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early legislative wins for Obama

Within his first month in office, President Obama can already point to two important pieces of legislation that have been enacted into law.

The first is the reauthorization of the State Children's Health Insurance Program (SCHIP). The second is the American Recovery and Reinvestment Act (ARRA).

The reauthorization of SCHIP was hardly surprising. Two somewhat different versions of the legislation had passed the Congress last year, only to be vetoed by President Bush, and the current extension was due to expire at the end of March.

The passage of the so-called "Stimulus Bill," containing a variety of very important healthcare provisions, fulfilled a promise made by the new administration and Congress to attempt to jump start the stalled economy and respond to a variety of long-postponed Democratic priorities. Its passage was somewhat more challenging, requiring the agreement of three Republicans in the Senate. In actuality, only two were required, but none of them wanted to be the deciding vote.

SCHIP

The reauthorization of SCHIP was passed within the first two weeks after the President's inauguration and extends the program through 2013. The law provides an addition $44 billion above the $25 billion of spending that had been in the current line—the so-called baseline spending. The program adds 4 million children to the 7 million already covered. The substantial displacement of children from private insurance to public insurance that had been so much a part of the earlier discussion was not even raised as part of the reauthorization debate.

ARRA

The passage of a stimulus bill containing several important health provisions was less predictable, as was the speed of its passage. In addition to a variety of spending programs for public works, education, military construction, and agriculture were changes to several important healthcare programs. The most important of these are the expansions in funding for Medicaid, the new subsidies for COBRA, subsidies for health IT, and funding for comparative effectiveness research.

Medicaid. States have been particularly hard hit during the economic downturn because the demand for income support and other assistance programs has increased at the same time that their revenues from property taxes, sales taxes, and income taxes have declined. Unlike the federal government, states are almost always required to keep their budgets in fiscal balance. In response to the states' repeated requests for increased Medicaid funding, the ARRA provides two types of increased support for Medicaid. Two-thirds of the $87 billion of Medicaid funding will go to states for across-the-board increases in their Medicaid matches, and the remainder will be distributed to states based on their unemployment rates.

COBRA. The increase in the number of unemployed has led to increased numbers of previously insured people either becoming uninsured after losing their jobs or becoming at risk for being uninsured. Although most people are eligible for COBRA, the cost of the insurance—102 percent of the total cost of the plan offered by the employee—is prohibitive for most individuals, particularly those who have lost their employment. Historically, only individuals who had predictably high spending needs have chosen the COBRA option, causing obvious problems of adverse selection for the employers.

The new provision provides a 65 percent subsidy to purchase COBRA for workers with incomes less than $125,000 who lose (or lost) their jobs between September 2008 and January 2010. It also allows people laid off after Sept. 1, 2008, an additional 60 days to decide whether to take the COBRA option.

Health IT. Support for IT will be provided by grants and loans by the Department of Health and Human Services (HHS) and through payments from Medicare and Medicaid. HHS will provide $2 billion in grants and loans, and Medicare and Medicaid will provide incentive payments to physicians and hospitals.

The payments to providers use the same type of incentive/penalty structure that is being used to encourage electronic prescribing under Medicare. Physicians are eligible to receive up to $48,000 from Medicare and $64,000 from Medicaid, and hospitals could receive up to $11 million for the adoption of electronic medical records (EMRs). Starting in 2015, physicians and hospitals who have not adopted EMRs will start to face penalties from Medicare and Medicaid. Many important decisions will need to be made as to what types of electronic systems will qualify for payments, when and how the funding will be allocated, and the standards that will be in place to ensure interoperability between EMRs and to protect patient privacy.

Comparative effectiveness. In what may have been one of the more surprising inclusions, $1.1 billion was provided for comparative effectiveness research: $300 million for Agency for Healthcare Research and Quality (AHRQ), $400 million the National Institute of Health (NIH), and $400 for the secretary of HHS to allocate. The Institute of Medicine is to advise the secretary of HHS on priority-setting for the comparative effectiveness research no later than June 30, 2009.

There was a dispute between the House and Senate as to whether to label the work *comparative clinical effectiveness*, wording used in the Senate version, or *comparative effectiveness*, as used in the House. The latter prevailed, but language was included to indicate that the research was not to be used to mandate coverage or reimbursement.

Implications for Further Healthcare Reform

These first two legislative successes were important, but their passage was highly likely given the strong Democratic majorities in both the House and Senate and the strong belief that the country urgently needed a stimulus to respond to the deteriorating economic climate. The obstacles to enacting broader healthcare reform will be more challenging, in part because of the large additions to the debt that have occurred with the financial rescue packages passed in the fall and with the ARRA, just passed.

At the moment, most groups and their representatives are remaining polite and positive in their response. No one should mistake these initial responses for acquiescence.

A "down payment" budget for healthcare reform was recently released, estimated to represent half to two-thirds of the cost of universal coverage, with half of its funding coming from changes in the tax code for high-income individuals. Because the latter includes limiting the deductions for home mortgages and charitable contributions, there has already been widespread push back from both Democrats and Republicans about some of the specifics.

As always in healthcare reform, the devil will be in the details. At the moment, most groups and their representatives are remaining polite and positive in their response. No one should mistake these initial responses for acquiescence. ●

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