



# *SBLC WEEKLY*

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## **FAMILIAR CONCEPTS**

The Republican Majority has delivered on its promise to pass legislation to repeal the health care reform law, the Patient Protection and Affordable Care Act (PPACA), enacted last year. H.R. 2 passed the House by a 245-189 vote. The next day, the House passed a resolution, H. Res. 9, which directs the Committee on Education and the Workforce, the Committee on Energy and Commerce, the Committee on the Judiciary, and the Committee on Ways and Means, each to report to the House legislation proposing changes to existing law within each committee's jurisdiction with provisions that--

- (1) foster economic growth and private sector job creation by eliminating job-killing policies and regulations;
- (2) lower health care premiums through increased competition and choice;
- (3) preserve a patient's ability to keep his or her health plan if he or she likes it;
- (4) provide people with pre-existing conditions access to affordable health coverage;

- (5) reform the medical liability system to reduce unnecessary and wasteful health care spending;
- (6) increase the number of insured Americans;
- (7) protect the doctor-patient relationship;
- (8) provide the States greater flexibility to administer Medicaid programs;
- (9) expand incentives to encourage personal responsibility for health care coverage and costs;
- (10) prohibit taxpayer funding of abortions and provide conscience protections for health care providers;
- (11) eliminate duplicative government programs and wasteful spending;
- (12) do not accelerate the insolvency of entitlement programs or increase the tax burden on Americans, or
- (13) enact a permanent fix to the flawed Medicare sustainable growth rate formula used to determine physician payments under title XVIII of the Social Security Act to preserve health care for the nation's seniors and to provide a stable environment for physicians

The committee chairs have indicated with respect to health care, they will work to pass legislation to establish Association

Health Plans (AHPs), reform medical malpractice law, expand Health Savings Accounts (HSAs), and allow the purchase of insurance across state lines.

As a practical matter, the Senate is not likely to consider H.R. 2. With respect to alternative health care reform measures that may pass in the House, it is not likely the Senate majority is going to allow any measures to move until the fate of health care reform is determined by the United States Supreme Court.

House Resolution 9 is a matter of internal policy in the House. It is not voted upon by the Senate and does not go to the President. It does not include a date by which the committees must report bills back to the House. The House will still have to vote to approve the bills when the committees report them to the House, and the Resolution has absolutely no authority in the Senate. The bills passed as a result of the process initiated by the Resolution are just like any other bills sent to the Senate by the House.

On a policy level, the package of alternative reforms that the House majority will move through the House fall into two camps –

initiatives that cannot be reconciled with the system put in place by last year's reform law, and those that could peacefully co-exist as they are complementary or compatible with the new system.

In the former category, are AHPs and across state line purchasing. The delivery system for providing health care insurance under last year's law is the state based health care Exchanges. The Exchanges would never be viable if there are non-geographic alternatives that siphon off the low risk insured.

In the latter category, medical malpractice reform could be beneficial under any system that retains medical practitioner liability. Last year's reform "nicked" Health Savings Accounts but did not do away with them so expanding HSAs might fall into this bucket as well.

### ***ASSOCIATION HEALTH PLANS***

The version of the AHP bill in the 110th Congress, the Small Business Health Fairness Act, would have established a number of provisions that plans must include to become certified as Association Health Plans (AHPs), and would have exempted such plans from state insurance laws and regulatory oversight. The proposal would have removed states' authority to apply a large body of insurance laws and regulations including consumer protections, solvency and fair market practices, grievances and appeals procedures, premium taxation, and prohibitions on discrimination. Instead, the measure would have established the federal government as having the sole regulatory authority over these entities except in the case of state laws that prohibit the exclusion of a specific disease from coverage, or

relate to newborn and maternal minimum hospital stays, and mental health parity.

The AHP concept began to morph as Democrats embraced some of the themes and eventually the state Exchanges created by PPACA included some of components of the AHP concept.

The States are required to have Exchanges in place by 2014. Individuals may obtain their coverage through these Exchanges. Most subsidies under PPACA for individuals are tied to coverage through the Exchanges.

These Exchanges will include Small Health Option Programs (SHOPs) through which small businesses may obtain coverage. Generally, small businesses with up to 100 employees will be able to acquire coverage through the Exchanges. After 2016, States may expand the pools to include larger employers.

States are permitted to create regional Exchanges.

### ***MEDICAL MALPRACTICE REFORM***

What's might medical malpractice reform look like? Back in 2003, the House considered a bill the "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003," that would have capped noneconomic damages in medical malpractice lawsuits at \$250,000 and place other limits on lawsuits. The legislation also sought to limit punitive damages to two times the economic damages or \$250,000, whichever is greater. Under the proposal, limitations would have been placed on attorneys' fees to reduce incentives for unnecessarily large award requests by plaintiffs'

attorneys. The number of years a plaintiff has to file health care liability action would have been limited to ensure that claims are brought while evidence and witnesses are available.

House Judiciary Committee Chairman Lamar Smith (R-TX) said he could introduce this Congress' version as early as this week.

Last year's health care reform law established demonstration grants for states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.

During the health care reform debate in the last Congress, the Congressional Budget Office (CBO) estimated that implementation of a package of medical malpractice reforms would reduce total national premiums for medical liability insurance by about 10 percent. CBO estimated that the direct costs that providers would incur in 2009 for medical malpractice liability—which consist of malpractice insurance premiums together with settlements, awards, and administrative costs not covered by insurance—would total approximately \$35 billion, or about 2 percent of total health care expenditures. Therefore lowering premiums for medical liability insurance by 10 percent would reduce total national health care expenditures by about 0.2 percent.

CBO also assessed the impact of tort reform to include not only direct savings from lower premiums for medical liability insurance but also indirect savings from reduced utilization of health care services.

CBO estimated a package of reforms would reduce total national health care spending by about 0.5 percent (about \$11 billion in 2009). That figure is the sum of the direct reduction in spending of 0.2 percent from lower medical liability premiums and an additional indirect reduction of 0.3 percent from slightly less utilization of health care services.

In the case of the federal budget, enactment of such a package of proposals would reduce mandatory spending for Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits program by roughly \$41 billion over the next 10 years

### **HEALTH SAVINGS ACCOUNTS**

Individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account (HSA). An HSA is a tax-exempt account held by a trustee or custodian for the benefit of the individual. The decision to create and fund an HSA is made on an individual-by-individual basis and does not require any action on the part of the employer.

Contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize their deductions on their tax return (rather than claiming the standard deduction). Income from investments made in HSAs is not

taxable and the overall income is not taxable upon disbursement for medical expenses. For 2011, the maximum aggregate annual contribution that could be made to an HSA was \$3,050 in the case of self-only coverage and \$6,150 in the case of family coverage. The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up contributions").

A high deductible health plan is a health plan that has an annual deductible that was at least \$1,200 for self-only coverage or \$2,400 for family coverage for 2011 and that limited the sum of the annual deductible and other payments that the individual must make with respect to covered benefits to no more than \$5,950 in the case of self-only coverage and \$11,900 in the case of family coverage for 2011.

Distributions from an HSA that are used for qualified medical expenses are excludable from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income. An additional 10 percent tax\* is added for all HSA disbursements not made for qualified medical expenses. The additional 10-percent tax does not apply, however, if the distribution is made after death, disability, or attainment of age of Medicare eligibility (currently, age 65). *\*As a result of the enactment of PPACA, the additional tax on distributions from an HSA that are not used for qualified medical expenses is increased to 20 percent of the disbursed amount, starting in 2011.*

Separately, PPACA made some changes regarding over the counter drug expenses.

Under the provision, the cost of over-the-counter medicines may not be reimbursed with excludible income through a Health FSA, HRA, HSA, or Archer MSA, unless the medicine is prescribed by a physician, effective January 1, 2011.

According to the Employee Benefits Research Institute, in 2010, there was \$7.7 billion in HSAs and health reimbursement arrangements (HRAs), spread across 5.7 million accounts. This is up from 2006, when there were 1.2 million accounts with \$835.4 million in assets, and 2009, when 5 million accounts held \$7.1 billion in assets.

Presumably, a new proposal in the House might return the distribution tax back to its original 10 percent level.

Before PPACA, the principal expansion efforts were to adjust the amount allowable as a deduction for health savings accounts and eliminate the restriction on purchasing health insurance from a health savings account.