

**MEMORANDUM**

**To:** PPSV Clients  
**From:** Peter Thomas, Adam Renfro Chrisney and Theresa Morgan  
**Date:** November 4, 2009  
**Re:** **Revised House Health Reform Bill - Summary**

---

On October 29<sup>th</sup>, the House Democratic leadership released health care reform legislation (H.R. 3962) with the intent of bringing the bill to the House floor for debate in the very near future. The bill would expand coverage to 96 percent of Americans. Entitled the “Affordable Health Care for America Act,” the bill includes a public insurance option with negotiated provider reimbursement rates (rather than Medicare rates). In addition, all those with incomes less than 150 percent of the federal poverty level (FPL) would qualify for Medicaid, compared with 133% in the original House bill and in the Senate legislation. The bill also creates health insurance exchanges, establishes new consumer protections and provides significant federal subsidies to purchase coverage.

To pay for this expansion in coverage, the bill includes a 5.4% surtax on high-income households with adjusted gross incomes over \$1 million for a family and \$500,000 for individuals. These thresholds were increased significantly from the original House bill which created the surtax at \$350,000 for families and \$250,000 for individuals. The new House bill cuts the amount that medical device manufacturers would pay to offset the cost of health reform from \$40 billion over ten years to \$20 billion through a 2.5% excise tax on medical device manufacturers. The House bill also increases significantly cuts in payments to the pharmaceutical industry, from \$80 billion in the Senate bill to more than double that figure. A large portion of this sum will pay for an accelerated elimination of the “donut hole” under Medicare Part D drug plans.

The gross cost of the House's health care legislation is \$1,055 billion between 2010 and 2019 with a net cost, after subtracting revenue from taxes and fees, of \$894 billion, according to the Congressional Budget Office (CBO). The bill is forecasted to reduce the federal deficit by \$104 billion over ten years but increase federal health care expenditures by \$598 billion more than the government would spend without the legislation. The bill would still leave 18 million people without coverage, including millions of illegal aliens. With respect to the public option, CBO forecasts that approximately six million Americans would enroll in this new public program.

The House is expected to soon release a “manager’s amendment” of the new bill with further revisions and begin debate as early as this week. In the Senate, Majority Leader Reid (D-NV) is

leading the process of melding the Senate versions into a single bill for floor consideration. Reid has not announced when the new bill will be released nor when the Senate will begin its debate.

## **Major Changes in the Current House Bill Compared to H.R. 3200:**

### **Health Reform:**

Public Option: Modified to allow the Secretary to negotiate rates with providers that participate in the public plan, rather than using Medicare rates. The bill gives members of Congress the option of joining the public plan.

Health Insurance Exchange: Creates single federal Health Insurance Exchange in which insurance plans will compete for consumers. Permits states to offer their own exchange or participate in multi-state exchanges in lieu of the federal exchange. Medicaid-eligible individuals will be enrolled in Medicaid, not the Exchange.

Co-Ops: Provides start-up loans to establish not-for-profit or cooperative plans to compete with private plans, similar to the Senate approach.

Mandates: Maintains individual mandate to obtain coverage and employer mandate to provide coverage to employees, with certain exceptions.

### Small Employers:

- Exempts 86% of small employers from requirement to offer or contribute to coverage;
- Increases the size of employers allowed to purchase coverage through the exchange within the first three years, so that in the third year large employers can begin being phased-in.
- Limits small business tax credit to a two-year period per firm to help transition.

State Compacts: Allows states to enter agreements to allow the sale of insurance across state lines, as long as that insurance is subject to the laws of the home state; the home state retains the responsibility for the consumer protections of its residents and residents retain the right to bring a claim in a state court where the resident resides. Creates state grant program to assist states in regulating insurance plans in secondary states.

Premium Credits: The new bill scales back these credits so that individuals and families between 150% and 400% of the federal poverty level (FPL) will pay a larger share of premiums over time compared to H.R. 3200.

- Increases to 12% of income the exception for individuals and families with employer coverage who can receive the credits in the exchange.
- Sets an out-of-pocket maximum of \$500 for an individual and \$1000 for a family at the lowest income tier rising to \$5,000 for an individual and \$10,000 for a family at the highest income tier for individuals receiving affordability credits.

Premium Rate Review: Provides for review, disclosure and rationale of insurance rate increases to discourage excessive premium increases.

Interim High-Risk Pool: Creates a national financial assistance program for those who are uninsured or denied a policy due to pre-existing conditions. The HHS Secretary can administer

directly or through state high risk pools. The program sunsets when the Exchange becomes operational or when the \$5 billion in funding is exhausted.

Anti-trust: For health and medical malpractice insurers, the bill repeals the long-held exemption from liability for fixing prices, dividing up territories, or monopolizing markets.

Private Insurance Reforms:

- In 2010, shortens the time that plans can look back for pre-existing conditions from 6 months to 30 days and shortens the time plans may exclude coverage of certain benefits generally from 12 months to 3 months. In 2013, implements complete prohibition on pre-existing condition exclusions.
- Requires guaranteed issue and renewal of insurance policies and prohibits the use of “rescission” of insurance plans except in instances of fraud.
- Limits age rating to a ratio of 2 to 1 as opposed to 4 to 1 in the Senate bill; allows variation in premiums based on geographic area and family size as permitted by state insurance commissioners and a new federal Health Choices Commissioner.
- Provides authority to the Health Choices Commissioner to set non-discrimination rules and ensures that mental health and substance use disorder parity and genetic nondiscrimination laws apply to qualified health benefits plans.
- Requires health insurance issuers in the small and large group markets to meet a medical loss ratio of not less than 85% in order to limit administration costs and profit-taking. Directs the Secretary to require that plans in the individual market also meet a medical loss ratio of not less than 85% so long as it does not destabilize the existing individual market. If plans exceed that limit, rebates to enrollees are required.

COBRA: Permits individuals to remain in their COBRA policy until the Health Insurance Exchange fully implemented.

Essential Benefits Package:

- Specifically includes coverage of durable medical equipment, prosthetics, orthotics and related suppliers (“DMEPOS”).
- Requires plans to pay for reconstructive surgery for children with congenital or developmental “deformities,” diseases or injuries.

Provider Non-discrimination: Preserves state-enacted provider non-discrimination laws.

Employer Wellness Programs: Establishes a grant program for small employers using non-discriminatory incentives for health and wellness. This approach is very different from the Senate legislation that permits significant differentials in premiums based on the achievement of certain health indicators.

Annual and Lifetime Caps in Benefits: Starting in 2010, prohibits group health plans and insurers from utilizing lifetime limits on benefits. Within the essential benefits package offered by insurers through the exchange, there is also a ban on annual limits.

Comparative Effectiveness Research (CER):

- Increases the independence of the CER Commission from the Department of HHS but retains this Commission under HHS control;
- Improves accounting for subpopulations, including the disability population, in study design and implementation;
- Clarifies that CER is not considered as a mandate for payment, coverage or treatment.

### **Medicare/Medicaid:**

Accountable Care Organizations & Medical Home Pilots: Requires specific benchmarks to expand these programs and to test them in a variety of settings and geographic regions; allows for program expansion if successful; can now include any eligible beneficiary.

Medicare Innovation Center: Created by 2011 to test new payment models (bundling) to encourage higher quality and lower costs; similar to language in the Senate Finance bill.

Physician Payments (SGR): Removes the overhaul of the Medicare physician payment formula. The House intends to address the long-term problem of the Medicare physician fee schedule through separate legislation.

Medical Malpractice: Creates a new voluntary state grant program to explore alternatives to reduce medical malpractice insurance costs and, thereby, reduce defensive medicine.

Bundling: Protects patients in the context of coordinating care and bundling payments (including the concept of continuing care hospitals (CCH) for the benefit of people with chronic conditions and disabilities) and fully tests these models before full implementation.

Hospice Moratorium: Extends a 1-year moratorium on regulatory changes phasing out the budget neutrality factor to ensure that hospices continue to receive the same wage reimbursement rate for fiscal year 2010.

Home Health: Requires MedPAC to study Medicare margin variation amongst these agencies.

Part D “Donut Hole”: Accelerates closure of the Medicare Part D “donut hole” by \$500 in 2010; completely closed by 2019. Pays for this closure by requiring drug manufacturers to provide Medicaid rebates for drugs used by dual eligibles. Also provides 50% discount for brand-name drugs for Part D enrollees in the donut hole.

Medicare Drug Price Negotiation: HHS Secretary will be required to negotiate prices under the Part D drug program. This has been a contentious issue ever since enactment of Part D in 2004.

Biosimilars: Establishes Part B payment methodologies for interchangeable and biosimilar products. Requires the Secretary to approve applications for biological products that have been shown to be biosimilar or interchangeable to an already licensed biological product (the reference product). Giving brands and biosimilars the same billing codes could result in lower average sales prices for brand biologics.

Generic Drugs: Clarifies that Part D plans may offer generic drugs to enrollees with zero copayment to encourage the use of lower-cost generic drugs.

### Medicaid:

- Raises federal floor of Medicaid coverage from 133% to 150 % FPL.
- Keeps 100% FMAP for expansion population costs in 2013, 2014; 91% in 2015 and later, largely removing the burden from states to expand coverage to these populations,
- Extends the stimulus bill's FMAP assistance for states with high unemployment rates.
- Increases reimbursement for physicians to Medicare rates through federal funding.
- Provides for supplemental payments to skilled nursing facilities with high disproportionate share hospital (DSH) rates.
- Requires the new Medicaid and CHIP Payment Advisory Committee (MACPAC) to examine payment rates to nursing facilities in each State and report to Congress by 2011.

### SCHIP Program:

- Allows the CHIP program to expire in December of 2013 as exchange is implemented.
- Provides for coverage of children through Medicaid or the exchange.

CLASS Act: Creates a new voluntary long-term care insurance program to help purchase services and supports for people with functional limitations that will save money for the Medicaid program. The Senate HELP bill also includes this new insurance program.

Community Choice Option: The House bill omits the Community Choice Option, leading to more Medicaid funding for home and community-based care rather than institution-based care, but the House will likely adopt the Senate provision in conference.

### **Public Health:**

Disparities Research: Expands the term "health disparities" so that research will include disability populations when studying population-specific differences in the presence of disease, health outcomes, or access to health care.

Emergency Rooms & Trauma Centers: Creates grants to strengthen capacity for these facilities.

Wellness Programs: Authorizes wellness grants that prohibit the use of discriminatory incentives. Provides support for research on incentivizing proven healthy behaviors and for the inclusion of effective incentive programs in the essential benefits package or in community prevention and wellness programs.

Accessibility of Medical Diagnostic Equipment: Provides for the development of guidelines and regulations to ensure that new medical diagnostic equipment is accessible to, and usable by, individuals with disabilities.

Advanced Care Planning: Despite the controversy surrounding so-called "death panels," the merged bill preserves provisions to allow Medicare to reimburse providers for presenting patients with information about resources available for advanced care planning which is voluntary to the individual.

Mental Health: Creates new training programs for mental and behavioral professionals to promote interdisciplinary training and care coordination.

Menu Labeling: Requires chain restaurants to publish the calorie content of their menu items directly on menus and to make other nutritional information available so that consumers can make informed choices.

Autism: Supports training activities to address the unmet need of those with autism and related developmental disabilities.

Telehealth: Reauthorizes grant programs to support telehealth networks and resource centers plus incentives to coordinate licensure activities among states.

340B Program: Extends the 340B drug discount program to certain rural and other hospitals (including critical access hospitals). However, the merged bill omits a provision that was in HR 3200 to extend the 340B drug discount to the inpatient setting in safety net hospitals.

Abortion Services: As part of concessions to gain the support of some moderates and conservatives, the bill prohibits abortion services from being made part of the essential benefits package. Prohibits federal funds from being used to pay for abortion (except in cases of rape, incest, and to save the life of the woman). Where abortion coverage is provided, funds for this purpose must be segregated from other funds, including in the allocation of affordability credits.