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U.S. SENATE REPUBLICAN POLICY COMMITTEE

Legislative Notice

No. 35 March 22, 2010

H.R. 4872 – Health Care and Education Affordability Reconciliation Act of 2010

H.R. 4872 was passed by the House on March 21, 2010 by a vote of 220-211.

Noteworthy

- H.R. 4872 is intended to make changes to the Senate-passed health care bill (H.R. 3590), while also making reforms to student lending and education programs.

- The Congressional Budget Office has estimated that, when coupled with H.R. 3590, the bill would spend a total of $940 billion on health insurance coverage expansions over 10 years (fiscal years 2010-2019). However, these provisions exclude other non-coverage related mandatory and discretionary health and education spending included in both measures, bringing the total cost in the bill's first 10 years to $1.2 trillion. The Republican staff of the Senate Budget Committee estimates that the total spending in the Senate bill's first 10 years of full implementation (fiscal years 2014-2023) would be $2.4 trillion.

- The reconciliation bill reduces Medicare spending by an additional $60.5 billion to pay for new health care entitlements, and when combined with the Senate bill cuts Medicare Advantage plans by $202.3 billion.

- The reconciliation bill raises taxes by an additional $48.9 billion when compared to the Senate bill, for an overall tax increase of $573.2 billion. The bill specifically taxes investment income for individuals with incomes over $200,000 and families with incomes over $250,000. The bill also delays the implementation of the "Cadillac tax" on high-cost health plans from 2013 in the Senate bill until 2018, but lowers the inflation adjustment, so more plans will be hit by this tax over time.

- The bill increases from $750 to $2,000 per worker the "free rider" penalty, and imposes the penalty on firms' part-time employees as well as their full-time workers.

- The bill would end the Federal Family Education Loan (FFEL) program, converting all student lending to the government-run Direct Lending (DL) program. Some of the savings from this change would be used to fund new federal spending on Pell Grants and other mandatory spending for higher education, while other spending would be diverted to the bill's health care provisions.

Bill Provisions

Title I—Coverage, Medicare, Medicaid, and Revenues

Subsidies: The bill increases subsidies for health coverage, offered as refundable, advance-able tax credits payable directly to insurance companies. Specifically, the bill raises premium subsidy levels for those with incomes between 133 and 150 percent of the federal poverty level (FPL), and those between 250 and 400 percent. Individuals with incomes between 300 and 400 percent of FPL would be forced to pay 9.5 percent of their adjusted gross income on health insurance, instead of 9.8 percent in the Senate bill. The federal portion of cost-sharing would also be increased for individuals with income of between 133 and 250 percent of FPL.

The bill revises the income definitions in the Senate bill, using "modified adjusted gross income" (MAGI) instead of "modified gross income" to determine subsidy eligibility, and permitting states to disregard five percent of applicants' income with respect to determining Medicaid eligibility, effectively raising the eligibility threshold to 138 percent of FPL (up from 133 percent in the Senate-passed bill). The bill also includes an additional adjustment and trigger mechanism after 2018 to slow the growth of the premium subsidy levels. The Congressional Budget Office (CBO) has stated that "over time, the spending on exchange subsidies would therefore fall back toward the level under H.R. 3590 by itself."[1]

Increase in Individual Mandate: The bill modifies the penalty for not having health insurance that qualifies as "minimum essential coverage" from $750 or two percent of income to $695 or 2.5 percent of income, indexed for inflation after 2016. The effect of this is to shift the burden of the mandate slightly from lower income Americans to upper income Americans. *Raises $2 billion more in revenue than the Senate bill.*

Increase in Employer Mandate: The bill increases the "free-rider" penalty for businesses with more than 50 employees that do not offer health insurance and have at least one employee receiving a government subsidy for health insurance in the exchange. The penalty rises from $750 per full time employee to $2,000 per full time employee. The first 30 workers are disregarded in calculating the penalty. The bill strikes the construction industry's exclusion from the small business exemption. *Raises $25 billion more than the Senate bill.*

Implementation Funding: The bill provides $1 billion in new mandatory spending in a "Health Insurance Reform Implementation Fund" created within the Department of Health and Human Services.

[1] Congressional Budget Office score of H.R. 4872 incorporating the manager's amendment, March 20, 2010, http://cbo.gov/ftpdocs/113xx/doc11379/Manager%27sAmendmenttoReconciliationProposal.pdf, p. 12.

Medicare Part D "Doughnut Hole": The bill provides a $250 rebate in 2010 for any Medicare beneficiary who enters the prescription drug coverage gap. This flat $250 payment is not tied to a beneficiary's actual spending within the coverage gap; thus a beneficiary would receive the full $250 payment if he or she only entered the "doughnut hole" by $10. The bill also postpones the start of the prescription drug "discount" program created in the Senate bill by six months, until January 1, 2011.

The bill starts a process of closing the "doughnut hole" beginning in 2011; however, that gap will not be filled until 2020—outside the 10-year budget window. Some may view the delay as a budgetary gimmick designed to mask the true cost of this new entitlement. The bill also reduces the growth of the true out-of-pocket threshold for Part D plans, beginning in 2014.

Medicare Advantage Cuts: The bill imposes more cuts to Medicare Advantage (MA), phasing in a new system of blended benchmarks. Benchmarks will be phased in beginning in 2012, and are based on overall levels of Medicare spending, with low-cost areas receiving up to 115 percent of traditional Medicare spending and high-cost areas receiving 95 percent of traditional Medicare spending. Benchmarks are phased in over longer periods in areas currently receiving higher MA rebates. These cuts, over and above those included in the Senate bill, will further reduce access to both MA plans and the additional benefits they provide.

The bill establishes a new mechanism to increase payments to "high-quality" MA plans, even though traditional Medicare does not base its payments on quality measures. Plans receiving at least four stars on a new scorecard will be subject to bonus payments of five percent in 2014 and succeeding years, with those amounts doubled in urban markets with high MA penetration and below-average Medicare spending. The bill requires additional adjustments to MA plan payments reflecting differences in coding intensity compared to traditional Medicare—adjustments that were increased in the House manager's amendment—and repeals a comparative cost adjustment program created as part of the Medicare Modernization Act (P.L. 108-173). The bill requires MA plans to spend at least 85 percent of their premium costs on medical claims, and directs rebates from plans not meeting that threshold into a management account at the Centers for Medicare and Medicaid Services.

Other Medicare Provisions: The bill begins reductions in Medicare disproportionate share hospital (DSH) payments in 2014, rather than 2015 in the Senate bill, but lessens the overall impact of DSH reductions by $3 billion through 2019. The bill makes further market basket adjustments to inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospitals beyond those in the underlying Senate bill. The bill also accelerates and expands changes in the Senate bill regarding the presumed increase in utilization rates for imaging services, resulting in an additional $1.2 billion in savings, and adjusts the physician practice expense geographic adjustment for 2010. Finally, the bill provides a total of $400 million for payments in fiscal years (FY) 2011 and 2012 to "qualified hospitals" ranking within the lowest quartile of counties in Medicare spending.

Physician Self-Referral: The bill extends from August 1, 2010 to December 31, 2010 the implementation of a ban on new physician-owned hospitals included in the Senate bill. It also

adds a limited exception to growth caps on existing physician-owned facilities for those hospitals that treat the largest number of Medicaid patients in their county.

Medicaid Funding: The bill amends the Senate legislation to "fix" the Cornhusker Kickback, such that all states would have 100 percent of their Medicaid expansion costs paid in 2014 through 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and future years. These provisions still leave states responsible for tens of billions of dollars in unfunded liabilities through 2019—and more in the years outside of the budget window. The bill provides for a five-year transition period in 2014-2018 for "expansion states" that have already broadened their Medicaid programs to include the populations (namely, childless adults) covered under the Senate bill.

The bill provides an increase in Medicaid reimbursement levels to the prevailing Medicare rates in each Medicare fee schedule area, fully funded by the federal government—but only for years 2013 and 2014. Many may consider this "cliff" in the years following 2014 a budgetary gimmick to mask the bill's true cost, similar to the sustainable growth rate mechanism now used to calculate Medicare physician reimbursements. Some may also question whether this reimbursement bias in favor of primary care will give providers and states a greater incentive to classify their treatments as primary care, in order to receive higher reimbursements fully paid for by federal dollars.

The bill further reduces Medicaid disproportionate share hospital (DSH) payments beyond those included in the Senate bill, and establishes a payment methodology whereby the largest DSH reductions would be imposed on the states with the largest reduction in the number of uninsured individuals. The bill includes special language increasing DSH allotments for Tennessee.

Other Medicaid Provisions: The bill increases Medicaid funding for American territories, delays establishment of the "community first choice option" for long-term care services from October 2010 to October 2011, and narrows the definition of a covered drug under the Medicaid drug rebate program.

Fraud and Abuse Provisions: The bill re-defines "community mental health centers" within Medicare, and repeals a section of the Medicare statute related to prepayment medical review. The bill includes a total of $250 million in new funding for the Health Care Fraud and Abuse Control Fund, and links future increases in funding for the Medicaid Integrity Program to consumer price inflation. It also provides for a 90-day period of enhanced oversight of the initial claims of durable medical equipment (DME) providers in cases deemed a significant risk of fraud.

Tax Increases

Decrease in High-cost Plans Excise Tax: The bill delays the effective date of the high-cost plans tax from 2013 to 2018. It also raises the thresholds for what qualifies as a high-cost plan to $10,200 for singles and $27,500 for families. That number is increased by 100 percent plus another percentage point for each percentage point the cost of the Federal Employees Health Benefits Standard Blue Cross/Blue Shield plan grows over 55 percent between 2010 and 2018.

The bill strikes the transition rule for high-cost states, and indexes the thresholds after 2020 to Consumer Price Index (CPI) inflation instead of inflation plus one percent. It includes a carve-out for multiemployer plans (generally covering unionized firms) that allows single employees to qualify for higher the family threshold. *Raises $116.9 billion less than the Senate bill.*

New Tax on Investment Income: The bill imposes a 3.8 percent tax on investment income (interest, dividends, annuities, royalties, or rents, business income derived from a passive activity, and net capital gain unless derived from disposition of property held in the ordinary course of business) for singles whose MAGI exceeds $200,000 and families whose MAGI exceeds $250,000. It exempts active income from certain business ownership stakes and expenses and distributions from retirement plans. These thresholds are not indexed for inflation, so an increasing number of Americans will be subject to these investment and wage taxes over time. *Raises $123.4 billion more than the Senate bill.*

Delay Limitation of Flexible Spending Accounts by Two Years: The bill delays the effective date of the $2,500 cap on flexible spending accounts from 2011 to 2013. *Raises $1 billion less than the Senate bill.*

Increase in Tax on Pharmaceutical Industry: The bill delays the effective date of the pharmaceutical tax one year to 2011, increases the annual fee within the budget window to $4.1 billion in 2018, and increases the per-year fee in perpetuity to $2.8 billion. *Raises $4.8 billion more than the Senate bill within the budget window.*

Increase in Tax on Medical Device Manufacturers: The bill changes the annual fee with a set dollar amount to an excise tax on medical device sales of 2.3 percent of the price of the device. It then delays implementation until 2013. The bill exempts eyeglasses, contact lenses, hearing aids, and "generally purchased" goods, and eliminates the exemption for Class I devices, which are commonly used medical devices such as tongue depressors and bed pans. *Raises $800 million more than the Senate bill.*

Increased Fees on Health Insurers: The bill delays the effective date for the tax on insurance companies from 2010 to 2014. It also provides an exclusion for voluntary employees' beneficiary associations and non-profit insurers that receive more than 80 percent of gross revenue from certain government programs. It increases the annual fee to $14.3 billion in 2018, increasing annually thereafter based on premium growth. *Raises $500 million more than the Senate bill within the budget window and more outside it.*

Delay of Elimination of Deductible Part D Subsidy: The bill ends the deduction for the Medicare Part D subsidy two years later, in 2013. *Raises $900 million less than the Senate-passed bill.*

Elimination of Cellulosic Biofuel Credit for "Black Liquor": The bill uses the revenue raiser from the Senate-passed Baucus extenders bill (H.R. 4213) that prevents a byproduct from paper production known as "black liquor" from qualifying for the cellulosic biofuels tax credit. *Raises $23.6 billion over ten years.*

Codification of the Economic Substance Doctrine: The bill uses the revenue raiser from the Senate-passed Baucus extenders bill that codifies a judicial code used to determine the economic substance of a transaction for tax purposes. *Raises $4.5 billion over ten years.*

Gross Tax Increase for Health Care Bills

	Senate bill	Reconciliation Bill plus Senate bill	*Implied Effects of Reconciliation bill*
Cadillac plan tax	$148.9	$32.0	*($116.9)*
Employer W-2 reporting of health benefits	Negligible	Negligible	--
Conform definition of medical expenses	$5.0	$5.0	*$0.0*
Increase penalty for nonqualified HSA deductions	$1.3	$1.4	*$0.1*
Limit FSAs to $2,500	$14.0	$13.0	*($1.0)*
Corporate information reporting	$17.1	$17.1	*$0.0*
Requirements for non-profit hospitals	Negligible	Negligible	--
Pharma fee	$22.2	$27.0	*$4.8*
Device manufacturer fee	$19.2	$20.0	*$0.8*
Health insurer fee	$59.6	$60.1	*$0.5*
Eliminate subsidy related to Part D	$5.4	$4.5	*($0.9)*
Raise 7.5 percent AGI floor to 10 percent	$15.2	$15.2	*$0.0*
$500k deduction cap on pay for health insurers	$0.6	$0.6	*$0.0*
Medicare (HI) tax on wage and investment income	$86.8	$210.2	*$123.4*
Section 833 treatment of certain insurers (the Blues)	$0.4	$0.4	*$0.0*
Tanning tax	$2.7	$2.7	*$0.0*
Fee on health plans for Comparative Effectiveness Trust Fund	$2.6	$2.6	*$0.0*
Deny eligibility of "black liquor" for cellulosic biofuels credit	n/a	$23.6	*$23.6*
Codify economic substance doctrine	n/a	$4.5	*$4.5*
Individual mandate penalties	$15.0	$17.0	*$2.0*
Employer mandate penalty	$27.0	$52.0	*$25.0*
Effects of coverage provisions on revenues	$63.0	$50.0	*($17.0)*
Other changes in revenue	$14.3	$14.3	*$0.0*
Total	**$520.3**	**$573.2**	*$48.9*

Title II – Education and Health

Federal Pell Grants: The bill provides mandatory funding to increase the maximum Pell Grant to $5,500 in 2010 with increases up to $5,975 by 2017. Beginning in 2013, Pell Grant increases would be indexed to inflation using the CPI. *CBO estimates this will cost $22.6 billion over 10 years*.

Student Financial Assistance: The bill provides $13.5 billion in mandatory funds to partially cover the discretionary Pell Grant shortfall. Funds will remain available until September 30, 2012.

College Access Challenge Grant Program: The bill provides mandatory funding of $750 million over five years to promote partnerships between federal, state, and local governments and philanthropic organizations through matching formula grants to increase the number of low-income students who are prepared to enter and succeed in postsecondary education.

Historically Black Colleges and Universities: The bill provides mandatory funding in the amount of $2.55 billion for Historically Black Colleges and Universities through FY 2019.

Termination of Federal Family Education Loan Appropriations: The bill ensures that no funds can be expended after June 30, 2010, to support new lending activity in the Federal Family Education Loan (FFEL) program. It shifts all new loans to the federally-run Direct Loan (DL) program. *CBO estimates this will save $61 billion over $10 years.*

Federal Consolidated Loans: The bill gives temporary authority for certain borrowers who are still in school to consolidate their loans into a Direct consolidation loan. These loans would have the same terms as Direct consolidation loans except the interest rate on the underlying loans would be the applicable in-school rates and not rounded up to the nearest one-tenth. The goal of this provision is to ensure students have one servicer of their loans that could be split between the FFEL and DL program after the transition. *CBO predicts this will cost $40 billion*.

Direct Loans at Institutions Outside the United States: The bill allows foreign institutions to participate in the DL program by making arrangements with domestic banks designated by the Secretary of Education for loans to American students attending those institutions. Under current law, American students attending foreign institutions can only receive a federal loan through the FFEL program.

Contracts, Mandatory Funds: The bill provides mandatory funds and requires the Secretary of Education to award contracts to non-profit loan servicing agencies. Each eligible agency would be given a maximum of 100,000 student loans to service initially. The bill provides $50 million in mandatory funds for the Department of Education to provide technical assistance to institutions of higher education so they can switch from FFEL to DL. It also provides $50 million in mandatory funds for FYs 2010 and 2011 ($25 million each year) for payments to loan servicers for retaining jobs.

Income Based Repayment: Beginning July 1, 2014 the bill would expand the existing income-based repayment program that limits the percentage of an individual's income that goes to student loan repayment, as well as the length of time they have to pay off the loan. The provision would decrease the limit on loan payments from 15 percent to 10 percent of individual income and forgive loans after 20 years rather than 25 years. *CBO estimates this will cost $1.5 billion over 10 years*.

Insurance Reforms: The bill applies to all "grandfathered" health plans the provisions in the Senate bill regarding excessive waiting periods before becoming eligible for employer-based insurance, lifetime limits on benefits, rescissions, and coverage of dependents, and clarifies that only non-married dependents may remain on their parents' insurance policies until turning 26.

340B Program: The bill repeals the Senate bill's expansion of the program to inpatient drugs, and exempts orphan drugs from the program with respect to new participants in same.

Community Health Centers: The bill increases mandatory funding for community health centers by $2.5 billion. Neither the reconciliation bill nor the Senate-passed measures include any prohibition on community health centers using these federal funds to offer elective abortion.

Cost

According to CBO, the reconciliation bill, when combined with the Senate bill, would spend a total of $938 billion on coverage expansions. These provisions exclude other non-coverage spending: $93.9 billion in related mandatory health spending in the Senate bill; $50.3 billion in mandatory health spending in the reconciliation bill; $41.6 billion in mandatory education spending in the reconciliation bill; and at least $70 billion in discretionary spending included in the Senate bill. These bring the total cost in the bill's first 10 years to $1.2 trillion. Moreover, the Republican staff of the Senate Budget Committee estimates that the total spending in the Senate bill's first 10 years of full implementation (FY 2014-2023) would be $2.4 trillion.

To pay for the additional spending on health insurance subsidies and education, the bill would raise taxes by an additional $50 billion, and reduce Medicare spending by $60.5 billion. The reconciliation bill and the Senate bill impose Medicare Advantage cuts totaling $202.3 billion. Tax increases include $25 billion in additional revenue from the employer mandate; $23.6 billion from removing "black liquor" from the cellulosic biofuels tax credit; $123.4 billion from the new Medicare taxes on investment income—all offset by a $119 billion reduction in revenue from the "Cadillac tax" delay. The bill also includes $67 billion in savings from the abolition of the FFEL program, which is channeled into $41 billion in new education spending and $19 billion in new health care spending.

CBO found that H.R. 4872 and H.R. 3590 would provide health insurance coverage to an additional 32 million individuals 2019—half of them through Medicaid. Individuals enrolled in employer-based coverage would decline by about three million overall—six to seven million would gain access to employer coverage, but eight to 11 million would lose their offer of

coverage and/or purchase a policy elsewhere. Overall, 23 million individuals would remain uninsured, about one-third of them undocumented immigrants.

The CBO score notes that the federal budgetary commitment to health care would rise by an additional $180 billion in the next ten years under the reconciliation bill. The reconciliation bill and H.R. 3590 combined would increase the federal budgetary commitment to health care by a total of $390 billion in the 2010-2019 period. Like H.R. 3590, H.R. 4872 contains unfunded mandates that would exceed the threshold levels in the Unfunded Mandates Reform Act.

There are several important caveats in the CBO analysis. First, the long-term deficit projections "reflect an assumption that the key provisions of the reconciliation proposal [i.e. H.R. 4872] and H.R. 3590 are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the sustainable growth rate mechanism governing Medicare's payments to physicians has frequently been modified to avoid reductions in those payments, and legislation to do so again is currently under consideration by the Congress."[2]

Second, the "reconciliation proposal and H.R. 3590 would maintain and put into effect a number of policies that might be difficult to sustain over a long period of time. Under current law, payment rates for physicians' services in Medicare would be reduced by about 21 percent in 2010 and then decline further in subsequent years; the proposal makes no changes to those provisions. At the same time, the legislation includes a number of provisions that would constrain payment rates for other providers of Medicare services. In particular, increases in payment rates for many providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care)."[3]

[2] Ibid., pp. 13-14.
[3] Ibid., p. 14.