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The Road Ahead: What's Happening in Congress?

While the House has narrowly passed a comprehensive health reform bill, and the Senate is consumed with its most intense and fast-moving debate over a major domestic initiative in decades, Ropes & Gray completes its first annual cycle of quarterly newsletters addressing the politics and substance of health reform. Last week Senate negotiations produced a major breakthrough with the announcement of a deal to accept an alternative to the controversial public plan option. This compromise is only one of many being negotiated in closed-door sessions that are taking place between individual Senators on a parallel track to the public debate on the Senate floor. These individual agreements are being wrapped up in a single, comprehensive "manager's amendment," that is expected to be brought to a vote before adjournment. As of this writing, the debate has taken a temporary hiatus as the Senate leadership awaits the Congressional Budget Office's analysis of the cost of the manager's amendment, which for many Senators will decide whether they vote for it. If 60 votes can be garnered for the amendment, it is likely that the Majority Leader will move to final passage of the bill, with some hoping that can occur as early as next week.

As Democrats begin to coalesce over the contents of the bill, prospects that it will pass the Senate before the end of the year are on the rise. It is now widely anticipated that the House will reluctantly accede to many—if not all—of the compromises reached in the Senate in the interest of sending a bill to the President. If so (and it is still a big "if"), we may be on the verge of an historic overhaul of the health care system that will affect every American, every employer, and every segment of the health care industry. But, even if a Rose Garden signing ceremony takes place, substantial policymaking lies ahead. Despite more than 2,000 pages of legislative text, the details of the revamped system remain to be filled in at the agency level—primarily Health and Human Sevices (HHS), which will be charged with undertaking a massive implementation effort on a scale not seen in recent memory. Because the devil is always in the details, it will be important not only to understand the final legislation when and if a bill is signed into law, but also to monitor closely the implementation of those provisions of most interest to your organization.

That's where Ropes & Gray can help. In addition to our Health Reform Resource Center, where you can access all of the important legislation, amendments, cost estimates, and other analyses in real time, we provide webinars, client alerts, a side-by-side comparison of the House and Senate bills, and other useful tools as the debate proceeds (look for a timeline for implementation in the near future).

We will continue to publish our quarterly *Health Reform Matters* newsletter through next year. In the meantime, contact your regular Ropes & Gray attorney to discuss how we might help you with tailored analyses of the impact of the bill on your organization and help you stay on top of developments through the implementation phase.

In this edition of *Health Reform Matters*, we begin by examining the major points of differences between the House and Senate approaches to the bill ("Differences Remaining in House and Senate Approaches"). Although ultimately the Senate may have more clout in negotiations over the bill's final contours, the willingness of the various wings of the Democratic party in the House to follow the Senate should not be taken for granted. In "Delivery System Reform: Do the House and Senate Bills Deliver?," we take a closer look at the major provisions in the bills to undertake fundamental restructuring of the health care delivery system. We pause to check in on the views of the major constituent groups toward the turn that reform has taken in "Current Stakeholder Perspectives on Health Reform." And finally, in "Finding a Way to Pay for Health Reform," we review the health care savings, the new revenue sources, and the tax law changes that are likely to be tapped to finance the nearly trillion-dollar legislation. ■

Differences Remaining in House and Senate Approaches

While the broad contours of the health reform bills under consideration in the two houses of Congress are the same, stark differences remain in some important particulars of the approaches adopted by the House and under debate in the Senate. If the Senate succeeds in passing a bill, the Congressional Democratic Leadership faces a formidable task in resolving these differences as it seeks to send health reform legislation to the President early next year.

- **Public Plan.** The bill adopted by the House and the original legislation brought by Majority Leader Harry Reid (D-NV) to the Senate floor would create a national public plan overseen by the Secretary of Health and Human Services (HHS), who would negotiate provider rates. Under both bills, these rates could not exceed the average rates paid by other Exchange plans; the House bill also requires that payment rates be no less than Medicare rates. After several key members of the Senate Democratic caucus rejected the Majority Leader's public plan proposal, a small group of Senators negotiated a compromise that was unveiled with great fanfare last week. Under the compromise, there will be no public, government-run plan. Instead, two national plans would be offered by private insurance companies under the supervision of the federal Office of Personnel Management (OPM) (which oversees the federal employees' health plans). With OPM negotiating premiums, and a national risk pool, it is hoped that these plans would provide an affordable choice akin to what the public option was designed to accomplish. In addition, in a proposal strongly opposed by provider groups that object to Medicare rates, the deal would allow individuals ages 55-64 to buy into Medicare as an alternative to purchasing a private plan.
- **Coverage Mandates and Subsidies.** The House bill requires employers to provide coverage and assesses a fee equal to 8% of an employer's payroll on employers who fail to do so. In contrast, the Senate bill contains no such mandate, instead requiring employers to pay a capped per employee fee of up to $400 for only those employees receiving a tax credit to purchase Exchange coverage. While there has been little disagreement over the individual mandate contained in each bill, the amount of subsidies provided to purchase coverage is likely to remain a sticking point. The House-adopted bill provides more generous subsidies to low-income individuals and families than the bill currently under debate in the Senate.
- **Medicaid Expansion.** Both the House and Senate bills would significantly expand the Medicaid program—the House bill requires states to cover individuals with incomes up to 150% of the federal poverty level (FPL) while the Senate bill requires coverage up to 133% FPL. Although the House bill imposes greater coverage responsibilities on the states, the House bill also provides more generous federal matching payments to assist states to meet these responsibilities, including extending for an additional six months the enhanced Medicaid matching rate that states received under the American Recovery and Reinvestment Act.
- **Immigrant Access to Coverage.** Both the House and Senate bills strictly prohibit the provision of health insurance subsidies to undocumented immigrants. The House bill, however, goes a step further by prohibiting such immigrants from using their own funds to purchase coverage through a health insurance exchange.
- **Effective Date of Coverage Expansion.** Notably, the coverage expansion provisions take effect one year earlier under the House bill—in 2013—than under the Senate bill, which does not establish a health insurance exchange or expand Medicaid until 2014. With the next presidential election occurring before coverage is extended under either version, the effective date of the coverage expansion could have significant political implications for President Obama.
- **Medicare Payment Reform.** The House and Senate bills each would adopt extensive Medicare payment reforms, the most significant of which would require the Secretary of HHS to adopt on a fast-track basis Medicare payment reforms recommended by an independent body. The House charges the Institute of Medicine with the task of developing such policies, while the Senate bill would establish a new Medicare Independent Advisory Board for this purpose. The Senate provision would extract more savings from the Medicare program by requiring the Board to achieve specified savings targets. Additionally, under the Senate bill, if Congress rejects the Board's policy proposals, Congress must adopt legislation to achieve the savings targets. The Senate bill also would achieve Medicare payment reform through the adoption of value-based purchasing in Medicare, a policy not adopted by the House.
- **Abortion.** Access to abortion services has become a flash point in the health reform debate. The House bill specifies that individuals who receive federal subsidies to purchase a plan through an exchange may not choose plans that cover abortions for which federal funding is prohibited. In contrast, the Senate bill permits plans participating in an exchange to cover abortion services for subsidized individuals as long as no public funds are used to pay for these service

As the Senate continues to debate and amend its version of health reform, these and other differences could become even more significant. And with extremely close margins in the House and the Senate—the House bill passed by a margin of only 5 votes and 60 votes are needed in the Senate to close off debate—the more the bills diverge, the more challenging the task will be of securing the votes necessary to pass final legislation. For more detail on the differences

between the two versions, see Ropes & Gray's side-by-side chart posted on our Health Reform Resource Center, which we continue to update daily as the bill moves through the Senate. ■

Delivery System Reform: Do the House and Senate Bills Deliver?

In addition to expanding health care coverage, a clear goal of the current reform efforts is to overhaul the delivery system in ways that will improve quality and efficiency while reducing costs—in the vernacular of the moment, seeking to "bend the cost curve" over the long haul. While particulars differ, both the House and Senate bills introduce a variety of new mechanisms and incentives geared toward achieving these goals. Many of these measures seek to foster the integration of components of the delivery system, coordinate patient care, and align payment incentives to improve quality.

- **Accountable Care Organizations.** The driving principle of Accountable Care Organizations, (ACOs) is to make providers collectively responsible for quality, cost, and resource use for particular patient populations. ACOs would align incentives by tying payments to quality and allowing participating providers—including physicians and possibly hospitals and other providers—to share in any cost savings that result from their efforts. ACOs would need to have in place legal structures that would allow them to distribute shared savings among their providers. Both the House and Senate bills establish ACO pilot programs under Medicare and Medicaid, although the Senate's Medicaid ACO program is limited to pediatric ACOs.

- **Hospital Readmission Policies.** Preventable hospital readmissions are a significant source of excess health care costs: in fact, one study has found that unplanned readmissions cost Medicare $17.4 billion between 2003 and 2004. Both the House and Senate bills would seek to reduce "excess readmissions" for certain specified conditions by reducing Medicare hospital payments—for all admissions, not just for the specified conditions—for hospitals with high readmission rates. The House bill would also provide some funding to hospitals with high disproportionate share populations for transitional care services and other assistance to address patient noncompliance issues.

- **Bundling Payments for Acute and Post-Acute Care.** Payment bundling, as conceived under the House and Senate bills, would provide for a single payment for acute and post-acute care to enhance incentives for more efficient, coordinated care. Neither of the two bills provides for the immediate establishment of a specific bundled payment program in Medicare; instead, they establish Medicare (and, in the Senate, Medicaid) pilot programs to test the approach. In addition, the House bill would require the Centers for Medicare and Medicaid Services (CMS) to devise a plan establishing bundled payments for Medicare no more than three years after enactment of the bill, although additional Congressional authorization would be required before such payment is mandated program-wide.

- **Medical Homes.** The patient-centered medical home model seeks to improve continuity of care by making a patient's primary care physician responsible for coordinating the overall care and wellness of a patient. Both bills contain provisions supporting the formation of patient-oriented medical homes. The House bill establishes Medicare and Medicaid pilot programs, while the Senate would create a new "health home" option for states under Medicaid. Under either bill, medical homes would likely be tested under the new Payment Innovation Center (see below). The Senate bill also establishes a grant program to support community-based, interdisciplinary "health teams" that would be required to support patient-centered medical homes, and creates a "Primary Care Extension Program" that would, in part, assist primary care providers in implementing this model.

- **Value-Based Purchasing Programs.** In adopting value-based purchasing mechanisms, payors and purchasers of health care attach payment incentives to attainment of specified quality or cost targets. The Senate bill includes a plan for gradual implementation of value-based purchasing in Medicare, beginning in 2013 with hospitals. The bill would subsequently add a value-based payment modifier to the physician fee schedule, while requiring the Secretary to develop a plan that, subject to the approval of Congress, would extend value-based purchasing to skilled nursing facilities and home health agencies. By contrast, the House bill delegates to the Institute of Medicine (IOM) the task of studying and making recommendations on the implementation of a quality- and cost-based "value index" for adjustment of Medicare payments on a regional or provider-level basis. The IOM recommendations would then be considered by Congress on a fast-track basis.

- **Community-Based Collaborative Care Networks.** While most proposed delivery system reforms focus on Medicare or Medicaid beneficiaries, the community-based collaborative care network model is specifically targeted to encourage the formation of networks to increase effective access for

medically underserved and low-income populations. The House bill would establish a program to fund the creation of Community-Based Collaborative Care Networks (CCNs) and would require CCNs to be included in the bundled payments described above.

- **Innovation Center.** Both the House and Senate bills would establish a Payment Innovation Center at CMS, which would have broad authority to test and evaluate pilot programs designed to foster patient-centered care, improve quality and reduce costs—including models not currently foreseen. The Center would then be able to expand successful programs or terminate those that do not work, without the need for additional legislation.

Implementation of Proposed Delivery System Reforms

Health care delivery system reform would involve complex and politically sensitive initiatives relating to the fundamental structure and organization of, and payment for, health care. Many of the proposed delivery system reforms would not be implemented immediately or on a widespread basis but instead rely on pilot or demonstration programs or, in some cases, further study and required issuance of future recommendations or plans. While some have criticized this approach as overly timid, it has the advantage of flexibility in policy design, and it may also offer greater opportunity for stakeholders to weigh in before system-wide changes are made.

While debate over how—and how fast—to restructure the delivery system is in full swing on Capitol Hill, there is widespread consensus on the need to undertake such restructuring and on the promise of many of the ideas described above. Consequently, even if the larger health reform effort fails, expect to see delivery system reform move forward nonetheless in the years ahead. ■

Current Stakeholder Perspectives on Health Reform

With the health reform debate currently focused on a handful of hot-button issues (as described in our article, "Differences Remaining in House and Senate Approaches") it is easy to lose sight of the panoply of interests at stake as Congress inches nearer to the most significant overhaul of our health care system since the 1965 creation of Medicare and Medicaid. The reform process was formally launched last March with a feel-good White House summit at which all the key stakeholder groups pledged their cooperation and support. Now, as we draw close to the end of the messy, "sausage-making" process of assembling a bill that can actually pass both houses, it is timely to check in on these stakeholder groups—whether they still express support, where their concerns lie, and, for some of them, whether deals cut over the summer are still in force.

- **Hospitals.** As hospital uncompensated care burdens continue to increase, the hospital industry has generally embraced health reform and its promise of expanded coverage. Although hospitals, like many providers, clearly stand to benefit from an expansion of the insured population, both the House and Senate bills contain significant Medicare and Medicaid payment reductions. The industry cut a deal over the summer with the White House and Senate Finance Committee Chair Max Baucus (D-MT) to limit industry cuts to $155 billion, comprised of reductions in Medicare payment updates and in Medicare and Medicaid "disproportionate share hospital" payments. For the most part, that deal is still holding in the Senate bill. Meanwhile, additional payment reforms designed to restructure the delivery system (see "Delivery System Reform: Do the House and Senate Bills Deliver?") could significantly increase hospitals' financial burdens if they are unable to achieve the quality and efficiency targets behind these reforms. Moreover, hospitals are concerned that the expansion of the Medicaid program and the creation of a federally-run health plan could erode payment rates, creating offsetting uncompensated care burdens even as coverage expands.
- **Physicians.** The most significant reform issue confronting physicians is an impending 21% reduction in Medicare rates that will take effect January 1, 2010, unless Congress takes action to prevent the cut. Both the House and Senate health reform bills would eliminate the 2010 scheduled cut. Attempts to include a permanent fix, however, in the health reform bill ultimately proved too expensive and were stripped out. Unless the payment formula is reformed, additional formula-driven cuts will occur in future years, perpetuating the now familiar cycle of temporary fixes. The House recently passed a separate bill that would reform the current formula to prevent the future cuts at a cost of $210 billion to the federal government; the prospects for passage of a similar Senate bill remain dim. Physicians are also watching closely—with interest and mounting concern—the myriad delivery and payment system reform efforts included in the legislation.
- **Pharmaceutical and Device Industries.** The pharmaceutical and device industries stand to gain from an expanded customer base once the bills' coverage expansions take effect. For this reason, these industries have generally supported reform. In an additional boon to the branded drug industry, both bills would provide a 12-year exclusivity period to branded biologics in exchange for permitting follow-on biologics to obtain marketing approval. At the same time, Congress is looking to the pharmaceutical and device industries to foot the bills for a portion of the expansion. As described in the related article, "Finding a Way to Pay for Health Reform," both the House and

Senate bill impose very significant financing burdens on the industry. While $80 billion in cuts were agreed to in advance in another White House-industry deal, there is pressure to extract more, especially as lawmakers aspire to close the so-called "donut hole" gap in coverage that continues to plague the Medicare prescription drug program. Moreover, in the Senate, a highly popular amendment to allow drug reimportation stalled progress on the overall bill for an entire week as a result of industry protests against further unraveling of the negotiated deal.

- **Health Insurers.** The House and Senate bills would dramatically expand the number of individuals with private health insurance, thereby generating significant new business for the insurance industry. In contrast to the Clinton-era reform efforts, the industry approached the current debate supportive of reform, and is willing to accept new regulatory mandates in exchange for an anticipated surge in covered lives. However, as House and Senate leadership increasingly appeared to insist on the inclusion of a public plan, the opposition of insurers intensified, fueled by their concern that such a plan would have an unfair competitive edge if backed by the negotiating weight of the federal government. Moreover, as described in the related article, "Finding a Way to Pay for Health Reform," both bills impose heavy fees on the industry to fund reform. Tensions between the industry and Congressional leadership have escalated in recent weeks, as the industry has stepped up its criticism of the current bills. Reflecting this tension, both the House and Senate have moved toward eliminating the antitrust exemption that health insurance has enjoyed for the last 64 years, and the Senate has even proposed to impose caps on the deductibility of compensation for insurance company executives.
- **Employers.** Many employers, especially small employers, are concerned about the prospect of an employer mandate to provide coverage. The House bill would impose such a mandate, and the Senate bill would require employers to pay a fee for each employee who is subsidized under the bill to purchase his or her own coverage. Although the bills provide assistance to certain small employers to pay for coverage and, in limited cases, would permit the sale of health insurance across state lines in order to pool risk and reduce cost, many small employers remain concerned that coverage will remain unaffordable. At the same time, for employers both large and small who currently provide coverage, an expansion of employer-based insurance is a welcome "leveling of the playing field"—especially for those operating in highly competitive industries.
- **Labor.** The major labor unions have long championed health reform that achieves universal coverage and provides a robust public plan option, but they remain leery of any reforms that could reduce the level of collectively bargained benefits their members currently enjoy. The Senate proposal to tax high-value health plans is one such reform that has stirred significant concern among organized labor, which views such a tax as unfairly targeting the generous health benefits that many unions have achieved through negotiations with employers.
- **Consumers.** The primary concern for consumers of health care is affordability, particularly in view of the individual mandate that both the House and Senate bills impose. Many consumer advocates believe that a public plan will be the sole affordable option for many families, making this option, they argue, essential to expanded coverage. Although both bills provide subsidies to purchase coverage to individuals with household incomes up to 400% of the federal poverty level (approximately $88,000 for a family of four), families would be expected to pay premiums equal to up to 9.8% of income under the Senate bill and up to 12% of income under the House bill. ■

Finding a Way to Pay for Health Reform

Expanding health insurance coverage to over 90% of residents is anything but cheap—the price tag on the House bill is $1.1 trillion while the cost of the Senate bill is only twelve digits—$848 billion. Legislators in the House and Senate have zeroed in on three basic ways to cover these enormous costs: (1) cutting health care expenditures, (2) reducing health care tax breaks, and (3) raising revenue with new taxes. The House and Senate largely agree on how to cut health care expenditures and reduce tax subsidies but take fundamentally different approaches to raising revenue. If the revenue provisions of the Senate bill do not significantly change before the final floor vote, a battle royale between the House and Senate over their differing revenue-raising philosophies may unfold in the days ahead.

Cutting Expenditures

Ideally health reform would be financed through measures to make the delivery system more efficient—by "bending the cost curve" (see the related article, "Delivery System Reform: Do the House and Senate Bills Deliver?"). But those measures are not projected to yield anywhere near the necessary savings in the crucial ten-year budget window in which legislation is scored, because most are gradually phased in through pilot programs and studies. As a result, in order to extract substantial health system savings, both the House and Senate are relying on straight cuts in Medicare and Medicaid payments. The

most significant of these are: (1) adjusting "market basket" indices, (2) cutting Medicare Advantage payments, and (3) cutting disproportionate share hospital payments.

1) **Productivity Adjustments.** Both bills contain significant "productivity adjustments" to market basket indices that are used to update Medicare payment rates each year to keep pace with providers' costs of providing services. The Senate bill achieves ten-year savings of $150 billion through a downward "productivity" adjustment (to account for economy-wide productivity gains) in the annual market basket increase in payments for nearly all providers other than professional providers. Included in this formula reduction would be payments for hospital inpatient and outpatient services, skilled nursing facilities, long term care hospitals, inpatient rehabilitation facilities, home health agencies, hospice care, dialysis, ambulance, ambulatory surgical centers, laboratory services, durable medical equipment, and prosthetics and orthotics. In addition, inpatient hospital services and home health services are subject to further market basket reductions on top of these productivity adjustments. The market basket adjustments in the House bill save slightly less, $131 billion, by making productivity-related cuts in many of the same service areas as the Senate bill, in addition to freezing updates in earlier years for skilled nursing and long term care facilities.

2) **Medicare Advantage Payments.** The largest health care spending cuts in the House bill are made to Medicare Advantage payments, saving $170 billion over ten years. The majority of these savings are derived from basing Medicare Advantage payments on comparable fee-for-service costs with bonus payments for quality. Although the Senate bill does not cut Medicare Advantage quite as deeply as the House bill, it does achieve $118 billion in savings over ten years by using the average Medicare Advantage plan bid rates in each market to set Medicare Advantage payment rates. In the first days of floor debate, the Senate rejected a Republican amendment that would have stripped a significant portion of these cuts from the bill.

3) **Disproportionate Share Hospital Payments.** Both bills extract savings through cuts to Medicare and Medicaid disproportionate share hospital (DSH) payments that are intended to support hospitals with the highest burdens of uncompensated care. On the theory that this burden will be reduced under health reform, the bills phase down DSH payments after coverage expands, although the Senate's cuts are quicker and deeper than the House's. The Senate bill cuts nearly $43 billion from DSH payments over ten years (about $22 billion in Medicaid cuts and $20 billion in Medicare), which is more than double the $20 billion over ten years (equally split between Medicaid and Medicare) cut by the House bill.

Reducing Tax Breaks

Even though health care represents one of the largest federal tax expenditures, the changes being proposed in this favorable treatment are both small in comparison to other cuts and a far cry from the proposals to eliminate the tax exclusion for employer-provided coverage that were once prominent in discussions of reform. Two of the larger cuts in health-related tax benefits are made to (1) health flexible spending arrangements and (2) the deductibility of medical expenses over 7.5% adjusted gross income (AGI). Both bills limit annual salary contributions to health flexible spending arrangements to $2,500, with scored savings of $13-$14 billion over ten years. Although the House bill does not change the deductibility of medical expenses over 7.5% of AGI, the Senate would increase the threshold to 10% of AGI (for individuals under 65 years of age), saving $15 billion over ten years.

Raising Revenue

The most fundamental difference between the financing provisions of the two health reform bills lies in their approaches to raising revenue. The Senate looks primarily to the health care system as the source of new revenue, while the House levies tax increases on the wealthiest Americans. Because of its higher price tag, the House bill must, and does, raise more revenue than the Senate bill: $561 billion over ten years as compared to $372 billion in the Senate. The House achieves this result primarily through a 5.4% surcharge on individuals with income in excess of $500,000 ($1 million for joint returns), which is expected to yield $461 billion over ten years.

In contrast, the Senate bill draws the majority of its revenue from a controversial 40% excise tax on the value of health plan coverage in excess of $8,500 for an individual ($23,000 for a family). This excise tax on so-called "gold-plated health plans" would raise $149 billion over ten years and, according to its supporters, would steer employers away from extravagant health plans that drive up health care spending, thereby redirecting those resources into higher salaries. (As an interesting side note, the excise tax is projected to raise the majority of its revenue from income taxes paid on increased salaries, not from revenue directly collected by taxing gold-plated health plans.) But opponents—most notably union groups that over the years have bargained for increased benefits at the expense of increased wages—fear that although the excise tax would be imposed on insurers, workers will ultimately absorb the cost in the form of decreased salaries or benefits.

The bills include a few other noteworthy revenue provisions, although of smaller magnitude. Both bills would impose a per-enrollee fee on insurers to finance comparative effectiveness research.

The Senate would impose a $6.7 billion annual fee on health insurance plans, based on an insurer's net premiums and third party administration fees. Both the House and Senate would impose new excise taxes on medical devices, although the Senate's version would begin with 2009 sales rather than 2013 sales as in the House. The Senate would also tax sales of branded pharmaceuticals to certain government programs beginning after December 31, 2008. Finally, expect to hear rumblings about the so-called "Botax" in the Senate bill, which would impose a 5% tax on elective cosmetic surgery performed on or after January 1, 2010.

Given the Congressional leadership's oft-repeated commitment to financing reform without increasing the deficit, tough choices on financing lie ahead, with few painless options on the table and the support of important constituencies hanging in the balance. While the Democratic caucuses in both houses struggle to reach consensus on this make-or-break legislation, the leadership faces a daunting challenge in finding the right mix of financing measures to pay for the bill. Stay tuned. ■

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