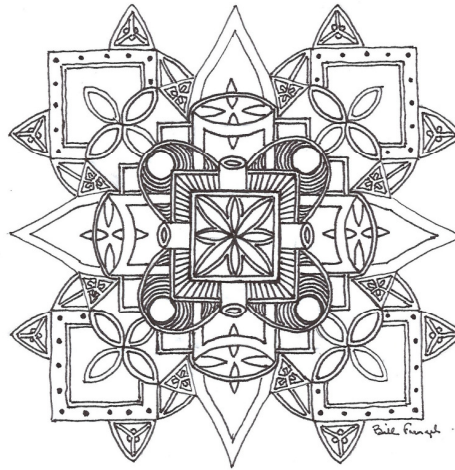


**Comparing Health Care Plans:
A Guide to Health Care Reform Proposals
In the 111th Congress**



September 28, 2009

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SUMMARY OF HEALTH CARE SAVINGS

Provision	House Tri-Committee	HELP Committee	Finance Committee	President's Reserve Fund
Mandate Provisions	\$237	\$88	\$47	X
Individual Mandates	\$29	\$36	\$20	X
Play-or-Pay Provisions	\$208	\$52	\$27	X
Coverage Expansion	-\$1,264	-\$779 / -\$1,279*	-\$769	X
Insurance Subsidies	-\$773	-\$723	-\$458 ^a	X
Medicaid Expansion	-\$438	X / -\$500*	-\$287	X
Small Business Tax Credit	-\$53	-\$56	-\$24	X
Other Spending	-\$292	\$34	-\$48	X
Physician Payment Updates	-\$229	X	-\$11	X
Long-Term Care Insurance	n/a	\$58 [^]	n/a	X
Medicare Prescription Drug Coverage	n/a ⁺	X	-\$19	X
Other Spending	-\$63	-\$24	-\$18	X
Spending Offsets	\$491	X	\$471	\$645
Prescription Drug Costs	\$47 ⁺	X	\$15	\$105
Medicare Advantage Cuts	\$162	X	\$125	\$176
Provider Payment Updates	\$196	X	\$182	\$110
Medicare Premium Increase	n/a	X	\$34	\$8
Medicare Payment Commission	n/a	X	\$23 [#]	\$2 [#]
Measures to Slow Health Cost Growth	\$5	X	\$5	\$47
Measures to Reduce Federal Health Care Spending	\$81	X	\$87	\$197
Tax Increases	\$589	X	\$348	\$296
Surtax on High Earners	\$544	X	n/a	n/a
Limit Itemized Deductions	n/a	X	n/a	\$269
Excise Tax on High Cost Insurance	n/a	X	\$215	n/a
Limits to Corporate Tax Benefits	\$37	X	\$17	\$27
Limits to Health Care Tax Benefits	\$8	X	\$23	n/a
Fees on Health Care Companies	n/a	X	\$93	n/a
Interaction Effects	\$0	\$46	\$1	-\$33
Ten Year Budgetary Impact	-\$239	-\$611 / -\$1,111*	\$49	\$908
Deficit in the Tenth Year	-\$65	-\$120 / -\$216*	\$16	\$130
Coverage Impact	37 million	21 million / 38 million*	29 million	n/a

Note: Estimates in billions; positive numbers represent a decrease in the deficit

Sources: CBO, JCT, OMB, and US Budget Watch calculations

X = Not addressed in the proposal, but expected in the final bill

^aIncludes \$6 billion to fund CO-OP startup; *Assumes the addition of the Medicaid expansion as per CBO's rough estimate; [^]Decreases deficit in short-run due to 5-year vesting period; [#]\$25 billion in costs net of \$20 billion in fees; ⁺Costs of expanding prescription drug coverage incorporated into savings estimate for reducing payments; [#]Actual savings from establishing a commission to propose or enact payment changes are highly uncertain.

COMPARING HEALTH CARE PLANS: A GUIDE TO HEALTH CARE REFORM PROPOSALS IN THE 111TH CONGRESS

Background

The country is engaged in a national debate over the future of the U.S. health care system. Most agree on the problems: costs are too high and growing too rapidly, coverage is lacking for millions of Americans, quality measures have fallen behind many other developed nations, and existing federal programs and tax expenditures are putting immense strain on federal and state budgets.

Yet, while there is broad agreement that reform is necessary, there is by no means a consensus on what changes are needed. The three major goals of expanding coverage, improving quality, and reducing costs are very often in conflict. And considerable disagreements exist over the relative importance of these goals and the best ways to achieve them.

Recent months have seen a flurry of comprehensive proposals. The three most prominent are a bill from three Committees in the House of Representatives, another from the Senate Committee on Health, Education, Labor and Pensions (HELP), and a third bill from the Senate Finance Committee.

All three bills expand coverage through a combination of employer and individual mandates, the creation of health insurance exchanges, the provision of subsidies for lower-income individuals, and the expansion of Medicaid.¹

At the same time, the bills have a number of differences. They vary in the size of subsidies provided and taxes and penalties imposed, and thus differ in terms of overall costs for expanding coverage. They also differ in how they would offset these new costs, though in all cases, savings come primarily from Medicare, Medicaid, and new taxes.

To meet the test of fiscally responsible reform, a plan must go beyond simply offsetting the costs. Because health care is the leading driver of massive, long-term deficits facing the country, reform must also significantly slow the growth of government spending on health care. US Budget Watch has summarized the major reform bills being considered by Congress to provide detailed information about the fiscal effects of the plans.² A subsequent paper will offer a comparative analysis of the proposals.

¹ Due to jurisdictional issues, this expansion is called for but not written into the HELP bill.

² This document is based primarily on versions of the bills as they were presented to CBO. It does not necessarily capture the impact of the many amendments and changes which have been made or are currently under consideration. Additionally, the descriptions may not capture all exemptions and exceptions. All numbers are ten-year savings.

House Tri-Committee Plan (“America's Affordable Health Choices Act”)

In mid-July, the House Energy and Commerce Committee, Ways and Means Committee, and Education and Labor Committee jointly introduced the America's Affordable Health Choices Act of 2009. The bill mandates and subsidizes health care coverage, creates a health insurance exchange, and expands Medicaid. According to the Congressional Budget Office (CBO), the plan would reduce the number of the uninsured from about 20 percent of the population to about 6 percent.

The coverage provisions in the bill would cost about \$1 trillion during the next 10 years, even taking into account nearly \$250 billion in penalties and payments from uninsured individuals and employers who do not provide coverage. Furthermore, the bill would include about \$300 billion in additional spending. To cover these costs, it calls for spending cuts and reforms within Medicare and Medicaid as well as a surtax on high earners and several smaller revenue raisers.

All three House committees have reported a version of the America's Affordable Health Choices Act. Although the Energy and Commerce Committee made some significant changes to the bill, and the Education and Labor Committee proposed some amendments, the major provisions of the original bill remain intact. They include:

Individual Mandates **\$29 billion**
Most individuals would be required to purchase “acceptable health coverage” which, among other requirements, would limit annual out-of-pocket expenses to \$5,000 a person or \$10,000 for a family. Failure to possess such coverage would result in a tax equal to as much as 2.5 percent of an individual’s income, with the amount not to exceed the average national premium for a basic coverage plan within the exchange.

Play-or-Pay Provisions **\$208 billion**
Firms with annual payrolls of more than \$250,000 would be subject to a “play-or-pay” requirement in which they would either have to offer qualifying insurance to their employees and contribute substantially toward their premiums or pay the government a fee generally equaling 8 percent of their payroll.

Health Insurance Exchange with a Public Option **n/a³**
In order to facilitate the purchase of insurance on the individual market, the House bill would create a National Health Insurance Exchange for individuals not already enrolled in qualified insurance. Purchasers would be able to choose options with differing levels of coverage, although regulations—such as a minimum benefits package and restrictions on risk-based premiums—would be imposed.

³ Administrative costs not yet scored.

Among available choices would be a “public plan” administered by the Department of Health and Human Services. This plan would have to be self-sustaining (it would not receive general revenue funding), and would generally pay health care providers 5 percent more than Medicare for the three years following its establishment. After that, rates would be set independently, rather than dictated by the law.

Insurance Subsidies

-\$773 billion

The government would subsidize the purchase of insurance within the exchange for those making between 133 percent and 400 percent of the federal poverty line (which is currently \$11,000 for a typical average individual and \$22,000 for a family of four). Subsidies would be provided on a sliding scale and designed to limit the premiums of those purchasing low-cost plans to between 1.5 percent and 11 percent of their income, while also limiting out-of-pocket expenses. Subsidies would begin in 2013 and would grow as health care costs increased. CBO estimates that the average subsidy would be worth about \$4,600 in 2014 and about \$6,000 by 2019.

Medicaid Expansion

-\$438 billion

Anyone making less than 133 percent of the federal poverty line would become eligible for Medicaid. Newborns without insurance coverage and certain other low-income individuals also would be covered. Eligibility expansion would begin in 2013, with all new costs financed by the federal government rather than the states.

Small Business Tax Credit

-\$53 billion

Businesses with fewer than 25 full-time employees who earn, on average, less than \$40,000 a year would be eligible for a tax credit—provided they contributed substantially to employee health coverage. The credit would pay half the costs of premiums for businesses with fewer than 10 employees who earn, on average, less than \$20,000 a year. The credit would phase out as the businesses and average wages grew and would not be available for employees making more than \$80,000 a year.

Regulatory Changes

n/a

In addition to expanding coverage and regulating insurance purchased through the exchange, the House bill would create a number of new parameters for traditional private insurance. Most significantly, insurance companies would be required to cover and maintain coverage of all individuals, regardless of risk or pre-existing conditions. Additionally, there would be limits on how much rates could differ between individuals, marketing would be somewhat restricted, and limits would be placed on the percentage of premiums going toward administrative costs and profits, as opposed to health care.

Physician Payments Update

-\$229 billion

Current law relies on a formula known as the Sustainable Growth Rate (SGR) for the reimbursement of physicians under Medicare. The SGR often has grown significantly more slowly than health care costs, and, beginning in 2002, it called for cuts in physician

payments. Starting in 2003, however, policymakers waived the SGR formula in favor of ad-hoc freezes or increases. Rather than allowing these temporary patches to continue, the House bill would replace the SGR with an inflation-based system.

Medicare Prescription Drug Coverage

n/a⁴

Under the standard Medicare Part D plan, there is currently a “donut hole” in which the government does not cover the cost of an individual’s prescription drugs (roughly between \$2,700 and \$6,200 in 2009). The House bill would require pharmaceutical companies to offer most individuals a 50 percent rebate for prescription drugs purchased within the donut hole. It would also gradually raise the floor and lower the cap on the donut hole, eliminating it completely by 2022.

Other Spending

-\$63 billion

The bill also includes a number of other smaller spending items including higher payments for certain procedures in Medicare and Medicaid, an expansion of the Medicaid Savings Program and other low-income subsidies, health care grant money to U.S. territories, and several other small measures. In addition, the bill would temporarily fund a reinsurance program for employers offering health insurance to retirees.

Prescriptions Drug Costs

\$47 billion⁵

The House bill finances its expansion of Medicare Part D by creating a new rebate program. The program would require drug manufacturers to pay the federal government the difference between Medicare and Medicaid drug prices for dual eligible individuals. In addition, the bill extends and increases existing Medicaid discounts for prescription drugs.

Medicare Advantage Cuts

\$162 billion

Medicare’s private insurance option—Medicare Advantage—now costs substantially more per patient than does traditional Medicare. Subsidies to Medicare Advantage would be reduced to bring them roughly in line with the traditional Medicare program. Several smaller reforms to the program would also be implemented.

Provider Payment Updates

\$196 billion

The growth of provider payments within Medicare would be slowed. In particular, the way payments are updated for hospitals, nursing facilities, and other providers would be changed in order to account for annual productivity increases.

⁴ CBO estimates the effects of this expansion in conjunction with other measures to reduce prescription drugs prices (see “Prescription Drug Costs”).

⁵ Savings net of costs for expanding Medicare Part D coverage.

Measures to Slow Health Care Cost Growth

\$5 billion⁶

Included in the House bill are a number of measures that are designed to reduce the size and slow the growth of economy-wide health care costs. Many of these measures would take the form of payment reforms within Medicare and Medicaid. And while they would all be designed to reduce *overall* health care costs, some are projected to actually increase *federal* costs – either because they require up front investment, they are targeted mainly at reducing private health care costs, or because CBO does not have sufficient evidence to score them as providing substantial savings. Among the more significant measures, the plan would:

- Reform payments to discourage unnecessary hospital readmissions.
- Create an Accountable Care Organization pilot program to help hospitals and physicians better manage and coordinate care.
- Establish a pilot program for payment “bundling” to encourage more cost-efficient delivery of care.
- Increase payments to primary care providers and promote medical homes designed to coordinate care.
- Fund new health treatment comparative effectiveness research and develop new quality measures.
- Encourage greater price transparency throughout the health care system.
- Encourage greater use of preventative services and wellness programs.

Measures to Reduce Federal Health Care Spending

\$81 billion

In addition to measures designed to reduce or slow overall health care costs, the House bill includes a number of provisions designed to reduce the costs to the federal government of Medicare and Medicaid. While they would lower federal health care spending, these measures would likely do little to decrease private health care spending, and may in fact increase private costs. Among the more significant measures, the bill would:

- Reform and reduce home health payments and payments to skilled nursing facilities to better reflect costs.
- Reduce disproportionate share hospital (DSH) payments, which pay hospitals for providing uncompensated care, at the discretion of the Secretary of Health and Human Services beginning in 2017.
- Address fraud, waste, and abuse in Medicare and Medicaid through more enforcement, better data analysis, higher penalties, and several new procedures.
- Reduce payments on certain imaging services.
- Eliminate funding to the Medicare Improvement Fund, which was scheduled to receive \$23 billion in 2014.

⁶ Net savings after accounting for roughly \$25 billion in new costs, the majority of which occur in the first few years after the bill is enacted.

Surtax on High Earners**\$544 billion**

Individuals earning between \$350,000 and \$500,000 a year would be taxed at a rate of 1 percent through 2012 and 2 percent thereafter. Those earning between \$500,000 and \$1 million would be taxed at a rate of 1.5 percent through 2012 and 3 percent thereafter. Incomes of more than \$1 million would be taxed at a rate of 5.4 percent beginning in 2012 with no subsequent increase. Should new projected saving from cost-cutting provisions exceed CBO estimates by more than \$150 billion over 10 years, the rates would not increase in 2013. And should savings exceed CBO estimates by more than \$175 billion, the 1 percent and 1.5 percent rates would be abolished, although the 5.4 percent surtax would remain in either case.

Limits to Corporate Tax Breaks**\$37 billion**

Included in the House bill are three provisions which would raise corporate tax revenue. For one, the bill would delay the implementation of “world-wide interest allocation rules” until 2020. It would also limit the extent to which tax treaties could reduce tax liabilities through deductible related party payments. Finally, the bill would codify into law the “economic substance doctrine,” which, essentially, requires tax-advantaged transactions to have an economic rational outside of the tax benefits themselves.

Limits on Definition of “Qualified Medical Expenses”**\$8 billion**

The House bill would also limit, somewhat, several health care related tax benefits. It does this by changing the definition of qualified medical expenses for Health Savings Accounts, Flexible Savings Accounts, and other similar accounts in order to conform to the definition set forth for the medical expenses itemized deduction. Among other things, this would disallow the purchase of over-the-counter medications through these plans.

Interaction Effects**\$0 billion**

The Congressional Budget Office and the Joint Committee on Taxation expect some interactive effects among the provisions in the bill itself and between the bill and current laws governing tax rates and Medicare premiums. However, the interactions that would increase costs and those that would reduce them are expected to roughly cancel one another out.

Total Ten Year Budget Impact	-\$239 billion
Memorandum:	
Budgetary Impact in the Tenth Year	-\$65 billion
Coverage Expansion in the Tenth Year	37 million

Senate HELP Committee (“Affordable Health Choices Act”)

In early July, the Senate Health, Education, Labor, and Pensions (HELP) Committee released a draft of the Affordable Health Choices Act. The bill mandates and subsidizes health care coverage and creates a health insurance exchange. According to CBO, the bill would reduce the number of the uninsured from about 20 percent of the population to about 12 percent. The committee envisions that many of the remaining uninsured would be covered by an expansion of Medicaid, although such a provision is not included in its bill because of jurisdictional issues.

The coverage provisions in the bill would net to around \$700 billion during the next decade, after taking into account roughly \$90 billion in penalties and payments from uninsured individuals and employers who do not provide coverage. Although not included in this version, the bill is also supposed to include a large expansion of Medicaid (likely costing around \$500 billion), and a number of tax and spending policies designed to pay for the bill. Again, because of jurisdictional issues, these provisions are expected to be added later by the Senate Finance Committee.

The bill has been reported out of the Senate HELP Committee. Below are descriptions of its major provisions.

Individual Mandates **\$36 billion**
Individuals generally would be required to purchase health insurance. Most of those making more than 150 percent of the federal poverty line who fail to accept an insurance plan would pay a penalty equal to half of the price of the lowest cost plan offered in a health insurance exchange.

Play-or-Pay Provisions **\$52 billion**
Firms with 25 or more employees that do not offer qualifying insurance, in which they pay at least 60 percent toward their employees’ premiums, would be required to pay a \$750 per person penalty (\$375 for part-time employees). The penalty would be indexed to inflation.

Health Insurance Exchanges With a Public Option **n/a⁷**
To facilitate the purchase of insurance on the individual market, state-based “gateways” would be administered by governmental agencies or nonprofit organizations. States would be free to establish multiple gateways or form regional gateways with other states. If any areas lacked gateways by 2014, the federal government would step in. Individuals not enrolled in qualified insurance programs would be able to purchase insurance through a gateway, choosing from a variety of coverage options, although regulations such as a minimum-benefits package and restrictions on risk-based premiums would be imposed.

⁷ Administrative costs not yet scored.

Among the options would be a public plan administered by the Department of Health and Human Services through contracts with local entities. This plan would receive no general revenue funds so it would have to be self-sustaining. It would pay providers at rates set by the secretary of Health and Human Services, which would likely be in line with privately negotiated rates.

Insurance Subsidies

-\$723 billion

The government would subsidize the purchase of insurance within the gateways for those making between 150 percent and 400 percent of the federal poverty line (roughly \$11,000 for a typical individual and \$22,000 for a family of four). Subsidies would be provided on a sliding scale and designed to limit the premium contributions of those purchasing low-cost plans to between 1 percent and 12.5 percent of their income. Subsidies would be set in 2013, after which the caps would be indexed for medical inflation, meaning that the proportion of premiums paid for by the government would decline over time, although the overall size of its contribution would increase. The Congressional Budget Office estimates the average subsidy would be worth about \$4,700 in 2014 and around \$6,100 by 2019.

Medicaid Expansion

n/a / -\$500 billion⁸

The Senate HELP bill envisions expanding Medicaid to individuals making below 150 percent of the federal poverty line. Because of jurisdictional issues, however, no such provision is included in the bill itself. The Congressional Budget Office has estimated that adding such a provision would cost around \$500 billion over ten years—although there is a wide margin of error depending on exactly how the provision is designed.

Small Business Tax Credit

-\$56 billion

Businesses with fewer than 50 full-time employees who earn, on average, less than \$50,000 a year would be eligible for a tax credit—provided they offered and contributed at least 60 percent to the cost of employee health coverage. These businesses generally would receive tax credits equal to \$1,000 per covered employee and \$2,000 per covered family. Businesses could not take credits for more than three consecutive years.

Regulatory Changes

n/a

In addition to expanding coverage and regulating insurance purchased through the exchange, the Senate HELP bill would create a number of new parameters for traditional private insurance. Most significantly, insurance companies would be required to cover and maintain coverage of all individuals, regardless of risk or preexisting conditions. They would also be limited in how much their rates could differ among individuals and would be required to reform payment structures to offer incentives for coordinated care, disease management, preventative care, and reduction of medical errors. Additionally, the bill would direct insurers to consider those younger than age 26 as dependents.

⁸ CBO estimates that adding a Medicaid provision to the HELP bill would increase costs by around \$500 billion, although they concede that there is a wide margin of error.

Long-Term Care Insurance**\$58 billion**

The Community Living Assistance Services and Supports Act (the CLASS Act) provision of the bill establishes a voluntary government-run long-term care insurance program. The Congressional Budget Office estimates that premiums would average about \$65 a month and benefits about \$75 a day. Over time, however, premiums would need to increase to about \$85 a month, and benefits would need to be reduced to about \$50 a day to avoid depleting the trust fund set up by the program. Technically, this program is projected to reduce the deficit during the next decade by \$58 billion; this is mainly because of a five-year vesting requirement. Deficits would likely increase by at least that amount beyond the 10-year budget window.

Other Spending and Savings**-\$24 billion**

The bill also includes a number of other smaller spending items including measures to improve public health, increase access to medical clinics, encourage prevention and support wellness initiatives, and fund medical research. The bill would also modify certain prescription drug patent laws in order to more quickly bring some generic drugs to market.

Measures to Finance Coverage Expansion**n/a**

Because the HELP Committee does not have jurisdiction over policies related to Medicare, Medicaid, or taxes, it will develop additional policies in conjunction with the Senate Finance Committee.

Interaction Effects**\$46 billion**

The Congressional Budget Office and Joint Committee on Taxation have estimated there to be a number interaction and secondary effects of the legislation. In particular, coverage expansion under the bill would result in reduced costs for Medicaid and CHIP, as well as higher overall tax revenue.

Total Ten Year Budget Impact	-\$611 billion / -\$1,111 billion
Memorandum:	
Budgetary Impact in the Tenth Year	-\$120 billion / -\$216 billion
Coverage Expansion in the Tenth Year	21 million / 38 million

Senate Finance Committee (“America’s Healthy Future Act”)

In mid-September, Senate Finance Committee Chairman Max Baucus introduced his “Chairman’s Mark” of the ‘America’s Healthy Future Act’. By mandating and subsidizing health coverage, creating a new health insurance exchange, and expanding Medicaid, the bill would significantly reduce the number of uninsured – from around 20 percent of the population to around 9 percent, according to CBO.

In total, the coverage provisions of the bill would sum to around \$725 billion over the next ten years, accounting for nearly \$50 billion in revenues from uninsured individuals and employers who do not provide coverage. In addition, the bill would include about \$50 billion in other spending. To pay for these costs, the bill would enact a number of spending cuts and reforms within Medicare and Medicaid, impose fees on a number of health care companies, and tax high cost insurance plans.

Since being introduced, Chairman Baucus has made several changes to the bill – many of which we describe in the footnotes. And many more changes are expected, in the form of amendments, as the bill makes its way through the Committee. Below we have described the major provisions of the original Chairman’s Mark.

Individual Mandates⁹

\$20 billion

Individuals would generally be required to purchase health insurance. For those making between 100 percent and 300 percent of the federal poverty line, failure to possess insurance would result in an annual fine of \$750 per person, but no more than \$1,500 for a family. Those making more than 300 percent of the poverty line would face a fine of \$950, but no more than \$3,800 for a family. Rates would be indexed to medical price inflation, and exemptions would be available to certain groups, mainly those that could not afford any insurance plan on less than 10 percent of their income.

“Play-or-Pay” Provisions

\$27 billion

Technically, employers would not be required to provide insurance, but those with more than 50 employees would be required to pay for the full cost of subsidies provided to their employees. These costs would be capped at \$400 times the total number of employees. Individuals receiving employer coverage would be ineligible for subsidies within a health insurance exchange.

⁹ The updated Chairman’s Mark would reduce the maximum penalty to \$1,900 for families making over 300 percent of the poverty line.

Health Insurance Exchange with “CO-OP” Options

-\$6 billion¹⁰

To facilitate the purchase of insurance in the individual and small-group markets, state-based exchanges would be created both for individuals and for small businesses. Purchasers would be able to choose from a variety of insurance options with differing levels of coverage, although regulations such as a minimum-benefits package and restrictions on risk-based premiums would be imposed. Younger participants would have the option of buying low-cost “young invincible” catastrophic insurance.

The Finance bill would also facilitate the establishment of Consumer Operated and Oriented Plans (CO-OPs) through loans and grants. These non-profit insurers would compete against existing private insurance companies in the health exchanges, but would not receive any government funding beyond 2015.

Insurance Subsidies¹¹

-\$452 billion

The government would use a refundable tax credit to subsidize the purchase of insurance within the health insurance exchanges for those making between 100 percent and 400 percent of the federal poverty line, (around \$11,000 for a typical individual and \$22,000 for a family of four in 2009). Subsidies would be provided on a sliding scale and be designed to limit the premium contributions of those purchasing a medium-cost plan to between 3 percent and 13 percent of income, while also limiting out-of-pocket expenses for those making less than 300 percent of the poverty line. Subsidies would generally begin in 2013. They would be indexed so that enrollees would pay a constant share of premiums, meaning that an increasing portion of their income would go toward purchasing insurance. The Congressional Budget Office estimates the average subsidy would be worth about \$4,200 in 2015 and about \$5,000 by 2019.

Medicaid Expansion

-\$287 billion

In addition, the Finance bill would expand Medicaid eligibility to all individuals making below 133 percent of the federal poverty line, although those making above 100 percent of the poverty line could alternatively opt to buy subsidized insurance through the exchange. On average, the federal government would pay 90 percent of the costs for newly eligible recipients.

Small Business Tax Credit

-\$24 billion

In 2011 and 2012, firms with 25 or fewer workers who earn, on average, less than \$40,000 a year would be eligible for a non-refundable tax credit worth as much as 35 percent of insurance costs. Beginning in 2013, small businesses could purchase insurance on a health insurance exchange, where they could receive a credit for as much as 50 percent of

¹⁰ Includes start-up funds for CO-OPs but excludes administrative costs of setting up health insurance exchanges.

¹¹ The updated Chairman’s Mark increases the subsidies so that premiums are limited to between two and twelve percent of income.

insurance costs for two years (although the full credit would be available only to firms with fewer than 10 workers who earn, on average, less than \$20,000 a year).

Regulatory Changes

n/a

Employer-provided insurance could generally continue under the current regulatory regime, in the Finance bill, except that employers typically would be required to provide first-dollar coverage for preventative services and would have to limit out-of-pocket expenses for employees to levels set for the catastrophic insurance that accompanies health savings accounts (HSAs). If an employer offered insurance that required employees to contribute more than 13 percent of their income, those employees could choose to buy insurance from a health insurance exchange, and the employer would be responsible for part of or the entire provided subsidy.

Insurance provided within the exchanges or on the individual or small-group market would have restrictions, including a ban on denying or limiting coverage based on preexisting conditions. A limit would also be placed on how much premiums could differ between individuals.

Physicians Payments Update for 2010

-\$11 billion

The Finance bill would also replace the 21 percent cut in Medicare physician payments for 2010 with a 0.5 percent increase. The bill would not, however, address future scheduled cuts in physician payments, which would likely grow over time and have been averted on an ad-hoc basis in the past.

Medicare Prescription Drug Coverage

-\$19 billion

Under the standard Medicare Part D plan, there is currently a “donut hole” in which the government does not cover the cost of an individual’s prescription drugs (roughly between \$2,700 and \$6,200 in 2009). The Finance bill would require drug companies to offer 50 percent discounts (or rebates) on drugs purchased within the donut hole (by threat of disallowing the coverage of those drugs by Medicare prescription drug programs). The bill would also effectively halve the size of the donut hole by measuring it according to the “true cost” of drugs, rather than the discounted price.

Other Spending¹²

-\$18 billion

There would also be a number of other smaller spending items, including higher payments for certain procedures in Medicare and Medicaid, additional funding for pregnant women and children, funding to support high-risk pools until 2013, and several other small measures. The bill also calls for \$20 billion worth of reinsurance, although this is financed directly by health insurance companies.

¹² The updated Chairman’s Mark includes an additional \$5 billion in reinsurance for employer-sponsored retiree coverage. A number of smaller spending measures would also be added.

Prescriptions Drug Costs**\$15 billion**

The bill would require all Medicaid plans to cover prescription pills but would also enact a number of cost-cutting measures. For one, the bill would require drug companies to offer larger rebates to the Medicaid program, as a condition for participation. Additionally, the bill would reduce the limit on the federal share of any prescription drug purchases, in order to encourage states to purchase on a more cost-effective basis. Other smaller changes would also be implemented, both to the Part D and Medicaid prescription drug programs.

Medicare Advantage Cuts¹³**\$125 billion**

Currently, Medicare's private insurance option—Medicare Advantage—costs substantially more per patient than traditional Medicare. Subsidies to Medicare Advantage would be reduced by setting benchmarks based on competitive bidding to bring them more closely in line with the traditional Medicare program. The bill would offer bonus payments for plans that coordinate care or rank highly on measures of quality or improvement. The new payment system would be phased in by 2015.

Provider Payment Updates**\$182 billion**

The Finance bill would slow the growth of provider payments within Medicare. In particular, changes would be made to the way payments are updated for hospitals, nursing facilities, and other providers in order to account for annual productivity increases.

Medicare Premium Increase for High Earners**\$34 billion**

The bill would means test Medicare subsidies so that Part B and Part D premiums would rise for higher earners. For Medicare Part B, the plan would expand current means testing by freezing the threshold above which higher premiums have to be paid (currently \$85,000 for an individual) through 2019 before indexing it again. The plan would also implement higher Part D premiums for recipients above the Part B earnings threshold.

Medicare Payment Commission**\$23 billion¹⁴**

The bill would establish a new, independent Medicare Commission which would make proposals for improving Medicare quality and extending the system's solvency. The commission's recommendations would go into effect automatically unless blocked by legislative action or replaced by equivalent proposals. Moreover, the commission would be required to make recommendations if the Medicare trustees projected that Medicare would grow faster than halfway between inflation and medical cost growth before 2019 or by more than 1 percentage point beyond GDP after 2019.¹⁵

¹³ The updated Chairman's Mark grandfathered in extra benefits in certain Medicare Advantage plans.

¹⁴ Estimate based on considerable amounts of uncertainty. If allowed to continue, savings from the commission would likely be considerably higher beyond the ten year budget window.

¹⁵ A joint resolution of Congress would be necessary to continue the commission beyond 2019 (in the updated Chairman's Mark, the Congress would have to vote affirmatively to discontinue to commission).

In addition to the Medicare Commission, the bill would establish a number of advisory boards, committees, institutes, and centers designed to advise on improving the quality and efficiency of health care delivery. The secretary of Health and Human Services would be required to provide a plan to Congress on how to reform the Medicare wage index system.

Measures to Slow Health Care Cost Growth **\$5 billion**¹⁶

Included in the Finance bill are a number of measures that are designed to reduce the size and slow the growth of economy-wide health care costs. Many of these measures would take the form of payment reforms within Medicare and Medicaid. And while they would all be designed to reduce *overall* health care costs, some are projected to actually increase *federal* costs – either because they require up front investment, they are targeted mainly at reducing private health care costs, or CBO does not have sufficient evidence to score them as providing substantial savings. The more significant measures would:

- Improve transparency by requiring employers to report the cost of health insurance policies to their employees, insurance companies to report the percentage of their revenue going toward profit and administrative costs, and hospital to list standard prices for all procedures.
- Allow for states to enter into agreements allowing the purchase of insurance across state lines.
- Expand Medicare and Medicaid coverage for preventative and wellness services while exploring options for providing healthy lifestyle incentives.
- Implement “value-based purchasing” in Medicare to encourage high-quality and low-cost provision of care.
- Create an Accountable Care Organization pilot program to help hospitals and physicians better manage and coordinate care.
- Establish a national pilot program for payment “bundling” in Medicare (and demonstration projects in Medicaid) to encourage more cost-efficient delivery of care
- Fund comparative effectiveness and quality research, increase reporting, and establish an “Innovation Center” at CMS to test new payment models to improve quality and reduce cost within Medicare.
- Reduce payments for hospitals with high rates of readmission or medical error.
- Increase payments to primary care providers.

Measures to Reduce Federal Health Care Spending **\$87 billion**

In addition to measures designed to reduce or slow overall health care costs, the Finance bill includes a number of provisions designed to reduce costs to Medicare and Medicaid. While they would lower federal health care spending, these measures would likely do little to decrease private health care spending, and may in fact increase private costs. The more significant measures would:

¹⁶ Number calculated net of new spending.

- Reform and reduce home health payments to better reflect costs.
- Reduce disproportionate share hospital (DSH) payments, which pay hospitals for providing uncompensated care, in proportion to the reduction in uninsured individuals.
- Address fraud, waste, and abuse in Medicare and Medicaid through more enforcement, better data analysis, higher penalties, and several new procedures.
- Reduce payments on certain imaging services.
- Eliminate funding to the Medicare Improvement Fund, which was scheduled to receive \$23 billion in 2014.

Excise Tax on High-Cost Insurance¹⁷ \$215 billion

To help pay for coverage expansion, the Finance bill would impose a 35 percent tax on insurance companies and administrators for the cost of any health insurance plan going beyond \$8,000 for individuals or \$21,000 for families. The goal of this tax would be both to increase revenue and discourage the purchase of high-end health insurance plans (therefore slowing overall growth). The threshold would be indexed to inflation and allowed to vary somewhat by state in the early years.

Corporate Information Reporting \$17 billion

In order to reduce the tax gap, the Finance bill would also increase required information reporting with regards to transactions to corporations. The new information could then be used to improve tax compliance.

Limits on Health Care Tax Benefits¹⁸ \$23 billion

The Finance bill would also limit or eliminate a number of small health care tax benefits. Specifically, contributions to Flexible Savings Accounts (FSAs) would be limited to \$2,000 a year, the penalty for withdrawing money from Health Savings Accounts (HSAs) for non-medical expenses would be doubled, and the definition of qualified medical expenses for HSAs and FSAs would be standardized. In addition, the tax exclusion for employers who maintain drug benefits for Part D eligible retirees would be eliminated.

Fees on Health Care Companies \$93 billion¹⁹

Beginning in 2010, certain health care companies would pay yearly fees based on market share. The fees would be designed to raise \$2.3 billion annually from pharmaceutical

¹⁷ The updated Chairman’s Mark taxes at a 40 percent rate, rather than 35. However, this threshold is indexed to grow one percentage point faster than inflation each year (rather than at inflation), and insurance plans for workers over age 55 or in high risk professions would be subject to higher thresholds. These changes would cost around \$10 billion over ten years, and more beyond the budget window.

¹⁸ The updated Chairman’s Mark includes an addition \$14 billion in revenue raisers, mainly by increasing the cost threshold above which medical expenses can be deducted for tax purposes.

¹⁹ Although the fees themselves would raise around \$130 billion across 10 years, some of this would be offset by interactions with other parts of the tax code.

manufacturers, \$4 billion from medical device manufacturers, \$6 billion from health insurance providers, and \$750 million from clinical laboratories.

Interaction Effects

\$1 billion

The Congressional Budget Office and Joint Committee on Taxation have estimated there to be numerous interaction effects between various provisions within the bill, and between those provisions and current laws governing tax rates and Medicare premiums. Taken together, however, those interactions which increase costs and those which reduce costs roughly cancel out.

Total Ten Year Budget Impact	\$49 billion
Memorandum:	
Budgetary Impact in the Tenth Year	\$16 billion
Coverage Expansion in the Tenth Year	29 million

Other Health Care Plans

Although the three plans described are the most pertinent to the health care reform debate, several other comprehensive or partial plans have been introduced. Most have not been scored in their entirety and are unlikely to pass at this time. However, as they might weigh heavily on the debate, we have offered brief descriptions of some of them below.

President Obama's Health Care Reserve Fund **\$908 billion**

While President Obama has not put forth a comprehensive plan, he has proposed more than \$900 billion in offsets to pay for health care reform. Roughly \$300 billion of this comes from tax increases—primarily through a change that would allow higher earners to deduct eligible items only at a 28 percent rate and not at the higher tax rate they would otherwise be facing. The President's reserve fund also institutes smaller measures to reduce the tax gap and end corporate tax loopholes.

The President's plan further calls for around \$600 billion in Medicare and Medicaid spending reductions, the largest coming from reducing subsidies to Medicare Advantage through competitive bidding, slowing the growth of provider payments to account for productivity, reducing spending on prescription drugs in Medicare Part D, and cutting disproportional share hospital (DSH) payments. Also included are payment reforms designed to promote the efficient and effective delivery of care and a proposal to charge wealthy Medicare Part D enrollees higher insurance premiums. Finally, outside the reserve fund, the administration has put forward a plan to empower an outside body, the Independent Medicare Advisory Council, to enact future Medicare payment reforms.

Wyden-Bennett Bill ("Healthy Americans Act") **Budget Neutral / Positive**²⁰

The Wyden-Bennett bill, sponsored by Senator Wyden (D-OR) and Senator Bennett (R-UT), would replace the current tax exclusion for employer-sponsored health care insurance with a smaller fixed tax deduction indexed to inflation. The savings would be used to finance universal coverage. The plan would mandate the purchase of insurance through state-run exchanges (enforced through automatic withholding). Sliding scale subsidies would be offered to those making up to 400 percent of the federal poverty line.

Employers would drop employees from their current coverage by "cashing out" their insurance plans, and wages would go up by the value of the health insurance. Additionally, employers would be required to pay a tax between 3 percent and 26 percent of the average national premium to purchase a minimum benefits package. According to CBO, the plan would cover nearly all Americans and be roughly deficit neutral once fully implemented. Over the long-term, the plan would reduce budget deficits considerably.

²⁰ CBO estimates the Wyden-Bennett bill to be "roughly budget neutral" in its first year of full implementation. Beyond that, they expect costs to grow more slowly than savings.

Coburn-Burr/Ryan-Nunes Bill (“Patients’ Choice Act”) **Budget Neutral / Positive**

The Patients’ Choice Act, proposed by Senator Coburn (R-OK), and Senator Burr (R-NC), Congressman Ryan (R-WI), and Congressman Nunes (R-CA), would replace the tax exclusion for employer-sponsored health care insurance with a larger fixed tax credit unrelated to the amount of insurance purchased. In addition to the tax credit, the bill would provide subsidies for those making below 200 percent of the federal poverty line and create state-based exchanges from which to purchase health insurance. It would also expand the role of health savings accounts (HSAs).

To finance the costs of the plan, beyond eliminating the tax exclusion, the bill would reduce subsidies to Medicare Advantage, increase premiums for wealthier Medicare enrollees, enact several Medicare and Medicaid payment changes, and implement medical malpractice liability reform based on the creation of “health courts.” To ensure deficit neutrality, the tax credit could not exceed the savings generated in any given year.

Price Bill (“Empowering Patients First Act”) **Unknown**

The Empowering Patients First Act, originally put out by the Republican Study Committee, would establish association plans and an individual membership association through which individuals and employers could purchase coverage. It would subsidize the purchase of insurance by making individual premiums tax deductible and providing tax credits of up to \$2,000 per individual (\$5,000 for a family of four) for those making under 300 percent of the federal poverty line. The plan would encourage states to form high-risk or reinsurance pools.

To help finance the plan and slow health care cost growth, the bill would allow insurers to sell across state lines, enact medical malpractice liability reform, reduce disproportionate share hospital (DSH) payments to reflect reductions in the uninsured, address Medicare and Medicaid waste and fraud, and reinstate the “Medicare Trigger,” a provision that would require the President to submit to Congress a plan to reduce spending or raise revenue if the Medicare subsidy threatened to exceed 45 percent of annual expenditures. Additionally, the plan would place caps on non-defense discretionary spending.

* * *

To enact any reform, the Senate, the House of Representatives, and the Obama Administration will need to agree upon a single bill – one which will likely have elements of all the major proposals discussed above. Expanding health insurance will be extremely expensive, notably, at a time when the federal budget is already facing huge fiscal imbalances. Merely offsetting the new costs of a bill will not be sufficient to make a reform plan fiscally responsible since those offsets could otherwise be used to help close the long-term fiscal gap. Instead, a fiscally responsible plan must include aggressive measures that would help slow the growth of overall health care spending and reduce health care costs for the federal government. As debate and negotiation continues, we urge a strong focus on cost; not just over the next ten years, but over the long-term.