House and Senate look to final health care talks

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(AP) -- How many Americans will get subsidized medical coverage - plus who will pay for it - will be front-burner issues when Congress returns next month to complete President Barack Obama's health care remake.

Pocketbook concerns join abortion and whether Uncle Sam should peddle insurance as the top bones of contention for negotiators who must resolve difference between the House and Senate bills.

The negotiations are the last chance for Democrats to shape the legislation to deliver concrete benefits to Americans skeptical that it will help control skyrocketing premiums as it expands coverage to millions more.

"People will really begin to focus on some of the core issues that have received less attention," said Rep. Chris Van Hollen, D-Md., a member of the House leadership. "These are the bread-and-butter issues that will have the most significant impact on people's pocketbooks."

Broadly speaking, both bills would gradually expand coverage, while banning objectionable insurance industry practices such as turning down people with health problems. Eventually, all Americans would be required to carry health insurance, with government subsidies to make premiums more affordable for many of them.

Those covered by big employers wouldn't see major changes, but individuals buying their own policies and small businesses would be able to shop for competitively priced plans in an insurance supermarket called an exchange. Medicare cuts and an assortment of taxes and fees would pay for the bills.

Democrats are under pressure to reconcile the House and Senate versions before Obama's first State of the Union speech. Not yet scheduled, it's usually delivered in late January or early February. Republicans will wage legislative guerrilla warfare to delay an agreement.

There's not much time, and apparently not much give either.

Senate moderates say they won't vote for a bill that changes the basic terms they agreed to with Majority Leader Harry Reid.

Independent Sen. Joe Lieberman of Connecticut and conservative Sen. Ben Nelson, D-Neb., have drawn a line against reintroducing a government-run insurance plan to compete with the likes of Aetna and Wellpoint. The House bill includes it, but Reid, D-Nev., needs every member of his 60-vote coalition to hold off GOP opponents.

More difficult to solve is the issue of how to restrict taxpayer funding for abortions. Abortion opponents disagree among themselves over the Senate's approach. Abortion rights supporters are completely against the more restrictive House language and are divided on how the Senate has handled it.

Obama will probably have to step in to settle disputes and keep things moving.

Democrats have options on how to handle the negotiations. They could

agree to a limited set of changes, allowing each chamber to pass identically amended bills. Or they could set up a formal conference committee to resolve differences. Leaders have made no decision yet. Naming a conference committee would signal that the issues have proven difficult.

Yet the longer Democrats argue, the more suspicious the public becomes about remaking the health care system. "The making of salami and legislation is not pretty for people to watch," said Harvard professor Robert Blendon, who tracks public opinion on health care. "It has left them nervous that the interests of middle-income people are not being served."

That's one reason leading Democrats are arguing for a focus on pocketbook issues in the homestretch.

"There will be a certain amount of replaying issues that have been hot-button issues, but I think there will also be a refocusing, especially on cost," said Senate Budget Committee Chairman Kent Conrad, D-N.D. "At the end of the day, when all of us go home, what we hear about is the ever-increasing, ever-escalating costs."

There are some signs of that already.

Last week, Reid pledged on the Senate floor to close the coverage gap in Medicare prescription benefit - as the House bill already does. The message was aimed at seniors worried that Medicare cuts to hospitals and other providers will jeopardize their care.

And Conrad said senators may go along with the House timetable for expanding coverage, which calls for starting subsidies in 2013, a year earlier than the Senate bill.

The House bill provides coverage to 36 million, while the Senate covers 31 million. Lawmakers in the House want the Senate to move toward their number.

Another priority will be to make sure the final bill promotes competition in the health insurance market, which in many states is dominated by one or two large carriers.

Though it sounds arcane, a major problem for negotiators is whether the new insurance supermarket should be state-based, as in the Senate bill, or national, as the House calls for. Some advocates say a national approach provides stronger consumer protection.

Finally, the issue of who to tax won't be easy.

Unions are adamantly opposed to the Senate plan, which would impose a 40 percent tax on high-cost health insurance above $8,500 for an individual plan, $23,000 for families. Organized labor sees the tax on so-called Cadillac plans as a hit on its members, who have fought for years for better-than-average coverage. Unions are a core Democratic constituency and many House Democrats want to knock out the insurance tax.

The Obama administration, however, supports such a tax. In a recent session with reporters, White House economic adviser Christina Romer called the tax "a very effective cost-growth containment mechanism," arguing that it will force people into more efficient plans.

Rep. Joe Courtney, D-Conn., wasn't buying it. "The most troublesome component of the Senate bill remains the 40 percent excise tax on high-cost health care premiums," he said. More than 190 House Democrats agree. Instead, they want to tax upper-income earners.

A comparison of House, Senate health care bills

A comparison of the health care bills passed by the Senate and House:

The Senate Democratic bill (Patient Protection and Affordable Care Act):

WHO'S COVERED: About 94 percent of legal residents under age 65 - compared with 83 percent now. Government subsidies to help buy coverage start in 2014. Of the remaining 24 million people under age 65 left uninsured, about one-third would be illegal immigrants.

COST: Coverage provisions cost $871 billion over 10 years.

HOW IT'S PAID FOR: Fees on insurance companies, drugmakers, medical device manufacturers. Medicare payroll tax increased to 2.35 percent on income over $200,000 a year for individuals, $250,000 for couples. A 10 percent sales tax on tanning salons, to be paid by the person soaking up the rays. Cuts to Medicare and Medicaid. Forty percent excise tax on insurance companies, keyed to premiums paid on health care plans costing more than $8,500 annually for individuals and $23,000 for families. Fees for employers whose workers receive government subsidies to help them pay premiums. Fines on people who fail to purchase coverage.

REQUIREMENTS FOR INDIVIDUALS: Almost everyone must get coverage through an employer, on their own or through a government plan. Exemptions for economic hardship. Those who are obligated to buy coverage and refuse to do so would pay a fine starting at $95 in 2014 and rising to $750.

REQUIREMENTS FOR EMPLOYERS: Not required to offer coverage, but companies with more than 50 employees would pay a fee of $750 per employee if the government ends up subsidizing employees' coverage.

SUBSIDIES: Tax credits for individuals and families likely making up to 400 percent of the federal poverty level, which computes to $88,200 for a family of four. Tax credits for small employers.

BENEFITS PACKAGE: All plans sold to individuals and small businesses would have to cover basic benefits. The government would set four levels of coverage. The least generous would pay an estimated 60 percent of health care costs per year; the most generous would cover an estimated 90 percent.

INSURANCE INDUSTRY RESTRICTIONS: Starting in 2014: no denial of coverage based on pre-existing conditions. No higher premiums allowed for pre-existing conditions or gender. Limits on higher premiums based on age and family size. Starting upon enactment of legislation: children up to age 26 can stay on parents insurance; no lifetime limits on coverage.

GOVERNMENT-RUN PLAN: In place of a government-run insurance option, the estimated 26 million Americans purchasing coverage through new insurance exchanges would have the option of signing up for national plans overseen by the same office that manages health coverage for federal employees and members of Congress. Those plans would be privately owned, but one of them would have to be operated on a nonprofit basis, as many Blue Cross Blue Shield plans are now.

HOW YOU CHOOSE YOUR HEALTH INSURANCE: Self-employed people, uninsured individuals and small businesses could pick a plan offered through new state-based purchasing pools. Would generally

encourage employees to keep work-provided coverage.

DRUGS: Grants 12 years of market protection to high-tech drugs used to combat cancer, Parkinson's and other deadly diseases. Drug companies contribute $80 billion over 10 years with the majority of the money used to limit the prescription coverage gap in Medicare.

CHANGES TO MEDICAID: Income eligibility levels likely to be standardized to 133 percent of poverty - $29,327 a year for a family of four - for parents, children and pregnant women. Federal government would pick up the full cost of the expansion during the first three years. States could negotiate with insurers to arrange coverage for people with incomes slightly higher than the cutoff for Medicaid.

LONG-TERM CARE: New voluntary long-term care insurance program would provide a basic benefit designed to help seniors and disabled people avoid going into nursing homes.

ANTITRUST: Maintains the health insurance industry's decades-old antitrust exemption.

ILLEGAL IMMIGRANTS: Would be barred from receiving government subsidies or using their own money to buy coverage offered by private companies in the exchanges.

ABORTION: The bill tries to maintain a strict separation between taxpayer funds and private premiums that would pay for abortion coverage. No health plan would be required to offer coverage for the procedure. In plans that do cover abortion, beneficiaries would have to pay for it separately, and those funds would have to be kept in a separate account from taxpayer money. Moreover, individual states would be able to prohibit abortion coverage in plans offered through the exchange, after passing specific legislation to that effect. Exceptions would be

made for cases of rape, incest and danger to the life of the mother.

The House bill (Affordable Health Care for America Act):

WHO'S COVERED: About 96 percent of legal residents under age 65 - compared with 83 percent now. Government subsidies to help buy coverage start in 2013. About one-third of the remaining 18 million people under age 65 left uninsured would be illegal immigrants.

COST: The Congressional Budget Office says the bill's cost of expanding insurance coverage over 10 years is $1.055 trillion. The net cost is $894 billion, factoring in penalties on individuals and employers who don't comply with new requirements. That's under President Barack Obama's $900 billion goal. However, those figures leave out a variety of new costs in the bill, including increased prescription drug coverage for seniors under Medicare, so the measure may be around $1.2 trillion.

HOW IT'S PAID FOR: $460 billion over the next decade from new income taxes on single people making more than $500,000 a year and couples making more than $1 million. The original House bill taxed individuals making $280,000 a year and couples making more than $350,000, but the threshold was increased in response to lawmakers' concerns that the taxes would hit too many people and small businesses.

There are also more than $400 billion in cuts to Medicare and Medicaid; a new $20 billion fee on medical device makers; $13 billion from limiting contributions to flexible spending accounts; sizable penalties paid by individuals and employers who don't obtain coverage; and a mix of other corporate taxes and fees.

REQUIREMENTS FOR INDIVIDUALS: Individuals must have

insurance, enforced through a tax penalty of 2.5 percent of income. People can apply for hardship waivers if coverage is unaffordable.

REQUIREMENTS FOR EMPLOYERS: Employers must provide insurance to their employees or pay a penalty of 8 percent of payroll. Companies with payrolls under $500,000 annually are exempt - a change from the original $250,000 level to accommodate concerns of moderate Democrats - and the penalty is phased in for companies with payrolls between $500,000 and $750,000.

Small businesses - those with 10 or fewer workers - get tax credits to help them provide coverage.

SUBSIDIES: Individuals and families with annual income up to 400 percent of poverty level, or $88,000 for a family of four, would get sliding-scale subsidies to help them buy coverage. The subsidies would begin in 2013.

HOW YOU CHOOSE YOUR HEALTH INSURANCE: Beginning in 2013, through a new Health Insurance Exchange open to individuals and, initially, small employers. It could be expanded to large employers over time. States could opt to operate their own exchanges in place of the national exchange if they follow federal rules.

BENEFITS PACKAGE: A committee would recommend a so-called essential benefits package including preventive services. Out-of-pocket costs would be capped. The new benefit package would be the basic benefit package offered in the exchange.

INSURANCE INDUSTRY RESTRICTIONS: Starting in 2013, no denial of coverage based on pre-existing conditions. No higher premiums allowed for pre-existing conditions or gender. Limits on higher premiums based on age.

GOVERNMENT-RUN PLAN: A new public plan available through the insurance exchanges would be set up and run by the health and human services secretary. Democrats originally designed the plan to pay Medicare rates plus 5 percent to doctors. But the final version - preferred by moderate lawmakers - would let the HHS secretary negotiate rates with providers.

CHANGES TO MEDICAID: The federal-state insurance program for the poor would be expanded to cover all individuals under age 65 with incomes up to 150 percent of the federal poverty level, which is $33,075 per year for a family of four. The federal government would pick up the full cost of the expansion in 2013 and 2014; thereafter the federal government would pay 91 percent and states would pay 9 percent.

DRUGS: Grants 12 years of market protection to high-tech drugs used to combat cancer, Parkinson's and other deadly diseases. Phases out the gap in Medicare prescription drug coverage by 2019. Requires the HHS secretary to negotiate drug prices on behalf of Medicare beneficiaries.

LONG-TERM CARE: New voluntary long-term care insurance program would provide a basic benefit designed to help seniors and disabled people avoid going into nursing homes.

ANTITRUST: Would strip the health insurance industry of a long-standing exemption from antitrust laws covering market allocation, price-fixing and bid rigging. The bill also would give the Federal Trade Commission authority to look into the health insurance industry at its own initiative.

ILLEGAL IMMIGRANTS: Would be barred from receiving government subsidies but permitted to use their own money to buy coverage offered by private companies in the exchange.

ABORTION: Private companies in the exchange could not offer plans covering abortion if those plans received federal subsidy money. Most plans in the exchange would be affected, because most consumers in the exchange would be using federal subsidy money to buy coverage. The new government plan could not offer abortion coverage. Insurance companies would be permitted to offer supplemental abortion coverage in separate plans that people could buy with their own money. Use of federal money for abortion coverage would be limited to cases of rape, incest or danger to the woman's life.