



U . S . SENATE REPUBLICAN POLICY COMMITTEE

Legislative Notice

No. 28

December 2, 2009

**H.R. 3590: The Quality, Affordable Health Care
for All Americans Act**

Calendar No. 175

H.R. 3590, the Service Members Home Ownership Tax Act of 2009, was read twice and placed on the Calendar on October 13, 2009. On November 21, Majority Leader Reid offered a complete substitute amendment to the bill, containing the text of the Quality, Affordable Health Care for All Americans Act.

Noteworthy

- H.R. 3590 is intended to expand access to health insurance, reform the health insurance market to provide additional consumer protections, and improve the health care delivery system to reduce costs and produce better outcomes.
- While the bill would expand insurance coverage to 94 percent of the legal population (24 million Americans would still be without coverage) and could improve the functioning of the individual and small group insurance markets, many experts question whether it will effectively control costs or reform the health-care delivery system.
- The Congressional Budget Office (CBO) estimates that the coverage provisions in the bill will cost \$848 billion over 10 years (fiscal years 2010-2019). However, the major provisions in the bill would not take effect until January 1, 2014, meaning the bill uses 10 years of revenue to pay for six years of coverage. Republican staff on the Senate Budget Committee estimates that the total spending in the bill over 10 years of full implementation (FYs 2014-2023) would exceed \$2.5 trillion.
- To pay for the expansion of insurance coverage, the bill increases taxes by \$493.6 billion, and reduces Medicare spending by \$464.6 billion. Specifically, the bill would cut \$134.9 billion from hospitals, \$120 billion from Medicare Advantage (MA), \$14.6 billion from nursing homes, \$42.1 billion from home health agencies, and \$7.7 billion from hospices.
- Among the more prominent taxes, the bill includes a new 40 percent excise tax on health insurance plans that exceed \$8,500 for individuals and \$23,000 for families, raising \$149.1 billion over 10 years; a new Medicare payroll tax on higher-income individuals that raises \$53.8 billion; a \$60.4 billion tax on health insurers; a \$22.2 billion tax on drug manufacturers; and a \$19.3 billion tax on medical device manufacturers.
- H.R. 3590 mandates that all lawful residents purchase qualified insurance coverage or pay a penalty. The penalty for not having qualified health insurance would be \$750, phased in over three years beginning in 2014.
- The bill would provide tax credits for individuals between 133 and 400 percent of the federal poverty level (FPL)—\$29,330 to \$88,000 for a family of four—to help them purchase

insurance coverage. Credits would be available on a sliding scale based on income.

- A government-run plan (or “public option”) would be available through the exchange unless a state passes a law opting out of the government plan.
 - The bill would create a tax on employers with more than 50 full time workers if their employees receive a subsidy through the exchange. This so-called “free rider” mandate would increase taxes on employers by \$28 billion.
 - Medicaid would be expanded to cover all individuals up to 133 percent of the FPL, which would increase the number of individuals covered under the program by more than 40 percent.
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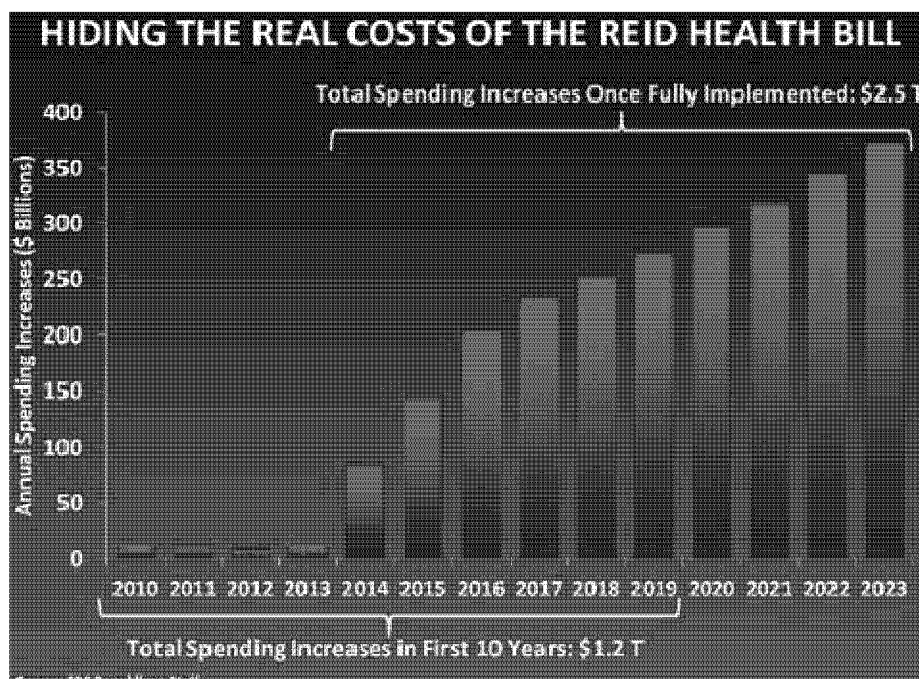
Summary

On July 15, 2009, the Health, Education, Labor, and Pensions (HELP) Committee voted to report the Affordable Health Choices Act, by a vote of 13-10. In September, HELP Committee Chairman Harkin introduced S. 1679 as an original measure and the bill was placed on the Calendar on September 17; Calendar #161. On October 13, the Finance Committee voted 14-9 to report S. 1796, the America's Healthy Future Act of 2009, S. Rpt. 111-89. Following the Finance Committee’s action, the Majority Leader combined the HELP and Finance bills into The Quality, Affordable Health Care for All Americans Act. This combined bill was introduced as a substitute amendment to H.R. 3590, *Service Members Home Ownership Tax Act of 2009*, on November 21, 2009. On October 7, 2009, the House passed its health care legislation, H.R. 3962, the Affordable Health Care for America Act, by a vote of 220-215.

H.R. 3590 is intended to expand access to health insurance, reform the health insurance market to provide additional consumer protections, and improve the health care delivery system to reduce costs and produce better outcomes. While the bill would expand insurance coverage to 94 percent of the legal population (24 million Americans would still be without coverage) and could improve the functioning of the individual and small group insurance markets, many experts question whether it will effectively control costs or reform the health-care delivery system.¹

¹ For example, the *New York Times* reported: “Experts — including some who have consulted closely with the White House, like Dr. Denis A. Cortese, chief executive of the Mayo Clinic — say the measures take only baby steps toward revamping the current fee-for-service system, which drives up costs by paying health providers for each visit or procedure performed.” [*New York Times*, “Democrats Raise Alarms Over Costs of Health Bills,” November 11, 2009]. National Public Radio reported that “critics from across the political spectrum say the legislation does little to rein in runaway health care costs.” [National Public Radio, “Analyzing Democrats' Word Shift on Health Care,” November 17, 2009]. The *Washington Post* wrote: “Instead of revolutionizing how care is delivered and paid for, experts say, the legislation being shaped takes a cautious approach to reining in costs. ... Overall, Democratic lawmakers have turned to ‘tried and true’ strategies for reducing spending that merely ratchet down payments rather than fundamentally changing how the health-care system operates, said Drew Altman, head of the nonpartisan Kaiser Family Foundation.” [*Washington Post*, “Health bills too timid on cutting costs, experts say,” November 4, 2009]. And respected columnist David Broder wrote: “While the CBO said that both the House-passed bill and the one Reid has drafted meet Obama's test by being budget-neutral, every expert I have talked to says that the public has it right. These bills, as they stand, are budget-busters.” [David Broder, *Washington Post*, “A budget-buster in the making,” November 22, 2009].

The Congressional Budget Office (CBO) estimates that the coverage provisions in the bill will cost \$848 billion over 10 years (FYs 2010-2019). However, the bill includes several budget gimmicks that hide the real cost of the legislation. The major provisions in the bill would not take effect until January 1, 2014, meaning the bill uses 10 years of revenue to pay for six years of coverage.² Republican staff on the Senate Budget Committee estimates that the total spending in the bill over 10 years of full implementation (FYs 2014-2023) would exceed \$2.5 trillion.³ Additionally, the bill assumes that doctors providing services to Medicare beneficiaries will receive a 23 percent payment cut in 2011, which would continue into subsequent years.⁴ CBO scored the bill brought to the Senate floor to eliminate this cut as costing \$247 billion.⁵ Moreover, the Community Living Assistance Services and Supports (CLASS) Act included in the bill generates \$72 billion over the 10-year budget window, but later turns to deficits. For this reason, Senate Budget Committee Chairman Senator Conrad called the CLASS Act “a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of.”⁶



To pay for the expansion of insurance coverage, the bill increases taxes by \$493.6 billion, and reduces Medicare spending by \$464.6 billion.⁷ Specifically, the bill would cut \$134.9 billion

² While the bill includes some provisions that will take effect immediately, such as increased funding to high-risk pools, they will not significantly reduce the number of uninsured or reform the insurance markets.

³ Senator Judd Gregg, Ranking Member, Senate Budget Committee, “The Facts on the Senate Democrats’ Health Care Reform Bill,” November 19, 2009. Available at: <http://budget.senate.gov/republican/pressarchive/2009-11-19HealthCareFactSheet.pdf>.

⁴ The bill provides physicians with only a one-year 0.5 percent update.

⁵ CBO score of S. 1776. Available at: <http://www.cbo.gov/ftpdocs/106xx/doc10674/s1776GreggLtr.pdf>.

⁶ *Washington Post*, “Proposed long-term insurance program raises questions,” October 27, 2009. The Community Living Assistance Services and Supports (CLASS) Act creates a new federal long-term care insurance program that provides cash benefits to purchase non-medical services.

⁷ Despite current unfunded liabilities of more than \$37 trillion over 75 years, the bill cuts Medicare by half a trillion dollars to fund yet another entitlement program rather than strengthening Medicare. The Administration’s chief health actuary called these Medicare cuts “unrealistic” and “unlikely to be sustainable on a permanent annual basis.”

from hospitals, \$120 billion from Medicare Advantage (MA), \$14.6 billion from nursing homes, \$42.1 billion from home health agencies, and \$7.7 billion from hospices.

Among the more prominent taxes, the bill includes a new 40 percent excise tax on health insurance plans that exceed \$8,500 for individuals and \$23,000 for families, raising \$149.1 billion over 10 years; a new Medicare payroll tax on higher-income individuals that raises \$53.8 billion; a \$60.4 billion tax on health insurers; a \$22.2 billion tax on drug manufacturers; and a \$19.3 billion tax on medical device manufacturers. The bill also includes new taxes on individuals without, and employers who do not offer, qualified health insurance.

H.R. 3590 mandates that all lawful residents purchase qualified insurance coverage or pay a penalty. The penalty for not having qualified health insurance would be \$750, phased in over three years beginning in 2014. The bill would provide tax credits for individuals between 133 and 400 percent of the federal poverty level (FPL)—\$29,330 to \$88,000 for a family of four—to help them purchase insurance coverage. Credits would be available on a sliding scale based on income. Individuals would be required to purchase insurance through newly created state Health Benefit Exchanges in order to get a subsidy. A government-run plan (or “public option”) would be available through the exchange unless a state passes a law opting out of the government plan. CBO has said that the government plan in the bill, which would have to negotiate provider rates, would have premiums higher than plans offered by private providers.⁸

While much of the focus of health care reform has been on “affordability,” CBO estimates that premiums for individuals without employer-sponsored coverage would increase 10 to 13 percent (or \$2,100 per family) under the bill.⁹ CBO estimates that only 19 million people will receive a subsidy to help them afford this health insurance. H.R. 3590 therefore requires nearly 14 million Americans to purchase unsubsidized insurance that is more expensive than they could get under current law. For small businesses and larger employers, CBO concludes that the bill does little, if anything, to control increases in health insurance costs.¹⁰ None of the 162 million individuals who CBO estimates will have employer-based coverage in 2019 will be eligible for a subsidy to help them afford insurance coverage. Additionally, the rating restrictions in the bill will result in higher premiums for many young and healthy Americans.¹¹

Because of the bill’s severe cuts to Medicare, “providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and might end their participation in the program (possibly jeopardizing access to care for beneficiaries).” Richard Foster, Department of Health and Human Services, Estimated Financial Effects of the “America’s Affordable Health Choices Act of 2009” (H.R. 3962), as Passed by the House on November 7, 2009. Available at: http://republicans.waysandmeans.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_H_R_3962_11-13-09.pdf

⁸ CBO score of the Patient Protection and Affordable Care Act, November 18, 2009. Available at: http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf.

⁹ CBO Letter to Senator Evan Bayh, November 30, 2009.

¹⁰ According to CBO, premiums for small businesses could increase by one percent or be reduced by up to two percent. CBO expects that, with the bill, the average plan in 2016 in the small group market will cost \$7,800 for an individual or \$19,200 for a family. Premiums for large employers could remain unchanged or decline up to three percent. The cost of the average policy in the large group market would be \$7,300 for an individual or \$20,100 for a family.

¹¹ Testimony of Commissioner Sandy Praeger, State of Kansas, on behalf of The National Association of Insurance Commissioners before the Committee on Health, Education, Labor and Pensions, United States Senate, “Increasing Health Costs Facing Small Businesses,” November 3, 2009.

The bill would create a tax on employers with more than 50 full time workers if their employees receive a subsidy through the exchange. This so-called “free rider” mandate would increase taxes on employers by \$28 billion. Even with this penalty, CBO estimates that five million Americans would lose their employer coverage under the bill. CBO also has confirmed that these new taxes will ultimately be paid by workers—particularly low-income workers—through reduced wages and lost jobs.¹²

Medicaid would be expanded to cover all individuals up to 133 percent of the FPL, which would increase the number of individuals covered under the program by more than 40 percent.¹³ While the federal government absorbs more than 90 percent of the costs of this expansion, the bill still creates a huge new unfunded mandate on the states by requiring that states spend an additional \$25 billion for their share of the expansion. Additionally, the bill would do little to resolve the problem of limited provider participation in Medicaid caused by the low reimbursement rates to physicians.

The bill would extend to the individual market many of the protections currently applicable to the employer market.¹⁴ The bill provides that guaranteed issue and guaranteed renewal rules would be imposed on all individual and small group health insurance plans, and the use of exclusions for pre-existing conditions would be prohibited. Federal rating rules would limit the amount that insurers could charge individuals based on their age but would continue to allow other factors such as tobacco use and geography. The bill would eliminate lifetime limits and “unreasonable” annual limits on coverage and would cap out of pocket expenses to the levels in effect for Health Savings Accounts (HSAs). It would expand access to preventive services and includes a number of new public health programs. Dependent coverage would be extended to cover “children” up to age 26.

While much of the debate surrounding health care reform has focused on “bending the cost curve” to reduce federal spending on health care, in its analysis of the Reid bill CBO concluded that “federal outlays for health care would increase during the 2010-19 period, as would the federal budgetary commitment to health care.”¹⁵ (emphasis added). Federal outlays and the federal budget commitment for health care would increase over 2010-2019 by a net amount of about \$160 billion. After 2019, the bill leaves the cost curve unchanged as CBO expects that in the decade following the 10-year budget window, the increases and decreases in the federal budgetary commitment to health care resulting from the Reid bill would “roughly balance out.” However, CBO cautioned, “These longer-term calculations of budgetary savings assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation.”¹⁶

¹² CBO, “Effects of Changes to the Health Insurance System on Labor Markets,” July 13, 2009.

<http://www.cbo.gov/ftpdocs/104xx/doc10435/07-13-HealthCareAndLaborMarkets.pdf>

¹³ According to CBO, Medicaid currently is projected to cover 35 million Americans in 2019, and 15 million more Americans will be covered in that year under the bill. 133 percent of the FPL currently is \$14,403 for an individual and \$29,330 for a family of four.

¹⁴ Currently, insurers in the individual market “underwrite” policies to determine the risk, and appropriate cost, of insuring an individual based on his or her health status. In contrast, the employer market, with a few exceptions, does not allow employers to charge individuals based on health status or to deny people coverage for pre-existing conditions.

¹⁵ CBO score of the Patient Protection and Affordable Care Act, November 18, 2009.

¹⁶ CBO score of the Patient Protection and Affordable Care Act, November 18, 2009.

The bill includes many provisions that purport to improve the delivery system. However, most of these are demonstration projects or otherwise limited in scope.¹⁷ These include expanded value-based purchasing, voluntary accountable care organizations with shared savings, and a voluntary bundled payment pilot program.¹⁸ The bill also includes more controversial provisions, including expanded comparative effectiveness research and a new Medicare Advisory Board that will have the authority to make cuts to Medicare that will go into effect immediately in the absence of intervening congressional action. Supporters say these policies are necessary to ensure that we promote only the most effective medical procedures and interventions. Critics of these proposals believe they give unaccountable bureaucrats too much power over what treatments Americans will receive.

Major Provisions

Insurance Market Reforms: All legal American residents would be required to enroll in a health care plan that meets a defined minimum benefit level. The bill would impose guaranteed issue and guaranteed renewal rules on all individual and small group health insurance plans (groups from 1-100, with an option for states to limit it to 1-50 until 2016),¹⁹ and prohibit exclusions for preexisting conditions. Federal rating rules would mean carriers could only vary premiums based on age (3:1), geographic area, tobacco use (1.5:1), and family composition (3:1).²⁰ The proposed effective date for the reforms is January 1, 2014, which is a full year later than the original Finance Committee bill and the House bill. Existing policies purchased in the individual market would be “grandfathered” (so that they would not have to conform to new rules), but tax credits would not be available to individuals enrolled in these plans.²¹

The permissible age rating variation has been significantly reduced in this bill from the earlier Finance Committee bill. The Reid bill only allows insurers to vary the rate they charge young enrollees as compared to older enrollees by a 3:1 margin. This means that young and healthy people will be forced to pay higher premiums to subsidize the cost of older and sicker people.²²

¹⁷ This is why many experts question whether the legislation truly will do enough to bend the cost curve. For example Jeffrey Flier, Dean of the Harvard Medical School, wrote in the *Wall Street Journal*: “In discussions with dozens of health-care leaders and economists, I find near unanimity of opinion that, whatever its shape, the final legislation that will emerge from Congress will markedly accelerate national health-care spending rather than restrain it. Likewise, nearly all agree that the legislation would do little or nothing to improve quality or change health-care's dysfunctional delivery system.” *Wall Street Journal*, “Health ‘Reform’ Gets a Failing Grade,” November 18, 2009.

¹⁸ Most of the “reforms” put in place to reduce spending are simply reductions in market-basket payment updates to providers. The bill incorporates a productivity adjustment into the update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities and implements additional reductions for certain providers.

¹⁹ Beginning in 2017, states have the option to expand their exchange to allow the participation of employers with more than 100 employees.

²⁰ So, for instance, premiums paid by the oldest adults could be three times the rate paid by the youngest.

²¹ CBO estimated that “relatively few non-group policies would remain grandfathered by 2016.” CBO Letter to Senator Bayh, November 30, 2009.

²² *USA Today* wrote in an editorial: “The young have already been handed crippling government debts and obligations, driven largely by retiree benefit programs such as Medicare and Social Security. They pay hefty payroll taxes to support those programs. It would be unfair to order them to shoulder the burden of supporting near-retirees as well.” *USA Today*, “Our view on health care: Don’t soak the young in pricing medical coverage,” October 23, 2009.

A 5:1 age rating with a 7.5:1 total variation, as proposed in the original Finance Committee bill, more accurately reflects the higher costs of insuring older individuals.²³

The bill includes a new provision that requires the Secretary of Health and Human Services (HHS) and the states to establish a process to review “unreasonable” annual rate increases for health insurance premiums. A state can then recommend that a particular insurer not be allowed to participate in the state’s exchange if there is a “pattern or practice of excessive or unjustified premium increases.” The bill also sets limits on medical loss ratios—the percentage of premiums paid to claims costs as compared to other expenses. The bill would require insurers to provide a rebate to enrollees if the amount paid for non-claims costs exceeds 20 percent in the group market or 25 percent in the individual market.

Individual Mandate: Beginning in 2013, individuals would be required to purchase insurance coverage equivalent to a bronze plan in the individual or small group market, or an employer-provided plan that meets certain requirements.²⁴ Exemptions would be permitted on religious grounds and for undocumented immigrants. Individuals must attest to coverage on their tax returns, and insurers must report information on their enrollees to the IRS. An exemption from the mandate applies if the premiums for the lowest-cost plan available exceed eight percent of income (which is deemed “unaffordable” coverage) and for individuals below 100 percent of the FPL. The penalty would be \$750 per adult with a maximum of three times the individual penalty per family. The mandate phases in according to the following schedule: In year 2014, \$95; 2015, \$350; 2016 and after, \$750.²⁵ The penalty is indexed to cost of living, not premium inflation, so that the penalty will become smaller relative to the cost of insurance over time, thereby weakening the incentive to purchase insurance. Failure to pay the penalty would not result in criminal penalties.²⁶

CBO estimates that penalties paid by uninsured individuals would total \$8 billion from FY 2010 to 2019. The Joint Tax Committee has said that this tax will fall predominantly on individuals and families earning less than \$250,000 per year, contradicting President Obama’s pledge not to increase taxes on these people.²⁷

Benefit Requirements: Within six months of enactment, all health insurance plans offered on the individual and small group market would be required to cover a list of “essential health benefits,” including emergency services, hospitalization, physician services, outpatient services, maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, and mental health and substance abuse services. The essential health benefits should be equal in scope to typical employer plans, as certified by actuaries for the Centers for Medicare and Medicaid Services (CMS). Plans could not charge cost-sharing (e.g.,

²³ The House bill uses a 2:1 age variation, which magnifies this concern even more.

²⁴ Medicare, Medicaid, SCHIP, TRICARE, VA, and grandfathered plans would also meet the coverage requirement.

²⁵ Many commentators believe this mandate is too weak to provide a sufficient incentive to encourage young and healthy individuals to enroll in insurance. Harvard economics professor Martin Feldstein wrote that “the levels of these fines are generally too low to cause a rational individual to insure.” The result could be a “spiral” of rising premiums and an increasing number of uninsured. Martin Feldstein, *Washington Post*, “Obamacare’s Nasty Surprise,” November 6, 2009.

²⁶ The House bill and earlier versions of the Senate bill would allow for criminal penalties and even jail time for intentional failure to pay the mandate.

²⁷ For example, in remarks in Dover, New Hampshire, September 12, 2008.

deductibles, copayments) for preventive care services rated A or B by the U.S. Preventive Services Taskforce (USPSTF).²⁸

Additionally, plans are prohibited from imposing lifetime limits on benefits or “unreasonable” annual limits. (This provision is effective six months after enactment). Small group health plans could not charge out of pocket cost-sharing beyond \$2,000 for an individual or \$4,000 for a family. Individual market plans could not charge cost-sharing greater than the HSA limit (\$5,950 for an individual and \$11,900 for a family) indexed to premium growth. No waiting period of more than 90 days would be permitted. Dependent coverage would be required up to age 26. Rescissions would be prohibited except in the case of fraud or intentional misrepresentation of a material fact. The bill also includes a number of provisions intended to improve transparency and quality through increased and more uniform reporting requirements.

Health Insurance Exchange: By 2014, states would be required to establish an American Health Benefit Exchange for the individual and small group markets. Insurers operating in the state would be required to participate in the exchange, although private insurers could sell policies directly to consumers as well. Individuals could only receive tax credits if they purchase coverage through the exchange. Plans sold inside and outside the exchange must share the same risk pool. The exchange must, among other things, certify plans for participation in the exchange; operate a toll-free telephone line; maintain a Web site with comparative information; rate each plan based on quality and price; and provide a calculator to assist people in determining if they are eligible for a subsidy.

The exchange is more regulatory than an earlier version in the Finance Committee. The bill provides the exchange authority to exclude plans and leverage to dictate prices. For example, an exchange administrator could refuse to let a plan offer coverage in the exchange if it is “in the interests” of qualified individuals or employers. This “best interest” standard is left undefined, giving the exchange great discretion to include or exclude plans.²⁹ The bill also includes a new requirement that plans must submit a justification for any premium increase prior to implementation of the increase.

State mandates that exceed federal requirements would not apply inside the exchange unless the state agrees to reimburse for their cost. State mandates would continue to apply to coverage offered outside of the exchange. Members of Congress would be required to obtain coverage through the exchange—they would not be required to enroll in a government-run plan as required by the HELP Committee bill. Regional or interstate exchanges would be permitted if states agreed by mutual consent. Stand alone dental plans would also be offered on the exchange.

²⁸ This provision became controversial when the USPSTF recommended against annual mammogram screenings for most women under 50. Section 2713 of the bill would require every health plan to cover, without cost-sharing, USPSTF-recommended prevention services. That provision directly links coverage decisions made by the USPSTF and the care Americans will receive.

²⁹ For example, if a state determined that having only a government-run option offered through the exchange was “in the interests” of its citizens, this language would appear to make it permissible for the exchange to exclude all private plans.

The bill proposes four actuarial levels³⁰ of benefits that can be offered through the exchange based on the actuarial value of the plan (which represents the share of annual health expenses paid by the plan).³¹ The bronze plan would represent the lowest actuarial value plan that would meet the mandate requirement. In order to participate in the exchange, health insurers must offer at least a gold and silver plan. The levels are:

- Platinum: (90 percent actuarial value)
- Gold: (80 percent)
- Silver: (70 percent)
- Bronze: (60 percent)

In addition, a lower cost catastrophic plan would be available only to individuals under age 30 or those who are exempt from the mandate because of affordability, and only in the individual market. It would provide essential coverage when an individual reached the cost-sharing limit, and three primary care visits would be available at no cost.

Tax Credits/Subsidies: Beginning January 1, 2014, the bill proposes refundable tax credits to individuals with a Modified Adjusted Gross Income up to 400 percent FPL, with the amount of the credit tied to both premium levels and income. (In 2009, the FPL is \$22,050 for a family of four.) Credits would be available on a sliding scale basis so that an individual would have to pay no more than 9.8 percent of his or her income for premiums.³² An employee eligible for employer coverage can get a subsidy through the exchange only if the employer coverage is less than 60 percent actuarial value or if the premium exceeds 9.8 percent of the employee's household income.

The credits would be tied to the silver plan and based on the income of the individual. The exchange credits would equal the difference between the premium for the reference plan and a specified share of the taxpayer's income. Out of pocket maximums (based on the HSA limit of \$5,950 for individuals and \$11,900 for families) would be reduced by two-thirds for those between 100 and 200 percent FPL, by one-half for those between 200-300 percent FPL, and by one-third for those between 300-400 percent FPL. CBO estimates that the costs of the subsidies in the exchange would grow at a full eight percent a year. CBO estimates that the IRS would need an additional \$5 billion-\$10 billion to implement the provisions in the bill.³³ CBO also

³⁰ "Actuarial value" refers to the percentage of the average expected medical costs that a plan will cover. A plan with a 60 percent actuarial value will cover, on average, 60 percent of an enrollee's costs. However, if a person has unexpectedly high costs because of a serious illness, the plan would cover a significantly higher percentage of an enrollee's costs.

³¹ As a point of reference, according to the Congressional Research Service (CRS) the Blue Cross Blue Shield Standard Option in FEHB pays for 87 percent of health expenses. Medicaid for children pays 100 percent.

³² This amount would also be on a sliding scale, with those at the lower end paying no more than 2.8 percent of their income for premiums. Note that this amount is for premiums only; it does not include cost sharing. CBO showed that, when including cost-sharing, individuals could still be required to contribute a significant portion of their income. For example, CBO determined that, "A family of four with income of about \$54,000 (also 225 percent of the FPL in 2016) could expect to pay about 17 percent of its income for premiums and cost sharing for the reference plan." CBO, Letter to Harry Reid, November 20, 2009.

³³ Illegal immigrants are not eligible for tax credits. The person's name, Social Security number, and date of birth must be verified by the Social Security Administration. Critics of this verification provision argue that this provision only verifies that the offered Social Security number is valid, not that the number belongs to the person applying for the benefit. They argue that more stringent enforcement mechanisms would be necessary to prevent illegal aliens from receiving benefits.

estimates that these subsidies will cost \$447 billion over 10 years, and that 19 million people will receive a subsidy to help them buy health insurance.

Employer Mandate: All employers with more than 50 employees that do not offer coverage would be required to pay a “free rider” tax for each employee who receives a tax credit for health insurance through a state exchange. Individuals are eligible for a subsidy through the exchange if they earn less than 400 percent FPL and they do not have an affordable offer of employer coverage (an offer that covers more than 60 percent of the actuarial value of the plan and that has premiums below 9.8 percent of their income).

The free-rider penalty works differently depending on whether the employer offers coverage. If an employer has more than 50 full-time employees (FTE), does not offer coverage, and has at least one FTE getting credit, then the penalty is \$750 per FTE.

If the employer has more than 50 full-time employees, offers coverage, and has at least one FTE getting a subsidy in the exchange, the employer pays the lesser of \$3,000 for each of those employees receiving a credit or \$750 for each of their total full-time employees.

Although the surcharges would be imposed on the firms, workers in those firms would ultimately bear the burden of those fees. As a result, the effects of an employer surcharge could be concentrated among workers whose wages could not easily adjust to absorb its full cost. Specifically, CBO said about the impacts of a “free-rider” penalty: “[T]he employment loss would be concentrated disproportionately among low-income workers who employers expected would be more likely to obtain subsidies from the government (for example, unmarried individuals who do not receive family coverage through a spouse’s job).”³⁴ CBO estimates that taxes on employers from this “free-rider” penalty would total \$28 billion over FYs 2010-2019. Even with the “free-rider” penalty, CBO estimates that five million individuals would lose their employer-sponsored coverage. Many experts believe that this number severely underestimates the impacts and that a significant number of employers will decide to drop coverage.

Government-Run Plan: Starting January 1, 2014, a government-run plan would be available through the exchange. States would have the option of not participating in (“opting out” of) the plan. Even with the opt-out, CBO estimates that two-thirds of Americans are expected to have a government plan available in their state. The plan would be administered by the Secretary of HHS. The plan would negotiate rates with providers, and physicians would not have to participate as a condition of participation in Medicare. The government would provide start-up funds, but the plan would have to pay these back within nine years and charge premiums that cover costs.

CBO estimates that total enrollment in the plan would be three million to four million. According to CBO, the government-run plan “would typically have premiums that were somewhat higher than the average premiums for the private plans in the exchanges.”³⁵ This is because of adverse risk selection and the failure of a government-run plan to effectively manage utilization.

³⁴ CBO, “Effects of Changes to the Health Insurance System on Labor Markets,” July 13, 2009. <http://www.cbo.gov/ftpdocs/104xx/doc10435/07-13-HealthCareAndLaborMarkets.pdf>

³⁵ CBO score of the Patient Protection and Affordable Care Act, November 18, 2009.

Co-Ops: The bill authorizes \$6 billion to fund Consumer Operated and Oriented Plans (co-ops) in the individual and small group markets. Federal loans would be provided to assist with start-up costs, while grants would be used to ensure the co-ops could meet state solvency requirements. CBO has said that the provisions on co-ops have “very little effect” on enrollment because “they seem unlikely to establish a significant market presence in many areas of the country.” For that reason, CBO estimates that only \$3 billion of the \$6 billion available to co-ops would be spent over the 2010-2019 period.³⁶

Cuts to Medicare Advantage: The bill includes a new competitive bidding program that will cut \$120 billion from Medicare Advantage (MA).³⁷ Plans would have to submit bids, and the benchmark paid to plans would be the average of the local plan bids. The benchmarks currently range from about 100 percent to more than 150 percent of local per capita spending in the fee-for-service sector. Plans that bid below the benchmark would receive 100 percent of the difference and must use those funds to reduce cost-sharing or provide other benefits (but could no longer use rebates to subsidize Part B or D premiums). Plans that bid above the benchmark would have to charge the difference to their enrollees. The provision also creates performance bonus payments based on a plan’s level of care coordination and care management and achievement on quality rankings. According to CBO, this change will result in reduced extra benefits, like vision care, free flu shots, and dental coverage.³⁸ Average additional benefits offered by MA plans would drop from \$135 to \$49 per month in 2019. Enrollment in MA plans in 2019 is projected to be 2.6 million lower than under current law.

The bill includes language from an amendment offered by Senator Nelson (Florida) to the Finance Committee bill that grandfathered extra benefits for current MA enrollees in high-cost areas of the country where average plan bids are at or below 75 percent of local fee-for-service costs. The provision would apply to certain MA bidding regions, not to states as a whole. The extra benefits would be reduced by five percent each year beginning in 2013. Additionally, the HHS Secretary would provide “transitional” benefits in 2012 to MA beneficiaries in some areas of the country who would otherwise experience a “significant reduction” in extra benefits. A new provision was added that grants the Secretary the authority to deny MA plan bids if the bid proposes a “significant” increase in cost-sharing or decrease in benefits. The bill includes new bonus payments for coordination of care programs.

Small Business Tax Credits: The bill includes a sliding scale tax credit for small businesses. From 2011 to 2013, a temporary credit would be available for up to 35 percent of employer costs for employers who provide 50 percent of the cost of a health plan. The credit is limited to firms with fewer than 25 workers with wages up to \$40,000. In 2014, the credit would be available only to firms that purchase insurance through the exchange. The full credit would be available to businesses with 10 or fewer workers whose average wages are less than \$20,000, and it would

³⁶ CBO letter to Senator Baucus, October 7, 2009

³⁷ For more details on the impact on MA plans, see CBO, “Comparison of Projected Enrollment in MA Plans and Subsidies for Extra Benefits Not Covered by Medicare Under Current Law and Under the Patient Protection and Affordable Care Act,” November 21, 2009. Available at: http://www.cbo.gov/ftpdocs/107xx/doc10731/Effects_of_PPACA_on_MA_Enrollment_and_Extra_Benefits_Not_Covered_by_Medicare.pdf.

³⁸ This impact would appear to violate President Obama’s pledge that if you like what you have you can keep it, during, among other times, his health care address to Congress on September 9, 2009.

phase out for employers with 25 workers with average wages up to \$40,000. The credit would equal 50 percent of total premium cost for full-time employees. It would only be available to a firm for two years. CBO says this tax credit will cost \$27 billion over 10 years.

Medicaid Expansion: Beginning on January 1, 2014, states must expand eligibility to all children, parents, and childless adults up to 133 percent FPL (\$14,403 for an individual and \$29,326 for a family of four). Between 2014 and 2016, the federal government will pay 100 percent of the cost of covering newly eligible individuals. In 2017 and 2018, the federal share drops to roughly 90 percent.³⁹ States are required to continue their CHIP programs through 2019 at current eligibility levels. The estimated cost to states for their portion of the costs for expansion is \$25 billion.⁴⁰

According to CBO, Medicaid is projected to cover 35 million Americans in 2019, and 15 million more Americans will be covered in that year under the bill—an increase in Medicaid enrollment of more than 40 percent. The Reid bill does not do anything to increase provider payments in Medicaid, even though numerous studies show that Medicaid offers limited access to physicians—particularly specialists—because of low reimbursement rates.⁴¹ CBO estimates the Medicaid expansion will cost \$374 billion.

Comparative Effectiveness Research: Section 6301 of the bill would establish a nonprofit corporation, the Patient Centered Outcomes Research Institute (PCORI), to conduct comparative effectiveness research (CER). PCORI would establish and implement CER priorities and a CER research agenda, and contract with researchers. This institute will replace the Federal Coordinating Council created in the American Recovery and Reinvestment Act of 2009. To pay for these activities, the bill would impose a new \$2 per covered life tax on insurance policies. CBO estimates this would raise \$2.6 billion through 2019.

Opponents of this provision express concern that other governments, like the United Kingdom, use CER to decide which treatments patients can and cannot have. In HELP and Finance Committee markups, Republicans offered amendments to prohibit the government from using CER to make coverage decisions. The amendments failed on party line votes. The bill says that the HHS Secretary may use evidence and findings from CER research “to make a determination regarding coverage” as long as it is done through an open and transparent process.

Medicare Advisory Board: The Medicare Advisory Board would have the authority to set payment updates to Medicare providers and propose other payment reforms, subject to presidential or congressional disapproval. Congress would be required to consider legislation implementing the proposal or alternative proposals with the same budgetary impact on a fast

³⁹ The Reid bill provides \$100 million in additional matching funds for the state of Louisiana.

⁴⁰ The bill also increases the brand-name drug and generic rebate amounts and extends the Medicaid drug rebate to include drugs dispensed to enrollees of Medicaid health plans.

⁴¹ A survey of physicians showed that fewer than 50 percent of specialists accept new Medicaid patients in many major metropolitan areas, including Houston, Dallas, Miami, Washington, New York, and Los Angeles. The survey also found that “Medicaid is not widely accepted in most markets surveyed, in at least some of the medical specialties reviewed, and, in some cases, all of them.” Merritt Hawkins and Associates, “2009 Survey of Physician Appointment Wait Times,” available at: <http://www.merrithawkins.com/pdf/mha2009waittimesurvey.pdf>.

track basis.⁴² The recommendations of the board would go into effect automatically unless blocked by subsequent legislative action. For FYs 2015 through 2019, such recommendations would be required if the Medicare trustees projected that the program's spending per beneficiary would grow more rapidly than a measure of inflation (the average of the growth rates of the consumer price index for medical services and the overall index for all urban consumers). After 2019, recommendations would be required if projected growth exceeded the rate of increase in national health expenditures per capita. The board would develop its first set of recommendations during 2013 for implementation in 2015.

CBO said that, because language was inserted to protect agreements with various special interests in the health care industry, the board would target reductions in subsidies for benefits offered by MA plans and Part D plans.⁴³ While the policies considered by the board are not supposed to include proposals that would increase beneficiary costs, this would appear to contradict that requirement. CBO estimates that the provision would reduce Medicare spending by an additional \$23.4 billion from 2015 to 2019.

CLASS Act: The Community Living Assistance Services and Supports (CLASS) Act creates a new federal long-term care insurance program that provides cash benefits to purchase non-medical services. Eligible enrollees who are unable to perform at least two activities of daily life (such as dressing, bathing, and eating) would receive benefits to pay for support services in a community setting. Severely impaired enrollees could apply their benefit toward the cost of residential care in a nursing facility.

CBO estimates that the average monthly premium in 2011 would be about \$123 (premiums for new enrollees would increase with inflation in later years), and enrollment in the program would be slightly less than 10 million people by 2019 (or about 3.5 percent of the adult population).

The CBO and the Administration's chief health actuaries have both said that this act will run significant budget shortfalls outside the 10-year budget window. CBO wrote that under the current benefit structure, "the program would add to future federal budget deficits in large and growing fashion."⁴⁴ This is true even though the proposals require the Secretary of HHS to set premiums to ensure the program's solvency for 75 years. The Chief Actuary of HHS also said that the program faces "a significant risk of failure" because the high costs will attract sicker people and lead to low participation.⁴⁵

⁴² A similar provision was established by the Medicare 45 percent "trigger," which provided a fast track procedure to reduce Medicare spending if general revenues were projected to cover more than 45 percent of overall Medicare costs. Since the trigger was enacted in the Medicare Modernization Act in 2003, Congress has never used the procedures to reduce Medicare spending. If this history is any guide, lawmakers are likely to postpone or avoid cuts proposed by the Medicare Commission on a regular basis.

⁴³ CBO said that the Advisory Board would target "changes to payment rates or methodologies for services furnished in the fee-for-service sector by providers other than hospitals, physicians, hospices, and suppliers of durable medical equipment that is offered through competitive bidding." See CBO score of the Patient Protection and Affordable Care Act, November 18, 2009.

⁴⁴ CBO letter to Senator Hagan, July 6, 2009.

⁴⁵ Richard Foster, Chief Actuary Center for Medicare and Medicaid Services, Estimated Financial Effects of the "America's Affordable Health Choices Act of 2009" (H.R. 3962), as passed by the House on November 7, 2009, November 13, 2009.

Abortion: The bill does not include the House-approved prohibition on abortion funding. The bill authorizes the HHS Secretary to mandate abortion coverage as a medical benefit if the secretary can certify that no federal funds will pay for abortion coverage. The bill requires each exchange to offer a plan that covers elective abortions and one that does not cover elective abortions. In cases where a plan covers elective abortions, the bill prohibits tax credits or cost sharing to pay for abortion coverage by requiring funds to be segregated. However, money is fungible and it is not possible to ensure that no federal funds will pay for abortion coverage unless the money for abortion coverage is collected in a separate account and the services covered by a separate plan, as is done under Medicaid. Because it includes no such provision, this bill would arguably allow for federal funds to pay for plans that cover abortions.

The bill provides that state laws on abortion coverage are not preempted. However, it also requires each exchange to offer a plan that covers abortion, which contradicts the preemption language. The bill also includes a conscience clause that prohibits discrimination against providers who are unwilling and *willing* to offer abortions. This could require providers and health plans to contract with abortion providers and contradicts current law, which protects only unwilling providers. And the bill requires plans offered in the exchange to include abortion providers in their provider networks. This requirement would force insurers to contract with abortion providers, even if the insurer objects to abortion.

The U.S. Conference of Catholic Bishops strongly opposes the language in the bill. The Bishops wrote in a letter to Senator Reid: “Specifically, it violates the longstanding federal policy against the use of federal funds for elective abortions and health plans that include such abortions - a policy upheld in all health programs covered by the Hyde Amendment, the Children’s Health Insurance Program, the Federal Employee Health Benefits Program - and now in the House-passed “Affordable Health Care for America Act.” We believe legislation that violates this moral principle is not true health care reform and must be amended to reflect it. If that fails, the current legislation should be opposed.”⁴⁶

Workplace Wellness: The bill includes a provision expanding the ability of businesses to offer incentives to employees for participating in wellness activities and meeting healthy behavior targets. The bill would codify the existing regulations and expand the reward allowed for meeting wellness targets to 30 percent (from 20 percent) of the employee’s premiums.

Medical Liability Reform: The bill includes only a Sense of the Senate on medical liability reform. This is despite statements by the president about the importance of medical liability reform and a CBO report finding that reforms could reduce federal budget deficits by \$54 billion over the next 10 years.

Taxes

H.R. 3590 includes almost a half trillion dollars in new taxes, fees, and penalties on individuals and businesses. In addition, the bill provides approximately \$447 billion in advance, refundable tax credits to pay for health insurance. Below is a brief description of these tax increases and the tax credit for health insurance.

⁴⁶ United States Conference of Catholic Bishops, Letter to Senator Harry Reid, November 20, 2009.

Tax Increases on Individuals and Workers:

High Cost Plan Tax – Health insurance plans that exceed \$8,500 for individuals and \$23,000 for families would be subject to a 40 percent excise tax payable by insurance companies or administrators of a self-insured arrangement. The 17 highest cost states (determined by HHS and the Treasury Department in 2012) would receive a higher threshold for three years. The limit for retirees and workers in “high risk professions” and workers who repair or install electrical or telephone lines would also be higher (\$9,850 for single and \$26,000 for family plans). The tax would be effective January 1, 2013 and would raise \$149.1 billion through 2019.

“Medicare AMT” Payroll Tax – Increases the Hospital Insurance (HI) payroll tax rate on wages in excess of \$200,000 for an individual and \$250,000 for a married couple from 1.45 percent to 1.95 percent. This expansion of the Medicare payroll tax would be a major break from past practice by using dedicated Medicare taxes to pay for non-Medicare programs. And because the income thresholds are not indexed for inflation, this new tax will hit more and more Americans each year as inflation drives up their wages. The tax would be effective January 1, 2013, and would raise \$53.8 billion through 2019.

Itemized Medical Expense Deduction – A taxpayer would no longer be able to deduct medical expenses that exceed 7.5 percent of adjusted gross income. Instead, the income threshold would be raised to 10 percent. Taxpayers 65 or older, however, can continue to use the current 7.5 percent threshold, but only through 2016. The tax would be effective January 1, 2013, and would raise \$15.2 billion through 2019.

\$2,500 Cap on FSAs – Contributions to a health Flexible Spending Arrangement (FSA) would be limited to \$2,500 per year. The limit is not indexed. The tax would be effective January 1, 2011, and would raise \$14.6 billion through 2019.

Excise Tax on Cosmetic Surgery – Imposes a five percent excise tax on cosmetic surgery or other similar procedures. The tax would be effective January 1, 2010, and would raise \$5.8 billion through 2019.

Over-the-Counter Medicine – The cost of over-the-counter medicine (other than doctor prescribed medicine) may no longer be reimbursed through an FSA, a Health Reimbursement Arrangement, or an HSA tax-free. The tax would be effective January 1, 2011, and would raise \$5 billion through 2019.

Nonqualified HSA Distribution – The penalty for distributions from an HSA that are not used for qualified medical expenses prior to age 65 would be increased from 10 percent to 20 percent. The tax would be effective January 1, 2011, and would raise \$1.3 billion through 2019.

Fees on Health Care Industry:

Fees on Health Insurers – An annual fee of \$6.7 billion would be imposed on health insurance companies. An employer self-insuring its employees’ medical claims would be exempt from the fee, but insurance companies administering a self-insured arrangement on behalf of employers

would be subject to the fee. The fee would be effective January 1, 2010, and would raise \$60.4 billion through 2019.

Fees on Drug Manufacturers – An annual fee of \$2.2 billion would be imposed on manufacturers of prescription drugs. The fee would be effective January 1, 2010, and would raise \$22.2 billion through 2019.

Fees on Medical Device Manufacturers – An annual fee of \$2 billion would be imposed on manufacturers of medical devices. The fee would be effective January 1, 2010, and would raise \$19.3 billion through 2019.

Fees on Insurance Plans for Comparative Effectiveness Research Trust Fund – A fee would be imposed on health insurance policies and on health care coverage provided under a self-insured arrangement to fund research on comparative effectiveness. The fee would be effective October 1, 2012, and would raise \$2.6 billion through 2019.

Tax Increases on Businesses:

Corporate Information Reporting – Businesses paying \$600 or more during the year to corporate providers of products and services would be required to file a report with each provider and the IRS. Information reporting already is required on payments for services to non-corporate providers. The requirement would be effective January 1, 2012, and is expected to raise \$17 billion through 2019.

Elimination of Deduction for Expenses Attributable to Part D Subsidy – Currently, the subsidy for an employer sponsoring a prescription drug plan under Medicare Part D is excludable from income and expenses related to the subsidies are deductible as a business expense. Under the bill, the amount otherwise deductible for retiree prescription drug expenses is reduced by the amount of the excludable subsidy. The proposal would be effective January 1, 2011, and would raise \$5.4 billion through 2019.

Limitation on Deduction of Compensation Paid By Insurance Companies – Health insurance companies would be prohibited from deducting compensation in excess of \$500,000 paid to officers, employees, directors, and service providers (e.g., consultants). The prohibition would be effective January 1, 2013, and would raise \$600 million through 2019.

Deny Deduction for Certain Blue Cross/Blue Shield Organizations – Blue Cross/Blue Shield and other qualifying organizations would lose special deductions for certain claims and expenses unless the organizations spend at least 85 percent of their premium income on clinical services provided to policyholders. The policy would be effective January 1, 2010, and would raise \$400 million through 2019.

Summary of Tax Provisions (in billions of dollars)

	H.R. 3590
Cadillac plan tax	149.1
Employer W-2 reporting of health benefits	Negligible
Conform definition of medical expenses	5
Increase penalty for nonqualified HSA deductions	1.3
Limit FSAs to \$2,500	14.6
Corporate information reporting	17.1
Requirements for non-profit hospitals	Negligible
Pharma fee, effective 2010	22.2
Device manufacturer fee, effective 2010	19.3
Health insurer fee, effective 2010	60.4
Eliminate subsidy related to Part D	5.4
Raise 7.5 percent AGI floor to 10 percent	15.2
\$500k deduction cap on pay for health insurers	0.6
HI payroll tax over \$200k single/\$250k married	53.8
Section 833 treatment of Blue Cross/Blue Shield	0.4
Cosmetic surgery tax	5.8
Comparative effectiveness trust fund fee	2.6
Individual and employer mandate penalties	36
Effects of coverage provisions on revenues	70
Other changes in revenue	14.8
TOTAL	\$493.6 billion

Other Noteworthy Provisions

Risk Adjustment and Reinsurance: A system of risk adjustment would be established by the Secretary of HHS that would apply to all plans in the individual and small group market. Additionally, all private health insurers would be required to pay a broad-based fee of \$25 billion to a non-profit reinsurance entity from 2014-2016. Risk corridors modeled after the Part D program would be established for the individual and small group markets for plans choosing to participate and would be in effect for three years.

Reinsurance for Retirees: \$5 billion is appropriated to subsidize high-cost claims for employer-sponsored retiree coverage for people between ages 55 and 64. The program reimburses participating employment-based plans for 80 percent of the cost of benefits that exceed \$15,000 but are below \$90,000. A plan is eligible if it implements programs to save costs for individuals with chronic diseases and high-cost conditions.

Interstate Compacts for the Purchase of Insurance: The National Association of Insurance Commissioners would be required to establish model rules for “health care choice compacts” to

provide for the purchase of insurance across state lines between states participating in the compact. National plans with uniform benefit packages that meet the benefit requirements for plans sold in the exchange could sell across state lines, but they must offer plans in at least 60 percent of states in the first year and 80 percent by the fifth year. Critics argue that this would largely reflect current law and would have little impact.

Temporary Expansion of High-Risk Pools: The bill provides \$5 billion total until 2014 to subsidize high-risk pools until the new insurance exchanges are operational. It is unlikely that this amount will be sufficient to cover the expected cost. The *Associated Press* reported that this “new federal fund to provide temporary coverage for people with health problems would quickly run out of cash. ... [T]he budget office estimates that the money would be used up before the end of 2011.”⁴⁷

State Option for Basic Health Plan: States would be permitted to establish a federally funded state plan for people with incomes between 133 and 200 percent of the FPL. States could negotiate with providers for coverage. The funding level would be based on the value of individual tax credits and subsidies that would have otherwise been provided to that state. However, the state would only receive 85 percent of the funds that would otherwise be distributed.⁴⁸

Disclosure of Health Insurer Spending: Beginning in 2010, insurers would be required to report the percentage of premium dollars spent on items other than medical care.

Auto-Enrollment: Employers with more than 200 employees must automatically enroll employees in health coverage.

Disproportionate Share Hospital Payments (DSH): Reduces DSH payments to states by 50 percent if the rate of uninsurance decreases by 45 percent. DSH payments would continue to decrease in proportion to additional reductions in the rate of uninsurance. A state’s allotment could not be reduced by more than 65 percent compared to its FY 2012 allotment.

Increased Coverage in the “Doughnut Hole:” Beginning July 1, 2010, drug manufacturers would be required to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased in the coverage gap. The CBO score shows that the provision, which was part of a deal reached between pharmaceutical companies and the White House, will cost the government \$19.5 billion over 10 years.⁴⁹ This is because the current coverage gap encourages many seniors to switch to less expensive generic medications. This subsidy will encourage more seniors to stay on more expensive brand name medications.

⁴⁷ *Associated Press*, “Gaps for consumers in Democrat health care bills,” November 23, 2009.

⁴⁸ Senator Cantwell introduced this amendment to support programs mirroring the Basic Health plan in her state. However, the *New York Times* reported that premium prices under that program have soared, there is a waiting list for coverage, and the state has pushed as many as 40,000 people off its rolls. *New York Times*: Prescriptions, “Washington’s Way on Health Care (The Other Washington),” October 1, 2009.

⁴⁹ The *New York Times* reported that, “Under the newly proposed plan from Senator Max Baucus, the drug industry’s offer to help Medicare patients save money will end up costing Medicare itself — taxpayers, that is — a lot more money.” *New York Times*, “Baucus Plan: Saving Patients Money Would Cost the Medicare Drug Program Billions,” September 17, 2009.

Means Testing Part D Benefits: The bill will reduce Part D premium subsidies for high-income beneficiaries to mirror the means-testing provisions currently applicable to Part B premiums. CBO estimates this will save \$10.7 billion over 10 years.

Moratorium on Specialty Hospitals: The bill includes a moratorium on building or expanding physician-owned specialty hospitals. Hospitals with a provider agreement in effect as of February 1, 2010, will be grandfathered-in under the policy provided they meet certain requirements.

Follow-on Biologics: This bill provides for an abbreviated approval pathway for follow-on biologics (biological products that are highly similar to or interchangeable with their brand-name counterparts). An application for a biosimilar or interchangeable product could not be approved until 12 years from the date on which the reference product was approved. CBO estimates that this provision would reduce direct spending by an estimated \$7 billion over 2010-2019.

Voluntary Accountable Care Organizations (ACOs): Groups of providers who meet certain statutory requirements could form ACOs that, if they meet benchmarks for quality of care, can receive a share of savings they achieve for the Medicare program.

National pilot program for bundled payments: Creates a five-year voluntary pilot program to encourage hospitals, doctors, and post-acute care providers to implement bundled payment models to coordinate care.

Value-based purchasing program for hospitals: A hospital value-based purchasing program would start in FY 2013 that would tie a percentage of a hospital's reimbursement to performance on quality measures tied to common but high-cost conditions.

Value-Based Modifier for Physician Payment Formula: The Secretary of HHS would be required to apply a separate, budget-neutral payment modifier to the fee-for-service physician payment formula. The payment modifier will pay physicians differentially based upon the relative quality of the care they achieve for Medicare beneficiaries relative to cost.⁵⁰

CMS Innovation Center: The bill would establish a new Center for Medicare and Medicaid Innovation to develop and test innovative payment and delivery system models to improve the quality and reduce the cost of medical care.

Medical Homes: Medical home models would be encouraged under the CMS Innovation Center. The bill would also create a program to establish and fund the development of community health teams to aid in the development of medical homes by promoting community-based care.

Hospital-Acquired Conditions: Hospitals in the top 25th percentile for the acquisition of certain hospital acquired conditions would be subject to a Medicare payment penalty.

⁵⁰ CRS analyzed a similar provision in House legislation and found that, "not all the changes would necessarily be consistent with the principle of rewarding providers who deliver higher quality care." Congressional Research Service, "Evaluation of a Value Index-Based Reform Proposal for Physician Payment," June 17, 2009.

Hospital Disclosure of Charges: Beginning in 2010, hospitals would be required to list standard charges for all services and Medicare diagnostic related groups.

Public Health Programs: The bill includes a number of new public health programs. These include a National Prevention, Health Promotion, and Public Health Council to provide coordination and leadership on public health issues; a number of new public-health prevention education outreach initiatives, and a new CDC national education campaign supporting workplace wellness programs.

Administration Position

The Obama Administration issued a Statement of Administration Policy (SAP) in favor of H.R. 3590. The Administration wrote, “The Senate legislation includes critical reforms to the insurance industry, so that Americans will no longer have to worry that they will be denied coverage, or that their coverage will be dropped or watered down when they need it most. It covers virtually all Americans and ensures that all Americans with health insurance are protected against high, out-of-pocket spending. The Administration is pleased that the bill includes a public health insurance option offered in an Exchange. As the President has said throughout this process, a public option that competes with private insurers is one of the best ways to provide the choice and competition that are so badly needed in today’s market.”⁵¹

Cost

CBO estimates that the coverage provisions in the bill will cost \$848 billion over 10 years (fiscal years 2010-2019). However, the bill includes several budget gimmicks that hide the real cost of the legislation. The major provisions in the bill would not take effect until January 1, 2014, meaning the bill uses 10 years of revenue to pay for six years of coverage. Republican staff on the Senate Budget Committee estimates that the total spending in the bill over 10 years of full implementation (FYs 2014-2023) would exceed \$2.5 trillion.

To pay for the expansion of insurance coverage, the bill increases taxes by \$493.6 billion, and reduces Medicare spending by \$464.6 billion. Specifically, the bill would cut \$134.9 billion from hospitals, \$120 billion from Medicare Advantage (MA), \$14.6 billion from nursing homes, \$42.1 billion from home health agencies, and \$7.7 billion from hospices. Among the more prominent taxes, the bill includes a new 40 percent excise tax on health insurance plans that exceed \$8,500 for individuals and \$23,000 for families, raising \$149.1 billion over 10 years; a new Medicare payroll tax on higher-income individuals that raises \$53.8 billion; a \$60.4 billion tax on health insurers; a \$22.2 billion tax on drug manufacturers; and a \$19.3 billion tax on medical device manufacturers. The bill also includes new taxes on individuals without, and employers who do not offer, qualified health insurance.

⁵¹ Statement of Administration Policy, H.R. 3590 — Patient Protection and Affordable Care Act, November 20, 2009. Available at: http://www.whitehouse.gov/omb/assets/sap_111/saphr3590s_20091120.pdf.