THIS WEEK IN HEALTH CARE REFORM

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In the most significant health care reform development since President Obama took office, the House of Representatives passed the Affordable Health Care for America Act (H.R. 3962) late Saturday evening, November 7. Now that the House's work is done, all eyes turn toward the Senate, where Senate Majority Leader Harry Reid (D-NV) and other Democratic leaders continue working to merge the separate health care reform bills passed by the Senate Finance Committee (S. 1796) and the Health, Education, Labor and Pensions (HELP) Committee (S. 1679).

The Week Past

Home for the holidays: House approves health care reform legislation. Health reform advocates in the House secured a victory for President Obama and the Democratic leadership, approving H.R. 3962 by a vote of 220-215 and thereby making good on their objective of passing health care reform legislation before leaving town for the Veterans Day recess.

Only one Republican, Representative Joseph Cao (R-LA), crossed party lines to vote with 219 Democrats in approving the bill, while 39 Democrats joined the remaining 176 Republicans in opposing the measure. In the final hours of debate, the path to passage was clear once Democrats worked out late-emerging differences regarding the use of federal funds for abortion-related services and access to Exchange-based coverage for illegal immigrants.

The final approved version of H.R. 3962 incorporates a 42-page "Manager's Amendment" that was offered earlier in the week by Representative John Dingell (D-MI) and contained various technical and substantive changes to the original 1,990-page bill. Of particular interest, the Manager's Amendment delays, from 2011 to 2013, implementation of the provision that reduces the employer business deduction for retiree prescription drug expenses. The provision would reduce the deduction by the amount of the federal government's 28% Medicare Part D retiree drug subsidy (RDS) that employers receive.

Only two amendments were considered during the House floor debate:

- an amendment prohibiting federal funding for abortion-related services in the public plan option and in private Exchange-based plans (except in limited circumstances), which was approved
- a 219-page Republican substitute health reform bill, which was defeated largely on a party-line vote.

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Recapping key elements of the House-passed bill. As reported last week, the key employer-facing and revenue-raising provisions of H.R. 3962 would:

- mandate most legal residents to enroll in "acceptable" health coverage or pay a tax based on 2.5% of their modified adjusted gross income above a specified threshold, but in no case more than the "applicable national average premium" for self-only (or family) coverage under an Exchange-based basic plan

- mandate employers, generally with payrolls greater than $500,000 per year, to either:
  - "pay" a per-employee penalty equal to 8% of an employer's average wages, or
  - "play" by contributing at least 72.5% of the premium for basic individual coverage and 65% of the premium for basic family coverage for full-time employees (and a proportional amount for part-time employees); current employment-based health plan designs would be grandfathered for five years, at which time any plan offered by an employer would have to meet (and could exceed) the requirements of the "essential benefits package"

- reform the individual and small group health insurance market to:
  - require insurers to issue guaranteed coverage regardless of health status
  - prohibit preexisting condition exclusions
  - eliminate annual and lifetime benefit limits
  - limit the range of premiums an insurer may charge based on certain factors (e.g., age [2:1], geographic area, family size)

- establish new health insurance Exchanges as a means for private insurers and a new public plan to offer standard health insurance plans (i.e., basic, enhanced, premium, premium plus), each of which must include a core set of covered benefits

- establish a government-run public health plan option to compete with private insurers in the Exchanges, and for which the federal government would be required to negotiate health care provider reimbursement rates using Medicare rates as a floor

- provide premium and cost-sharing subsidies to low- and middle-income individuals with incomes up to 400% of the federal poverty level (FPL) — $43,320 individual, $58,280 couple, $88,200 family of four, in 2009 — who obtain their coverage through the Exchange:
  - a full-time employee could opt out of employer-offered health coverage and receive subsidies through the Exchange only if the employer's coverage is "unaffordable" — i.e., costs more than 12% of the employee's modified adjusted gross income

- establish a temporary reinsurance program under which the government would pay 80% of the cost of employer group health plan benefits provided to retirees age 55 through 64 in excess of $15,000 and less than $90,000 — with the stipulation that employers use the funds to lower costs for the plan (e.g., to reduce premium costs for the employer or to reduce premium contributions, copayments, deductibles, coinsurance or other out-of-pocket costs for plan participants)

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- require employer group health plans that provide dependent coverage to allow dependent children, at their parent's option, to remain on their parent's plan through age 26

- require that employer group health plans provide coverage for outpatient and inpatient diagnosis and treatment (e.g., reconstructive surgery) of a minor child's (under age 22) congenital or developmental deformity, disease or injury

- immediately limit an employer group health plan's ability to use preexisting condition exclusions until 2013, when such provisions would generally be prohibited

- extend the duration of COBRA coverage to allow qualified beneficiaries to keep their COBRA coverage beyond the applicable 18-,29- or 36-month period until the Exchange is established (i.e., 2013)

- extend the gross income exclusion for employer-provided health coverage to include coverage for a person who is eligible for coverage under the employer's plan but who is not a spouse or dependent under federal tax law, such as a domestic partner, same-sex spouse or adult child of an employee

- prohibit employers from reducing retirees' health benefits after those individuals have retired, unless the same reduction is imposed on the benefits provided to active participants

- impose a 5.4% income tax surcharge on the portion of high-income taxpayers' adjusted gross incomes that exceeds $500,000 for single filers and $1 million for married individuals filing jointly (not indexed to inflation)

- impose a $2,500 limit on contributions to health flexible spending arrangements (FSAs)

- prohibit the reimbursement of over-the-counter drugs from health FSAs, health reimbursement arrangements (HRAs) and health savings accounts (HSAs)

- reduce an employer's income tax deduction for retiree prescription drug expenses by the amount of the federal government's 28% Medicare Part D RDS received by the employer

- increase the penalty from 10% to 20% for HSA withdrawals prior to age 65 that are not used for qualified medical expenses

- assess an annual per-capita tax (e.g., $2 per covered life) on insured and self-insured plans to fund comparative effectiveness research

- allow the FDA to approve generic versions of biological or biotech drugs ("follow-on biologics") that have been determined to be both safe and effective, while giving manufacturers of patented biotechnology products 12 years of market exclusivity

- implement several changes to the Medicare Part D prescription drug program, including:
  - a 50% discount off brand-name drugs for expenses incurred during the Part D donut hole
  - an immediate $500 reduction and, in time, complete elimination of the donut hole

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  - required government negotiation with pharmaceutical manufacturers for Part D drug discounts

- expand Medicaid eligibility across all states to individuals with incomes up to 150% of the FPL

- create a voluntary, public long-term care insurance program that provides a daily or weekly cash benefit to individuals with functional limitations, who are not covered by private long-term care insurance or Medicaid, to help purchase the services and supports needed to maintain personal and financial independence
  - employees would be default-enrolled at a 100% employee contribution, unless the employee declines coverage.

The Week Ahead

A long December? The Senate has lots of work to do. Senate Democratic leaders continue working toward completion of a merged bill, although it's unclear exactly what will be in the bill or when that bill will reach the Senate floor for consideration. Reportedly, debate on the Senate floor could begin shortly after Senator Reid receives the Congressional Budget Office's cost estimate of the merged bill, which may come this week.

It is likely that the Senate debate will be more protracted than the House debate, with many amendments considered, particularly since Senator Reid needs to enlist 60 votes in support of the bill in order to prevent a Republican filibuster. That said, it won't be surprising if the Senate debate continues well into December and possibly into early 2010.

Finally, if and when the Senate approves its version of health care reform legislation, a House-Senate conference committee must convene to negotiate a compromise bill based on the respective House- and Senate-approved versions of the bill. Procedurally, each chamber will have to approve that final compromise version of health reform in order for President Obama to sign a bill into law.

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