



# House Action Reports

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## Senate Health Care Overhaul Bill

This Fact Sheet deals with the Senate amendment to HR 3590, Patient Care and Affordable Care Act, which the House may consider on Sunday, March 21.

The measure, which passed the Senate on December 24, requires most individuals to purchase health insurance or pay a tax; creates state-run "exchanges," through which people without employer-provided coverage could purchase insurance; places new requirements on private insurance companies; and expands Medicaid to cover all those with incomes of up to 133% of the federal poverty line. The Senate-passed bill does not create a government-run "public option." CBO estimates the gross cost of the measure's expansion of coverage would be \$875 billion over 10 years, but taking fees and penalties into account would be \$624 billion. CBO estimates that it would reduce the deficit by \$118 billion over 10 years when all provisions are considered.

The House is expected to consider a separate bill (HR 4872) that would modify portions of the Senate measure, including the revenue provisions, subsidies to buy insurance and federal funding for the expansion of Medicaid. CBO estimates that the gross costs of the two measures combined would be \$940 billion over 10 years, but after offsets are taken into account, the measures would reduce the deficit by a net \$138 billion.

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## Section I

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### Background & Summary

The effort to change the way that Americans access health insurance has become the defining issue of the beginning of the Obama administration. More so than the efforts to prevent a credit collapse or rein in the foreclosure crisis, the debate about whether and how to reshape health insurance in ways that reduce the growth in costs and increase access to insurance has dominated the political agenda for more than a year. By many accounts, the domestic health insurance system is facing major challenges — unemployment remains high, premiums for employer-sponsored and individual market insurance continue to increase along with health services costs, and safety-net programs are strained because of falling state revenue streams. Despite these challenges, proposals to substantially change the provision of health insurance have continued to elude political consensus.

Over the months, the health care debate has increasingly focused on the political struggle between the two major parties. Leaders from both parties have made efforts to mobilize voters to either support or oppose the current health overhaul proposal. Many members have been inundated with constituent communications, from the "town hall" meetings held last August to the last-minute robocalls that have been activated this week. Republicans have generally been united in their opposition to both the House- and Senate-passed versions of the legislation. Democrats in the House, however, have been divided in their support, with some more conservative members pledging to oppose the bill and with more liberal members maintaining that the legislation does not go far enough to provide health coverage.

Public opinion has varied throughout the process, but in the most recent health tracking poll conducted by the Kaiser Family Foundation in February, more than half of respondents (54%) indicated that they were "frustrated" with the process of the health overhaul debate, and 59% believed that the delay in reaching a final agreement was because both Democrats and Republicans are "playing politics" with the issue. Pollster.com, which aggregates and tracks information from multiple polls, reports that currently, 49% of the public opposes the current health reform proposal, and 43% supports it — and these percentages have remained fairly stable since July 2009, when the proportion of the public who opposes the bill first surpassed supporters. The most recent poll released by NBC News/Wall Street Journal found an essentially even split in public opinion about what action Congress should take with respect to the current legislation, with 46% of the public supporting passage of the current health care proposal, and 45% opposing passage of the proposal.

If this bill garners the votes to pass the House, the Congress will be poised to send to President Obama a victory on his highest-profile domestic policy item — legislation that represents the most sweeping change to federal health care policy since the enactment of Medicare in 1965.

## **House Bill**

On Nov. 7, 2009, the House passed, by a vote of 220 to 215, a bill that would have required almost every individual to obtain health insurance (see House Action Reports Fact Sheet No. 111-21, November 5, 2009 and House Action Reports Floor Summary No. 111-19, November 9, 2009). Specifically, the House bill would have expanded categorical eligibility for Medicaid to all citizens with incomes of up to 150% of the federal poverty level; required employers to provide coverage or contribute to a fund for coverage; created a national health insurance "exchange" through which individuals without access to employer-sponsored coverage could purchase insurance; and created a government-run insurance plan — the "public option" — within the exchange system.

The House bill's costs were offset primarily by imposing a surtax on the gross income of more than \$500,000 for individuals or \$1 million for couples, and by reducing payments to private insurers participating in the Medicare Advantage program to the same level paid to providers in traditional fee-for-service Medicare. CBO estimated that the gross cost of the House-passed bill would be \$1.05 trillion through FY 2019, but that after the bill's taxes, fees, penalties, and spending cuts were taken into account, it would reduce the deficit by \$109 billion.

During House debate, access to abortion services proved to be one of the most contentious issues within the Democratic caucus. The House adopted, by a vote of 240 to 194, an amendment sponsored by abortion opponent Rep. Bart Stupak, D-Mich., that applied the restrictions of the "Hyde Amendment" to programs in the bill, including the public option. The Hyde Amendment prohibits the use of federal government funds to pay for or make available abortions, except in the case of rape or incest, or if the life of the woman is endangered. Under the House-passed provision, insurance companies that offered plans on insurance exchanges could not provide abortion coverage to women receiving federal subsidies, but those women could buy supplemental coverage with their own private funds. Additionally, the House bill required insurers, if they offer a plan on the exchange that covers abortion, to also offer a nearly identical plan that would not cover abortion.

## **Senate Bill & House-Senate Differences**

On Dec. 24, 2009, the Senate passed its version of health overhaul legislation (HR 3590) by a party-line vote of 60 to 39. (On Oct. 8, 2009, the House passed HR 3590

under suspension of the rules by a vote of 416 to 0. As passed by the House, the bill would have extended a first-time homebuyer tax credit through Nov. 30, 2010, for military, Foreign Service and intelligence agency personnel who are posted abroad for at least 90 days during 2009. The Senate completely replaced the text of the bill with its version of a health care overhaul.)

The Senate-passed bill, like the House measure, required most U.S. citizens and legal residents to obtain health insurance, but there were many key points of differences between the two measures. For example, the Senate measure created state-based health insurance exchanges, rather than the national exchange in the House bill, and the Senate measure did not include a public option. The Senate-passed measure also provides lower levels of subsidies to assist low- and moderate-income households in purchasing health coverage; includes a new excise tax on high-cost health insurance plans, often referred to as "Cadillac plans"; and contains abortion restrictions that are viewed as weaker than those in the House version.

The most high-profile difference, however, was the state-specific provisions that were included in the Senate measure to win support from specific senators, including extra funding for Medicaid programs in Nebraska and Massachusetts.

### **House-Senate Negotiations**

Rather than negotiating in a conference committee, Democratic leaders in January announced that they would negotiate an agreement that would then be considered as a House amendment to the Senate-passed measure, which would then return to the Senate for further action. This so-called "ping pong" approach was intended to avoid procedural obstacles that could have been mounted by Republicans in the Senate, who universally opposed the legislation.

Major points of disagreement remained to be ironed out, including the controversial provision in the Senate version that extends indefinitely full federal funding to expand Medicaid coverage in Nebraska. House leaders also sought changes that would increase federal subsidies for those who purchase insurance in the exchanges, and increase the threshold at which the new tax on high-cost health plans would kick in. Anti-abortion Democrats in the House, led by Stupak, called for language that more explicitly stated that abortions could not be covered in the new health insurance exchanges, which would have been closer to the House-passed provision.

After the election of Republican Scott P. Brown to fill the Massachusetts Senate seat that was held by Edward M. Kennedy for 47 years, the Democrats lost their 60-seat majority in the Senate which almost certainly would have been required to pass a health care agreement negotiated with the House. Instead of the ping pong approach, which would have required the Senate to act again on the large health care measure, Democratic

leaders have decided to have the House clear the Senate-passed bill (HR 3590) for the president's signature, and also consider and pass a second measure that would make changes to the Senate bill, based on negotiations between the White House and House and Senate leaders.

These changes to the Senate bill are expected to be included as part of a reconciliation measure, which would require only a simple majority for Senate passage, i.e., 50 votes plus the vice president.

### **Reconciliation Measure**

On Monday, the House Budget Committee reported a reconciliation bill (HR 4872). The reported version of the bill did not, however, reflect the agreement negotiated by congressional leaders and the administration, but rather was an amalgam of provisions sent to the Budget Committee by other committees under the reconciliation instructions in the FY 2010 budget resolution (S Con Res 13). The measure includes health care provisions sent to the Budget Committee by the Ways and Means and Education and Labor committees, as well as changes to student-loan programs transmitted by the Education and Labor Committee.

As anticipated, on Thursday, House and Senate leaders released a substitute for the reconciliation bill that reflects agreed-upon changes to the Senate-passed health overhaul measure. The Rules Committee is expected to meet Saturday to recommend a rule governing consideration of the Senate-passed health care overhaul and the reconciliation measure. That recommended rule is expected to replace the reconciliation language reported by the Budget Committee (HR 4872) with the agreed-upon changes were released on Thursday.

The reconciliation measure makes a number of changes to provisions in the Senate-passed bill. It eliminates the provision that would give Nebraska full federal funding for new Medicaid enrollees for an unlimited time; delays until 2018 the excise tax on high-cost health insurance plans; and increases the federal subsidies that would be provided to low- and moderate-income families to obtain health insurance through the state-based exchanges created by the Senate bill. Provisions relating to abortion and banning illegal immigrants from obtaining health insurance are not altered, primarily because those provisions do not have budgetary implications, as provisions in reconciliations are required.

In addition to the provisions relating to health care, the reconciliation measure also includes provisions to make the federal government the sole lender for student loans.

The debate over how the Rules Committee should provide for floor consideration of the bills also has become a major point of contention. Democratic leaders, including

Rules Committee Chairwoman Louise Slaughter, have considered reporting a rule under which the House would be considered to have concurred in the Senate amendment upon passage of the reconciliation bill, thus clearing the Senate-passed measure without requiring a separate vote on the measure. Republican critics have attacked such a "deeming" rule as a perversion of the legislative process, while Democratic leaders have responded that such criticisms are "hypocritical" because Republican-controlled Congresses have used such procedures in the past.

As of press time, the exact procedure that would be used had not been announced. The Legislative Day for the day the measures are scheduled will describe those provisions.

### **Summary of the Senate Amendment to HR 3590**

The Senate amendment to HR 3590 overhauls the health care insurance system by — requiring most individuals to obtain health insurance, creating state-run "exchanges" through which those without access to affordable insurance could purchase coverage, offering subsidies to low-income and moderate-income families to purchase coverage, creating penalties for employers with workers who receive federal subsidies to purchase insurance in the exchanges, and placing new requirements on health insurance plans. The bill expands categorical eligibility for Medicaid to those with incomes of up to 133% of the federal poverty level.

The measure's expansion of health care coverage would cost a gross \$875 billion through FY 2019, according to an estimate by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT). If Congress also enacts the separate reconciliation measure (HR 4872), the agencies estimate that the gross cost of the expansion of health care coverage would be \$940 billion over that time period.

The measure, as passed by the Senate, offsets the cost of expanded insurance in several ways. The largest source of revenue would be a tax on high-cost health insurance plans, referred to as "Cadillac" plans, which would generate an estimated \$149 billion over 10 years. The reconciliation measure, would, however, delay implementation of that tax, and CBO estimates that the modified provision would generate an estimated \$32 billion over that time period. The Senate-passed measure also reduces payments to Medicare Advantage (MA) plans, which would reduce mandatory spending by an estimated \$118.1 billion over 10 years. (As modified by the reconciliation measure, the changes to the MA payments would generate an estimated \$129.7 billion over 10 years.)

Taking the offsets into account, the Senate amendment would reduce the deficit by a net \$118 billion through FY 2019, according to CBO and JCT. If Congress also enacts the reconciliation measure and the Senate amendment, CBO and JCT estimate a net reduction the deficit of \$138 billion over the period of FY 2010 through FY 2019.

(In comparison, the expansion of coverage in the House-passed overhaul bill (HR 3962) would have cost a gross \$1.05 trillion through FY 2019, according to CBO, but the bill included offsets to generate a net reduction in the deficit of \$109 billion over that time period. The largest offset in the House-passed bill would have been a tax "surcharge" on high-income households, which would have generated an estimated \$460 billion over 10 years.)

### **Health Insurance Expansions**

The measure requires almost all citizens and legal residents to obtain health insurance coverage, either through their employer plans, through Medicare or Medicaid coverage, or through the new health insurance exchanges created by the bill.

Currently, there are an estimated 50 million U.S. residents who lack health insurance. According to CBO, enactment of the Senate-passed bill would reduce the estimated number of uninsured to 24 million by 2019, 31 million fewer than if the bill had not been enacted. If enacted, CBO estimates that from 2010 through 2019, 25 million people would enroll in the new health insurance exchanges, and 15 million additional people would be enrolled in Medicaid or the Children's Health Insurance Program (CHIP). Four million people would lose employer-sponsored insurance, according to CBO.

CBO estimates that if Congress enacts both the Senate-passed measure and the reconciliation bill (HR 4872), the number of residents without health insurance would decline by 32 million over the period of FY 2010 through FY 2019. By 2019, 24 million people would be enrolled in the new exchanges, and 16 million additional people would be enrolled in Medicaid or the Children's Health Insurance Program (CHIP). Four million people would lose employer-sponsored insurance, according to CBO.

### ***Health Insurance Exchanges***

The measure creates a system of state-run health insurance exchanges through which individuals or families could purchase health coverage, if they do not have access to "affordable" insurance through their employers. (The House-passed bill would have created a national exchange system, although it would have allowed states to create their own insurance exchanges if approved by the federal government.) States could form regional exchanges as long as the exchanges served a distinct geographic area. The measure also creates separate exchanges through which small businesses — defined as those with 100 or fewer employees — could purchase health insurance. Beginning in 2017, employers with more than 100 employees also could participate in these business exchanges.

Unlike the House-passed bill, the measure does not include a so-called public option in which a new government-run insurer would compete with private insurers in the new exchanges. The Senate-amended bill does, however, require the Office of Personnel Management (OPM) to contract with private insurance companies in order to offer at least two multi-state plans in each insurance exchange. At least one multi-state plan would have to be operated by a nonprofit, and at least one such plan could not offer abortion coverage beyond what is permitted under federal law.

The measure provides that families or individuals with incomes between 100% and 400% of the federal poverty level (currently, between \$22,500 and \$88,200 for a family of four) would be eligible to receive tax credits from the federal government in order to purchase insurance through the exchanges. It also imposes phased-in penalties for those who do not have health insurance. In the 2016 tax year, when penalties are fully phased in, those without health insurance would pay a tax penalty of \$750 per year up to the maximum of either three times that amount or 2% of the household income, whichever is less. The measure includes several exceptions to the requirement that individuals have insurance.

The reconciliation bill (HR 4872) increases these subsidies, and also increases the penalties that uninsured individuals would have to pay.

### ***Employer Requirements***

The House overhaul bill would have required most employers to offer their employees health insurance, or make a contribution on their behalf to cover insurance.

The Senate bill instead penalizes employers who have full-time employees who receive subsidies to purchase insurance through the new exchanges. Under the measure, employers with more than 50 employees who do not offer insurance would pay a fine of \$750 for each full-time employee who receives a subsidy to purchase health insurance through the exchanges. Employers with more than 50 employees who do offer coverage, but have subsidy-receiving employees would pay a fine of either \$3,000 for each employee receiving a subsidy, or \$750 for each full-time employee, whichever would be less.

The reconciliation bill (HR 4872) changes the employer penalties, and creates a penalty of \$2,000 per full-time employee for firms with more than 50 employees that do not offer health insurance benefits.

### ***Medicaid***

The Senate-passed bill expands categorical eligibility for Medicaid to all individuals with incomes of up to 133% of the federal poverty level, which currently is \$14,404 for

an individual or \$29,327 for a family of four. (The House-passed bill would have expanded eligibility to 150% of the federal poverty level.)

Current law specifies that children and pregnant women are entitled to Medicaid coverage, but parents and adults without dependent children are not federally entitled to Medicaid no matter how low their income, although many states have expanded coverage to these populations.

The measure also creates a new formula, called the Modified Adjusted Gross Income method, which states would be required to use to calculate Medicaid eligibility. (Currently, states vary in the way they calculate eligibility. Some states consider only gross income, while other states disregard certain types of income, or deduct certain living expenses from income.)

In 2016 and 2017, states would receive 100% federal funding to cover those newly eligible for Medicaid. Starting in 2017, states would receive an increase in federal matching rates for Medicaid coverage, but in most cases would not become 100% federal funding for those covered under the expanding eligibility. Nebraska would continue to receive 100% federal funding for those newly eligible for Medicaid indefinitely under the measure.

The reconciliation bill (HR 4872) eliminates the Nebraska provision and modifies the FMAP formula so that it is more generous to states that have previously expanded Medicaid to cover adults with incomes of at least 100% of the federal poverty level.

### ***CHIP***

The measure extends funding for the Children's Health Insurance Program (CHIP) through FY 2015. Beginning in 2015, it increases by 23 percentage points the federal matching rate for states' CHIP programs. It also requires states to maintain current eligibility rules for CHIP through 2019, which is known as a "maintenance of effort" clause. (The House-passed bill would have transferred children eligible for coverage under CHIP to either Medicaid or the health insurance exchange starting in FY 2016.)

### **Regulating Private Insurance**

The Senate bill creates a number of new regulations for firms that provide health insurance in both the group and individual markets. As of 2014, the measure prohibits insurers from denying coverage because of a pre-existing condition, but children could not be denied coverage because of pre-existing conditions within six months of enactment. It also prohibits insurers from setting lifetime limits on the dollar value of health care, and starting in 2014, prohibits insurers from setting annual spending limits. Prior to 2014, insurers could only set reasonable annual spending limits approved by the

federal government. The measure also prohibits health insurers from rescinding previously issued coverage, except in instances of fraud or "intentional misrepresentation."

The Senate amendment also does the following:

- **Temporary High-Risk Pool** — Creates a temporary high-risk pool for individuals who have been uninsured for several months and who have pre-existing conditions. Starting in 2014, this high-risk pool would end, and individuals covered through the pool would then receive coverage through the new state insurance exchanges created by the measure.
- **Preventive Care** — Requires insurers to cover preventive services and immunizations recommended by federal health agencies, without any cost-sharing requirements, such as co-payments.
- **Coverage for Dependents** — Permits unmarried children to remain covered through their parents' health plans through age 26.
- **Reporting Clinical vs. Administrative Costs** — Requires insurers to publicly report the percentage of total premium revenue that was spent on clinical services, quality and administrative costs. It requires insurers to refund each enrollee by the amount by which premium revenue spent for administrative costs exceeds 15% in the group market and 20% in the individual market. (The requirement to provide refunds would expire on Dec. 31, 2013, but the reporting requirement would not.)

### Medicare

The measure creates an Independent Payment Advisory Board (IPAC) to draft legislative proposals to slow the growth rate in Medicare spending if spending exceeds a certain target rate, starting in 2014. The bill explicitly prohibits the IPAC from making recommendations that would ration care, or change benefits, eligibility rules, or require cost-sharing, such as premiums and co-payments. The measure also makes a number of other changes designed to reduce the growth of Medicare spending.

### ***Medicare Advantage***

The measure reduces payments under the Medicare Advantage program over a four-year period beginning in 2012. Payments under Medicare Advantage would be based on the average plan bids in each market by 2014. Starting in 2014, the measure creates bonus payments in Medicare Advantage for quality of care and care coordination. (The House-passed bill would have gradually decreased payments to Medicare Advantage until they were the same as those for traditional fee-for-service Medicare.) The Senate bill essentially exempts plans operating in Florida from the decrease in payments, however, this provision is expected to be removed in subsequent reconciliation legislation.

The reconciliation measure (HR 4872) modifies this provision to reduce the payments starting in FY 2011, and to re-formulate payments according to local costs.

### ***Drug Coverage 'Doughnut Hole'***

The bill requires drug makers to give seniors a 50% discount on any purchases made while they are in the coverage gap in Medicare's prescription drug benefit, known as the "doughnut hole." It also increases the spending threshold that beneficiaries must reach to fall into the coverage gap by \$500 in 2010. (In contrast, the House bill would have provided the \$500 increase in 2010, and then phased out the doughnut hole for the Medicare prescription drug program by 2019.)

The reconciliation bill (HR 4872) modifies this provision to phase out the "doughnut hole," by 2020 at an estimated cost of \$37.6 billion over 10 years.

### **Abortion**

The measure specifies that insurers participating in health insurance exchanges would not be required to offer abortion coverage, and it allows states to prohibit abortion coverage in their exchanges. It stipulates that insurance plans within state exchanges that offer abortion coverage beyond the scope of the "Hyde Amendment" — which limits federal funding for abortions to cases where the woman's life is in danger, or in cases of rape or incest — to provide separate accounts for women who choose to purchase such coverage, to ensure that no federal funds go toward providing abortions outside the scope of the Hyde Amendment. The measure also prohibits health insurance plans in the exchanges from discriminating against any health care provider because of a provider's unwillingness to provide abortion services.

(The House overhaul bill, as modified by an amendment sponsored by Rep. Bart Stupak, D-Mich., extended provisions of the Hyde Amendment to plans covered by the bill. Specifically, it prohibited the use of funds authorized or appropriated

by the measure to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, unless a pregnancy is the result of rape or incest, or if there is danger to the mother's life. The Stupak amendment also struck provisions in the House bill that would have required the measure's public health option to cover abortions for which public funds are allowed.)

## Revenue Provisions

### *Tax on High-Cost Health Insurance Plans*

The Senate amendment imposes an excise tax on high-cost health insurance plans, referred to as "Cadillac plans," starting in FY 2013. The measure levies a 40% tax on the portion of employer-sponsored health insurance plans that exceeds aggregate costs of greater than \$8,500 per year for individual coverage, or \$23,000 per year for family coverage. After 2013, these threshold amounts would increase according to inflation.

This provision drew opposition from labor unions, who said that it would place a heavy tax burden on working families who are struggling in the weak economy. The White House maintained that the provision was an essential component to pay for health care overhaul legislation, and that only the very rich would be affected by the tax, as the vast majority of employer-sponsored plans currently offered would not be expensive enough to be affected by the tax.

CBO estimates that this provision would increase revenue by \$149 billion over the period of FY 2010 through FY 2019.

The reconciliation bill (HR 4872) changes this provision, by delaying the tax so it would not take effect until 2018 and increasing the threshold of the value of the health plans that would be subject to the tax. As modified by the reconciliation bill, JCT estimates that the tax would increase revenue by \$32 billion through FY 2019.

### *Other Revenue Provisions*

The measure also includes the following revenue provisions:

- **New Industry Fees** — The Senate bill creates new annual, industry-wide fees for health insurance firms, medical device manufacturers and pharmaceutical manufacturers. (The House measure would have imposed a 2.5% excise tax on medical devices.) The measure creates formulas to allocate the fees across these industries based on their market shares. The reconciliation bill (HR 4872) modifies these fees.

- **Medicare Hospital Payroll Tax** — The measure increases the payroll tax for individuals with annual earnings greater than \$200,000, or for couples with earnings greater than \$250,000. The reconciliation bill (HR 4872) also applies this tax increase to investment income, such as dividends or capital gains.
- **Tanning Service Tax** — The measure imposes a 10% tax on indoor tanning services.

### *No Income Tax Surcharge*

The measure does not include the provision in the House health care bill that would have imposed a 5.4% surcharge on any adjusted gross income in excess of \$500,000 for an individual earner or \$1 million for a couple.

### **Other Provisions**

The measure also does the following:

- **Biosimilar Drugs** — Authorizes the Food and Drug Administration to regulate and approve generic versions of biologic drugs (so-called biosimilar drugs), and provides that brand-name biologic drug makers could have 12 years of market exclusivity before biosimilars could go on the market.
- **Long-Term Care** — Establishes a new voluntary program known as the Community Living Assistance Service and Support (CLASS) program that would help individuals with functional limitations obtain services and financial support.
- **Immigrants** — Requires verification of citizenship status when determining if individuals are eligible to receive subsidies to purchase health insurance through the exchanges, and prohibits illegal immigrants and incarcerated individuals from purchasing coverage through the health insurance exchanges established by the measure.

- **Menu Labeling** — Requires chain restaurants and vending machines to prominently post information about caloric content of food items.
- **Medical Malpractice** — Authorizes grants to permit states to develop and evaluate alternatives to the current tort system for medical malpractice cases. (The House-passed bill would have provided incentive payments to states that enact new laws providing alternatives to traditional medical malpractice litigation.)

## CBO & JCT Cost Estimate

### *Estimate for Senate Measure*

The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimate that the measure would result in a net reduction in the federal deficit of \$118 billion over the period of FY 2010 through FY 2019. Specifically, the agencies estimate that the measure's provisions to expand health insurance would increase the deficit by \$624 billion over the period of FY 2010 through FY 2019, but that mandatory spending would decline by \$478 billion, and revenue would increase by \$264 billion over that time period.

### *Combined Effects of Senate Bill & Reconciliation Measure*

In a preliminary cost estimate for the reconciliation bill (HR 4872), CBO and JCT estimate that enacting both the Senate amendment to HR 3590 and HR 4872 would result in a net reduction in the federal deficit of \$138 billion over the period of FY 2010 through FY 2019. The agencies estimate that provisions in the two measures that would expand access to health insurance would result in a net decrease in the federal deficit of \$119 billion over the period of FY 2010 through FY 2019, and that the provisions relating to student loans would result in a net decrease in the federal deficit of \$19.4 billion over that time.

### *Long-Term Effects*

According to CBO, its analysis in consultation with JCT indicates that the Senate-passed health care overhaul would, in the decade after FY 2019, have a total effect that would be "in a broad range" between one-quarter percent and one-half percent of gross domestic product (GDP).

The analysis finds that the combined effects of the Senate-passed overhaul and the reconciliation bill would be, in a broad range, about one-half of GDP.

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**References**

No committees have acted on the Senate amendment to the bill, which was passed by the Senate on Dec. 24, 2009 by a vote of 60 to 39.

The House passed its version of the legislation (HR 3962) by a vote of 220 to 215 on Nov. 7, 2009 (See House Action Reports Fact Sheet No. 111-21, Nov. 5, 2009 and Floor Summary No. 111-19, Nov. 9, 2009).

See CQ Weekly, pp. 628, 568, 567, 240, 236 & 46. See 2009 CQ Weekly, pp. 2945, 2944, 2884, 2772, 2698, 2662, 2650, 2592, 1971, 1940, 1848, 772, 524 & 114.

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## Section II

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### Health Insurance Market Overhaul

This section deals with provisions the Senate amendment to HR 3590, Patient Protection and Affordable Care Act, that would overhaul the health insurance marketplace by, among other things, creating a system of state-run health insurance exchanges; requiring individuals to obtain health insurance or pay a penalty; requiring employers to make payments if they do not offer affordable coverage and then employees obtain insurance through insurance exchanges; and imposing new requirements on health insurance plans. Most of these changes are designed to reshape the individual health insurance market — i.e., private insurance for people who do not have employer-sponsored coverage and are not eligible for public insurance coverage — although it also contains some provisions intended to encourage employers to continue to offer coverage.

Most of the changes in the measure would take effect in 2014 — compared to 2014 in the House health care measure (HR 3962) — but the bill includes a number of immediate changes including a temporary program to provide insurance to individuals who are deemed "high risk" because of health conditions, requiring continued coverage of children under their parents' plans up to their 26th birthdays, and prohibiting insurers from denying coverage to people who have pre-existing conditions.

### Cost Estimate

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that the measure's proposed expansion in insurance coverage would have a projected net cost of \$624 billion over 10 years, but that the cost of these provisions would be more than offset through other provisions in the measure, including a reduction in mandatory spending of \$478 billion, and increased revenue of \$264 billion, resulting in a net reduction in the deficit of \$118 billion. CBO and JCT estimate that, over the period of FY 2010 through FY 2019, the measure would result in a net enrollment of 25 million people in the new health insurance exchanges, and a net decline in employer-sponsored insurance of 4 million people.

In a preliminary cost estimate, CBO and JCT estimate that if both the Senate-passed bill and the reconciliation measure (HR 4872) are enacted, then the health care expansion provisions in the measures would have a net cost a net \$794 billion over the period of FY 2010 through FY 2019. These costs would be offset, however, resulting a net reduction in the deficit of \$119 billion for the health expansion-related provisions. (The education-related provisions included in the reconciliation bill would result in an additional reduction of \$19.4 billion.) CBO and JCT estimate that over the period of FY 2010 through FY 2019, enacting both the Senate bill and the reconciliation measure would result in a net enrollment of 24 million people in the new health insurance exchanges, and a net decline in employer-sponsored insurance of 4 million people.

By comparison, CBO and JCT estimated that the insurance expansion provisions in the House health care measure would have a net cost of a net \$891 billion over 10 years, but that, taking offsets into account, it would have resulted in a net reduction in the deficit of \$138 billion over the period of FY 2010 through FY 2019. CBO and JCT estimated that the House-passed measure would have resulted in a net enrollment of 21 million people in a health insurance exchange, and a net increase in employer-sponsored coverage of 6 million people.

## **Health Insurance Regulations**

The majority of the measure's changes to the health insurance market do not take effect until 2014, but the measure includes provisions referred to as "immediate reforms" that are intended to expand access to coverage in advance of the larger overhaul.

### **National High-Risk Pool Program**

Like the House bill, the Senate measure requires the Health and Human Services Department (HHS) to establish a temporary, national high-risk insurance pool program that would provide health care benefits to eligible individuals starting 90 days after enactment, and until the health insurance exchanges created by the bill are functioning. The measure permits HHS to carry out this responsibility either directly, or through state high-risk pool programs through agreements, grants or contracts with states. It also imposes a "maintenance of effort" requirement for states that already have their own high-risk pools in effect, meaning that those states would be required to continue to operate their pools.

#### ***Eligibility***

In order to be eligible for the high-risk pool, an individual could not be eligible for Medicare, Medicaid or an employer-based plan, and could not have had insurance during the six-month period prior to applying. The measure prohibits illegal immigrants from receiving coverage through the high-risk pool. In addition, it requires individuals to be "medically eligible," meaning those people who have a pre-existing condition as defined by HHS.

#### ***Protection Against 'Dumping'***

The measure requires HHS to establish criteria for determining whether health insurance firms and employment-based health plans have discouraged individuals from remaining enrolled because of an individual's health status. An issuer or plan who matches the criteria established by HHS would be responsible for reimbursing the high-risk pool program for medical expenses incurred by the program for individuals who were encouraged to leave an insurance plan.

### ***Participant Costs***

The Senate-passed bill permits monthly premiums to vary by age, but stipulates that the ratio of the highest premium to the lowest premium could not exceed 4-to-1. (The House health care measure would have required a 2-to-1 ratio). The measure limits maximum annual participant cost-sharing to \$5,950 for an individual or \$11,900 for a family, the same as current law covering health-savings account arrangements.

### ***Funding***

Like the House version, the measure appropriates \$5 billion to pay claims and cover administrative costs of the high-risk pool that exceed the premiums that are collected. If the funding in a fiscal year is insufficient, the measure directs HHS to make necessary adjustments.

## **Requirements for Health Insurers**

In a similar manner to the House-passed health overhaul bill, the measure creates a number of new regulations to govern how health insurers operate their plans. Some of these provisions take effect immediately, although most would take effect in 2014, when the new health insurance exchanges created by the bill would become functional.

### ***Premiums***

The Senate-passed bill requires health insurers that offer coverage in the small- and large-group markets to publicly report what proportions of premiums are spent for specific services — reimbursement for clinical services provided, efforts to promote quality of care, and administrative costs. These reporting requirements would take effect immediately upon enactment.

The measure also requires insurers to provide rebates to enrollees if the medical loss ratio for a given year is below 85% for large-group plans, or 80% for small-group and individual market plans. This provision is intended to limit administrative costs for insurers to 15% for large groups, and to 20% for small group and individual coverage. (The House health care overhaul bill included a similar provision.) The rebates would be required starting in 2011, and would be required only until the health insurance exchanges are fully established.

### ***Review of Premium Increases***

The Senate measure — similar to the House version — creates a process for reviewing premium increases by health insurers, which would take effect immediately upon enactment.

Under an initial process, the measure directs HHS, in conjunction with the states, to establish an annual review process that would start in 2010. The bill stipulates that this process would require health insurers to submit a justification of any premium increase prior to implementing the increase. The submitted information would have to be placed prominently on the insurer's Web site, and HHS would have to ensure public disclosure of the information.

The measure creates a continuing review process, which would start in 2014, through which states would monitor premium increases inside and outside their insurance exchanges. It creates a program under which states that meet certain requirements could receive grants to assist them in reviewing and approving (where allowed by state law) premium increases. The measure appropriates \$250 million for the grants through FY 2014 (compared to \$1 billion provided in the House health overhaul measure), and requires that any funding unused by FY 2014 would be redirected to cover other insurance overhaul provisions. Grants could range from \$1 million to \$5 million.

### ***Protection Against Rescission of Coverage***

The measure stipulates that a health insurer could rescind group or individual coverage only with clear and convincing evidence of fraud or intentional misrepresentation by an enrollee. It also requires that insurers provide adequate prior notice to enrollees in the case of a rescission. This provision would take effect immediately upon enactment.

### ***Coverage of Young Adults***

The measure requires insurance plans to allow parents to continue coverage for dependent children who would otherwise not have health insurance until a child reaches his or her 26th birthday (the House health care bill would have extended coverage through children's 27th birthday). This provision would take effect immediately upon enactment.

### ***Pre-Existing Conditions & Other Rate-Setting Criteria***

The measure prohibits insurers that offer group or individual coverage from denying coverage because a potential enrollee has a pre-existing condition, starting in 2014. Specifically, the measure prohibits insurers from creating eligibility rules based on:

- Health status;
- medical condition, including physical and mental illnesses, or medical history;

- claims history;
- previous health services received;
- genetic information;
- evidence of insurability, including domestic violence history;
- disability; or
- other conditions determined by HHS.

(The House-passed health bill would have reduced the "look back" period — how long insurers can look back for a pre-existing condition — to 30 days, from the six months now commonly used.)

In addition, the Senate measure sets specific rating rules that insurers would have to use beginning in 2014. When considering rates for beneficiaries, insurers could only take into account whether a policy would cover an individual or a family; the age of those covered (with a restriction that rates for adults could not vary by a ratio of greater than 3 to 1); tobacco use (with a restriction that rates based on tobacco use could not vary by a ratio of greater than 1.5 to 1); and the rating area. The rating areas would be determined by states.

### ***Coverage of Preventive Care***

The measure requires health insurers to cover certain preventive care services without requiring any cost-sharing — i.e., co-payments, co-insurance or deductibles — from enrollees in group or individual plans. The services required to be covered under this provision include vaccinations and screening recommended by federal agencies.

The measure specifically states that the recommendations of the federal Preventive Service Task Force regarding breast cancer screening and mammography issued in November 2009 would not apply, and therefore, insurers would be required to provide mammograms more frequently than current guidelines call for. (In its 2009 recommendation, the task force stated that women younger than age 50 did not need to undergo mammograms absent a family history of breast cancer, and that women age 50 and older need to undergo mammograms only once every two years. This recommendation amounted to a reduction in screening compared to previous guidelines, which called for annual mammograms for women age 40 and over, and caused an uproar among certain advocacy groups that maintained that more frequent screenings are needed.)

### ***Elimination of Lifetime Limits***

The measure prohibits insurers from setting lifetime limits on the dollar value of health care, and, starting in 2014, prohibits insurers from setting annual spending limits. Prior to 2014, insurers could only set "reasonable" annual spending limits approved by the federal government.

### ***Retiree Reinsurance***

Like the House-passed health measure, the Senate bill requires HHS to establish, within 90 days of enactment, a temporary reinsurance program that would provide reimbursement to employment-based plans to assist with the costs of providing health benefits to retirees and their spouses, surviving spouses, and dependents of retirees. The provision covers retirees who are 55 or older but ineligible for Medicare coverage, thus generally covering those from 55 to 64. Plans would apply to HHS in order to participate in the program.

The measure permits HHS to reimburse plans for 80% of costs of a claim that exceeds \$15,000, but is less than \$90,000, and it provides for annual inflationary increases to those amounts.

The measure appropriates \$5 billion, which would be available without fiscal year limitations, for this program.

## **New Coverage Requirements**

The measure requires nearly all individuals to have health insurance and also requires employers to pay penalties for any employee who receives federal subsidies through the new state-based exchanges, whether or not the employer offers health insurance to such employees. Unlike the House health overhaul bill, under which most insurance provisions would have started in 2013, most of the health insurance provisions in this measure begin in 2014.

### **Individual Mandate**

The Senate-passed bill requires most citizens and legal residents to have "minimum essential coverage," which is defined as employer-sponsored coverage; government programs including Medicare, Medicaid, or CHIP; or coverage obtained through the new health insurance exchanges created under the measure. The requirement would take effect after Dec. 31, 2013.

### ***Penalty Taxes***

The measure imposes a penalty tax on individuals or married couples who do not have health care coverage for themselves or children that meet the coverage requirements. This tax would be \$750 per household member, per year. The measure sets a maximum of three times that amount, i.e., \$2,250 per household, or 2% of household income, whichever is less. Penalties for children younger than age 18 would be half the amount charged for adults, i.e., \$375. The penalties would be phased-in over the period of 2014 through 2016, and, starting in 2016, the penalties would be increased according to inflation.

According to CBO and JCT, these penalties would generate \$15 billion in revenue over the period of FY 2010 through FY 2019.

**Note:** The reconciliation measure (HR 4872) changes these penalties to increase the percentage of income that would be the maximum amount that could be paid as a penalty. In 2016 and subsequent years, the maximum penalty payment would be 2.5% of income. According to a preliminary estimate from CBO and JCT, as modified by the reconciliation bill, these penalties would generate \$17 billion in revenue over the period of FY 2010 through FY 2019.

(The penalty in the House-passed health overhaul measure would have been 2.5% of a taxpayer's adjusted gross income over a threshold amount for tax filing. In 2009, that threshold was \$9,350 for individuals and \$18,700 for couples. CBO and JCT estimated those penalties would have generated \$33 billion in revenue over 10 years.)

### ***Exceptions to Individual Mandate***

Under the Senate measure, the individual mandate, and the penalty tax, would not apply to the following populations:

- Illegal immigrants or individuals who are incarcerated;
- individuals who cannot afford coverage, defined as those whose contribution to the cost of insurance is greater than 8% of household income;
- Individuals who have a household income that is less than 100% of the federal poverty level (currently, \$10,830 per year for an individual, or \$22,050 for a family of four), although under the measure, people at this income level would be entitled to coverage

under Medicaid;

- members of American Indian tribes;
- individuals who are uninsured for a short period of time, defined as less than three continuous months;
- individuals for whom obtaining health insurance would create a "hardship," as determined by HHS; and
- those who belong to certain religious groups with tenets that include conscientious objection to private or public insurance.

### **Employer Requirements**

Unlike the House health insurance overhaul bill, the Senate-passed measure does not include the "play-or-pay" provision that would have required employers to either offer health insurance to employees or to pay a penalty. Instead, the Senate version penalizes employers that have employees who receive federal subsidies to purchase health insurance through the new exchanges that are established by the measure.

Specifically, the measure treats employers that offer health insurance to employees differently than it does employers that do not offer health insurance to employees. It exempts any employer with 50 or fewer employees from the requirements.

For employers that offer health insurance to employees, it stipulates that if any full-time employee receives a federal subsidy to purchase insurance on the exchanges, employers would face a penalty of the lesser of \$3,000 for each employee (full-time, or part-time) who receives a subsidy, or \$750 per full-time employee. It imposes further penalties for employers that require a waiting period for employees to enroll in health coverage — \$400 for each employee who has a 30-to-60 day waiting period, or \$600 for any employee who has a 61-to-90 day waiting period.

For employers who do not offer health insurance to employees, the bill stipulates that for each full-time employee who receives a subsidy to purchase insurance through an exchange, the employer would face a fine of \$750 per employee.

According to the annual Employer Health Benefits Survey conducted by the Kaiser Family Foundation, in 2009, 60% of firms offered health insurance coverage to employees. Among large firms (those with 200 or more workers), 98% offer health benefits, compared to 59% of small firms (those with between 3 and 199 workers).

According to an estimate by CBO and JCT, the measure would result in a net decline in the number of people who receive insurance through their employers of 4 million people over from 2010 to 2019. The estimate also reports that penalties paid by employers under this provision would increase revenue by \$27 billion over that time period.

**Note:** The reconciliation bill (HR 4872) changes the way employer penalties would be calculated for firms that offer health insurance coverage. It also increases the penalty for firms with more than 50 employees that do not offer health insurance of \$2,000 per full-time employee. In a preliminary estimate, CBO and JCT estimate that the employer penalties, as modified by the reconciliation bill, would increase revenue by \$52 billion over the period of FY 2010 through FY 2019.

(By comparison, CBO and JCT estimated that the House-passed bill would have resulted in a net increase in the number of people who receive insurance through their employers of 6 million people over the period of FY 2010 through FY 2019. The employer penalties in the House-passed "play or pay" provision were estimated as increasing revenue by an estimated \$135 billion over that time period.)

### ***Vouchers***

Unlike the House version, the Senate bill requires employers that offer health benefits to offer vouchers to purchase insurance in the exchanges for low- and moderate-income employees for whom the cost of employer coverage is high. Specifically, employers would have to offer vouchers to employees with incomes of up to 400% of the federal poverty level whose contribution to employer-sponsored insurance constitutes between 8% and 9.8% of income.

Currently, 400% of federal poverty is \$43,320 for an individual or \$88,200 for a family of four, meaning that 8% of annual gross income would be \$3,466 for an individual or \$7,056 for these individuals. The Kaiser Family Foundation survey found that in 2009, the average annual employee contribution across all income groups was \$779 for individual coverage and \$3,515 for family coverage.

### ***Automatic Enrollment***

Similar to the House version, the Senate measure requires employers with more than 200 employees automatically enroll new, full-time employees in one of the benefits plans offered, and to maintain such coverage each year unless employees opt-out. It requires employers to provide adequate notice so that employees may choose to opt-out. Typically, most large employers already maintain coverage from year-to-year unless employees opt-out during open enrollment periods.

## State Health Insurance Exchanges

The House-passed health overhaul measure would have established a national health insurance exchange managed by a new federal agency, which would have started in 2013. The House's measure would have allowed states to operate their own exchanges as long as they met federal approval. It also created a government-sponsored health insurance plan to be offered through the exchange — the highly controversial "public option."

In contrast, the Senate bill creates a system of state-based health insurance exchanges through which individuals or businesses with up to 100 employees would be able to purchase health insurance, beginning in 2014. It does not create a public option, although it does direct the federal Office of Personnel Management (OPM) to contract with insurers to offer plans in the exchange. It also does not prohibit states from offering totally state-financed health insurance coverage, as several states currently do for low- and moderate-income residents. It also specifically states that nothing in the measure could be construed to require individuals to terminate health insurance that they had on the date of enactment.

According to an estimate by CBO and JCT, approximately 25 million people would be expected to receive health insurance through the new exchanges by 2019. By comparison, CBO and JCT estimated that 21 million people would have been expected to obtain insurance through the health insurance exchanges under the House-passed bill by 2019.

## American Health Benefit Exchanges

The Senate-passed bill requires states to create "American Health Benefit Exchanges" by Jan. 1, 2014, which would offer different health insurance plans to certain individuals and small businesses. Such exchanges could be administered by either a governmental agency (the bill does not specify whether local or state-level), or a nonprofit entity that is established by a state. The measure provides federal funding for states to create the exchanges, but requires that the exchanges must be financially self-sustaining by Jan. 1, 2015.

The measure sets a number of requirements for the plans that could be offered through the exchanges. Health plans offered through the exchanges would have to meet the following requirements, which would be put forth in rulemaking by HHS:

- Offer a "sufficient choice of providers" to enrollees;
- include in their networks health care providers that would provide adequate services to medically underserved and low-income communities;

- meet certain standards for clinical access, utilization management and other quality measures;
- contract with outreach specialists who would conduct outreach and enrollment assistance services; and
- report, in plain language, information about enrollment statistics, claims payments, cost-sharing requirements, and the number of claims that are denied.

### ***Multi-State & Regional Exchanges***

Like the House-passed overhaul measure, the Senate measure permits two or more states to enter into agreements to operate multi-state or regional exchanges, as long as HHS approves the arrangements and as long as such exchanges cover a "distinct geographic area." (The measure does not specify whether regional exchanges could cover metropolitan areas that spread throughout multiple states, such as Washington, D.C., or New York, or if those exchanges would have to cover entire states.)

The measure further permits multi-state or regional exchanges to contract with external entities to run the operations. In order to qualify, an entity would have to have experience administering health coverage plans, and could not be a health insurer.

### ***CO-OP Program***

Similarly to the House-passed health bill, the Senate measure creates a new Consumer Operated and Oriented Plan (CO-OP) program that is intended to encourage the development of nonprofit entities to provide health insurance coverage. The measure appropriates \$6 billion for federal loans grants to help finance the CO-OP program, which would have to be awarded by July 1, 2013. The measure sets a number of requirements for plans that could receive federal funding to participate in the CO-OP program. Plans could not be existing health insurers as of July 2009; could not be administered by state or local governments; would have to use any profits to improve benefits, lower premiums, or otherwise improve health coverage for beneficiaries; and would have to comply with applicable state insurance regulations.

### ***OPM Contracts with Multi-State Plans***

Unlike the House-passed health overhaul measure, the Senate bill does not create a government run insurance plan that would compete in the exchanges — i.e., the public option.

Instead, the measure requires OPM to contract with health insurers to offer at least two multi-state plans in each new state health insurance exchange. These health plans would have to provide both individual and employer health plans. Under the bill, one of the two multi-state plans required in each exchange would have to be run by a nonprofit organization, and one plan would not be permitted to offer abortion services coverage beyond the specifications of the Hyde Amendment — i.e., only in cases where a woman's life is in danger or in cases of rape or incest. The measure requires the multi-state plans to meet state insurance regulations, and also meet the requirements for participating plans in the new exchanges, but it also allows individual states to create additional regulations that these plans would have to meet.

### ***Abortion***

The measure allows states to prohibit coverage of abortion services within their exchanges. It specifically states that enactment of the measure would not pre-empt state laws pertaining to abortion services.

It includes a so-called conscience clause — that prohibits any health insurer that participates in a new health exchange from discriminating against health providers who are unwilling to provide abortion services or refer patients to providers who do provide abortion services.

Under the Senate measure, plans in a state exchange that cover abortion services beyond the scope of federal law — i.e., abortions that are not needed to save a woman's life or in the case of rape or incest — would have to segregate payments for that abortion coverage into a separate account for enrollees who receive federal subsidies to purchase insurance. Essentially, enrollees would have two premium payments: One would be only for coverage of abortion services, and a second could not be paid for by federal funds.

In addition, the measure requires HHS to estimate the monthly actuarial cost of covering abortions beyond the scope of those permitted under federal law. HHS would be banned from considering any cost reduction estimated to result from providing such abortions.

## **Eligibility for the Exchanges**

### ***Individual Eligibility***

The Senate-passed measure permits citizens and legal residents who are not incarcerated to obtain coverage through the new health insurance exchanges. (This eligibility is broader than the House-passed health bill, which would have allowed citizens or residents who did not receive coverage through their employers or through Medicare, Medicaid, or Veterans Affairs benefits.)

The House-passed bill, however, also would have dissolved the federal Children's Health Insurance Program (CHIP) through which states provide coverage to low- and moderate-income children who are not poor enough to qualify for Medicaid, and would have instead made those children eligible to enroll in the exchange system. The Senate bill maintains CHIP in its current form, meaning that even if their parents enroll for health coverage through the exchanges, children in households with certain income levels would continue to be eligible for CHIP.

### ***Employer Eligibility***

The measure creates Small Business Health Options Program (SHOP) Exchanges, and makes employers with 100 or fewer employees eligible to purchase coverage through the new exchanges starting in 2014. States would have the option of creating one exchange to serve both individuals and businesses, or establishing a separate exchange for businesses only. Starting in 2017, businesses with more than 100 employees could purchase health insurance through the exchanges.

(By contrast, the House-passed health bill would have phased-in business participation in the exchanges over three years, but would have permitted larger employers to participate in the exchanges beginning in 2015.)

## **Benefits Structure in the Exchanges**

### ***Essential Benefits Package***

The Senate measure, like the House version, requires all qualified health benefits plans in the exchanges to provide coverage that meets or exceeds the standards of an "essential benefits package." The measure specifies the elements that would be covered in such a package, as well as the process for determining the standards.

All health plans — whether offered within or outside of the exchange — would be required to offer at least the essential benefits package. Plans outside of the exchange could offer additional coverage, while plans within the exchange could offer additional benefits as part of the premium-plus package.

Under the measure, an "essential benefits package" would be required to cover, at a minimum, the following services:

- Outpatient services;
- emergency services;
- hospitalization;

- maternity and newborn care;
- mental health services, including behavioral health treatment;
- prescription drugs;
- laboratory services;
- preventive and wellness services and chronic disease management;
- rehabilitative services; and
- pediatric services, including dental and vision care.

The Senate bill states that abortion coverage could not be required as part of the essential benefits package.

### ***Limit on Annual Out-of-Pocket Costs***

The measure bars out-of-pocket expenses from exceeding the standards set for Health Savings Account (HSA) plans under current law — \$5,950 for an individual or \$11,900 for a family in 2010. (The House version would have capped out-of-pocket expenses at \$5,000 for an individual and \$10,000 for a family. Those amounts would have been indexed for inflation using the Consumer Price Index for Urban Consumers.)

In addition, the Senate version places further limits on out-of-pocket expenses for low- and moderate-income households in the following income tiers:

- Households with an annual income of between 100% and 200% of the federal poverty level would have out-of-pocket limits equal to one-third of the HSA standards (\$1,983 for an individual or \$3,967 for a family in 2010).
- Households with an annual income of between 200% and 300% of the federal poverty level would have out-of-pocket limits equal to half of the HSA standards (\$2,975 for an individual or \$5,950 for a family in 2010).
- Households with an annual income of between 300%

and 400% of the federal poverty level would have out-of-pocket limits equal to two-thirds of the HSA standards (\$3,987 for an individual or \$7,973 for a family in 2010).

### ***Benefit Categories***

The House-passed health overhaul measure would have created four different benefit plan tiers. The Senate version creates similar benefit tiers, but includes the following five different tiers:

- **Bronze Plan** — The Bronze Plan would represent the minimum level of health coverage available through the exchanges, and would cover 60% of the costs of the medical benefits provided.
- **Silver Plan** — The Silver Plan would cover 70% of the costs of the medical benefits provided.
- **Gold Plan** — The Gold Plan would cover 80% of the costs of the medical benefits provided.
- **Platinum Plan** — The Platinum Plan would represent the most generous health insurance coverage available through the exchanges, and would cover 90% of the costs of medical benefits.
- **Catastrophic Plan** — The Catastrophic Plan would be available only to individuals ages 30 or younger who are exempt from the requirement to purchase health insurance, and would cover only medically catastrophic events (e.g., injuries sustained in a major car accident), with the maximum amount of cost-sharing permitted under the bill. This plan would be available only to individuals, and not to employers.

### ***Basic Health Plan***

The measure permits states to create a Basic Health Plan, which would provide coverage to uninsured individuals with annual household incomes of between 133% and 200% of the federal poverty level, which is currently between \$14,404 and \$21,600 for an individual or between \$29,327 and \$44,100 for a family of four. States would have to

contract with private insurers that would provide at least the essential benefits package required by the measure.

### **Subsidies for Individuals & Employers**

Like the House-passed health insurance overhaul measure, the Senate-passed bill provides federal funding for subsidies to allow low- and moderate-income individuals and families to purchase health insurance through the new exchanges. The economics of insurance are such that if health insurance premiums are more expensive than the penalty levied for not obtaining insurance, then many healthy people would choose to pay the penalty rather than purchasing health insurance. Thus, only the sickest people would choose to participate in the insurance exchanges, leading to a "death spiral" in which premiums continually increase to reflect the high expected medical costs of enrollees.

For this reason, the structure of insurance subsidies has been a critical point in the debate about how to structure the exchanges created by health overhaul legislation. Generally, the House-passed version included more generous subsidy levels than the Senate-passed bill, and the reconciliation bill (HR 4872) modifies this provision (see note below).

### **Premium Tax Credits for Individuals & Families**

The bill, as passed by the Senate, provides for federal premium tax credits for those with household incomes of between 100% and 400% of the federal poverty level, which is currently an annual income of between \$22,050 and \$88,200 for a family of four.

Generally, the measure bases premium tax credits on the second lowest-cost of any "Silver Plans" offered in a beneficiaries' state exchange. For households with annual incomes of 100% up to 133% of the federal poverty line, the measure provides premium credits so that those families' premium contributions would be no more than 2% of household income. For households with incomes of between 133% of the federal poverty level and 400% of the federal poverty level, the measure creates a formula under which premium subsidies would be provided on a sliding scale so that families would spend no more 2.8% of income on premiums at 133% of the poverty level, up to 9.8% of income for families with incomes of 400% of the federal poverty level.

**Note:** The reconciliation bill (HR 4872) changes these subsidies to make them more generous. It lowers the maximum amount so that families with incomes of up to 400% of the federal poverty level would spend no more than 9.5% of income premiums and also increases the subsidies that would be provided to families with incomes of less than 250% of the federal poverty level.

The measure specifies that premium tax credits would be reduced if any member of a household is illegally residing in the United States — for instance, if four people were supported on a particular income, and one family member is an illegal immigrant, then the measure would consider the family income to be supporting only three people.

In addition, the measure provides cost-sharing subsidies to households with annual incomes of 100%, up to 400% of the federal poverty level, and provides that American Indians with incomes of less than 300% of the federal poverty level would be exempt from any cost-sharing requirements in plans offered through the new health insurance exchanges.

The measure reduces cost-sharing requirements as follows:

- Households with an annual income of between 100% and 200% of the federal poverty level would have out-of-pocket limits reduced by two-thirds;
- households with an annual income of between 200% and 300% of the federal poverty level would have out-of-pocket limits reduced by one-half; and
- households with an annual income of between 300% and 400% of the federal poverty level would have out-of-pocket limits reduced by one-third.

The measure requires the Government Accountability Office (GAO) to conduct a study regarding the insurance affordability in the exchanges, and to submit the report and any legislative recommendations to Congress within five years of enactment.

CBO estimates that premium tax credits and cost-sharing subsidies would increase direct (mandatory) spending by \$337 billion over the period of FY 2010 through FY 2019.

### ***Abortion***

The Senate-passed bill includes provisions to ensure that the federal premium tax credits could not be used to pay for coverage that provides abortion services beyond the scope of current federal law (i.e., abortions that are not needed to save a woman's life or that are not in the case of rape or incest). It provides that if a plan in a state exchange provides coverage for abortion services beyond the scope of federal law, then the plan would have to segregate payment accounts for individuals who receive premium tax credits to purchase insurance. Essentially, enrollees would have two premium payments, one of which would be only for abortion services and a second, which would have to be paid solely by non-federal funds.

### ***Overlap with Medicaid & CHIP Eligibility***

Under the measure, individuals with incomes of less than 100% of the federal poverty level would be exempted from the requirement to obtain a minimum level of health insurance, although these individuals would be eligible for Medicaid. The measure creates federal premium tax credits for individuals with household incomes between 100% and 133% of the federal poverty level to purchase health insurance through the new insurance exchanges created under the bill, even though these individuals also would be eligible for Medicaid. The bill specifies that any individual who applies for coverage in a state exchange would also be screened for eligibility for Medicaid or CHIP, and be enrolled if eligible (i.e., a "screen and enroll" requirement). The bill is silent on whether adults with incomes between 100% and 133% of poverty would be dually eligible for both Medicaid and premium credits to purchase insurance in the exchanges, but does specify that premium tax credits would be disregarded as income when determining Medicaid eligibility. Under current law, for individuals who are eligible for Medicaid, but are enrolled in private coverage, Medicaid is required to "wrap around" to cover any services that are not covered under the private health plan.

Additionally, low-income children would continue to be eligible for coverage under Medicaid. The measure states that children who meet income eligibility guidelines for CHIP, but are unable to enroll because a state has frozen enrollment due to budget constraints, would be eligible for premium tax credits to obtain health insurance through the new exchanges. Starting in FY 2016, the measure permits states to transition CHIP-eligible children to receive coverage through one of the new health insurance exchanges, instead of CHIP, as long as HHS approves this transition.

(See Section III of this Fact Sheet for details about new eligibility rules for Medicaid and CHIP.)

### **Tax Credits for Small Businesses**

The measure provides tax credits to assist certain small businesses that opt to offer insurance coverage. It provides a tax credit to employers with 25 or fewer employees who have annual average incomes of less than \$50,000. It phases-in these tax credits. In tax years 2010 through 2013, qualifying small employers could receive a tax credit of 35% of the employer contribution to health insurance premiums, as long as the employer contributes at least 50% of the total premium costs, on an aggregate basis, not a per-employee-basis. In tax years 2014 and on, it provides a tax credit of 50% for qualified employers for the first two years when an employer purchases health insurance through a state exchange, provided that the employer contributes at least 50% of total premium costs. Tax-exempt small businesses (e.g., religious organizations) that meet all the other requirements would be eligible for tax credits of up to 35% of their contribution to employees' health insurance premiums.

## Abortion

Under a provision of current law known as the Hyde Amendment, which has been added each year since 1977 to the Labor-HHS-Education appropriations bill, federal health programs, including Medicaid, are prohibited from using federal funds to pay for abortions, with exceptions in cases of rape, incest or danger to a woman's life. The Hyde Amendment does not, however, ban the use of private funds by a state, locality, entity or private person to pay for abortions.

The Senate-passed measure specifies that insurers participating in health insurance exchanges would not be required to offer abortion coverage, and it allows states to prohibit abortion coverage in their exchanges. It stipulates that insurance plans within state exchanges that offer abortion coverage beyond the scope of the Hyde Amendment would have to provide separate accounts for women who choose to purchase such coverage, to ensure that no federal funds go toward providing abortions outside the scope of current law.

Like the House-passed health care bill, the Senate version also includes a "conscience clause" stipulating that no plan participating in the exchange could discriminate against an individual health care provider or health care facility because of its willingness or unwillingness to provide, pay for, provide coverage of, or provide referral for, abortion services.

The House overhaul bill, as modified by an amendment sponsored by Rep. Bart Stupak, D-Mich., extended provisions of the Hyde Amendment to plans covered by the bill — thereby ensuring that the policy would remain enshrined in law even if future appropriations bills did not include the policy. Specifically, the House-passed version prohibited the use of funds authorized or appropriated by the measure to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, unless a pregnancy is the result of rape or incest, or if there is danger to the mother's life. The Stupak amendment also struck provisions in the House bill that would have required the measure's public health option to cover abortions for which public funds are allowed.

Abortion restrictions have been a key point of controversy during debate about how to create new health insurance exchanges. Anti-abortion Democrats in the House, led by Stupak, have maintained that abortion restrictions in the Senate-passed measure are not strong enough, and have threatened to oppose the Senate measure in House floor consideration. Initially, it was expected that House and Senate leaders would reach a compromise agreement regarding abortion language that would be incorporated in a final version of the legislation that would be cleared for the president. The reconciliation measure, which modifies provision in the Senate-passed bill, does not address abortion policy, as reconciliation measures can only contain budget-related provisions.

As of press time, it was not known if, or how, remaining House-Senate differences on abortion policy might be resolved.

### **Severability**

Unlike the House-passed health overhaul measure, this measure does not include a severability clause. (Under a severability clause, if any provision in the bill, or any application of a provision to any person or circumstance, is held to be unconstitutional, then the remainder of the provisions of the bill and the application of its provisions to any other person or circumstance would not be affected.)

## Section III

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### Changes to Medicare, Medicaid & CHIP

This section describes the numerous changes that the Senate amendment to HR 3590 makes to Medicare, Medicaid and the Children's Health Insurance Program (CHIP). Among other things, the bill expands eligibility for Medicaid to those with household incomes of up to 133% of the federal poverty level, reduces payments the Medicare Advantage (MA) program, maintains CHIP in its current form and increases federal matching funds for CHIP, and eliminates co-payments and deductibles for certain preventive services.

According to a cost estimate by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT), enacting the bill would result in a net increase in enrollment in Medicaid and CHIP of 15 million people over the period of FY 2010 through FY 2019. CBO and JCT estimate that expanding Medicaid and providing additional funding for CHIP would result in outlays of \$386 billion over that time period.

A preliminary estimate by CBO and JCT finds that enacting both the Senate-passed bill and the reconciliation measure (HR 4872) would result in a net increase in enrollment in Medicaid and CHIP of 16 million people over the period of FY 2010 through FY 2019. CBO and JCT estimate that Medicaid and CHIP provisions as modified by the reconciliation bill, would result in outlays of \$434 billion over that time period.

In comparison, CBO and JCT estimated the House-passed measure would have resulted in the same net increase in enrollment in Medicaid and CHIP — 15 million people over the period of FY 2010 through FY 2019. CBO and JCT estimated that the House-passed measure would have resulted in outlays of \$425 billion over that time period.

### Medicare

The Medicare program, which provides health insurance to elderly and disabled individuals, is administered by the Centers for Medicare and Medicaid Services (CMS).

#### Independent Payment Advisory Board

The measure creates an Independent Payment Advisory Board (IPAC) to draft legislative proposals to slow the growth rate in Medicare spending if spending exceeds a certain target rate. (The House health care overhaul (HR 3962) did not include similar provisions.) It directs CMS to project, on April 15, 2013, whether Medicare spending would exceed the projected growth in the Consumer Price Index. If so, the new 15-member IPAC would meet and submit to Congress and the president recommendations on how to slow Medicare's growth. Such recommendations would be due by Jan. 15, 2014. Beginning in January 2018, the method used to determine whether

the IPAC must make recommendations would change to require a Medicare growth rate that exceeds gross domestic product growth plus one percent.

The Congressional Budget Office (CBO) estimates that the new IPAC recommendations would reduce mandatory spending by \$28 billion over the period of FY 2010 through FY 2019.

The IPAC would have the responsibility to focus on ways to slow Medicare spending, through recommendations that could include reimbursement reductions to MA plans or to prescription drug plans, or recommendations to restructure payment mechanisms generally. The measure specifies that the targeted savings rate would be 0.5% of projected total Medicare spending in 2015, 1% in 2016, 1.25% in 2017, 1.5% in 2018 and beyond. The savings target rate could be less than the specified levels, if recommended by the chief actuary of CMS.

The Senate bill explicitly prohibits the IPAC from making recommendations that would ration care, or change benefits, eligibility rules, or require cost-sharing, such as premiums and co-payments. It also directs the IPAC to consider beneficiaries' access to care and the quality of care when making any recommendation.

### ***Congressional Consideration of IPAC Recommendations***

The measure requires Congress to consider the legislative proposals submitted by the IPAC. If Congress does not act on a proposal by August 15 in the year it is submitted, CMS would be required to implement the proposal as submitted to Congress and the president by the IPAC.

Specifically, the measure requires that the Energy and Commerce and Ways and Means committees and the Senate Finance Committee act on the IPAC proposals by April 1 of any year in which a proposal is submitted. If the committees do not take action by the deadline, the legislation would be automatically discharged and available for consideration by the full chamber. The bill specifies that during floor consideration, amendments that would overturn cost-savings recommendations, or amendments that are not germane to the legislation would not be in order; and it requires a three-fifths majority in the Senate to appeal the ruling of the chair that any amendment is not in order. It also limits Senate debate on any amendments to one hour, and limits total debate time in the Senate to 30 hours, thus preventing filibusters.

### **Part A Program**

The Medicare Part A program covers inpatient hospital services, including inpatient rehabilitation care.

### ***'Market Basket Updates'***

The measure makes several changes to the market basket updates used to determine the reimbursement for certain services under Medicare Part A. Generally, market baskets are used to adjust payments each year based on projected changes in indexes that are used to measure how much more or less it would cost to buy the same goods and services.

Like the House-passed health care bill, the measure incorporates "productivity adjustments" — adjustments based on gains in productivity — into several market baskets used under Part A that do not currently incorporate such provisions. The adjustments would be phased in during different years for different types of providers, and would affect skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, hospice care and other providers.

CBO estimates that incorporating productivity improvements into market basket updates — most currently do not use them — would reduce mandatory spending by \$146.7 billion through FY 2019, including changes to both the Part A and Part B programs. (The House-passed bill would have resulted in reduced revenue of \$102 billion over that time.)

**Note:** The reconciliation bill (HR 4872) modifies this provision by revising the hospital market-basket update formula. A preliminary estimate by CBO and JCT projects that the modified provision would reduce mandatory spending by \$156.6 billion through FY 2019, including changes to both the Part A and Part B programs.

### ***DSH Payments***

Medicare disproportionate share hospital (DSH) payments are provided to hospitals that treat a disproportionate share of low-income patients. The Senate-passed bill reduces DSH payments by 75% starting in FY 2015, and then increases payments based on the percentage of the population that is uninsured and the amount of care provided to uninsured patients.

(The House measure would have required the Department of Health and Human Services (HHS) to provide a report to Congress on Medicare DSH payments by Jan. 1, 2016, and adjust DSH payments based on the reduction of the number of uninsured people.)

CBO estimates that this provision would reduce mandatory spending by \$25.1 billion through FY 2019.

**Note:** The reconciliation bill (HR 4872) modifies this provision to reduce DSH payments starting in FY 2014, and decreases the ten-year reduction in DSH payments by

\$3 billion. In a preliminary cost estimate, CBO and JCT estimate that the provision as modified would reduce mandatory spending by \$22.1 billion through FY 2019.

### **Part B Program**

The Medicare Part B program covers outpatient health care services, including doctor fees.

#### ***No 'Doc Fix'***

The measure does not include the "doc fix," a provision that would permanently change the Medicare cost-control formula (known as the "sustainable growth rate") governing the Medicare reimbursement rate for physicians required by a 1997 budget reconciliation law (PL 105-33). Since 2002, those cost-control provisions have required cuts in the payments. Congress has enacted a series of short-term fixes to prevent reductions in the reimbursement rates, most recently in early March. The current temporary "doc fix" is scheduled to expire on March 31, but a measure (HR 4857), passed by the House Wednesday, would extend it through April 30.

#### ***Medicare Part B Premiums***

Currently, Medicare Part B premiums are calculated based on income levels, and beneficiaries pay premiums based on their annual incomes two years prior to the coverage year. According to CMS, in 2010, most Medicare beneficiaries will pay \$96.40 per month for Part B coverage, although some new beneficiaries will pay \$110.50. The Senate measure, unlike the House version, freezes the income levels used to calculate Medicare Part B premiums in 2011 through 2019 to levels set for 2010.

CBO estimates that this provision would reduce mandatory spending by \$25 billion through FY 2019.

#### ***Market Basket Updates***

As with the Part A program, the measure requires market basket updates for the Part B program, including the addition of adjustments for productivity gains for outpatient hospital services. Ambulance services, ambulatory surgical care, and durable medical equipment that are not subject to competitive bidding would also receive productivity adjustments, and the bill replaces the existing update for laboratory services.

CBO estimates that the market basket updates for both Part A and Part B would reduce mandatory spending by \$146.7 billion through FY 2019.

### ***Durable Medical Equipment***

The measure makes changes to the durable medical equipment law, although the provisions differ from the House-passed bill. It requires the prescribing physician to document that the physician "himself or herself has had a face-to-face encounter" with the patient, in order to certify that a patient needs durable medical equipment. It allows the use of electronic technologies to communicate with patients, known as telehealth, to count as a face-to-face encounter.

The measure also expands the competitive bidding process for durable medical equipment.

It waives a surety bond requirement, under which a supplier must provide a bond of at least \$50,000 to receive a provider number and obtain payment, for certain pharmacies and eyewear suppliers. It also exempts certain pharmacies from accreditation requirements for selling diabetic testing supplies, canes and crutches. Finally, it includes provisions intended to ensure a supply of oxygen equipment, including cases in which an oxygen provider files for bankruptcy.

### **Provisions for Parts A & B**

The measure includes several provisions that apply to both Part A and Part B of Medicare.

### ***Medicare Improvement Fund***

The Senate-passed bill eliminates the Medicare Improvement Fund, which is a fund that allows CMS to fund improvements to the original fee-for-service program under Medicare Parts A and B. CBO estimates that this provision would reduce mandatory spending by \$20.7 billion through FY 2019.

### ***Therapy Spending Caps Exceptions***

The measure extends through December 31 the ability of the CMS to provide exceptions from the current spending cap for physical and rehabilitative therapy in Medicare. Under current law, that ability is set to expire on March 31. If CMS is unable to provide exceptions, Medicare beneficiaries would face an annual spending limit of \$1,840 for physical and rehabilitative therapy. In 2008, Congress enacted a law (PL 110-275) that allowed the CMS to provide beneficiaries exceptions from this limit, but the exceptions process expired on Dec. 31, 2009, and was later re-authorized through March by the Temporary Extension Act (PL 111-144).

### ***Other Medicare Provisions***

The measure also does the following:

- **Mental Health** — Authorizes, through December 31, a 5% increase in Medicare reimbursements for mental health services provided by psychologists and social workers. (On January 1, reimbursements to such providers were decreased by 5%.)
- **Ambulance Services** — Extends through December 31 increased Medicare reimbursements for ambulance services. For urban ambulance services, the measure authorizes a 2% increase in reimbursements, and for rural areas, a 3% increase. These increased payments expired as of Dec. 31, 2009.
- **Rural Hospital Grants** — Extends through 2012 the Medicare rural hospital flexibility program, which allows rural hospitals to receive grants for initiatives to increase access to health care in rural areas through the creation of rural health networks. Under current law, the program is set to expire at the end of FY 2010.
- **Hospital Wage Adjustments** — Extends through FY 2010 a provision of current law that permits certain hospitals to be eligible in a higher-wage index area, allowing them to receive higher Medicare reimbursements. Medicare takes into account the costs of wages in its hospital reimbursement calculations, so hospitals that are in low-wage areas would receive lower payments. The provision allowing hospitals to be re-classified in a higher-wage area was first enacted as part of the Medicare Modernization Act (PL 108-173), and expired on Sept. 30, 2009.

### **Medicare Part C/Medicare Advantage**

Medicare Part C — better known as Medicare Advantage (MA) — is an alternative to traditional Medicare under which Medicare-eligible individuals are insured by private

firms rather than the federal government. The program was designated MA under the 2003 prescription drug law (PL 108-173) which replaced the "Medicare+Choice" program with MA.

The private plans receive a per-person amount to cover certain benefits. Premiums for Medicare B coverage are paid to Medicare, but additional amounts may be paid to the MA provider. Plans under MA include Medicare health maintenance organization (HMOs), preferred provider organizations (PPOs), private fee-for-service plans, and Medicare special needs plans. Prescription drugs also can be covered under MA plans, and generally are.

The measure changes several elements of the MA program, which has been controversial. Private plans under MA are now paid 14% more on average than traditional fee-for-service Medicare.

### ***Change in Payment Structure***

Like the House health care bill, the measure reduces payments to MA plans. Specifically, it reduces payments so that they would be equal to the average of plan bids in each market area. (The House bill would have reduced payments to be equal to those provided under traditional fee-for-service Medicare.) These payment reductions would be phased in during the course of four years, starting in 2012. Like the House version, the measure also allows for bonus payments to MA plans for quality of care, care coordination and improvement in delivery of care, beginning in 2014.

The reductions in payments, however, would not apply in areas in which plan bids are equal to or less than 75% of the cost of traditional fee-for-service Medicare. The measure provides extra benefits for MA plan beneficiaries in certain service areas if they experience a "significant reduction" in benefits. Such areas would include large urban areas, and areas in which more than 30% of Medicare beneficiaries were enrolled in MA plans in 2009.

According to CBO, these changes would reduce mandatory spending by \$118.1 billion through FY 2019, compared to an estimated reduction of \$154.3 billion under the House measure.

**Note:** The reconciliation bill (HR 4872) modifies this provision by freezing MA payments in 2011 and then re-formulating payments according to local costs. Under the new formula, which would be phased-in, MA payments would range from 95% of traditional Medicare spending in high-cost areas to 115% of traditional Medicare spending in low-cost areas. A preliminary estimate by CBO and JCT finds that, as modified by the reconciliation bill, the provision would reduce mandatory spending by \$129.7 billion over the period of FY 2010 through FY 2019.

The reconciliation measure also requires that MA plans spend at least 85% of their revenue on medical costs, essentially limiting administrative costs to 15%. As of press time CBO and JCT had not yet completed a cost estimate for this provision.

### ***MA Special Needs Plans***

The 2003 Medicare overhaul (PL 108-173) created a new type of MA plan known as the special needs plan, which focuses on those with special needs. The plan can target enrollment toward those who are institutionalized, dually eligible for Medicare and Medicaid, or those with severe or disabling conditions.

The measure allows certain types of plans to continue to operate as MA plans — thus receiving increased reimbursements — through Dec. 31, 2013.

### ***Other MA Changes***

The Senate amendment also does the following:

- Prohibits MA plans from charging beneficiaries higher levels of cost-sharing than those charged under traditional fee-for-service Medicare;
- allows 45 days in each calendar year for beneficiaries to disenroll from an MA plan and return to traditional Medicare coverage;
- permits CMS to deny bids by MA plans that provide lower benefit levels, or have higher cost-sharing requirements, compared to traditional Medicare, starting in 2011; and
- Permits CMS to develop standards to evaluate MediGap plans.

### **Medicare Part D/Prescription Drug Coverage**

The Medicare Part D program, created under the 2003 Medicare Modernization Act (PL 108-173), offers prescription drug coverage for those eligible for Medicare. Those who elect to take the prescription drug coverage go through a private insurer that offers a prescription drug plan.

### ***Reduced Subsidies for High-Income Earners***

Under current law, the federal government provides subsidies for Medicare beneficiaries to purchase private prescription drug coverage. For instance, low-income individuals are eligible to receive reduced Part D premiums, as well as assistance with cost-sharing requirements, such as co-payments or co-insurance. According to CMS, Medicare beneficiaries will pay an average of \$30 per month for prescription drug coverage premiums in 2010.

The Senate-passed bill — unlike the House version — reduces premium subsidies for individuals with annual incomes greater than \$85,000 for an individual, or \$170,000 for a couple starting Jan. 1, 2011, effectively increasing Part D premiums for those affected. According to CBO, this provision is expected to reduce mandatory spending by \$10.7 billion through FY 2019.

### ***Reducing the 'Doughnut Hole'***

Under the 2003 law that created Part D, after a beneficiary meets his or her deductible for the year, a beneficiary will have 75% of his or her drug costs covered by the government up until a set dollar amount, which was initially set at \$2,250, but has increased to \$2,830 in 2010 as a result of inflationary increases permitted beginning in 2007. After that dollar amount has been reached, the beneficiary is responsible for 100% of the cost of prescriptions up to another dollar amount, known as the catastrophic threshold, which is \$6,440 in 2010. The federal government is responsible for 95% of the costs above that upper limit for the rest of the year. The middle portion, in which the patient is responsible for the full cost, is known as the coverage gap or "doughnut hole." CMS estimated that 31.7% of Part D enrollees, or 8.3 million people, reached the initial coverage limit in 2007.

The House-passed version (HR 3962) would have phased out this "doughnut hole" over 10 years, and, for 2010, would have immediately increased by \$500 the threshold amount at which the doughnut hole begins. The Senate bill maintains the \$500 increase to the threshold amount for 2010, however, it does not totally eliminate the "doughnut hole." Instead, it creates a new discount program for Medicare beneficiaries who have high annual drug costs and therefore fall into the "doughnut hole." Under the new program, CMS would enter into agreements with drug makers to provide discounts to these beneficiaries.

CBO estimates that the new drug discount program would increase mandatory spending by \$17.8 billion through from FY 2010 through FY 2019.

**Note:** The reconciliation measure (HR 4872) alters this provision by providing a \$250 rebate for beneficiaries who fall into the "doughnut hole" in 2010. It also increases

the discount for beneficiaries in the coverage gap, providing a discount of 50% on brand-name drugs in 2011, which would increase use to 75% on brand-name and generic drugs in 2020. CBO and JCT estimate that this provision, as modified by the reconciliation bill, would increase mandatory spending by \$37.6 billion over the period of FY 2010 through FY 2019.

### ***Other Part D Changes***

The Senate-passed bill also does the following:

- Allows HIV/AIDS drugs or those prescribed through the Indian Health Service to count toward beneficiaries' annual out-of-pocket maximum;
- Requires that drug plans use a uniform system for appeals and exceptions processes; and
- Requires drug plans to develop new systems to eliminate wasteful practices in long-term care facilities, which CBO estimates would reduce mandatory spending by \$5.7 billion through FY 2019.

### **Rural Access Provisions**

Like the House bill, the Senate measure includes several provisions intended to provide greater access to Medicare beneficiaries in rural areas.

The measure extends through FY 2010 a provision of law that provides "hold harmless" payments to protect rural hospitals from financial losses they might otherwise face under Medicare payment systems. Hospitals would receive such payments through the end of 2011. It also extends through FY 2011 a provision in the 2003 Medicare law that provided funding for one-time geographic re-classification of hospitals.

The measure also extends and expands several demonstration projects designed to improve the quality of care in rural areas.

## **Medicare Payment & Care Models**

### **Medicare Shared Savings Program**

The measure creates a new Medicare Shared Savings Program, starting in January 2012, that is intended to provide for greater coordination of care for services delivered

through Medicare parts A and B (i.e., hospital and physician office services) to beneficiaries enrolled in traditional fee-for-service Medicare.

Specifically, it permits qualified health care providers to form Accountable Care Organizations (ACOs). ACOs that meet certain quality standards would be eligible to receive payments from the federal government. In order to qualify as an ACO eligible for payments, the measure requires any group of providers to meet certain criteria, including having a leadership and administrative structure in place, demonstrate a willingness to take responsibility for the overall quality and cost of care of Medicare beneficiaries who are assigned to the ACO; agreeing to contract with CMS for at least three years; and other requirements. It also requires that ACOs submit data, as determined by CMS, of a nature that would allow CMS to evaluate the quality of care being provided.

CBO estimates that this provision would reduce mandatory spending by \$4.9 billion through FY 2019.

### **Center for Medicare & Medicaid Innovation**

The measure creates a new Center for Medicare and Medicaid Innovation (CMI), which would be a part of CMS. The new CMI would be directed to evaluate "innovative payment and service delivery models" that would reduce costs without negatively affecting the quality of care or the scope of benefits provided to enrollees. Some of the models that would be explored under the measure include: payment based through patient-centered medical homes; contracting directly with groups of providers for care coordination; the use of comprehensive care plans for geriatric care; community-based health teams that would support medical homes; and promoting greater access to outpatient services when possible.

CBO estimates that the creation of the CMI would reduce mandatory spending by \$1.3 billion through FY 2019.

### **Hospital Re-Admissions Reduction Program**

The measure reduces reimbursements to hospitals for what are considered to be preventable re-admissions of Medicare beneficiaries. The provision is intended to incentivize hospitals and health care providers to allow for adequate medical follow-up to prevent multiple hospital re-admissions for patients with chronic conditions. Starting in FY 2012, CMS would reduce payments by specified percentages, depending on the billing code, for preventable hospital re-admissions. The measure instructs CMS to determine the number of hospital re-admissions for a given condition that would be considered excessive, and thus subject to reduced reimbursements. It also directs CMS, within two years of enactment, to create a new program that would assist hospitals in reducing excessive re-admissions.

CBO estimates that this provision would reduce mandatory spending by \$7.1 billion through FY 2019.

## **Medicaid & CHIP**

The measure makes a number of changes to Medicaid and CHIP. Medicare provides coverage to low-income individuals that meet requirements under state and federal law. Each state runs its own Medicaid program and sets its own guidelines regarding eligibility, benefits, beneficiary cost-sharing, and provider reimbursement rates. The federal government provides federal matching funds to states for the cost of services. Payments are then made from states to providers of health care services. CHIP is a program through which the federal government provides block grants to states, which in turn provide additional coverage for children who are not eligible for traditional Medicaid. The intent of CHIP is to provide health coverage to low- and moderate-income children in families with incomes that are too high to qualify for Medicaid.

Some of the changes made to Medicaid are part of the measure's broader overhaul of health insurance, particularly an expansion of Medicaid eligibility. According to CBO and the Joint Committee on Taxation, if the measure is enacted, an estimated 15 million more people would be covered under Medicaid or CHIP than would be covered if current law continues. CBO estimates that provisions relating to Medicaid and CHIP coverage would increase federal outlays by \$386 billion over the period of FY 2010 through FY 2019.

### **Medicaid Eligibility Expansion**

Generally, states are required to cover certain populations under Medicaid — pregnant women and children age five or younger with family incomes of 133% of the federal poverty level (\$29,327 for a family of four in 2009); children age 6 through their 19th birthday with household incomes of up to 100% of the federal poverty line; and elderly or disabled individuals who have very low incomes. States generally cannot, however, receive federal reimbursement to cover those who are not pregnant, not elderly, not disabled or who do not have dependent children without waiver approval from HHS. Many states have waivers in place to either expand income eligibility higher than the federal minimums for pregnant women and children, or to extend coverage to childless adults. In most states, coverage available to low-income parents and childless adults is extremely limited — the median income eligibility for Medicaid for parents among all states is 64% of the federal poverty level, and 32 states do not offer coverage to adults without dependent children in their homes.

#### ***Eligibility***

The measure expands categorical eligibility under Medicaid to cover all individuals

with household incomes of up to 133% of the federal poverty level, effective in 2014. Currently, 133% of the federal poverty level is an annual income of \$14,404 for an individual or \$29,327 for a family of four. (The House health care bill would have expanded Medicaid eligibility to those with incomes of up to 150% of the federal poverty level.) Under the measure, state Medicaid programs would be required to cover individuals who would not traditionally qualify for Medicaid, including those under age 65, those who are not disabled and those without dependent children.

### ***Maintenance of Effort***

The measure bars states from changing their Medicaid programs in a way that imposes more restrictive standards, methodologies or procedures than were in effect on the date of enactment — a so-called "maintenance of effort" requirement — through Dec. 31, 2013.

### ***Premium Assistance***

Under current law, states have the option of allowing people who are eligible for Medicaid coverage to instead receive premium assistance from the state for employer-sponsored coverage, if such premium assistance is cost effective for the state. States can either require that people eligible for Medicaid instead receive premium assistance, or can allow premium assistance if an eligible individual requests it. The measure requires that all states provide premium assistance to those eligible for Medicaid if they have employer-sponsored coverage available.

### **Increased Federal Funds**

Currently, states consider parents and childless adults differently in terms of Medicaid eligibility. All states provide Medicaid to parents, and state income eligibility for parents in traditional Medicaid ranges from 24% of the federal poverty level in Alabama to 215% of the federal poverty level in Minnesota. Eighteen states provide Medicaid coverage to childless adults, and an additional five states and the District of Columbia provide state-funded coverage to childless adults.

Under the Senate-passed bill, the federal government would cover 100% of the cost of coverage to newly eligible people — including both parents and childless adults — from 2014 through 2016. In 2017 and after, states would receive an increase in federal matching funds for Medicaid as calculated through the Federal Matching Adjustments Percentages (FMAP).

States that did not previously cover parents or childless adults with incomes of at least 100% of the federal poverty level would receive an increased FMAP of 34.3 percentage points in 2017, and 33.3 points in 2018, to cover newly eligible

individuals. Starting in 2019, all states would receive an increased FMAP of 32.3 percentage points.

States that previously covered either parents or childless adults with incomes of 100% of the poverty level or greater, but still have enrollees who would become newly eligible under the measure, would receive an increased FMAP of 30.3 percentage points in 2017, and 31.3 percentage points in 2018 for those who are newly eligible. For instance, a state that previously covered parents with incomes of 100% of the federal poverty but did not previously cover childless adults would receive this FMAP increase for childless adults who become eligible under the bill. States that previously covered either parents or childless adults with incomes of 100% of the poverty level or greater would also receive an increased FMAP of 2.2 percentage points in 2014 through 2019 for those people who were already covered under a state Medicaid program. For instance, a state that previously covered parents with incomes of 100% of the federal poverty but did not previously cover childless adults would receive this FMAP increase for parents who continue to be enrolled in Medicaid after enactment of the bill. Starting in 2019, all states would receive an increased FMAP of 32.3 percentage points.

The measure provides an additional 0.5 percentage point increase for parents and childless adults who were previously enrolled in Medicaid in Massachusetts.

Under the bill, Nebraska would continue to receive 100% federal funding for newly eligible individuals, for an unlimited time.

**Note:** The reconciliation bill (HR 4872) modifies this provision to eliminate the 100% federal funding for Nebraska. In addition, the reconciliation bill changes the formula for the increased FMAP to states in order to provide more generous federal matching funds for states that have previously expanded Medicaid eligibility to the levels required in the Senate-passed bill.

### **New Medicaid Eligibility Formula**

Under current law, the methods that states use to determine income eligibility in their Medicaid programs vary widely. Some states use a gross income test — i.e., if a household's total income is above a certain eligibility threshold, the state will not consider the application for Medicaid. Many states disregard certain types of income (e.g., child support payments) or deduct certain costs from income (e.g., child-care costs) when determining income eligibility. These "disregards" and deductions may occur after a gross income test, if the state has one. In addition, many states impose an asset test when determining income eligibility for parents, and a small number of states have an asset test for children's eligibility. Some states have used income disregards to substantially expand eligibility without state legislative action — for instance, if a state has a particularly low income eligibility level, the Medicaid program can disregard a high amount of income in order to allow more people to meet the eligibility level.

The measure changes the way that states calculate income eligibility for Medicaid to create a uniform method called the "Modified Adjusted Gross Income" method. It stipulates that all states must use this method, which would use each household's modified adjusted gross income, as determined for federal income taxes, to determine eligibility. States would no longer be permitted to disregard income or deduct certain types of income when determining eligibility. The measure also prohibits states from imposing an asset test when determining eligibility for Medicaid.

Under the measure, individuals with incomes of less than 100% of the federal poverty level would be exempted from the requirement to obtain a minimum level of health insurance, although these individuals would be eligible for Medicaid. The measure creates federal premium tax credits for individuals with household incomes between 100% and 133% of the federal poverty level to purchase health insurance through the new insurance exchanges created under the bill, even though these individuals also would be eligible for Medicaid. The bill requires that any individual who applies for coverage in a state exchange would also be screened for eligibility for Medicaid or CHIP, and be enrolled if eligible (i.e., a "screen and enroll" requirement). The bill is silent on whether those with incomes between 100% and 133% of poverty would be dually eligible for both Medicaid and premium credits to purchase insurance in the exchanges, but specifies that premium tax credits would be disregarded as income when determining Medicaid eligibility. Under current law, for individuals who are eligible for Medicaid, but are enrolled in private coverage, Medicaid is required to "wrap around" to cover any services that are not covered under the private health plan. Under current law, for individuals who are eligible for Medicaid, but are enrolled in private coverage, Medicaid is required to "wrap around" to cover any services that are not covered under the private health plan. (See Section II of this Fact Sheet for details about eligibility and premium and cost-sharing assistance provided in the new state insurance exchanges created by the measure.)

### **CHIP**

The Senate-passed bill maintains CHIP in its current form, and authorizes increased federal funding to state CHIP programs starting in FY 2014. (The House-passed bill would have barred further funding for the CHIP program after FY 2013, after which enrolled children would have been shifted to the Medicaid program with its expanded eligibility, or to the health insurance exchange created by the measure.)

The Senate measure bars states from changing their CHIP programs in a way that imposes more restrictive standards, methodologies or procedures than were in effect on June 16, 2009 — a so-called "maintenance of effort" requirement — through Sept. 30, 2019.

Starting in FY 2014, states would receive an increase of 23 percentage points in their federal matching funds for CHIP, to a cap of 100% of the cost of a state's program. This provision effectively increases the minimum federal match for CHIP programs to 88%, from 65%, meaning that states would have to fund, at most, 12% of the cost of their CHIP programs. The federal matching rates provided to states in FY 2010 range from 65% to 83% of the total cost of the CHIP program; under this measure, the range would be 88% to 100%.

The measure states that children who meet income eligibility guidelines for CHIP, but are unable to enroll because a state has frozen enrollment due to budget constraints, would be eligible for premium tax credits to obtain health insurance through the new exchanges set up under the bill. The measure stipulates, however, that children who receive subsidized coverage through the new state exchanges would be deemed ineligible for coverage through CHIP, meaning that they could not have supplemental coverage through CHIP if a state program re-opened after they were enrolled in coverage through an exchange. Starting in FY 2016, the measure permits states to transition CHIP-eligible children to receive coverage through one of the new health insurance exchanges, instead of CHIP, as long as HHS approves this transition.

(See Section II of this Fact Sheet for details about eligibility and premium and cost-sharing assistance provided in the new state insurance exchanges.)

### Medicaid DSH Payments

The measure requires a reduction in federal matching payments to states for Medicaid Disproportionate Share Hospital (DSH) payments, which are additional reimbursements for hospitals that serve a disproportionate share of low-income individuals. Specifically, the measure would reduce states' DSH payments by 50% in many cases, or by 25% for states that receive low DSH payments. These reductions would not take effect until a state's uninsured rate had decreased by 45%. (The House-passed bill would have required a DSH payment reduction of \$10 billion over three years.)

CBO estimates that this provision would reduce mandatory spending by \$18 billion through FY 2019.

**Note:** The reconciliation bill (HR 4872) modifies this provision by requiring a total reduction in DSH payments of \$14.1 billion over 10 years, rather than the \$18.1 billion in the Senate measures. It also specifies that the reduction in DSH payments would begin in FY 2014, rather than when the rate of insured people reached a certain target.

### **Medicaid Prescription Drugs**

Like the House-passed bill, the measure increases the rebate that Medicaid programs receive for brand-name drugs by 23.1%, and also stipulates that Medicaid managed care plans that are run by private insurers would receive this discount. In addition, the measure increases the Medicaid drug rebate for generic drugs to 13% of the average manufacturer price. CBO estimates that this provision would reduce mandatory spending by \$38 billion through FY 2019.

### **Other Medicaid Provisions**

The measure also does the following:

- Increases federal matching payments for Medicaid programs in the five U.S. territories, increasing the FMAP from 50% to 55%, at an estimated cost of \$5.3 billion through FY 2019 (**Note:** the reconciliation bill (HR 4872) further increases this funding level);
- reduces any scheduled reductions in federal Medicaid matching funds to states that have experienced major disasters;
- permits all hospitals to provide Medicaid services to individuals who are deemed to have "presumptive eligibility" for Medicaid based on a preliminary screening; and
- creates a new, optional Medicaid benefit in which states could provide community-based services to individuals with disabilities who would otherwise require services in a hospital or nursing facility.

## Section IV

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### Long-Term Care, Medical Workforce, Public Health & Other Provisions

This section describes provisions of the Senate amendment to HR 3590 that deal with long-term care, medical workforce, public health funding, medical malpractice, and other provisions.

#### Long-Term Care

Like the House-passed health care overhaul measure (HR 3962), the Senate measure establishes a new national voluntary insurance program called the Community Living Assistance Services and Support (CLASS) program that would assist adults with functional limitations in purchasing community living assistance services, while also establishing an infrastructure to address national needs, alleviate burdens on family caregivers and address institutional bias.

#### *Benefit Plan*

The measure directs the Health and Human Services (HHS) Department to develop at least three actuarially sound benefit plans as alternatives for designation as the CLASS Independence Benefit Plan to provide benefits. The premiums established in the first and subsequent years would have to be based on actuarial analysis of the 75-year costs to ensure solvency for that 75-year period. The bill requires a five-year vesting period and benefit triggers. The plan would have to provide for payment of a cash benefit with an average of at least \$50 per day, and permits the payment to vary based on functional ability, be paid either daily or weekly, and not be subject to lifetime or aggregate limits.

Plans would be reviewed by a new CLASS Independence Advisory Council, which would recommend a plan that would be offered to the public. HHS would designate a plan by Oct. 1, 2012, taking the advisory council's recommendation into consideration.

#### *Premiums*

Once set, a monthly premium would generally remain the same as long as an individual is enrolled. The measure provides exceptions to guarantee the program's solvency, but increases under that case would not apply to those 65 or older or to those who have paid premiums for at least 20 years. Premiums could be recalculated if someone re-enrolls after three months of lapsed payments and the measure allows for penalties for re-enrollment after a five-year lapse. HHS would be permitted to factor in administrative costs, including up to 3% of premiums in the first five years, and 5% in later years.

Premiums would be deducted from paychecks, although HHS would provide alternate mechanisms for those whose employers will not deduct the payments.

The bill requires the Treasury Department to deposit 100% of collected premiums in a new CLASS Independence Fund in the Treasury that would be overseen by a board of trustees. The bill allows the new fund to be invested and managed in the same manner as the Federal Supplementary Medical Insurance Trust Fund.

### ***Eligibility & Enrollment***

The measure provides eligibility to those 18 or older who receive qualifying taxable wages, and who are actively employed, but who are not patients in a hospital, nursing home, care facility or institution for mental diseases and receiving Medicaid assistance. It also excludes those confined in correctional facilities.

The measure requires HHS to create procedures for the automatic enrollment of eligible individuals by their employers, as well as alternative arrangements for the self-employed, for those with more than one employer, for those whose employers do not participate, or for spouses of eligible individuals not subject to automatic enrollment. The measure allows eligible individuals to opt out at any time in the way HHS allows.

### ***Benefits***

The measure requires HHS to develop an application process for obtaining benefits and directs HHS to designate an entity by 2012 to assess eligibility, enter into agreements with state protection and advocacy systems, and enter into agreement with public and private entities to provide assistance and counseling. Benefits would include cash benefits, advocacy services, and advice and assistance counseling. Each eligible beneficiary would have a Life Independence Account, into which cash benefits would be paid and used to purchase services. Beneficiaries could have authorized representatives to access cash benefits on their behalf. The measure requires benefits to supplement — not supplant — other health care benefits and benefits that would be disregarded when determining eligibility for other programs, like food stamps, health programs or veterans' benefits.

### ***CBO Cost Estimate***

According to the Congressional Budget Office (CBO), this provision would reduce mandatory spending by \$70.2 billion over the period of FY 2010 through FY 2019. This reduction would occur largely because cash flows would result in net receipts for the early years of the program because the program would pay less in benefits than it would receive from the collection of premiums. CBO notes that the program would eventually see net outlays — once benefits exceed the premiums paid — and that in the decade after 2029, the CLASS program likely would begin to increase budget deficits.

## **Elder Justice**

The measure contains a provision that is intended to protect the rights of elderly patients who are seeking care in long-term care facilities or nursing homes.

The measure authorizes a total of \$52.5 million in fiscal years 2011 through 2014 for HHS to award grants to conduct agency activities that promote education and training in the field of long-term care. Funds could be used for training grants, projects to install electronic health records in long-term care facilities, or programs to recruit workers to the field of long-term care.

The bill authorizes a grant program through which HHS would award grants to create mobile forensic centers to investigate allegations of crimes against elders, and authorizes \$18 million in fiscal years 2011 through 2014 for the grants. It also authorizes \$15 million for HHS to provide funds to state and local adult protective services agencies to investigate elder abuse, as well as to collect and disseminate data on the prevalence of elder abuse and best practices to prevent such abuse.

In addition, the bill creates a new Elder Justice Coordinating Council within HHS, as well as a new Advisory Board on Elder Abuse, Neglect and Exploitation, which would conduct research and make recommendations to the Coordinating Council. The goal of the council and advisory board would be to coordinate among HHS, the Justice Department, and state and local governmental agencies regarding efforts to combat elder abuse or neglect. The measure authorizes such sums as are necessary for the coordinating council, and \$13.5 million in fiscal years 2011 and 2012 for the advisory board.

## **Physician Self-Referrals**

Current law (known as the "Stark law") prohibits physicians from referring Medicare or Medicaid patients for certain health services to hospitals in which physicians have a direct financial interest. Such financial interests include ownership or investment, or compensation agreements. The Stark law includes certain exceptions from this ban on so-called self-referrals — it allows physicians to refer these patients to hospitals in which they have a financial interest if the referring physician is authorized to perform medical services at the hospital, or if the financial interest of the referring physician is in the whole hospital, rather than a specific part or department.

The Senate-passed bill, like the House health care measure, places new restrictions on this "whole hospital" exception. The provision is intended to close what supporters view as a loophole that creates potential conflicts of interest and potential impacts on patient safety and Medicare costs.

The measure generally prohibits new physician-owned hospitals from receiving Medicare reimbursements. Specifically, it permits physician self-referrals to hospitals only if the hospitals meet the following new criteria:

- **Provider Agreements** — Physician-owned hospitals must have a Medicare provider agreement in operation as of Aug. 1, 2010 (a provision that effectively grandfathers in existing physician-owned hospitals).
- **Report to HHS**— Hospitals would have to submit annually to HHS a report that identifies physician owners or investors, as well as other owners or investors, and the nature and extent of all financial interests. These reports would be made publicly available on the agency's Web site.
- **Disclosure of Financial Interest** — Hospitals would have to have in place a process through which referring physicians who have a financial interest in the hospital disclose those interests to patients.
- **Limitation on Expansion** — Such hospitals would not be permitted to add operating rooms, procedure rooms or patient beds after enactment, although hospitals could apply for an exception from this expansion limitation. (The House health care bill would have permitted some expansion if criteria were met.)
- **Public Disclosure** — Hospitals would have to disclose any physician ownership or investments on their Web sites, and in any advertising materials.

This provision has drawn opposition from the American Medical Association (AMA), which maintains that it would severely limit the viability of physician-owned hospitals, and effectively shut down many physician-owned hospitals that are currently operating because of the strict referral rules. According to the AMA, physician-owned hospitals provide some of the highest-quality care to patients.

In its cost estimate for the introduced version, CBO estimated that limiting exceptions for physician referrals would save \$500 million through FY 2019.

**Note:** The reconciliation bill (HR 4872) changes this provision by delaying the effective date to Dec. 31, 2010, rather than Aug. 1, 2010. In a preliminary cost estimate, CBO and JCT estimate that the modified provision would reduce mandatory spending by \$500 million over the period of FY 2010 through FY 2019.

## **Medical Workforce Provisions**

### ***Graduate Medical Education***

"Graduate Medical Education" (GME) refers to the training that individuals undergo after completing medical school, also known as a residency. All physicians are required to complete a residency before they can practice medicine. Federal funding is used to support GME positions in community hospitals and academic medical institutions.

The Senate-passed bill includes provisions intended to increase GME training positions in states that have physician shortages, or in high-demand areas of specialization. Specifically, the Senate bill re-allocates GME positions that are currently vacant to other areas, giving priority to locations with physician shortages and those seeking to practice medicine in the areas of primary care or general surgery.

It also authorizes \$25 million in FY 2010, and \$50 million in each of fiscal years 2011 and 2012, for grants to create new Teaching Health Centers. Under this program, HHS would award grants to educational institutions that provide graduate medical education in primary care (e.g., pediatrics, family medicine or geriatrics). Such centers would have to be community-based, ambulatory medical centers. Federally qualified health centers and other community health centers would be eligible to become teaching centers.

### ***Nursing Shortage***

The Senate-passed bill, like the House version, includes a number of provisions designed to address the current shortage of nurses working in the health care field by providing for additional grants, scholarships and workforce training programs.

The measure directs HHS to enter into contracts with educational institutions in order to create a "Career Ladder" program, which would be intended to promote career development and advancement opportunities for those in the field of nursing. It also reauthorizes a current advanced nursing education grant program, and makes programs that teach nurse-midwifery eligible for such grants. In addition, the measure authorizes \$338 million over six years for the Public Health Service Act nursing programs.

### ***National Health Service Corps Program***

The National Health Service Corps program is intended to provide health care to areas with a shortage of health professionals by offering scholarships and loan repayments to those who agree to work in certain areas designated as health professional shortage areas. The program is administered by the Health Resources and Services Administration (HRSA).

The measure authorizes \$4 billion in additional funding in fiscal years 2010 through 2015 for the Corps scholarship and loan repayment program.

### ***Other Medical Education Provisions***

The Senate-passed bill contains a number of provisions intended to improve education and training opportunities in the health care field. It does the following:

- Authorizes scholarships for disadvantaged students who commit to work as primary care providers in medically underserved areas;
- authorizes grants to hospitals, medical schools or other health care entities to develop and operate training programs for physicians and physician assistants who specialize in primary care;
- authorizes \$10.8 million over five years for education and training in the field of geriatrics; and
- authorizes \$60 million in FY 2010 and such sums as may be necessary in fiscal years 2011 through 2015 for scholarships for mid-career public health professionals who are employed in health positions in federal, state, local or tribal agencies.

### **Comparative Effectiveness Research**

The economic stimulus law (PL 111-1) provided \$1.1 billion for "comparative effectiveness research" conducted by the Agency for Healthcare Research and Quality (AHRQ), the federal agency charged with improving the safety and efficiency of American health care. Comparative effectiveness research is generally intended to determine which medical treatments, screenings, technologies and diagnostic tests (or combinations of treatments or tests) are the most effective. Opponents of comparative effectiveness research claim that such information will lead to eliminating necessary care for those who need it.

The Senate-passed bill repeals this federal coordinating council.

Instead, the measure creates a new Patient-Centered Outcomes Research Institute, which would be a nonprofit entity that would identify research priorities and conduct research to compare the effectiveness of medical treatments and technologies. The measure states that the purpose of this institute would be "to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis."

The institute would be administered by a board of governors, and by different advisory panels for specific medical areas. The institute would have to report annually to Congress on its actions and also would have to make information publicly available through a Web site.

The measure appropriates \$210 million for the institute in fiscal years 2010 through 2012, and \$150 million in each of fiscal years 2013 through 2019.

## **Public Health Investments**

### ***Restaurant Menu Labeling***

The Senate-passed bill, like the House version, requires chain restaurants and food vending machines to list nutritional information for each available item. This provision would apply to restaurants that have at least 20 establishments that conduct business under the same name, regardless of the ownership structure of the restaurants. Similarly, it would apply to businesses that operate 20 or more vending machines.

Specifically, the bill requires that restaurant menus disclose the caloric content of each standard menu item, as well as a "succinct statement" regarding the daily recommended intake of calories, in a way that is easily understood by the general public. Calorie labeling would have to be placed near menu boards, drive-through window menus, and near food in self-service areas such as buffets or salad bars. Vending machine operators would have to post caloric content in proximity to the food item being sold or next to the selection button on the vending machine.

Food sellers would have to have a "reasonable basis" for determining the caloric content of their menu items, which could include nutrient databases, cookbooks or laboratory analyses.

The measure requires the Agriculture Department to issue regulations to implement this provision within one year of enactment.

### ***Health Centers Reauthorizations***

Under current law, specific types of health care centers are eligible for federal support. Generally, these are health centers that provide care to underserved populations.

Community Health Centers (CHCs) provide primary care services in areas where economic, geographic or cultural barriers limit access to primary health care. The measure appropriates a total of \$7 billion over fiscal years 2011 through 2015 for community health centers.

**Note:** The reconciliation bill (HR 4872) provides a total of \$11 billion over the period of FY 2011 through FY 2015 for community health centers.

Federally Qualified Health Centers (FQHCs) are "safety net" providers that may include community health clinics or mobile clinics that may serve homeless people, or Indian Health centers. The measure authorizes an additional \$33.9 billion over fiscal years 2010 through 2015, for Federally qualified Health Centers.

Under current law, the assistance programs for the centers are authorized through FY 2012; this measure extends the authorization through FY 2015.

### ***Wellness Benefits***

The Senate-passed bill does the following which is aimed at improving wellness services:

- **Employer Grants** — Authorizes \$200 million over the period of FY 2011 through FY 2015 for grants for small employers (defined as those with up to 100 employees) that offer wellness benefits to employees.
- **Wellness Incentives** — Allows employers to offer incentives to employees to participate in wellness programs. Such incentives could include discounts on health insurance premiums, extra benefits, or a reduction in insurance cost-sharing. In addition, the measure creates pilot programs to test such incentives within entire states in the individual insurance markets.
- **Evidence-based Programs** — Creates a grant program to assist entities in delivering

evidence-based and community-based prevention and wellness services. Among those eligible would be state, local or tribal health departments; public or private entities and a consortia of two or more entities, which could be a community partnership representing a "health empowerment zone."

### **Medical Malpractice**

The Senate-passed bill, unlike the measure passed by the House, creates a five-year demonstration program in which states could evaluate alternatives to the current medical liability tort system.

(The House-passed overhaul bill would have allowed HHS to make incentive payments to each state that has an alternative medical liability law that was enacted by the state after the measure became law. The payments would have been made to the states if HHS determined that the state law was effective and that it contained certain elements, but the measure would have barred the state laws from limiting attorneys' fees or imposing caps on damages.)

Under the Senate bill, HHS could award grants to states that develop pilot programs that would allow for the resolution of medical malpractice disputes, and would promote a reduction of medical errors by encouraging the collection and analysis of relevant data. For instance, states could propose a "no fault" dispute resolution process, in which all victims of certain errors would be compensated equally and health care providers would not be held at fault. States would have to identify funding sources by which any victims' compensation would be paid. In addition, states would have to identify a "scope of jurisdiction" for the alternative system they are testing, and notify patients who fall within that scope. Scopes could be a geographic area, a health care system, a specific group of health care providers, or a specific specialization within medical practice.

The measure directs HHS to give preference when awarding grants, to states that have developed an alternative process in consultation with relevant stakeholders (including both health care providers and patient advocates), and that make proposals that are likely to improve patient safety and access to medical malpractice insurance.

It authorizes \$50 million over the period of FY 2011 through FY 2015 for these grants.

### **Biologic Drug Patents & Regulation of Biosimilars**

Biologic drugs are a new technology in which drug manufacturers use living cells to produce drug technology. Biologics are often used to treat cancers, or chronic but

debilitating conditions, such as psoriasis or arthritis. Biologics are typically very expensive, costing tens or thousands of dollars for a year's course of treatment. Because biologics are often prescribed for chronic conditions, they have the potential to dramatically improve quality of life for patients, but those patients can incur high costs as they may take multiple treatment courses.

Generic versions of biologics are referred to as biosimilar drugs. Currently, the Food and Drug Administration (FDA) does not have statutory authority to approve biosimilars. At issue in the debate about allowing the FDA to approve and regulate biosimilars is the question of how many years of patent protection should be provided to brand-name biologic drugs.

Like the House-passed bill, the Senate measure creates a process through which the FDA would receive and approve applications for offering biological products that are either similar to, or interchangeable with, a biological product that had already been approved, known as a reference product. The provisions are intended to be analogous to an existing process for approving generic chemical drugs.

The application would include certain information, such as data that show a product is biosimilar, information that the new biological product and reference product use the same mechanism or mechanisms of action, proof that conditions of use have been previously approved for the reference product, information on administration and dosage, and information on the facilities involved with the product.

If the FDA determines that the information shows that a product is biosimilar or meets safety standards for interchangeability, and the applicant consents to facility inspections, then HHS would license the product. If a product contains certain dangerous ingredients, such as toxins or controlled substances, it could be licensed only after consultation with national security and drug enforcement agencies and a determination that there would be no increased risk to public health or security.

The measure provides exclusivity for the first interchangeable product for certain periods, and stipulates that a biosimilar product application could not be approved until 12 years after the date that a reference product is first approved. It provides for an additional six months for reference products with demonstrated benefits from pediatric studies. FDA would have to require labelling and packaging that uniquely identifies the biosimilar product.

## **Indian Health Care**

Like the House bill, the Senate-passed measure reauthorizes the Indian Health Care Improvement Act. The law governs the provision of health care through the HHS Indian Health Service (IHS) to native Americans and Alaskan natives. The original 1976 Indian

Health Care Improvement Act (PL 94-437), which was built on earlier legislation and extended several times, technically expired on Sept. 30, 2000, but was continued through 2001.

In 2009, the director of the IHS testified that the system provides services to nearly 1.5 million American Indians and Alaska Natives through hospitals, health centers and clinics located in 35 States, often representing the only source of health care for many American Indian and Alaska Native individuals, especially for those who live in the most remote and poverty-stricken areas of the United States. The IHS Web site notes that the provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes.

### ***Health, Human Resources & Development***

The measure authorizes such sums as may be necessary for several efforts to increase, to the maximum extent feasible, the number of American Indians entering health care professions, and also to ensure an optimum supply of health professionals to native populations through the IHS, tribal and urban health care entities.

The bill authorizes the IHS to make grants to tribes, tribal organizations, urban Indian organizations, and public and nonprofit entities to recruit American Indians into the health professions. It authorizes the IHS to provide scholarships to native Americans for compensatory pre-professional education or pre-graduate education leading to a baccalaureate degree in a preparatory field for a health profession.

The measure authorizes Indian Health Scholarships for American Indians who are enrolled, either full-time or part-time, in accredited schools pursuing courses of study in the health professions, which would largely follow the requirements of the Public Health Services Act. The measure also directs the IHS to establish and administer an Indian Health Service Loan Repayment Program.

The bill directs IHS to provide grants of up to \$300,000 to each of nine colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging American Indians to enter into the behavioral health field. The measure provides grants under the Quentin N. Burdick American Indians Into Nursing Program and requires a nursing residency program.

The bill allows certain recipients of assistance to participate in extern programs and authorizes continuing education allowances. It directs the IHS to maintain a Community Health Representative Program that provides for the training of Indians as community health representatives and uses those representatives to provide health care, health promotion and disease prevention in Indian communities.

The bill directs the IHS to require that appropriate employees who serve tribal groups receive educational instruction in the history and culture of such tribes and their relationship to the IHS. It permits retention bonuses for professionals working with the IHS or tribal groups who agree to stay on for one year. The measure also bars the removal of a National Health Service Corps member from covered programs unless HHS can ensure no loss in service.

The measure establishes a Treasury fund called the Indian Health Scholarship and Loan Repayment Recovery Fund, which would consist of amounts collected as a result of breaches of contracts under certain programs. Any such funds would be spent on scholarships and other recruitment programs.

### ***Health Services***

The Senate-passed bill authorizes the IHS to expend money from the Indian Health Care Improvement Fund for certain purposes. It directs the IHS to provide health promotion and disease prevention services to American Indians to achieve certain objectives. It provides for the monitoring and treatment of diabetes among native populations. It permits the IHS to provide long-term care services with Indian tribes and organizations.

The measure directs the IHS to make funding available for research to further the performance of the health service responsibilities of Indian Health Programs, including clinical and non-clinical research. It directs the IHS to provide for mammography and other cancer screenings that meet the recommendations of the United States Preventive Services Task Force, and also requires the establishment of an epidemiology center in each IHS area. The bill authorizes the IHS to provide reimbursement for certain travel costs. It also authorizes grants for projects related to infectious diseases.

The bill directs the IHS to award grants to Indian tribes and tribal organizations to develop comprehensive school health education programs for children from preschool through grade 12 for the benefit of Indian children. It also permits the IHS to establish and administer a program to provide grants for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths.

The measure authorizes the IHS to provide funding for hospice care, assisted living, long-term care, and home- and community-based services. It directs the IHS to monitor and improve the quality of health care for Indian women and permits the establishment of an Office of Indian Men's Health. The bill requires the monitoring of environmental and nuclear health hazards.

Under the measure, the IHS would be required to provide funds for health care programs, functions, services, activities, information technology and facilities operated by Tribal Health Programs on the same basis as such funds that are provided to IHS versions. The bill also establishes a Catastrophic Health Emergency Fund to pay for treatment for victims of disasters or catastrophic illness.

### ***Access to Health Care Services***

The measure stipulates how payments under an Indian Health Program would be treated under Medicare, Medicaid or CHIP. It directs IHS to make grants or enter into contracts for outreach and enrollment. The bill permits the federal government, tribes and tribal organizations to recover from third parties any reasonable charge incurred for health services. Any reimbursements received for health services would be credited to the respective entity.

The measure authorizes tribes and tribal organizations to use funds for IHS health care to purchase health benefits coverage meeting certain requirements. It permits HHS to enter into, or expand arrangements for, the IHS and tribal groups to share facilities and services with the Veterans Affairs (VA) and Defense departments, but requires consultation with affected tribes. It also requires HHS to provide for payment of veteran-related treatment authorized by the VA under a memorandum of understanding.

### ***Behavioral Health Programs***

The bill authorizes such sums as may be necessary for behavioral health programs for native populations, and it directs the IHS to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services and mental health programs.

The bill requires the establishment of a mental health technician training and employment program for Indians within IHS, authorizes grants for Indian women treatment programs, establishes youth behavioral health programs (including for substance abuse), and authorizes a demonstration project to tele-mental services for youth. The measure authorizes the provision of at least one inpatient mental health facility in each IHS area, as well as a program of community education in behavioral health. The measure also directs the IHS to create programs for the delivery of innovative community-based services for tribal communities. It authorizes the development of fetal alcohol disorder programs, as well as child sexual abuse and prevention treatment programs and domestic and sexual violence treatment programs in every service area.

The measure directs the IHS to award grants or contracts for the conduct of research on the incidence and prevalence of behavioral health problems among American Indians, including American Indians in urban areas.

### ***Social Security Act Programs***

The measure makes Indian Health Programs eligible for Medicare and Medicaid payments for items and services if those services meet the program requirements. It includes outreach provisions to enroll additional American Indians in CHIP and Medicaid.

The measure requires HHS to conduct a study to identify barriers to interstate coordination of enrollment and coverage under the Medicaid and CHIP programs for those who are eligible but — because of educational needs, migration of families, emergency evacuations, or otherwise — frequently change their state of residency or otherwise are temporarily present outside of the state of their residency.

# Section V

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## Revenue Provisions

This section describes the provisions of the Senate amendment to HR 3590 that would generate federal revenue in order to offset the cost of the measure's expansion of insurance coverage and make other health-related changes to the federal tax code.

This section does not discuss tax provisions directly relating to the measure's insurance mandates — such as the penalties for failing to meet the individual or employer coverage requirements — nor does it cover the credit intended to help smaller business obtain insurance coverage for their employees. (See Section II of this Fact Sheet for descriptions of these provisions.) This section also does not discuss changes to Medicare that would decrease mandatory spending, such as decreased payments to Medicare Advantage plans or adjustments to how fee-for-service payments are made. (See Section III of this Fact Sheet for descriptions of these provisions.)

Unlike the House-passed bill, this measure does not include a provision that would have created a new 5.4% surtax on high-income individuals with taxable income over \$50,000 and couples with taxable income over \$1 million, which would have raised an estimated \$460.5 billion in revenue over 10 years. The Senate-passed measure instead includes a tax on high-cost health insurance plans (so called Cadillac plans), which would raise an estimated \$149 billion in revenue over 10 years; and also increases the Medicare payroll tax on households with high incomes, which would raise an estimated \$87 billion in revenue over that time.

**Note:** The reconciliation measure (HR 4872) modifies both the tax on high-cost health plans and the Medicare payroll tax increase. According to JCT, as modified by that measure, the tax on high-cost health care plans would generate an estimated \$32 billion through FY 2019, and the increase in the Medicare payroll tax would generate an estimated \$210.2 billion over through FY 2019.

Other revenue provisions in the Senate-passed bill include new fees on the insurance industry, drug makers and medical device makers; limits on contributions to certain tax-protected health accounts; and an increase in the out-of-pocket threshold that taxpayers must reach before they can claim deductions for medical expenses.

**Note:** The reconciliation bill (HR 4872) also includes two new provisions that were not included in the Senate-passed health care bill, but were in the House-passed version. It modifies a a \$1.01-per-gallon credit for the production of biofuels from cellulosic feedstocks, which was designed to encourage production of biofuels that are not derived from feedstocks. There are concerns that since its creation, some taxpayers have been trying to obtain the credit for non-processed fuels, including "black liquor, which is a byproduct from paper manufacturing. The reconciliation bill modifies the rules of the

credit to, among other things, preclude black liquor from eligibility. In addition, the reconciliation measure clarifies the application of the "economic substance doctrine," which is a judicial doctrine developed through several court cases which generally denies tax benefits from a transaction unless it has "economic substance," i.e., that it results in a meaningful change in a taxpayer's economic condition, not just a tax benefit.

### **Cost Estimates**

According to a cost estimate published by the Joint Committee on Taxation (JCT), the tax provisions discussed in this section would generate a net \$398.8 billion over the period of FY 2010 through FY 2019. (In comparison, JCT had estimated that the revenue provisions included in the House-passed health care bill (HR 3962) would have generated a net \$578.6 billion over that time period.)

**Note:** JCT estimates that if Congress enacts both the Senate amendment to HR 3590 and the reconciliation bill (HR 4872), the revenue provisions would generate a net \$437.8 billion over the period of FY 2010 through FY 2019.

### **Tax on High-Cost Health Insurance Plans**

The bill imposes an excise tax on high-cost health insurance plans, starting in 2013. The measure institutes a 40% tax on the portion of employer-sponsored health insurance plans that exceed aggregate costs of greater than \$8,500 per year for individual coverage or \$23,500 per year for family coverage. After 2013, these amounts would increase according to inflation.

This revenue provision has drawn strong opposition from labor unions, who have said that it would place a heavy tax burden on working families who are struggling in the weak economy. Opponents of the tax also have said that it would disproportionately hurt those who live in areas of the country that have higher insurance costs. The White House has maintained that the provision is an essential component to pay for health care legislation, and that only the very rich would be effected by the tax, as the vast majority of employer-sponsored plans currently offered would not be expensive enough to be effected by the tax. This excise tax may be altered in subsequent reconciliation legislation, possibly to increase the threshold of the value of health plans to which the tax would apply.

In 2009, the average premiums for employer-sponsored health plans were \$4,824 for an individual plan and \$13,375 for a family plan, according to the Kaiser Family Foundation's annual Employer Health Benefits Survey, although firms in the Northeast and those comprised of older workers have significantly higher health plan costs than other firms. Overall, the survey found that 2% of all individual coverage plans cost more than \$8,000 per year, and 4% of family coverage plans cost more than \$20,000 per year.

In calculating the aggregate costs of employer-sponsored plans, the measure includes both the employee and employer portions of the costs of health insurance premiums, excluding vision and dental plan costs. The measure also considers employer contributions to health savings accounts and flexible spending accounts to be part of the costs of health insurance plans and therefore subject to taxation above the agreed-upon thresholds.

The Senate-passed measure increases the threshold amount at which the tax would be applied for certain high-cost groups. For those enrolled in retirement plans, and for firefighters and law enforcement officers, the tax would apply to the portion of annual health insurance costs in excess of \$9,850 for individual coverage or \$26,000 for family coverage. For "high-cost states" — defined as the 17 states with the most-expensive employer sponsored insurance in 2012 — the measure increases the threshold at which the tax would be applied to 120% of the general threshold for 2013, 110% for 2014, and 105% for 2015. Long-term care insurance would not be subject to these taxes.

JCT estimates that this provision would increase revenue by \$148.9 billion over the period of FY 2010 through FY 2019. Less than 20% of the revenue — \$26 billion — would come from employers paying the excise tax, according to JCT, because employers would likely reduce the value of health insurance plans and instead provide employees with higher salaries or other benefits. Thus, more than 80% of the revenue raised by this provision, an estimated \$123 billion, would be in the form of increased income and payroll taxes.

**Note:** The reconciliation bill (HR 4872) modifies this provision by delaying the tax until 2018, and by increasing the threshold at which the tax would apply to \$10,200 for individual coverage and \$27,500 for family coverage. JCT estimates that the provision, as modified by the reconciliation bill, would generate \$32 billion over the period of FY 2010 through FY 2019.

### **Increase Medicare Payroll Tax for High-Income Taxpayers**

The measure increases the Medicare Part A payroll tax (the hospital insurance tax) rate by 0.9 percentage points on annual earnings that exceed \$200,000 for individuals, or \$250,000 for couples. This increase would result in a Part A payroll tax of 2.35% — up from the current 1.45% — at those income levels starting in 2013.

According to JCT, this provision would increase revenue by \$86.8 billion over the period of FY 2010 through FY 2019.

**Note:** The reconciliation bill (HR 4872) modifies this provision to increase the tax rate and apply the increased payroll tax to investment income, a provision that had been sought by the White House. As modified, JCT estimates that the provision would generate \$210.2 billion over the period of FY 2010 through FY 2019.

## New Industry Fees

The measure creates new fees for health insurers, medical device manufacturers and pharmaceutical manufacturers. JCT estimates that, taken together, these new industry fees would increase revenue by \$101 billion over the period of FY 2010 through FY 2019.

**Note:** As modified by the reconciliation bill (HR 4872), JCT estimates that these new industry fees would increase revenue by \$107.1 over the period of FY 2010 through FY 2019.

### *Fees for Health Insurers*

The Senate-passed measure creates a new annual flat fee that would be levied on the insurance industry. In tax year 2011, the fee would be \$2 billion. It would increase to \$4 billion in 2012, \$7 billion in 2013, \$9 billion in 2014 through 2016, and \$10 billion in 2017 and later years. The measure distributes these fees across the insurance industry based on net amounts of premiums written, and takes into account the market share of insurers.

The bill exempts health insurers that have net premiums of \$25 million or less, and that have income from self-insured employer plans of \$5 million or less. It also exempts certain nonprofit insurers that have a medical loss ratio — i.e., the percentage of premiums going to pay for medical care — of 92% across all markets.

This provision would increase revenue by \$59.6 billion over the period of FY 2010 through FY 2019, according to JCT.

**Note:** The reconciliation bill (HR 4872) modifies this provision by delaying the industry fees until 2014, and modifies the way the fees would be assessed to different insurers. JCT estimates that as modified by the reconciliation language, this provision would increase revenue by \$60.1 billion over the period of FY 2010 through FY 2019.

### *Fees for Medical Device Makers*

The Senate-passed bill creates a new annual fee of \$2 billion for the medical device manufacturers and importers, which would be effective for any sales made starting in 2011. Starting in 2017, the fee would increase to \$3 billion per year. (The House-passed health overhaul bill, by contrast, would have imposed a 2.5% tax on the sale price of medical devices, which would apply to the first taxable sale, starting on Jan. 1, 2013.)

The measure creates a formula that would levy the fee across the industry, based on firms' gross receipts. Firms that have gross annual receipts of \$5 million or less would be

exempt from the fee. In order to calculate gross receipts from medical devices, the formula would consider only Class III devices (i.e., those classified as the most invasive and/or risky by the FDA) and Class II devices (those devices that are somewhat risky or invasive) with a retail value of more than \$100.

JCT estimates that this provision would increase revenue by \$19.2 billion over the period of FY 2010 through FY 2019.

**Note:** The reconciliation bill (HR 4872) modifies this provision by creating an excise tax of 2.9% on sales of certain medical devices, starting in 2013. JCT estimates that this provision, as modified, would increase revenue by \$20 billion through FY 2019.

### ***Fees for Pharmaceutical Manufacturers***

In addition, the measure creates a new annual fee of \$2.3 billion for firms that make or import name-brand pharmaceutical products. Like the fees for insurers and medical device makers, the measure creates a formula to allocate the fee across firms, based on a firm's annual sales of brand-name pharmaceuticals. It exempts firms that have annual drug sales of \$5 million or less. This fee would begin in 2010, and would remain the same in future years.

According to JCT, this provision would increase revenue by \$22.2 billion over the period of FY 2010 through FY 2019.

**Note:** The reconciliation bill (HR 4872) modifies this provision by delaying the fees until 2011, and increasing the amount of the fees. JCT estimates that, as modified by the reconciliation measure, the provision would increase revenue by \$27 billion over the period of FY 2010 through FY 2019.

## **Medical Expense Deductions**

The Senate measure, unlike the House health overhaul bill, amends current tax law to increase the threshold at which taxpayers could begin to deduct medical expenses. Under current law, taxpayers can claim an itemized deduction for any out-of-pocket costs for medical expenses that exceed 7.5% of adjusted gross income. The bill increases this threshold to 10%, meaning that taxpayers would have to spend at least 10% of adjusted gross income on medical expenses before they could claim a deduction for those costs.

The measure maintains current law with respect to the definition of medical expenses that can be deducted. According to the IRS, these medical expenses include payments to health care providers for the diagnosis, treatment, or prevention of disease, and include health care premiums paid and some long-term care service payments. Purchases to maintain overall health, such as vitamins or gym memberships, do not count as medical expenses that can be deducted.

This provision would increase revenue by \$15.2 billion over the period of FY 2010 through FY 2019, according to JCT.

### ***Definition of Medical Expenses for Health Accounts***

The measure, like the House health care overhaul bill, amends the current-law definition of medical expenses for employer-provided health coverage — including flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs) — as well as health savings accounts (HSAs) and Archer medical savings accounts (Archer MSAs) to conform the definition to the one used for purposes of the itemized deduction. In order to claim a deduction for medicine or drugs, any such medicine must be a prescribed drug or insulin. Deductions are not permitted for over-the-counter medicine.

The bill would apply that same standard to the health care arrangements described above, thus barring the use of money in such accounts for over-the-counter medicine.

JCT estimates that this change, which would apply to expenses incurred after Dec. 31, 2010, would raise \$5 billion through FY 2019.

### ***Executive Compensation***

In addition, the Senate-passed bill limits to \$500,000 the amount of executive and employee compensation that could be deducted by certain health insurance firms. The provision is intended to encourage health insurers to curtail what some consider to be excessive executive compensation.

This provision would take effect starting in the tax year 2010. From 2010 through 2013, this provision would define health insurance firms as health insurance issuers that receive premiums from providing health insurance. Starting in 2014, it would define health insurers as those entities in which at least 25% of gross premium receipts come from providing minimum essential coverage as defined in the bill — either individual or group markets, or through participating in the new health insurance exchanges.

JCT estimates that this provision would increase revenue by \$600 million over the period of FY 2010 through FY 2019.

## **Limits on Accounts**

### ***Limit Contributions to FSAs***

FSAs are offered by employers and permit employees to deposit pre-tax amounts into an account to cover out-of-pocket expenses for qualifying medical expenses such as prescription drug co-payments, co-payments for office visits and over-the-counter

medicines. There is currently no limit to the amount that someone can deposit into an FSA, although employers may set up a cap, and most do.

Like the House health overhaul measure, the Senate bill limits annual contributions to FSAs provided under cafeteria plans to \$2,500. This limit would take effect in 2011 under the measure, compared to 2013 in the House bill. The measure also provides for inflationary increases for that limit in subsequent years.

JCT estimates that this provision would increase revenue by \$14 billion over the period of FY 2010 through FY 2019.

**Note:** The reconciliation bill (HR 4872) modifies this provision by delaying the annual contribution limit until 2013. JCT estimates that, as modified, the provision would increase revenue by \$13 billion through FY 2019.

### ***Increase Penalty for Ineligible HSA Distributions***

Under current law, if a taxpayer takes money from a health savings account for use on something that is not a qualifying expense, such as a non-medical expense, he or she can be subjected to a 10% penalty.

Like the House health overhaul measure, the Senate bill increases that penalty to 20%, starting in 2011.

In addition, the Senate bill also increases the tax penalty for using money from an Archer Medical Savings Account from 15% to 20%, starting in 2011. (Archer Medical Savings Accounts were the precursors to HSAs under current tax law.)

JCT estimates that this provision would increase revenue by \$1.3 billion through FY 2019.

### ***Tax Treatment of Subsidized Employer-Provided Drug Benefits***

Certain employers can receive federal subsidies for Medicare Part D prescription drug benefits that they provide to retirees, and any such subsidy can be excluded from gross income and shielded from taxation. Current law also permits employers to claim a deduction for such expenses, even though they are subsidized by the government.

The measure, like the House health care bill, bars employers from claiming a deduction for subsidized expenses for providing drug benefits to retirees in these cases. The tax would apply starting in 2011.

JCT estimates that this provision would increase revenue by \$5.4 billion over the period of FY 2010 through FY 2019.

**Note:** The reconciliation bill (HR 4872) modifies this provision by delaying it until tax year 2013. JCT estimates that as modified, the provision would increase revenue by \$4.5 billion over the period of FY 2010 through FY 2019.

## Other Revenue Provisions

The measure also does the following:

- **Indian Health Benefits** — Stipulates that Indian health benefits would be excluded from gross income, and thus not subject to taxation. JCT estimates that this provision would cost \$9 billion through FY 2019. (The House health care bill included similar language.)
- **Disclosure of Aggregate Employee Health Benefits Costs** — Requires employers to disclose the aggregate costs of providing health benefits to employees on employees' W-2 forms, starting in 2011. JCT estimates that this provision would have a negligible effect on federal revenue.
- **Tanning Tax** — Imposes a new 10% tax on indoor tanning services. JCT estimates this tax would increase revenue by \$2.7 billion through FY 2019.
- **Information Reporting** — Expands current-law information reporting requirements to require a taxpayer to require information returns on payments made to corporations if the aggregate amount of a payment or payments exceeds \$600 in a calendar year. JCT estimates this provision would increase revenue by \$17.1 billion through FY 2019.

# Section VI

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## Arguments For & Against the Senate-Passed Bill

This Section summarizes arguments being made by supporters and opponents of the Senate Amendment to HR 3590, Patient Protection and Affordable Care Act (see note at end of Section).

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### Arguments FOR the Bill

Supporters of the Senate-passed health care overhaul bill argue that it presents a once-in-a-generation opportunity for Congress to enact a comprehensive health care policy that would expand access to insurance coverage to tens of millions of Americans. The simple facts about health care reform have been stated repeatedly in this debate, but they bear repeating — last year, this country spent more than \$2 trillion, or an estimated 18% of gross domestic product, on health care. And yet, what do we get for that money? We have dismal infant mortality rates, an unacceptably high rate of medical errors, emergency rooms strained to overcapacity by people who can't get health care anywhere else, and 50 million people without any type of health insurance. Yes, the United States does have the best medical care in the world, but only if you can afford to pay for it. The problem is that an increasing numbers of our fellow citizens cannot. That is why members must make the difficult, but correct, decision to support this important legislation and send it to the president.

The most important thing about this bill is that it will allow millions of Americans to obtain health insurance by creating new choices for consumers. Americans who already have health insurance that they like can keep their coverage. Those without insurance, or with unaffordable insurance, will have a new array of choices to ensure that they can receive affordable, quality coverage.

The bill doesn't simply provide an insurance card, however, it also provides protections for consumers to ensure that they get their money's worth for the premiums they pay. For instance, insurance companies would no longer be allowed to deny insurance coverage to women just because they had been victims of domestic violence, as is currently permitted in eight states and the District of Columbia. It reins in some of the most despicable practices that insurance companies use to make big profits. But in order for these new insurance reforms to work properly, it is necessary to bring all Americans into the system. Doing so will ensure

that citizens receive preventive care and also receive more advance treatment when they need it. It is simply ridiculous that some Republicans are claiming that legislation expanding insurance to all Americans is unconstitutional. Why should insurance company executives and their fat-cat Washington lobbyists continue to make millions of dollars a year, while at the same time denying essential coverage to the people who need it most? Clearly, we must change this system, and that is what this bill does.

The measure also takes the important and long-overdue step of expanding Medicaid eligibility to all low-income Americans. Currently, only low-income pregnant women and children are entitled to Medicaid eligibility. An adult without children could literally be penniless, and still would be ineligible for Medicaid in the majority of states. In the richest country in the world, this situation is unacceptable. By expanding both private insurance and safety-net programs for the poor, this legislation takes a reasonable and well-thought-out approach to changing the status quo. This provision is more important than ever as the nation's job market continues to struggle.

Opponents have argued repeatedly about new government spending that is allegedly included in the bill. The fact is, however, that this responsible measure completely offsets all new spending and will actually reduce the deficit over the long term. According to the nonpartisan Congressional Budget Office (CBO), it will reduce the federal deficit by \$118 billion over 10 years, a significant amount of money by any accounting. Unlike the current state of affairs, where we spend ever more money and have ever-higher numbers of uninsured citizens, this bill produces a cost savings, while providing needed health care coverage to millions more people. CBO also estimates that the bill would provide health insurance to an additional 31 million Americans by 2019. Any member who believes that we must address the rising costs of health care should support this bill. Without substantial reform, out-of-control costs will only get worse, rising to \$4.4 trillion, more than 20% of the economy, by 2018. Moreover, the number of uninsured will reach 61 million by 2020 without the bill. Do we really want a future where the cost of health care for the average family of four is projected to rise \$1,800 every year for years to come — while insurance companies making ever-larger profits?

The Senate-passed bill is not perfect, and the problematic provisions of the measure will be fixed in the reconciliation bill that will be considered through a full and open debate process. Because Republican obstructionism has prevented formal conference negotiations from proceeding, it is necessary that these problems be fixed through a reconciliation measure, which is a process that has been used multiple times before to pass legislation that will reduce our federal deficit. The use of reconciliation is not some sort of secret, backroom process — it is simply a way that Congress can consider bills to reduce the deficit.

A vote against this measure is a vote to support the status quo, in which millions of Americans are forced to go without medical care simply because they cannot afford it. Members have a truly historic opportunity to vote to support sweeping changes to improve our health care system in a way that provides better access to quality, affordable care.

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### **Arguments AGAINST the Bill**

Opponents of the Senate-passed health overhaul bill argue that it is an attempt to force an expensive, unconstitutional government-run medical regime down the throats of unwilling citizens. America has the best medical care in the world — that is why even Canadian government officials come here for heart surgery instead of getting it through Canada's socialist system — and the Democratic majority in this Congress wants to take that away and replace it with government controlled health care. We need look no further than England or France, where health care is rationed and governments deny dying cancer patients life-saving treatments, to see that injecting more government control into the medical system is a bad idea. Instead of seeking real reforms that address the causes of skyrocketing care, in typical fashion, this bill simply throws more of our taxpayer dollars at bureaucrats in Washington in the hope that they will do a better job practicing medicine than doctors. This measure is a monstrosity and should be defeated.

No one is arguing that Americans should not be able to purchase health insurance coverage, if they so choose. The idea that the government can force citizens to purchase a product that they do not want, as this bill does, is unprecedented and is very likely unconstitutional. That's why several states already are preparing to file lawsuits challenging the bill. Under the bill, if you don't like your choice

of health insurance plans, you will still be required to buy coverage, or pay a steep fine. What the health insurance market needs is the latitude to develop innovative policies and the ability to sell these policies across state lines. The idea that, somehow, a government-based system will be able to do a good job of promoting competition to drive such innovation is laughable at best. There is a real likelihood that even if this measure is enacted, the so-called state "exchanges" will be too bogged down by red tape and regulation to be functional. Unfortunately, it is the American consumer who will suffer.

Furthermore, the legislation expands entitlement programs that already are fiscally unsustainable. Even liberals agree that state Medicaid programs face major problems, as state cuts to provider rates lead fewer and fewer doctors to participate in the system. Yet, instead of tackling these challenges with responsible solutions to reform the Medicaid program, Democratic leaders simply want to kick the can down the road by expanding the program in its current form, and meanwhile adding ever-more people to it.

This bill does nothing to rein in costs. In fact, what it does is throw good taxpayer money after ever-higher premium costs — creating 10 years of tax increases to pay for six years of coverage. You may see supporters of the bill trotting out the Congressional Budget Office score showing some alleged cost savings. It is important to note that the CBO score is nothing but a mirage of imaginary budget cuts that will never actually occur. That is because CBO has to score the legislation exactly as directed by the legislative text, no matter how unrealistic. You might plan to win the lottery too, but it would be unwise to plan your family budget on your anticipated lottery winnings. American families understand that they have to balance their household budgets in a responsible way, and it is not unrealistic for them to expect this Congress to do the same. Poll after poll shows high public dissatisfaction with this bill and with the performance of this Congress. It is easy to see why, when this bill fails to address the real drivers of health care costs and instead contains a wide range of job-killing tax hikes.

Speaker Nancy Pelosi pledged that this would be the most open, transparent Congress in history. In fact, Democrat leaders have resorted to their same old tactics of cutting back-room deals and doling out favors to special interest groups. Members will not even be able to cast an up-or-down vote on this bill — instead, it will be "deemed" passed in

what is clearly an unconstitutional maneuver designed to protect Democrats from taking a vote on a bad bill that their constituents dislike. Rather than using an open debate to change reprehensible provisions like the "Cornhusker kickback," the majority is using an arcane budget process to force the legislation through Congress. If Democrats had truly wanted an open debate on health care reform, there could have been a bipartisan process that would have resulted in a sensible measure to control spiralling health care costs and improve the quality of care. Instead, the process has devolved into a series of top-secret negotiations, resulting in its embarrassing conclusion this week.

If this bill is enacted into law, it will have disastrous consequences for our health care system, our federal budget, and our economy. This is a bad bill that has been brought to the floor through a bad process, and it is critical that members vote to defeat this bill.

**Note:** The arguments presented above are not House Action Reports' arguments, nor do they represent our evaluation of the measure. As indicated, they are arguments that supporters are making on behalf of the measure and that opponents are making against it. House Action Reports attempts only to summarize the arguments on both sides as cogently as possible.