RSC Republican Study Committee
REP. TOM PRICE, M.D. (R-GA), CHAIRMAN
PAUL TELLER, EXECUTIVE DIRECTOR
424 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
rsc.price.house.gov
ph (202) 226-9717 / fax (202) 226-1633

RSC Policy Brief: Stumbling Blocks to Merging the House and Senate Government Takeover of Health Care Bills

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Despite, Obama's promise to bring all parties together to negotiate in front of the American people, there will not be a formal Conference, and instead the government takeover of health care negotiations are currently taking place behind closed doors in secret without any Republican input.

Conference/Process for Reconciling the Bills: The House will use a "ping-pong" strategy of sorts where the bill will be sent back to the Senate with all changes in the form of an amendment in order to avoid as many 60-vote thresholds as possible. This strategy also allows the Democrats to avoid any Republican input (including a Motion to Recommit) and a public viewing of the process on C-SPAN which they have already requested (which was done for the ARRA).

However, unless the House simply rubber stamps the Senate bill, Democrat leadership still has to overcome at least one more 60-vote threshold in the Senate, thus increasing the leverage of the Senate in negotiations.

Below are some of the highlights of the major obstacles to enacting a final bill:

Stumbling Blocks:

Illegal Immigrants' Ability to Purchase Coverage in the Exchange

- **House:** The House bill fails to adequately address citizen verification for individuals applying for low-income affordability subsidies in the Exchange, or enrolling in Medicaid/CHIP, or enrolling in high risk pools. Furthermore, the House bill **allows** illegal immigrants to purchase insurance through the Exchange using their own dollars.
- **Senate:** Unlike the House bill, the Senate language will not allow illegal immigrants to purchase coverage through the Exchange using their own dollars. However, because the Senate bill contains the same insufficient and ineffective verification methods as the House, some conservatives may be concerned that it would still allow for illegal immigrants to access the Exchange.
- According to news reports, some House Democrats, who have been opposed to the Senate provisions due to concerns that illegal immigrants will not be given coverage, are ready to concede so long as President Obama promises that any future comprehensive immigration bill will give illegal immigrants access to health care coverage.

Federal Funding of Abortion

- **House:** The House language maintains current law and provides that no federal funding will go towards the funding of abortions.
- **Senate:** The Senate bill still allows for the funding of abortion, and is very different from the Stupak language that passed the House with the support of 64 Democrats.

- Specifically Nelson's "compromise" would require those enrolled in a plan that covers abortion to make separate payments into an account that will be used for abortions, therefore creating public and "private" funds. Just because the funds are put into another account does not mean they are not federal dollars subsidizing abortions. Money is fungible and attempts to separate taxpayer dollars and private dollars to pay for an abortion is nothing more than a deceitful shell game.
- The bill includes a mandate that every state provide an insurance plan option that does not cover abortion, while giving each state the right to pass a law barring insurance coverage for abortion within state borders (which was already allowed in the underlying bill). However, even if a state chooses to opt out, an individual's tax dollars may go toward plans that cover abortion in other states.
- Each state through the new government run plan ("Multi-State Plan") overseen by the Office of Management Personnel (OMP) can provide access to two plans – only one of which must exclude abortions. Currently no plan under the Federal Employee Health Benefits Plan (FEHBP), overseen by OMP, provides for abortion coverage.
- Additionally, it fails to fix Sen. Mikulski's amendment, which gives the Health Resources and Services Administration (HRSA) the power to require private insurance plans include abortion coverage under the title of "preventive care."
- Finally, the bill fails to provide adequate conscience protections, as it does not prohibit any government entity or program from discriminating against health care providers that do not want to participate in abortions.

The Government-Run Option vs. the Federally Overseen "Multi-State Plan"

- **House:** Beginning in 2013, the bill creates a **government-run health insurance Plan** or "public plan", run by government bureaucrats, paid for on the backs of taxpayers ($2 billion in "start-up funds") to "compete" in the Exchange. The Lewin Group estimates that the uneven playing field will cause as many as 114 million people to be dumped into the government plan due to lower provider payments and cost shifting onto private plans. According to CBO, under the initially negotiated rates, the plan "would typically have premiums that are somewhat higher than the average premiums for the private plans in the exchanges…The public plan would have lower administrative costs than those private plans but would probably engage in less management of utilization by its enrollees and attract a less healthy pool of enrollees." However, as we have seen with Medicare and Medicaid, there is nothing to prohibit the government from changing the rules and tilting the field in their direction through price fixing, cutting payments, or rationing care.
- **Senate: New government-run "Multi-State" plan:** Although the government-run plan with a state-opt out was removed, the Senate bill still allows for the federal government through the Office of Personnel Management (OPM), to run, oversee and "negotiate" with new "Multi-State" plans offered in State Exchanges and available nationwide. At least one of the "Multi-state" plans must be non-profit, and at least one plan must not offer coverage of abortions. In order to be "qualified", a plan must still be licensed in each state and meet all state and federal requirements including newly established standards for medical loss ratios, profit margins, and premiums. OMP-run multi-state plans must cover all essential health benefits and meet all of the requirements of a qualified health plan, and comply with 3:1 age rating. Furthermore, like the House bill, the Senate bill contains a CO-OP Program to help organize and fund ($6 billion) the creation of even more not-for-profit insurance companies**.** The CO-OPs would only have to pay back the loans or grants plus interest if they violate the terms of the program. Otherwise they are financed on the back of the taxpayer with **no prohibition on the CO-OP from receiving a bail-out if it fails.**
- According to news reports, House Democrats are open to abandoning their beloved "public option" if the Senate will agree to repeal health insurers' current antitrust exemption. Democrats view this "compromise" as a way to further regulate and intimidate insurers. Contrary to Democrats claim that a repeal will increase competition and bring down costs, CBO has found that it may actually increase premium costs due to being subject to additional (federal) litigation, but more than likely would have

no effect as "state laws already bar the activities that would be prohibited under federal law if this bill was enacted."

Financing the Expansion of Coverage Through New Taxes

- **House:** The bill increases taxes by *$460.5 billion* from a 5.4% surtax on "wealthy" individuals and small businesses with income over $500,000 ($1 million for married filing jointly). Although Democrats argue that the surtax on the "wealthy" only affects 1.2% of small businesses, JCT found that 1/3 of the $460.5 billion raised will be from business income. Also of note, the income thresholds for this tax are not indexed for inflation which means the tax will eventually hit the middle-class.
- **Senate:** The Senate bill imposes a union opposed *$148.9 billion* tax on "Cadillac plans". In addition the Senate bill raises the Medicare payroll tax by 0.9% on individuals making $200,000 and families making $250,000 **(which creates a new marriage penalty)**, a tax increase of *$86.8 billion*.
- CQ reported that House members are open to using the Senate' Medicare tax on the wealthy, however this in and of itself will not get them enough money to finance the expansion. Members are also weighing a hybrid scheme where the level for a "Cadillac" plan is raised to affect less union members and some level of the surtax is maintained.

Independent Medicare Advisory Board (IMAB), Also Known as "MedPAC on Steroids"

- **House:** The House Bill does not contain the IMAB, but does contain other federal boards empowered to make arbitrary cuts, including the Comparative Effectiveness Research advisory committee and the CMS Innovation Center.
- **Senate:** The bill contains boards similar to the House included provisions, as well as the Independent Medicare Advisory Board (IMAB), or "MedPAC on Steroids," made up of non-elected government bureaucrats that are empowered to make arbitrary cuts to Medicare providers that will limit access to care for seniors. Congress would be required to consider legislation implementing the proposal or alternative proposals with the same budgetary impact on a fast track basis. The recommendations of the board would go into effect automatically unless blocked by subsequent legislative action.
  - IMAB's recommendations would be required if the Chief Actuary for the Medicare program projected that Medicare's spending per beneficiary would grow faster than the average of the growth rates of the consumer price index (CPI) for medical services and the overall index for all urban consumers for fiscal years 2015 through 2019.
  - After 2019, the threshold would be increased and IMAB's recommendations would be required if Medicare spending growth rose faster than gross domestic product (GDP) per capita plus 1 percentage point.
  - Of note, CBO revised its long-term estimate to take into account this change in 2019, such that it lowered the projected savings by 0.25% of GDP or $500 billion.

Structure and Enforcement of Individual and Employer Mandates

- **House: Employer Mandates ($135 billion in taxes)**
  - The House pay-or-play employer mandate would require employers to provide qualified coverage to all employees with a small business exemption, defined as firms with payrolls less than $500,000 regardless of size. However, firms with payrolls above $500,000 would be subject to phased in penalties so that a firm with aggregate wages above $750,000 would pay a tax penalty of up to 8% of average wages.
  - If an employer offers coverage but does not pay 72.5% of a single employee's health premium (65% of a employee's family coverage), then the employer must pay an excise tax equal to 8% of average wages. The definition of a full time employee will be determined by the Commissioner and an employers' contribution to part-time employees' coverage will be on a prorated basis.

- Furthermore, even if a business offers "qualified" insurance but the employee declines coverage, and instead obtains coverage through the Exchange, the employer must still pay the 8% tax to the Exchange.
- Like the individual mandate, the payroll exemption is not indexed and thus over time fewer small businesses will qualify for an exemption.
- While the bill does provide a small business tax credit, it is far from sufficient, as it is only available for two years and phases out for firms with more than 10 employees (while excluding individuals with incomes over $80,000 for purposes of calculating the credit).

- **Individual Mandate ($33 billion in taxes)**
  - Individuals who don't purchase "acceptable health care coverage" will be forced to pay a tax of 2.5% of modified adjusted gross income (MAGI), not to exceed the national average premium in the Exchange. According to CBO, the share of income that enrollees would have to contribute toward premiums was **increased** from the previous version and indexed so that federal subsidies would grow more slowly over time. Some conservatives may be concerned that this breaks President Obama's pledge not raise taxes on individuals making less than $250,000.
- **Senate: Employer "Free Rider" Mandate ($28 billion in taxes)**
  - Under the senate's employer mandates, firms with more than 50 full-time employees (defined as 30 hours a week) who do *not offer* coverage would be subject to a tax penalty ($750 per full-time employee) — if at least one of its full-time employees enrolled in an exchange plan *and* received a premium subsidy.
  - Furthermore, if an employer *does* offer coverage but an employee decides to opt out and enroll in an exchange plan (if the employer coverage is deemed "unaffordable"), it will still be subject to a penalty (the lesser of either $3,000 for each of those employees receiving a premium subsidy or $750 for each of their total full-time employees).
  - The bill requires employers to provide a "free choice voucher" equal to the employer's portion of the premium paid for the highest cost plan they sponsor. The voucher would be available to employees below 400% FPL, whose required contribution is between 8% and 9.8% of their income.
  - Like the House bill, the Senate bill provides a temporary and insufficient small business tax credit.
- **Individual Mandate ($15 billion in taxes)**
  - Individuals who do not purchase qualified insurance would have to pay a phased-in tax penalty or go to jail. The penalty is tied to the higher of a flat dollar amount (up to $750 in 2016 for an individual, a max of $2,250 for a family) or 2% of taxable income up to the national average of the "Bronze" (lowest value) premium level.

The Size of the Medicaid Eligibility Expansion

- **House:** Increases Medicaid eligibility to all individuals up to 150% of the Federal Poverty Level (FPL), up from 100% under current law, hurting already thinly stretched state budgets (a $34 billion unfunded mandate as the Federal Government will only pay 100% of the cost for covering newly eligible enrollees until 2015) while dumping 15 million more people onto an already unsustainable entitlement program with poor patient access and care.
- **Senate*:*** Increases Medicaid eligibility to all individuals up to 133% of the Federal Poverty Level (FPL). Like the House bill, the federal government would pay 100% of the costs for covering newly eligible enrollees through 2016—after which all but 1 state (NE) would have to pick up the $26 billion dollar tab on this unfunded mandate.
- News reports indicate that Nelson wants to expand the special deal he secured for Nebraska to all states or allow for states to opt-out. But this presents no real choice as states would lose out on federal funding (100% FMAP) indefinitely for all newly eligible individuals while still subsidizing other states that opt-in.

Other Issues

- **"PhRMA Deal":** According to reports, influential House members such as Rep. Waxman still want

to fight against the "deal" PhRMA made with the Senate and White House. While both bills begin to fill in the Medicare Part D "donut hole", House Democrats want the final product to include the mandate to expand Medicaid drug rebates under Medicare to dual-eligibles. The House bill would also give the Secretary of HHS the authority to "negotiate" Medicare drug prices by repealing the non-interference clause, which many conservatives argue is a form of price controls.

- **Exchanges and Insurers:** House Democrats also prefer the House's version of a national insurance Exchange (vs. the Senate's state-based exchanges) as it would allow for more federal oversight and enforcement, such as denying insurers the possibility to participate in the Exchange if they don't follow the new regulations and mandates.
- **Premium Credits/Implementation Date:** Speaker Pelosi has indicated she wants the final product to include the House bill's larger premium subsidies and the earlier implementation date for the major insurance reforms (2014 in the Senate vs. 2013 in the House).

RSC Staff Contact: Emily Henehan Murry, emily.murry@mail.house.gov, (202) 225-9286