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Implementation Timeline for the Government Takeover of Healthcare: H.R. 3590 and the Reconciliation Package

(Black ink indicates the timeline of H.R. 3590 while blue indicates the timeline of H.R. 4872)

2010

- **Effective immediately, the de facto elimination of the private individual market:** 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.

- **"Immediate access to insurance for uninsured individuals with a pre-existing condition" through a *national* high risk pool** established by the Secretary of HHS 90 days after enactment. *This is virtually the same Republican idea (state–based) that Democrats trashed as not providing coverage for pre-existing conditions.*

- **Certain Medicare cuts begin.**

- **Temporary small business tax credit ($37 billion)** that, according to the Chamber of Commerce and NFIB, will do little to make purchasing insurance affordable for more small firms.

- **Eliminates pre-existing condition exclusion for dependent children (under 19 years of age).**
  - Beginning 6 months after enactment for all plans (including employer plans). This provision will apply to all people in 2014. *The main concern is the language will still allow insurance companies to deny coverage to children with pre-existing conditions, as the statute only states insurance companies cannot drop coverage for children with pre-existing conditions.*

- **Prohibits rescission of insurance for all plans** *(already prohibited by HIPAA in most cases).*
  - Beginning 6 months after enactment for all plans (including "grandfathered" plans).

- **Requires all group and individual market plans to institute an "effective" appeals process.**
  - Beginning 6 months after enactment for all plans.

- **Eliminates lifetime limits and restricts use of annual limits for small group and individual plans.**

- Beginning 6 months after enactment, this provision ends lifetime limits for all plans (including "grandfathered" plans) and restricts annual limits for group plans (eliminated entirely in 2014 for all group plans).

- **"Children" permitted to stay on their parents' insurance policies until age 26.**
  - Beginning 6 months after enactment for all plans (including "grandfathered" plans).

- **Prohibits plans in the small group and individual market from charging co-pays for preventive care services rated A or B by the U.S. Preventive Services Taskforce (USPSTF).**
  - Beginning 6 months after enactment.

- **Creates a temporary "Reinsurance" subsidy program for retirees established by the Secretary of HHS** 90 days after enactment for health benefits provided to 55-64 year old retirees and their dependents. *Some conservatives may be concerned that unions and state agencies or political subdivisions were included in the definition of ''eligible employment-based plan.'' to buy off states and unions whose rich benefits are costly but must be maintained due to contracts or law.*

- **Reduces the Part D "Donut Hole"** by $500 and requires a 50% brand name drugs and biologics discount when beneficiaries fall into the coverage gap. Applies means testing to Part D such that "wealthy" seniors ($85,000/$170,000) will begin to pay higher premiums in 2011.
  - Beginning in 2010, provides a $250 rebate to Part D enrollees who enter the "donut hole."
  - Beginning in 2011, provides a 50% discount on all brand name drugs in the donut hole and begins phasing in additional discounts on brand-name and generic drugs.

- ***$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 July 1, 2010.

- ***$0.4 billion*** **health organization tax increase** from prohibiting non-profit BCBS organizations from taking a special deduction under Internal Revenue Code (IRC) Section 833, including the deduction for 25% of claims and expenses and the 100% deduction for unearned premium reserves unless they have a medical loss ratio of at least 85%.

- **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.

- **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.

- **Establishes the Patient Centered Outcomes Research Institute (PCORI), a non-profit corporation, to conduct comparative effectiveness research (CER).** PCORI will replace the Federal Coordinating Council, created in ARRA of 2009. The bill will allow 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. *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.*

- **New federal rate review:** 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." *This federalized regulation over health insurance price increases could result in federally mandated price fixing that could further accelerate and eventually destroy the private insurance market.*

- **Prohibition on Physician-Owned Hospitals (POHs):** Places a moratorium on new POH if it does not have a provider agreement to participate in Medicare in place by August 1, 2010 and places a de facto prohibition on the growth of existing facilities.
    - Delays the Date by which POHs must have a provider agreement in place to participate in Medicare from August 1, 2010 to December 31, 2010. Adds language, added to the House bill in the Manager's amendment 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.

- **Physician Medicare payments decrease 21% effective April 1, 2010 without further congressional action.**

2011

- **Long term care entitlement program, the "CLASS Act:"** Creates a government-sponsored long term care insurance program that would automatically enroll individuals unless they actively opt-out. *This provision is another unsustainable program being used to disguise the short-term costs of the broader bill through a budget gimmick.*

- **$118 billion in cuts to Medicare Advantage (plus $16 billion in interactions):** Starts the transition to competitive bidding in order to cut payments to Medicare Advantage plans. *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.*
    - The reconciliation bill would increase the cuts to Medicare Advantage by $17.5 million (to $135.6 billion) and Medicare Advantage interactions by $53 billion (to $70.3 billion), freeze payments to MA plans in 2011 to 2010 levels and phase in cuts beginning in 2012. Bases 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.

- **Prohibits cost-sharing for Preventative Services in Medicare.**

- **Tighter insurance restrictions on Medical Loss Ratio (MLR):** Requires all insurers both before and after establishment of the Exchanges to have a MLR of 80% in the small group and individual market and 85% in the large 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. *Some conservatives may be concerned 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.*

- ***$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 2010.
    - Beginning in 2011.

- ***$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** from subjecting non-qualified distributions from HSAs to a tax of 20% on the disbursed amount (current law is 10%), beginning in 2011.

- **Secretary of HHS must established Internet portal to provide information on coverage options.**

2012

- ***Raises taxes by $17.1 billion*** through expanding of 1099-MISC information reporting to corporations beginning in 2012.

- **Establishes Accountable Care Organization, Hospital value- based purchasing payment system and Medicare payment penalties for hospitals with the highest readmission rates for selected conditions.**

2013

- ***$210.2 billion* Medicare payroll and investment income tax increase:** 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 will hit more of the middle class.
    - Adds an additional 3.8% tax on net investment income for these same individuals, estates and trusts. 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 and any item taken into account in determining self-employment income.

- ***$19.2 billion* tax increase:** Imposes an annual non-deductible tax on medical devices manufacturers with sales of $5 billion or less. Exempts all Class I products and Class II products that are sold to mainly to consumers and are under $100.

- ***$20 billion* Tax Increase:** Moves the tax on medical devices manufactures and importers back two years from 2011 to 2013 and changes it to an annual 2.3% excise tax while simultaneously expanding taxable items to Class I medical devices (in addition to Class II and III).

- ***$13 billion* FSA tax increase:** Places an annual cap of $2,500 on FSAs indexed to CPI-U, 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.
  - Beginning in 2013.

- **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). 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.
  - Beginning in 2013.

- ***$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 after 2012 for services performed after 2009.

- ***$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.

- ***2.6 billion* CER tax increase:** Places a new tax on insurance policies to fund the Patient-Centered Outcomes Research Trust Fund but provides 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).

- **Temporary primary care physician payment increase:** The bill also employs a budget gimmick whereby it increase 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.*

2014

- ***$59.6 billion* health insurer tax increase:** Imposes an annual, non-deductible tax on health insurers, allocated based on market share of net premiums.
  - ***$60.1 billion* Tax Increase:** Moves the tax back three years to **2014**. 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.

- **Insurance market Reforms:** The bill requires all individual and small group plans to comply with new federal regulations. 6 months after enactment all plans must provide for guarantee issue and renewability, prohibit the exclusion of pre-existing conditions, and ban lifetime and annual limits as well as comply with federal rating rules: 3:1 community rating based on age, family structure, and geography, 1.5:1 based on tobacco use.

- **Establishes health insurance Exchanges in each State and requires all plans to abide by a minimum benefit standard, cost-sharing restrictions, and cap on out-of pocket expenses.**

- **CO-OPS are established.** The OPM will run, oversee, and "negotiate" with new "Multi-State" plans offered in State Exchange and available nationwide. *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.***

- **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.

- **Implements a $17 billion tax increase due to the individual mandate:** The penalty is tied to the higher of flat dollar amount ($750 for 2016) or 2 % of taxable income up to the national average of the "Bronze" (lowest value) plan premium. Individuals are exempt from the mandate if premiums for the lowest cost plan available exceed 8% of their income. *In addition to being unconstitutional, an individual mandate necessitates a government definition of acceptable health care coverage.*
    - The reconciliation bill lowers the flat dollar tax penalty to $695 for an individual while also raising the percent of income that is an alternative payment amount from 2% to 2.5% of taxable income. 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).

- **Implements a $52 billion tax increase due to the employer mandate:** The bill requires employers with over 50 employees to offer coverage for pay $750 for each employee who receives a subsidy in the Exchange and levies a penalty tax for those that do offer coverage but it is deemed "unaffordable" (more than 9.8% of income). Contains a provision to hurt small non-union construction firms as firms with more than 5 people are not exempt from the mandate. *The National Federation of Independent Businesses estimates this mandate will result in 1.6 million job losses between now and 2013.*
    - 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 and 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 to a flat $3,000 per employee. Includes part-time workers for purposes of the determining the employer's status as a "large business". Removes the penalty on construction companies.

- **Premium tax credits become available for "low-income" individuals and families from 133% FPL to 400% FPL** but can only be used to purchase coverage in their state Exchange, thus driving people out of "grandfathered" plans and into government approved plans.
    - Increases subsidies by $15 billion (to a total of $464 billion) so that individuals receive more generous credits as the portion of income they must pay for health care before the credit kicks in is lowered.

- **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). Upon enactment, the bill further requires states to do "maintenance of efforts" for current Medicaid and CHIP eligibility.
    - 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 it does remove 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 so that the state share of the costs of covering non-pregnant childless adults by 50% in 2014 phasing up to 90% in 2018.

- **Small business tax credit.** Allows for two additional years of tax credits if small businesses participate in the Exchange.

- **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.

2015

- **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. 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.

2018

- **$148.9 billion "Cadillac tax" increase:** Imposes an excise tax of 40% on insurance companies and plan administrators for any health insurance plan that is above the threshold of $8,500 for singles and $23,000 for family plans Includes higher thresholds for "high-risk professionals" and "high cost" states.
    - Delays 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, raising taxes by $32 billion

(down from $148.9 billion). Includes additional carve-outs for retirees, and the cost of vision or dental plans and individuals with "self-only" coverage under a collectively bargained (union) health plan (including state and local government employees) so that they receive s family coverage exemption ($27,500 as compared to $10,200 for non-union workers).

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