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RSC Policy Brief: Extended Summary of the Democrats' Government Takeover of Health Care (H.R. 3590) and Reconciliation (H.R. 4872)

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The Reconciliation Bill Still Permits the Senate Bill to Contain:

- **Mandates:** The proposal maintains the individual mandate and the Senate's "free-rider" employer mandate.
- **Cuts to Medicare and tax increases to pay for the expansion and creation of new entitlement programs:** The bill increases taxes that will harm small businesses and middle-class families by *$569.2 billion* over ten years. The bill also includes *$528.5 billion* in cuts to Medicare, cutting benefits and raising premiums on seniors. These cuts are not used to reduce the deficit, or improve the solvency of the Medicare program, but instead to create new entitlement programs.
- **New bureaucratic boards that cede the definition of quality and gives more power to the federal government:** Maintains provisions such as the Patient Centered Outcomes Research Institute (comparative effectiveness research board), the Independent Payment Advisory Board IPAB (or "MedPAC on steroids"), and more.
- **A form of a government-run plan:** The proposal maintains mandated exchanges in each state, the OPM overseen Multi-State Plans, and Co-Ops.
- **Special Deals:** Despite the 100% federal funding for Nebraska's Medicaid expansion "cornhusker kickback" being removed, the rest of the states now have to share less of the burden of the Medicaid expansion – similar to what Senator Harkin predicted: "In 2017, as you know, when we have to start phasing back from 100%, and going down to 98%, they are going to say, 'Wait, there is one state that stays at 100?' And every governor in the country is going to say, 'Why doesn't our state stay there?'…When you look at it, I thought well, god, good, it is going to be the impetus for all the states to stay at 100%. So he [Nelson] might have done all of us a favor."
  - The "Louisiana Purchase," University of Connecticut "U-Con" deal, and the asbestos money for Montana are still in the bill while additional sweeteners have been added.
  - **Removes Just One of Many Deals:** Strikes the extremely narrow carve-out (added in the reconciliation bill) that would have allowed state-owned banks to continue to participate in the FFEL program. The state-owned Bank of North Dakota is the only state-owned bank in the nation, which would have made it the only eligible bank to participate. Many were calling this the "Bismark Bank Job" or the "Bismark Buyout." Although initially supported by Sen. Conrad, once it was publically criticized, it is reported that he decided to seek its removal.
  - **"Rocky Top Vote Swap":** The bill provides full Medicaid Disproportionate Share Payments (DSH) for Tennessee.
  - **Extra Medicare Payments for Providers in Rural Areas:** These new provisions appear to be the "deal" made with Rep. DeFazio who had threatened to vote no unless changes were made. This benefits, Reps. Defazio, Kind, and Braley among others.
  - **Deal for Tax-exempt insurers: Kaiser Permanente and Geisinger?:** The bill provides a partial exclusion for non-profit plans in which no net earnings go to private shareholders or individuals

(and no "substantial" part of activities is "carrying on propaganda or attempting to influence legislation and does not intervene in any political campaign).
  - Click here for the previous list of special "deals" that still exists (with the exceptions of the "cornhusker kickback", related FMAP provisions, and "GatorAid)."
- **Broken promises:** Obama set several parameters, including that the bill would cost under $900 billion, not raise taxes on those making under $250,000, families' health insurance premiums will go down by $2,500 a year, and if individuals liked what they had they could keep it – however none of these promises are kept by President's rewrite of the Senate bill (as put together in the reconciliation bill).
- **Budget Gimmicks:**
  - **Tax Now Spend Later:** The Senate bill employs a trick by implementing 10 years of tax increases and cuts to Medicare in order to pay for just 6 years of benefits. This allows the bill's cost during the 10 year budget window to appear far less than it actually will cost when fully implemented.
  - **SGR Reform Anyone?:** The Senate bill leaves out the physician SGR "fix" which CBO now estimates will cost $286 billion, and the President's own Administration (OMB) estimates will cost $371 billion. Thus CBO assumes that a 21% SGR cut goes into effect. If previous House SGR "fix" proposals were enacted, CBO has estimated that this bill would actually increase the deficit by $59 billion.
  - **Double Dipping:** During the White House health care "summit," the Vice President claimed that the health care plan would "extend the life of the Medicare Trust Fund". However, the massive cuts to Medicare in the bill are not used to improve the programs solvency, but instead spent on new entitlement spending and government programs. The truth is either you're extending the life of Medicare or you're paying for the bill. You can't claim both. That would be double counting. CBO agrees.
  - **The "Ponzi Scheme" a.k.a the CLASS Act:** The bill would create a government-sponsored long term care insurance program that would automatically enroll individuals unless they actively opt-out. The CLASS Act is another unsustainable program being used to disguise the short-term costs of the broader bill through a budget gimmick. It would raise billions over the first ten years (while paying out $0 in benefits for half of that time), but then will begin to increase the deficit after FY2029.
- **Does Not Bend the Cost Curve:**
  - According to CBO, the Senate bill increases federal outlays for health care by about $210 billion, and the **combined effect of enacting the Senate and reconciliation bills would be to increase that commitment by about $390 billion over 10 years.**
  - CMS' Actuaries have found that the Senate bill alone will increase National Health Expenditures (NHE) by $222 billion above current projections. Additionally, the actuaries have serious doubts about the proposed Medicare cuts actually occurring.
  - Even CBO has doubts that the long-term cost containment mechanisms will remain intact: "Those longer-term calculations reflect an assumption that the provisions of the reconciliation proposal and H.R. 3590 are enacted and remain unchanged throughout the next two decades, *which is often not the case* for major legislation."
- **Reduces the Deficit? Complies with the Blue Dog's Highly Touted PAYGO?:**
  - According to CBO, $114 billion of the $143 billion in net deficit reduction that Democrats claim ($124 billion from health care and $19 billion from education) is on-budget, while some portion of Social Security revenues are identified as being part of the $29 billion off-budget items. Previous CBO estimates pegged the off-budget deficit reductions at $53 billion, however the Manager's Amendment to the reconciliation bill struck the provisions that would have require no

net impact on the Social Security Trust Fund in order to address trust fund interactions that had arisen due to the new "Cadillac Tax."

- Furthermore, the CLASS Act is exempted – under the Statutory PAYGO bill that passed the House and Senate – for purposes of counting it as savings and as such the premiums collected for the program can't be counted toward reducing the deficit.
- Thus, in reality, if you remove the off-budget Social Security Revenues ($29 billion) and the CLASS Act ($70 billion) from the deficit impact, at a maximum the bill decreases the deficit by **$44 billion.** If you account for CBO's incomplete discretionary spending estimate ($114 billion), the bill increases the deficit by **$70 billion**. And if you account for Medicare double dipping ($528.5 billion), the overall deficit increase is **$598.5 billion**. Finally, if you add back in the SGR "fix" using the President's figures ($371 billion), the total deficit will increase by a staggering **$969.5 billion**.

H.R. 4872 Does NOT Contain:

- The President's proposed **"Health Insurance Rate Authority"** which would have vested powers in the Secretary of HHS, and a new bureaucratic board, to regulate and block rate increases. The board would have been a substantial departure from the current structure of state health insurance regulation and oversight, and ignores the unique differences in each state (such as the geographical makeup, state market regulation and mandates) that drive up costs, and continues a flawed push by the Democrats for a one-size-fits-all approach. The most dangerous outcome of this rate-setting board would have been federally mandated price fixing that could further accelerate and eventually destroy the private insurance market.
- The **Stupak language** that maintains current law and provides that no federal funding will go towards the funding of abortions.
- Changes to appease the Congressional Hispanic Caucus by allowing **illegal immigrants** to purchase coverage through the exchange using their own dollars. However, the Senate bill still contains the same insufficient and ineffective verification methods as the House, causing some to be concerned that it would still allow for illegal immigrants to access the Exchange and subsidies.
- **Real medical liability reform:** No real changes to the insufficient medical liability provisions as passed in the Senate bill.

Cost to Taxpayers: CBO has scored the combined bill's gross cost of coverage as $938 billion (compared to the Senate cost estimate of $875 billion not including discretionary costs).

The total cost of Senate bill with the changes in the reconciliation bill is nearly *$1.2 trillion* of new mandatory spending (not including the $371 billion "Doc Fix" proposed in the President's budget). Furthermore, when including CBO's estimated cost to states of the mandated Medicaid expansion ($20 billion), as well as authorized discretionary spending for grants, public programs, changes and funding for a variety of agencies that would be responsible for implementing the Senate bill (up to $114 billion according to the Senate Budget Committee Republican Staff), the total cost of the bill is more like *$1.33 trillion*.

In addition, CBO has released a letter to Rep. Paul Ryan (R-WI) that provides more analysis of the real world budgetary impact of enacting this bill. In this letter, CBO notes that including the cost of H.R. 3961 (the House-passed "doc fix") would mean that the legislation increases the deficit by $59 billion over ten years.

The bill also includes several other budget gimmicks that many observers would argue lead to a net deficit impact in excess of $59 billion. Many of the provisions that worsen the deficit take effect near the

end of the budget window. Consequently, a bill that was sold as costing $900 billion, according to Senate Budget Committee Republican Staff, will actually end up costing $2.64 trillion (not including education spending) in the first ten years of full implementation. In addition, many of the provisions that are intended to either increase tax revenues or restrain entitlement spending are likely to be scaled back or never take effect at all. For example, the bill increases taxes on so-called "Cadillac" plans starting in 2018—which makes it very likely it will never take effect at all. The bill's strategy for reducing Medicare spending is to go after providers. These cuts also are likely to not be implemented as scored.

Taxes

Taxes: The bill increases taxes by ***$569.2 billion*** over ten years—up $48.9 billion from the Senate bill. It further **raises taxes on middle class families**, breaking President Obama's pledge not to tax Americans earning less than $250,000. The major tax provisions and changes include:

Non-Health Care Related Tax Increases ($49.7 billion)

- **Raises taxes by *$4.5 billion*** by eliminating the exclusion employer plans receive in connection with offering qualified retiree prescription drug coverage under the Part D retiree drug subsidy program (RDS) beginning in 2013 (as opposed to 2011 in the Senate bill). Under current law, these plans are not subject to the corporate income tax. Some conservatives may be concerned that eliminating this favorable tax treatment will lead to employers dropping drug benefits for retirees.
- **Raises taxes by *$23.6 billion*** beginning in 2010 by prohibiting so-called "black liquor"—a wood pulp byproduct that can be used as an alternative bio-fuel—from becoming eligible to receive a tax credit for cellulosic bio-fuel production that was established in the 2008 farm bill. This tax was not included in the Senate bill.
- **Raises taxes by *$4.5 billion*** by codifying the "Economic Substance Doctrine," which starting in 2010 allows the IRS to disallow a tax deduction, or other tax relief provision, simply because the IRS deems that the motive of the taxpayer was not primarily business-related (as opposed to tax-related). This tax was not in the Senate bill.
- **Corporate Timing Tax Shift Gimmick:** This provision would apply a 15.75 percentage point corporate tax timing shifts to corporations in 2014. This provision is merely a revenue timing shift, a gimmick used to comply with the House's PAYGO rule, yet would have real-world implications, as it forces certain companies to pay more of their tax payments earlier (*$8.8 billion).* Given the time value of money, earlier payments harm the bottom line of employers. This tax was not in the Senate bill.
- ***Raises taxes by $17.1 billion*** through expanding of 1099-MISC information reporting to corporations beginning in 2012.

Health Insurance Taxes ($519.5 billion): The bill includes limitations on Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), taxes on medical devices, health plans and other items including:

- ***$210.2 billion*** **Medicare Payroll and Investment Income Tax Increase:** Beginning in 2013, the bill maintains the Senate bill's increase of the Medicare payroll tax by 0.9% on individuals making $200,000 and families making $250,000 *(not indexed to inflation)* **which creates a new marriage penalty and over time that will hit more of the middle class.**
  - The bill adds an additional 3.8% tax on net investment income for these same individuals, estates, and trusts. This is income derived from the ordinary course of business that is not a passive activity such as active participation in an S-Corp or distributions from qualified plans (listed on page 91), and any item taken into account in determining self-employment income.

- Net income investment is defined as: gross income from interest, dividends, annuities, royalties, rents, other gross income derived from a trade or business involving passive activities, *and net gain from selling property* (other than property held in trade or business).
- Despite the Administration's claim that this additional tax revenue would be used to make Medicare's Hospital Insurance (HI) trust fund more sustainable, according to CBO, such money would in fact go towards the expansion and creation of new entitlement programs.

- ***$2.7 billion* Indoor Tanning Tax Increase:** The bill maintains the Senate excise tax (10% of the amount paid for the service by the customer) on indoor tanning services starting in 2010.
- ***$20 billion* tax increase:** Moves the Senate bill's tax on medical devices manufacturers and importers back two years from 2011 to 2013, and changes it to an annual 2.3% excise tax. The Manager's Amendment reduced the tax from 2.9% to 2.3%, while simultaneously expanding taxable items to Class I medical devices (in addition to Class II and III). Items that are still exempt include contact lenses, eyeglasses, hearing aids, and other devices that are generally purchased at retail by the public at the Secretary's discretion.
- ***$5 billion* HSA Tax Increase:** Excludes non-prescription medications from being purchased with pre-tax dollars beginning in 2011.
- ***$1.4 billion* in HSA Penalty Tax Increases:** Subjects non-qualified distributions from HSAs to a tax of 20% on the disbursed amount (current law is 10%), beginning in 2011.
- ***$13 billion* FSA Tax Increase:** Places an annual cap of $2,500 on FSAs, which are currently uncapped due to the "use-it-or-lose-it rule" whereby at the end of a plan year money remaining in an FSA must be forfeited by the employee. The cap would be indexed to CPI-U beginning in 2013 (back two years from 2011).
- ***$60.1 billion* Health Insurer Tax Increase:** Pushes back the annual, non-deductible tax on health insurers, allocated based on market share of net premiums, by three years (from 2011 to 2014). The fee is phased at $8 billion in 2014 (up from $2 billion in 2011, $4 billion in 2012, $7 billion in 2013, and $9 billion in 2014 – 2016), $11.3 billion in 2015 and 2016, $13.9 billion in 2017, $14.3 billion in 2018, and indexed to medical cost growth thereafter (up from $10 billion in 2017 and thereafter). Provides a partial exclusion for non-profit plans, plans where no net earnings go to private shareholders or individuals (and no "substantial" part of activities is "carrying on propaganda or attempting to influence legislation and does not intervene in any political campaign), and plans where 80% of the revenue is from government programs for low-income, elderly, or disabled individuals.
- ***$2.6 billion* CER Tax Increase**: Places a new tax on insurance policies to fund the Patient-Centered Outcomes Research Trust Fund. The Senate bill provided an exemption from the health insurer fee for nonprofit insurers that meet certain requirements (only two insurers in the states of Nebraska and Michigan qualify), including a high Medical Loss Ratio (MLR).
- ***$32 billion* "Cadillac Tax" Increase:** Places a tax on high-cost "Cadillac" plans beginning in 2018 (reduced from $148.9 billion due to a special deal for the unions). Includes additional carve-outs for "high-risk professionals," retirees, and the cost of vision or dental plans.
- ***$27 billion* Drug Tax Increase:** Places an annual non-deductible "fee" or tax on pharmaceutical manufacturers allocated according to market share and not applying to companies with sales of branded pharmaceuticals of $5 million or less. The tax is increased by $7.8 billion phased in beginning in 2011.
- ***$0.4 billion* Health Organization Tax Increase** from modifying section 833 treatment of certain health organizations beginning in 2010.
- ***$0.6 billion* Insurance Executive Pay Tax Increase** from placing a $500,000 deduction limitation on taxable year remuneration to insurance executives (officers, employees, directors, and service providers of covered health insurance providers) beginning in 2012.

- ***$15.2 billion*** **in Health Care Deduction for Expenses Tax Increases** from raising the 7.5% AGI floor on medical expenses deduction to 10% in 2013. The AGI floor for individuals age 65 and older (and their spouses) remains at 7.5% through 2016.
- ***$60.3 billion tax increase*** from "other revenue effects."

Unions and the "Cadillac Tax" on high-cost plans: The Senate–passed bill was already chock-full of union carve outs (provisions to hurt small, non-union construction firms, and a higher threshold before the "Cadillac" tax hits for retirees and "high risk professionals"). But under the new bill, the "deal" made in January between the White House and unions will be maintained, including:

- A delay in implementation of the "Cadillac Tax" for 5 years (from 2013 to 2018), and an increase in the thresholds from $23,000 for family coverage and $8,500 for individual coverage to $27,500 and $10,200 respectively.
- Increases the "high risk professional" threshold from $1,300 to $1,650 for individual coverage and $3,000 to $3,450 for family coverage above the otherwise established threshold.
- **A carve-out for individuals with "self-only" coverage under a collectively bargained (union) health plan** (including state and local government employees) so that they receives family coverage exemption ($27,500 as compared to $10,200 for non-union workers).
- Dental and vision plans (estimated to be an additional $1,500 carve out) will be removed from the calculation of the threshold costs for the "Cadillac Tax."
- Other thresholds may be tweaked upwards to take into account other factors that may increase the cost of a plan, such as age and gender, which would benefit union plans with high percentages of older workers.
- If health costs rise faster than expected, the thresholds are automatically increased (likely removing a large portion of the expected revenue from the tax) if the per-employee cost under the FEHBP BCBS Standard Option in 2018 increases above expectations based on 2010 plus general inflation.
- Adds to the definition of "employee" any former employee, surviving spouse, or other primary insured individual.
- Finally, the bill removes the higher threshold transition period for the 17 "high cost" states.

Insurance Regulations and Mandates

The reconciliation proposal **spends $63 billion more** on "coverage cost" than the Senate bill, **but only covers one million more people**. The bill also keeps intact both the employer and individual mandate proposed in the Senate, with increases to the subsidies and penalties for non-compliance.

Employer mandate ($52 billion tax increase): An employer mandate is a tax on jobs that the National Federation of Independent Businesses estimates will result in **1.6 million job losses between now and 2013.** Furthermore, the Senate bill encourages employers to drop coverage and dump people into an exchange rather than pay the increased rates associated with the costly mandates.

- Although the Senate bill exempts employers with 50 or less full-time employees, the reconciliation bill now includes part-time workers for purposes of the determining the employer's status as a "large business." Specifically, the bill would require employers, on a monthly basis, to divide the number of hours of part-time employees by 120. For Example: a firm that hires 40 full time employees and 30 part time employees, who work 20 hours a week, or 2,400 hours a month, would then have to add 20 employees to their count for "full-time employees" and thus would qualify as a "large business."
- The bill removes the fine in the Senate bill on employers if employees have to wait to enroll in coverage.
- It reduces the tax penalty for non-compliance on businesses with more than 50 employees by subtracting out the first 30 workers from the payment calculation but at the same time increases the

fines for employers who *do not offer* coverage to $2,000 up from $750 — if at least one of its full-time employees enrolled in an exchange plan *and* receive a premium subsidy.

- It increases the penalty that large employers *who offer* coverage, but it is deemed "unaffordable" by the government, have to pay if an employee receives a premium credit from 400% of the payment amount to a flat $3,000 per employee. "Affordable" is defined as a plan that covers at least 60% of the costs and has premiums below 9.8% of income
- The bill requires employers to provide a "free choice voucher" equal to the employer's portion of the premium paid for the highest cost plan they sponsor. The voucher would be available to employees below 400% Federal Poverty Level (FPL), whose required contribution is between 8% and 9.8% of their income.
- The Senate bill also provides a temporary small business tax credit of $37 billion that according to the Chamber of Commerce and NFIB will do little to make purchasing insurance affordable for more small firms.

Individual mandate ($17 billion in tax increases): In addition to being unconstitutional, an individual mandate necessitates a government definition of acceptable health care coverage. Because the benefit packages found in the Democrats' health care bills are quite large (or in some cases still to be determined by an unelected bureaucratic board or the Secretary of HHS), it is likely that millions of Americans would be unable to keep their existing health care coverage and be forced to pay for more expensive health insurance, participate in a government-run plan, or pay a fine.

- Under the Senate bill, the penalty is tied to the higher of flat dollar amount or 2.5% of taxable income up to the national average of the "Bronze" (lowest value) plan premium, bringing in $17 billion in tax revenue. Individuals are exempt from the mandate if premiums for the lowest cost plan available exceed 8% of their income.
- Individuals must attest to coverage on their tax returns and insurers must also report information to the IRS about their enrollees. Violators could be charged with a misdemeanor and could face up to a year in jail or a $25,000 penalty, according to Joint Committee on Taxation Chief of Staff Thomas Barthold.
- The reconciliation bill lowers the flat dollar tax penalty established in the Senate bill from $750 to $695 for an individual and $2,250 to $2,085 for a family in 2016, while also raising the percent of income that is an alternative payment amount from 2% to 2.5% of taxable income up to the national average of the "bronze" plan (phased in at 1% in 2014, 2% in 2015, and 2.5% in 2016 and thereafter). This may increase overall premiums due to the young and healthy opting to pay the fine instead of purchasing coverage, leaving only the older, sicker patients in the pool.
- The reconciliation bill also expands the number of families and individuals exempt from the penalty from 100% of FPL under the Senate bill, to those with income levels below the filing threshold (for the appropriate family size).
- The final bill omits protections for military health plans as it fails to list TRICARE as a plan that meets the minimum standards and thus is a "qualified" plan for the purpose of the individual mandate. A stand alone corrections bill to include TRICARE (H.R. 4887), the "TRICARE Affirmation Act," was passed separately on March 20, 2010.

Regulation over Health Insurance Price Increases: The Secretary in conjunction with the states shall set up an annual review process for monitoring increases in health insurance premiums. Insurers in the exchange must submit justification for any premium increase prior to implementation. The Senate bill would require the Secretary of HHS and the states to establish a continuing premium review process in the exchanges to determine whether there is "particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases".

"Grandfathered" Plans: Despite the claim that current health care plans are "grandfathered" in, if an individual's current insurance company makes any additions to its plan (such as including more people other than dependents or employees or adding a newly found cure for cancer), it would trigger the mandate to have a government approved plan. "Grandfathered" plans would still be required to comply with certain reforms, and individuals who choose to enroll in these plans would not be able to use a tax credits, essentially allowing these plans to wither on the vine. Six months after passage, the reconciliation bill would require "grandfathered" individual and small group plans to do the following:

- Prohibit practices such as the rescission of insurance, excessive waiting periods, and life-time limits.
- Requires "young adults" be allowed to stay on their parents' insurance plan until age 26.

Beginning in 2014, the reconciliation bill prohibits practices by group plans such as pre-existing condition exclusions, restricts annual limits 6 months after enactment, and eliminates them entirely in 2014.

Insurance Market Reforms: The bill requires all individual and small group plans to comply with new federal regulations. Six months after enactment, these plans must:

- Eliminate pre-existing condition exclusions for children.
- Not charge co-pays for preventive care services rated A or B by the U.S. Preventive Services Taskforce (USPSTF).
- Allow for dependent coverage for "children" up to age 26.
- Prohibit rescission except in the case of fraud.
- Group plans must not have lifetime limit and individual plans must restrict the use.

Tighter insurance restrictions on Medical Loss Ratio (MLR): Beginning in 2011, the bill requires all insurers both before and after the establishment of the exchanges to have a MLR of 80% in the small group and individual market, and 85% in the large group market, forcing insurers to cut down on administrative costs such as Health IT, fraud detection, care management, etc. Plans that exceed this must give a rebate to consumers, and states can determine a higher MLR rate in any market. This is a new federal intrusion into private companies as it dictates how companies can allocate their resources. According to CBO, if the government dictates MLR up to 90% (combined with the bills other regulations) it would essentially make private insurance a government program, dramatically adding to the cost of the bill.

As of 2014 all small group and individual plans must to the following:

- Provide for guarantee issue and renewability, prohibit the exclusion of pre-existing conditions, and ban lifetime and annual limits.
- Comply with federal rating rules: 3:1 community rating based on age, family structure, and geography; 1.5:1 based on tobacco use.

Exchange: Effective 2014, the bill creates state based Health Benefit Exchanges and implements health insurance reforms.

- In 2014, the Exchanges are limited to those who do not have access to employer-based coverage (or that coverage is deemed "unaffordable"), those who are not eligible for existing public programs and small businesses. In 2017, the exchanges are opened up to businesses of all sizes. Members of Congress, and their personal office staff, would be required to obtain coverage through the exchange.
- The Exchange will offer 4 highly structured types of plans starting off with a "bronze" level with the highest cost-sharing (60%), and moving toward a richer benefit with lower cost sharing for the "silver" (70%), "gold" (80%), and "platinum" (90%) level plans.

- All exchange plans must be a Qualified Health Benefit Plan (QHBP) and abide by the rules regulating insurance set forth in the bill including the essential health benefits and be offered by licensed insurers that offer at least one qualified health plan at the silver and gold levels.
- The bill allows for individual market plans to provide a "catastrophic plan" to those under the age of 30, or who are exempt from the individual responsibility requirement (however this plan is still subject to benefit requirements and cost-sharing limits). This provision may cause some conservatives to be concerned that innovative plans will cease to exist

"Essential Health Benefits Package": By 2014, all plans must abide by a minimum benefit standard, cost-sharing restrictions, and cap on out-of pocket expenses. The out-of-pocket cap on medical expenses for individual plans is tied to HSA limits ($5,950 for an individual and $11,900 for a family), while small group plans are limited to $2,000 for an individual, or $4,000 for a family. The bill also provides for the restriction and possible elimination of some HSAs as "qualified plans" since the minimum cost-sharing actuarial equivalence for health plans is being set at 60%, and HSAs cost sharing structures are anywhere from 55%-65%. All plans must cover a specific list of government set benefits including: ambulatory and emergency services, hospitalization, maternity and newborn care, mental health and substance services, prescription drugs, rehabilitative, habilitative, lab services, prevention and wellness services, and chronic management and pediatric service (oral and vision).

Premium Subsidies: The bill increases subsidies by $15 billion (to a total of $464 billion) so that "low-income" individuals between 133% and 400% FPL receive more generous credits as the portion of income they must pay for health care before the credit kicks in is lowered. The credits can only be used to purchase coverage in their state exchange.

- The subsidies (tied to the "silver" plan) are based on a sliding scale such that individuals at 300% FPL must pay 2% of their income before they receive any subsidy amount, while individuals up to 400% FPL must pay 9.5%. The bill also decreases the specific out-of-pocket maximum levels of cost sharing at each income tier so that plans must cover more of the cost.
- Despite Democrats' claims, the bill will increase premiums by 10-13%. As JCT, CBO, and six other studies have shown, imposing new benefit mandates, taxes on insurance policies, health care products, and various new insurance regulations, will drive up the cost of premiums for patients of all ages.

Government-Run "Multi-State" Plan: Although the government-run plan with a state-opt out was removed, the Senate bill still allows for the federal government, through the Office of Personnel Management (OPM), to run, oversee and "negotiate" with new "Multi-State" plans offered in State Exchanges and available nationwide. At least one of the "Multi-state" plans must be non-profit, and at least one plan must not offer coverage of abortions. In order to be "qualified," a plan must still be licensed in each state and meet all state and federal requirements including newly established standards for medical loss ratios, profit margins, and premiums. OMP-run multi-state plans must cover all essential health benefits and meet all of the requirements of a qualified health plan, and comply with 3:1 age rating. Furthermore, like the House bill, the Senate bill contains a CO-OP Program to help organize and fund ($6 billion) the creation of even more not-for-profit insurance companies. The CO-OPs would only have to pay back the loans or grants plus interest if they violate the terms of the program. Otherwise they are financed on the back of the taxpayer with **no prohibition on the CO-OP from receiving a bail-out if it fails.**

Risk Adjustment and Reinsurance: For 2014-2016, the Secretary of HHS would be required to develop a system of risk adjustment for all individual and small group market plans run by a non-profit entity. All private health insurers would be required to pay a broad-based fee of $25 billion.

"Reinsurance" Subsidy Program for Retirees: 90 days after enactment, the Secretary of HHS will establish a temporary program to reimburse employment-based plans for 80% of claims that exceed $15,000 but are less than $90,000 (CPI annual adjustment), for health benefits provided to 55-64 year old retirees and their dependents. During the Pelosi rewrite of this provision in the House bill, unions and state agencies or political subdivisions were included in the definition of ''eligible employment-based plan.'' Some conservatives may be concerned that this was added in to buy off states and unions whose rich benefits are costly but must be maintained due to contracts or law.

Interim High Risk Pool: The Senate bill will establish a *national* interim high risk pool of sorts (costing $5 billion) beginning in 2010 through the establishment of exchanges in 2014. The inclusion of this provision is interesting, considering that when RSC offered such a proposal, House Majority Leader Hoyer criticized it. Click here for a must read.

State Option for Basic Health Coverage: Allows for individuals, with incomes of less than 133% FPL, who are not eligible for Medicaid (including legal immigrants who are not eligible for Medicaid due to the five-year waiting period) to be eligible for the new state-run, federally-funded, basic health program that states can establish for "low-income" individuals above 133% FPL.

Other Reconciliation Changes:

- Clarifies that kids covered on their parents plan through age 26 are allowed to be claimed as part of the costs for deduction for health insurance costs on their parent's returns (example: self-employed individuals claiming costs as a tax deduction can add the cost of dependents until age 26).
- Establishes, and funds at a total of $1 billion, a "Health Insurance Reform Implementation Fund" within HHS, to carry out the bill.

Medicare

Increased Medicare Cuts in the Reconciliation Bill:

- Increase the cuts to Medicare Advantage by $17.5 billion (to $135.6 billion) and Medicare Advantage interactions by $53 billion (to $70.3 billion).
- Further decrease Medicare market basket updates by $9.9 billion (to $156.6 billion) for long term acute care hospitals, outpatient hospitals, and inpatient hospitals.
- Increase equipment utilization for imaging beginning in 2011 to 75% (up from 50% under current law) as opposed to phasing up from 60% in 2010 to 75% by 2014, resulting in an additional $1.2 billion in cuts (to $2.3 billion).

Delayed Date for Prohibition on Physician-Owned Hospitals: The reconciliation bill pushes back the date from August 1, 2010 to December 31, 2010 by which a physician-owned hospital must have a provider agreement to participate in Medicare. The bill also adds language that would allow for a special rule for certain "high Medicaid facilities" in relation to the new "conditions for approval" that existing specialty hospitals must abide by in order to grow their facilities under the bill.

Medicare Part D: The bill still cuts Medicare by half a trillion dollars in order to finance new entitlement programs, but tries to buy off seniors' support through closing the Medicare Part D "donut hole" by an additional $24.8 billion dollars (increasing the cost to $42.6 billion). This was done by providing a $250 dollar rebate beginning in 2010, and by requiring a 50% discount on brand-name drugs during the coverage gap beginning in 2011 (excluding certain high income and LIS enrollees). The bill reduces co-insurance payments on all Part D drugs to the traditional Medicare 25% beneficiary / 75%

federal government match rate by 2020. When similar provisions were included in the House bill, CBO found that these changes would raise Medicare Part B premiums by $25 billion and Part D premiums by 20%. Finally, the bill clarifies that the manufacturers' payments are excluded from the definition of average manufacturer price (AMP).

The Manager's Amendment added a provision that reduces the growth of out-of-pocket costs thresholds for seniors in Medicare Part D beginning in 2014 with a cliff in FY 2020 so that the out-of-pocket cost threshold will go back to what it would have otherwise been had this provision not occurred.

Medicare Advantage (MA): The proposal also increases cuts to MA (relative to the Senate bill) through linking benchmark payments to different percentages of traditional Medicare fee-for-service costs (FFS) in a particular area with a variety of bonus payments and adjustments.

- The reconciliation bill would freeze payments to MA plans in 2011 to 2010 levels and phase in cuts beginning in 2012.
- The bill would base benchmark payment rates depending on how an areas' FFS cost compare to other areas (divided into quarters) such that the highest expenditure areas would receive 95% of base payment rate, and the lowest-spending area would receive 115% of base payment rate.
- Benchmarks payments for quality bonuses are phased in from 1.5% - 3% beginning in 2012.
- Implements a "star" system for payments phased in over time such that lower rated plans will receive a smaller rebate (reduced from 75% now to between 50%-70% depending upon their quality performance scores).
- The reconciliation bill would gain additional savings through continuing the ability of the government (set to expire in 2010) to cut payments for unjustified coding patterns in MA plans that have raised payments more rapidly than the evidence of their enrollees' health status and costs suggests is warranted. The Manager's Amendment modifies this provision added in reconciliation by moving up the date for requiring a minimum coding adjustment factor from 2019 to 2014.
- Requires MA plans to adhere to an 85% MLR or be subject to penalties.

By cutting Medicare Advantage, Democrats would effectively make the choice of additional coverage found under private insurance unfeasible for millions of senior citizens. Ultimately, CMS estimated that enrollment under Medicare Advantage would decrease by 8.5 million, which would force many seniors back into traditional Medicare due to decreased benefits under the plans.

Independent Payment Advisory Board (IPAB): The bill maintains the "MedPAC on Steroids" board made up of non-elected government bureaucrats that are empowered to make arbitrary cuts to Medicare providers and make recommendations to non-federal health programs that will limit access to care for seniors.

- While the language doesn't specifically make changes to the IPAB language, the increased cuts to overall Medicare in the bill (mainly due to further cuts to MA) reduces the overall Medicare cuts the board would implement by $12.6 billion so that total expected cuts will be $15.5 billion (up $2.5 billion with the changes made in Manager's Amendment).
- Congress would be required to consider legislation implementing the proposal or alternative proposals with the same budgetary impact on a fast track basis. The recommendations of the board would go into effect automatically unless blocked by subsequent legislative action.
- IMAB's recommendations would be required if the Chief Actuary for the Medicare program projected that Medicare's spending per beneficiary would grow faster than the average of the growth rates of the consumer price index (CPI) for medical services and the overall index for all urban consumers for fiscal years 2015 through 2019.

- After 2019, the threshold would be increased and IMAB's recommendations would be required if Medicare spending growth rose faster than per capita gross domestic product (GDP) plus 1 percentage point.
- Of note, CBO revised its long-term estimate of this provision in the Senate bill to take into account this change in 2019, such that it lowered the projected savings by 0.25% of GDP or $500 billion.

Medicare Payments to Hospitals and Doctors Based on Geographic Areas: These new provisions appear to be the "deal" made with Rep. DeFazio who had threatened to vote no unless changes were made.

- **The Manager's Amendment** modifies the Practice Expense (PE) Geographic Adjustment for 2010 so that the employee wage and rent portions of the PE reflect 1/2 of the difference between the relative costs of employee wages and rents in the fee schedule area and the national average as opposed to the previous "3/4" in the underlying bill thus lowering it relative to the national average. CBO estimates this will **increase spending by $400 million.** This "deal" helps rural areas as their overhead costs, compared to urban providers, are lower resulting in lower Medicare payments.
- **The Manager's Amendment adds $400 million in payments** for "qualifying hospitals" for FY 2011-2012. "Qualifying hospitals" are those that rank within the lowest quartile of counties in Medicare spending (ranked by risk adjusted spending per Medicare enrollee).

Medicaid

Medicaid Expansion and Federal Funding: Despite an estimated **$80 billion** in taxpayer dollars lost *every year* due to Medicare and Medicaid fraud, the bill drastically expands the currently unsustainable Medicaid program from 100% of FPL to 133%, hurting already thinly stretched state budgets (a $20 billion unfunded mandate over ten years). Upon enactment, the bill further requires states to do "maintenance of efforts" for current Medicaid and CHIP eligibility.

- **The bill increases both the number of individuals covered under Medicaid (up 1 million, to 16 million, or half of the newly covered individuals) and the federal government's share of spending by $48 billion (to $434 billion).**
- The reconciliation bill simply pushes back the date at which all states must begin to pick up the tab for the costs associated with the mandated expansion to 133% FPL, with maintenance of efforts phasing down the federal share in 2017 from 95% down to 90% indefinitely after 2020.
- While the proposal makes a big ado about removing the Nebraska FMAP deal (and subsequently the Massachusetts and Vermont special FMAP increases) the bill now provides a special deal to "expansion states" that already expanded eligibility. The bill reduces the state share of the costs of covering non-pregnant childless adults by 50% in 2014, phasing up to 90% in 2018. Beginning in 2019 will bear the same cost share of covering non-pregnant childless adults (new eligables) as other states
- The bill modifies income definitions so that Medicaid and CHIP, among other programs' income definitions, are now calculated based on modified adjusted gross income vs. modified gross income, and allows for a 5% income disregard for determination of Medicaid eligibility for individuals whose income increases above the upper income limit.
- **Some conservatives may be concerned that Congress is passing up an important opportunity to tailor and prioritize Medicaid for the *lowest-income* individuals.**

Medicaid Rebates: The bill requires drug manufacturers to expand Medicaid drug rebates under Medicare to dual-eligibles in 2010, and a modified Medicaid rebate to any low-income subsidy individual in 2015. Beginning in 2010, Medicaid rebates are vastly expanded in size from 15.1% to 23.1%, as they

are extended to Medicaid managed care organizations (MCOs), and applied to line extensions of certain types of drug.

Drugs (340B): The Reconciliation bill removes the 340B expansion under the Senate bill to inpatient drugs, excludes orphan drugs from the required discounts to new entities, and bans group purchasing organizations.

Temporary Primary Care Physician Payment Increase: The bill also employs a budget gimmick whereby it increases payments to primary care practitioners in Medicaid by $8.3 billion (equal to 100% of Medicare rates) for only 2 years (2013 and 2014), and would then effectively reduce payments by 50% in 2015.

- History has shown that this two year increase will likely be increased every year after the "sunset date" thus hiding the true cost of the provision. While many conservatives may believe that physicians in Medicaid should be paid more, many may be believe that we should not be expanding this flawed program to begin with.
- Some conservatives may see this new gimmick as just another SGR, the physician payment formula that doesn't work. Like with the Medicaid eligibility increase, this payment increase would result in an unfunded state mandate in future years.

Education

Federal Family Education Loan (FFEL): The bill terminates the FFEL program after June 30, 2010 and requires the transition to the government-run Direct Loan (DL) program. CBO projects a savings of approximately $61 billion over ten years. This number is significantly less than the originally projected $87 billion because many colleges and universities have already changed to the DL program. Of that $61 billion, the bill diverts $9 billion in savings to a $1.2 trillion health care bill and $10 billion in savings toward deficit reduction. The $42 billion difference will be used for new education spending.

Pell Grants:

- *Provides a total of $36 billion to increase the maximum Pell Grant award*. Beginning in 2013, the grant amount will then be inflated to reflect changes in the Consumer Price Index each year through the 2017-2018 year. Increases are suspended after 2018. (H.R. 3221 had increased the amount at the rate of CPI plus 1 percent.)
- *The bill increases the maximum amount available for Pell Grant awards.* The bill increases the maximum grant award from $5,550 in FY2010 to $5,975 in FY2020, which assumes a discretionary award of $4,860. The original House-passed bill increased Pell Grants to $6,900 by FY2019.
- *Includes $13.5 billion in funding to help fill a Pell Grant shortfall.* A shortfall of approximately $6 billion exists due to increased demand for Pell Grants in recent months. Costs for maintaining the $4,860 maximum Pell Grant have increased due to increased demand for the program.

College Access Challenge Grant Program (CACGP): Authorizes $150 per year for five years for the CACGP which is a program in existence that, according to its website, "fosters partnerships among federal, state, and local governments and philanthropic organizations through matching challenge grants that are aimed at increasing the number of low-income students who are prepared to enter and succeed in postsecondary education."

Historically Black Colleges and Universities and Other Minority-Serving Institutions: Provides $255 million in mandatory spending per year from FY2010 through FY2019 for these institutions, for a total of approximately $2.6 billion over ten years.

Direct Loans to Students Studying Abroad: Loans will be distributed through a financial institution located within the U.S.

Contracts: Provides $1.4 billion over ten years for a requirement that the Secretary contract with non-for-profit servicers on some Direct Loans.

Among other things, the bill does *not* include (which were included in the House-passed H.R. 3221):

- H.R. 3221 had authorized $4.04 billion for FY2010 and FY2011 for the U.S. Secretary of Education to make grants to state educational agencies for the modernization, renovation, or repair of public school facilities
- Changes to the Perkins Loan program; and
- Early education funding.

Other Problematic Provisions

Long Term Care Entitlement Program, the "CLASS Act": The CLASS Act faced major opposition from Senate Democrats, including Senator Conrad, the Chairman of the Budget Committee, who called it a "Ponzi Scheme." It would create a government-sponsored long term care insurance program that would automatically enroll individuals unless they actively opt-out.

- Individuals must first pay premiums (set by the federal government and estimated to be $123/month on average) for five years in exchange for a meager $50-a-day benefit to partially cover the cost of care. The provision would only add confusion about Medicare coverage of long-term care without covering the true cost of care and may cause seniors to drop their current coverage, amounting to a federal take-over of the private long-term health insurance system.
- The CLASS Act is another unsustainable program being used to disguise the short-term costs of the broader bill through a budget gimmick. It would raise billions over the first ten years (while paying out $0 in benefits for half of that time), but then will begin to increase the deficit following FY2029.
- Despite claiming it would strengthen the provision it is unclear how as previous attempts have not absolved concerns raised by numerous organizations including CBO, the Concord Coalition, as well as the American Academy of Actuaries, who found that due to its program design, the program would require massive premium increases and benefit decreases by 2019 to remain solvent.

Abortion: The Senate bill still allows for the funding of abortion, and is very different from the Stupak language that passed the House with the support of 64 Democrats. Specifically:

- Nelson's "compromise" would require those enrolled in a plan that covers abortion to make separate payments into an account that will be used for abortions, therefore creating public and "private" funds. Just because the funds are put into another account does not mean they are not federal dollars subsidizing abortions. Money is fungible and attempts to separate taxpayer dollars and private dollars to pay for an abortion is nothing more than a deceitful shell game.
- The bill includes a mandate that every state provide an insurance plan option that does not cover abortion, while giving each state the right to pass a law barring insurance coverage for abortion within state borders (which was already allowed in the underlying bill). However, even if a state chooses to opt out, an individual's tax dollars may go toward plans that cover abortion in other states.
- Each state through the new government run plan ("Multi-State Plan") overseen by the Office of Management Personnel (OMP) can provide access to two plans – only one of which must exclude abortions. Currently no plan under the Federal Employee Health Benefits Plan (FEHBP), overseen by OMP, provides for abortion coverage.

- Additionally, it fails to fix Sen. Mikulski's amendment, which gives the Health Resources and Services Administration (HRSA) the power to require private insurance plans include abortion coverage under the title of "preventive care."
- Finally, the bill fails to provide adequate conscience protections, as it does not prohibit any government entity or program from discriminating against health care providers that do not want to participate in abortions.

Comparative Effectiveness Research: The bill still establishes the Patient Centered Outcomes Research Institute (PCORI), a nonprofit corporation, to conduct comparative effectiveness research (CER). PCORI will replace the Federal Coordinating Council created in the American Recovery and Reinvestment Act of 2009. Despite repeated attempts by Republicans to prohibit the government from using CER to make coverage decisions, such amendments failed along party lines. This unelected, bureaucrat-appointed board will lead to rationing and make one-size-fits-all judgments prohibiting treatment options on the basis of cost.

- The bill allows the Secretary of HHS to use CER findings to make a determination regarding coverage as long as it is done through an open and transparent process.
- To pay for these activities, the bill would impose a new "fair share" tax on insurance policies.