LEGISLATIVE DIGEST
HOUSE REPUBLICAN CONFERENCE | Mike Pence, Chairman

Speaker Pelosi's Health Care Bill: A Government Takeover of Health Care

November 3, 2009

FLOOR SITUATION

On October 29, 2009, Speaker Pelosi and the House Democrat leadership introduced H.R. 3962, the Affordable Health Care for America Act. The legislation combines provisions in earlier versions approved by the Committees on Education and Labor, Energy and Commerce, and Ways and Means, as well as other provisions negotiated behind closed doors by the Democrat leadership. The bill is expected on the floor later this week under a likely closed rule.

EXECUTIVE SUMMARY

The bill sets the tone for a Washington takeover of the health care system—one defined by federal regulation, mandates, myriad new programs, and higher federal spending. The bill would ensure the heavy hand of federal bureaucrats over the United States health care system, levying costly new taxes on individuals and businesses who do not comply. Many Members may question how additional federal mandates and bureaucratic diktats raising costs appreciably for all Americans would make health care more "affordable." Many Members may also be concerned that the bill's provisions—only partially masked by budgetary gimmicks and "smoke-and-mirrors" accounting—cost nearly $1.3 trillion, financed largely by significant job-killing tax increases imposed on small businesses during a recession.

Buried within the contents of the 1,990 page bill—as well as a separate 13-page bill (H.R. 3961) that would increase the deficit by more than $200 billion—are details that will see a massive federal involvement in the health care of every American, including the following:

- Creation of a government-run health plan that experts say would result in up to 114 million Americans losing their current coverage—a clear violation of any pledge to allow individuals to keep their current health plan;
- Nearly half a trillion dollars in tax increases on certain income filers, a majority of whom are small businesses—and $729.5 billion in tax increases overall;
- Insurance regulations that would raise costs for nearly all Americans, particularly young Americans, and confine choice of plans to those approved by a board of bureaucrats;
- New price controls on health insurance companies that provide perverse incentives to keep individuals sick rather than managing chronic disease, while impeding patient access to important services just because those services do not provide a direct clinical benefit;
- Additional federal mandates that would significantly erode the flexibility currently provided to employers—and could result in firms dropping coverage;
- Massive expansion of Medicaid to all individuals with incomes below 150 percent of the Federal Poverty Level ($33,075 for a family of four), replacing the existing private health coverage of millions with taxpayer-funded health care—and imposing tens of billions of dollars in new unfunded mandates on States;
- Denial of health plan choice to 15 million Americans, consigning them instead to a Medicaid program riddled with bureaucratic obstacles and poor access to care, such that its own beneficiaries do not consider it "real insurance;"

- Language opening employers operating group health plans to State law remedies and private causes of action—subjecting employers to review by 50 different State court rulings, thereby raising costs and encouraging more employers to drop their current health plans;
- Liability "reforms" intended to ensure trial lawyers do not have their compensation reduced, rather than meaningful changes that would reduce the cost of health care by eliminating wasteful defensive medicine practices;
- Establishment of a bureaucrat-run health Exchange that would abolish the private market for individual insurance outside the Exchange—and could evolve into a single-payer approach due to the Exchange's ability to cannibalize existing employer plans;
- Creation of a new government board, the "Health Benefits Advisory Committee," that would empower federal bureaucrats to impose new mandates on individuals and insurance carriers;
- Taxation of individuals who do not purchase a level of health coverage that meets the diktats of a board of bureaucrats—including those who cannot afford the coverage options provided;
- New, job-killing taxes—$135 billion worth—on employers who cannot afford to provide their workers health insurance, resulting in up to 5.5 million lost jobs, according to a model developed by President Obama's chief economic advisor;
- Penalties as high as $500,000 on employers who make honest mistakes when filing paperwork with the government health board—which would likely dissuade businesses from continuing to provide coverage, increasing enrollment in the bureaucrat-run Exchange;
- "Low-income" health insurance subsidies to a family of four making up to $88,200;
- Arbitrary and harmful cuts to popular Medicare Advantage plans that would result in millions of seniors losing their current health coverage; and
- Expanded price controls on pharmaceutical products that would discourage companies from producing life-saving breakthrough treatments.

SUMMARY

Division A—Affordable Health Care Choices

This division would create a new entitlement—a government-run health plan causing as many as 114 million Americans to lose their current coverage—intended to provide all Americans with "affordable" health insurance. The bill also imposes new mandates and regulations on individual and employer-sponsored health insurance, while raising taxes on businesses who do not offer coverage and individuals who do not purchase coverage meeting federal bureaucrats' standards. Details of the division include:

Immediate Reforms

In an attempt to disguise the fact that the bill's coverage expansions do not take effect until 2013, the bill includes several provisions intended to provide immediate benefits, including:

High-Risk Pools: The bill appropriates $5 billion for a national temporary high-risk pool program, scheduled to take effect in January 2010 and terminate at such time the Exchange is established. Eligible individuals would include those denied individual health coverage due to pre-existing conditions, as well as those eligible for guaranteed issue coverage under the Health Insurance Portability and Accountability Act (HIPAA). The bill sets benefit parameters, including a maximum premium of 125 percent of an individual health insurance policy, little variation in rates for age, and deductible and cost-sharing levels. While supporting the concept of high-risk pools, Members may question the need for a national program to supplant existing State-based risk pools—and further question the need for the bill's new mandates and bureaucracies in the years after the Exchange is created if Democrats agree that risk pools can provide quality coverage to those with pre-existing conditions.

Price Controls: Beginning in 2010, the bill requires insurers with a ratio of total medical expenses to overall costs (i.e. a medical loss ratio), of less than 85 percent to offer rebates to beneficiaries. Some

Members may view this provision as a government-imposed price control, one that could be viewed as ignoring the advice of Administration advisor Ezekiel Emanuel, who wrote that "some administrative [i.e. non-claims] costs are not only necessary but beneficial." Some Members may also be concerned that such price controls, by requiring plans to pay out most of their premiums in medical claims, would give carriers a strong (and perverse) disincentive not to improve the health of their enrollees through prevention and wellness initiatives—as doing so would reduce the percentage of spending paid on actual claims below the bureaucrat-acceptable limits. The bill would also "require health insurance issuers to submit a justification for any premium increases" in advance.

Rescissions; Dependent Coverage: Beginning in July 2010, insurers could rescind policies "only upon clear and convincing evidence of fraud…under procedures that provide for independent, external third-party review." Beginning in January 2010, insurers that provide dependent coverage to beneficiaries would be required to cover all dependents under age 27.

Pre-Existing Condition Exclusions: Beginning in January 2010, the bill reduces pre-existing limitation exclusions by nine months, and shortens the "look-back" window for determining such exclusions from six months before enrollment to 30 days before enrollment. While supporting efforts such as high-risk pools to allow individuals with pre-existing conditions to obtain coverage, some Members may be concerned that these provisions could raise premiums for employers, potentially prompting some to drop coverage entirely.

Other Insurance Restrictions: Beginning in January 2010, the bill prohibits domestic violence from being considered a pre-existing condition in the few States that do not already prohibit this practice, requires coverage of outpatient treatments for children's congenital deformities, and eliminates lifetime aggregate limits on coverage. Also includes language requiring the Secretary to undertake a program of administrative simplification designed to ensure the rapid processing of claims and other related data.

Retiree Coverage: Beginning on the date of enactment, the bill prohibits group health plans from "reducing the benefits provided under the plan to a retired participant, or beneficiary of such participant" after the worker retires "unless such restriction is also made with respect to active participants." Some Members may be concerned that this provision, by restricting employers' flexibility to adjust retiree health coverage, may encourage firms to drop their health plans entirely—undermining the argument that "If you like your current plan, you can keep it."

Reinsurance for Pre-Medicare Retirees: Beginning 90 days after enactment, the bill would appropriate $10 billion to finance reinsurance payments to employers (including multiemployer and other union plans) who offer coverage to retired workers aged 55 to 64 who are not eligible for Medicare. The Trust Fund would pay 80 percent of claim costs for all retiree claims exceeding $15,000, subject to a maximum of $90,000; payments must be used to reduce overall insurance premiums or other out-of-pocket costs. Some Members may be concerned that such reinsurance programs, by providing federal reimbursement of high-cost claims, would serve as a disincentive for employers to monitor the health status of their enrollees.

Expanded Federal COBRA Mandates: Upon enactment, H.R. 3962 imposes a new unfunded mandate on businesses, by requiring an extension of COBRA coverage until such time as subsidies in the Exchange become available. As individuals electing COBRA coverage have been documented to have health costs 45 percent higher than those of active employees, this provision would raise costs for businesses—as well as premiums paid by current employees—while encouraging firms to drop coverage entirely to avoid the expanded federal mandates.

Grant Programs: Creates two new grant programs—one providing grants of up to $50,000 to offset half the cost of small employers' wellness programs, and the second funding grants for various State-

based access initiatives, including insurance Exchanges, reinsurance programs, purchasing collaboratives, and other similar strategies.

Coverage Expansions and Regulations

Abolition of Private Insurance Market: The bill imposes new regulations on all health insurance offerings, with only limited exceptions. Existing individual market policies could remain in effect—but only so long as the carrier "does not change any of its terms and conditions, including benefits and cost-sharing," as determined by the new Health Choices Commissioner, once the bill takes effect. This provision would prohibit these plans from adding new, innovative, and breakthrough treatments as covered benefits, and would ensure that plans' risk pools can only get older and sicker, putting these plans at a significant disadvantage to those operating under the government-run Exchange. Some Members may be concerned that this provision would effectively prohibit individuals from keeping their current coverage, as few carriers would be able to abide by these restrictions without cancelling current enrollees' plans.

With the exception of grandfathered individual plans with the numerous restrictions imposed as outlined above, insurance purchased on the individual market "may only be offered" until the Exchange comes into effect. Some Members may be concerned by this outright abolition of the private market for individual health insurance, requiring all coverage to be purchased through the bureaucrat-run Exchange.

Employer coverage shall be considered exempt from the additional federal mandates, but only for a five year "grace period"—after which all the bill's mandates shall apply. Some Members may be concerned first that this provision, by applying new federal mandates and regulations to employer-sponsored coverage, would increase health costs for businesses and their workers, and second that, by tying the hands of businesses, this provision would have the effect of encouraging employers to drop existing coverage, leaving their employees to join the government-run health plan.

Insurance Restrictions: The bill would require both insurance carriers and employer health plans to accept all applicants without conditions, regardless of the applicant's health status, beginning in 2013. In addition, carriers could vary premiums solely based upon family structure, geography, and age; insurance companies could not vary premiums by age by more than 2 to 1 (i.e., charge older individuals more than twice younger applicants). As surveys have indicated that average premiums for individuals aged 18-24 are nearly one-quarter the average premium paid by individuals aged 60-64, some Members may be concerned that the very narrow age variations would function as a significant transfer of wealth from younger to older Americans—and by raising premiums for young and healthy individuals, may discourage their purchase of insurance. Some Members, noting that the bill does not permit premiums to vary based upon benefits provided—i.e. differing cost-sharing levels—may therefore question how the bill's regulatory regime would provide any variation from "one size fits all" offerings.

The bill requires plans to comply with to-be-developed standards ending "discrimination in health benefits or benefit structures" for applicable plans, "building from" existing law requirements under the Employee Retirement Income Security Act (ERISA) governing group health coverage. Some Members may view these additional bureaucratic provisions as an invitation for costly lawsuits regarding perceived discrimination that would do little to improve Americans' health—and much to raise health costs.

The bill also requires health insurance plans to notify members at least 90 days in advance of ***any*** change in benefits coverage, and to "meet such standards respecting provider networks as the Commissioner may establish"—which some Members may construe as allowing bureaucrats to regulate access to doctors and reject any (or all) private health insurance offering on the grounds that its network access is insufficient. Conversely, the government-run plan is significantly advantaged because it would be automatically approved within the Exchange without subjecting its provider networks to scrutiny. Further, many may be concerned that these network adequacy provisions, when coupled with language

in the bill requiring that a plan that includes abortion be made available in every region, could lead to mandates to "protect" access to abortion services (such as the establishment of abortion clinics)—or that all private employers include abortion clinics in their networks for them to be considered "adequate."

Benefits Package: The bill prohibits all qualified plans from imposing cost-sharing on preventive services, as well as annual or lifetime limits on benefits. As more than half of all individuals currently enrolled in group health plans have some form of lifetime maximum on their benefits, some Members may be concerned that these additional mandates would increase costs and discourage the take-up for insurance. Some Members may also be concerned that the bill's provisions insulating individuals from the price of their health care would raise overall health costs—exactly the opposite of the legislation's supposed purpose.

Annual cost-sharing would be limited to $5,000 per individual or $10,000 per family, with limits indexed to general inflation (i.e. not medical inflation) annually. Benefits must cover 70 percent of total health expenses regardless of the cost sharing. Services mandated fall into ten categories: hospitalization; outpatient hospital and clinic services; professional services; physician-administered supplies and equipment; prescription drugs; rehabilitative and habilitative services; mental health services; preventive services; maternity benefits; well child care "for children under 21 years of age;" and durable medical equipment. The bill also requires coverage of domestic violence counseling, and includes a study to examine the inclusion of oral health in the benefits package, but prohibits mandatory coverage of abortion under any circumstance.

Benefits Committee: The bill establishes a new government health board called the "Health Benefits Advisory Committee," chaired by the Surgeon General, to make recommendations on minimum federal benefit standards and cost-sharing levels. Up to eight of the Committee's maximum 26 members may be federal employees, and a further nine would be Presidential appointees.

The bill eliminates language in earlier drafts stating that Committee should "ensure that essential benefits coverage does not lead to rationing of health care." Some Members may view this change as an admission that the bureaucrats on the Advisory Committee—and the new government-run health plan—would therefore deny access to life-saving services and treatments on cost grounds.

Some Members may be concerned with federal bureaucrats having undue influence on the definition of insurance for purposes of the individual mandate. Members may also be concerned that the Committee could evolve into the type of Federal Health Board envisioned by former Senator Tom Daschle, who conceived that such an entity could dictate requirements that private health plans reject certain clinically effective treatments on cost grounds.

Additional Requirements: The bill would impose other requirements on insurance companies, including uniform marketing standards, grievance and appeals processes (both internal and external), transparency, and prompt claims payment—all of which would be subject to review by the new bureaucracy established through the Commissioner's office. The bill also requires insurers to make disclosures on plan documents in "plain language"—and directs the new federal Commissioner "to develop and issue guidance on best practices of plain language writing." In addition, the bill requires carriers using pharmaceutical benefit managers to provide the federal government with payment and sales information on a regular basis—proprietary information which some may be concerned would be disclosed to the public, confidentiality requirements notwithstanding.

The bill requires plans to disseminate information regarding end-of-life planning, but does not pre-empt State laws regarding advanced care planning and assisted suicide. Because laws in States like Oregon and Washington explicitly forbid the term assisted suicide, choosing instead to call euthanasia "dying with dignity," some Members may be concerned that such States could be permitted to distribute materials about assisted suicide options.

New Bureaucracy: The bill establishes a new government agency, the "Health Choices Administration," governed by a Commissioner. The Administration would be charged with governing the Exchange, enforcing plan standards, and distributing taxpayer-funded subsidies to purchase health insurance to anyone with incomes below four times the federal poverty level ($88,200 for a family of four). The Commissioner would be empowered to impose the same sanctions—including civil monetary penalties, suspension of enrollment of individuals in the plan, and/or suspension of credit payments to plans—granted to the Centers for Medicare and Medicaid Services with respect to Medicare Advantage plans. Some Members may be concerned that the bill's provisions permitting federal bureaucrats to interfere in the enrollment of private individuals in ostensibly private health insurance plans confirms the over-arching nature of the government takeover of insurance contemplated in the bill.

The bill requires the Commissioner to conduct audits of health benefits plans in conjunction with States, and further authorizes the Commissioner to "recoup from qualified health benefits plans reimbursement for the costs of such examinations." Some Members may be concerned these provisions could lead to overlapping and duplicative requirements on private businesses—as well as higher costs due to inspections by a "health care police," which businesses themselves would have to finance.

Pre-Emption: The bill makes clear that its additional mandates and regulations "do not supersede any requirements" under existing law, "except insofar as such requirements prevent the application of a requirement" in the bill. The bill also makes clear that existing State private rights of action would apply to plans as currently permitted under existing law—and would further apply State private rights of action to all employers who purchase health coverage through the Exchange, effectively eviscerating ERISA pre-emption offered to these employers. Many may be concerned that these additional mandates, and the duplicative layers of regulation they create, would raise costs and encourage additional employers to drop their existing coverage offerings.

Whistleblower Provisions: The bill establishes whistleblower protections against employees who file complaints regarding actual or potential violations of the Act's provisions, and permits employees to bring actions for damages under provisions in the Consumer Product Safety Act. Some Members may be concerned that these provisions would increase the number of lawsuits filed against firms by disgruntled employees, raising the cost of health care—exactly the opposite effect of the bill's purported goal.

Lawsuits by State Attorneys General: The bill permits any State attorney general to bring civil actions in State courts on behalf of any resident of that State "for violation of any provisions of this title or regulations thereunder." Many may be concerned that this new provision would further expand the scope of lawsuits that would raise costs, and further encourage employers to drop coverage entirely, rather than dealing with possible lawsuits filed by each of the 50 State attorneys general.

State Laws on Abortion; Conscience: Language in the bill appears to prevent State laws from being overturned and benefits plans from discriminating against health care providers because of their willingness or unwillingness to "provide, pay for, provide coverage of, or refer for abortions." However it is unclear how federal bureaucrats might interpret these provisions. Additionally, as it is extremely likely that contraception will be mandated under the federal minimum benefits package, many may want this conscience protection expanded to include contraception in order to protect health care providers with moral objections to the provision of or referral for contraceptive coverage.

Anti-Trust Exemption: The bill repeals portions of the McCarran-Ferguson Act regarding insurance companies' anti-trust exemption, prohibiting collusion or other monopoly conduct except in cases of sharing historical data, performing actuarial services, and gathering information to set rates. Particularly as the Congressional Budget Office found that repealing insurers' anti-trust exemption would have no meaningful impact on insurance premiums—and could actually result in premium increases—many may

be concerned by what appears to be an attempt by the Democrat majority to extract political retribution on health insurance companies for failing sufficiently to support their government takeover of health care.

Creation of Exchange: The bill creates within the federal government a nationwide Health Insurance Exchange. Uninsured individuals would be eligible to purchase an Exchange plan, as would those whose existing employer coverage is deemed "insufficient" by the federal government. Once deemed eligible to enroll in the Exchange, individuals would be permitted to remain in the Exchange until becoming Medicare-eligible—a provision that would likely result in a significant and permanent migration of individuals into the bureaucrat-run Exchange over time. New Medicaid beneficiaries may enroll in Exchange plans, but may not enroll in Medicaid while in an Exchange plan.

Employers with 25 or fewer employees would be permitted to join the Exchange in its first year, with employers with 25-50 employees permitted to join in its second year. Employers with fewer than 100 employees would be permitted to enroll in the third year, and all employers would also be eligible to join, if permitted to do so by the Commissioner. Many may note the limits on employer eligibility are significantly higher than in H.R. 3200, thus expanding the scope of the government-run Exchange.

One or more States could establish their own Exchanges, provided that no more than one Exchange operates in any State. However, the federal Commissioner would retain enforcement authority, and further could terminate the State Exchange at any time if the Commissioner determines the State "is no longer capable of carrying out such functions in accordance with the requirements of this subtitle."

The bill would further require the Commissioner to negotiate premium levels with insurance companies, requiring the denial of "excessive premiums and premium increases" (terms undefined) and permitting the Commissioner to waive federal acquisition regulations in the process. Many may be concerned first that this provision would further increase the role of federal bureaucrats in micro-managing private insurance companies, and second would permit the Commissioner to deny all private plans access to the Exchange for the mere reason that an Administration desires to enroll all Americans in the government-run health plan.

Abortion and the Exchange: The bill would ***require*** coverage for abortion by at least one insurance plan offered in the Exchange. This mandate would be a significant expansion from current federal regulations on insurance coverage, which state that, "Health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion, are not required to be paid by an employer." While the bill would also require one plan that does not cover abortions to be offered in the Exchanges, many may be concerned that the new mandate to abortion access could in turn lead to federal actions to "protect" access to abortions—such as mandates for abortion clinics, drugs, etc.

The bill specifically permits taxpayer subsidies to flow to private health plans that include abortion, but creates an accounting scheme designed to designate private dollars as abortion dollars and public dollars as non-abortion dollars. Specifically, these provisions claim to segregate public funds from abortion coverage and would allegedly prevent funds used on abortion from being considered when determining whether plans meet federal actuarial standards.

However, press reports have been skeptical about whether and how this accounting mechanism would prevent federal funding of abortions. The accounting scheme has likewise been rejected by pro-life organizations, which recognize it as a clear departure from long-standing federal policy against funding plans covering abortion (e.g., Federal Employee Health Benefits Program, Medicaid, SCHIP, etc.). Many may believe that the only way to prevent fungible federal funds from subsidizing abortion coverage is to prevent plans whose beneficiaries receive federal subsidies from covering abortions. To that end, many may note that insurance plans within the FEHBP have been prohibited from offering abortion coverage since 1995, and federal employees have expressed strong satisfaction with their choice of plan options.

Exchange Benefit Standards: The bill requires the Commissioner to establish benefit standards for Exchange plans—basic (covering 70 percent of expenses), enhanced (85 percent of expenses), premium (95 percent of expenses), and premium-plus (premium coverage plus additional benefits for an enumerated supplemental premium). Cost-sharing may be permitted to vary by only 10 percent for each benefit category, such that a standard providing for a $20 co-payment would allow plans to define co-payments within a range of $18-22. Some Members may be concerned that these onerous, bureaucrat-imposed standards would hinder the introduction of innovative models to improve enrollees' health and wellness—and by insulating individuals from the cost of health services, could raise health care costs.

State Benefit Mandates: State benefit mandates would continue to apply to plans offered through the Exchange—but only if the State agrees to reimburse the Exchange for the increase in low-income subsidies provided to individuals as a result of an increase in the basic premium rate attributable to the benefit mandates.

Requirements on Exchange Plans: The bill requires plans offered in the Exchange to be State-licensed; plans shall also be required to contract with certain provider entities and must include "culturally and linguistically appropriate services and communications." Carriers also may not "use coercive practices to force providers not to contract with other entities" offering coverage through the Exchange. However, the bill places no such prohibitions on the government-run plan, thus permitting the Department of Health and Human Services to use its authority to set conditions of participation in a way that would undercut private insurance plans and effectively drive them out of business.

The bill gives the Commissioner the power to reduce out-of-network co-payments if the Commissioner determines a plan's network is inadequate, turning the plan into a fragmented and archaic fee-for-service delivery model that does nothing to coordinate care. The Commissioner also has authority to impose monetary sanctions, prohibit plans from enrolling new individuals, or terminate contracts.

Enrollment: The bill requires the Commissioner to engage in outreach regarding enrollment, establish enrollment periods, and disseminate information about plan choices. The Commissioner is required to develop an auto-enrollment process for subsidy-eligible individuals who do not choose a plan. Some Members may note that **nothing in the bill prohibits the Commissioner from auto-enrolling all individuals in the government-run plan—thus creating a single-payer system through bureaucratic fiat**.

The bill includes language requiring participants in Exchange plans to pay premiums directly to the plans themselves, and not through the Exchange. Some Members may view this provision as being inserted because the Congressional Budget Office would score premiums to insurance carriers routed through governmental entities (i.e. Exchanges) as part of the federal budget—and therefore an attempt to mask the true nature of the government takeover of health care the legislation contemplates.

Newborns born in the United States who are "not otherwise covered under acceptable coverage" shall automatically be enrolled in Medicaid; SCHIP eligible children shall be enrolled through the Exchange. The bill provides for individuals in new Medicaid expansion populations to join the Exchange, if they so choose; beneficiaries failing to choose an Exchange plan would be enrolled in Medicaid—and existing Medicaid beneficiaries would not be given a choice to enroll in Exchange plans.

Risk Pooling: The bill requires the Commissioner to establish "a mechanism whereby there is an adjustment made of the premium amounts payable" to plans to reflect differing risk profiles in a manner that minimizes adverse selection—and allows the Commissioner to determine all of the details of this mechanism.

Trust Fund: The bill creates a Trust Fund for the Exchange, and permits "such amounts as the Commissioner determines are necessary" to be transferred from the Trust Fund to finance the Exchange's operations. The Trust Fund would collect amounts received from taxes by individuals not complying with the individual mandate, employers failing to provide adequate health coverage, and general government appropriations. Some Members may be concerned that this open-ended source of appropriations for the bureaucrat-run Exchange would by definition constitute unfair competition against employer-provided insurance.

Interstate Compacts: Beginning in 2015, the bill permits multiple States to form "Health Care Choice Compacts" to buy health insurance across State lines, requires the Secretary and the National Association of Insurance Commissioners to develop model guidelines for same. Individuals would maintain the right to bring legal claims in their State of residence, and States would receive grants of up to $1 million annually to regulate coverage sold in secondary States. Some may note that these compact provisions would not address the issue of State benefit mandates that raise the cost of health insurance coverage—and the bill as a whole would increase the size and scope of mandates placed on plans, further raising their cost.

Insurance Co-Operatives: The bill establishes a Consumer Operated and Oriented Plan (CO-OP) program to provide grants or loans for the establishment of non-profit insurance cooperatives to be offered through the Exchange, but does not require States to establish such cooperatives. The bill authorizes $5 billion in appropriations for start-up loans or grants to help meet state solvency requirements. Some Members may be concerned that cooperatives funded through federal start-up grants would in time require ongoing federal subsidies, and that a "Fannie Med" co-op would do for health care what Fannie Mae and Freddie Mac have done for the housing sector.

Government-Run Health Plan: The bill requires the Department of Health and Human Services to establish a "public health insurance option" that "shall only be made available through the Health Insurance Exchange." The bill states the plan shall comply with requirements related to other Exchange plans, and offer basic, enhanced, and premium plan options. However, the bill does not limit the number of government-run plans nor does it give the Exchange the authority to reject, sanction, or terminate the government-run plan; therefore, some Members may be concerned that the bill's headings regarding a "level playing field" belie the reality of the plain text.

The government-run plan would be empowered to collect individuals' personal health information, posting a significant privacy risk to all Americans. The government-run plan would have access to federal courts for enforcement actions—a significant advantage over private insurance plans, whose enrollees may only sue in State courts.

The bill gives the government-run health plans $2 billion in "start-up funds"—as well as access to 90 days' worth of premiums as "reserves"—from the Treasury, with repayment—not including interest—to be made over a 10-year period. The bill requires the Secretary to establish premium rates that can fully finance the cost of benefits, administrative costs, and "an appropriate amount for a contingency margin" as developed by the Secretary. Some Members may be concerned that this provision would allow the Secretary to determine the plan's own capital reserve requirements, which could be significantly less than those imposed on private insurance carriers under State law, and question why Democrats who criticized banks for maintaining insufficient reserves are now permitting a government-run health plan to do the exact same thing—unless their motive is to give the government-run health plan a built-in bias.

While the bill includes a new provision stating that the government-run plan shall not receive "any federal funds for purposes of insolvency," many may point to the recent examples of Fannie Mae and Freddie Mac as evidence that no government-run health plan—which experts all agree would enroll several million Americans at minimum—would ever be permitted to fail without a federal bailout.

While the Secretary would be required to "negotiate" reimbursement rates with doctors and hospitals, **nothing in the bill prohibits the Secretary from using such negotiation to impose Medicare reimbursement levels on providers as part of a government-imposed "negotiation**." Should such a scenario occur, the Lewin Group has estimated that as many as 114 million individuals could lose access to their current coverage under a government-run plan—and that a government-run plan reimbursing at Medicare rates would actually result in a net $16,207 decrease in reimbursements per physician per year, even after accounting for the newly insured.

The bill requires Medicare providers, including physicians, to participate in the government-run plan unless they opt-out of said participation, and provides that all providers who accept the government-run plan's reimbursement rates shall be considered "preferred physicians"—regardless of their quality or expertise—and creates a new category of "participating, non-preferred physicians" who agree to abide by balance billing requirements similar to those in Medicare. Other providers may participate in the government-run plan only if they agree to accept the plan's reimbursement rates as payment in full. Some Members may be concerned that these provisions would therefore compel providers to accept lower reimbursements by the government-run plan in order to garner the government's approval.

The bill requires the Secretary to "establish conditions of participation for health care providers" under the government-run plan—however it includes no guidance or conditions under which the Secretary must establish those conditions. Many Members may be concerned that the bill would allow the Secretary to prohibit doctors from participating in other health plans as a condition of participation in the government-run plan—a way to co-opt existing provider networks and subvert private health coverage.

The bill also allows the Secretary to apply Medicare anti-fraud provisions to the government-run plan. Some Members, noting that Medicare has been placed on the Government Accountability Office's high-risk list since 1990 due to fraud payments totaling more than $10 billion annually, may question whether these provisions would be sufficient to prevent similar massive amounts of fraud from the government-run plan.

Finally, **the bill also permits—but does not require—Members of Congress to enroll in the government-run health plan**. Many may question why a Democrat majority insistent on creating a government-run health plan causing millions of Americans to lose their current coverage is not sufficiently confident in its superiority that they would not want to commit themselves to enrolling in it.

"Low-Income" Subsidies: The bill provides for "affordability credits" through the Exchange—and only through the Exchange, again putting employer health plans at a disadvantage. Subsidies could be used only for basic plans in the first two years, but all plans thereafter. Individuals with access to employer-sponsored insurance whose group premium costs would exceed 12 percent of adjusted gross income would be eligible for subsidies.

The bill provides that the Commissioner may authorize State Medicaid agencies—as well as other "public entit[ies]"—to make determinations of eligibility for subsidies and exempts the subsidy regime from the five-year waiting period on federal benefits established as part of the 1996 welfare reform law (P.L. 104-193), giving individuals a strong incentive to emigrate to the United States in order to obtain subsidized health benefits without a waiting period. Despite the bill's purported prohibition on payments to immigrants not lawfully present, and the insertion of a citizenship verification regime based upon that enacted in this year's SCHIP reauthorization (P.L. 111-3), some may be concerned that the provisions as drafted would not require individuals to verify their identity when confirming eligibility for subsidies—encouraging identity fraud while still permitting undocumented immigrants and other ineligible individuals from obtaining taxpayer-subsidized benefits.

Premium subsidies provided would be determined on a six-tier sliding scale, such that individuals with incomes under 150 percent of the Federal Poverty Level (FPL, $33,075 for a family of four in 2009) would

be expected to pay 1.5 percent of their income, while individuals with incomes at 400 percent FPL ($88,200 for a family of four) would be expected to pay 12 percent of their income. Subsidies would be capped at the average premium for the three lowest-cost basic plans, and would be indexed to maintain a constant percentage of total premium costs paid by the government. Members may also note that as subsidies would be based on adjusted gross income, individuals with total incomes well in excess of the AGI threshold could qualify for subsidies—such that a family of four with $100,000 of total earnings could qualify for subsidies if $12,000 of that income was placed in a 401(k) plan and therefore not counted for purposes of calculating the AGI limits.

The bill further provides for cost-sharing subsidies, such that individuals with incomes under 150 percent FPL would be covered for 97 percent of expenses, while individuals with incomes at 400 percent FPL would have a basic plan covering 70 percent (the statutory minimum). Some Members may be concerned that these rich benefit packages, in addition to raising subsidy costs for the federal government, would insulate plan participants from the effects of higher health spending, resulting in an increase in overall health costs—exactly the opposite of the bill's purported purpose.

Income for determining subsidy levels would be verified through the Treasury Department and the Internal Revenue Service. The bill provides for self-reporting of changes in income that could affect eligibility for benefits—provisions that could invite fraud by individuals seeking to claim additional benefits.

"Pay-or-Play" Mandate on Employers: In order to meet acceptable coverage standards, the bill requires that employers offer coverage, and contribute to such coverage at least 72.5 percent of the cost of a basic individual policy—as defined by the bureaucrats on the Health Benefits Advisory Council—and at least 65 percent of the cost of a basic family policy, for full-time employees. Employers must also auto-enroll their employees in group coverage, with an appropriate opt-out mechanism, in order to comply with the mandate. The bill further extends the employer mandate to part-time employees, with contribution levels to be determined by the Commissioner, and mandates that <u>any health care contribution "for which there is a corresponding reduction in the compensation of the employee" will not comply with the mandate—which many Members may be concerned will increase overall costs for employers, encouraging them to lay off workers</u>.

Employers must comply with the mandate by "paying" a tax of 8 percent of wages in lieu of "playing" by offering benefits that meet the criteria above. <u>In addition, beginning in the Exchange's second year, employers whose workers choose to purchase coverage through the Exchange would be forced to pay the 8 percent tax to finance their workers' Exchange policy—even if they offer other coverage to their employees</u>.

The bill includes a limited exemption for small businesses from the employer mandate—those with total payroll under $500,000 annually would be exempt, and those with payrolls of between $500,000 and $750,000 would be subjected to lower tax penalties (2-6 percent, as opposed to 8 percent for firms with payrolls over $750,000). However, <u>as these limits are not indexed for inflation, the threshold amounts would likely become increasingly irrelevant over time</u>, as virtually all employers would be subjected to the 8 percent payroll tax.

The bill amends ERISA to require the Secretary of Labor to conduct regular plan audits and "conduct investigations" and audits "to discover non-compliance" with the mandate. The bill provides a further penalty of $100 per employee per day for non-compliance with the "pay-or-play" mandate—subject only to a limit of $500,000 for unintentional failures on the part of the employer.

Some Members may be concerned that the bill would impose added costs on businesses with respect to both their payroll and administrative overhead. Given that an economic model developed by Council of Economic Advisors Chair Christina Romer found that an employer mandate could result in the loss of up

to 5.5 million jobs, some Members may oppose any effort to impose new taxes on businesses, particularly during a recession. Some Members may find the small business exemption insufficient—no matter at what level it would be set—since the threshold level could always be modified in the future to finance shortfalls in the government-run plans, and result in negative effects at the margins (e.g. a restaurant owner not hiring an additional worker—or increasing wages—if such actions would eliminate his small business exemption and subject him to an 8 percent payroll tax). Some Members may also be concerned that the bill's mandates—coupled with a potential new $500,000 tax on small businesses for even unintentional deviations from federal bureaucratic diktats—would effectively encourage employers to drop their existing coverage due to fear of inadvertent penalties, resulting in more individuals losing access to their current plans and being forced into the government-run health plan.

Individual Mandate: The bill places a tax on individuals who do not purchase "acceptable health care coverage," as defined by the bureaucratic standards in the bill. The tax would constitute 2.5 percent of adjusted gross income, up to the amount of the national average premium through the Exchange. The tax would not apply to dependent filers, non-resident aliens, individuals resident outside the United States, and those exempted on religious grounds. "Acceptable coverage" includes qualified Exchange plans, "grandfathered" individual and group health plans, Medicare and Medicaid plans, and military and veterans' benefits.

Some Members may note that for individuals with incomes of under $100,000, the cost of complying with the mandate would be under $2,000—raising questions of how effective the mandate will be, as paying the tax would in many cases cost less than purchasing an insurance policy. Despite, or perhaps because of, this fact, some Members may be concerned that the bill language does not include a clear affordability exemption from the mandate; thus, if the many benefit mandates imposed raise premiums so as to make coverage less affordable for many Americans, they will have no choice but to pay an additional tax as their "penalty" for not being able to afford coverage. Therefore, some Members may agree with then-Senator Barack Obama, who in a February 2008 debate pointed out that in Massachusetts, the one State with an individual mandate, "there are people who are paying fines and still can't afford [health insurance], so now they're worse off than they were. They don't have health insurance and they're paying a fine." Thus this provision would not only violate then-Senator Obama's opposition to an individual mandate to purchase insurance—it would also violate his pledge not to raise taxes on individuals making under $250,000.

Small Business Tax Credit: The bill provides a health insurance tax credit for small businesses, equal to 50 percent of the cost of coverage for firms where the average employee compensation is less than $20,000, establishing a perverse incentive to keep wages low. Firms with 10 or fewer employees are eligible for the full credit, which phases out entirely for firms with more than 25 workers. Individuals with incomes of over $80,000 do not count for purposes of determining the credit amount. Some Members may question how an individual making $80,000 could qualify as "highly-compensated" for purposes of the small business tax credit, but—if in a family of four—would be eligible for "low-income" subsidies available to families with incomes under $88,200 per year.

Tax Increases

Taxes on Health Plans: The bill prohibits the reimbursement of over-the-counter pharmaceuticals from Health Savings Accounts (HSAs), Medical Savings Accounts, Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs), and increases the penalties for non-qualified HSA withdrawals from 10 percent to 20 percent, effective in 2011. Because these savings vehicles are tax-preferred, adopting these provisions would raise taxes by $6.3 billion over ten years, according to the Joint Committee on Taxation.

H.R. 3962 would place a cap on FSA contributions, beginning in 2012; contributions could only total $2,500 per year, subject to annual adjustments linked to the growth in general (not medical) inflation.

Members may be concerned that these provisions would first raise taxes by $13.3 billion, and second—by imposing additional restrictions on health savings vehicles popular with tens of millions of Americans—undermine the promise that "If you like your current coverage, you can keep it." At least 8 million individuals hold insurance policies eligible for HSAs, and millions more participate in FSAs. All these individuals would be subject to additional coverage restrictions—and tax increases—under this provision.

The bill also repeals the current-law tax deductibility of subsidies provided to companies offering prescription drug coverage to retirees, raising taxes by $3 billion. Many may be concerned that this provision would lead to companies dropping their current coverage as a result.

Taxes on Health Products: H.R. 3962 would impose a 2.5 percent excise tax on medical devices, beginning in 2013, raising taxes by $20 billion. Many may echo the concerns of the Congressional Budget Office, and other independent experts, who have confirmed that this tax would be passed on to consumers in the form of higher prices—and ultimately higher premiums.

Taxes on Small Businesses: The bill also imposes a new 5.4 percent "surtax" on individuals with incomes over incomes over $500,000 and families with incomes greater than $1 million. The tax would apply beginning in 2011. ***The Joint Committee on Taxation estimates that such provisions would raise taxes by $544 billion over ten years***. As more than half of all high-income filers are small businesses, many Members may be concerned that this provision would cripple small businesses and destroy jobs during a deep recession.

Worldwide Interest: The bill delays for an additional ten years the application of worldwide interest allocation provisions first enacted into law (but never implemented) in 2004, which JCT estimates would raise $26.1 billion over ten years. Some Members may be concerned that, in addition to increasing taxes on businesses during a recession, further extension of these provisions would create undue uncertainty for many firms in an uncertain enough economic climate.

Treaty Benefits: The bill would limit the treaty benefits for certain deductible payments made by members of multinational entities in the U.S. that are controlled by foreign parent corporations in nations that hold tax treaties with the U.S. The bill prohibits certain previously negotiated tax reductions on payments to foreign affiliates under current tax treaties. Some Members may be concerned that this provision would violate previously negotiated treaties and impose higher taxes on foreign companies with affiliates that create jobs in the U.S. Some Members may also be concerned this provision could harm U.S. business by spurring retaliatory acts from foreign companies. JCT scores this provision as raising $7.5 billion over ten years.

Economic Substance: The bill codifies the economic substance doctrine—which is used to prohibit tax benefits on transactions that are deemed to lack "economic substance." The bill states that a transaction has economic substance only if the transaction changes the taxpayer's "economic position" in "a meaningful way" and the taxpayer has a "substantial purpose" for entering into the transaction. In addition, the bill would impose a 20 percent penalty on understatements attributable to a transaction lacking economic substance (40 percent in cases where certain facts are not disclosed). Some Members may be concerned that this provision would impose new burdens of proof and new liability penalties on taxpayers for making routine business decisions related to taxes. JCT scores this provision as raising $5.7 billion over ten years.

Domestic Partner Benefits: The bill extends current tax benefits for health insurance—including the exclusion from income and payroll taxes for participants in employer-sponsored coverage, the above-the-line deduction for health insurance premiums paid by self-employed individuals, and FSAs and HRAs—to "eligible beneficiaries," defined as "any individual who is eligible to receive benefits or coverage under an accident or health plan." Under current law, while employer-sponsored coverage provided to spouses and children is generally excluded from income, domestic partners do not qualify for similar treatment, as

the Internal Revenue Code does not classify them as dependents, and the Defense of Marriage Act (P.L. 104-199) prohibits their classification as spouses. This section would effectively expand the current-law health insurance tax benefits to domestic partners and their children, beginning in 2010; the provisions would reduce revenue by $4 billion over ten years, according to JCT.

Division B—Medicare and Medicaid Provisions

This division contains a significant expansion of Medicaid, that imposes tens of billions of dollars in unfunded mandates on already-strapped States, cuts to Medicare Advantage plans that would cause millions of seniors to lose their current plans, and other expansions of the Medicare and Medicaid programs. Details of the division include:

Medicare Provisions

Part A Market Basket Updates: The bill freezes skilled nursing facility and inpatient rehabilitation facility payment rates for 2010. The bill also incorporates an Administration proposal to reduce market basket updates to reflect productivity gains made throughout the entire economy, effective in 2010 and 2011. The bill permits the Centers for Medicare and Medicaid Services (CMS) to recalibrate and adjust the case mix factor for skilled nursing facility payments and to revise and reduce the payment system for non-therapy ancillary services at same, and extends moratoria on certain hospice payment regulations through Fiscal Year 2010.

Disproportionate Share Hospital Payments: The bill requires a study of Medicare Disproportionate Share Hospital (DSH) payments' effectiveness on reducing the number of uninsured individuals and directs the Secretary to reduce disproportionate share hospital (DSH) payments to hospitals, beginning in 2017, by up to 50 percent if there is a reduction in the number of uninsured by 8 percentage points during the 2012-14 period.

Physician Payment Provisions: The bill omits provisions addressing the Sustainable Growth Rate (SGR) mechanism for Medicare physician payments, as the Democrat majority chose instead to include those provisions in stand-alone companion legislation (H.R. 3961) that would not pay for its more than $200 billion cost. Many may view this attempt to omit costly provisions that would increase federal deficits from the main health care bill as a patently transparent budgetary gimmick.

The bill provides for feedback mechanisms for physicians to review their billing and procedure practices compared to their peers, and includes bonus payments of 5 percent for physicians participating in counties within the lowest 5 percent of total Medicare spending for 2011 and 2012, extends incentive payments under the Physician Quality Reporting Initiative through 2011 and 2012, and requires ambulatory surgical centers to submit cost and quality data to CMS. The bill reduces market basket updates for outpatient hospitals, ambulance services, laboratory services, and durable medical equipment not subject to competitive bidding to reflect productivity gains in the overall economy, increases the presumed utilization of imaging equipment—so as to reduce overall payment levels for imaging services—includes provisions regarding oxygen suppliers, bond requirements, and election to take ownership of rented durable medical equipment. The bill also establishes Medicare payment levels for follow-on biologics, equal to the average sales price plus a 6 percent dispensing fee.

Hospital Re-Admissions: The bill reduces payments to hospitals with higher-than-expected re-admission rates based on their overall case mix, excluding planned or unrelated re-admissions. The provision could reduce overall hospital payments by no more than 1 percent in 2012 and 5 percent in 2015 and subsequent years. Hospitals receiving more than 30 percent of their annual revenue from DSH funds would receive an increase in their DSH payments of up to 5 percent to provide for transitional services for patients post-discharge. The bill provides for payment reductions of up to 1 percent for post-acute care providers (i.e. skilled nursing facilities, inpatient rehabilitation facilities, home health agencies,

and long-term care hospitals) in instances where beneficiaries were readmitted within 30 days after discharge, and creates a pilot program for bundling post-acute care services.

Home Health: The bill freezes home health agency payment rates in 2010, accelerates the implementation of case mix changes for 2011, so as to reduce the effect of "up-coding" or changes to classification codes, and requires CMS to re-base the entire prospective payment classification system by 2011—or reduce all home health payments by 5 percent. The bill also reduces market basket updates for home health agencies to reflect productivity gains in the overall economy.

Physician-Owned Hospitals: The bill would essentially eliminate these innovative facilities by imposing additional restrictions on so-called specialty hospitals by limiting the "whole hospital" exemption against physician self-referral. Specifically, the bill would only extend the exemption to facilities with a Medicare reimbursement arrangement in place as of January 1, 2009, such that any new specialty hospital—including those currently under development or construction—would not be eligible for the self-referral exemption. The bill would also place restrictions on the expansion of current specialty hospitals' capacity, such that any existing specialty hospital would be unable to expand its facilities, except under limited circumstances. Given the advances which physician-owned hospitals have made in increasing quality of care and decreasing patient infection rates, some Members may be concerned that these additional restrictions may impede the development of new innovations within the health care industry.

Geographic Adjustment Factors: The bill requires an Institute of Medicine study regarding the accuracy of Medicare geographic adjustment factors, as well as directions to the Secretary to revise geographic adjustment factors for Medicare payment systems in a way that would not result in an overall reduction in payment rates. The bill provides $8 billion in funding from the Medicare Improvement Fund to provide payment increases addressing geographic disparities in reimbursement levels as recommended by the study—however, "hold harmless" provisions ensuring rural areas will only receive additional payments, and cannot have their payments decreased, apply only until 2014.

H.R. 3692 requires a second Institute of Medicine study regarding a new payment methodology regarding geographic variation in health care spending and promoting high value in health care, and requires the Institute to make recommendations by April 2011 for changes to Medicare reimbursement formulae in Parts A and B (exclusive of graduate medical education, DSH payments, and other add-ons) to reflect value in health care. The Secretary of HHS would be required to convert the report into a series of deficit-neutral proposals to change Medicare payment policies to reflect the Institute's recommendations. The bill provides for expedited procedures for the Secretary's report to be considered by Congress, but grants the Secretary the authority to make these proposed changes unilaterally, unless Congress passes a joint resolution of disapproval by May 31, 2012.

Many may be concerned by the prospect of unelected federal bureaucrats being given *carte blanche* authority to remake the Medicare system, **particularly as the bill does not prohibit federal bureaucrats from denying patients access to costly but effective treatments and services**. Many may view the provisions providing a Congressional vote largely irrelevant, as a two-thirds majority in both chambers would be required to overcome a near-certain veto by President Obama of a resolution disapproving his Administration's own actions. Moreover, there is nothing in these proposals that would prohibit the respective boards of bureaucrats from reducing—or even eliminating entirely—any temporary payment increases for rural providers.

Medicare Advantage: The bill reduces Medicare Advantage (MA) payment benchmarks to traditional Medicare fee-for-service levels over a three-year period. Some Members may be concerned that this arbitrary adjustment would reduce access for millions of seniors to MA plans that have brought additional benefits—undermining Democrats' pledge that if Americans like the coverage they have, they will be able to keep it under health reform.

Even though no other Medicare provider is paid on the basis of quality, the bill provides for a quality improvement adjustment for MA plans in low spending counties with high MA enrollment of up to 5 percent, based on re-admission rates, prevention quality, and other related measures. Incentive payments would be available to the top quintile of plans, and the top quintile of most improved plans. However, the Secretary may disqualify plans as not highly ranked, irrespective of their quantitative performance, "if the Secretary has identified deficiencies in the plan's compliance." The bill also requires CMS to make annual adjustments to MA plan payments to reflect differences in coding patterns between MA plans and government-run Medicare, and eliminates the three month open-enrollment period for Medicare Advantage plans, confining changes in enrollment to the period between November 1 and December 15. The bill extends reasonable cost contract provisions through 2012, and limits CMS' waiver authority for employer group MA plans unless 90 percent of enrollees reside in a county in which the MA organization offers an eligible plan.

The bill imposes requirements on MA plans to offer cost-sharing no greater than that provided in government-run Medicare, and imposes price controls on MA plans, limiting their ability to offer innovative benefit packages. Specifically, the bill requires MA plans to report their ratio of total medical expenses to overall costs (i.e. a medical loss ratio), requires plans with a medical loss ratio of less than 85 percent to offer rebates to beneficiaries, prohibits plans with a medical loss ratio below 85 percent for three consecutive years from enrolling new beneficiaries, and excludes plans with a medical loss ratio below 85 percent for five consecutive years. Particularly as the Government Accountability Office noted in a report on this issue that "there is no definitive standard for what a medical loss ratio should be," some Members may be concerned about this attempt by federal bureaucrats to impose arbitrary price controls on private companies. Again, this policy would encourage plans to keep seniors sick, rather than manage their chronic disease.

The bill includes language that no State shall be prohibited "from imposing civil monetary penalties, in accordance with laws and procedures of the State, against Medicare Advantage organizations, [prescription drug plan] sponsors, or agents or brokers of such organizations" for marketing violations. Some may be concerned that these provisions would encourage overzealous enforcement of laws by certain States, raising costs for businesses and ultimately for seniors enrolled in MA plans.

The bill also gives the Secretary blanket authority to reject "any or every bid by an MA organization," as well as any bid by a carrier offering private Part D Medicare prescription drug coverage. Some Members may be concerned that this provision gives federal bureaucrats the power to eliminate the MA program entirely—by rejecting all plan bids for nothing more than the arbitrary reason than that an Administration wishes to force the 10 million beneficiaries enrolled in MA back into traditional, government-run Medicare against their will.

Part D Provisions: The bill extends price controls, via Medicaid drug rebates, to all Medicare beneficiaries receiving a full low-income subsidy. This provision would constitute a broader expansion of the Medicaid rebate than its application solely to existing individuals dually eligible for Medicare and Medicaid, as approximately 9 million beneficiaries with incomes under 135 percent of poverty are eligible for the full low-income subsidy. Some Members may be concerned that expanding prescription drug price controls into the only part of Medicare that consistently comes in under budget would constitute a further intrusion of government into the health care marketplace, and do so in a way that harms the introduction of new breakthrough drugs and treatments. Some Members may also note that CBO has previously stated that an expansion of the Medicaid drug rebate to Medicare would result in drug companies raising private-sector prices—potentially resulting in higher prices for many Americans.

The bill phases in prescription drug coverage in the Medicare Part D "doughnut hole," by increasing the initial coverage limit by $500 beginning in 2010; beginning in 2011, coverage limits would increase and annual out-of-pocket maximums would decrease until the "doughnut hole" would be eliminated in 2019.

The bill also requires drug manufacturers, as a condition of participation in Part D, to sign a "discount agreement" providing discounts of 50 percent to beneficiaries in the "doughnut hole" prior to its elimination. The total price (exclusive of the discount) would be used towards determining when the beneficiary reaches the out-of-pocket maximum that triggers catastrophic coverage under the Part D benefit. Given the ostensibly voluntary nature of the agreement with pharmaceutical manufacturers that led to this provision, some Members may question why the bill links participation in the Part D program to these "voluntary" discounts—one that amounts to a form of price control.

The bill would expand current law protections against formulary changes by permitting beneficiaries to change plans whenever a plan is "materially changed…to reduce the coverage…of the drug." Thus the bill would now allow beneficiaries to switch Part D plans whenever a plan changes its formulary that would result in higher cost-sharing requirements. Some Members may be concerned that this provision—which essentially prohibits plans from adjusting their formularies to reflect new generic drugs coming on the market mid-year—would result in higher administrative costs and lack of stability for plans.

The bill includes provisions requiring the Secretary to "negotiate" prices with pharmaceutical companies for Part D prescription drugs, while prohibiting the Secretary from establishing drug formularies. As a result, CBO scored this provision as providing no savings—because it has previously stated that the federal government can lower prices through "negotiation" only be denying patients access to certain costly drugs. Given the lack of savings associated with this provision, some may question its inclusion in the bill.

Other Provisions: The bill extends certain hospital re-classifications for two years, as well as a two-year extension of certain ambulance provisions and the therapy caps exceptions process. The bill expands the Medicare entitlement, effective in 2012, to include coverage of immunosuppressive drugs for end-stage renal disease patients no longer eligible for Medicare benefits due to a kidney transplant. The bill also establishes a demonstration program on the use of patient decision-making aids, to educate beneficiaries regarding their treatment options, and expands the definition of physician services to include voluntary consultations regarding end-of-life decision-making. Some Members may be concerned that this latter provision would result in government-paid consultations encouraging assisted suicide or other forms of euthanasia.

Expansion of Subsidy Programs: The bill expands the asset test definition for the low-income subsidy program under Part D, allows the release of tax return data for purposes of determining eligibility, and increases the maximum amount of assets permissible to $17,000 for an individual and $34,000 for couples. Some Members, noting that the asset tests were already expanded and simplified in legislation enacted last year (P.L. 110-275), may question the need for a further expansion of federal welfare benefits in the form of low-income subsidies.

The bill applies the low-income subsidy asset tests to the Medicare Savings Program—but only for 2010 and 2011, which some Members may view as a budgetary gimmick designed to mask the true cost of the bill. The bill also eliminates all cost-sharing for dual eligible beneficiaries receiving home and community-based services who would otherwise be institutionalized in a nursing home, and permits individuals to self-certify their asset eligibility for low-income subsidy programs, and to obtain reimbursement from plans for cost-sharing retroactive to the date of purported eligibility for subsidies—provisions that could serve as an invitation for fraudulent activity.

The bill eliminates current law random assignment of dual eligible beneficiaries in Part D plans, requiring CMS to develop "an intelligent assignment process…to maximize the access of such individual[s] to necessary prescription drugs while minimizing costs to such individual[s] and the program." Some Members may question precisely how bureaucrats at CMS would be able to ascertain the best plan choice for individual seniors.

Language Services: The bill requires a study by CMS regarding language communication and "ways that Medicare should develop payment systems for language services," and authorizes a demonstration project of at least 24 grants of no more than $500,000 to providers to expand language communication and interpretation services.

Accountable Care Organizations: The bill establishes a pilot program to create accountable care organizations (ACOs) designed to improve coordination of care and improve system efficiencies. ACOs would include a group of physicians, including a sufficient number of primary care physicians, and could also include hospitals and other providers. ACOs would be eligible to receive a portion (as determined by CMS) of the savings from a reduction in projected spending under Parts A, B, and D for beneficiaries enrolled in the ACO, provided the ACO meets annual quality targets for clinical care. ACOs would also be permitted to receive their payments on a partially-captitated basis, as determined by CMS. The Secretary may make the pilot program permanent, provided that the CMS Chief Actuary certifies that the program would reduce Medicare spending. The bill includes a similar independence at home demonstration program for chronically ill beneficiaries with multiple functional dependencies; physician and nurse practitioner teams would receive incentive payments for reducing patients' projected Medicare spending by at least 5 percent.

Medical Home Pilot: The bill would establish a pilot program to provide medical home services for beneficiaries—with such medical home "providing first contact, continuous, and comprehensive care." Specifically, the bill provides for monthly risk-adjusted payments for medical home services provided to sicker-than-average Medicare beneficiaries (i.e. those above the 50th percentile), as well as payments for community-based medical home services provided to beneficiaries with multiple chronic illnesses. The bill provides a total of $1.7 billion in additional funding for payments under the pilot programs. The Secretary may make the pilot programs permanent, provided that the CMS Chief Actuary certifies that the permanent program would reduce estimated Medicare spending.

Primary Care Provisions: The bill provides a 5 percent increase in reimbursements for physicians and other primary care providers beginning in 2011, and a 10 percent increase for providers practicing in underserved areas. These increases would be in addition to the overall physician reimbursement changes outlined above.

Prevention and Mental Health: The bill eliminates co-payments and cost-sharing for certain preventive services. While supporting the encouragement of preventive care, some Members may believe that a blanket waiver of all cost-sharing for a list of services would encourage unnecessary or superfluous consumption of these treatments. The bill also expands the list of Medicare covered services to include marriage, family therapist, and mental health counselor services. Some Members may be concerned that this provision could result in non-Medicare beneficiaries (i.e., spouses and family members under age 65) receiving free mental health services from the federal government.

Comparative Effectiveness Research: The legislation includes language regarding the comparative effectiveness of various medical services and treatment options. The bill would establish another government center for comparative effectiveness research to gauge the effectiveness of medical treatments, a commission of federal bureaucrats and others to set priorities, and a trust fund in the U.S. Treasury to support the research. The trust fund's research would be financed by transfers from the cash-strapped Medicare Trust Funds, along with new taxes on insurance plans imposed on a *per capita* basis. While the bill includes a purportedly anti-rationing prohibition stating that the section could not "change the standards or requirements for coverage," some Members may still be concerned that other agencies (i.e. the Centers for Medicare and Medicaid Services) will use comparative effectiveness research—including cost-effectiveness research—to make coverage and/or reimbursement decisions, which could lead to government rationing of life-saving drugs, therapies, and treatments.

Nursing Home Provisions: The bill includes nearly 100 pages of requirements and regulations with respect to nursing facilities (reimbursed through Medicaid) and skilled nursing facilities (reimbursed through Medicare) providing nursing home care, including requirements for the public disclosure of entities exercising operational and functional control of nursing facilities, as well as those who "provide management or administrative services…or accounting or financial services to the facility"—provisions which some Members may view as overly broad and likely to increase administrative costs without providing meaningful disclosure.

The bill requires facilities to have compliance and ethics programs in operation that meet standards set in federal regulations, as well as specific parameters laid out in the bill. The bill requires facilities to "use due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations"—broad requirements which some Members may view as potentially extending liability to an entire organization for one individual's misdeeds.

The bill requires CMS to implement a quality assurance and performance improvement program for facilities, requires facilities to submit plans to meet best practice standards under such program, and calls for a GAO study examining the extent to which large multi-facility nursing home chains are under-capitalized and whether such conditions, if present, adversely impact care provided.

The bill creates a standardized complaint form for facilities and imposes requirements on States to maintain complaint processes, complete with various whistleblower protections. Some Members could be concerned that these provisions would constitute an invitation to lawsuits against nursing home facilities, the cost of which could significantly hinder the facility's ability to provide quality patient care.

The bill expands an existing program of background checks for long-term care facility employees, and modifies existing penalty provisions to allow fines—imposed by CMS in the case of skilled nursing facilities and States in the case of nursing facilities—of up to $100,000, in instances where facilities' deficiencies are "found to be a direct proximate cause of death of a resident," and up to $3,050 per day for "any other deficiency" found not to cause "actual harm or immediate jeopardy." Penalties for incidental, first-time infractions may be reduced if the facility self-reports the infraction and takes remedial action within ten days. The bill notes that "some portion of" the penalties collected "may be used to support activities that benefit residents."

The bill establishes a two-year pilot program to create a national monitor to oversee "large intrastate chains of skilled nursing facilities and nursing facilities" that apply to participate in the program, requires facilities to provide at least 60 days' notice prior to their closure, and adds dementia management and resident abuse to the list of required training courses for nurses aides working in relevant facilities.

Quality Improvement: The bill establishes a new program of national priorities for quality improvement and directs the Agency for Healthcare Research and Quality to help develop a series of quality measures that can assess patient care and outcomes in consultation with a group of stakeholders.

Disclosure of Physician Relationships: The bill imposes new reporting requirements on drug and device manufacturers and distributors to disclose their financial relationships with physicians and other health care providers. Specifically, manufacturers and distributors would be required to disclose the details behind any "transfer of value directly, indirectly, or through an agent," with some limited exceptions. A "transfer of value" includes any drug sample, gift, travel, honoraria, educational funding or consulting fees, stocks, or other ownership interest. The bill establishes a new federal standard, but allows States to exceed the federal standard.

The bill authorizes penalties of between $1,000 and $10,000 for each instance of non-reporting, up to a maximum fine of $150,000; knowing violations of non-reporting carry penalties of between $10,000 and

$100,000 for each instance, up to a maximum find of the greater of $1,000,000 or 0.1 percent of total annual revenues—which for large companies could significantly exceed $1 million. Some Members may be concerned at the significant penalties imposed for even incidental and unintentional non-compliance with the rigorous disclosure protocols established in the bill—and further question whether this disclosure would provide meaningful information to patients.

The bill further permits State Attorneys General to bring actions pursuant to this section upon notifying the Secretary about a specific case. Some Members may be concerned that this provision would result in additional lawsuits, which, coupled with the millions of dollars in potential fines above, would further raise costs for manufacturers and discourage the development and diffusion of life-saving breakthroughs.

Health Care Infections: The bill requires hospitals and ambulatory surgical centers participating in Medicare or Medicaid to submit public reports on hospital-acquired infections to the Centers for Disease Control, and requires such information to be made publicly available.

Graduate Medical Education (GME): The bill provides for the re-distribution of unused GME training slots, beginning in 2011, to hospitals, provided that no hospital shall receive more than 20 additional positions, and that all re-distributed residency positions be directed towards primary care. The bill permits activities in non-provider settings to count towards GME resident time, including participation in scholarly conferences and other educational activities.

Anti-Fraud Provisions: The bill increases funding for anti-fraud efforts by $100 million per year, and also increases penalties imposed on plans offering coverage through MA, Medicaid, or Part D related to knowingly mis-representing facts "in any application to participate or enroll" in federal programs. The bill also makes eligible for penalties the knowing submission of false claims data, a failure to grant timely access to inspector general audits or investigations, submission of claims when an individual is excluded from program participation. The bill provisions state that MA or Part D plans providing false information to CMS can be fined three times the amount of the revenues obtained as a result of such mis-representation. The bill also includes language prohibiting excluded individuals, as well as entities carrying out the directions of individuals whom such entities know to be excluded, from receiving Medicare or Medicaid reimbursements.

The bill mandates the exclusion of officers and owners of entities convicted of fraud, permits the Secretary to impose additional screening and oversight requirements—including a moratorium on enrolling new providers—given significant risk of fraudulent activity, and requires providers to disclose in applications for enrollment or renewed enrollment current or previous affiliations with providers suspended or excluded from the programs in question. The bill requires providers to adopt waste, fraud, and abuse compliance programs, subject to a $50,000 fine for non-compliance, and reduces from 36 months to 12 months the maximum lookback period for providers to submit Medicare claims.

The bill requires physicians ordering durable medical equipment (DME) or home health services to be participating physicians within the Medicare program, and requires providers to maintain and provide access to written documentation for DME and home health requests and referrals. Home health and DME services would require a face-to-face encounter with a provider prior to a physician certification of eligibility. The bill also extends the Inspector General's subpoena authority, and requires individuals to return overpayments within 60 days of said overpayment coming to light, subject to civil penalties. The bill requires that all Medicare payments to providers be made in electronic form to insured depository institutions. Finally, the bill grants the Inspector General access to all Medicare and Medicaid claims databases, including MA and Part D contract information, and consolidates two existing data banks of information.

Medicaid and SCHIP Provisions

Medicaid Expansion: The bill expands Medicaid to all individuals—including non-disabled, childless adults not currently eligible for benefits—with incomes below 150 percent FPL ($33,075 for a family of four in 2009). The bill's expansion of Medicaid to an estimated 15 million individuals would be fully paid for by the federal government only through 2014—thus imposing billions in unfunded mandates on States, which would be expected to pay nearly 10 percent of the cost of the expansion beginning in 2015. According to the preliminary Congressional Budget Office (CBO) score of the bill, this provision alone would require States to pay an additional $34 billion in matching funds over the next decade. However, States cannot afford their current Medicaid programs, which is why Congress included a $90 billion Medicaid bailout in the "stimulus" package—as well as an additional $23.5 billion bailout in H.R. 3962.

Many Members may be concerned by both the cost and scope of this unprecedented expansion of Medicaid to millions more Americans. Members may also note that a plurality of individuals (44 percent) with incomes between one and two times the poverty level have private health insurance; expanding Medicaid to 133 percent FPL would provide a strong incentive for the employers of these individuals to drop their current coverage so they can instead enroll in the government-run plan. Moreover, given Medicaid's history of poor beneficiary access to care—as one Medicaid beneficiary noted, "You feel so helpless thinking, something's wrong with this child and I can't even get her into a doctor....When we had real insurance, we would call and come in at the drop of a hat"—some Members may believe that Medicaid itself needs fundamental reform—and beneficiaries need the choice of access to quality private coverage rather than a government-run plan.

Medicaid/Exchange Interactions: The bill requires States to accept and enroll individuals documented by the Exchange as having incomes under 150 percent FPL, and all those documented by the Exchange as being eligible for Medicaid under traditional guidelines. The bill also excludes any payments related to erroneous eligibility determinations for Exchange plans from States' Medicaid error rates—which some Members may be concerned could encourage States to enroll beneficiaries not eligible for benefits.

In general, the bill would ***require*** currently eligible Medicaid beneficiaries—as well as expansion populations with income under 150 percent FPL—to remain in the government-run Medicaid program; such individuals would not receive affordability credits to purchase coverage on the Exchange. Some Members may be concerned that these provisions would result in significant disparities among low-income beneficiaries. Many may question the logic behind provisions that allow a family of four with $34,000 in annual income a choice (albeit a choice narrowly defined by bureaucratic standards) of health insurance options in the Exchange, while denying the same choice to a family with $1,000 less in income.

The bill imposes maintenance of effort requirements on States, prohibiting the voters or elected leaders of a State from reducing eligibility levels in that State's Medicaid and SCHIP programs after the bill's enactment, and prohibits States from imposing asset tests on several new categories of beneficiaries. (The bill does provide for a transition for SCHIP beneficiaries to join the Exchange once it is established, and repeals the SCHIP program at the end of Fiscal Year 2014.) Some Members may be concerned that these restrictions—which Tennessee Democrat Gov. Phil Bredesen termed "the mother of all unfunded mandates" on States—and could prompt a scenario envisioned by the head of Washington State's Medicaid program, whereby States facing severe financial distress may say, "'I have to get out of the Medicaid program altogether.'"

The bill also requires a study of Medicaid Disproportionate Share Hospital (DSH) payments' effectiveness on reducing the number of uninsured individuals, and includes a total of $10 billion in Medicaid DSH payment reductions in Fiscal Years 2017-2019, based on the States that have the lowest number of uninsured patients.

Preventive Services: The bill requires Medicaid to cover certain preventive services, as well as recommended vaccines, with zero cost-sharing. While supporting the encouragement of preventive care, some Members may question whether a blanket waiver of all cost-sharing for a list of services would encourage unnecessary or superfluous consumption of these treatments. The bill also permits Medicaid coverage of tobacco cessation programs, as well as optional coverage of nurse home visitation services.

Family Planning Services: The bill includes several provisions related to family planning services. Specifically, the bill would amend the definition of a "benchmark State Medicaid plan" to require family planning services for individuals with incomes up to the highest Medicaid income threshold in each State. The bill also permits States to establish "presumptive eligibility" programs for family planning services, which would allow Medicaid-eligible entities—including Planned Parenthood clinics—temporarily to enroll individuals in the Medicaid program for up to 61 days and places no limit on the number of times an individual can be presumptively enrolled by the same entity. Under this provision, a person could be repeatedly presumptively enrolled in the Medicaid program for years without ever having to document that the individual is actually qualified to receive taxpayer-funded Medicaid benefits.

Some Members may be concerned that these changes would, by altering the definition of a benchmark plan, undermine the flexibility established in the Deficit Reduction Act to allow States to determine the design of their Medicaid plans, expanding the federal government's role in financing family planning services. Some Members may also be concerned that the presumptive eligibility provisions would enable wealthy individuals or undocumented aliens to obtain free family planning services—and potentially other health care benefits—financed by the federal government, based solely on a presumption of possible eligibility by Planned Parenthood or other clinics.

Access to Services: The bill requires States to increase reimbursements to Medicaid primary care providers so that all such providers would be paid at Medicare rates by 2012. However, as with the expansion discussed above, States would be forced to pay nearly 10 percent of the cost of these increased payments—yet another unfunded mandate on States. The bill requires the Secretary to establish a medical home pilot program for Medicaid, similar to the Medicare program described above, and provides $1.2 billion to finance additional federal costs over the five-year period of the project.

The bill gives States the option to cover "ambulatory services that are offered at a freestanding birth center," defined as any non-hospital location "where childbirth is planned to occur away from the pregnant woman's residence," and requires coverage for podiatrists and optometrists. The bill further requires States retain coverage for juveniles enrolled in Medicaid "immediately before becoming an inmate of a public institution," and maintain such coverage after the inmate's release "unless and until there is a determination that the individual is no longer eligible to be so enrolled." H.R. 3962 permits States to establish Medicaid accountable care organization programs, and permits States to cover therapeutic foster care as well as certain low-income HIV positive individuals at an enhanced federal match.

The bill extends for two additional years the Transitional Medical Assistance (TMA) program that provides Medicaid benefits for low-income families transitioning from welfare to work. Traditionally, the TMA provisions have been coupled with an extension of Title V abstinence education funding during the passage of health care bills. However, the Title V funds were excluded from the bill language, and therefore expired on July 1, 2009. Some Members may be concerned by the removal of the Title V abstinence education funding and the potential end of this program.

The bill eliminates SCHIP coverage waiting periods for infants whose parents recently lost employer coverage or whose group coverage premiums exceed 10 percent of family incomes, and requires that stand-alone SCHIP programs must implement 12-month continuous eligibility programs. Some Members may be concerned that these provisions, in restricting States' flexibility, would exacerbate the movement of individuals from private to government-run coverage and allow individuals to continue to receive

federally-financed benefits long after they became ineligible. The bill also provides a State option to disregard income in order to cover under Medicaid individuals who have exhausted all private prescription drug coverage and who face costs for orphan drugs exceeding $200,000 annually.

Medicaid Pharmaceutical Price Controls: With respect to payments to pharmacists, the bill changes the federal upper reimbursement limit from 250 percent of the average manufacturer price (AMP) of the lowest therapeutic equivalent to 130 percent of the volume-weighted AMPs of all therapeutic equivalents. Manufacturers would be required to provide additional rebates for new formulations (e.g. extended-release versions) of existing drugs. The bill also increases the minimum Medicaid rebate for single-source (i.e. patented drugs) from 15.1 percent to 22.1 percent, and—for the first time—applies the rebate to drugs purchased by Medicaid managed care organizations, which already have the ability to negotiate lower prices. Some Members may be concerned that this language, by increasing the Medicaid rebate nearly 50 percent and extending the scope of its price controls, represents a further intrusion of government into the marketplace—and one that could result in loss of access to potentially life-saving treatments, by reducing companies' incentive to develop new products. The bill also requires States to return the entire portion of such rebates back to the federal government, which many may view as a particularly onerous requirement given the other unfunded mandates imposed on States in the bill.

Extension of "Stimulus" Funding: The bill provides for an extra two quarters of increased Medicaid funding for States, covering the first two calendar quarters of 2011. The "stimulus" legislation (P.L. 111-5) provided a 6.2 percent across-the-board increase in the federal matching rate to all States, as well up to an additional 11.5 percent for States with significant increases in unemployment. Many may question the logic of providing $24 billion to extend this "stimulus" funding to States—only to impose $34 billion in unfunded mandates on these same States in the same bill.

Other Provisions: The bill provides circumstances under which States can submit reimbursement claims for graduate medical education—a service that has never before been recognized as subject to reimbursement under the original Medicaid statute. The bill provides $6 billion for a new nursing facility supplemental payment program to provide quality payments to institutions providing care under both the Medicare and Medicaid programs. The bill also grants CMS the authority to reject payment for certain "never events" resulting from medical errors and other "health care acquired conditions," and requires that States must have hospital price transparency reporting regimes in place. The bill requires providers to adopt waste, fraud, and abuse programs, extends other anti-fraud provisions and includes a two-year extension of the Qualifying Individual program, which provides assistance through Medicaid for low-income seniors in paying their Medicare premiums. Some Members may be concerned that the bill also regulates medical loss ratios for Medicaid managed care organizations, requiring the Secretary to hold such organizations to a minimum 85 percent payout—adding a government-imposed price control, and one that the Government Accountability Office has admitted is entirely arbitrary.

The bill would repeal provisions in the Medicare Modernization Act requiring expedited procedures for the President to submit, and Congress to consider, "trigger" legislation remedying Medicare's funding shortfalls, as well as provisions regarding a Medicare premium support demonstration project scheduled to start in 2010. At a time when the Medicare Part A Trust Fund is scheduled to be exhausted in 2017, some Members may be concerned that these changes would eliminate provisions designed to have Congress take action to remedy Medicare's looming fiscal crisis and one possible solution (i.e. premium support).

The bill extends an existing gainsharing demonstration project, requires a new "identifiable office or program" within CMS to focus on protecting dual eligibles, and provides for new grants to States to support home visitation programs for families with children and families expecting children. The visitation program would be similar to the capped allotment funding mechanism used in SCHIP; federal funding would total $750 million in the first five years, and State allotments would be determined on the basis of each State's relative proportion of children in families below 200 percent FPL. The federal government

would provide a matching reimbursement rate, starting at 85 percent in 2010 before falling to 75 percent in 2012. At a time when existing entitlements are fiscally unsustainable, some Members may question the wisdom of establishing yet another federal entitlement—this one a new home visitation program to teach parents "skills to interact with their child."

Innovation Center: H.R. 3962 creates a Center for Medicare and Medicaid Innovation within CMS. The Center would test new delivery models designed to improve care while reducing costs, with preliminary testing lasting no longer than seven years and subsequent expansions contingent on improving quality while reducing costs. Funding would total $350 million in Fiscal Year 2010, and $6.5 billion over ten years.

Division C—Public Health

This division of the bill would purportedly improve public health and wellness through a variety of federal programs and increased spending. While supporting the goal of better health and wellness for all Americans, some Members may be concerned by the bill's apparent approach that additional federal spending *ipso facto* will improve individuals' health. Details of the division include:

New Mandatory Spending: The bill appropriates $33.9 billion in new mandatory spending over ten years for a "Public Health Investment Fund," of which $15.4 billion is dedicated to a "Prevention and Wellness Trust." This increase in mandatory spending is intended to fund programs established in the bill, as well as other programs in the Public Health Service Act. However, many may note that the bill's lower spending levels—H.R. 3200 as introduced spent $88.7 billion on public health programs—stems solely from the fact that the Democrat majority only included five fiscal years of spending in H.R. 3962, compared to ten fiscal years in the earlier version. In other words, rather than reducing actual spending levels, the majority decided to "hide" nearly $55 billion in spending under the highly tenuous assumption that once enacted, this multi-billion dollar program would simply be allowed to expire in 2014. Many may view such a tactic as a budgetary gimmick designed to mask the bill's true costs.

Community Health Centers: The bill authorizes an additional $38.8 billion from the Public Health Investment Fund for grants to community health centers—funding over and above the significant increase provided in the $13.3 billion, five-year reauthorization that passed just last year (P.L. 110-355). Some Members may be concerned by the significant increase in authorization levels given the federal deficits approaching 10 percent of GDP. The bill also extends liability protections to volunteer practitioners at such centers.

Workforce Provisions: The bill would increase maximum loan repayment levels for participants in the National Health Service Corps from $35,000 to $50,000 per year, further adjusted for inflation, and authorizes an additional $2.9 billion in appropriations for loan repayments. The bill also creates a new program for primary care in addition to the existing National Health Service Corps, which would fund a loan forgiveness program in exchange for each year of service by an individual in an underserved area. The bill would also reduce certain student loan interest payments for participants in certain medical loan programs, which data from the Department of Health and Human Services indicates would actually reduce the number of individuals able to access such programs.

The bill would award grants to hospitals and other entities to plan, develop, or operate training programs and provide financial assistance to students with respect to certain medical specialties, including primary care physicians and dentistry, and increase student loan limits for nursing students and faculty. The bill would further award grants to health professions schools for the training of, and/or financial assistance to, medical residents training in community-based settings, public health professionals, and graduate medical residents in preventive medicine specialties. The bill would make certain modifications to existing programs for diversity centers and increase loan repayment limits for such programs by $15,000 (plus a new inflation adjustment) per year. The bill amends provisions relating to grants for cultural and

linguistic competence training and authorizes new grants for interdisciplinary training designed to reduce health disparities and to support the operation of school-based health clinics. While the language in the school-based clinic program prevents the clinics themselves from providing abortions, some Members may be concerned that these federally-funded clinics could refer underage students to other entities (e.g., Planned Parenthood) for abortions.

The bill would establish a Public Health Workforce Corps with its own scholarship program to address workforce shortages. The scholarship program would include up to four years of tuition and fees, as well as a $1,269 monthly stipend during the academic year. The Corps would have a further loan forgiveness program for individuals who commit to at least two years of service, providing up to $35,000 annually in loan forgiveness to participants.

The bill would authorize grants administered by the Secretary of Labor "to create a career ladder to nursing" for "a health care entity that is jointly administered by a health care employer and a labor union" in order to fund "paid leave time and continued health coverage to incumbent workers to allow their participation" in various training programs, or "contributions to a joint labor-management training fund which administers the program involved." Some Members may be concerned that this provision would enable labor unions to receive federal grant funds in order to train their members.

Finally, the bill would create a national wellness strategy, two new advisory boards on preventive care, an Assistant Secretary for Health Information, an Advisory Committee on Health Workforce Evaluation and Analysis, and a National Center for Health Workforce Analysis. Some Members may question the necessity and wisdom of establishing multiple new bureaucracies to attempt to analyze and manage America's health levels along with the entire health care workforce.

Expanded Price Controls: The bill expands participation in the 340B program, which reduces the price paid for outpatient pharmaceuticals purchased by certain entities. Specifically, the bill expands the program to children's hospitals, critical access hospitals, rural referral centers, and sole community hospitals, while also including several new reporting requirements and penalties in an attempt to ensure compliance with the regime. Some Members may be concerned that this language, by extending the scope of price controls on pharmaceutical products, represents a further intrusion of government price controls into the marketplace—and one that could result in loss of access to potentially life-saving treatments, by reducing companies' incentive to develop new products. In addition, the bill would also create a National Medical Device Registry "to facilitate analysis of post-market safety and outcomes data" for Class III medical devices and Class II devices classified as life-sustaining.

Newly Added Bureaucracies and Programs: The bill includes at least 30 new and several reauthorized grant programs and bureaucracies added to the health "reform" bill since its introduction as H.R. 3200, some of which were considered during the Energy and Commerce Committee's markup of the latter measure. The measures include programs running a gamut of public health issues from influenza vaccines in schools to community-based overweight and obesity prevention. While supporting healthy behaviors and improved wellness, some Members may be concerned by the majority's apparent belief that the route to such behaviors lies largely through action by the federal government. Moreover, some may have concerns about several of the specific programs being created—including a "healthy teen initiative" on teen pregnancy, and a medical liability program that funds incentive grants to States **only on condition that such States "not limit attorneys' fees or impose caps on damages**."

Nutrition Labeling for Restaurants: The bill imposes new federal requirements on chain restaurants and vending machines to display nutrition labeling. Federal requirements would apply to chain restaurants "with 20 or more locations doing business under the same name," and include all menu items except condiments and "temporary menu items appearing on the menu for less than 60 days per calendar year." The bill would require restaurants to list the caloric content of menu items "adjacent to the name of the standard menu item, so as to be clearly associated" with same, and would further

require "a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu." The Secretary would be further empowered to promulgate regulations requiring additional disclosures beyond caloric content.

Vending machine operators "owning or operating 20 or more vending machines" that do not permit purchasers to review nutrition information prior to purchase "shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article." Some Members may be concerned that these requirements will increase administrative burdens for business in order to provide additional information that may or not be helpful to consumers—and may or may not in fact reflect the nutritional content of the food as actually prepared for the customer (as opposed to the food as prepared when quantifying the disclosure requirements of the "food police").

Generics and Follow-On Biologics: The bill prohibits generic drug manufacturers from receiving "anything of value" with respect to a patent dispute with brand-name manufacturers, and prohibits generic manufacturers from agreeing to forego sales and manufacturing for any period of time in relation to a patent dispute with brand-name manufacturers. The bill also establishes a Food and Drug Administration approval process for generic biosimilars, also referred to as follow-on biologics. Grants a period of exclusivity for brand-name products of 12 years, with a six-month extension possible in cases where a manufacturer agrees to an FDA request for pediatric studies. The bill gives FDA the authority to issue general or specific guidance documents (subject to a notice-and-comment period) regarding product classifications.

New Long-Term Care Entitlement: The bill would create a new entitlement to long-term care services, financed by a new "Independence Fund" generated from beneficiary premiums. The plan would have monthly premiums developed by actuaries; late enrollees would pay age-adjusted premiums. All individuals over 18 receiving wage or self-employment income would be automatically enrolled in the program; premiums would be automatically deducted from workers' wages. Individuals would only be able to disenroll from the program "during an annual disenrollment period." Premiums would not increase so long as the individual remained enrolled in the program (or the program had sufficient reserves for a 20-year period of solvency).

The minimum cash benefit would be $50 per day, with amounts scaled for levels of functional ability—and benefits not subject to lifetime or aggregate limits. In the case of beneficiaries enrolled in Medicaid, the beneficiary would receive either 5 percent (for institutionalized patients) or 50 percent (for patients in home and community-based services) of the cash benefit, with the balance applied to the cost of coverage, and Medicaid providing secondary payments. Benefits would also include advocacy services and advice and assistance counseling in addition to the cash benefit.

Benefit eligibility would be determined by State Disability Determination Services (DDS) within 30 days; "an application that is pending after 45 days shall be deemed approved." Particularly given the backlog in processing Social Security disability claims using the same DDS system—where the time necessary to process an average claim has grown to 106 days—some Members may be concerned that making all claims pending 45 days eligible for benefits would constitute a recipe for the approval of virtually all long-term care claims, including many dubious or fraudulent ones.

Many may be concerned by the concept of creating a new, expansive federal entitlement program when Medicare itself is not actuarially sound and the Medicare Hospital Insurance Trust Fund is scheduled to be insolvent by 2017. Moreover, while the new entitlement would generate revenue during the initial ten-year budgetary window—as individuals pay premiums but would not be able to collect benefits—the additional entitlement obligations would only increase federal deficit in future years. As even Democrats

such as Senate Budget Committee Chairman Kent Conrad (D-ND) have called the program a "Ponzi scheme," many may find any legislation that relies upon such a program to maintain "deficit-neutrality" fiscally irresponsible and not credible.

Division D—Indian Health Service

When introduced as H.R. 3962, the Pelosi health care bill added the provisions of H.R. 2708, the Indian Health Care Improvement Act, to the prior provisions in H.R. 3200 already considered by the three primary Committees of jurisdiction. **Many may note that this procedural maneuver allows Democrats to avoid a vote—either in Committee or on the House floor—about whether or not to codify the Hyde Amendment's prohibition on federal abortion funding for the Indian Health Service**. The bill and the underlying statute it would replace include language prohibiting the Indian Health Service from using federal funds to pay for abortions ***only if the Hyde Amendment's protections are renewed every year***. Such an amendment passed the Senate last year—but Indian Health Service legislation was not considered by the full Energy and Commerce Committee, or on the House floor, either last Congress or this Congress due to this issue.

According to the Congressional Research Service, the Indian Health Service (IHS) provides services to about 1.8 million members of the 562 federally recognized American Indian and Alaska Native tribes. Health services are available within 161 local service areas in largely rural communities, along with 34 urban Indian health projects; services can be delivered by the IHS directly, or by tribes and tribal organizations through self-determination compacts. Though estimates vary, at least 1.4 million individuals received service at IHS facilities in 2006. Funding sources for the Service include federal appropriations for IHS health services ($2.97 billion in Fiscal Year 2008), facilities ($374.6 million, and a special diabetes program ($150 million), along with collections from Medicare, Medicaid, and private insurance ($786 million). In Fiscal Year 2008, the program received a total of $4.28 in funding.

Program Reauthorization: The bill reauthorizes and rewrites the Indian Health Care Improvement Act, in all cases authorizing "such sums" as may be necessary to fund the Service. In addition to reauthorizing and creating a range of health professionals grant programs, the bill greatly expands the definition of "health promotion" and "disease prevention" to broaden the range of services provided by the Service. The bill also broadens provisions on diabetes prevention and control, adds oral health to the list of Indian school health education programs, and expands provision of hospice care and home- and community-based services. The bill contains new diabetes screening requirements, and amends certain construction requirements. Notably, the bill expands Davis-Bacon prevailing wage restrictions—applying them to facilities constructed by tribes using IHS funds, in addition to those constructed by the IHS itself. Some Members may be concerned that these provisions would increase costs to the federal government.

The bill reauthorizes urban Indian health programs, which provide services not only to members of federally recognized tribes, but also to members of State recognized tribes, members of tribes with federal recognition revoked after 1940, non-member descendants of tribes, and other individuals considered to be Indian by the Departments of Interior and HHS. Some Members may be concerned that providing these services outside of membership in a federally recognized tribe may constitute the provision of racially-based services, which may violate the Constitution's equal protection standards. In reauthorizing programs on Indian mental health services, the bill includes a new program for sexual abuse prevention that provides funding to treat "perpetrators of sexual abuse who are Indian or members of an Indian tribe." Some may be concerned at the use of federal taxpayer dollars to support sexual predators.

Funding: The bill provides that 100 percent of reimbursements paid to the IHS from Medicare or Medicaid must be returned to the service unit that provided the service—up from a current-law requirement of 80 percent—and permits tribal health programs to bill SCHIP directly for reimbursement (currently such programs can only bill Medicare and Medicaid directly). The bill expands existing

outreach grants to include SCHIP enrollment outreach activities, and includes a new provision allowing tribes to use federal funds to purchase health insurance coverage—except that such coverage may not include a high-deductible plan or HSA. The bill also includes new provisions regarding guidelines for sharing veterans and Defense Department health facilities and treatments, and codifies a current regulatory ruling that the Service shall function as a "payor of last resort" in all cases. The bill includes a study examining whether the Navajo Nation should be considered a State for purposes of receiving reimbursements and federal matching funds under the Medicaid program.

Finally, the bill expands Medicaid, Medicare, and SCHIP reimbursement criteria to make all Indian health programs subject for payment—broadening eligibility beyond the current-law definition limited to IHS facilities—makes other definitional changes, and adds provisions to increase enrollment in SCHIP by exempting Indian outreach activities from the 10 percent cap on federal expenditures for outreach activities.

COST AND OTHER CONCERNS

Cost: According to the Congressional Budget Office's preliminary score, H.R. 3962 would spend nearly $1.3 trillion over its first ten years. More specifically, CBO estimates that the bill would spend $1.055 trillion to finance coverage expansions—$425 billion for the Medicaid expansions, $605 billion for "low-income" subsidies, and $25 billion for small business tax credits. Democrats' lower $894 billion number conveniently includes offsetting revenue from more than $150 billion in tax increases (only a portion of the $729.5 billion in total tax increases)—$33 billion from individuals who do not purchase government-forced health coverage and $135 billion from employers that do not offer government-forced insurance.

The more than $1 trillion in spending on coverage expansions does not even include additional federal spending included in the legislation—including extension of Medicaid "stimulus" funding to the States, a new reinsurance program for retirees, and a $34 billion trust fund for public health—that totals $224.5 billion. When combined with the cost of the coverage expansions, **total spending under the bill actually approaches $1.3 trillion**.

Both in its score of H.R. 3962 and in a separate document comparing it to the Senate Finance Committee bill (S. 1796), CBO notes that over both a 10 and 20-year period, H.R. 3962 "**would increase both federal outlays for health care and the federal budgetary commitment to health care, relative to the amounts under current law**." Many members may be concerned that spending at least $1.3 trillion to finance a government takeover of health care would not only not help the growth in health costs, but—by creating massive and unsustainable new entitlements—would also make the federal budget situation much worse.

Savings would come from reductions within the Medicare program, of which the biggest are cuts to Medicare Advantage plans (net cut of $170 billion), reductions in adjustments to certain market-basket updates for hospitals and other providers (total of $143.6 billion), skilled nursing facility payment reductions (total of $23.9 billion), various reductions to home health providers (total of $56.7 billion), and reduction in imaging payments ($3 billion).

Tax Increases: Offsetting payments include $33 billion in taxes on individuals not complying with the mandate to purchase coverage, as well as a total of $135 billion in taxes and payments by businesses associated with the "pay-or-play" mandate. Members may note that the tax from the insurance mandate would apply on individuals with incomes under $250,000, thus breaking a central promise of then-Senator Obama's presidential campaign.

The Joint Committee on Taxation notes that the bill provisions would increase federal revenues by $561.5 billion over ten years—over and above the $168 billion in tax increases related to the individual and employer mandates noted above—**for a total of $729.5 billion in tax increases over ten years**.

JCT found that the "surtax" would raise $460.5 billion, corporate reporting would raise $17.1 billion, the worldwide interest implementation delay would raise $26.1 billion, the treaty withholding provisions would raise $7.5 billion, and the codification of the economic substance doctrine would raise $5.7 billion. Taxes on Health Savings Accounts (HSAs) and other similar savings vehicles would raise $19.6 billion, while provisions relating to retiree drug subsidies would raise taxes by $3 billion. An excise tax on medical devices—which experts agree would be passed on to customers in the form of higher prices and insurance premiums—would raise taxes by $20 billion. Finally, the tax on health benefits used to finance the Comparative Effectiveness Research Trust Fund would raise $2 billion over ten years.

Out-Year Spending: The score indicates that of the nearly $1.055 trillion in spending for coverage expansions under the specifications examined by CBO, only $7 billion—or only 0.7%—of such spending would occur during the first three years following implementation. Moreover, the bill in its final year would spend a total of $208 billion to finance coverage expansions. **In other words, the Democrat bill spends so much, it needs eight years of higher taxes to finance six years of spending—and even then cannot come into proper balance without relying on budgetary gimmicks**.

Budgetary Gimmicks: While the CBO score claims H.R. 3962 would reduce the deficit by $104 billion in its first ten years, Democrats achieved that "deficit-neutral" solely by excluding the cost of reforming the Sustainable Growth Rate (SGR) mechanism for Medicare physician payments—the total cost of which stands at $285 billion over ten years, according to CBO—from this bill, and including it instead in a separate companion bill (H.R. 3961) that is not paid for. While Members may support reform of the SGR mechanism, many may oppose what amounts to an obvious attempt to incorporate a permanent "doc fix" into the baseline—a gimmick designed solely to hide the apparent cost of health "reform."

OMB Director Orszag, testifying before the House Budget Committee in June, asserted that the White House would not support legislation that was not balanced in the long-term—and further stated that the Administration would not support legislation that increased the deficit in the tenth and final year of the budgetary window. After taking into account Democrat budgetary gimmicks, H.R. 3962 fails that test—as the bill's purported $10 billion surplus in 2019 is more than outweighed by the $38 billion cost of physician payment reform.

The Pelosi bill also relies on more than $70 billion in revenue from a new program for long-term care services. As the long-term care program requires individuals to contribute five years' worth of premiums before becoming eligible for benefits, the program would find its revenue over the first ten years diverted to finance other spending in Democrats' health care "reform." However, as even Democrats, such as Senate Budget Committee Chairman Kent Conrad (D-ND), have called the program a "Ponzi scheme," many may find any legislation that relies upon such a program to maintain "deficit-neutrality" fiscally irresponsible and not credible.

Coverage: The score also claims that the number of uninsured individuals would be reduced to 18 million by the end of the ten-year budgetary window, a reduction of 36 million in 2019 when compared to current law projections. Approximately 21 million individuals would purchase their health insurance from the Exchange, including more than 6 million individuals who would lose their current private health coverage purchased on the individual market and enroll in the government-run Exchange.

The CBO score asserts that employer-based coverage would increase slightly, due to the individual and employer mandates. However, the bill permits the government-run health plan in H.R. 3962 to reimburse providers at Medicare rates, which are 20-25 percent lower than private insurance rates—thus permitting the government plan to undercut private insurers. Particularly as the Lewin Group has indicated that under such a scenario, a government-run plan would cause up to 114 million Americans to lose their current coverage, some Members may question CBO's apparent assumption that employers would not choose to drop their health plans to enroll their workers in a government-run plan with purportedly lower costs than existing coverage.

Undocumented Individuals: The CBO score notes that the specifications examined would extend coverage to 94 percent of the total population, and 96 percent of the population excluding unauthorized immigrants. However, the score goes on to note that of the 18 million individuals remaining uninsured, "one third"—or about 6 million—would be undocumented immigrants. Given that most estimates have placed the total undocumented population at approximately 10-12 million nationwide, some Members may question whether this statement presumes that some undocumented immigrants would obtain health insurance—including health insurance funded by federal subsidies.

It is also worth noting that in its preliminary score of H.R. 3200, CBO found that in 2019 there would be "about 17 million nonelderly residents uninsured (nearly half of whom would be unauthorized immigrants)." In other words, the number of projected uninsured who are also undocumented immigrants declined from about 8 million under H.R. 3200 to 6 million under the latest Pelosi bill. Many may question what changes in the Pelosi legislation resulted in 2 million undocumented immigrants suddenly obtaining health coverage.

STAFF CONTACT

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