Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

Special Series: Health Reform Issues

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HOUSE HEALTH REFORM BILL EXPANDS COVERAGE AND LOWERS HEALTH COST GROWTH, WHILE REDUCING DEFICITS

By Edwin Park, Judith Solomon, Paul Van de Water, Sarah Lueck and January Angeles

The comprehensive health reform legislation that House Democratic leaders unveiled on October 29 would make significant progress in three critical areas: expanding health coverage and ensuring that such coverage is affordable, slowing the growth in health care costs, and instituting essential reforms in the health insurance market.

Moreover, the bill's cost is more than fully offset; that is, the legislation would *reduce* budget deficits by $138 billion over ten years, according to the Congressional Budget Office (CBO).[1] The bill's revenues and spending reductions would grow faster than the cost of the coverage provisions, according to CBO, which estimates that the bill would modestly reduce deficits in years *after* 2019 as well.

Policymakers could further improve the legislation by incorporating, at some stage of the legislative process, a provision to limit the tax exclusion for employer-sponsored health insurance such as a modified version of the excise tax on high-cost plans in the Senate Finance Committee's health reform bill. This would further reduce health care cost growth.[2]

The full House may consider the bill, which merges the three bills approved this summer by the House Ways and Means, Energy and Commerce, and Education and Labor Committees, as early as next week. The bill's highlights include the following:

- **Expanding coverage.** Under the House bill, 96 percent of non-elderly legal residents in the United States would have health insurance by 2019. Relative to current law, the bill would reduce the number of uninsured by 36 million, or two-thirds, by 2019, according to CBO's preliminary estimates.[3] The bill would cover 7 million more of the uninsured by 2019 than the bill that the Senate Finance Committee approved earlier this month.

[1] Congressional Budget Office, "Letter to the Honorable John D. Dingell," November 20, 2009.

[2] See Paul N. Van de Water, "Excise Tax on Very High-Cost Health Plans Is a Sound Element of Health Reform," Center on Budget and Policy Priorities, revised October 22, 2009. http://www.cbpp.org/cms/index.cfm?fa-view&id=2957.

[3] Congressional Budget Office, *op cit* and Congressional Budget Office, "Letter to the Honorable Charles B. Rangel," October 29, 2009.

- **Slowing health care cost growth.** The bill would take a number of steps, particularly within Medicare, to institute efficiencies to lower costs and change how health care is delivered to improve the quality of care. CBO estimates that the bill would substantially slow Medicare's growth rate.[4]

  CBO Director Elmendorf has noted that changing Medicare's payment rules is one of "two powerful policy levers" that the federal government has available to encourage changes in medical practice and thereby slow the increase in health care costs.[5] The other lever that Elmendorf identified, a limit on the open-ended tax subsidy for employer-sponsored health insurance, is part of the Senate Finance Committee bill.

- **Reforming the health insurance market.** The bill includes essential reforms that would greatly improve access to affordable and comprehensive health insurance coverage for people (and employers) at all income levels. It would bar insurance companies from denying coverage or charging higher premiums to enrollees that have health problems and would limit insurers' ability to charge higher premiums to individuals simply because they are older. It also would set minimum standards regarding what insurers could offer, including an annual cap on out-of-pocket costs and a ban on annual or lifetime benefit limits. These reforms would apply to all policies purchased in the individual market and, over time, all employer-sponsored plans as well.

  The House bill would establish a national health insurance exchange to make a range of health coverage options available to individuals and small businesses. The bill also would limit the ability of insurers to craft benefit packages in ways designed to attract enrollment by those who are healthy and to discourage enrollment by those in poorer health; it apparently would do so to a greater degree than the Finance Committee bill. As a result of these measures, the House bill would substantially lower the risk of "adverse selection" (the separation of healthier and less-healthy individuals into separate insurance arrangements), which otherwise could drive up premiums in the health insurance exchange.

Overall, the House bill compares quite favorably to the bill that will likely emerge in the Senate, which is expected to be based largely on the Senate Finance Committee bill (while also including elements of the Senate HELP bill).

Expanding Coverage and Making Insurance More Affordable

As noted, by 2019, the House bill would expand coverage to 7 million more of the uninsured than

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[4] CBO estimates that average annual growth in Medicare spending per beneficiary would decline to 4 percent, on average, during the next two decades, compared with a historical average of 7 percent. This estimate assumes that Congress will not act to forestall the reductions scheduled in physician payment rates in coming years. That, of course, is unlikely. Nevertheless, if CBO took into account the expected enactment of legislation to avert the scheduled reductions in physician payments, it is likely that it still would estimate annual growth in Medicare spending per beneficiary to be significantly lower under the House bill than it was the past or would be in the future in the absence of the bill. That is because the Medicare savings in the bill are significantly larger than the cost of cancelling the scheduled reductions in the Medicare physician payment rates.

[5] Douglas W. Elmendorf, Letter to the Honorable Kent Conrad and the Honorable Judd Gregg, June 16, 2009.

the Senate Finance Committee bill. According to CBO, the Finance Committee bill would reduce the number of uninsured by 29 million in 2019, as compared to what the number would be if no policy changes are made. The House bill would reduce the number of uninsured by 36 million.

The House bill's more robust coverage gains largely reflect its more significant expansion of Medicaid, its larger premium and cost-sharing credits for low- and moderate-income individuals and families — which make health care more affordable for these people — and its stronger requirements both on individuals to enroll in health coverage and on employers to offer coverage or pay a penalty.

Expanded Medicaid Eligibility for the Lowest-Income People

The House bill sets a new income limit for Medicaid of 150 percent of the poverty line. This limit would apply to children and adults under age 65 who are not eligible for Medicare. For the first time, low-income adults who do not have dependent children (and are not elderly or disabled) would be eligible for Medicaid. (The Senate Finance Committee bill would expand Medicaid to 133 percent of the poverty line.)

Medicaid is the most effective way to provide comprehensive and affordable coverage to people with very low incomes and thereby ensure that the low-income uninsured gain coverage. Medicaid beneficiaries generally do not pay premiums, and co-payments do not exceed $3 for most health care services. Medicaid covers a broad array of services and supports well-suited to the needs of low-income people, who are more likely than people with higher incomes to be in fair or poor health. Medicaid is also significantly less costly, on a per-beneficiary basis, than private insurance (after adjusting for health status), largely due to its lower provider rates and administrative costs.[6] CBO has found that setting the Medicaid income limit lower and moving more people into the new health insurance exchange instead, with subsidies to enable them to purchase coverage there, would cost the federal government significantly more.

The House bill's greater reliance on Medicaid in helping to cover the uninsured is apparently one of the reasons why the House bill would reduce the number of uninsured by a larger extent than the Senate bill.

Premium and Cost-Sharing Credits for Low- and Moderate-Income People

Individuals and families who have incomes above the Medicaid income limit but below 400 percent of the poverty line would receive "premium credits" to help them purchase health insurance in the new health insurance exchange. (The bill's exchange provision is discussed on page 7.) For example, under the House bill, a family of three earning $32,000 (175 percent of the poverty line for a family of that size) would receive a credit that would limit its premium to $1,360 a year (if the health reform bill were in effect in 2009), considerably less than the $2,013 a year the family would have to pay under the Finance Committee bill. The increased affordability under the House bill

[6] The House bill addresses the need for a sufficient number of additional Medicaid providers to be available to treat the large number of newly eligible beneficiaries by increasing payments for primary care providers. Increases would begin in 2010; by 2012, providers would receive the same payment rates as Medicare pays for primary care services. The federal government would pay the full cost of these increased provider rates until 2015, and 91 percent of the increased rates thereafter.

(relative to the Finance Committee bill) would enable more families of limited means to purchase health insurance.

In addition, the bill would provide cost-sharing assistance (i.e., assistance with deductibles and co-payments) on a sliding scale to people earning less than 400 percent of the poverty line to ensure that they can actually afford to see a doctor and seek care. The maximum out-of-pocket costs a family of three earning $32,000 would have to pay each year (in addition to the insurance premiums) would be $2,000; under the Finance Committee bill, the maximum such a family would pay would be nearly twice this amount.

Shared Responsibility Requirements for Individuals and Employers

The House bill includes a more robust requirement for individuals to have health insurance than the Finance Committee bill. The Finance Committee exempts households from the penalty that it would establish for not having coverage if they would have to pay more than 8 percent of their income for premiums. As a result, there is risk that under the Finance bill, significant numbers of people in good health would forgo coverage. That would cause the pool of people buying coverage through the exchange to be less healthy on average, and consequently would result in higher premiums and increased subsidy costs for the government. The House bill, in contrast, waives the penalty for not having coverage only for households that would experience a hardship based on their individual circumstances. Moreover, the House bill sets the penalty for not having coverage at 2.5 percent of adjusted gross income, considerably higher than the Finance Committee bill, which phases in the penalty to a maximum of $750 per adult in 2017. As a result, the House bill would likely cause many more individuals, particularly those who are healthier, to enroll in coverage rather than remain uninsured.[7]

The House bill also includes a stronger, simpler requirement on employers to offer health coverage than the troubling provision in the Finance Committee bill. Under the House bill, employers must either offer coverage meeting certain standards or pay a fee equal to a percentage of their payroll. (Most small employers would be exempt from this requirement.) This provision, along with the requirement for individuals to have coverage, is the reason why CBO estimates that the House bill would increase the number of people enrolled in employer-sponsored insurance in 2019 by 6 million, relative to current law.

In contrast, the Finance Committee bill would modestly reduce employer-sponsored insurance, by 3 million. Its employer responsibility requirement would penalize only those firms whose workers receive premium tax credits through the new health insurance exchange, whether employers offer coverage or not. This would give employers an incentive not to hire workers whose family incomes are low enough to qualify them for premium credits.

[7] See January Angeles and Judith Solomon, "Finance Committee Health Reform Bill Makes Improvements, But Still Falls Short of What Is Needed for Many People to Afford Health Care," Center on Budget and Policy Priorities, October 13, 2009.

Making Medicare More Efficient and Slowing the Growth in Health Care Costs

The House bill includes a number of provisions that would make Medicare more efficient, which would help slow the growth in health care costs as well as help pay for health reform and desirable beneficiary improvements to Medicare (including improvements to the Medicare drug benefit and making more low-income Medicare beneficiaries eligible for help with their premiums, deductibles and co-payments). Many of these provisions are in line with the recommendations of the Medicare Payment Advisory Commission (MedPAC), Congress' expert nonpartisan advisory body on Medicare payment policy, on how to modify provider payment rates and encourage efficiency while ensuring that payments are adequate so that beneficiaries continue to have access to health care providers.

Elimination of Medicare Advantage Overpayments

One key provision in the House bill, which MedPAC has long recommended, would eliminate the overpayments that private insurers receive through the Medicare Advantage program. Even though private plans were brought into Medicare to lower costs, it currently costs the federal government 14 percent *more* on average, or over $1,100 more per person, to cover the same beneficiaries through private plans than through traditional Medicare. These overpayments drive up beneficiary premiums and advance the date when the Medicare Hospital Insurance Trust Fund is projected to become insolvent by 17 months. While the Finance Committee bill significantly scales back these overpayments (thereby saving nearly $120 billion over ten years), the House bill would phase these overpayments out altogether over three years, as MedPAC has recommended. Along with other Medicare Advantage savings in the House bill, eliminating the overpayments would lower Medicare spending by $170 billion over ten years.

Reductions in Medicare Drug Costs

In addition, the House bill would lower the cost of prescription drugs in Medicare. Prior to the establishment of the Medicare Part D drug benefit, *Medicaid* provided prescription drug coverage to more than 6 million "dual eligibles" (low-income Medicare beneficiaries who also are enrolled in Medicaid). In 2006, drug coverage for these dual eligibles shifted to Medicare. When Congress created the drug benefit, it assumed that the private insurers participating in Part D would be able to negotiate larger rebates from drug manufacturers than Medicaid had required. But an increasing body of research demonstrates that the rebates negotiated by Part D plans are well below the Medicaid rebates, which means the federal government is incurring significantly higher drug costs for dual eligibles than it previously incurred under Medicaid.

The House bill addresses this problem by requiring drug manufacturers to provide, at a minimum, the same rebates for drugs provided to dual eligibles under Medicare Part D as Medicaid would require. The bill would devote some of the savings from this provision to filling the so-called "doughnut hole" in the Part D drug benefit.[8] Even after financing this improvement to the

[8] Under the Medicare Part D drug benefit, Medicare beneficiaries are required to pay for 100 percent of the cost of their medications once they exceed an initial coverage limit, until their total out-of-pocket drug costs (excluding their

Medicare drug benefit, CBO estimates that this provision of the House bill would still produce net savings of $42 billion over ten years to help pay for health reform. The Finance Committee bill does not include this provision (or the closing of the doughnut hole in the drug benefit).

Other Medicare Reforms

In addition to instituting cost efficiencies in Medicare, the House bill (like the Finance Committee bill) takes important steps toward restructuring Medicare's payment system to promote effective, high-value health care. It reduces Medicare payments to hospitals with high readmission rates to encourage them to do a better job of preventing avoidable readmissions. It creates an alternative payment model to reward Accountable Care Organizations — physician-led organizations that take responsibility for the cost and quality of the care they deliver. It expands efforts to assess the feasibility of paying for qualified patient-centered medical homes and of bundling payments for hospitals and post-acute providers. To the extent that these approaches prove successful, the bill would require the Secretary of Health and Human Services to implement them on a larger scale. The bill also contains numerous provisions to improve program integrity and reduce fraudulent payments in both Medicare and Medicaid. Because Medicare has served in the past as a leader in developing and testing effective payment reforms that are later adopted widely by private insurers, these reforms have the potential to slow health care growth not only in Medicare but throughout the U.S. health care system.[9]

Public Plan Insurance Option

The House bill also includes a "public plan" health insurance option within the new health insurance exchange. Such an option would likely spur competition among private insurers and likely moderate premium cost growth in the exchange. That, in turn, could ease the burden both on the federal government, by limiting growth in the cost of the credits to help low- and moderate-income families purchase coverage through the exchange, and on such families themselves. (If premiums rose more slowly, these families' required premium payments would climb more slowly as well.) The Finance Committee bill does not include a public option, though the plan that Senator Majority Leader Harry Reid is developing may include a public plan similar to the one in the House bill.

Surcharge on Very High-Income Households

To help finance health reform, the House bill includes a 5.4-percent surcharge on households with incomes over $1,000,000 ($500,000 for single taxpayers). The proposal is reasonable and well targeted: in recent decades, incomes have grown disproportionately for households at the very top of the income scale, while the percentage of income they pay in taxes has fallen substantially. Increased revenue from high-income taxpayers is an entirely appropriate way to help finance health reform.

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premiums) exceed a threshold set several thousand dollars higher. The result is that beneficiaries must pay as much as $3,450 in drug costs within this gap in coverage, known as the "doughnut hole," which discourages the use of needed drugs and likely produces poorer health outcomes.

[9] See, for example, Paul N. Van de Water, "Medicare Changes Can Complement Health Reform," Center on Budget and Policy Priorities, July 31, 2008.

Another source of financing for health reform, which could supplement a surcharge, would be to place some limits on the open-ended tax subsidy for employer-sponsored health plans regardless of a plan's cost, such as through the Finance Committee bill's excise tax on high-cost health plans, with some modifications. This not only is a reasonable way to raise part of the revenue needed to pay for health reform but also would help to slow health care cost growth, a necessary step to ensuring that health reform will succeed and be sustainable over time.

The House bill includes several other, smaller changes in the tax treatment of health care that are in the Senate Finance Committee bill as well, such as a tightening of the rules governing flexible spending accounts, health savings accounts, and similar tax-favored health accounts, so that the accounts do less to encourage wasteful or inessential health care spending. These reforms should help reduce total health care expenditures while providing some savings to help finance health care reform.

Reforming the Insurance Market

The House bill includes a number of important reforms to the health insurance market that would greatly improve access to affordable and comprehensive health insurance coverage for people (and employers) at all income levels. For example, like the bills that the Senate Finance Committee and Senate HELP Committee approved, the House bill would bar insurance companies from denying coverage or charging higher premiums to enrollees that have health problems.

The House bill would also greatly limit insurers' ability to charge higher premiums to individuals simply because they are older. The bill would permit premiums for the oldest enrollees to be no more than twice the premiums charged to the youngest people. The Finance Committee bill, in contrast, would allow older people to be charged up to four times more than younger people, making it more likely that many people in their fifties and sixties (or the small businesses that employ them) would continue to be charged prices that likely would cause a substantial number of them to go without coverage.

In addition, the bill would set minimum standards regarding what insurers could offer, including an annual cap on out-of-pocket costs and a prohibition on annual or lifetime benefit limits (which can cause coverage to shut off for some people who become very sick or have a chronic illness). It would also establish an "essential benefits" package that all insurance plans would be required, at a minimum, to provide.

While the Finance Committee bill, as well, would set benefit standards, it appears to allow much greater variation than the House bill in the scope of benefits included in the various plans that insurers could provide (i.e., in the extent to which various health care services may be covered or limited). For example, while inpatient hospital stays would have to be covered, insurers would retain great flexibility over the extent of that coverage. Such an approach is problematic, because it could enable insurers to continue designing specific benefit packages in ways that are calculated to attract healthier, lower-cost individuals and to discourage enrollment by those in poorer health. (Many private Medicare Advantage plans, for example, charge much higher co-payments for chemotherapy services or cover fewer hospital days in order to deter people with various illnesses or conditions from signing up with them.)

Such practices by insurers can provoke "adverse selection," in which healthier and less-healthy people separate into different insurance arrangements; adverse selection drives up the costs of the health insurance plans that enroll people who are in average or below-average health. That, in turn, increases the premiums that such plans must charge and the costs to the government of the premium credits needed to make coverage affordable for low- and moderate-income households who enroll in these plans. Over time, such adverse selection could undermine the ability of the new health insurance exchange to provide stable, decent-quality coverage at a price that is affordable for families and the federal government. The provisions in the House bill governing how the exchange would operate and the benefit packages that insurers would provide are designed in ways that should substantially reduce such risks.

The House bill would apply the above reforms to all new policies purchased in the individual health insurance market and, over time, to all employer-sponsored plans.[10] The Finance Committee bill, in contrast, would apply many of its insurance market reforms more narrowly — to new individual-market policies and small employers of up to 50 workers (or of up to 100 workers at the option of the state), but not to *all* employers. This could leave businesses that are larger, but still modest in size, with continued difficulty in affording coverage if they have older or sicker workforces. Some of these businesses may also have trouble finding policies with adequate benefits.

Finally, the House bill would create a national Health Insurance Exchange to make multiple insurance coverage options available to individuals and to small businesses in every state. States would have the option to substitute their own exchanges if they obtain federal approval, comply with all federal requirements, and demonstrate that they can carry out exchange functions such as enrollment and administration of the subsidies for low-income people. The exchange would help people looking for coverage on their own (and many small businesses) to make well-informed choices and find a plan that meets their needs, no matter where they reside. The national exchange is also likely to reduce the high administrative costs that plans offered in the individual and small-group markets typically have today, and would be open not only to individuals but also (by its third year of operation) to businesses with up to 100 workers that wish to use the exchange to purchase coverage (and potentially to larger businesses as well, at the discretion of the Commissioner responsible for overseeing the exchange).

In contrast, the Finance Committee bill would rely on states to each establish their own exchanges. This is likely to result in substantial state-to-state variation that could increase complexity for consumers and insurers, provide less access to affordable, decent-quality insurance, and produce smaller cost savings than under a strong, national exchange (because administrative costs would likely be lower with a national exchange and because some state insurance markets would likely continue to have limited competition among only a handful of insurers).[11]

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[10] Existing individual-market plans would be "grandfathered" for people who are currently enrolled in them. Existing small employer plans would have five years to meet the new rules.

[11] In addition, whether larger businesses could purchase coverage through the exchanges would depend upon whether states took up an option (starting in 2017) to allow those firms to do so.

Conclusion

The House health reform bill achieves near-universal coverage and institutes badly needed reforms in the health insurance market without increasing the budget deficit. It produces substantial Medicare savings that would help strengthen that program financially (although much more will ultimately need to be done on that front). And it would somewhat slow the growth in health care costs.

In several aspects, the bill represents stronger policy reform than the Senate legislation now being developed. It would make coverage substantially more affordable for uninsured low- and moderate-income people, while placing strong but reasonable requirements on individuals to enroll in health insurance and on employers to offer coverage. Together, these provisions allow the House bill to produce larger coverage gains than under the Finance Committee bill.

The House bill takes important steps to slow the rate of growth in health care costs, producing significantly greater efficiencies than the Finance Committee bill with regard to private plan overpayments and prescription drug costs in Medicare. It also goes further than the Finance Committee bill in instituting reforms to enable health insurance markets to function more effectively, including measures to enable the new exchanges to be viable over the long run by reducing the risks of adverse selection (and the higher premium charges that adverse selection brings). The House bill does not, however, contain a key element of the Senate bill that would contribute to slowing health care growth — an excise tax on high-cost insurance plans. Incorporation of such a provision into the House bill at some stage of the legislative process would make a strong bill even stronger.