



**Weighing The Options**  
By Adam Dougherty, MPH  
Insure the Uninsured Project  
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Federal health reform legislation has reached a critical point. The mathematical reality is that the present bills could no longer pass the Senate due to the filibuster rules requiring 60 votes. Republican political success in Massachusetts all but assures their position of unwavering opposition through next November's elections. The reality for health reformers is that something must get done quickly as federal reform efforts have dragged on for nearly a year. The combination of public fatigue, election year anxiety, and an economy with unconscionably high unemployment further narrows the window of time. As such, the options left on the table can be prioritized while Congressional leaders and the President reflect on the best path forward.

Speaker Pelosi stated today that the votes are not there to simply pass the Senate's Patient Protection and Affordable Care Act out of the House and into law.<sup>1</sup> The White House and Congressional leadership would need to identify the major sticking points in the Senate bill that House members are unwilling to support, and develop a separate budget reconciliation bill to "improve" the verbatim Senate version. Acting on the reconciliation bill in the Senate only requires 51 votes. The Senate bill in concert with the reconciliation measure would need to command majority support in both the House and Senate. Pelosi can then offer the mini-bill and the Senate bill in simultaneous votes in the House prior to a Presidential double signature into law.

As nearly 90% of the two versions are identical,<sup>2</sup> the companion would look something like the Manager's Amendments submitted by Pelosi and Reid prior to their houses' votes. Much of this work has already been done in conference with the President over the past few weeks, including a compromise on the scaled-back excise tax, increased federal aid for state Medicaid programs, and improved subsidies for individuals in the Exchange. Not only would this path be the fastest towards tangible results, it may even result in a better bill that as policy, House and Senate majorities could surely support.

Since the reconciliation bill can only include issues impacting the federal budget, the House must stomach some of the Senate's non-budgetary differences.<sup>3</sup> Are House Democrats ready to sacrifice the anti-trust exemption repeal, slightly varying abortion language, exclusion of undocumented and newly legal immigrants in the Exchange, or a 3:1 age rating in place of a 2:1 rating to get coverage for most of the uninsured?

We should also ponder what is actually a budgetary issue, especially so with major provisions such as the structure of the Health Insurance Exchange and the minimum benefits standard. These decisions would fall to the Senate Parliamentarian, a man named Alan Frumin.<sup>4</sup>

If House Democrats are unable to unify around a reconciliation bill, then there several other directions federal health reform can go. Representative Grijalva (who is also

leading the House liberals against the Senate bill) and others have floated the idea of a pared back bill to be pursued entirely through the reconciliation process. The structural provisions of the current legislation are notably interdependent, though, and any major deletion would effectively implode a bill (see the following paragraph). A similar idea would be to start from scratch, where legislative language for a clean and quick Health Reform *LITE* would be developed and pursued through reconciliation. Certain ‘expendable’ provisions are indeed present in the bill, some of which could have large bipartisan majority support such as public health, Graduate Medical Education reform, and infrastructure investment in community clinics and school based health centers. Others controversial provisions, such as the CLASS program may not sustain a simple majority. Removal of these provisions could reduce the overall cost of the bill and simplify the language (maybe even reducing the page number to below the 1,000 mark). The backlash against full reconciliation could be exponential.

The final option would be to cleave the bill into pieces, hoping for broad support on the most popular aspects and passing as many bills as possible. Many individual provisions enjoy significant public and bipartisan support, including insurance market reform, coverage expansion to the uninsured, affordability subsidies and closing the Medicare donut hole. It is extremely difficult to silo the reform provisions, due to the interdependent nature of the entire effort.<sup>5</sup> For example, if Congress were to pass a package of widely popular insurance market regulations including individual guaranteed issue and renewal, restrictions on premium rating variation, and other consumer protections without an individual mandate we would see a large influx of sick individuals into risk pools, effectively creating the death spiral of adverse selection. This is why the insurance regulations have to be coupled with an individual mandate, in order to balance the market the very few who get sick or injured in a given year with mostly healthy individuals. The mandate makes the bill less appealing across the political spectrum, but is necessary outside of a Medicare-for-all-like system.

You cannot impose or enforce a mandate if insurance is unaffordable for low- and middle-income individuals who do not qualify for public coverage. For this reason, subsidies must be available to those who can’t purchase insurance on their own. Where do you find subsidies? There are limited choices, perhaps a high-income tax (though unpopular on many fronts) or perhaps from savings from the healthcare system itself. Or you can save money by combining the subsidies with a modest expansion of Medicaid, though this still requires some financing so that state budgets are protected. All of a sudden what started as the insurance regulation package has developed a striking resemblance to the bills currently being considered in Congress, and that is why the bills look the way they do given our hybrid of public programs and the private insurance market. The bills on paper were only developed this past year, but the methodology behind them is the result of decades of research pilots and experimentation at the state level and cannot simply be piecemealed with positive results. If the goal is bipartisan support on as many pieces as possible, singular bills will amount to little more than options for state pilot projects and at most a possible increase in federal assistance for Medicaid programs. Even then the bills would have to go through Committees, the CBO, and the usual legislative delays of federal government. True bipartisanship, such as the

consumer-oriented Wyden-Bennet bill<sup>6</sup>, which lacked majority support in both parties, was overlooked long ago.

The above analysis results in a tough choice: persuade the House to accept a mini-bill through reconciliation to be coupled with the as-is Senate bill, or accept defeat as a party that enjoys a 40-seat advantage in the House, a 19 seat advantage in the Senate, and control of the Presidency and move on. Speaker Pelosi may have to sacrifice the votes of some liberal Representatives if she can garner support from a handful of the 39 centrist Democrats, who would certainly find the Senate bill more appealing. Numerous groups are already calling on Congress to press forward with a plan, and sustained, clear-eyed and unambivalent support for reform will be crucial as this week's dust settles.

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<sup>1</sup> Slajda, R, Pelosi: There Aren't Enough Votes to Pass the Senate Bill, Talking Points Memo DC, January 21, 2010 at: <http://tpmdc.talkingpointsmemo.com/2010/01/pelosi-there-arent-enough-votes-to-pass-the-senate-bill.php>

<sup>2</sup> Tri-Committee, House and Senate Comparison, January 2010: [http://www.google.com/url?sa=t&source=web&ct=res&cd=1&ved=0CA0QFjAA&url=http%3A%2F%2Fwww.speaker.gov%2Fpdf%2FHScomparison.pdf&ei=Hd1YS\\_TjBIviNb2j8dsE&usg=AFQjCNET0BjNzL\\_KjApemgWl0piqhsiRAA&sig2=GtKaJSTjkc4TnzliXCq5rg](http://www.google.com/url?sa=t&source=web&ct=res&cd=1&ved=0CA0QFjAA&url=http%3A%2F%2Fwww.speaker.gov%2Fpdf%2FHScomparison.pdf&ei=Hd1YS_TjBIviNb2j8dsE&usg=AFQjCNET0BjNzL_KjApemgWl0piqhsiRAA&sig2=GtKaJSTjkc4TnzliXCq5rg)

<sup>3</sup> Ibid

<sup>4</sup> Dan Amira, New Yorker Alan Frumin, Senate Parliamentarian, in the Hot Seat Once More, New York Magazine, January 20, 2010: [http://nymag.com/daily/intel/2010/01/new\\_yorker\\_alan\\_frumin\\_senate.html](http://nymag.com/daily/intel/2010/01/new_yorker_alan_frumin_senate.html)

<sup>5</sup> Paul Krugman, One Health Care Reform, Indivisible, NYT Blog, January 10, 2010 at: <http://krugman.blogs.nytimes.com/2010/01/08/one-health-care-reform-indivisible/>

<sup>6</sup> Edwin Park, An Examination of the Wyden-Bennett Health Reform Plan, Center on Budget and Policy Priorities, September 2008 at <http://www.cbpp.org/cms/?fa=view&id=674>