POLICYBRIEF
HOUSE REPUBLICAN CONFERENCE | Mike Pence, Chairman

Senate Democrat Health "Reform" Legislation: Short Summary of the Government Takeover of Health Care

December 21, 2009

BACKGROUND AND EXECUTIVE SUMMARY

On November 18, 2009, Senator Harry Reid and the Senate Democrat leadership introduced the Patient Protection and Affordable Care Act as an amendment to a House-passed bill (H.R. 3590). The full Senate began consideration of the legislation on November 21, 2009. Backroom deals produced a manager's amendment that was introduced early on the morning of December 19, and a vote on final passage of the bill as amended could come as early as December 24, 2009.

Buried within the contents of the more than 2,000 page bill—as well as the separate 383-page manager's amendment, and a 276 page Indian Health Care reauthorization that would be enacted by reference—are details that would see a massive federal takeover of the health care system in America, including the following:

- A new regime of government-run exchanges that would cause as many as 10 million Americans to lose their current employer-sponsored coverage—thus breaking the central promise of then-Senator Obama's presidential campaign;
- An increase in total national health spending, as well as an increase in premiums that could total $2,100 per year—a far cry from then-Senator Obama's promise to lower costs for families by $2,500 annually;
- Stifling insurance regulations that would raise premiums and encourage employers to drop coverage;
- Trillions of dollars in new federal spending that would exacerbate the deficit and imperil the nation's long-term fiscal solvency;
- A board of unelected bureaucrats being empowered to re-write Medicare statutes in a way that could well lead to government rationing of health care;
- Federal funding of insurance policies that cover elective abortion—and an unprecedented federally managed plan that would cover elective abortion procedures;
- Tens of billions in unfunded mandates in the form of a massive Medicaid expansion that would compel all States—except Nebraska—to dedicate more scarce taxpayer resources to fund government-run health coverage in their States—or alternatively to drop Medicaid entirely;
- Taxes on all Americans—individuals who purchase insurance, individuals who do not purchase insurance, and small and large businesses alike—that would kill jobs and raise premiums; and
- Cuts to Medicare Advantage plans that would result in higher premiums and dropped coverage for more than 10 million seniors.

SUMMARY OF KEY PROVISIONS

The Government Takeover

Creation of Exchange: The bill requires States to create their own Health Benefit Exchanges. Uninsured individuals would be eligible to purchase an Exchange plan, as would those whose existing employer coverage is deemed "insufficient" by the federal government. Employees with an "unaffordable" offer of group coverage would be able to take the value of their employer's contribution in

the form of a tax-free voucher to shop for plans on the Exchange. The bill allows States to open Exchanges to all employers beginning in 2017, further expanding the scope and reach of the government-run Exchanges.

Benefit Standards: The bill establishes a process for the Secretary of Health and Human Services to impose benefit standards for all plans. Plans in the Exchange would fall into several tiers: bronze (covering 60 percent of anticipated expenses), silver (70 percent), gold (80 percent), and platinum (90 percent). A young adult plan offering streamlined benefits would also be available, but only to individuals under aged 30. Employer plans—including those with Health Savings Accounts—could impose maximum deductibles of $2,000 for an individual or $4,000 for a family. These onerous standards would hinder the introduction of innovative models to improve enrollees' health and wellness—and by insulating individuals from the cost of health services with restrictive cost-sharing, could raise health care costs.

"Low-Income" Subsidies: The bill provides subsidies only through the Exchange, again putting private health plans at a disadvantage. Individuals with access to employer-sponsored insurance whose group premium costs exceed 9.8 percent of modified gross income would be eligible for subsidies. Some may note that the newly defined "modified gross income" (as opposed to adjusted gross income) excludes deductions for items like contributions to Individual Retirement Accounts (IRAs) or Health Savings Accounts (HSAs), thus imposing an effective tax on savings.

Premium subsidies provided would be determined on a sliding scale. Individuals with incomes above 133 percent of the Federal Poverty Level (FPL, $29,327 for a family of four in 2009) and thus ineligible for the Medicaid expansion would be able to receive subsidies, which would phase out entirely for individuals with incomes at 400 percent FPL ($88,200 for a family of four), who would be expected to pay 9.8 percent of their income. Many may also note that, because the definition of FPL for a couple is not twice the size of the poverty level for a single person, the bill creates a marriage penalty—meaning that married couples may lose hundreds, even thousands, of dollars in health insurance subsidies.

The bill further provides for cost-sharing subsidies, such that individuals with incomes under 100 percent FPL would have two-thirds of their cost-sharing covered for a platinum level plan, while individuals with incomes at 400 percent FPL would have one-third of their cost-sharing covered for a silver plan. These rich benefit packages, in addition to raising subsidy costs for the federal government, would insulate plan participants from the effects of higher health spending, resulting in an increase in overall health costs—exactly the opposite of the bill's purported purpose.

"Fannie Med" Co-Operatives and National Plan: The bill as amended requires the Office of Personnel Management (OPM) to "offer at least two multi-State qualified plans through each Exchange in each State." The bill requires that at least one insurance plan option offered be a non-profit entity.

The bill establishes a Consumer Operated and Oriented Plan (CO-OP) program to provide grants or loans for the establishment of non-profit insurance cooperatives to be offered through the Exchange, but does not require States to establish such cooperatives. The bill authorizes $6 billion in appropriations for start-up loans or grants to help meet state solvency requirements.

Many may be concerned that both the OPM federally sanctioned plans and cooperatives funded through federal start-up grants would in time require ongoing federal subsidies, and that a "Fannie Med" co-op would do for health care what Fannie Mae and Freddie Mac have done for the housing sector. Some may also note that former OPM Director Linda Springer has publicly expressed concern that her former office lacks the capacity to oversee such a project in the manner that it currently oversees the Federal Employee Health Benefits Program (FEHBP).

Medicaid Expansion: The bill would expand Medicaid to all individuals with incomes under 133 percent of the federal poverty level ($29,327 for a family of four). Under the bill, the bill's expansion of Medicaid

to more than 10 million individuals would be fully paid for by the federal government only through 2016—thus imposing billions in unfunded mandates on 49 States.

However, as part of the "compromise" negotiated by Leader Reid, one State—Nebraska, home of Sen. Ben Nelson—would have 100 percent of its Medicaid costs paid in perpetuity. Given public comments by Senate HELP Committee Chairman Tom Harkin (D-IA) that such a precedent could eventually lead to the federal government paying 100 percent of all Medicaid costs for all States, many may question whether this provision constitutes a special deal for Nebraska in exchange for Sen. Nelson's vote, or a way to grow federal spending later by shifting unfunded State mandates back on to federal taxpayer rolls.

Federal Funding of Abortion Coverage: The bill specifically permits taxpayer subsidies to flow to private health plans that include abortion, but creates an accounting scheme designed to designate private dollars as abortion dollars and public dollars as non-abortion dollars. Specifically, the provisions claim to segregate public funds from abortion coverage and would allegedly prevent funds used on abortion from being considered when determining whether plans meet federal actuarial standards. However, press reports have been skeptical about whether and how this accounting mechanism would prevent federal funding of abortions. The accounting scheme has likewise been rejected by pro-life organizations, which recognize it as a clear departure from long-standing federal policy against funding plans covering abortion (e.g., Federal Employee Health Benefits Program, Medicaid, SCHIP, etc.).

Unlike government-run programs like Medicare and Medicaid, which can specifically prohibit coverage of a particular service, funds provided to a third-party insurance company to subsidize an individual's coverage would by definition make that individual's "supplemental" abortion coverage more affordable. Therefore many Members may believe that the only way to prevent federal funds from subsidizing abortion coverage is to prevent plans whose beneficiaries receive federal subsidies from covering abortions.

The bill as amended by the manager's amendment would modify the segregation regime slightly, requiring plans to follow "generally accepted accounting requirements" while establishing the regime. The bill also allows States to "prohibit abortion coverage in qualified health plans" offered in their State's Exchange. However, these provisions would still result in federal funds flowing to plans that cover elective abortions—and would not prohibit citizens in States which have opted-out of elective abortion coverage in their own Exchange seeing their federal funds flow to plans that cover elective abortion in other States. To that end, even pro-life Democrats like Rep. Bart Stupak (D-MI) have criticized the bill language as unacceptable, and a far cry from the standards established in the Stupak amendment—which extended the current law Hyde Amendment prohibitions on federal funding for abortion coverage--that passed on a strong bipartisan vote in the House.

Further, the "Fannie Mae" model administered through OPM created by the manager's amendment contains ***zero*** prohibition on coverage of elective abortion—an unprecedented federal sanctioning of plans that cover elective abortions. To that end, many may note that insurance plans within the FEHBP—which Members of Congress themselves utilize—have been prohibited from offering abortion coverage since 1995, and federal employees have expressed strong satisfaction with their choice of plan options.

Medicare Payment Board: The bill would create a new Independent Medicare Advisory Board established to make recommendations about the future growth of Medicare spending. The appointed bureaucrats would be required to submit recommendations to Congress to keep Medicare spending below targeted levels—and such recommendations would be legally binding absent legislative action by Congress.

Particularly given the controversy surrounding the recent recommendations by the US Preventive Services Task Force with respect to mammogram coverage, many may be concerned that the Medicare Board contemplated by the legislation could result in additional coverage decisions being made by unelected

bureaucrats largely or exclusively on cost grounds. Moreover, many may be concerned that in time this provision could closely resemble a concept advocated by former Senator Tom Daschle—a board of unelected bureaucrats making health care decisions for all health plans nationwide, including decisions about which therapies and treatments the federal government will cover. In his book *Critical*, Daschle wrote that, "We won't be able to make a significant dent in health-care spending without getting into the nitty-gritty of which treatments are the most clinically valuable and cost-effective."

Funneling Patients into Government Care

Federal Insurance Restrictions: The bill imposes new regulations on all health insurance offerings, with only limited exceptions. The bill imposes price controls on insurance offerings, requiring insurers with a ratio of total medical expenses to overall costs (i.e. a medical loss ratio), of less than 80 percent in the individual and small group market, or 85 percent in the large group market, to offer rebates to beneficiaries. Some Members may be concerned that government-imposed price controls, by requiring plans to pay out most of their premiums in medical claims, would give carriers a strong disincentive not to improve the health of their enrollees through prevention and wellness initiatives—as doing so would reduce the percentage of spending paid on actual claims below the bureaucrat-acceptable limits. The bill would also "require health plans…to submit a justification for any premium increase" in advance, and permit Exchanges to reject bids by insurance companies with "excessive" (term undefined) price increases—thus permitting bureaucrats to exercise arbitrary controls over health insurance companies.

Existing policies could remain in effect—but only so long as an individual does not move, change jobs, or experience any other material change in life status. Contrary to President Obama's repeated promises that "You will not have to change [health insurance] plans," CBO found that "relatively few non-group policies would remain grandfathered by 2016"—meaning millions of individuals would lose their current individual health insurance plans as a result of Democrats' government takeover of health care.

Mandates on Employers; "Fair Share" Penalties: The bill imposes a series of mandates related to employers offering health insurance coverage. Specifically, the bill taxes large employer plans (i.e. with more than 50 workers) that impose long "waiting periods" of over 30 days on coverage eligibility up to $600 per full-time employee. The bill also taxes large employers who do not offer coverage, or who offer coverage that results in employees obtaining subsidies because that coverage costs more than 9.8 percent of modified gross income, to pay taxes. The penalty in the first instance is $750 per employee, and in the second instance constitutes $3,000 per employee receiving subsidies, or $750 per worker, whichever is less.

Members may be concerned that the "fair share" penalties would most adversely affect those workers whom health "reform" is intended to help. For instance, the taxes **would discourage employers from hiring married individuals or parents raising children**—as such individuals would be more likely to qualify for subsidies, thus triggering penalties. In particular, single parents would be much more likely to qualify for insurance subsidies based upon their income, making it much less likely that such workers would be hired. The liberal Center for Budget and Policy Priorities also previously notes that the provisions "likely would have discriminatory racial effects on hiring and firing. Because minorities are much more likely to have low family incomes than non-minorities, **a larger share of prospective minority workers would likely be harmed**."

Individual Mandate: The bill places a tax on individuals who do not purchase "minimum essential coverage," as defined by the bureaucratic standards in the bill. The tax would constitute 2 percent of adjusted gross income, up to the amount of the national average premium for bronze plans offered through the Exchange. The tax would not apply to non-resident aliens, those exempted on religious grounds, individuals for whom coverage is "unaffordable" (i.e. costing more than 8 percent of modified gross income), and those with short (i.e. fewer than three month) gaps in coverage. "Acceptable

coverage" includes qualified Exchange plans, "grandfathered" individual and group health plans, Medicare and Medicaid plans, and military and veterans' benefits.

For individuals with incomes of under $100,000, the cost of complying with the mandate would be under $2,000—raising questions of how effective the mandate would be, as paying the tax would in many cases cost less than purchasing an insurance policy. As then-Senator Barack Obama pointed out in a February 2008 debate, in Massachusetts, the one State with an individual mandate, "there are people who are paying fines and still can't afford [health insurance], so now they're worse off than they were. They don't have health insurance and they're paying a fine."

Medicare Advantage: The bill would phase in a system of Medicare Advantage (MA) competitive bidding over a three-year period beginning in 2012. The bill also imposes an arbitrary adjustment on MA payment benchmarks as part of the competitive bidding process. Many may note that despite its title, traditional Medicare would not be required to compete head-to-head against private health plans in MA "competitive bidding"—thus giving government-run Medicare an advantage. The Congressional Budget Office has stated that these provisions would collectively cut $120 billion from Medicare Advantage, and would result in millions of seniors losing access to their current plans, and/or having the extra benefits—reduced cost-sharing, dental and vision coverage, etc.—that MA plans provide curtailed or eliminated entirely.

The bill also gives the Secretary blanket authority to reject "any or every bid by an MA organization," as well as any bid by a carrier offering private Part D Medicare prescription drug coverage, giving federal bureaucrats the power to eliminate the MA program entirely—by rejecting all plan bids for nothing more than the arbitrary reason that an Administration wishes to force the 10 million beneficiaries enrolled in MA back into traditional, government-run Medicare against their will.

Tax Increases

Government-Forced Insurance Penalties: Offsetting payments to finance the government takeover of health care would include taxes on individuals not complying with the mandate to purchase coverage, as well as taxes by businesses associated with the "fair share" penalties, as outlined above. The individual mandate as modified by the manager's amendment would raise $15 billion and $28 billion respectively over ten years.

"Cadillac" Tax on High-Cost Plans: The bill imposes a 40 percent excise tax on the excess cost of employer-sponsored plans above threshold amounts. In 2013, the threshold amounts would be $8,500 for an individual policy and $23,000 for a family policy. Individuals in certain "high-risk professions" would be subject to a higher threshold, and the 17 States with the highest costs (as determined by the average employer-sponsored insurance premium) would see the threshold amounts phased in during the years 2013-2015. In future years the threshold amount would be raised for inflation at the rate of general price inflation (i.e. Consumer Price Index) plus one percent—which based on past trends would imply that the "Cadillac" tax would hit more plans over time. According to the Joint Committee on Taxation, the provisions would raise $148.9 billion over ten years.

While some Members may support changing the current tax treatment of health insurance, many may oppose the bill's model of raising taxes to finance a government takeover of health care. Many may also note that the bill applies a standard 40 percent tax on all plans regardless of the purchaser's income—potentially subjecting millions of low-income and middle-class families with employer-sponsored coverage to tax rates exceeding the highest marginal rate under current law.

Higher Payroll Taxes: The bill imposes a 0.9 percent increase in Medicare payroll taxes on individuals with incomes over $200,000 and families with incomes over $250,000, raising $86.8 billion over ten years. **The tax is NOT indexed for inflation, meaning it would affect many more taxpayers**

over time. In addition to being administratively burdensome—as individual employers would have to base tax withholding in part on the salary of an employee's spouse—many may be concerned about the precedent set for diverting Medicare payroll taxes in a way that finances a $2.5 trillion new entitlement scheme for younger Americans.

Taxes on Health Plans: The bill prohibits the reimbursement of over-the-counter pharmaceuticals from Health Savings Accounts (HSAs), Medical Savings Accounts, Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs), and increases the penalties for non-qualified HSA withdrawals from 10 percent to 20 percent, effective in 2011. Because these savings vehicles are tax-preferred, adopting these provisions would raise taxes by $6.3 billion over ten years, according to the Joint Committee on Taxation.

The bill would place a cap on FSA contributions, beginning in 2012; contributions could only total $2,500 per year, subject to annual adjustments linked to the growth in general (not medical) inflation. Members may be concerned that these provisions would first raise taxes by $13.3 billion, and second—by imposing additional restrictions on health savings vehicles popular with tens of millions of Americans—undermine the promise that "If you like your current coverage, you can keep it." At least 8 million individuals hold insurance policies eligible for HSAs, and millions more participate in FSAs. All these individuals would be subject to additional coverage restrictions—and tax increases—under this provision.

The bill raises the threshold to itemize health expenses from 7.5 percent to 10 percent of adjusted gross income, beginning in 2013; seniors over age 65 would receive a four-year extension of the 7.5 percent income threshold for four additional years (i.e. until 2017). This provision would raise taxes by $15.2 billion. The bill also repeals the current-law tax deductibility of subsidies provided to companies offering prescription drug coverage to retirees, raising taxes by $5.4 billion. Many may be concerned that this provision would lead to companies dropping their current coverage as a result.

Taxes on Health Products: The bill would impose several health-related excise taxes: A $2.3 billion tax on drug makers (raises $22.2 billion over ten years), an annual fee on medical device makers rising to $3 billion (raises $19.2 billion), and a tax on insurance companies that rises to $10 billion annually in beginning in 2011, raising taxes by $59.6 billion. Many may echo the concerns of the Congressional Budget Office, and other independent experts, who have confirmed that these taxes would be passed on to consumers in the form of higher prices—and ultimately higher premiums.

Taxes on Insurance Industry Executives: The bill would cap the deductibility of insurance industry executive salaries at $500,000 beginning in 2013, raising $600 million. Many may question why the insurance industry—alone among health care industries, or indeed all industries—warrants such treatment, and whether or not this provision constitutes an attempt to extract political retribution on a particular industry out of favor with Democrats.

COST AND OTHER CONCERNS

Cost: According to the Congressional Budget Office's preliminary score of H.R. 3590 and the manager's amendment to the bill, the legislation would spend nearly $1 trillion over its first ten years. More specifically, CBO estimates that the bill would spend $871 billion to finance coverage expansions—$395 billion for the Medicaid expansions, $436 billion for "low-income" subsidies, and $40 billion for small business tax credits. The spending on coverage expansions does not even include additional federal spending included in the legislation—including a new reinsurance program for retirees, $10 billion in mandatory spending on community health centers, closing the Medicare Part D "doughnut hole," and a $13 billion trust fund for public health—that totals $95.5 billion. When combined with the cost of the coverage expansions, total spending under the bill actually approaches $1 trillion. **Moreover, staff on the Senate Budget Committee have estimated that the bill's total cost in its first ten years once coverage expansions take effect (i.e. 2014-2023) approaches $2.5 trillion.**

In its score, CBO notes that "**under the legislation, federal outlays for health care would increase during the 2010-2019 period, as would the federal budgetary commitment to health care**"—by a total of $200 billion over that ten year period. Many may be concerned that spending at least $1 trillion to finance a government takeover of health care would not only not help the growth in health costs, but—by creating massive and unsustainable new entitlements—would also make the federal budget situation much worse.

Savings would come from reductions within the Medicare program, of which the biggest are cuts to Medicare Advantage plans (net cut of $119.9 billion), reductions in adjustments to certain market-basket updates for hospitals and other providers (total of $147 billion), skilled nursing facility payment reductions (total of $23.9 billion), various reductions to home health providers (total of $39.4 billion), and reduction in imaging payments ($3 billion). A further $35.7 billion in savings would come from reducing subsidies (i.e. means-testing) to Medicare Part D prescription drug plans for the first time, and from freezing the current annual adjustment to the Part B means test at its current level (i.e. $85,000 for a single retiree and $170,000 for a couple) until 2019. A further $28.2 billion in savings is projected from the automatic reductions in Medicare spending expected to be triggered by the Independent Medicare Advisory Board during the years 2015-2019.

CBO has also confirmed that the legislation as introduced would raise health care premiums for struggling middle-class families, resulting in non-group premium increases of $300 per year for individuals and $2,100 for families. While the Obama campaign promised that its plan would reduce premiums by $2,500 per year for families, CBO confirmed that premiums would still continue to rise—and for millions, premiums would rise higher than under current law.

In terms of overall spending on health care costs, many may note that the independent actuaries at the Centers for Medicare and Medicaid Services found that H.R. 3590 would raise total national health spending by more than $200 billion between 2010-2019. Many may cite this data point to question the effectiveness of Democrats' health "reform," given that the legislation was originally intended to ***reduce costs***, not raise them.

Tax Increases: Offsetting payments include $15 billion in taxes on individuals not complying with the mandate to purchase coverage, $149 billion from the "Cadillac tax" on high-premium insurance plans, $28 billion in payments by businesses associated with the employer "free rider" penalty, and $65 billion in associated other revenue interactions.

The Joint Committee on Taxation notes that other bill provisions would increase federal revenues over and above the $257 billion in tax increases noted above. JCT found that the increase in the Medicare

payroll tax would raise $86.8 billion, corporate reporting would raise $17.1 billion, the worldwide interest implementation delay would raise $26.1 billion, the treaty withholding provisions would raise $7.5 billion, and the codification of the economic substance doctrine would raise $5.7 billion. Taxes on Health Savings Accounts (HSAs) and other similar savings vehicles would raise $19.6 billion, while provisions relating to retiree drug subsidies would raise taxes by $5.4 billion. Raising the threshold to itemize health expenses from 7.5 percent to 10 percent of adjusted gross income would generate $15.2 billion in revenue, limiting the deductibility of insurance industry executive salaries would raise $600 million, and a 10 percent tax on indoor tanning services would raise $2.7 billion.

The excise tax on medical devices would raise taxes by $19.2 billion. Similar excise taxes on insurance companies and drug manufacturers would raise $59.6 billion and $22.2 billion respectively. Finally, the tax on health benefits used to finance the Comparative Effectiveness Research Trust Fund would raise $2.6 billion over ten years.

Out-Year Spending: The score indicates that of the $871 billion in spending for coverage expansions under the specifications examined by CBO, only $17 billion—or less than two percent—of such spending would occur during the first four years following implementation (i.e. 2010-2013). Moreover, the bill in its final year would spend a total of nearly $200 billion to finance coverage expansions. **In other words, the Democrat bill spends so much, it needs its many of its tax increases to take effect immediately to finance spending beginning in 2014—and even then cannot come into proper balance without relying on budgetary gimmicks**.

Budgetary Gimmicks: While the CBO score claims H.R. 3590 as amended would reduce the deficit by $132 billion in its first ten years, Democrats achieved that "deficit-neutral" solely by excluding the cost of reforming the Sustainable Growth Rate (SGR) mechanism for Medicare physician payments—the total cost of which stands at $285 billion over ten years, according to CBO—from this bill, and including it instead in separate legislation (H.R. 3961; S. 1776) that is not paid for. While Members may support reform of the SGR mechanism paid for in a fiscally responsible manner, many may view any legislation that presumes a more than 21 percent cut in Medicare payments to physicians in 2010 as an inherent gimmick designed solely to hide the apparent cost of health "reform."

The bill also relies on $72 billion in revenue from a new program for long-term care services. As the long-term care program requires individuals to contribute five years' worth of premiums before becoming eligible for benefits, the program would find its revenue over the first ten years diverted to finance other spending in Democrats' health care "reform." However, even Democrats, such as Senate Budget Committee Chairman Kent Conrad (D-ND), have called the program a "Ponzi scheme," and non-partisan actuaries at the Centers for Medicare and Medicaid Services found that the program faces "a significant risk of failure." Therefore, many may find any legislation that relies upon such a program to maintain "deficit-neutrality" fiscally irresponsible and not credible.

STAFF CONTACT

For more information or questions, please contact Chris Jacobs at 6-2302.