

November 19, 2009

MEMORANDUM

FROM: Michael Hammond

RE: The Reid Bill: The Mandates, Public Option,
Regulation, Rationing, and Taxes

EDITOR'S NOTE

Harry Reid's objective has been to secret the provisions of the most important piece of legislation in our lifetimes until he could cram it down Americans' throats because there was insufficient time to analyze and mobilize against it. To some extent, he has succeeded. I have done what I could, given the need to disseminate this at least a day before the Senate moved to cloture on the motion to proceed. I have therefore focused on the mandates, the public option, regulation, rationing, and taxes.

THE NUMBERS

-Cost:

-Reid's phony number: \$847 billion

-Including \$247 billion
in costs passed in
separate legislation or
achieved in phony
regulatory fixes: \$1.094 trillion

-Including both the
\$247 billion "doc fix"
and \$465 billion in phony
Medicare cuts which no
one believes will be
made: \$1.569 trillion

-For the first ten years
when the bill actually
goes into effect: about \$2.5 trillion

-Deficit:

-Reid's phony number: -\$127 billion

- Including \$247 billion in costs passed in separate legislation or achieved in phony regulatory fixes: +\$120 billion
- Including both the \$247 billion "doc fix" and the \$465 billion in phony Medicare cuts which no one believes will be made: +\$585 billion
- Medicare Cuts: \$465 billion
- Tax Increases: \$376 billion+++

SUMMARY

- This bill would require virtually every American to have -- not just insurance -- but the type of insurance approved by the Obama administration. The cost of this insurance is projected by PriceWaterhouse to be \$25,900 for a family policy by 2019. This is dramatically more than the premiums if Congress did nothing, with the only difference being that you would be required to pay the inflated premiums, under penalty of fine and, ultimately, imprisonment.
- You would almost certainly not be allowed to keep the insurance and providers you currently have. Virtually all of the 10.2 million seniors on Medicare Advantage would lose care. Virtually all non-unionized employers would find it in their economic interest to dump their employees onto the exchange. States would have a strong economic incentive to dump Medicare recipients onto the exchange. And the individual and employer "grandfather" clauses are full of holes.

SPECIFICS

IMMEDIATE CHANGES: Section 1001 would prohibit giving different types of benefits, based on the ability of employees to afford them and therefore would make it illegal for more highly compensated employees to opt for premium plans (section 1001, as inserted into section 2716 of the Public Health Service Act (hereafter "PHSA")).

Section 1001 also bans lifetime limits on coverage or annual limits on coverage exceeding statutory limits, thereby outlawing the cheap plans which many young, healthy Americans prefer.

Every customer who does not get a summary of benefits which precisely complies with section 1001 could result in a fine of up to \$1,000 per customer.

Section 1001 (section 2717 of the PHSA) requires the HHS Secretary to set "reporting" standards dealing with "health care provider reimbursement structures" which would --

- "improve health outcomes through implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives..."

"implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional..."

- "implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology..."

All of these provisions seem to be a wide-open invitation to regulations implementing health care rationing, in the guise of reporting requirements.

Section 1201 (inserting section 2705 into the PHSA) and 1001 (section 2717(a)(1)(D) and (b) of the PHSA) create wellness programs which allow consideration of behavioral issues in setting premiums and, presumably, determining

activities which are so dangerous that coverage might be suspended. The definition of "wellness" includes some very broad issues, including obesity and "lifestyle." But even these broad categories are not exclusive and do not prohibit, for example, the consideration of firearms ownership. Section 1201 specifically prevents consideration of the health of a person for purposes of setting rates, but, for any other "health status factor," premiums can vary by up to 30%, which may be increased to 50% under the discretion of the HHS Secretary. A "reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan." The "wellness" program qualifies under this section if it "has a reasonable chance of improving the health of ... participating individuals."

The Reid bill (section 2718(b) of the PHSA) requires a rebate if, in any given year, private premiums exceed medical payments by a given percentage.

Under section 2794 of the PHSA, the HHS Secretary would review "unreasonable" insurance premiums and can require insurers to "justif[y]" their rates.

By prohibiting the consideration of preexisting conditions (section 1101) and severely limiting the ability of Americans to buy cheap policies with high deductibles and copayments, the bill insures that the cost of insurance will go through the roof. This is particularly ironic because the ostensible reason for the bill is the escalating health care premiums -- and the effect of the premium increases on small business.

Section 1101 of the bill sets up "high risk pools." The initial "high risk pools" will supposedly cost \$5 billion. But, in an unusual provision, the Secretary is authorized to somehow "make adjustments" "for any fiscal year [in which there are insufficient funds]."

Section 1102 would spend \$5 billion on reinsurance for employment-based plans for people who are part of one of those plans and who retire prior to 55 -- a provision which, I'm guessing, was a payoff to labor unions.

Section 1104 gives the HHS Secretary the authority to promulgate broad rules with respect to "electronic standards." Subsection (b)(2), for example, amends the Social Security Act to require the Secretary to "adopt a single set of operating rules ... with the goal of creating as much uniformity in the implementation of the electronic standards as possible." The same section goes on to require health plans to certify, in writing, "that the data and information systems for such plan are in compliance with any applicable standards..." It goes on to provide that a health plan is not in compliance unless it "demonstrates to the Secretary that the plan conducts the electronic transactions ... in a manner that fully complies with the regulations of the Secretary..." Furthermore, anyone who provides services to a provider must comply as well. Again, the section requires health plans to certify to the Secretary "in such form as the Secretary may require, ... that the data and information systems for such plan are in compliance with any applicable revised standards and associated operating rules..." The Secretary is authorized to conduct "periodic audits" to insure this is so, and substantial penalties are provided for.

GRANDFATHER CLAUSE: The language of the grandfather clause is interesting: Section 151(a)(1) provides: "Nothing in this Act ... shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage..." Not to quibble, but this is different from saying that the grandfathered plan satisfies the mandate. Furthermore, grandfathered plans are exempted from Subtitles A and C, but neither contains the mandate.

Section 1251(d) specifically grandfathers health benefits offered pursuant to collective bargaining agreements.

MANDATED COVERAGE: Subtitle D defines the "qualified health plan" which Americans must have, under penalty of law. It must have "in effect a certification ... that such plan meets the criteria for certification described in section 1311(c)." (Section 1311(c) says: "The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans.") The mandated plan must also include statutorily mandated benefits [section 1302(a)], including mental health parity, "behavioral health treatment," preventive care (including

gym memberships), and pediatric dental care. And these statutory requirements are not exclusive, and section 1302(b)(4)(G) lays out a variety of generalized considerations which the HHS Secretary would use to set and revise benefits which Americans would be required to pay for. Subsection 1302(c) would limit deductibles and copayments. Subsection 1302(d) would set "levels of coverage," but the levels would be based wholly on financial issues such as the levels of deductibles. With the exception of a young person under 30 who obtained a hardship certification from the government or who could not buy "affordable" coverage (section 1302(e)), a healthy person could not buy catastrophic coverage, or coverage that forced him to pay for "services" (such as maternity services) that he did not need or want, or coverage that forced him to subsidize persons whose lifestyle choices had made them very sick.

ABORTION: Section 1303 sets out the rules for funding abortion. The public option would be required to fund abortions for any abortion which was allowed by the Hyde amendment, as it existed for the six previous months. Thus, if the Hyde amendment were amended to provide abortions in "health of the mother" cases (i.e., abortion-on-demand), the public option would have to provide abortions in those cases without any accounting artifices whatsoever. However, by segregating private and public funds, the HHS Secretary can allow the public option to immediately fund all abortions, including third trimester and partial birth abortions. We have seen, in connection with section 1008 of the Public Health Services Act, that Planned Parenthood is experienced in setting aside one room for abortions and another room in the same building for condoms -- and claiming that the condom money is not being used for abortions. In addition, for the first time in American history, under section 1303(a)(1)(D), the federal government will become a guarantor that abortion coverage is available to everyone in the country. Persons receiving subsidies would be subject to the same phony segregation rules. There is "non-state-and-federal preemption" language in section 1303(b) which is of dubious value. State parental consent laws could not be overturned, but state laws requiring abortion coverage also could not be preempted. Current conscience protection would not be affected, but it is far from clear that it would be extended in the way that would be required to cover the new applications created by this law. Finally, Title VII of

the 1964 Civil Rights Act would be explicitly grandfathered. Liberals have argued for some time that failure to provide abortions in cases where other medical services are funded constitutes discrimination on the basis of sex under that statute.

MEDICAID: Would be expanded to cover those earning up to 133% of the federal poverty level.

RATIONING: The central mechanism for rationing medical care among non-Medicare-covered individuals is section 1311(c), which says: "The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans." This open-ended grant of authority would allow the Secretary to write into "certified" policies a limitation on benefits in cases where treatment is not regarded as complying with "best practices." Other sections are even more explicit: Section 1311(g) sets up a "strategy" to save money through, inter alia, "the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices." Finally, there are the \$465 billion in Medicare cuts. Although the bill pretends that reductions in benefits and eligibility will be prohibited, it is unrealistic to assume that a Congress which cannot carry through with a 1997 commitment to cut the increase in doctors' reimbursements by \$247 billion will be able to comply with \$465 billion in cuts. The result will be "rationing by underpricing." The chief actuary for Medicare and Medicaid predicts that hospitals and providers will not treat persons at the levels of reimbursement which will result from this bill.

Sections 1321 et seq. provide various mechanisms for state "flexibility," but, by and large, apply only to states that are willing to throw even more money away than the statute requires.

Section 1331 would give the states "flexibility" to establish basic health programs for low-income individuals not eligible for Medicaid because they earn between 133% and 200% of the poverty level. On a related issue, one conservative think tank has found that virtually all 50 states would find it to their financial benefit to dump all of their Medicaid beneficiaries into the exchange. Although the CBO has not scored this eventuality, estimates

are that it would increase costs of the program by \$2 trillion.

Section 1333 is a nod to GOP calls for interstate sales of insurance, but it applies only in accordance with open-ended HHS regulatory authority to limit it and only if licensed in each state.

Section 1401 sets up a "refundable" health tax credit (which means that the government sends a check to people who otherwise have no tax liability). The credit equals "the excess ... of the adjusted monthly premium ... over 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year." The applicable percentage is "2.8 percent, increased by the number of percentage points (not greater than 7) which bears the same ratio to 7 percentage points as the taxpayer's household income for the taxable year in excess of 100 percent of the poverty line for a family of the size involved, bear to an amount equal to 200 percent of the poverty line for a family of the size involved." This is the easy part. The credit, which is supposedly intended for low-income, relatively uneducated Americans, goes on with 26 more pages of special rules and definitions.

Section 1402 reduces copayments, deductibles, etc., for persons earning less than 400% of the poverty level, in accordance with a sliding scale.

Section 1421 et seq. create s "small business tax credit" for employers with fewer than 25 employees. Under these provisions, a small business can supposedly deduct 50% of the exorbitant forced premiums required by this bill. If the average annual wage is over \$40,000, the employer could not benefit from this section. If the average annual salary is below \$40,000 (and the average cost of a family policy is, as PriceWaterhouse estimates, \$25,900 by 2019), this would still mean that the cost of the bill to small employers would be over 1/3 of the employees' gross pay.

Section 1501 would require virtually everyone in the country to have -- not just insurance -- but government-approved insurance. The statute justifies this by a 1944 case [*U.S. v. South-Eastern Underwriters Association*] holding that "insurance is interstate commerce subject to Federal regulation." Of course, the question of whether

"insurance" is interstate commerce is different from the question of whether not buying insurance (i.e., not doing anything) is interstate commerce. Furthermore, there is the question of whether a legally forced payment which is used to provide for the health care of others is a tax -- a tax not imposed by Congress, as required by Article I, Section 8, but imposed by bureaucrats and private parties -- and whether, furthermore, it is a capitation tax not commensurate with the census and not authorized by the Sixteenth Amendment. If the individual fails to comply, he will be subject to an IRS-administered fine, which, by 2017, will be \$1,500 for a married couple, indexed for inflation (\$2,250 for a married couple with a dependent 19 year-old). And, if the individual fails to pay the fine, because, for example, he cannot afford either the premium or the fine without selling his house or his business, he can be sentenced, notwithstanding the Schumer amendment, to up to \$250,000 in additional fines and up to five years in prison. There is an exemption for persons who would have to pay in excess of 8% of income for insurance.

Section 1511 et seq. provide for employer responsibilities. Section 1511 provides for automatic enrollment in the case of employers with over 200 employees. Under section 1513, an employer with employees eligible for the exchange who does not provide insurance must pay the "applicable amount," times the number of employees. The "amount," laid out in 26 U.S.C. 4980H(b)(2)(B), is up to \$600 each for each employee. Nevertheless, notwithstanding the potentially negative impact on jobs, this figure is low enough to make it almost always economically preferable to dump employees onto the exchange, rather than paying the spiraling costs of premiums under government-mandated insurance, even given the puny tax benefits which are made available under that section.

TAXES: (1) There is a 40% tax on insurance with premiums over \$23,000 (\$8,500 for individuals). Because these are not indexed to premium costs -- and because the average premium will soon be in excess of this level -- this is another Alternative Minimum Tax in the making. (2) The increases in small business taxes (for those filing taxes using Schedule C) would cripple jobs creation. The Medicare payroll tax would increase for these earners from 1.45% to 1.95. (3) In addition, there are increased taxes on HSA distributions (section 9004), increased taxes on

flexible spending arrangements under cafeteria plans (section 9005), an annual fee on pharmaceutical manufacturers which would be passed on to the consumer (section 9008), an annual fee on medical device manufacturers and importers which would be passed on to the consumer (section 9009), an annual fee on health insurance providers which would be passed on to the consumer (section 9010), elimination of the deduction for expenses allocable to Medicare Part D (section 9012), a tax on the very sick by increasing from 7.5% to 10% of income the level at which you can deduct health care expenses (section 9013), and the bo-tox tax (section 9017). This is in addition to the massive penalties imposed on the uninsured.