COMMENTARY SERIES

Who Remembers Reconciliation: A Last-Ditch Attempt to Salvage Health Care Reform?

Jennifer Pollom | January 21, 2010

Now that the dramatic finale in the Massachusetts Senate race has drawn to a close, many thoughts in Washington are turning to what Scott Brown's win will really mean for the Democrat's legislative agenda. Much has been made of the idea that Brown's win, and the dramatic loss by Senate Democrats of a 60-vote filibuster-proof margin, could spell the end of the health care bill currently limping its way through Congress. So what can the Democrats do to keep the bill alive without 60 votes? One idea is to turn to reconciliation, that arcane budget tool understood by few and forgotten by many. Moving a health care bill through the reconciliation process would require the Democrats to muster only 51 votes instead of 60 to pass a final bill. However, the reconciliation process comes with its own wacky rules and requirements that, should Congress choose to employ it, may result in a health care bill that is drastically different than what the President has promised.

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Let's start with some background. The reconciliation process was created as a deficit reduction tool. The process allows Congress to put pressure on Committees to make changes to spending programs that would otherwise be on autopilot. Each spring (or most springs), Congress passes a budget resolution laying out the fiscal blueprint for the year. The budget resolution is not signed by the President, so it isn't a law – it is essentially Congress's plan to willingly bind itself to a financial plan for the year. Included in the budget resolution in some years are reconciliation instructions to specific committees. These instructions direct a committee to increase revenues or cut spending in order to reduce the deficit and comply with the overall budget resolution. Important to remember is that these instructions are purposely vague. They include only a dollar amount –not a prescription for what a committee must to do in order to actually achieve the savings. Committees can choose to cut any program under their jurisdiction, so long as they hit the target dictated by the reconciliation instructions. Additionally, the dollar amount a Committee is required to hit is a net number, meaning the Committee could choose to fulfill the instruction by including large policy changes to a program, dramatically increasing spending in one area so long as sufficient spending cuts (or tax increases) are made elsewhere to achieve the overall target number. For instance, the Finance Committee could create huge increases in Medicare spending, so long as it made slightly larger cuts in spending (or raised taxes) elsewhere.

What's the big deal about reconciliation – why do we have a separate process for this? It isn't new news that reducing the deficit is hard work in Washington. Lawmakers are usually reluctant to endure the political pain it takes to cut mandatory spending programs, or raise taxes – the two most effective ways to reduce the deficit. In order to ease this painful process (and help ensure that deficit reduction bills have even a fighting chance to pass), the reconciliation process was created using less-

stringent procedural rules than would otherwise apply. *Most importantly, reconciliation bills are effectively filibuster-proof, meaning they only require a simple majority (in the case of the Senate, 51 votes) to pass.* This has become especially relevant in recent years when partisan efforts from both sides of the aisle have made it necessary to garner the full 60 votes that are required to overcome a filibuster threat. Additionally, reconciliation bills have a strict test for the types of amendments that can be offered, making it very hard to amend a reconciliation bill without lining up 60 votes to pass an amendment. This means that substantive and lengthy floor debate (and changes to a reconciliation bill) are unlikely if not impossible.

However, because a reconciliation bill effectively denies the minority party the regular procedural tools usually available to slow consideration of legislation in the Senate, in order to qualify for this special process, reconciliation bills must also fulfill a number of extra requirements. Chief among these is something known as the Byrd Rule (named of course for its creator, Senator Robert C. Byrd). The Byrd rule states that no "extraneous" provisions can be included in a reconciliation bill. In essence, this means that provisions which do not have a direct budgetary impact, or have a budgetary impact that is "merely incidental" to the provision's policy changes, will be ruled out of order and dropped from the legislation. Put another way – in order to be in a reconciliation bill, a provision has to actually affect the budget more than it tinkers with policy. If this seems to you like a slippery slope, ripe for arbitrary rulings, you're right!

So what could this mean for health care? In this year's budget resolution, Congress left the door open to utilize reconciliation to pass health care – should the need arise. They did this by including reconciliation instructions to the Finance Committee and the Health, Education, Labor and Pensions Committee in the Senate (the Committees with jurisdiction over taxes and most health care programs) to reduce the deficit by $1 billion each over the next five years. Theoretically those two committees could bring forward a health care bill that fulfills the vague requirement to save $1 billion each overall but that makes other massive policy changes – subject of course to the Byrd rule and other requirements discussed above. However, should Congress decide to abandon the current efforts to conference the respective House and Senate versions of health care reform, and instead decide to use reconciliation, the final legislation may end up looking dramatically different.

Why? Well, the Senate Parliamentarian is ultimately in charge of ruling what is or is not considered an extraneous provision under reconciliation, which results in a lot of guess work and attempts to read the tea leaves before a bill is brought up for consideration. However, the future of some provisions in the Senate-passed bill are easier to map out than others.

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A few provisions would easily pass the extraneousness test and remain in the bill. For instance, most tax increases, cuts to Medicare, and an expansion of Medicaid would easily be viewed as having significant budgetary impacts regardless of the policy changes. Conversely, it seems clear that the controversial provision prohibiting the use of federal funds for abortions would be easily ruled extraneous since the budgetary savings attributable to it are either minimal or nonexistent and the policy

change is considerable. This leaves a vast grey area of health care policy changes for which the policy considerations may outweigh the budgetary changes. Provisions such as the creation of a public health care option, requirements for an individual health care mandate, and the expansion of health care exchanges across state lines may very well be excluded from a final reconciliation bill.

Opponents of the idea of using reconciliation to pass health care reform cite several other issues. Among them, the principle purpose of the reconciliation process is to reduce the deficit not to create vast new programs. Few would argue that the purpose of health care reform in its current but arguably budget-busting state is ultimately to reduce the deficit. Therefore, some have stated that attempts to utilize the reconciliation process to avoid a 60-vote threshold would be inappropriate, at best. In fact, the original creator of the budget reconciliation process himself, Senator Byrd, has opposed using the process for health care reform. In a Dear Colleague letter dated April 2, 2009, he stated, "As one of the authors of the reconciliation process, I can tell you that…reconciliation was intended to adjust revenue and spending levels in order to reduce deficits…it was not designed to…restructure the entire health care system."

Additionally in a interesting turn, there are some late-breaking rumors that the Administration and Congress may try to pass the Senate-passed version of health care legislation through the House (thus sending it to the President) -- and then use reconciliation as a second effort to "perfect" the first one. This would allow the potentially extraneous provisions to pass outside of the reconciliation process and then utilize reconciliation to further hone the bill. At this stage, it's hard to see how exactly this would work. For example, the Senate language on the prohibition on funding abortions is seen as too light and therefore objectionable to many pro-life House Democrats. It is hard to see how that language could ultimately be modified through a reconciliation bill. It would be a wonder to see the House hold its nose and pass the Senate bill with all of the potential objections based on the understanding that a reconciliation bill would sail through to alter it immediately. However, as the saying goes, stranger things have happened!

So where does that leave us? A strict application of the Byrd rule could result in stripping down the health care legislation to a true budget bill that may do a lot to reduce the deficit, but little to fulfill the grand promises of a complete health care overhaul and reform. Items such as expanded coverage for uninsured Americans and the requirement to insure regardless of preexisting conditions have been central parts of the Obama Administration's reform push and may very well be excluded from a reconciliation measure. What could be left is a bill that could garner 50 votes- or even 59- but which stops far short of the comprehensive overhaul originally promised. On the other hand, a revamped and more moderate plan (suggested here) that would fix some of the cost-drivers embedded in the tax code and increase tax credits to help the uninsured might indeed pass reconciliation muster. The result could be a better (and potentially bipartisan) bill.. For many Americans, that may not be a bad thing.