

**Legislative Bulletin.....March 21, 2010**

**Contents:**

**H.R. 4872–The Health Care & Education Affordability Reconciliation Act of 2010**

**UPDATED**

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**Key Conservative Concerns**

*Take-Away Points*

*(The following outlines concerns with the Senate bill as changed by the Reconciliation bill)*

- ! -- **Raises Taxes:** The bill increases taxes by \$569.2 billion over ten years. This will harm small businesses and middle-class families. 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, but instead to create new entitlement programs.
- ! -- **Cost to Taxpayers:** The total cost of Senate bill with the changes in the reconciliation bill is nearly \$1.2 trillion (not including the \$371 billion “Doc Fix” proposed in the President’s budget). Furthermore, when including the 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. Finally, the bill costs \$2.64 trillion counting just the first ten years after full implementation.
- ! -- **Government Takeover:** The bill is a dramatic step away from personal, private coverage and choice, to a Washington-controlled healthcare system that rations care, limits choice, and reduces quality, innovation and competition.
- ! -- **Unconstitutional:** The U.S. Constitution and the principle of limited government are tested with the requirement that Americans purchase “acceptable” health care coverage or face a tax of 2.5% of modified adjusted gross income. The definition provided in the bill for “acceptable” coverage will surely force some Americans to purchase plans that include coverage they cannot afford, or don’t want or need.

- **Illegal Immigrants:** The bill fails to adequately address citizen verification for individuals applying for low-income affordability subsidies, or enrolling in Medicaid/CHIP, or enrolling in high risk pools.
- **Funds Abortions:** The bill permits federal funds to be spent on abortion services.
- **Lack of Medical Liability Reform:** Trial lawyers get off scot-free as Democrats pay lip service to real medical malpractice reform. Virtually no changes occurred from the insufficient medical liability provisions as passed in the Senate bill.
- **Forces Americans Out of Current Plans:** The government-run plan will force tens of millions out of the coverage they currently have. Even “grandfathered” plans are not safe.
- **Increases Premiums:** The Democrats’ health care plan will increase premiums by 10-13%. As JCT, CBO, and six other studies have shown, imposing new taxes on insurance policies, health care products, and various new insurance regulations will be drive up the cost for patients of all ages in the form of higher premiums.
- **Increases Personal Health Expenditures:** The Office of the Actuary (OACT) at CMS predicts overall national health expenditures under the Senate bill due to various regulations will jump by 0.6% or \$222 billion (if Medicare cuts are allowed to occur, which CBO has doubts about).
- **Bends the Curve in the Wrong Direction:** According to CBO “under the legislation, federal outlays for health care would increase during the 2010–2019 period, as would the federal budgetary commitment to health care.” CBO estimates that the federal commitment under the Senate bill would increase by \$210 billion while the combine effect of the reconciliation bill and Senate bill would be a staggering \$390 billion increase.
- **Constitutes a massive, permanent government takeover of the private student loan industry –** Liberals have been trying to achieve this goal since the early-1990’s, when the Direct Loan program (the government-run program) was created. This student loan bill has no place in a healthcare bill. The only reason that Democrats are placing the student loan provisions into the reconciliation bill is because they do not have 60 votes in the Senate to pass it on its own.
- **Choked Full of Special Deals:** The bill includes new backroom deals for to buy-off the votes of a few members in rural districts and old favorites such as the “Louisiana Purchase,” various provisions still part of the “Cornhusker kickback,” carve outs for unions, and many more.
- **Does not factor in market risk regarding defaults on student loans:** The CBO score for the student loan portions of the bill does not fully account for the cost of market risk (inevitable defaults on loans). Adjusting for the cost of market risk will increase the cost of the bill..
- **Potentially eliminates over 30,000 jobs:** The bill will eliminate the jobs of those involved in the private student loan industry.

*For more details on these concerns, see below.*

## **H.R.4872 — The Health Care & Education Affordability Reconciliation Act of 2010 (*Spratt, D-SC*)**

**Order of Business:** The bill is scheduled to be considered on Sunday, March 21, 2010. The rule provides for two separate votes. The first vote would be on the motion to concur with the Senate amendments to the “Patient Protection and Affordable Care Act” (H.R. 3590) and the second would be a vote on the reconciliation bill, the “Health Care & Education Affordability Reconciliation Act of 2010” (H.R. 4872). The rule would provide for two hours of debate total for both bills.

If the Senate bill passes, it shall be in order to consider the reconciliation bill under a closed rule, waiving all points of order except those arising under clause 10 of Rule XXI (PAYGO). The rule includes a Manager’s Amendment, which would be self-executed, waiving all points of order. Finally, the rule provides for one Motion to Recommit for the reconciliation bill.

Additionally, the rule specifies that until the completion of the first three sections of the resolution the Chair may decline to entertain any intervening motion, resolution, question, or notice as well as the question of consideration. The Chair may postpone proceedings until such time as determined by the Speaker. Finally, the second sentence of clause I (a) of rule XIX shall not apply.

If the Senate bill passes the House it will be sent straight to the President for signature with no assurances that the Senate would pass the reconciliation bill.

The Manager’s Amendment to H.R. 4872 would make a number of changes to the bill that are highlighted below.

### **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:** Specifically the proposal increases cuts Medicare Advantage plans and raises the Medicare payroll tax even higher (adding it to a tax on “unearned” income in addition to a tax on “high income individuals”).
- **New bureaucratic boards that cede the definition of quality and gives more power to the federal government:** Maintains provisions such as the comparative effectiveness research board, the Patient Centered Outcomes Research Institute, the Independent Payment Advisory Board IPAB (or “MedPAC on steroids”), and more.
- **A form of a government-run plan:** The proposal maintains 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 the 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.”
- **“Rocky Top Vote Swap”:** The bill now 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.
- 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 or restored by President’s rewrite of the Senate bill.
- **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 23% SGR cut goes into effect in 2011.
  - **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 following FY2029.
- **Does Not Bend the Cost Curve:**
  - According to CBO the Senate bill increased 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 just the alone Senate bill 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) would be 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 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 new powers in the Secretary of HHS and a new bureaucratic board to regulate and block rate increases. The new board is 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 be 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 gross cost of coverage as \$938 billion. 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 will actually end up costing **\$2.64 trillion** 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 means it very likely 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:** The bill increases taxes by **\$569.2 billion**—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). 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** 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.
- **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).
- **Corporate Timing Tax Shift Gimmick:** This provision would apply a 15.75 percentage point corporate tax timing shifts to corporations. 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.
- **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 tax increase:** Beginning in 2013, the bill increases 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.**
  - The bill 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 (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 tax increase:** Replaces the “botax” or excise tax on elective cosmetic surgery with a new excise tax starting in 2010 (10% of the amount paid for the service by the customer) on indoor tanning services.
- **\$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. 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 tax billion increase:** Excludes non-prescription medications from being purchased with pre-tax dollars beginning in 2011.
- **\$1.4 billion in 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.
- **\$13 billion 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 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 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 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 professional,” retirees, and the cost of vision or dental plans.
- **\$27 billion 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 tax increase** from modifying section 833 treatment of certain health organizations beginning in 2010.
- **\$0.6 billion 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 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.”

## **Title I – Coverage, Medicare, Medicaid, and Revenues**

### **Subtitle A – Coverage**

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 imposes new costs on businesses, which in turn makes it less likely that they will be able to create new jobs. 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.

- The 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 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 have to pay if an employee receives a premium credit from 400% of the payment amount to a flat \$3,000 per employee.
- 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 and insufficient small business tax credit.

**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.
- The reconciliation bill lowers the flat dollar tax penalty established in the Senate bill from \$750 to \$695 for an individual, and \$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, to those with income levels below the filing threshold (for the appropriate family size).

**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 receive a 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.

**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 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.

**Other Changes:**

- Modifies income definitions so that Medicaid and CHIP among other program 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.
- Adds information requirements for helping to determine excess payments made for individuals’ coverage in the exchange.
- 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: for 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.

**Subtitle B – Medicare**

**Increased Medicare Cuts:**

- 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, 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. The amendment allows these certain hospitals to grow if they:

- Have an annual percent of Medicaid admissions that (as determined by the Secretary) is greater than such a percent with respect to admissions for any other hospital in the country;
- Do not discriminate against beneficiaries covered under Federal programs (Medicaid, Medicare, etc); and,
- Meet other conditions set forth by the Secretary. This is four fewer conditions than placed on all other specialty hospitals.

**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). 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 manufactures' 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 \$14.7 billion so that total expected cuts will be \$13.3 billion.
- 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).

### **Subtitle C – 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). 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).**

- Despite vocal state opposition, the proposal 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. The expansion states beginning in 2019 will bear the same cost share of covering non-pregnant childless adults (new eligibles) as other states.
- **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.

**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.
- Some conservatives may see this new gimmick as just another SGR - a 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.

**Other Provisions:**

- Decreases the DSH cuts by \$4 billion dollars (total cuts are now at \$14 billion for the ten year budget window).
- Moves up the cuts one year to 2014, reducing the rate to minus 1.5 percentage points to minus 0.1 percentage points for FY 2014, and minus 0.2 percentage points for each of FY 2010, 2016 and 2017 – 2019.
- The bill provides \$1 billion in funding for territories that elect to establish an Exchange and increases Medicaid funding to territories by \$2 billion (up to \$7.3 billion).
- The bill imposes a one year delay in Community First Choice Option resulting in \$900 million in additional savings (up to \$6 billion). The program allows states to add home and community based long-term care services in their Medicaid programs for institutionalized or low-income beneficiaries.

**Subtitle D – Reducing Fraud, Waste and Abuse**

The bill deploys various additional program integrity provisions saving \$1.3 billion and authorizes \$200 million in additional funding to combat fraud, waste and abuse for FY 2011 - 2016. Those provisions include:

- The Reconciliation bill added to the definition of community mental health center that provides partial hospitalization services so that it must provide “a significant share” of its services to non-Medicare beneficiaries. The Manager’s amendment changes this definition from “significant share” to “at least 40%.”
- Repeals current law which allows a Medicare administrative contractor to conduct random prepayment review in order to develop a contractor-wide claims payment error rate.
- The Manager’s Amendment removed the provision that would have established a CMS-IRS Data Match to identify fraudulent providers. The IRS would have been required to share data on Medicare providers that have serious delinquent debt and allows CMS to use the information to not renew their billing privileges and recoup unpaid taxes from their Medicare reimbursement.
- Beginning in 2011, the bill requires CMS to withhold payment from DME providers if the Secretary determines that there is a significant risk of fraudulent activity.

Some conservatives may believe that before creating new government programs and expanding current fraud-ridden entitlement programs such as the Medicaid program, Congress should focus on reducing fraud in existing government programs.

## **Title II – Education and Health**

### **Subtitle A – 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 to service 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.

### **Subtitle B – Health**

**Insurance Reforms:** The President’s proposal would require “grandfathered” plans to do the following:

- Six months after passage the bill would prohibit all plans from practices such as the rescission of insurance, excessive waiting periods, and life-time limits. The bill also requires that “young adults” be allowed to stay on their parents’ insurance plan until age 26.
- Beginning in 2014, prohibits practices by group plans such as pre-existing condition exclusions and annual limits.

**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.

**Community Health Centers (CHC):** Increases mandatory funding for CHCs beginning in 2011 through 2015 by a total of \$2.5 billion.

### **Other Problematic Provisions NOT removed in the bill**

**CLASS Act:** It still contains the new unsustainable long-term care entitlement program – the CLASS Act, which faced major opposition from Senate Democrats, including Senator Conrad, the Chairman of the Budget Committee, who called it a “Ponzi Scheme”. The CLASS Act, would create a government-sponsored long term care insurance program that would automatically enroll individuals unless they actively opt-out. This amounts to a federal take-over of the private long-term health insurance system.

- Individuals would pay premium levels set by the federal government (estimated to be \$123/month on average) in exchange for a \$50-a-day benefits to cover the cost of care. However, an individual must first pay into the program through premiums for 5 years before they can receive any benefits. This means that the program would not pay anything out until 2016. Furthermore, the \$50-a-day allocation for long-term care insurance is only a portion of the actual cost of long-term care for seniors. The CLASS Act would only add confusion about Medicare coverage of long-term care without covering the true cost of care. This may cause seniors to drop their current coverage.
- The CLASS Act is another unsustainable program being used to disguise the short-term costs of the broader bill through a budget gimmick. According to the CBO, the CLASS Act would raise \$72 billion over the first ten years in the Senate bill (while paying out \$0 in benefits for half of that time), but will begin to increase the deficit following FY2029. A group of seven Democrat Senators stated in a letter to Senate Majority Leader Reid, “We have grave concerns that the real effect of the

provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues. This is especially the case if savings from the first decade of the program are spent on other health reform priorities.”

- Numerous organizations have raised concerns with the CLASS Act, 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. **Some conservatives may be concerned that this is another unsustainable program being used to disguise the short-term costs of the broader bill through a budget gimmick.**

**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.

**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.**

**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.

**Committee Action:** The original “shell” reconciliation bill was referred to the House Committees on Budget and reported out by a vote of 21-16 with two Democrats joining all Republicans to vote against the bill on March 15, 2010. H.R. 4872 was introduced on March 17, 2010.

**Does the Bill Expand the Size and Scope of the Federal Government?:** Yes, the bill provides \$1.2 trillion over 10 years in new mandatory spending. In general, the bill expands the number of eligible individuals for government programs, creates new federal grants and programs, and creates federal mandates and benefit levels for insurance, among other items. The bill increases taxes by more than \$500 billion over ten years. The bill also includes a back-door to a federal takeover of health care in America.

**Does the Bill Contain Any New State-Government, Local-Government, or Private-Sector Mandates?:** Yes. CBO and JCT have determined that the Senate bill which the reconciliation bill amends contains several private-sector and intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The total cost to the private-sector of those mandates, as estimated by CBO and JCT, would greatly exceed the threshold established in that act for private entities (\$141 million in 2010, adjusted annually for inflation). CBO estimates that the total cost of intergovernmental mandates would not exceed the annual threshold established for state, local, and tribal entities (\$70 million in 2010, adjusted annually for inflation). However, among other things, the legislation would increase the obligations of state budgets by requiring an additional \$20 billion over ten years.

**Does the Bill Comply with House Rules Regarding Earmarks/Limited Tax Benefits/Limited Tariff Benefits?:** There is no committee report citing any potential earmarks.

**Constitutional Authority:** There is no committee report citing constitutional authority available for H.R. 4872.

**Outside Groups:** A full list of groups opposed to the bill will be provided in a separate document.

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