services reauthorization, the *Indian Health Care Improvement Act*.

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