POLICY NEWS
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The President's Health Care Takeover - Provisions Going Into Effect in 2013

In less than three months, taxpayers and healthcare providers will be hit with an onslaught of new tax increases and cuts implemented under the president's health care takeover. The following is an overview of some of the most notable and destructive tax increases and limitations set to occur on or after January 1, 2013.

Medical Device Tax (Effective January 1, 2013)

- An excise tax of 2.3% will be imposed on the sale of any taxable medical device. The House passed H.R. 436, to repeal the medical device tax on June 7, 2012.
- The medical device excise tax is expected to result in 43,000 lost jobs and $3.5 billion in lost wages and benefits.
- A Pacific Research Institute report estimates that the medical device tax would lower industry research and development investment by $2 billion annually.
- Even former Senator Evan Bayh (D-IN), who voted for the health care takeover, recently issued a warning about the impending economic damage from the medical-device tax.

Medicare Tax Increase (Effective January 1, 2013)

- The Medicare Part A (hospital insurance) tax rate on wages will be increased by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly.
- A 3.8% assessment will be imposed on "unearned" income (including real estate transactions) for some taxpayers. According to the National Association of Realtors (NAR), "The new tax raises more than $210 billion (over 10 years), representing more than half of the total new expenditures in the health care takeover package. NAR expressed its strongest possible objections, but the legislation passed on a largely party line vote."

Limiting Flexible Spending Accounts (Effective January 1, 2013)

- The amount of contributions to a flexible spending account (FSA) for medical expenses will be limited to $2,500 per year for health FSA plan years beginning after December 31, 2012. The $2,500 limit will be indexed for cost-of-living adjustments for plan years beginning after December 31, 2013. Under prior law, there was no limit on the amount of contributions to an FSA unless the employer imposed one.
- Rep. Erik Paulsen has introduced H.R. 605, the Patient's Freedom to Choose Act, to repeal the cap on FSA contributions.

Employer Retiree Drug Subsidy (RDS) Deduction Elimination (Effective January 1, 2013)

- The federal tax-deduction for employers who receive the Medicare Part D retiree drug subsidy payments will be eliminated. The retiree drug subsidy was established by the Medicare

Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to encourage employers to continue offering prescription drug benefits to their retirees to prevent retirees from seeking benefits through Medicare Part D. The health care takeover law retains the drug subsidy but eliminates the employer's ability to deduct the amount of the subsidy.

- The Society for Human Resource Management has warned that "altering the tax treatment of this subsidy would come at a significant cost to those organizations offering the most comprehensive coverage to current and future retirees."

State Notification Regarding Exchanges (Effective January 1, 2013)

- States must declare to the Secretary of HHS their ability to operate an "American Health Benefit Exchange" by November 16, 2012, and HHS will issue approval for exchange operations by January 1, 2013. The health care law requires exchanges to be operational by January 1, 2014; however, open enrollment in the exchanges will begin October 1, 2013.

Consumer Oriented and Operated Plans (CO-OP) (Effective July 1, 2013)

- The Department of Health and Human Services is scheduled to award loans and grants to finance CO-OP start-up costs by July 1, 2013. CO-OPs are non-profit health insurance corporations that will be run by the CO-OP's beneficiary consumers, providers and employers in a state or region. Senator Conrad (D-ND) initially proposed the CO-Op program as a more politically-palatable alternative to a public option.
- The CO-OP program is set up for failure because the plans are prohibited from working with insurers already in operation, which limits their ability to gain from the experience and expertise of existing market players. White House budget documents show a 91 percent expected loss of the $3.4 billion already authorized for this particular loan subsidy program.
- Rep. Diane Black (R-TN), has introduced H.R. 6299, which will take the defective CO-OP loans off the books, establish prompt repayment policies for the defaulted loans, and replace it with the establishment of privately-sponsored group health plans, commonly known as Association Health Plans.

Medicare Disproportionate Share Hospital Payment Cuts (Effective October 1, 2013)

- Previously, Medicare provided additional funding to hospitals that serve a high population of low-income patients, which also helped preserve access for Medicare beneficiaries.
- These payments, called Medicare Disproportionate Share Hospital (DSH) payments, will be reduced by 75 percent beginning on October 1, 2013. Hospitals will subsequently receive additional payments based a formula that includes the reduction of their DSH funds, the percentage change in the uninsured under-65 population and the amount of uncompensated care provided.
- According to a recent study by the National Association of Urban Hospitals, this is by far the largest and most damaging of all of the government payment changes mandated by the president's health care takeover and will have an extremely damaging effect on the urban health care safety net.

Medicaid Disproportionate Share Hospital Payment Cuts (Effective October 1, 2013)

- Previously, state Medicaid programs were required to make DSH payments to qualifying hospitals that serve a high Medicaid and low-income population. The health care law will reduce states' Medicaid DSH allotments beginning on October 1, 2013.

- The health care law requires aggregate reductions in Medicaid DSH allotments equal to $500 million in FY2014, $600 million in FY2015, $600 million in FY2016, $1.8 billion in FY2017, $5.0 billion in FY2018, $5.6 billion in FY2019, and $4.0 billion in FY2020. The HHS Secretary is required to develop the methodology by which allotments are reduced, but this is yet another item that is still to be published.
- In states that are forced to opt-out of the Medicaid expansion due to its prohibitive costs, safety-net hospitals will experience undiminished costs and less federal support. According to Matt Salo, director of the National Association of Medicaid Directors, "the differential impact of DSH cuts on individual states is staggering."

For more information or questions please contact Lisa Collins at 5-2045.