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Senate Approves First Vote on Health Care Reform
Summary of "Manager's Amendment"

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Senate Majority Leader Reid has been working with moderate and progressive Senators to craft a "Manager's Amendment" to negotiate an acceptable bill. Sixty U.S. Senators now support the Senate's version of proposed health care reform, the Patient Protection and Affordable Care Act. It is expected that the Senate will have a final vote in favor of passing the reform package before adjourning for Christmas.

The U.S. House has already passed a health care reform bill, and the two legislative bodies will have to iron out differences in a Conference Committee, with negotiations likely beginning the week after Christmas. Both chambers then need to pass the bill that comes out of the Conference Committee before it is sent to the President for his signature.

While much still needs to be accomplished to make health care reform a reality, the Senate vote represents a tremendous step forward.

A summary of some of the key changes in the Manager's Amendment follows.

Who will be insured?

According to the non-partisan Congressional Budget Office, the Senate bill will insure an additional 31 million non-elderly, currently uninsured Americans. This leaves approximately 23 million uninsured non-elderly Americans, of which about one third are undocumented workers.

Key reforms in the private insurance market

- Beginning in 2011, insurers for large group plans must spend 85 cents of every dollar they receive on premiums on actual health care for consumers, and insurers of small group and individual market plans must spend at least 80 cents of every dollar on care. If less is spent, consumers will receive a rebate for the difference
- A ban on lifetime and annual benefit limits will be enacted. This will reduce the number of medical-related bankruptcies.
- Consumers will have the right to an independent appeal of any decision by an insurer to deny coverage.
- Consumers will also have the opportunity to choose from multi-state plans, of which at least one is a not-for-profit plan, overseen by the Office of Personnel Management (the same department that selects insurance plans for federal employees). These plans will be offered through Insurance Exchanges in each state.
- Multi-state plans must comply with a 3:1 ratio for age rating, or states may require a more protective rating (a lower ratio).

- Plan enrollees will be allowed to choose their primary care provider or pediatrician from any available participating provider. It precludes the need for prior authorization for emergencies or for a woman seeking gynecological or obstetric coverage.
- Insurers will be prohibited from dropping coverage because an individual chooses to participate in a clinical trial for cancer of other life threatening diseases.

Changes in eligibility

Legal immigrants with incomes under 133 percent of the Federal Poverty Level (FPL), who are ineligible for Medicaid because of the 5 year waiting period, are eligible for the basic health program.

Assistance for small businesses and employers

- Starts a small business tax credit in 2010, and expands the full credit to firms with average wages up to $25,000 (up from ($20,000). Credits are available to firms with average wages of $50,000 (up from $40,000).
- Requires employers that offer coverage and make a contribution to provide free choice vouchers to qualified employees for the purchase of qualified plans through an Exchange. The voucher must be equal to the contribution the employer would have made under his/her own plan. Employees qualify if their required contribution to the employer-sponsored plan is between 8 and 9.8 percent of their income. Free choice vouchers are not subject to taxation, and voucher recipients are not eligible for tax credits.

Changes to Medicaid

- States are required to cover youth who aged out of the foster care system beginning in 2014, and limits this to youth who have aged out as of the date of the enactment.
- States' option to cover adults at or below 133 percent of FPL is moved up to April 1, 2010. Most non-elderly individuals with incomes below 133 percent of FPL will be eligible beginning in 2014.

Changes in Medicaid/Children's Health Insurance Program/other supports for children

- Children who are not eligible to enroll in CHIP because state allotments are capped are eligible for tax credits in the Exchanges.
- Extends the reauthorization period of CHIP for 2 years, through September 30, 2015.
- States will receive a 23 percentage point increase in their federal match rates in fiscal years 2016-2019.
- States need to maintain current coverage for children in CHIP with incomes over 133 percent of FPL through fiscal year 2019. If this maintenance of effort is not met, the state will lose their Medicaid funding.
- Increases outreach and enrollment grants by $40 million.
- Immediate ban on excluding children with pre-existing conditions
- Precludes transitioning children from CHIP to coverage in the exchanges without certification of the Secretary of Health and Human Services.
- Creates a new option for states to provide CHIP coverage to children of state employees.
- Expands adoption tax credit and adoption assistance program and makes the program refundable.

Changes for seniors and individuals with a disability

- Clarifies that Medicare beneficiaries will not pay co-pays or deductibles for preventive services.

- Establishes Community Living Assistance Services and Supports (CLASS) provisions, which would establish a voluntary federal program for long-term care insurance.

Improving quality and cutting costs within the health care delivery system

- Allows the Secretary of HHS to expand the payment bundling project, if it is found to reduce costs and increase quality
- Increases support for the Rural Community Hospital demonstration and low volume hospitals, and protects funding for hospitals and doctors in "frontier" states.
- Test pilots pay-for-performance programs for some Medicare providers.
- Expands the scope of, and improves the Independent Medicare Advisory Board.
- Establishes a variety of quality reporting standards and systems and reports of performance information.
- Includes numerous supports to develop an expanded work force in health care, particularly in rural areas.
- Strengthens health care fraud enforcement, sets up state demonstrations to evaluate alternatives to medical tort legislation, and extends medical malpractice coverage to free clinics.
- Permanent reductions in Medicare payment rates for most services in the fee-for-services sector, other than physicians' services.
- Sets payment rates in the Medicare Advantage program on the basis of the average bids submitted by these programs in each market.
- Reductions in subsidies for non-Medicare benefits offered by Medicare Advantage plans.
- Reducing Medicaid and Medicare payments to hospitals that serve a large number of low-income patients.

Changes in proposals to raise new revenue to support health care reform

- Modifies the excise tax on high-cost employer-sponsored insurance.
- Indexes the $2,500 limit on flexible spending accounts to inflation after December 31, 2011.
- Eliminates the medical device manufacturing fee for 2011; enacts an annual fee of $2billion in 2011-2017, and $3 annually thereafter.
- Eliminates the health insurance provider fee in 2010; enacts it at $2 billion in 2011, rising to $10 billion in 2016 and thereafter. Creates a limited exemption for certain not-for-profit insurers who spend 90 percent of more of collected premiums on health care for consumers.
- Increases the hospital insurance tax for individuals/couples earning more than $200,000/$250,000 from .5 to .9 percentage points.
- Eliminates tax on cosmetic surgery, but enacts a 10 percent tax on indoor tanning services.

The Congressional Budget Office estimates that with the Manager's Amendment, the health care perform proposed by the Senate will reduce the federal deficit by $132 billion between 2010 and 2019.