US Senate committee set for vote on health care plan

Kate Randall
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The US Senate Finance Committee finished considering amendments to its health care proposal early Saturday morning. The committee will take a final vote on the legislation early this week after the Congressional Budget Office (CBO) assesses its cost.

The plan drafted by committee chairman Max Baucus, Democrat of Montana, will then go to the full Senate, where it must be reconciled with a proposal from the Senate health committee. Senate Majority Leader Harry Reid, Democrat of Nevada, expects full debate in the Senate to begin in mid-October.

The Senate plan must then be brought together with legislation being drafted in the House, with Reid and House Speaker Nancy Pelosi, Democrat of California, setting a goal of approving a final compromise bill to be sent to President Barack Obama to sign before Christmas.

The Baucus plan, the most conservative of the three main Congressional proposals, is also the version of legislation most broadly favored by Obama, who has stated that the plan contains "80 percent" of what he is looking for in an overhaul of the health care system.

In his Saturday radio address, the president made special mention of the plan, emphasizing that his vision of health care restructuring was aimed at defending private enterprise, to "help ensure that our entrepreneurs, our businesses, and our economy can thrive in the years ahead."

After weeks of wrangling, and votes on hundreds of amendments, the Baucus bill has been left essentially intact. The Finance Committee last Tuesday voted down two amendments that would have provided a "public option" on the insurance exchange where individuals and families without health insurance would be mandated to purchase coverage or pay a fine. (See "US Senate panel votes down 'public option' for health care".)

Obama has indicated that inclusion of the public option is not the be-all and end-all of any health care plan—"whether we have it or we don't have it, is not the entirety of health care reform"—and he can be expected to sign legislation that does not include it.

When the major features of the Baucus plan are analyzed, it is clear that far from overcoming the inequities in the present for-profit system, it will instead intensify them. While serving as a boondoggle for the insurance companies—with millions of Americans forced to purchase coverage—it will leave tens of millions with cut-rate care and will be financed primarily through deep cuts to Medicare and Medicaid.

The bill's cost is an estimated $900 billion over 10 years. In keeping with Obama's proposals, the Baucus plan pledges to be "deficit neutral." If the CBO determines this not to be the case, the Finance Committee will further trim costs before taking a final vote on the legislation.

In an ominous sign of what America's financial aristocracy expects from health care "reform," Alan Greenspan, former chairman of the Federal Reserve Board, commented on the Baucus plan in an interview on ABC's "This Week" on Sunday, "I would say revenue neutral is not adequate. In other words, we have to not only have a revenue neutral reform program, but simultaneously recognize that we have to address the longer term."

The Baucus plan proposes $377 billion in cuts to Medicare, or about 5 percent over 10 years (2010-2019). It would cut $200 billion by lowering payments to hospitals, nursing homes and other providers. It would also cut $113 billion from Medicare Advantage (MA) programs through which more than 10 million seniors receive Medicare benefits via private health insurance plans.

The Finance Committee members—like the authors of other Congressional health care legislation—cynically claim that such drastic cuts can be achieved while improving health care for the elderly, poor and disabled.

Further cuts will be made through the use of "comparative effectiveness research" (CER) to ration care. Among other mechanisms, the plan would require the secretary of Health and Human Services (HHS) to set up an Innovation Center with the Centers for Medicaid and Medicare Services to test health-care models "that transition primary care practices away from fee-for-service based reimbursement and toward

comprehensive payment."

It would also establish a 15-member independent Medicare Commission "that would develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries." The body, appointed by the president, would submit proposals to Congress to reduce "excess cost growth" in line with the Consumer Price Index (CPI).

Doctors oppose another provision in the Baucus plan that calls for the HHS secretary to reduce Medicare payments to doctors who administer the most tests and treatments. If doctors fall into the 90th percentile or above in their levels of treatment compared to other doctors, they would be penalized with a 5 percent reduction in Medicare reimbursements.

Doctors would also be called upon to submit data to the government to measure the quality of the treatment they dispense. Doctors eligible for the program who chose not to participate would be penalized 1.5 to 2 percent on certain Medicare payments, while those who did so successfully would get a 1 percent bonus.

As with every other Congressional plan, individuals and families would be mandated to purchase coverage, funneling billions into the insurance industry's coffers. As amended, the Baucus plan would exempt people from this mandate if the least expensive plan offered either through the exchange or from an employer amounted to more than 8 percent of income.

Businesses, on the other hand, would be under no obligation to provide their employees with coverage. Employers with more than 50 full-time workers would pay a nominal fee if the government ended up subsidizing coverage for their employees.

By means of a complicated formula, tax credits would be available to individuals making up to 400 percent of the federal poverty level, or about $88,200 for a family of four.

An additional tax would be levied on insurance companies on premiums costing more than $8,000 annually for individuals and $21,000 for families—so-called Cadillac plans.

Union workers are the most likely participants in such plans, having secured them in contract struggles at the expense of wages and other benefits. While this tax would be levied against insurance companies, costs would inevitably be passed down to beneficiaries in the form of higher premiums.

While not including a public option, an amendment to the Baucus plan would allow states to set up their own public plans. The measure, sponsored by Senator Maria Cantwell, Democrat of Washington, passed in a 12-11 vote by the finance panel largely along party lines. It would authorize states to enroll residents with incomes between 133 and 200 percent of the federal poverty level, who do not have employer-sponsored coverage, in a state-based public plan.

States would be under no obligation to provide such plans. They would negotiate payments rates directly with private health care providers, rather than basing payments on generally lower Medicare reimbursement rates, as had been envisioned under other federally run public plans. The state plans would be financed by the tax credits that would have gone to individuals enrolled in the plans, therefore not adding to federal outlays.

The Baucus plan calls for the expansion of so-called nonprofit health care cooperatives. Experience has shown that such privately run coops do not generally offer lower premiums, and their inclusion in the legislation is largely window dressing.

Like all the other Congressional versions of health care legislation, the Baucus plan includes certain restrictions on insurance companies, barring them from denial of coverage based on preexisting conditions, as well as limits on higher premiums based on age and family size.

An article in Sunday's *Washington Post* explains how insurers will seek to execute an end run around such restrictions. They could cherry-pick the healthiest individuals by offering benefits to attract certain segments of the population, or through their claims practices.

For instance, a policy that offers free health club memberships would tend to attract those who can use the equipment—namely the young and healthy. The chronically ill, on the other hand, would be put off by insurance companies that are uncooperative in settling claims.

To avoid those patients with expensive, chronic conditions, insurers could include in their networks fewer physicians specializing in those conditions, making these people less likely to enroll.

Mark V. Paul, a professor of health care management at the University of Pennsylvania's Wharton School, told the *Post* that a ban on discrimination would not automatically translate into an end to discrimination.

"It would probably increase the incentive for cherry-picking," Pauly said. As an insurer, "I'm strongly motivated to try to avoid you if I'm not allowed to charge you extra."