BRYAN CAVE
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Bryan Cave Health Reform Update

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On November 7, the House of Representatives passed the "Affordable Health Care for America Act" (H.R. 3962) by a vote of 220 to 215. Thirty-nine mostly centrist Democrats joined all but one Republican [Rep. Joseph Cao (R-LA)] in opposing the bill. After the House passed its health reform bill, President Obama released a statement urging the Senate to act on its own version of reform legislation as soon as possible in order to get the bill to the President's desk by the end of 2009.

On November 18, Senate Majority Leader Harry Reid (D-NV) unveiled the Senate's bill, the "Patient Protection and Affordable Care Act." The Congressional Budget Office (CBO) has estimated the gross cost of legislation will be $848 billion over 10 years. Due to strong Republican objections, the Senate could not reach an agreement to proceed to debate on the health care reform bill. Therefore, on Thursday, November 19th, Sen. Reid moved to proceed to H.R. 3590 (the legislative vehicle for the health care reform legislation) and then immediately filed cloture on the motion to proceed. Under a unanimous consent agreement, this cloture vote will take place on Saturday, November 21st, at 8 pm. Sixty votes are required to invoke cloture, and it appears that Sen. Reid has 58 committed "yes" votes from the Democratic caucus. Senators Landrieu and Lincoln have yet to publicly declare their intentions on the cloture vote. Virtually the entire Republican caucus has signaled their intention to vote "no" on cloture. Sen. Olympia Snowe (R-ME) has not yet signaled how she will vote. If cloture is invoked, all post-cloture debate time will be yielded back and the motion to proceed will be agreed to. After H.R. 3590 is reported, Sen. Reid will then be recognized to call up the "Patient Protection and Affordable Care Act" as his amendment by number only, which means that the full text of the amendment will not be read. The Senate is expected to begin debate on the full healthcare legislation after the Thanksgiving holiday.

Health Insurance Reforms

Contrary to the fierce opposition launched by the health insurance industry to President Clinton's health reform effort in 1993, the industry has charted a different course this time. Early in the health care debate, health insurers and their main trade associations, America's Health Insurance Plans (AHIP) and Blue Cross Blue Shield Association (BCBSA), insisted that covering the uninsured, improving quality, and implementing reforms to lower the cost of care are necessities. They uniformly endorsed insurance market reforms, including guaranteed issue and provisions to prevent exclusions based on pre-existing conditions and using health status or gender as factors in setting premiums. In return, they stated that health reform legislation must include an effective and enforceable individual mandate for the purchase of insurance to ensure an adequate spreading of risk and to prevent significant premium increases. Both the Senate and House bills include an individual mandate to obtain health coverage, including penalties for noncompliance. Republicans have criticized the individual mandate, saying it would force Americans to either buy insurance or face the prospect of jail and significant monetary penalties. Some have even raised constitutional concerns with a mandate.

However, the amount of the monetary penalties is generally much lower than the cost of insurance. During markup of the Senate Finance Committee bill, the committee adopted provisions that would severely weaken its

mandate. Thus, from the industry's perspective, both the House and Senate bills create a scenario where many individuals will be motivated to wait to buy coverage until they become ill.

In addition to the weakening of the personal responsibility requirement, the health insurance industry is extremely concerned about other provisions in the House and Senate bills that threaten to make coverage much more expensive, particularly for individuals and small employers. These provisions include:

- Setting minimum coverage and benefit requirements at levels above what is typically required in many states today.
- Limiting age discounts, which will significantly increase premiums for younger, healthier people (the House bill includes a 2:1 age rating band; the Senate includes a 3:1 rating band; insurers are calling for a 5:1 ratio).
- Setting a federal minimum loss ratio (MLR) (the House bill includes an 85 percent MLR requirement for all plans; the Senate bill requires public disclosure of MLR and a requirement to pay refunds if MLR is less than 80 percent in the group market and 75 percent in the individual market; it also includes an MLR requirement for some non-profit Blue Cross Blue Shield plans so they can continue to benefit from certain tax treatments).
- Imposing a new $6.7 billion annual insurer fee (included in the Senate bill).

The industry has released data and studies demonstrating the effect of these provisions on premium costs. The White House and Congressional leaders viewed the effort as a hostile act, despite the fact that AHIP, BCBSA, and individual plans maintained their support for reform. Unless the above provisions are changed, and the public plan option (discussed below) is eliminated, the industry is likely to shift from its current official position as an advocate for health reform to the more familiar posture of opposition, although some individual health plans could break with the rest of the industry.

Public Plan Option

Among the most controversial components of Congressional health reform proposals are the various public plan options. Health reform legislation passed by the House would establish a government-run health insurance option available within the national insurance exchange administered by the U.S. Department of Health and Human Services (HHS). The HHS Secretary would negotiate rates for providers that participate in the public option. While the bill would require that the government-run plan must survive on its own premiums, it would provide startup administrative funding. The public option would be required to amortize these costs into future premiums, similar to private plans, to ensure it operates on a level playing field with private insurers.

The Senate bill includes a "Community Health Insurance Option," that includes an "opt-out" provision for states that decide not to participate in that option. The plan, which would be offered through the state insurance exchanges, only would be required to cover "essential" health benefits, which the legislation describes as:

- ambulatory patient services
- emergency services

- hospitalization
- maternity and newborn care
- mental health and substance use disorder services, including behavioral health treatment
- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care.

States would have the option of requiring additional benefits but would be required to defray the costs. Premiums would be set by the HHS Secretary and adjusted geographically. The Secretary also would negotiate provider reimbursement rates, but they could not be higher than the rates paid by qualified private health plans.

All of the Senate's Republicans, including Sen. Olympia Snowe (R-ME), who voted in favor of the Finance Committee bill, oppose including a government-run plan in reform legislation. Several moderate Democrats have expressed doubts about such a plan as well. Sen. Reid said he decided to include a state opt-out plan rather than some other form of a public option, such as a state opt-in approach, because doing so would establish a level of "comfort" within the Democratic caucus. The opt-out approach still has not gained support from several key moderates.

Inclusion of the public plan in the Senate bill increases the likelihood that some form of a public plan option will be included in a final conference report. However, if such a provision cannot survive Senate debate, it is unclear whether the House could pass a conference report without it. As is often the case with major legislation, what is palatable in the Senate becomes the litmus test for compromise in conference.

Employer Mandate

Under the House-passed bill, employers must either provide health insurance to their employees or make a contribution to help fund the purchase of health insurance. Employers that choose to offer coverage must contribute at least 72.5 percent of the premium for workers and 65 percent for families. However, if the coverage is unaffordable for low-wage workers, those workers can choose subsidized coverage in the health insurance exchange, and the employer would be required to make a contribution to the exchange. Employers who do not offer qualified coverage must contribute 8 percent of their payroll to help cover the expenses of employees who seek coverage through the exchange.

The Senate reform bill would require employers with more than 200 employees automatically to enroll new full-time employees in coverage. The bill also contains a "free rider" provision that would require any employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit to make a payment of $750 per full-time employee. Employers who do offer coverage that is deemed unaffordable or do not provide essential coverage will pay the lesser of $3,000 for each of those employees receiving a credit or $750 for each of their full-time employees. This requirement will apply to employers with more than 50 employees and those who have at least one full-time employee receiving the premium assistance tax credit.

Most business associations and employer organizations have opposed an employer mandate, claiming it will lead to reduced salaries and jobs cuts. However, this provision has not been one of the main sticking points for most Members of Congress, and it is expected an employer mandate, at least for "large employers," will be included in the final reform package.

Physicians

Physicians are facing a 21.2 percent reduction in Medicare reimbursements effective January 1, 2010 under the Sustainable Growth Rate (SGR) formula. While the House bill does not address this issue, the House recently passed a separate bill, H.R. 3961, which would rebase the formula and include expenditure targets. The Senate bill includes a provision that would replace the scheduled reduction with a 0.5 percent update for 2010. Republicans have criticized this bill as a *quid pro quo* for the support of the American Medical Association for the reform bills.

The House bill includes a bonus payment system for selected primary care services effective January 1, 2011. The payment incentive would be 5 percent. If the practitioner provides services in an area designated as a primary care health professional shortage area, the bonus would be 10 percent. The provision is budget neutral, which means the bonus money for primary care would be obtained through payment reductions to procedural specialists. The surgeons and other proceduralists have expressed strong opposition to the budget neutrality provision.

Under the Senate bill, primary care practitioners, as well as general surgeons practicing in health professional shortage areas, would receive a 10 percent Medicare payment bonus for 5 years beginning in 2011. Half of the cost of the bonuses would be offset through an across-the-board reduction in all other services.

The House bill addresses the geographic practice cost index (GPCI) by extending the 1.00 floor for 3 years through December 2012. This would address geographic payment problems in low-cost areas. The Senate bill extends the floor on geographic adjustments to the work portion of the fee schedule through the end of 2010, with the effect of increasing practitioner fees in rural areas. The Senate bill also provides immediate relief to areas negatively impacted by the geographic adjustment for practice expenses, and it requires the HHS Secretary to improve the methodology for calculating practice expense adjustments beginning in 2012.

Both the House and Senate bills require the HHS Secretary to establish the medical home demonstration program for the purpose of evaluating Medicare payments to qualified patient-centered medical homes for furnishing medical home services to high-need beneficiaries in urban, rural, and underserved areas. Primary care physicians have strongly supported creation of medical homes. However, they would prefer the language not include the "high-need beneficiaries" provision.

Both the House and Senate bills would require physicians who order durable medical equipment (DME) or home health services for Medicare patients to be Medicare enrolled physicians or eligible professionals. It would also require face-to-face encounters with patients before a physician could certify eligibility for home health services or DME.

Finally, the House bill would modify the current Physician Quality Reporting Initiative (PQRI) to include a feedback program for physicians, integrate PQRI and electronic health record (EHR) reporting, and extend the years of bonus payments. The Senate bill extends PQRI through 2014 and creates an appeals and feedback process for participating professionals in PQRI. Under the Senate bill, beginning in 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced.

Nursing Provisions

The House and Senate health reform bills include several provisions that would impact the nursing community, including increasing loan repayment benefits for nursing students and faculty; incentives for pursuing nursing education; and clarifying that nurse-managed health centers are eligible for grant awards. The Senate bill would make several other improvements, including:

- Loan amounts for the Nursing Student Loan Program will be increased; updates the years for nursing schools to establish and maintain student loan funds .
- A new demonstration program for chronically ill Medicare beneficiaries will test payment incentives and service delivery using physician and nurse practitioner-directed home-based primary care teams.
- A $50 million grant program will support nurse-managed health clinics.
- Advanced nursing education grants for accredited Nurse Midwifery programs.
- Nurse education, practice, and retention grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention.
- Nurse faculty loan program for nurses who pursue careers in nurse education.
- A U.S. Public Health Sciences Track would be established to train physicians, dentists, nurses, physician assistants, mental and behavioral health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in affiliated institutions.
- HHS is directed to establish a demonstration program to increase graduate nurse education training under Medicare; the bill authorizes $50 million to be appropriated from the Medicare Hospital Insurance Trust Fund for each of the fiscal years 2012 through 2015 for such purpose.
- An increase in the payment rate for certified nurse midwives to match those paid to a physician. Under current law, certified nurse midwives are paid 65 percent of what a physician performing a service is paid.

The House bill would remove the cap on awards for nursing students pursuing a doctoral degree and would authorize $638 million over the next five years (FY 2011 – FY 2015) for nursing programs included in the Public Health Investment Fund. It also would expand the Advanced Education Nursing grants to allow schools to provide support to nursing students who agree to practice in underserved areas.

Additional House provisions include:

- Updates to the loan amounts for the Nursing Student Loan program; specifies that after 2012, the HHS Secretary has discretion to adjust this amount appropriately.

- Expands the Nurse Loan Repayment and Scholarship Programs to provide loan repayment for students who serve for a period of not less than two years as a faculty member at an accredited school of nursing.
- Establishes a Public Health Workforce Corps to address public health workforce shortages.
- Recognizes that Advanced Practice Registered Nurses (APRNs) are fundamental to ensuring access to primary care.
- Defines nurse-managed health centers (NMHCs) under the definitions of Title VIII eligible entities. The nurse-managed care model is recognized as a key to efficient, sensible, cost-effective primary health care.
- Creates an alternative pilot payment model within fee-for-service Medicare to reward physician-led organizations that take responsibility for the costs and quality of care received by their patients over time. Establishes that Accountable Care Organizations (ACOs) can include nurse practitioners and physician assistants.
- Directs the HHS Secretary to establish a pilot program to reward physicians and nurse practitioners who make their offices a "medical home" for patients by ensuring patient care is coordinated and comprehensive.
- Requires State Medicaid programs to reimburse primary care services furnished by physicians and other practitioners (including nurse practitioners) at no less than 80 percent of Medicare rates in 2010, 90 percent in 2011, and 100 percent in 2012 and after.
- Directs the Nursing Home Compare Medicare Website to release information on staffing data for each facility, including resident census data, hours of care provided per resident per day, staffing turnover and tenure. Data would be presented in a format for consumers to compare differences in staffing between facilities and State and national averages for facilities. The format is to include: differences in types of staff; relationship between staffing levels and quality of care; and an explanation that appropriate staffing levels vary based on patient mix.

Hospitals

The hospital industry was one of the sectors that struck a health care reform "deal" with Senate Finance Committee Chairman Max Baucus (D-MT) and the White House. The $155 billion (over 10 years) agreement was based on the understanding that expanding health insurance coverage to more U.S. residents would remove some of the financial burdens on hospitals, thereby enabling them to operate with fewer subsidies and payments from the federal government. Part of the savings would come from reducing Medicare and Medicaid disproportionate share hospital (DSH) payments, which help reimburse hospitals for some of the cost of treating uninsured and low-income patients. The House bill would reduce Medicaid DSH by $10 billion over 10 years and Medicare DSH by another $10 billion over the same time period.

The Senate bill reduces states' DSH allotments by 50 percent once the rate of uninsurance in a state decreases by 45 percent (low DSH states would receive a 25 percent reduction). As the rate of uninsurance continues to decline, states' DSH allotments would be reduced by a corresponding amount. The Senate bill sets a cap on the maximum reduction of DSH payments at no more than 65 percent compared to its FY 2012 allotment. Overall, the Senate bill would reduce Medicare and Medicaid DSH spending by $43 billion over 10 years. Of that amount, $22 billion would come from Medicaid and $21 billion would come from Medicare. However, the reductions are phased-in beginning in 2015.

Both bills include provisions that would reduce payments for certain avoidable hospital readmissions.

One of the industry's demands was that any public plan option would reimburse providers at a level above Medicare rates. Both the House and Senate bills require the HHS Secretary to negotiate public plan rates with hospitals and other providers. These negotiated rates may not exceed the average rates paid by health plans on the exchange. The House bill also requires that the rates not be less than Medicare rates.

Public hospitals had hoped that the House bill would expand the section 340B drug discount program to cover inpatient drugs. While this provision was included in the House Energy & Commerce Committee version, it was stripped from the final House bill. However, the Senate bill includes a provision that extends the section 340B discounts to inpatient drugs and also extends participation to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers.

Both the House and Senate bills include various demonstrations and grant programs in which hospitals can participate. These include Medicare and Medicaid ACO programs, grant programs for trauma centers, grants for workforce training, and medical home pilots.

Medicare

Both the House and Senate bills address the Medicare prescription drug benefit. The House bill eliminates the coverage gap portion, or "donut hole," over time, beginning with a $500 reduction in 2010, and completing the phase-out by 2019. To pay for the elimination of the gap, the House bill requires drug manufacturers to provide Medicaid rebates for drugs used by dual-eligible beneficiaries. Under the Senate bill, instead of paying 100 percent of their drug costs after falling into donut hole of the Part D prescription drug benefit, Medicare beneficiaries with low to moderate incomes would receive a 50 percent discount on the price of brand-name drugs covered by their plan. The Senate bill also eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

The Senate proposal would provide for updates based on the market basket or consumer price index minus full productivity estimates for all Parts A and B providers who are subject to a market basket or consumer price index update. This change would implement a full productivity adjustment for inpatient and outpatient hospital services, inpatient psychiatric facilities, inpatient rehabilitation, long term care hospital services and nursing homes beginning in 2012. It would implement a full productivity adjustment for hospice providers beginning in 2013. A full productivity adjustment for home health providers would begin in 2015. Adjustments for all other Part B providers would begin in 2011. The House bill contains a similar provision, except that it would not apply to enteral nutrition until 2014.

The Senate proposal would move Medicare Advantage program payments from their current payment system to one based on competitive bids from private insurers in each market. The House bill also reforms the Medicare Advantage payment system. Beginning in 2011, payments to Medicare Advantage plans would be reduced over a 3-year period until they are equal with fee-for-service rates. However, bonuses would be available in high-enrollment areas where the reductions would likely be disruptive to beneficiaries.

The Senate bill would create a 15-member, independent Medicare commission tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the commission's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The commission would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing. The House bill does not include such a commission.

The Senate bill includes changes to the Medicare DME, prosthetics, orthotics, and supplies competitive acquisition program. The Senate bill would expand the number of areas to be included in round 2 of the competitive bidding program from 79 of the largest metropolitan statistical areas (MSAs) to 100 of the largest MSAs, and to use competitively bid prices in all areas by 2016. The House bill includes a requirement that the Comptroller General conduct a study on the competitive bidding program.

Both the House and Senate bills would extend exceptions process for Medicare therapy caps. The Senate bill extends the exceptions process until December 31, 2010, while the House bill extends the process until December 31, 2011.

Pharmaceuticals

Drug makers are a key part of the Obama Administration's coalition to advance health care legislation. Earlier this year, the White House, Senate leaders, and the Pharmaceutical Research and Manufacturers of America (PhRMA) reached an agreement to provide for $80 billion in savings on drug prices over a 10-year period. Since the agreement, critics from the left and right have voiced concern. Many critics have questioned how this agreement will impact a possible drug importation amendment or a stand alone importation bill.

Another complicating factor is that recent reports indicate that the pharmaceutical industry may be asked to provide discounts above the $80 billion mark. Despite PhRMA's agreement with the White House and Senate Finance Committee Chairman Max Baucus (D-MT), House Democratic leaders say they are not bound by that agreement and believe more savings can and should be extracted from the drug industry. It is not yet clear if the pharmaceutical industry will begin to actively oppose health reform efforts or accept potential, additional cuts.

Both the House and Senate bills would reduce the Medicare prescription drug benefit coverage gap [See Medicare section for full details].

The Senate bill includes additional provisions impacting drug makers:

- Prescription drug makers and distributors must report to HHS information pertaining to drug samples currently being collected internally.
- Drug, device, biological and medical supply manufacturers must report gifts and other transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital.
- An annual flat fee of $2.3 billion would be imposed on the pharmaceutical manufacturing sector beginning in 2010, allocated according to market share. The fee does not apply to companies with sales of branded pharmaceuticals of $5 million or less.

The House bill would:

- Increase generic drug utilization by eliminating current requirements that prevent Part D and Medicare Advantage Prescription Drug plans from creating incentives for seniors to use lower-cost generic drugs.
- Increase the minimum percentage rebate on brand-name drugs to 23.1 percent of average manufacturer price; extends rebates to new formulations of brand-name drugs; and extends rebate requirement to drugs prescribed by Medicaid managed care organizations.

Regarding biosimilars, both the House and Senate bills sets the add-on payment rate for biosimilar products reimbursement under Medicare Part B at 6 percent of the average sales price of the brand biological product. Both the Senate and House bills create a process for an approval pathway for biosimilar products. Under both bills, the HHS Secretary would be required to license a biological product that is shown to be biosimilar to or interchangeable with a licensed biological product, known as the reference product. The reference product would have 12 years of market exclusivity before a biosimilar could be approved.

Prompt Pay

In July, the House Energy and Commerce Committee voted to include language in its health care reform legislation (H.R. 3200) that would remove many of the prompt pay discounts extended to drug wholesalers from the calculation of the manufacturers' Average Sales Price (ASP). The amendment excluded prompt pay discounts under ASP reporting of up to 2 percent of the wholesale acquisition cost of a drug for periods between January 1, 2011 and January 1, 2016. A broad coalition of providers and industry groups support the inclusion of this language in the health reform bill and has long supported legislation that would remove the prompt pay discounts from ASP. Including the discounts artificially lowers the reimbursement rate for chemotherapy and other treatments, resulting in reduced patient access in some cases.

Although this amendment was agreed to in the House Energy & Commerce Committee, when the three bills in the House were being reconciled, the Ways & Means Committee objected to the language. It was then stripped from the final bill that the House later approved. Since the Senate bill does not contain a prompt pay provision, there is an effort to have a provision similar to the Energy & Commerce measure offered as an amendment in the Senate. Several Senators have shown an interest.

Immigration

The coverage of legal and illegal immigrants under the health reform legislation is now a prominent and contentious issue. Although a difficult issue for many, it has not been seen as an issue that would derail health reform until now. Many Hispanic community advocates initially tried to keep health reform and immigration, their two key issues, on separate tracks. However, they now believe this may have been a misguided strategy and are now actively engaged in the debate, arguing that health care reform is not taking into account the special needs of the Hispanic community. The Congressional Hispanic Caucus is increasingly vocal and adamant on what they want, and do not want, in any health care legislation.

Republican criticism following the President's speech on health reform before a joint session of Congress led President Obama and the Democrats on the Senate Finance Committee to conclude that a strong position on limiting access of illegal immigrants to any newly created health care benefits is needed. As a result, the Senate Finance Committee bill precludes illegal immigrants from purchasing private insurance with their own money and precludes government subsidies on the newly created federal exchange, a position supported by President Obama. The bill released by Sen. Reid maintains this prohibition and requires the HHS Secretary to establish a program for determining whether a person is a US citizen or national or an alien lawfully present in the US.

The healthcare bill passed by the House is silent on the issue, but as there is no specific exclusion or eligibility requirements, the assumption is that illegal immigrants can purchase insurance on a newly created federal exchange with their own money and without government subsidies.

Proponents of access for illegal immigrants to the exchange argue that any indirect subsidy, because government money is used to establish the exchange, is so small that it would not amount to any significant benefit. Also, they say the cost of precluding access is very high and certainly greater than any possible indirect benefit. Without insurance, they argue that society pays the costs of health care for the uninsured and that verification of citizenship is expensive and would impose burdens on citizens as well. Opponents, on the other hand, argue that healthcare is being hijacked by the immigration issue and that anyone can purchase insurance on the open market.

There are some immigration issues that are widely supported by both sides. There is a widespread consensus that illegal immigrants should not get any federal subsidies or participate in any public option. Also, both bills provide that legal immigrants are eligible for government subsidies and can purchase insurance on the exchange. However, even here, there is debate over whether legal immigrants should be required to wait 5 years to be eligible for Medicaid, as is required under current law.

These issues will surface on the Senate floor and again in conference, and they will present a serious political hurdle.

Abortion

Struggling to obtain the 218 votes necessary to pass health reform legislation on November 7, House Democratic leaders agreed to allow Rep. Bart Stupak (D-MI) to offer an amendment to H.R. 3962 that would forbid private insurance plans receiving federal subsidies from covering elective abortion services and bar a new government-run insurance plan from offering such services, except in cases of rape or incest or when continuing the pregnancy threatens a woman's life. Abortion procedures could be insured in private plans, but only pursuant to the purchase of an additional rider to the insurance plan. The Stupak amendment was adopted by a vote of 240 to 194. Sixty-four Democrats joined with 176 Republicans in voting for the amendment.

The amendment has angered abortion rights supporters. Currently, insurance policies that offer elective abortion services are widely available in many, though not all, markets. Opponents of the Stupak Amendment are concerned that adoption of the Stupak Amendment would mean that the millions of women who have insurance coverage now for abortion procedures will lose this coverage once they begin purchasing subsidized insurance under the new insurance exchanges. They also question whether women will purchase a separate

rider for this coverage since abortions generally are unplanned and whether insurance companies would offer separate policies that include abortion procedures when many consumers are purchasing subsidized insurance policies without these procedures through the exchanges.

Abortion opponents say the Stupak Amendment is necessary to avoid any possibility of federal support for abortion by making the procedures available through a government subsidized insurance policy, regardless of whether there are sufficient private funds purchasing the policy to indicate that government funds were not necessarily used to underwrite the procedure. The U.S. Conference of Catholic Bishops heavily lobbied members of the House for this position.

As expected, the Senate bill does not include abortion language as restrictive as the House bill. The Senate bill would prohibit federal funds, including tax credits and subsidies, from being used to pay for abortions. Qualified, private health plans would be able to determine whether they will cover abortions allowed under the Hyde Amendment, abortions beyond those allowed by Hyde, or no abortion coverage at all. The bill states that abortion cannot be a mandated benefit as part of a minimum benefits package. The bill allows the government-run plan to cover elective abortions as long as it uses money collected as premiums — not subsidies — to pay for the procedure, and as long as the government does not bear any "insurance risk" for the coverage. The bill would require every insurance exchange to offer at least one plan that covers abortion and one that does not. Exchange plans that cover abortion — including the public option — would have to segregate revenue collected as private premiums from federal subsidy revenue and use only money from private premiums to pay for the procedure. The Senate bill also includes current "conscience" provisions that ensure that providers opposing abortions would not be discriminated against for refusing to perform these services.

While several Democrats who support abortion rights have found the language acceptable, some anti-abortion Democrats may offer an amendment to the bill during floor debate that would align the Senate bill more with the House bill. The language included by Senate Majority Leader Harry Reid (D-NV) was designed to appease both sides of the argument. It is not yet clear the degree to which the U.S. Conference of Catholic Bishops will be able to influence the Senate language.

Budget Estimates

The Congressional Budget Office estimated the House bill would cost a net of $891 billion over 10 years. The net cost includes a gross total of $1.052 trillion in subsidies provided through the exchanges, Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for small employers. These costs would be offset by $167 billion in collections of penalties paid by individuals and employers. The net effect on revenues and outlays is an additional $6 billion to the total cost. Both CBO and the Joint Committee on Tax estimate the number of non-elderly uninsured would be reduced by 36 million, leaving about 18 million uninsured (about one-third of whom would be undocumented immigrants). Those insured would rise from 83 percent to about 96 percent. CBO still has not completed an estimate of the discretionary costs for a number of federal programs and agencies with regard to implementation.

For the Senate bill, CBO estimates the bill would have a gross cost of $848 billion over 10 years. As drafted, the legislation would result in a net reduction of $130 billion in federal budget deficits. Some $77 billion of the reduction would be on-budget. CBO has not completed estimates of the implementation costs for selected federal government departments and agencies. The number of uninsured individuals would be reduced by 31

million, resulting in 24 million non-elderly uninsured residents (about one-third of these are estimated to be unauthorized immigrants). The share of non-elderly insured would increase from 83 percent to 94 percent. State spending on Medicaid is estimated to increase by $25 billion over 10 years. CBO estimates that premiums under the public option state-opt-out plan would be higher than average premiums for private plans. Public plan provider rates are estimated to be comparable to the rates paid by private insurers participating in the exchanges.

As noted above, the Senate bill would create an Independent Medicare Advisory Board (IMAB), which would be required to recommend changes in the Medicare program spending. This covers FYs 2015 through 2019. CBO estimates the IMAB provision would further reduce Medicare spending by $23 billion. The Senate bill also includes a new, voluntary, self-funded long-term care insurance program, known as the CLASS provision. This provision is estimated to reduce deficits by $72 billion over 10 years, including about $2 billion in savings to Medicaid. However, CBO estimates that during the next 10 years, the CLASS program would increase budget deficits.

Revenue Estimates

The JCT estimates enactment of the House bill would result in a net increase in revenues totaling $536 billion over ten years. These include the following taxes:

- Income Surtax: A 5.4 percent surtax on adjusted gross income (AGI) in excess of $500,000 for individuals ($1,000,000 for joint returns), which would produce $460.5 billion over 10 years. This provision is not indexed for inflation.

For the Senate bill, the JCT estimates the bill would increase revenues by a net of $371.9 billion over 10 years, including the following:

- A tax on "Cadillac Plans," producing $149.1 billion over 10 years.
- A 5 percent excise tax on cosmetic surgery and similar procedures, which is expected to raise $5.8 billion over 10 years.
- An increase in the hospital insurance tax rate (Medicare payroll tax) by 0.5 percentage points on an individual taxpayer earning over $200,000 ($250,000 for married couples filing jointly). The provision would be effective for calendar years beginning after December 31, 2012. The JCT has estimated the provision would raise $53.8 billion over 10 years.

Medical Devices

To help pay for the cost of health reform legislation, both the House and the Senate bills would impose a tax on medical devices. The Senate bill includes an annual flat fee of $2 billion on the medical device manufacturing sector beginning in 2010 allocated across the industry according to market share. The fee would not apply to companies with sales of medical devices in the United States of $5 million or less. The fee also would not apply to any sale of a Class I product or any sale of a Class II product that is primarily sold to consumers at retail for not more than $100 per unit.

The House version would be an excise tax imposed on the devices at the point of sale. The tax would be set at a level that would yield a total of $20 billion between 2013 and 2019. Because the tax would be imposed at point of sale, it would be paid primarily by wholesalers and distributors. However, manufacturers would be taxed directly for high-end medical device sales that are typically sold directly to hospitals. All exported and retail products would be exempt from the tax under the House plan, but the provision would not exempt any FDA Classification of device from the tax.

CMS Actuary Estimate of House Bill

On November 13, the Centers for Medicare & Medicaid Services (CMS) Chief Actuary released a memorandum estimating the financial effects of the House-passed bill. CMS estimated that those provisions intended to reduce the rate of growth in health care costs would actually have a "relatively small savings impact" on costs. CMS estimates the bill would have a net increase of $935 billion in federal expenditures. The expenditure increase would be partially offset by the penalties paid by individuals and employers. The 10-year net savings would be offset by about $571 billion of federal costs for the national coverage provisions.

CMS estimates the percentage of the population with health insurance would grow from 83 percent to 93 percent after full implementation — or an additional 34 million U.S. citizens and other legal residents. It also estimates the House bill's public plan option would have costs 5 percent below the average level for private plans but that public plan premiums would be about 4 percent higher than private plans due to the "anti-selection" by enrollees.

The House bill contains permanent annual productivity adjustments to price updates for institutional providers. CMS estimates that the payment reductions could lead many providers to terminate participation in the Medicare program.

CMS believes the bill would result in a $2.1 billion reduction in non-Medicare federal health care expenditures. This reduction is attributed to policy expectations due to the comparative effectiveness research provision in the bill.

CMS believes the "Community Living Assistance Services and Supports" [CLASS] would result in net savings of $39 billion over the first 9 years. Thereafter, CMS believes that net savings would decline. After 2025, CMS believes projected benefits would exceed premium revenues.

Political Outlook

Completing health reform is the biggest challenge facing the White House and Democrats in Congress. The President sought passage of health care reform before Congress' August break. Failure of Congress to meet that aspiration gave rise to a political environment in many states and districts that saw boisterous, combative town hall meetings. Other political events that occurred throughout the fall (e.g., rising unemployment, the war in Afghanistan, and financial regulatory reforms) have affected political debate, priorities and the political environment.

Although both Houses of Congress have revealed their reform plans, the following questions remain:

- Senate debate: How long?
- What will be the final product out of the Senate? Can the Senate pass a bill with a public plan option?
- Will House and Senate Leadership and the White House "pre-conference" the conference report while Senate debate is ongoing?
- Will House Leaders accept a Senate bill (with some modifications) that will reflect more of the Senate approach than the House approach?
- Will the President be able to sign a final bill before he delivers the State of the Union address?
- Will the American public ultimately view enactment of health reform as a significant achievement that will improve their lives or will it be viewed with skepticism?