the political purist who would prefer to tackle the healthcare dilemma in a vacuum. A few of the more collateral, controversial issues that are included in the current version of the Bill are as follows:

Rationing of Medical Care: Section 1151 affords the federal government the power to determine who is allowed readmission to the hospital, with no judicial review of their decision.

Opting Out of the Federal Plan: Section 104 states that anyone caught without acceptable coverage (as defined by the federal government) will be taxed at the rate of 2.5% of Adjusted Gross Income.

Acceptable Coverage: Section 122 states that the Federal government will determine the minimum services to be covered in each health plan, leaving no choice in this regard. In addition, the cost sharing under the essential benefits package shall be designed to provide a level of coverage that will provide benefits that are actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under the federal package. By setting this 70 percent actuarial value standard, the Bill makes health plans which pay for routine services, but carry insurance only for catastrophic events (Consumer driven healthcare plans and Health Savings Accounts), illegal.

The Role of Private Insurance: Section 313 addresses employer contributions in lieu of coverage and provides detail to the aforementioned "jobs tax." In addition, this section spells out the ability of the federal government to determine the adequacy of provider networks. This section will cause small businesses (the majority of employers in the U. S.) who try to stay with a private plan to face a payroll disadvantage against competitors who opt for the government "option," since current premiums are generally higher than the 8 percent payroll tax. In addition, with pressure for business owners to terminate private plans, millions of Americans will lose their private coverage, as fewer insurance carriers will stay in the market, short-circuiting the "myth" that employees can choose to keep their current plans if they so choose.

Setting Fees for Service: Section 223 provides for the unlimited ability of the government's authority to set payments to providers. The "Secretary" will decide what constitutes "excessive," "deficient" and "efficient" payments and services.

Scrutiny of Private Affairs: Sections 431 and 312 allow access to federal officials (other than the IRS) of all personal tax return information. Any stated "limits" to such information are circumvented by item (v), which allows federal officials to decide what information is "needed."

Automatic Enrollment: Sections 205 and 312 provide that if an individual takes no action whatsoever on his or her own behalf, that individual is automatically enrolled into their respective state Medicaid program. If an employee waives coverage under the employer-sponsored plan, then that employer has the responsibility to enroll that employee into the state Medicaid plan. When nearly every state is currently struggling with its own deficits, the addition of thousands of new Medicaid recipients will further tax cash-strapped states' budgets and facilities for offering health and human services to the newly enrolled.

Federal Officials Not Held Responsible: Sections 223 and 1123 state that there shall be no administrative or judicial review of a payment rate or methodology established under this Bill, guaranteeing "carte blanche" authority to the newly created bureaucracy in charge of healthcare.

Finally, a provision which has most recently been struck from some versions currently under consideration is a requirement that those receiving Social Security income report to "mandatory end-of-life" counseling, or forego their monthly income stipend. This form of regulation has been branded as "euthanasia" by many and has been the flashpoint at many of the recent "Town hall" meetings held by elected officials during their fall break.

So—What's next?

A Senate panel has until September 15, 2009, to deliver a bipartisan healthcare overhaul package before Democratic leaders take steps to push a Bill without broad Republican support. One measure open to Democrats is a procedure known as "reconciliation," which would shorten the period for debate and greatly restrict the Republican's ability to offer amendments.

As Massachusetts' experience has shown, a combination of Medicaid expansion and subsidies for other lower-income individuals, combined with mandates on employers and individuals, can significantly increase the numbers of those with coverage. However, these same steps that make healthcare accessible also foster a jump in demand, while providing no visible corresponding increase in supply. In addition, this is an extremely expensive approach, as Commonwealth taxpayers can attest. It is also an approach that is likely to be less effective on a national scale during a recession than when implemented in one relatively wealthy state during better economic times.

A large reduction in the number of uninsured with no new controls over costs carries its own risk. For larger businesses and their employees, already facing higher than CPI annual premium and out-of -pocket cost increases, the Bill provides little help. In fact, the increase in demand for care resulting from expanding coverage is likely to mean—in accordance with normal economic laws—even higher premiums. For government budgets, the draft Bill implies an ever-increasing crisis due to the expansion and automatic enrollment of the uninsured into Medicaid.

While the Bill's approach to reducing the number of uninsured seems to be at best problematic—and in which failure to achieve almost universal coverage may undermine attempts to impose restrictions on insurers' medical underwriting practices—the much greater failure is the absence of changes necessary to bring healthcare costs under control, and maintain (or increase) the level of quality care.

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Compliance Guide

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Healthcare Reform… Halftime Report

August 2009

Depending on which side of the Washington Beltway you stand, the August Congressional recess could not have gotten here soon enough. Many Democrats view the summer break as an untimely delay in the march toward passage of a controversial healthcare package through a (seemingly) uninformed Congress. Republicans, on the other hand, breathed a sigh of relief that such a break allows them to go home, regroup and gather momentum for a Fall battle that more closely resembles the college gridiron schedule with which they will compete for network TV exposure.

The good news for the Obama administration is that their efforts to bring healthcare reform to the forefront have been a rousing success. Embedded in that good news, an undercurrent of unrest that the administration either could not have anticipated, or has vastly underestimated, threatens to derail the "Yes We Can" express. Apparently, despite the admission of prominent members of Congress, many Americans DO read the fine print of proposed legislation and they are not amused.

An Overview of the Key Concepts

There is general agreement that for healthcare reform to be successful and meaningful, it must address three core concepts: cost containment, universal access and high quality.

Since policy-making is a "trickle down" process, it is important to review exactly what the public statements made by President Obama reveal about his preferential ordering of such concepts. His public statements indicate that universal access is the linchpin of his platform, followed by a number of (controversial) methods to pay for such broad coverage, followed (not too closely) by the concern for high quality care, which has been overshadowed by the other two challenges.

Meanwhile, three core healthcare reform plans are currently being debated in Congress: a House of Representatives plan, a Senate Finance Committee plan and a Senate Health, Education, Labor and Pension plan.

The Legislative Bill emerging from the House Committee (HR3200), which appears to be the lead Bill, would impose a mandate on larger employers to provide insurance, impose a second mandate on individuals to obtain coverage, prohibit medical underwriting by insurance carriers , establish a government-administered public plan to compete with insurer's offerings through a "Health Insurance Exchange," offer subsidies to lower-income individuals, and expand Medicaid.

The means of paying for healthcare reform include certain easily achievable savings from efforts such as attacking fraud and abuse, reducing waste and adding information technology. These concepts tend to be politically appealing but do not cover the costs of significant healthcare reform.

Other ways to achieve savings that could help fund healthcare reform include rationing care, lowering Medicare/Medicaid reimbursements to providers and/or increasing a myriad of individual and corporate taxes. Each of these approaches is, politically, much more challenging.

The Vehicle—Health Insurance Exchange

Despite a plethora of lightening rod proposals included in the legislation thus far, few have drawn opponents' ire as much as the proposed public plan option through the afore-mentioned Health Insurance Exchange. And, with all due respect, there is good reason for deep concern and in-depth discussion, as the implications associated with such an option will truly change the way in which Americans access (or do not access) and pay for healthcare in the future.

The Health Insurance Exchange (Exchange) would be run by the federal government, though states could opt out of the national structure and go it alone if they wish, as long as they follow the proposed federal rules. In the first year, the exchange would accept those without health insurance, those who are buying health insurance on their own and small businesses with fewer than ten people. In the second year, the Exchange accepts small businesses with fewer than twenty people. In the following years, "larger employers are permitted by the Commissioner," thereby making expansion of the planned coverage to larger employers discretionary, not mandatory.

Within this Exchange, both public and private offerings must offer a heavily regulated "basic plan." At first glance, it would appear to be a very comprehensive plan design: "Such plan must be equal in value to the prevailing employer-based insurance in the area; (editor's note: "Equal in value," "prevailing" and "area" are extremely vague, undefined terms that are counter to the specific language requirements currently required in any ERISA-based plan); and cost sharing cannot exceed $5,000 for individuals or $10,000 for families in the first year (indexed by inflation thereafter)." In addition to the basic plan, there is an "enhanced plan," which features less cost-sharing, and a "premium plan" above that, with even less cost sharing, and, finally, a "premium-plus" plan, which features the least cost-sharing.

The public plan offering(s) that will be incorporated into the Exchange, and which will compete side-by-side with private sector offerings, will be patterned after Medicare, using the same or similar infrastructure, will pay Medicare rates to hospitals, and Medicare rates plus five percent to physicians. This portion of the legislation has sparked a great deal of controversy over the true intent of the legislation, the fairness of public-private sector competition and the point at which much of the "savings" being heralded under the Administration's push begins to fall apart, as access to the plan in the early years is somewhat limited, relative to the population……but more on that later.

For their part, the Republican minority in both the House and Senate (and a few "blue dog" Democrats) favor a much more simplified version of healthcare reform, which differs in both scope and size but, most importantly, does not include a government-financed public option within a Health Insurance Exchange; instead it opts for a series of regional non-profit cooperatives as the competitor to the private sector.

Universal Access—The Cost

To finance the Democrat's Bill, which carries a price tag north of $1 trillion dollars over a ten-year period (conservative estimates are nearly double), the House Committee would tap two major revenue sources: Medicare and Medicaid spending cuts, which would save about $500 billion, and tax increases for high income individuals and couples, which would raise an estimated $544 billion.

Adding more financial concern to the business sector regarding funding the cost of a national healthcare plan, House Speaker Nancy Pelosi ignited a firestorm of protests from both Democrats and Republicans when she went beyond her proposed 5.4 percent income surtax by adding an increased payroll tax of up to 10 percent on workers and businesses that don't provide health insurance, putting to rest the illusion that no one making less than $250,000 in income will pay higher taxes.

The "jobs tax," as it has become known, works like this: companies with employee payroll of above $250,000 without a company-sponsored health plan would pay a tax starting at 2 percent of wages per employee. That rate would quickly rise to 8 percent on companies with total payroll of $400,000 or more. A tax credit would help very small businesses adjust to the new costs, but even a company with just a few workers is likely to be subject to this payroll levy. Since its initial unveiling, the payroll thresholds have been moved up to $500,000 and $750,000; however, most employers would still be impacted under these new, higher thresholds.

As a solution, a "jobs tax" is generally viewed as a payroll tax on labor and is thus shouldered, mostly, if not entirely, by workers. Employers merely collect the tax and then pass along its costs in lower wages and benefits. Democrats are aware of this, and in order to protect the very workers that they intend to help, have inserted a provision in the House Bill that prohibits companies from cutting wages to pay the tax. This provision would obviously start a round of "tit-for-tat" by employers who would lay off some workers, hire fewer new ones, or pay lower starting wages or reduced benefits to the workers they do hire.

As some Democrats have grown more nervous about the call to extract hundreds of billions of dollars from spending cuts and tax increases, testimony delivered by Congressional Budget Office (CBO) Director Douglas Elmendorf on July 16, 2009—indicating that the proposed reform measures would not control costs, but would actually increase them—energized the party's moderate and conservative wings to demand legislative language designed to constrain the spending.

Pressed further for his thoughts on the proposed reform package, Elmendorf stated that the current legislation "significantly expands the federal responsibility for health care." He added that there was "widespread support among health analysts" for changing the preferential tax treatment of employer-sponsored health benefits because doing so would give workers stronger incentives to seek lower-cost insurance. Elmendorf also recommended that Congress change the way Medicare pays providers, " to encourage a focus on cost-effectiveness and not encourage, as a fee-for-service system tends to, the delivery of additional services."

Universal Access—The Role of the Public (Government) Plan

As mentioned herein, the role of the public plan option(s) is rumored to be played by Medicare, or a plan that closely resembles the Medicare infrastructure and model. Some healthcare analysts state that such a suggestion is truly fiscally irresponsible. In considering whether to expand the government's role in the delivery of healthcare or health insurance, it is worth looking at the 45-year track record of Medicare and Medicaid.

These two programs already make the government the largest player in the healthcare industry and, given the original cost estimates of the expenditures associated with the Medicare program, the public should be vigilant about future cost estimates and any proposed solution that suggests Medicare be the cure for the ills of the healthcare access and delivery dilemma. To wit, when Medicare was being considered in the mid-1960s, the government projected that program outlays 25 years into the future would be $10 billion; instead, 25 years later, the outlays were $107 billion, making such cost estimates off by a factor of more than ten!

Medicaid, the state-oriented "sister" of Medicare, outdid her sibling by growing from 1968 outlays of $1.8 billion, to 2007 spending of $190.6 billion, an increase in dollar terms of 105.9 times, compared to an overall increase of government spending during that same forty -year span of 15.3 times. And that only includes federal spending on the Medicaid program, as there is roughly an equal amount spent by states due to federal mandates.

Mindful that the most recent estimates have the Medicare system running out of money as early as the year 2013 (without some fundamental change to its structure or funding), it is understandable why there is controversy over the suggestion that this program be the $1.2 trillion answer to our healthcare problems. In addition, but beyond the scope of this writing, there are undeniable links between the cost-shifting techniques of Medicare and Medicaid to the private sector and the lack of affordability of private and employer-based coverage. After all, someone has to pick up the cost of the deep discounts afforded Medicare over private carriers and there aren't a lot of other parties waiting in that line.

Collateral Damage—What Else is in HR3200?

HR3200 (also known as "America's Affordable Health Choices Act of 2009") contains more than just a suggested agenda for the improvement and affordability/access to healthcare for Americans, and perhaps herein lays its greatest struggle for approval.

In its effort to reform the way in which Americans seek and pay for such treatment, the drafters have taken the liberty to launch what can generally be described as a "social agenda overlay" for consideration by Congress, calling for unheard of government influence and power over decisions heretofore reserved for the doctor-patient relationship. These passages "muddy" the water for