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## Senate Leader Hoping Public Option Compromise Can Yield 60 Votes

Last Tuesday, Senate Majority Leader Harry Reid (D-NV) reported that he was close to corralling the 60 votes needed to pass health reform legislation prior to the Christmas break. This report rests on a compromise to excise the often-maligned government-run insurance plan from the health reform proposal in exchange for allowing Americans aged 55 to 64 to buy into Medicare and offering uninsured Americans the option of purchasing coverage from nonprofit insurance plans through a program administered by the federal Office of Personnel Management (OPM). OPM currently coordinates health insurance made available to all federal employees, including members of Congress. It has been reported that this compromise includes, or once may have included, a regulatory reform requiring private health insurers to devote a minimum of 90 percent of all premium dollars on health care spending for its enrollees, allowing the remaining 10 percent for the health insurer's administrative costs and profits. Even though the broad parameters of the Reid compromise, devised from the negotiations among five liberal and five moderate Democratic Senators, have been widely reported in the media, the legislative language and the particulars of program requirements remain secret, pending cost estimates from the Congressional Budget Office (CBO). It is assumed that Majority Leader Reid will continue to work in secret with the CBO on elements of this new reform compromise until a favorable CBO score can be obtained – just as the Leader did before unveiling the merged Senate leadership health reform bill.

The swirl of excitement that began early last week had waned considerably by the weekend as the realities of legislating a reform measure of this magnitude have taken hold. As of Monday morning, December 14, there is still no favorable CBO score to wrap around the Reid compromise. Also, since announced, those interest groups critical of the Reid compromise are making their opinions known.

The Medicare buy-in – requiring health care providers to be paid at lower than commercial market rates for more and more patients – has been criticized by many health care providers. The American Hospital Association, the Federation of American Hospitals, the American Medical Association and the American Medical Group Association have complained loudly that a significant expansion to Medicare would threaten the financial stability of physicians and hospitals, especially those in rural areas

with even lower reimbursement rates. It is now believed that the CBO is scoring a compromise measure in which the Medicare coverage for those aged 55 to 64 would not rely on compensating health care providers at current fee-for-service Medicare rates. Other critics of the Reid compromise object to an expansion of the overburdened Medicare system under any circumstance, arguing that it would jeopardize the fiscal stability of the entire Medicare program. In response, Sen. Max Baucus (D-MT) has indicated that Medicare costs for those aged 65 and older and Medicare costs for somewhat younger Americans who buy-in should be pooled separately. Still other critics of the Reid compromise have argued that these new health insurance options for uninsured Americans would be too expensive for many Americans, especially given the level of premiums charged for federal employees who participate in the Federal Employees Health Benefit Program administered by OPM. Finally, the proposal that health insurers must maintain medical loss ratios of at least 90 percent has been criticized by both health insurers and businesses that offer innovative health improvement programs and chronic care management to health insurers, whose fees may not be considered part of the insurers' medical expenses. A senior Democratic aide has now been quoted as indicating that this provision was considered in the negotiations, but has been rejected.

Procedurally, it is believed that Majority Leader Reid is amending the Senate bill by incorporating the public option compromise and the amendments which already have passed the Senate, and will present the amended Act as a single manager's amendment to be voted upon by the full Senate. However, on the path to this final vote, Reid must file three motions for cloture to stop the Republican filibuster and cut off debate. Reid needs to successfully stop debate on the Patient Protection and Affordable Care Act, itself, currently being debated on the Senate floor; on his manager's amendment, which we may see in the next several days; and on the legislative shell put forth to accomplish health reform in the Senate, the Service Members Home Ownership Tax Act. Although Reid may file all three cloture motions at the same time, the 90 hours of debate required for each motion must occur consecutively and could take six or seven days. Still, it may be imprudent for Reid to file the cloture motions before he has secured 60 votes on the entire health reform package, and that will not occur at least until the Senators have seen the compromise public option measure and its CBO score.

## Debate On Health Reform Includes Retiree Drug Subsidies Concerns

The debate on the Senate's health reform bill is drawing attention to the many provisions that will impact the existing Medicare program. One of those areas that has drawn little attention is the proposed change to the

taxation of retiree health coverage. The Senate and House health reform legislative proposals would end the current tax exclusion of the retiree drug subsidy currently enjoyed by many employers.

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## Debate On Health Reform Includes Retiree Drug Subsidies Concerns (cont'd.)

The Medicare program was amended by the Medicare Modernization Act of 2003 ("MMA") to provide a voluntary prescription drug benefit to Medicare beneficiaries, known as Part D. The benefit is available through health plans that contract with CMS to provide the programs, and participating seniors pay additional premiums for the Part D coverage. Congress wanted to encourage employers which had existing retiree health benefit programs to maintain their prescription drug coverage to help allay the costs to Medicare for the new Part D program. Therefore, MMA provided a 28 percent premium cost subsidy to employers who included drug benefits in their retiree health plans. The subsidies were designed to help offset the cost the employers incurred in providing the coverage.

Under the health reform proposal being debated in the Senate, and also part of the legislation already passed by the House, the tax exclusion for these Part D subsidies would cease. It is estimated that the tax exclusion is worth approximately \$3 billion in additional federal tax revenue, although proponents of this reform measure dispute that figure. The concerns are concentrated around the fear that employers will drop their retiree prescription drug programs if they are taxed on the

subsidy, which, in turn, could result in more Medicare beneficiaries obtaining the Medicare Part D coverage instead, thus increasing the overall cost to Medicare.

Organized labor is particularly concerned that, by eliminating employers' ability to exclude the subsidy for Part D retiree drugs from taxation, employers would be taxed on a benefit that they are ultimately providing to their retired employees. In a letter to House Speaker Nancy Pelosi, the American Benefits Council of the AFL-CIO expressed concern that the loss of the tax deductibility of the retiree drug subsidy might cause employers who used that subsidy to drop prescription drug coverage for retirees. A number of other organizations also have expressed a desire to be involved in the discussions with members of Congress regarding the potential taxation of the retiree prescription drug subsidy. Concerned entities, including organized labor and large employers, feel that the revenues from eliminating the tax exclusion are overestimated, and taxation will result in a decline of comprehensive retiree health coverage plans, some of which might be the subject of collective bargaining. Stay tuned to see if these concerns result in additional amendments to the Senate health reform legislation during the continuing debate.

## Senate Gridlock Over Controversial Amendments

Despite the attention devoted to Majority Leader Reid's compromise version of a government-run public option plan, the Senate began considering a number of amendments early in the week. Once Reid sent his public option compromise to the CBO for a cost estimate, the Senate went into a holding pattern and ended the weekend passing a package of fiscal 2010 spending bills, which authorize about \$600 billion in mandatory federal spending on government programs such as Medicare, Medicaid and Social Security. The chamber also stalled last week on a number of controversial amendments that still await votes.

On Tuesday, the Senate rejected, 54-45, an amendment co-sponsored by Sens. Ben Nelson (D-NE) and Orrin G. Hatch (R-UT) that would bar individuals who receive federal insurance subsidies from purchasing private policies that cover elective abortions and that would also ban abortion coverage under a government plan. Six Democrats joined Nelson in support of the proposal. Without this amendment, Nelson has threatened to support a Republican filibuster of the health reform bill. However, it is rumored that there could be a compromise involving tightening of current restrictions to make sure insurance companies do not use public money to pay for elective abortions.

Another controversial amendment last week came from Sen. Byron Dorgan (D-ND) and would allow consumers to import prescription drugs from other countries. Despite significant cost savings argued by the amendment's proponents, it has been criticized by the Obama Administration and the FDA. In a letter sent to the senators last week, the FDA expressed

concern that the plan would be difficult to implement and raises significant safety concerns. Democrats fear that, if Dorgan's proposal is approved, it would unravel a deal negotiated by the White House and the pharmaceutical industry earlier this year. Sen. Frank Lautenberg (D-NJ) also filed a side-by-side resolution to Dorgan's proposal that would make it more difficult to lift limits on drug importation. Dorgan is threatening to delay debate until the chamber votes on his language.

Sen. Mike Crapo (R-ID) also filed an amendment that would send the healthcare bill back to committee to remove all taxes on individuals who earn less than \$200,000 and families that earn less than \$250,000. Sen. Max Baucus filed a side-by-side resolution to this measure. Sunday afternoon, Minority Leader Mitch McConnell (R-KY) filed a cloture amendment on the Crapo proposal. The cloture vote would take place Tuesday morning unless an agreement is reached or Democrats move to table the amendment.

Finally, last Friday, at the urging of patient protection groups such as the American Cancer Society, the White House agreed to push for removal of language in the Senate legislation that permits insurance companies to place annual limits on the dollar value of health care expenses, as long as such limits are not "unreasonable." The current language does not define unreasonable limits and would leave the issue to agency rulemaking. Proponents of the current provisions argue that limits are necessary for controlling premium costs.