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RSC Info Alert: Highlights of the Democrat Manager's Amendment

Thought you might be interested in the following brief summary of the Democrat (Dingell) Manager's amendment.

The text of the amendment can be found at:
http://docs.house.gov/rules/health/111_hr3962_dingell.pdf.

Takeaway message – the Manger's Amendment makes the bill worse, not better; it further restricts businesses and insurers and pays lip service to immigration and fiscal restraint while centralizing more power in the federal government. The amendment appears to be trying to head off predicted insurance premium increases by increasing the states and the FTC's regulatory power. And despite all the press attention to the matter, it does not address abortion.

Some highlights include:

- Adds individuals on retiree health coverage whose annual increase in premiums exceed "such excessive percentage as the Secretary shall specify" to the list of people who qualify for the interim high risk pool.
- Adds citizen verification language for high risk pools (same verification language as other provisions in the bill)
- Beginning in 2010, it increases states' power in determining if an insurer should not be allowed to participate in the Exchange due to "excess or unjustified premium increases" (i.e. price gouging). Insurers must submit justification for any premium increase prior to implementation. Provides grants to the states ($1 billion) for giving information to the Commissioner relating to trends in premium increases. The Commissioner is to take these factors into consideration when making determinations about offering contracts to "qualified health benefit plans" (QHBPs). The Commissioner is also given the ability to monitor and keep track of these items starting in 2014 both inside and outside of the Exchange.
    - When considering whether to include larger employees in the exchange the commissioner should take into account excess of premium growth outside the Exchange compared to inside.
- When giving grants for state access programs, the language is changed to *only* allow not-for-profit (previously stated "business") to participate in "purchasing collaboratives" for it to be considered qualified for a grant.
- Includes a provision similar to Sen. Cantwell's amendment from Senate Finance that would allow for coverage in qualified "direct primary care medical home

plans" (DPM), provided that the plan meets all requirements applicable and the services covered are coordinated with the QHBP offering entity. DPM practices offer patients comprehensive primary care coverage outside of traditional insurance and include preventive, primary care and chronic disease management.

- Removes a provision under the section repealing the insurance anti-trust exemption, that continued to allow for "information gathering and rate setting activities of a state insurance commission or other state regulatory entity with the authority to set insurance rates". Gives the Federal Trade Commission (FTC) more authority over for-profit and not-for-profit insurers as a whole vs. just authority over the business of insurance.
- Applies Government Performance and Results Act of 1993 (GPRA) to executive agencies created in the bill.
- Weakens the role of the National Association of Insurance Commissioners (NAIC) in setting model guidelines for the creation of interstate compacts and instead requires the Secretary to develop them.
- Allows for a Medicare "cost-containment" waiver to remain in existence for provider payments in the public option.
- Three significant changes to the tax-related portions:
    - The effective date of the provision denying the tax deduction for employer health plans coordinating with Medicare Part D would be delayed for two years, beginning after 2012.
    - Changes the provision delaying the implementation of the worldwide interest allocation by nine years to a complete repeal.
    - Makes modifications to the current-law cellulosic biofuel producer credit, excludes certain fuels from eligibility for this credit, while making certain other fuels eligible.
- Creates a narrow carve out or special rule for certain "high Medicaid facilities" in relation to the new "conditions for approval" that existing specialty hospitals must abide by in order to grow their facilities under the bill. The amendment allows these certain hospitals to grow if they:
    - Have an annual percent of Medicaid admissions that (as determined by the Secretary) is greater than such a percent with respect to admissions for any other hospital in the country;
    - Does not discriminate against beneficiaries covered under Federal programs (Medicaid, Medicare, etc); and,
    - Meet other conditions set forth by the Secretary. This is four fewer conditions than placed on all other specialty hospitals.
- Adds a provision that allows the Secretary to establish quality indicators for care of people with Alzheimer's disease.
- Establishes a 90-day waiting period for first time DME provider claims (to reduce fraud).
- Requires a Medicare fraud and abuse hotline number to be displayed prominently on any statement or notice containing an explanation of benefits.
- Changes the revenue source for the "wellness fund" from general treasuries to from the "public health investment fund."

- Clarifies that a state can still receive a grant for allowed medical liability reforms even if they have enacted a separate reform that establishes caps or reduces lawyers' fees – as long as it is not combined with the reforms they will pay for. The bottom line however, is that the bill will still not pay for any law that enacts caps or reduces attorney fees.
- Another grant program ($30 million for 2011 and "such sums" for 2012) for mental health and substance abuse screening in primary care settings.
- Creates 5 new Offices of Minority Health in other agencies including in the Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, Health Resources and Services Administration, and the Food and Drug Administration.
- Adds a scaled down version of an amendment offered by Rep. Sullivan in Energy and Commerce that would have eliminated duplicate programs under the bill. The bill now allows for a study on duplication in Division C grant programs. At the Secretary's discretion, she could integrate the old program into the new and could potentially terminate the duplicative old program. If programs could not be integrated into existing programs, the Secretary is required to publish a rule terminating the duplicative programs. If Congress does not take a vote disapproving of those terminations, the duplicative programs would be eliminated. However, the money would not go away, it would just go to the new or integrated program;
- Creates a diabetes screening, awareness and outreach program.
- Makes improvements to vital statistics collection by the "education and training" of doctors on the importance of birth and death certificate data and how to properly fill them out.
- Takes out a Montana specific provision in the Indian Health Reauthorization portion.