

Key Committee Amendments to H.R. 3200

August 17, 2009

BACKGROUND

On July 14, 2009, the Chairmen of the three House Committees with jurisdiction over health care legislation—Education and Labor Chairman George Miller (D-CA), Energy and Commerce Chairman Henry Waxman (D-CA), and Ways and Means Committee Chairman Charlie Rangel (D-NY)—introduced H.R. 3200. On July 17, the Ways and Means Committee approved the bill by a 23-18 vote, and the Education and Labor Committee approved the bill by a 26-22 vote. The Energy and Commerce Committee approved its version of the legislation on July 31 by a 31-28 margin.

During consideration of H.R. 3200 in the three Committees, many amendments changed the bill text from the legislation as originally introduced. The Republican Conference has prepared the summaries below of the key substantive amendments offered by Republicans and Democrats that were adopted during the three markups.

AMENDMENT SUMMARIES

The list below is by no means exhaustive, and should not be construed as indicating that some or all of the amendments adopted in Committee will be incorporated into any manager's amendment considered by the Rules Committee. Moreover, at the time the Energy and Commerce Committee completed its markup on July 31, there were as many as 60 additional amendments pending to the bill; at that time, Chairman Waxman indicated that he would hold a second markup in September to allow those amendments to be considered (the precise legislative vehicle for doing so still being unclear) before any synthesis of the respective Committee products is brought to the House floor for consideration.

Education and Labor Amendments

Chairman's Mark: Prohibits group health plans from "reducing the benefits provided under the plan to a retired participant, or beneficiary of such participant" after the worker retires "unless such restriction is also made with respect to active participants." Some Members may be concerned that this provision, by restricting employers' flexibility to adjust retiree health coverage, may encourage firms to drop their health plans entirely—undermining the argument that "If you like your current plan, you can keep it."

The Chairman's mark also requires health plans to spend at least 85 percent of their premium revenue on medical claims, or offer rebates to their enrollees. Particularly as the Government Accountability Office noted in a [report](#) on this issue that "there is no definitive standard for what a medical loss ratio should be," some Members may be concerned about this attempt by federal bureaucrats to impose arbitrary price controls on private companies. Some Members may also be concerned that such price controls, by requiring plans to pay out most of their premiums in medical claims, would give carriers a strong (and perverse) disincentive not to improve the health of their enrollees—as doing so would reduce the percentage of spending paid on actual claims below the bureaucrat-acceptable limits.

The Chairman's mark also prohibits the transfer or use of prescription information, except in very limited circumstances. Some Members may be concerned that these new restrictions would prevent patients

from receiving information of benefit to them—for instance, materials regarding less costly generic alternatives.

Courtney: Effective six months after the date of enactment, reduces pre-existing limitation exclusions from one year to three months, and shortens the “look-back” window for determining such exclusions from six months before enrollment to 30 days before enrollment. While supporting efforts such as high-risk pools to allow individuals with pre-existing conditions to obtain coverage, some Members may be concerned that these provisions could raise premiums for employers, potentially prompting some to drop coverage entirely. A similar [amendment](#), offered by Rep. Sutton, was adopted at the Energy and Commerce Committee markup.

Titus: Expands eligibility for small employers seeking to purchase coverage on the Exchange. In 2013, employers with 15 or fewer employees would be eligible to join the Exchange (up from 10 in the base bill), in 2014, employers with 25 or fewer employees would be eligible (up from 20 in the base bill), and in 2015, all employers with 50 or fewer employees could join the Exchange (the base bill permits—but does not require—the Health Choices Commissioner to open the Exchange to employers with more than 20 workers). Adopted by a party-line vote of [29-19](#).

Scott: Expands the definition of the minimum benefits package to include early and periodic screening, diagnostic, and treatment services (as defined in the Medicaid statute) for all children under 21. Some Members may be concerned that this expansive definition—which includes “such other necessary...measures” to treat physical ailments, regardless of “whether or not such services are covered under the State [Medicaid] plan”—would significantly raise costs for businesses required to offer coverage, and the federal funds needed to subsidize Exchange enrollees receiving such rich benefits. Adopted by a [32-17 vote](#).

Kucinich: Permits States to seek a waiver of the Employee Retirement Income Security Act (ERISA) for a single-payer system that States may wish to adopt. Such a non-profit system—“under which private insurance duplicating the benefits provided in the single payer program is prohibited”—would operate in lieu of the proposed Exchanges, must provide benefits that meet or exceed federal benefit standards in the bill, and may not result in federal costs “neither substantially greater nor substantially less” than those associated with the underlying bill. While supporting the concept of State flexibility over health care regulations, some Members may be concerned by the provision’s prohibitions on private health insurance, which could cause millions of individuals to lose their current coverage. Adopted by a [27-19 vote](#).

Energy and Commerce Amendments

Capps: With regard to abortion in the government-run health plan, explicitly permits the Secretary to include abortion in the services offered by government-run plan, and—if the “Hyde amendment” restrictions on federal funding for abortion coverage are not renewed every year in the Labor-HHS appropriations bill—*requires* that the government-run plan cover abortions.

With regard to the subsidies authorized under the bill, referred to as “affordability credits,” the Capps amendment specifically permits taxpayer subsidies to flow to plans that include abortion, but creates an accounting scheme designed to designate private dollars as abortion dollars and public dollars as non-abortion dollars. The Capps accounting arrangement is rejected by pro-life organizations, which recognize that it is a clear departure from long-standing federal policy against funding health plans that include abortion (e.g., Federal Employee Health Benefits plan, Medicaid, SCHIP, DOD, etc).

Other provisions in the Capps amendment appear to prevent State laws from being overturned and prohibit the Secretary from mandating that all plans include abortion. Although in apparent conflict with the anti-mandate language, the Capps amendment also requires that a plan that includes abortion be

made available in every region—which could in turn lead to mandates that abortion clinics be established to “protect” access to abortions. Adopted by a party-line [30-28 vote](#), with six Democrats opposing.

Pallone: Includes language intended to serve as a placeholder for introduction of the Community Living Assistance Services and Supports (CLASS) Act (H.R. 1721), much of which lies within the jurisdiction of the Ways and Means Committee (and was therefore not germane to the sections considered by Energy and Commerce). That bill would create a new entitlement to long-term care services, financed by a new “Independence Fund” generated from beneficiary premiums. The Fund would be excluded from the federal budget for purposes of both the President and Congress, and subject to a “lock-box” that would prohibit any legislation from diverting monies from the Fund without the consent of 3/5 of the Senate.

Under H.R. 1721, the plan would have a level monthly premium of \$30, provided individuals enroll in the first year they are eligible to join. (Late enrollees would pay age-adjusted premiums.) All individuals over 18 receiving wage or self-employment income would be automatically enrolled in the program; premiums would be automatically deducted from workers’ wages, and firms would be eligible for a tax credit equal to 25 percent of the administrative cost of withholding. Individuals with incomes below 150 percent of the federal poverty level would pay a nominal monthly premium, subject to a self-attestation form verifying their status. Premiums would not increase so long as the individual remained enrolled in the program (or the program had sufficient reserves for a 20-year period of solvency), and under no circumstance could premiums more than double.

Under H.R. 1721, individuals’ eligibility for benefits would vest after five years. The minimum cash benefit would be \$50 per day, with amounts scaled for levels of functional ability—and benefits not subject to lifetime or aggregate limits.

Some Members may be concerned by the concept of creating a new, expansive federal entitlement program when Medicare itself is not actuarially sound and the Medicare Hospital Insurance Trust Fund is scheduled to be insolvent by 2017. Moreover, Members may note that the Congressional Budget Office, in [analyzing](#) similar provisions included in Section 191 of legislation considered by the Senate HELP Committee, found that **“if the Secretary did not modify the program to improve its actuarial soundness, the program would add to future federal budget deficits in a large and growing fashion beginning a few years beyond the 10-year budget window.”**

Rogers: Prohibits any federally sponsored comparative effectiveness research from being used by the federal government to deny or otherwise ration access to health care. A second, similar [amendment](#) offered by Rep. Gingrey prohibiting the Centers for Medicare and Medicaid Services from using cost-effectiveness criteria to make coverage determinations was also adopted. (However, Ways and Means Committee Democrats blocked a similar [amendment](#), offered by Rep. Herger, in their markup on a party-line [vote](#) of 26-15. Anti-rationing language was not offered in the Education and Labor Committee markup, as the issue falls outside the Committee’s jurisdiction.)

Stupak: Codifies the Hyde/Weldon annual appropriations provision, first enacted in FY 2005 and included in Labor, Health and Human Services Appropriations bills since then, providing conscience protection for health care entities by preventing local entities from discriminating against them if they refuse to provide, pay for, or refer for abortion. The amendment seeks to protect health care entities/workers from discrimination and participating in health care plans.

Eshoo: Establishes a Food and Drug Administration approval process for generic biosimilars, also referred to as follow-on biologics. Grants a period of exclusivity for brand-name products of 12 years, with a six-month extension possible in cases where a manufacturer agrees to an FDA request for pediatric studies. Gives FDA the authority to issue general or specific guidance documents (subject to a notice-and-comment period) regarding product classifications. Adopted by a [47-11 vote](#).

Ross: Includes placeholder language amending the small business exemption for the employer mandate, which lies within the jurisdiction of the Ways and Means Committee and technically was not germane to the Energy and Commerce markup. The language would increase the exemption level from \$250,000 to \$500,000 of overall annual payroll, and provide reduced tax penalties to firms with payroll between \$500,000 and \$750,000; the full 8 percent payroll tax would apply to firms over the latter threshold. Some Members may still be concerned that this provision would impose costly taxes on businesses in the middle of a recession—taxes which the Congressional Budget Office recently [noted](#) “could reduce the hiring of low-wage workers, whose wages could not fall by the full cost of...a substantial pay-or-play fee if they were close to the minimum wage.” Members may also note that the underlying bill includes no annual inflation adjustment for the small business exemption threshold—making the “compromise” agreement increasingly irrelevant over time.

Modifies the sliding-scale affordability subsidy levels, such that individuals with incomes equal to four times the federal poverty level (\$88,200 for a family of four) would be expected to pay 12 percent of their income on health coverage, as opposed to 11 percent in the underlying bill. Requires States to pay 10 percent of the cost of the bill’s Medicaid expansion, beginning in 2015; according to the preliminary CBO [score](#) of H.R. 3200 as introduced, this provision alone would require States to pay an additional \$35.8 billion in matching funds over the next decade. Given that Governors in both parties have already [voiced significant concerns](#) about what Tennessee Democrat Gov. Phil Bredesen termed “the mother of all unfunded mandates” being imposed upon States, some Members may be concerned that these provisions would have—as the head of Washington State’s Medicaid program recently [suggested](#)—States facing severe financial distress saying, “I have to get out of the Medicaid program altogether.”

Requires the Secretary to negotiate payment rates for the government-run plan, and notes that such payment levels should result “in payment levels that are not lower in the aggregate” than those paid under Medicare. Includes other changes intended to create a “level playing field” with respect to the government-run plan; however, Members may agree with CBO Director Elmendorf, who previously testified that it would be “extremely difficult” to create “a system where a public plan could compete on a level playing field” against private coverage. Clarifies that enrollment in the government-run health plan is voluntary; however, Members may note [studies](#) by the Lewin Group have found that up to 114 million Americans could lose their current health coverage due to the creation of a government-run plan.

Establishes a Consumer Operated and Oriented Plan (CO-OP) program to provide grants or loans for the establishment of non-profit insurance cooperatives to be offered through the Exchange, but does not require States to establish such cooperatives. Authorizes \$5 billion in appropriations for the Commissioner to make start-up loans or grants to help meet state solvency requirements. Some Members may be concerned that cooperatives funded through federal start-up grants would in time require ongoing federal subsidies, and that a co-op would do for health care what Fannie Mae and Freddie Mac have done for the housing sector.

Establishes a Center for Medicare and Medicaid Payment Innovation, intended to develop budget-neutral payment models that “address a defined population for which there are deficits in care leading to poor clinical outcomes.” Requires qualified plans to offer information regarding end-of-life planning, and notes that such entities “shall not promote suicide, assisted suicide, or the active hastening of death.” Contains provisions intended to retain insurance brokers’ role in enrolling individuals in health plans, as well as other provisions related to State-based Exchanges. Adopted by a party-line [33-26 vote](#), with three Democrats opposing.

Baldwin: Directs the Secretary of Health and Human Services to develop a formulary for the government-run plan, and requires qualified health plans to contract with pharmaceutical benefit managers (PBMs), which shall disclose prices paid for drugs to the Commissioner. Some Members may be concerned that these provisions would require the disclosure of proprietary price information and could lead to additional federal price controls placed on pharmaceutical companies and/or a restrictive

formulary in the government-run health plan. Permits States to establish accountable care organizations within their Medicaid programs, and permits a temporary enhanced federal match (up to 90 percent) for same. Includes language regarding administrative simplification of health care transactions, as well as an expansion of electronic funds transfer payments within Medicare.

Requires that any savings generated from the amendment's provisions be directed towards increasing affordability subsidies provided in the Exchange. The first of two progressive "unity" amendments attempting to mitigate what liberals viewed as the harmful effects of the Blue Dog proposal to reduce federal insurance subsidies. Adopted by a party-line [32-26 vote](#), with three Blue Dog Democrats opposing.

Schakowsky: Prohibits Exchange plans from increasing premiums at more than 150 percent of medical inflation levels, unless the plan adds extra benefits or the restriction would threaten its financial viability. Some Members may be concerned that this provision would impose a federal price control that would unfairly target plans enrolling sicker individuals with above-average cost increases. Requires the Secretary of Health and Human Services to negotiate drug prices covered under the Medicare Part D program. Requires that any savings generated from the price controls be directed towards increasing affordability subsidies provided in the Exchange. The second of two progressive "unity" amendments attempting to mitigate what liberals viewed as the harmful effects of the Blue Dog proposal to reduce federal insurance subsidies. Adopted by a party-line [32-23 vote](#), with two Blue Dog Democrats opposing.

Ways and Means Amendments

Chairman's Mark: Prohibits the reimbursement of over-the-counter pharmaceuticals from Health Savings Accounts (HSAs), Medical Savings Accounts, Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs), effective in 2010. Because these savings vehicles are tax-preferred, adopting this prohibition would raise taxes by \$8.2 billion over ten years, according to the Joint Committee on Taxation.

Members may be concerned that this provision would first raise taxes, and second—by imposing additional restrictions on savings vehicles popular with tens of millions of Americans—undermines the promise that "If you like your current coverage, you can keep it." At least [8 million individuals](#) hold insurance policies eligible for HSAs, and millions more participate in FSAs. All these individuals would be subject to additional coverage restrictions—and tax increases—under this provision.

In addition, the Chairman's mark extends current tax benefits for health insurance—including the exclusion from income and payroll taxes for participants in employer-sponsored coverage, the above-the-line deduction for health insurance premiums paid by self-employed individuals, and FSAs and HRAs—to "eligible beneficiaries," defined as "any individual who is eligible to receive benefits or coverage under an accident or health plan." Under current law, while employer-sponsored coverage provided to spouses and children is generally excluded from income, domestic partners do not qualify for similar treatment, as the Internal Revenue Code does not classify them as dependents, and the Defense of Marriage Act (P.L. 104-199) prohibits their classification as spouses. This section would effectively expand the current-law health insurance tax benefits to domestic partners and their children, beginning in 2010; the provisions would reduce revenue by \$4 billion over ten years, according to the Joint Committee on Taxation.

STAFF CONTACT

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