Health Care

In This Chapter

- Executive Summary
- Health Care in America
- Health Insurance Coverage of the Total Population, States (2009-2010), U.S. (2010)
- The Final Democrats' Health Care Overhaul law
- H.R. 3962: The House-Passed Health Care Reform Bill
- Health Care Overhaul Implementation Timeline
- Independent Payment Advisory Board (IPAB)
- Community Living Assistance Services and Support (CLASS) Act
- Legislative Efforts to Repeal, Defund and Replace in the 112th Congress
- Health Care Talking Points
- Additional Information and Resources

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EXECUTIVE SUMMARY

Unfortunately, during the previous 111th Congress, Democrats and President Obama opted to push through a government takeover of health care. The final health care overhaul package, among many other things: raises taxes, penalties and fees by $525 billion; creates an individual mandate for all Americans to obtain insurance or face an annual penalty; imposes a mandate on employers employing more than 50 people to provide health insurance to employees or face a penalty; contains nearly $500 billion in cuts to Medicare; cuts Medicare Advantage by more than $100 billion; increases premiums for those who buy health insurance on their own; and worsens the current national doctor shortage.

While America's doctors and medical institutions are the envy of the world, most Americans agree that the health care system in the United States is in desperate need of significant reform. But, the Democrats' government takeover of health care was and still is not the answer. Too many Americans lack health insurance, there are gaps in coverage and overall costs are increasing at an alarming rate. A key issue in the national health care debate is health care spending and cost. Americans are frustrated with an expensive and complicated system that many times does not meet their needs. Health care accounts for a remarkably large slice of the U.S. economic pie. Each year, health-related spending grows, often outpacing spending on other goods and services, meaning that the size of the slice increases. Among other things, rising health care costs make health insurance less affordable for individuals, families and businesses, contributing to the more than 45 million Americans who are uninsured and to the costly problem of extending coverage to them.

Obamacare

Total health expenditures in 2010 reached $2.6 trillion, which translates to $8,402 per person, or 17.9 percent of the nation's gross domestic product (GDP). Additionally, the federal government financed 29 percent of total health spending in 2010, a substantial increase from its share of 23 percent in 2007. Meanwhile, the shares of the total health care bill financed by state and local governments (16 percent), private businesses (21 percent) and households (28 percent) declined during the same period.

In addition to health care costs being too high in the current system, most people do not have the opportunity to pick the health plan that is right for them. That decision is taken out of their hands either by the government, by their employer or by the insurance company that is chosen. This one-size-fits-all approach many times causes customers to pay for coverage and benefits they do not want or need, while denying or limiting coverage and benefits that the customer may desire and be willing to buy.

Another key issue in the national health care debate is the role of the federal government. The United States Constitution does not explicitly address a right to health care. Republicans believe that individuals understand their health care needs better than government bureaucrats and that we need to inject actual competition into the system. Patients need more control, not less, because they, along with their doctors, are the only ones who can really say what works for them.

In the current 112th Congress, House Republicans have tackled the Democrats' government takeover of health care law on a variety of fronts. In addition to one of the very first votes taken in the House at the beginning of this Congress being a vote to repeal the law in full, Republicans have voted on and passed nearly 30 bills to restrict funds and limit the Administration's ability to implement the law. As of this writing, three programs have been three programs have been completely halted and seven provisions have been repealed/have had funding rescinded and signed into law. Republicans will continue to fight and pursue

strategic opportunities to get these and other defunding and repeal bills to President Obama's desk for signature.

HEALTH CARE IN AMERICA

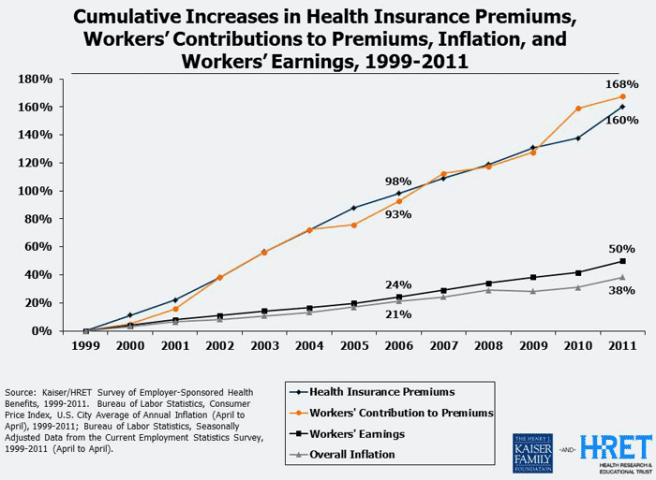
America's doctors and medical institutions are the envy of the world. The level of expertise and the pace of innovation in American health care are unmatched. Yet, America's health care system is at a crossroads faced with millions of uninsured citizens, rising costs, quality concerns and a lack of patient control. In the United States, health insurance markets are governed by a complex system of laws and regulations, many of which are outdated and counterproductive. Many Americans worry whether they will have access to medical care when they need it. Too many Americans lack health insurance, there are gaps in coverage and overall costs are increasing at an alarming rate. When they do get care, the bureaucracy of insurance companies is hard to navigate and understand in order to get reimbursement. Most agree that the health care system in the United States is in desperate need of significant reform.

Health Care Spending and Cost

A key issue in the national health care debate is health care spending and cost. Americans are frustrated with an expensive and complicated system that many times does not meet their needs. Many health care professionals do not get paid enough, patients are paying too much in premiums, fees and deductibles and – perhaps most alarming to the public – many people do not get any care at all. Health care accounts for a remarkably large slice of the U.S. economic pie. Each year, health-related spending grows, often outpacing spending on other goods and services, meaning that the size of the slice increases. These cost increases have a significant effect on households, businesses and government programs. Among other things, rising health care costs make health insurance less affordable for individuals, families and businesses, contributing to the more than 45 million Americans who are uninsured and to the costly problem of extending coverage to them; put pressure on businesses that offer insurance coverage to their employees; can be a major financial burden to families, even those that have insurance; can result in individuals not receiving the health care services they need; and take an increasing share of taxpayer dollars for government programs such as Medicare and Medicaid.

Editor's Note: *For more information regarding Medicare and Medicaid, please refer to the Medicare and Medicaid chapter of the 2012 NRCC Issues Book.*

Health coverage is provided by a wide array of public and private sources. Public sources include Medicare, Medicaid, the State Children's Health Insurance Program, federal and state employee health plans, the military and the Veterans Administration. According to the Centers for Medicare and Medicaid Services (CMS) National Health Expenditure Accounts data, U.S. health care spending grew 3.9 percent in 2010 (most recent available data) following record slow growth of 3.8 percent in 2009 – the two slowest rates of growth in the 51-year history of the National Health Expenditure Accounts. Total health expenditures in 2010 reached $2.6 trillion, which translates to $8,402 per person or 17.9 percent of the nation's gross domestic product (GDP). Additionally, the federal government financed 29 percent of total health spending in 2010, a substantial increase from its share of 23 percent in 2007. Meanwhile, the shares of the total health care bill financed by state and local governments (16



percent), private businesses (21 percent) and households (28 percent) declined during the same period.

Rising health care costs are not just a federal budget problem. Premiums for employer-provided health insurance, where millions of Americans get their coverage, jumped nine percent in 2011 while workers' wages great just two percent, according to a survey conducted by The Henry J. Kaiser Family Foundation (KFF). The average family policy costs more than $15,000 per year, more than the cost of a Chevy Aveo or a Ford Fiesta. Since KFF began doing this particular survey thirteen years ago, worker contributions to premiums have increased 168 percent, wages 50 percent and inflation 38 percent.

The following outlines health spending by type of service or product, per CMS' National Health Expenditure Accounts data for 2010 found here, unless otherwise noted:

Hospital Care: Hospital spending increased 4.9 percent to $814.0 billion in 2010 compared to 6.4-percent growth in 2009. Average annual growth in hospital spending between 2007 and 2010 was 5.5 percent. This was slower than the trend between 2003 and 2006, when spending increased an average of 7.4 percent per year. Growth in private health insurance spending for hospital services, which in 2010 accounted for 35 percent of all hospital care, slowed considerably in 2010.

Physician and Clinical Services: Spending on physician and clinical services increased 2.5 percent in 2010 to $515.5 billion, a deceleration from 3.3-percent growth in 2009. The 2010 deceleration reflects a decline in utilization, driven by a drop in total physician visits between 2009 and 2010 and a less severe flu season than in 2009.

Other Professional Services: Spending for other professional services, which includes providers of services such as physical therapy, chiropractic medicine and mental health, decelerated slightly in 2010, increasing 3.6 percent to $68.4 billion after growth of 3.8 percent in 2009.

Dental Services: Spending for dental services increased 2.3 percent in 2010 to $104.8 billion compared to growth of only 0.1 percent in 2009. Out-of-pocket spending for dental services (which accounts for more than 40 percent of dental spending) increased 0.5 percent in 2010 following a decline of 5.2 percent in 2009.

Other Health, Residential and Personal Care Services: Spending for other health, residential, and personal care services grew 5.3 percent in 2010 to $128.5 billion, a deceleration from growth of 7.7 percent in 2009. This category includes expenditures for medical services delivered in non-traditional settings (such as schools or community centers), ambulance providers and residential mental health and substance abuse facilities.

Home Health Care: Spending growth for freestanding home health care services slowed in 2010, increasing 6.2 percent to $70.2 billion following growth of 7.5 percent in 2009, as Medicare and Medicaid spending growth slowed in 2010.

Nursing Care Facilities and Continuing Care Retirement Communities: Spending for freestanding nursing care facilities and continuing care retirement communities increased 3.2 percent in 2010 to $143.1 billion, a deceleration from growth of 4.5 percent in 2009, driven by slower growth in Medicare and Medicaid spending.

Prescription Drugs: Retail prescription drug spending grew only 1.2 percent to $259.1 billion in 2010, a substantial slowdown from 5.1-percent growth in 2009. The slowdown was driven by slower growth in the

volume of drugs consumed, a continued increase in the use of generic medications, loss of patent protection for certain brand name drugs, fewer new drug introductions and a substantial increase in Medicaid prescription drug rebates.

Durable Medical Equipment: Spending for durable medical equipment, which includes items such as eyeglasses, contacts and hearing aids, increased 7.3 percent to $37.7 billion in 2010 after increasing 0.8 percent in 2009.

Other Non-durable Medical Products: Spending for other non-durable medical products, such as over-the-counter medicines, reached $44.8 billion, an increase of 2.6 percent in 2010, the same rate of growth as in 2009.

The following outlines health spending by major sources of funds, per CMS' National Health Expenditure Accounts data for 2010, also found here, unless otherwise noted:

Medicare: Medicare spending grew 5.0 percent in 2010 to $524.6 billion, a deceleration from growth of 7.0 percent in 2009. Spending for fee-for-service (FFS) Medicare grew 5.0 percent in 2010 following growth of 4.5 percent in 2009. Medicare Advantage spending increased 4.7 percent in 2010, a steep deceleration from 15.6-percent growth in 2009 that resulted from an adjustment to payment rates in 2010.

Medicaid: Total Medicaid spending grew 7.2 percent in 2010 to $401.4 billion, a deceleration from 8.9-percent growth in 2009, driven primarily by slower growth in enrollment. Federal Medicaid expenditures increased 8.9 percent, while state Medicaid expenditures grew 3.9 percent. This difference in growth was due to approximately $41 billion in enhanced federal aid to states – a result of increased Federal Medical Assistance Percentages (FMAP) mandated by the 2009 economic stimulus package.

Private Health Insurance: Growth in total spending for private health insurance premiums slowed in 2010 to 2.4 percent from 2.6 percent in 2009, continuing a deceleration that began in 2003. Growth in total benefit payments also slowed, from 3.7 percent in 2009 to 1.6 percent in 2010. The slowdown reflects a decline in private health insurance enrollment, increases in cost sharing, and a shift by some consumers to plans with lower premiums. However, for the first time in seven years, growth in total premiums exceeded growth in total benefits; as a result, the private health insurance net cost ratio increased from 11.4 percent in 2009 to 12.1 percent in 2010.

Out-of-Pocket: Out-of-pocket spending grew 1.8 percent in 2010, an acceleration from growth of 0.2 percent in 2009. Faster growth in 2010 partially reflects higher cost-sharing requirements for some employers consumers' switching to plans with lower premiums and higher deductibles and/or copayments, and the continued loss of health insurance coverage.

Health Insurance Coverage

People buy insurance to protect themselves against the possibility of financial loss in the future. For individuals, financial losses may result from the use of health care services. Health insurance provides protection against the possibility of financial loss due to high health care expenses. Also, people do not know ahead of time exactly what their health care expenses will be, so paying for health insurance on a regular basis helps smooth out their out-of-pocket spending. Americans obtain health insurance through a variety of methods and from different sources. People may get it through the private sector or from a publicly funded social insurance program. Consumers may purchase health coverage on their own, as part of

an employee group or through a trade or professional association. However, approximately 50 million Americans did not have health insurance coverage in 2010 – that is, around 16.3 percent of the total population was uninsured that year.

Traditionally, most Americans receive health insurance through their employers, which began following World War II. Employers offered benefits like health care as hiring incentives for new employees. In 2010, approximately 169 million people had employment-based health insurance, which accounts for approximately 55 percent of the total population. While most Americans with health insurance obtain it through the private sector, tens of millions get health coverage through public programs like Medicare and Medicaid. Many seniors continue to receive health care benefits through their former employers, while most rely at least to some extent on government-provided health care (Medicare and Medicaid).

While health coverage continues to be mostly a private enterprise in this country, government plays an increasingly significant role. As health insurance coverage has evolved from an uncommon benefit to a routine one, government's role in subsidizing and regulating that coverage also has changed. Over the years, government policy has continued to support the employer-based health care system by exempting employer-offered health benefits from income taxes but taxing health insurance purchased outside of one's employment. This means that there is almost no market for Americans to become "self-insured," because the cost is too high.

Health insurance coverage is not necessary to obtain health care, but it is a useful mechanism for accessing services in an environment of increasingly expensive health care. As health care costs continue to rise, more people need greater assistance with covering medical expenses. Health insurance provides some measure of protection for consumers, especially for those with limited means or greater-than-average need for medical care.

Limited Choices in Coverage

In addition to health care costs being too high in the current system, most people do not have the opportunity to pick the health plan that is right for them. That decision is taken out of their hands either by the government, by their employer or by the insurance company that is chosen. This one-size-fits-all approach many times causes customers to pay for coverage and benefits they do not want or need, while denying or limiting coverage and benefits that the customer may desire and be willing to buy. The decisions on what to cover are based on bureaucratic algorithms and actuarial charts of what is the most common wholesale price for the care of something, not on the actual specific health needs of workers. This is a particularly difficult problem as every year, newer diagnoses are developed along with more specific treatments. Workers are increasingly more like to be told they have a very specific illness that requires a very specialized treatment that falls outside the cost-effective pool set up by the insurance company. Additionally, as the cost of health care climbs, many employers, particularly small employers, are unable to pay the higher insurance premiums, shifting the large burden of health care costs back to employees. Health care costs are spiraling out of control and must be brought in line through equitable tax treatment and the introduction of competition in all levels of the health care marketplace.

Role of the Federal Government

Another key issue in the national health care debate is the role of the federal government. In the past, some Democrats have favored a "single-payer" national health insurance system similar to that seen in Canada or

Europe. Others proposed a new public plan modeled after Medicare that they claimed could compete with private health plans in a national health insurance exchange.

There are several approaches that were touted, but the essential ideology is that the management of the health insurance marketplace by the federal government is a way to ensure that everyone receives health insurance coverage – addressing the most politically salient of all the problems in health care. But this philosophy does not address all of the problems facing health care and in fact would exacerbate or create new problems in health care, particularly costs and access.

Underlying the health care reform debate are issues regarding the status of health or health care as a moral, legal or constitutional right. The United States Constitution does not explicitly address a right to health care. According to a Congressional Research Service (CRS) report, "The words 'health' or 'medical care' do not appear anywhere in the text of the Constitution. **The provisions in the Constitution indicate that the framers were somewhat more concerned with guaranteeing freedom *from* government, rather than with providing for specific rights to governmental services such as for health care.**"

Republicans believe that individuals understand their health care needs better than government bureaucrats and that we need to inject actual competition into the system. Patients need more control, not less, because they, along with their doctors, are the only ones who can really say what works for them. A health plan should be tailored to the needs of an individual patient and the primary health care relationship should be between doctor and patient. Republicans also believe that the most important issue facing health care to address is cost because lowering the cost will help solve many other health-related problems like access and affordability. They also believe that the best way to lower cost is to inject more market-based competition into the system.

HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION, STATES (2009-2010), U.S. (2010)

Editor's Note: *The following information is based on U.S. Census Data as compiled by statehealthfacts.org, a project of The Henry J. Kaiser Family Foundation. This data can be found here.*

State	Employer	Individual	Medicaid	Medicare	Other Public	Uninsured	Total
Alabama	2,293,317	151,547	712,560	698,959	59,844	744,089	4,660,316
Alaska	357,158	19,526	92,495	49,104	36,555	121,824	676,662
Arizona	2,884,043	335,823	1,268,486	775,001	71,225	1,258,578	6,593,156
Arkansas	1,212,502	113,840	491,754	449,058	53,925	540,330	2,861,409
California	16,653,354	2,219,707	6,935,398	3,622,707	305,830	7,162,713	36,899,709
Colorado	2,691,346	375,826	599,870	498,102	125,732	688,692	4,979,568
Connecticut	2,073,743	157,102	389,664	463,261	NSD	385,606	3,485,092
Delaware	464,667	33,037	136,308	128,533	7,950	107,128	877,623
District of Columbia	292,976	32,471	138,326	60,505	NSD	74,718	601,476
Florida	7,796,662	888,285	2,466,555	2,975,507	361,819	3,924,777	18,413,605
Georgia	4,755,286	479,146	1,330,272	914,876	249,304	1,942,563	9,671,447
Hawaii	685,927	48,274	194,362	174,711	31,081	94,515	1,228,870
Idaho	733,322	126,531	203,608	182,792	18,254	262,408	1,526,915
Illinois	6,643,979	604,785	2,077,803	1,539,986	83,885	1,863,831	12,814,269
Indiana	3,312,146	194,974	1,036,801	862,799	77,655	864,416	6,348,791
Iowa	1,659,259	183,406	402,761	356,833	26,011	345,006	2,973,276
Kansas	1,461,645	153,619	324,761	376,388	63,882	351,008	2,731,303
Kentucky	2,065,127	147,752	783,888	570,061	52,675	659,928	4,279,431
Louisiana	2,026,874	209,494	827,234	559,132	NSD	765,806	4,432,622
Maine	610,881	53,525	287,482	184,149	26,651	125,593	1,288,281
Maryland	3,363,614	269,378	603,305	635,783	59,708	749,672	5,681,460
Massachusetts	3,776,537	286,714	1,345,192	858,502	NSD	327,852	6,613,107
Michigan	5,112,516	442,902	1,550,408	1,368,419	NSD	1,272,598	9,785,290
Minnesota	2,965,091	287,378	748,538	671,756	53,542	463,075	5,189,380
Mississippi	1,148,124	132,786	618,437	378,592	44,221	555,339	2,877,499
Missouri	3,041,597	346,813	860,937	820,093	NSD	853,328	5,967,056
Montana	422,870	84,396	127,974	152,145	19,426	161,518	968,329
Nebraska	968,490	132,564	196,351	229,560	33,326	217,053	1,777,344
Nevada	1,341,913	132,039	259,594	297,954	45,020	552,404	2,628,924
New Hampshire	812,620	71,794	93,478	187,377	9,838	131,523	1,306,630
New Jersey	4,947,895	331,190	1,016,100	1,067,529	NSD	1,297,013	8,667,902
New Mexico	780,982	68,005	422,529	246,891	44,304	424,393	1,987,104

New York	9,195,874	764,113	4,065,143	2,332,296	66,635	2,797,060	19,221,121
North Carolina	4,356,610	391,798	1,443,815	1,199,522	217,816	1,620,297	9,229,858
North Dakota	341,547	66,022	57,261	82,660	8,768	74,128	630,386
Ohio	6,027,987	536,625	1,603,380	1,574,740	83,780	1,565,859	11,392,371
Oklahoma	1,707,237	133,484	569,790	505,435	80,050	638,519	3,634,515
Oregon	1,865,619	236,677	495,729	532,760	NSD	637,927	3,802,585
Pennsylvania	6,678,593	581,683	1,852,086	1,893,282	54,827	1,361,730	12,422,201
Rhode Island	544,239	39,735	180,170	141,647	9,930	121,778	1,037,499
South Carolina	2,102,349	188,093	618,833	674,061	80,874	843,605	4,507,815
South Dakota	403,245	60,493	103,322	110,508	17,561	104,778	799,907
Tennessee	2,924,891	311,416	1,054,851	873,008	146,058	933,658	6,243,882
Texas	11,059,096	926,555	3,966,983	2,313,572	339,021	6,234,887	24,840,114
United States	149,890,186	14,926,255	48,400,173	38,128,018	3,942,517	49,903,928	305,191,076
Utah	1,700,677	151,473	263,511	281,324	NSD	390,131	2,804,805
Vermont	311,277	23,762	141,565	78,334	NSD	58,715	619,155
Virginia	4,339,961	395,994	731,474	904,549	289,047	1,039,345	7,700,370
Washington	3,423,653	371,920	1,023,926	789,593	167,561	887,368	6,664,021
West Virginia	858,197	29,638	318,561	324,238	25,770	245,775	1,802,179
Wisconsin	3,090,694	297,411	832,646	822,484	NSD	511,511	5,584,702
Wyoming	281,322	32,638	61,882	61,649	10,322	88,005	535,818

THE FINAL DEMOCRATS' HEALTH CARE OVERHAUL LAW

Democrat leaders had initially hoped to reach a compromise on a final bill that could be passed by both the House and the Senate. However, Massachusetts Republican Scott P. Brown's special election to the United States Senate in January to replace the late-Senator Ted Kennedy (D-Mass.) complicated Democratic leaders' plans. Once Democrats in the Senate lost the 60-vote majority and their ability to cut off debate, Democrat leaders knew that a filibuster would thwart their plans.

After weeks of wrangling, Democrat leaders developed a new strategy under which the House would clear the Senate's health care bill as it was written (including all of the contentious provisions in the bill such as "sweetheart deals" and less restrictive abortion language) and it would be signed into law. Then both chambers would pass a separate bill making changes to the Senate bill that would be considered under the budget reconciliation process. In the Senate, budget reconciliation procedures block filibusters, limit the allowable amendments and allow a reconciliation measure to be passed in the Senate by a simple majority. The process was intended as a budget-control tool, but it also has been used to advance other policies, such as tax cuts or increased federal spending. To date, dozens of laws have been enacted using the reconciliation process. None, however, had been used on such a substantial and controversial piece of legislation as health care reform…until now.

Editor's Note: *For more information regarding budget reconciliation, please refer to the Budget and Federal Spending chapter of the 2012 NRCC Issues Book.*

House Passage of the Senate Health Bill Along With a Reconciliation Package

In the late hours of Sunday, March 21, 2010, the House voted 219 to 212 to clear the Senate-passed health care overhaul bill for the President. You can see how they voted here.

Directly after voting to clear the health care overhaul measure for President Obama, the House voted 220 to 211 to pass the reconciliation bill (H.R. 4872), thus sending it to the Senate. You can see how they voted here. On March 23, 2010, President Obama signed the underlying Senate bill into law (P.L. 111-148).

The reconciliation package made a number of changes to the recently enacted health care overhaul law (P.L. 111-148). There were a number of controversial provisions, such as a provision that extends indefinitely full federal funding to expand Medicaid coverage in Nebraska (the "Cornhusker Kickback"), the level of federal subsidies for lower-income households that purchase insurance in the new exchanges provided by the law is less than many Democrat members wanted and the threshold at which the new tax on high-cost health care plans will kick in was also viewed by many Democrats as too low. The reconciliation package was an attempt to address these concerns. It also included language previously passed by the House that makes dramatic changes to federal student loan programs, effectively ending the Federal Family Education Loan (FFEL) program, which would essentially make the government the sole originator of student loans.

Editor's Note: *For more information regarding the language which terminated the FFEL program, please refer to the Education chapter of the 2012 NRCC Issues Book.*

On March 23, 2010, the Senate began debate on the reconciliation bill (H.R. 4872), which faced staunch opposition from all Republican senators, who pledged to slow or block its process with procedural tactics. Over the course of the debate, the Senate considered and defeated dozens of Republican amendments to the bill during the course of a "vote-a-rama" that spilled over two days. Budgetary points of order were

raised against two provisions relating to the administration of Pell grants, which were then removed from the bill. The Senate then passed the bill, as amended, by a vote of 56 to 43. Because of the changes made during Senate debate, the House, on March 25, 2010, voted again on the reconciliation bill in order to complete legislative action and send it to the President (see how they voted here), thus concluding a historic and controversial path to an overhaul of the Nation's health care system.

Below are selected vote hits on Democrats who voted for the government takeover of health care:

- **The Democrats' final health care overhaul package was the combination of two bills, the Senate-passed health care bill and a reconciliation package**
  - On March 21, 2010, Democrats passed a motion to concur in the Senate amendment to the bill that would overhaul the nation's health insurance system and require most individuals to buy health insurance by 2014. It would create a system of national private insurance plans supervised by the Office of Personnel Management and create state-run marketplaces for purchasing health insurance. Those who do not obtain coverage would be subject to an excise tax. Excluded from the mandate would be those exempt from filing income tax and others with a hardship waiver, religious objection or those who cannot afford coverage. Employers with 50 or more workers would have to provide coverage or pay a fine if any employee gets a subsidized plan on the exchange. The bill would provide tax credits to certain small businesses for providing coverage and provide subsidies to individuals making up to four times the federal poverty level, excluding illegal immigrants. It would bar the use of federal funds to pay for abortions in the new programs created under the bill, except in the cases of rape, incest or if the woman's life is in danger. It would bar insurance companies from denying coverage based on pre-existing medical conditions beginning in 2014, and also bar them from dropping coverage of people who become ill. It would expand eligibility for Medicaid, shrink the coverage gap under the Medicare Part D prescription drug program and create an advisory board to reduce the per capita growth rate in Medicare spending. (Motion agreed to 219-212; D: 219-34; R: 0-178)[1]
  - On March 21, 2010, Democrats passed a bill that would make changes to a health care overhaul measure (H.R. 3590), revise student loans procedures and include revenue-raising provisions. It would increase federal subsidies to help low- and moderate-income families purchase coverage through health insurance exchanges established by the overhaul measure, phase out the coverage gap for Medicare prescription drug enrollees and adjust the federal matching funds for Medicaid. It also would make the federal government the sole originator of federal student loans and direct the savings generated to education programs, including Pell grants. It would increase penalties levied on employers that do not offer health benefits and change the formula used to calculate penalties on employers with workers who obtain subsidies to obtain health insurance through the exchanges. It would freeze Medicare Advantage payments in 2011 and then re-formulate payments according to local costs. It also would specify that in all states, the federal government would cover 100 percent of the cost of coverage to newly eligible Medicaid recipients from 2014 to 2016. It would delay for five years, until 2018, the effective date of a tax on high-cost health plans and adjust the dollar amounts used to determine who would be affected by the tax. It would repeal a provision to allow the cellulosic biofuels producer credit to be claimed by producers of

[1] H.R. 3590, CQ Vote #165, March 21, 2010

certain paper products. The bill would shift all new federal student lending to the Direct Loan Program beginning July 1, 2010. It would increase the maximum annual Pell Grant scholarship to $5,975 in 2017 and provide $2.6 billion for minority-serving institutions. (Passed 220-211; D: 220-33; R: 0-178)[2]

- **According to a *Wall Street Journal* Editorial, the democrat's final health care overhaul package will eventually cause "economic wreckage" and was "such a shoddy, jerry-rigged piece of work that the damage is coming sooner than even some critics expected"**

  - In a March 27, 2010, editorial, *The Wall Street Journal* wrote, "The Democratic political calculation with ObamaCare is the proverbial boiling frog: Gradually introduce a health-care entitlement by hiding the true costs, hook the middle class on new subsidies until they become unrepealable, but try to delay the adverse consequences and major new tax hikes so voters don't make the connection between their policy and the economic wreckage. But their bill was such a shoddy, jerry-rigged piece of work that the damage is coming sooner than even some critics expected."[3]

- **The democrats' final health care overhaul package has been called a government health care takeover**

  - In an April 2, 2010, editorial, *The Washington Times* wrote, "President Obama claimed it was necessary for the government to take over health care to make U.S. companies more competitive internationally. The president's argument was that Obamacare would lower company costs for providing health insurance. Surprise, surprise, the opposite is true, as corporations are predicting crippling health care costs in the wake of the Democrats' new law.

    "Barely a week after Mr. Obama signed the government health care takeover, numerous major corporations have announced huge write downs because of increased costs. These adjustments reflect sudden unexpected increases over what these firms had previously budgeted to spend before Obamacare became the law of the land."[4]

- **"Democrats have created a massive new entitlement that will add to the burden of debt piled on the next generation, menacing the nation's long-term well-being"**

  - In a March 25, 2010, opinion, *Roll Call* Executive Editor Morton M. Kondracke wrote, "Republicans are right in asserting that, instead of reducing unsustainable entitlement costs, the Democrats have created a massive new entitlement that will add to the burden of debt piled on the next generation, menacing the nation's long-term well-being.

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[2] H.R. 4872, CQ Vote #167, March 21, 2010
[3] Editorial, "The ObamaCare Writedowns," *The Wall Street Journal*, March 27, 2010, http://online.wsj.com/article/SB10001424052748704100604575146002445136066.html
[4] Editorial, "Obamacare sticks companies with higher bills," *The Washington Times*, April 2, 2010, http://www.washingtontimes.com/news/2010/apr/2/obamacare-sticks-companies-with-higher-bills/

"And they are right to say that health care was passed with special interest deals; in secret, Democrats-only negotiations; and with some votes 'purchased' with state-specific benefits."[5]

- **The democrats' health care overhaul raises taxes, penalties and fees by $525 billion**

  - In a March 20, 2010, letter to Speaker Nancy Pelosi, the non-partisan Congressional Budget Office estimated that the revenue provisions of the reconciliation package combined with H.R. 3590, the Senate health care legislation, would total $525 billion over the 2010-2019 period.[6]

  - In a March 24, 2010, article, the *Washington Times* reported, "The historic overhaul of the nation's health care system that President Obama signed Tuesday, when combined with the fixes making their way through Congress, will raise taxes over the next 10 years by more than a half-trillion dollars.

    "The tax increases range from hundreds of billions of dollars in new Medicare levies, including one that taxes investment income such as capital gains and dividends for the first time, to a 10 percent excise tax on indoor tanning services that will raise less than $3 billion over the next decade."[7]

- **Americans for Tax Reform and the Tax Foundation have both released a comprehensive list of taxes and penalties contained within the underlying bill**

  - The Americans for Tax Reform report, entitled, "Comprehensive list of tax hikes in government health bill to be voted on by House," can be accessed by visiting http://www.atr.org/comprehensive-list-tax-hikes-government-health-a4658

  - The Americans for Tax Reform report, entitled, "Comprehensive List of Net Tax Hikes in Health Reconciliation Bill," can be accessed by visiting http://www.atr.org/breaking-comprehensive-list-net-tax-hikes-a4688

  - The Tax Foundation report, entitled "Timeline of Tax Provisions in the House Health Care Bill," can be accessed by visiting http://www.taxfoundation.org/publications/show/26037.html

- **The democrats' health care overhaul creates an individual mandate for all Americans to obtain insurance or face an annual penalty**

  - In a March 19, 2010, article, *The Washington Post* reported, "All Americans would be required for the first time to obtain insurance or face an annual penalty of $695; employers could face penalties of $2,000 per worker for not offering affordable coverage. In exchange for the new business, private insurers would be subject to an array of rules, including a ban on the

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[5] Morton M. Kondracke opinion, "Democrats' Health Victory May Limit Losses in November," *Roll Call*, March 25, 2010
[6] Douglas W. Elmendorf, "Letter to Nancy Pelosi," Congressional Budget Office, March 20, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf
[7] David Dickson, "Healthy tax increases, not only on wealthy," *Washington Times*, March 24, 2010, http://www.washingtontimes.com/news/2010/mar/24/healthy-tax-increases-not-only-on-wealthy/

practice of denying coverage to people with preexisting medical conditions and a requirement that adult children be permitted to stay on their parents' policies until age 26."[8]

- **Nearly 4 million Americans - the vast majority of them middle class - will have to pay a penalty averaging a little more than $1,000 apiece in 2016 for not getting health insurance**
  - In an April 22, 2010, article, the Associated Press reported, "Nearly 4 million Americans - the vast majority of them middle class - will have to pay the new penalty for not getting health insurance when President Barack Obama's health care overhaul law kicks in, according to congressional estimates released Thursday.

    "The penalties will average a little more than $1,000 apiece in 2016, the Congressional Budget Office said in a report.

    "Most of the people paying the fine will be middle class. Obama pledged in 2008 not to raise taxes on individuals making less than $200,000 a year and couples making less than $250,000."[9]
  - The same article went on to report, "About 3 million of those required to pay fines in 2016 will have incomes below $59,000 for individuals and $120,000 for families of four, according to the CBO projections. The other 900,000 people who must pay the fine will have higher incomes."[10]
- **Penalties paid by individuals for failing to fulfill the mandate are expected to be $4 billion a year from 2017 through 2019**
  - In an April 22, 2010, article, the Associated Press reported, "Nearly 4 million Americans - the vast majority of them middle class - will have to pay the new penalty for not getting health insurance when President Barack Obama's health care overhaul law kicks in, according to congressional estimates released Thursday.

    "The penalties will average a little more than $1,000 apiece in 2016, the Congressional Budget Office said in a report.

    "Most of the people paying the fine will be middle class. Obama pledged in 2008 not to raise taxes on individuals making less than $200,000 a year and couples making less than $250,000."[11]
  - The same article went on to report, "About 3 million of those required to pay fines in 2016 will have incomes below $59,000 for individuals and $120,000 for families of four, according

[8] Lori Montgomery and Paul Kane, "House leaders announce $940 billion health-care compromise bill," *The Washington Post*, March 19, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/03/18/AR2010031801153.html
[9] Stephen Ohlemacher, "Nearly 4M to pay health insurance penalty by 2016," Associated Press, April 22, 2010, http://www.washingtontimes.com/news/2010/apr/22/4m-pay-insurance-penalty-2016/
[10] Stephen Ohlemacher, "Nearly 4M to pay health insurance penalty by 2016," Associated Press, April 22, 2010, http://www.washingtontimes.com/news/2010/apr/22/4m-pay-insurance-penalty-2016/
[11] Stephen Ohlemacher, "Nearly 4M to pay health insurance penalty by 2016," Associated Press, April 22, 2010, http://www.washingtontimes.com/news/2010/apr/22/4m-pay-insurance-penalty-2016/

to the CBO projections. The other 900,000 people who must pay the fine will have higher incomes.

"The government will collect about $4 billion a year in fines from 2017 through 2019, according to the report."[12]

- **26 states have filed a lawsuit challenging the individual mandate provision of the health care law as unconstitutional**

  - In a Jan. 20, 2011, article, Bloomberg reported, "Ohio, Wisconsin, Iowa, Kansas, Wyoming and Maine won permission to join a Florida lawsuit challenging the constitutionality of President Barack Obama's health-care reform legislation.

    "U.S. District Judge Roger Vinson in Pensacola, Florida, yesterday granted the states' motion for permission to be added to the lawsuit filed last year by then-Florida Attorney General Bill McCollom, bringing the total of plaintiff states to 26.

    ""The addition of six new states to our bipartisan legal challenge reflects broad, nationwide concern about the constitutionality of this sweeping and unprecedented federal legislation,' Texas Attorney General Greg Abbott said in a press statement.

    "The Patient Protection and Affordable Care Act, signed into law by Obama on March 23, bars insurers from denying coverage to people who are sick and from imposing lifetime limits on costs.

    "It also requires all citizens to obtain coverage or face a tax penalty. That individual mandate and expansions of Medicaid and employer-based coverage would extend health coverage to 32 million more people by 2019, according to the Congressional Budget Office.

    "Mandatory coverage would start in 2014. The government has called the minimum-coverage provision the linchpin of the reform effort because it would push younger and healthier people into the insurance pool.

    "Opponents told Vinson in a Dec. 16 court appearance that expansion of Medicaid -- the joint state and federal program to provide health care to the indigent -- would overwhelm state budgets.

    "Exceeds Authority

    "They also argued that the mandatory coverage provision exceeds the legislative authority of the U.S. Congress to regulate interstate commerce by attempting to control the inaction of the uninsured."[13]

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[12] Stephen Ohlemacher, "Nearly 4M to pay health insurance penalty by 2016," Associated Press, April 22, 2010, http://www.washingtontimes.com/news/2010/apr/22/4m-pay-insurance-penalty-2016/

[13] Andrew Harris, "Ohio, Wisconsin, Four More States Join Challenge to Obama Health Care," Bloomberg, Jan. 20, 2011, http://www.bloomberg.com/news/2011-01-20/ohio-wisconsin-four-more-states-join-challenge-to-obama-health-care.html

- **In December 2010, a federal judge in Virginia ruled that it is unconstitutional for the government to compel Americans to buy health insurance, concluding that the law is an unprecedented expansion of federal power and cannot be justified under Congress's authority to regulate interstate commerce**

    - In a Dec. 14, 2010, article, *The Washington Post* reported, "A federal judge in Virginia ruled Monday that it is unconstitutional for the government to compel Americans to buy health insurance, marking the first time a court has struck down any facet of the massive new law to overhaul the nation's health-care system.

      "Although the opinion by U.S. District Judge Henry E. Hudson gives significant political ammunition to the law's opponents, it does not invalidate the entire law or force federal and state officials to stop the work of putting it into effect - steps Virginia had asked him to take.

      "The ruling by Hudson, named to the bench by George W. Bush, sets up a conflict with opinions by two Democratic-appointed judges who have concluded recently that the law is constitutional. The cases are among two dozen in federal courts across the country that challenge many aspects of the law. The final word is widely expected to come from the U.S. Supreme Court.

      "In his 42-page opinion, Hudson concluded that requiring most people to get insurance or pay a fine - as the law mandates starting in 2014 - is an unprecedented expansion of federal power and cannot be justified under Congress's authority to regulate interstate commerce."[14]

- **In August 2011, the U.S. Appeals Court for the 11th Circuit, based in Atlanta, ruled that Congress exceeded its authority by requiring Americans to buy coverage**

    - In an Aug. 12, 2011, article, Reuters reported, "President Barack Obama's signature healthcare law suffered a setback on Friday when an appeals court ruled that it was unconstitutional to require all Americans to buy insurance or face a penalty.

      "The U.S. Appeals Court for the 11th Circuit, based in Atlanta, ruled 2 to 1 that Congress exceeded its authority by requiring Americans to buy coverage, but it unanimously reversed a lower court decision that threw out the entire law."[15]

Editor's Note: *As of this writing, a split among U.S. Circuit courts existed regarding the constitutionality of the individual mandate. An Aug. 12, 2011, decision by the U.S. Court of Appeals for the 11th Circuit ruling the mandate to purchase health insurance unconstitutional is currently being appealed by the U.S. Department of Justice and is being heard by the U.S. Supreme Court.*

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[14] Rosalind Helderman and Amy Goldstein, "Federal judge in Va. strikes down part of health-care law," *The Washington Post*, Dec. 14, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/12/13/AR2010121302420.html

[15] Jeremy Pelofsky and James Vicini, "Appeals court rules against Obama healthcare mandate," Reuters, Aug. 12, 2011, http://www.reuters.com/article/2011/08/12/us-usa-healthcare-idUSTRE77B4J320110812

- **The Democrats' health care overhaul creates a mandate on employers who employ more than 50 people to provide health insurance to their employees or face a penalty of $2,000 per employee beyond the first 30 workers**

  - In a Jan. 19, 2011, memo, The Heritage Foundation wrote, "One of the central goals of the Patient Protection and Affordable Care Act (PPACA) was to increase the number of individuals with health insurance coverage. To encourage employers to offer coverage, the new law creates a tax penalty on firms with more than 50 workers that fail to provide "adequate" coverage for their employees. The result is government intrusion into voluntary arrangements made between employer and employee.

    "The cost of the tax penalty will ultimately be borne by workers (lower wages and fewer jobs), shareholders (lower profits), and consumers (higher prices).

    "Section 1513 of PPACA amends the Internal Revenue Code of 1986 by adding "Section 4980H. Shared Responsibility for Employers Regarding Health Coverage." This section imposes tax penalties on certain firms that fail to offer adequate health care coverage to their employees. Beginning in 2014, all companies with 50 or more full-time employees (or their equivalent)[3] that do not offer "qualified" health insurance or pay at least 60 percent of premiums to their workers will face financial penalties if at least one employee receives subsidized coverage in an exchange. The annual tax penalty will be equal to $2,000 for every full-time employee (or their equivalent) beyond the first 30 workers."[16]

  - On July 26, 2010, *Time* magazine reported, "Of all the aspects of the new Patient Protection and Affordable Care Act that critics fiercely object to, few generate more ire than the mandates. The health-reform law's individual mandate — requiring every legal U.S. resident to carry health insurance (with some limited exceptions) — has prompted a multistate lawsuit challenging its constitutionality, while the requirement that employers with 50 or more employees provide coverage to workers or pay a stiff fine is despised by business groups."[17]

- **Within a week after final passage of the bill, major companies reported that they would take significant financial losses due to passage of the new law**

  - In a March 27, 2010, editorial, *The Wall Street Journal* wrote, "It's been a banner week for Democrats: Obama Care passed Congress in its final form on Thursday night, and the returns are already rolling in. Yesterday AT&T announced that it will be forced to make a $1 billion write-down due solely to the health bill, in what has become a wave of such corporate losses."[18]

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[16] Brian Blase, "Obamacare and the Employer Mandate: Cutting Jobs and Wages," The Heritage Foundation, Jan. 19, 2011
[17] Kate Pickert, "Health Reform: Weighing Up the Employer Mandate," *Time*, July 26, 2010, http://www.time.com/time/business/article/0,8599,2006418,00.html
[18] Editorial, "The Obama Care Writedowns," *The Wall Street Journal*, March 27, 2010, http://online.wsj.com/article/SB10001424052748704100604575146002445136066.html

- In a March 29, 2010, article, the Associated Press reported, "Insurer Prudential Financial Inc. said Monday that it will take a $100 million charge in the first quarter in relation to the recent health care overhaul legislation.

  "The life insurance and annuities provider said in a regulatory filing that it will take the charge against earnings in the first quarter.

  "Prudential joins a growing list of companies that have said they will take accounting charges because of the health care bills. AT&T said last week it would take a $1 billion charge in the first quarter. AK Steel Corp., 3M Co., Caterpillar Inc., Deere & Co. and Valero Energy have also said they would take smaller charges."[19]

- **Penalties paid by employers for failing to fulfill the mandate are expected to be $52 billion between 2014 and 2019**

  - In a March 20, 2010, letter to Nancy Pelosi, the Congressional Budget Office included Table 4 entitled; Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as passed by the Senate; which estimated $52 billion in penalty payments by employers in the years between 2014 and 2019.[20]

  - In a Jan. 19, 2011, memo, The Heritage Foundation wrote, "The Congressional Budget Office (CBO) estimates that the employer mandate will cost businesses $52 billion in tax penalties from 2014 to 2019.5 In addition to the tax penalties faced by businesses that offer 'inadequate' coverage to their employees, businesses that conform to the mandate will face compliance costs. Therefore, many businesses will have less profit with which to compensate their employees and shareholders, resulting in lower wages for employees and diminished portfolios for shareholders."[21]

- **According to congressional testimony by Douglas Elmendorf, director of the non-partisan Congressional Budget Office, the democrats' health care overhaul will cause a reduction of 800,000 jobs, because some people will no longer have to work just to afford health insurance**

  - In a Feb. 10, 2011, article, *Politico* reported, "CBO Director Douglas Elmendorf told the House Budget Committee on Thursday that the health care law will reduce employment by 0.5 percent by 2021 because some people will no longer have to work just to afford health insurance.

    ""That means that if the reduction in the labor used was workers working the average number of hours in the economy and earning the average wage, that there would be a

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[19] Staff Writer, "Prudential to take $100M health care charge in 1Q," Business Insider, March 29, 2010, http://www.businessinsider.com/prudential-to-take-100m-health-care-charge-in-1q-2010-3
[20] Douglas W. Elmendorf, "Letter to Nancy Pelosi," Congressional Budget Office, March 20, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf
[21] Brian Blase, "Obamacare and the Employer Mandate: Cutting Jobs and Wages," The Heritage Foundation, Jan. 19, 2011, http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-the-Employer-Mandate-Cutting-Jobs-and-Wages#_ftnref5

reduction of 800,000 workers,' Elmendorf said in an exchange with Rep. John Campbell (R-CA).

"The report, published in August, said, 'The Congressional Budget Office estimates that the legislation, on net, will reduce the amount of labor used in the economy by a small amount—roughly half a percent—primarily by reducing the amount of labor that workers choose to supply … That net effect reflects changes in incentives in the labor market that operate in both directions: Some provisions of the legislation will discourage people from working more hours or entering the workforce, and other provisions will encourage them to work more.'"[22]

Editor's note: *To see video of the testimony, see* http://www.youtube.com/HouseBudgetCommittee#p/a/u/0/QlBvrp4qV7Q

- **The final health care overhaul legislation contains approximately $500 billion in cuts to Medicare**
  - In a March 20, 2010, letter to Speaker Nancy Pelosi, the non-partisan Congressional Budget Office estimated that the combined effect of H.R. 4872, the health care reconciliation package, and H.R. 3590, the Senate health bill, would result in a $455 reduction in Medicare spending over the 2010-2019 period.[23]
  - In a March 29, 2010, article, CNN.com's *Political Ticker* reported, "The reform plan includes cutting the costs of Medicare, the government-run health plan for seniors, by about $500 billion."[24]
  - In a March 24, 2010, article regarding the health care reconciliation package, *The Washington Post* reported, "It would cut an additional $60 billion from Medicare, bringing total cuts to the program to more than $500 billion over the next 10 years. And it would delay a tax on high-cost insurance polices [sic] until 2018, replacing the lost revenue by imposing the Medicare payroll tax on investment income for families earning more than $250,000 a year."[25]
- **Medicare Advantage alone would be cut by more than $100 billion**
  - In a March 20, 2010, letter to Speaker Nancy Pelosi, the non-partisan Congressional Budget Office estimated that the combined effect of H.R. 4872, the health care reconciliation

[22] J. Lester Feder and Kate Nocera, "CBO: Health law to shrink workforce by 800,000," *Politico*, Feb. 10, 2011, http://www.politico.com/news/stories/0211/49273.html
[23] Congressional Budget Office, "Letter to the Honorable Nancy Pelosi," March 20, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf
[24] CNN, "Pelosi: GOP used fear to turn elderly against health care bill," *Political Ticker* , http://politicalticker.blogs.cnn.com/2010/03/29/pelosi-gop-used-fear-campaign-to-turn-elderly-against-health-care-bill/?fbid=RG1cchj7Ilz, accessed March 31, 2010
[25] Shailagh Murray and Lori Montgomery, With Senate 'fixes' bill, GOP sees last chance to change health-care reform," *The Washington Post*, March 24, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/03/23/AR2010032303957.html

package, and H.R. 3590, the Senate health bill, would result in a $136 billion reduction in Medicare Advantage over the 2010-2019 period.[26]

- In a March 19, 2010, article, the *Columbus Dispatch* reported, "But to achieve the savings to the treasury, the bill calls for $500 billion during the next 10 years in reductions in growth of Medicare, including $131.9 billion in cuts to Medicare Advantage, a privately run, subsidized plan popular with seniors."[27]

- **25.6 percent of all Medicare beneficiaries had Medicare Advantage plans in 2011**

  - According to The Henry J Kaiser Family Foundation's analysis of Centers for Medicare and Medicaid Services (CMS) data, 25.6 percent of all Medicare beneficiaries had Medicare Advantage plans in 2011.[28]

- **7.4 million fewer seniors nationwide could be enrolled in Medicare Advantage as a result of the cuts**

  - According to an April 22, 2010, report by Richard S. Foster, Chief Actuary of the Centers for Medicare and Medicaid Services, "The new provisions will generally reduce MA [Medicare Advantage] rebates to plans and thereby result in less generous benefit packages. We estimate that in 2017, when the MA provisions will be fully phased in, enrollment in MA plans will be lower by about 50 percent (from its projected level of 14.8 million under the prior law to 7.4 million under the new law)"[29]

- **The Independent Payment Advisory Board (IPAB) was created by the 2010 health care law, and in April 2011, President Obama called for increasing the panel's authority as part of his deficit-reduction plan**

  - According to a May 8, 2011, Kaiser Health News article, "The Independent Payment Advisory Board was created by the 2010 health care law. Last month, in releasing his deficit-reduction plan, President Barack Obama called for increasing the panel's authority, saying it was critical to controlling the costs of Medicare, estimated at $524 billion in fiscal 2010. Republicans and some Democrats have denounced IPAB, saying it will be made up of unelected bureaucrats who will wind up rationing care to Medicare beneficiaries."[30]

- **IPAB's job is to come up with ways to cut Medicare spending if it grows too fast**

  - In a May 14, 2011, article, *Politico* reported, "Wanted: nationally known health care experts to serve on controversial health care board that will make painful Medicare spending cuts.

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[26] Congressional Budget Office, "Letter to the Honorable Nancy Pelosi," March 20, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf
[27] Jack Torry and Jonathan Riskind, "Health-care reform fight," *Columbus Dispatch*, March 19, 2010
[28] "Medicare Advantage (MA) Plan Penetration, 2011," The Henry J Kaiser Family Foundation, http://www.statehealthfacts.org/comparetable.jsp?ind=329&cat=6
[29] Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act as Amended," Centers for Medicare and Medicaid Services, April 22, 2010, http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf
[30] Bara Vaida, "The IPAB: How Could It Change Medicare?" Kaiser Health News, May 8, 2011, http://www.kaiserhealthnews.org/Stories/2011/May/09/ipab-faq.aspx

"Must be willing to quit current job to do it. Also, must be willing to go through bloody and humiliating confirmation fight.

"That's the job description for the 15 members of the Independent Payment Advisory Board — the new panel created by President Barack Obama's health care law to come up with ways to cut Medicare spending if it grows too fast."[31]

- **The law states that the board may not "include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums, increase Medicare beneficiary cost sharing or otherwise restrict benefits or modify eligibility criteria"**
  - In a Jan. 26, 2011, article, *Politico* reported, "The law states that the board may not 'include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums, increase Medicare beneficiary cost sharing or otherwise restrict benefits or modify eligibility criteria.' The Congressional Budget Office says the board could save up to $15.5 billion by 2019 with much more savings expected later because Medicare payments to hospitals will be exempted until fiscal 2020. Medicare spending was projected to total $509 billion in 2010."[32]

- **"While IPAB's authority is restricted, it can reduce Medicare's reimbursement rates for medical service providers. This is sure to ration care or increase consumer cost sharing, since if the item cannot be paid for under Medicare consumers will have no choice but to purchase it or go without"**
  - According to a May 5, 2011, guest column by Julie Reiskin (Executive Director of the Colorado Cross-Disability Coalition and a member of the Obama Administration) in the *Denver Post*, "While IPAB's authority is restricted, it can reduce Medicare's reimbursement rates for medical service providers. This is sure to ration care or increase consumer cost sharing, since if the item cannot be paid for under Medicare consumers will have no choice but to purchase it or go without.

    "Medicare rates in many areas are already well-below market ones. Many doctors report they lose money by treating Medicare patients. Some have simply stopped treating program beneficiaries altogether. Medicare is already set to slash physician reimbursements by 27 percent next year. If IPAB starts cutting rates even more, the doctor shortage problem in Colorado could be greatly deepened."[33] [34]

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[31] David Nather, "Medicare cost-cutting job could be worst in D.C.," *Politico*, May 14, 2011, http://www.politico.com/news/stories/0511/54952.html
[32] Bara Vaida, "Health groups rise against panel," *Politico*, Jan. 26, 2011, http://www.politico.com/news/stories/0111/48166.html
[33] Julie Reiskin column, "The Wrong Way to Fix Medicare Spending," *Denver Post*, May 5, 2011, http://www.denverpost.com/opinion/ci_17993137?source=rss&utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+dp-opinion+%28Denver+Post%3A+Opinion%29
[34] Press Release, "President Obama Announces More Key Administration Post," The White House, Aug. 6, 2009, http://www.whitehouse.gov/the-press-office/president-obama-announces-more-key-administration-posts-8-6-09

- **Once the board has made up its mind, its cuts would automatically take effect, unless Congress agrees on an alternative package or can get a supermajority to block IPAB's plan**

    - In a May 17, 2011, article, *Investor's Business Daily* reported, "Under the law, the president would appoint 15 experts to the board. Starting in 2014, it would be charged with making sure Medicare hits specific spending targets. Because IPAB can't touch benefits, deductibles or co-payments, those cuts would largely focus on provider fees.

      "Once the board has made up its mind, its cuts would automatically take effect, unless Congress agrees on an alternative package or can get a supermajority to block IPAB's plan. And IPAB decisions would be immune from administrative or judicial review."[35]

- **"While IPAB defenders say the law specifically bars rationing, critics argue that cutting provider payments would have that effect"**

    - In a May 17, 2011, article, *Investor's Business Daily* reported, "While IPAB defenders say the law specifically bars rationing, critics argue that cutting provider payments would have that effect.

      "They say IPAB-imposed payment cuts could accelerate doctors' exodus from Medicare, restricting seniors' access to care. In 2009, 13% of family doctors said they didn't participate in Medicare, up from 6% in 2004, according to the American Academy of Family Physicians."[36]

- ***The Wall Street Journal* said that the democrats' plan would cut Medicare via political rationing, with the goal of letting IPAB throw granny over the cliff if Medicare isn't reformed**

    - According to a May 26, 2011, *Wall Street Journal* editorial, "One place to start is by attacking the Democratic plan to cut Medicare via political rationing. Mr. Ryan's budget had the virtue of embarrassing President Obama's spend-more initial budget, and the White House responded by proposing to increase the power of the new Independent Payment Advisory Board (IPAB) to decide what, and how much, Medicare will pay for. The ObamaCare bill goes to great lengths to shelter this 15-member, unelected board from Congressional review, with the goal of letting these bureaucrats throw granny over the cliff if Medicare isn't reformed. Yet few Americans know anything about IPAB or its rationing intentions."[37]

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[35] John Merline, "ObamaCare's IPAB Under Fire," *Investor's Business Daily*, May 17, 2011, http://news.investors.com/Article/572358/201105161812/ObamaCares-IPAB-Under-Fire.htm
[36] John Merline, "ObamaCare's IPAB Under Fire," *Investor's Business Daily*, May 17, 2011, http://news.investors.com/Article/572358/201105161812/ObamaCares-IPAB-Under-Fire.htm
[37] Editorial, "The GOP's New York Spanking," *The Wall Street Journal*, May 26, 2011, http://online.wsj.com/article/SB10001424052702304520804576345442590223566.html

- **Several House Democrats have signed on to support a bill to repeal IPAB; The National Committee to Preserve Social Security and Medicare is also actively lobbying for its repeal**

  - In a June 8, 2011, article, *Politico* reported, "Several House Democrats have signed on to support a bill to repeal the Independent Payment Advisory Board, a panel created by the law that is supposed to help control rising costs in Medicare. The National Committee to Preserve Social Security and Medicare, a prominent supporter of the law, is now actively lobbying for its repeal, too."[38]

- **Regarding IPAB, Democratic Rep. Allyson Schwartz said, "I cannot condone the implementation of a flawed policy that will risk beneficiary access to care"**

  - In an April 15, 2011, press release, Rep. Allyson Schwartz said, "I cannot condone the implementation of a flawed policy that will risk beneficiary access to care. We can and will address the unsustainable rate of growth in health care spending. Repeal of IPAB will allow us to focus our efforts on the promotion of thoughtful innovations that will achieve cost savings by incentivizing efficient, high quality care for all Americans,"[39]

  - Schwartz also said, "We cannot impose a financial burden on patients and providers to conceal inherent flaws in our health care system through arbitrary cuts"[40]

  - In an April 15, 2011, press release, Rep. Allyson Schwartz said, "Since Medicare's inception, Congressional oversight of the program has ensured transparency and an open dialogue with our constituents that allow us to assess the needs and address the concerns of beneficiaries. We cannot impose a financial burden on patients and providers to conceal inherent flaws in our health care system through arbitrary cuts."[41]

- **In a May 2011 op-ed, Rep. Schwartz wrote that "IPAB brings unpredictability and uncertainty to providers and has the potential for stifling innovation and collaboration"**

  - In a May 22, 2011, op-ed in *USA Today*, Rep. Allyson Schwartz wrote, "We all agree that Medicare costs must be contained and that the payment system is flawed and needs to be replaced. But simply cutting reimbursements is not the answer. IPAB brings unpredictability and uncertainty to providers and has the potential for stifling innovation and collaboration.

    "The threat of reduced payments is the least imaginative option and most unlikely to result in the kind of heath care we know seniors and all Americans deserve."[42]

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[38] Jennifer Haberkorn, "Medicare pay board is losing vital support," *Politico*, June 8, 2011, http://www.politico.com/news/stories/0611/56467.html
[39] Press Release, "Schwartz: IPAB Is The Wrong Path Toward Medicare Payment Reform," Rep. Allyson Schwartz official website, April 15, 2011, http://www.house.gov/apps/list/press/pa13_schwartz/pr_apr15_ipabletter.html
[40] Press Release, "Schwartz: IPAB Is The Wrong Path Toward Medicare Payment Reform," Rep. Allyson Schwartz official website, April 15, 2011, http://www.house.gov/apps/list/press/pa13_schwartz/pr_apr15_ipabletter.html
[41] Press Release, "Schwartz: IPAB Is The Wrong Path Toward Medicare Payment Reform," Rep. Allyson Schwartz official website, April 15, 2011, http://www.house.gov/apps/list/press/pa13_schwartz/pr_apr15_ipabletter.html
[42] Rep. Allyson Schwartz op-ed, "Opposing view: Repeal Medicare board," *USA Today*, May 22, 2011, http://www.usatoday.com/news/opinion/editorials/2011-05-22-Opposing-view-Repeal-Medicare-board_n.htm

- **Rep. Schwartz also wrote that "the threat of reduced payments is the least imaginative option and most unlikely to result in the kind of heath care we know seniors and all Americans deserve"**

  - In a May 22, 2011, op-ed in *USA Today*, Rep. Allyson Schwartz wrote, "We all agree that Medicare costs must be contained and that the payment system is flawed and needs to be replaced. But simply cutting reimbursements is not the answer. IPAB brings unpredictability and uncertainty to providers and has the potential for stifling innovation and collaboration.

    "The threat of reduced payments is the least imaginative option and most unlikely to result in the kind of heath care we know seniors and all Americans deserve."[43]

- **IPAB is a concern for consumer organizations such as AARP, that fears the Medicare savings targets could have an "unintended impact on beneficiaries' access to, or quality of, care"**

  - In a Jan. 26, 2011, article, *Politico* reported, "Doctors groups have been the most vocal critics on Capitol Hill, but the board is also a concern for consumer organizations such as AARP, a lobby group for adults aged 50 and over that fears the Medicare savings targets could have an 'unintended impact on beneficiaries' access to, or quality of, care,' said spokesman David Allen. Dozens of organizations representing a variety of interests, including those of Medicare beneficiaries, social workers and hospices, signed a letter last January to Senate Majority Leader Harry Reid (D-Nev.) expressing their 'strong opposition' to the board."[44]

- **Max Richtman, executive vice president and acting CEO of the National Committee to Preserve Social Security and Medicare said, "IPAB turns Medicare into a scapegoat"**

  - In a June 8, 2011, article, *Politico* reported, "For more than a year, the National Committee and other supporters of the reform law who didn't like the IPAB were willing to put up with it for the greater good of the law. But in recent weeks, that support has waned.

    "'IPAB turns Medicare into a scapegoat,' said Max Richtman, executive vice president and acting CEO of the National Committee to Preserve Social Security and Medicare. 'Medicare will be forced to make reductions without addressing the rest of the health care costs.'"[45]

- **AARP's chief executive said, "Relying on arbitrary spending targets is not a good way to make health policy, especially when decisions may be left to the unelected and unaccountable"**

  - In an April 20, 2011, article, *The New York Times* reported, "Democrats and Republicans are joining to oppose one of the most important features of President Obama's new deficit

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[43] Rep. Allyson Schwartz op-ed, "Opposing view: Repeal Medicare board," *USA Today*, May 22, 2011, http://www.usatoday.com/news/opinion/editorials/2011-05-22-Opposing-view-Repeal-Medicare-board_n.htm
[44] Bara Vaida, "Health groups rise against panel," *Politico*, Jan. 26, 2011, http://www.politico.com/news/stories/0111/48166.html
[45] Jennifer Haberkorn, "Medicare pay board is losing vital support," *Politico*, June 8, 2011, http://www.politico.com/news/stories/0611/56467.html

reduction plan, a powerful independent board that could make sweeping cuts in the growth of Medicare spending."[46]

- According to the same article, "AARP, the American Medical Association and the American Hospital Association voiced concern about the president's latest proposal.

  "'Relying on arbitrary spending targets is not a good way to make health policy, especially when decisions may be left to the unelected and unaccountable,' said A. Barry Rand, chief executive of AARP, the lobby for older Americans.

  "Under the law, the board cannot make recommendations to 'ration health care,' raise revenues or increase beneficiaries' premiums, deductibles or co-payments. This increases the likelihood that the board will try to save money by trimming Medicare payments to health care providers."[47]

- **Doctors and drugmakers will bear the brunt of Medicare reductions, according to officials from those groups, and the president of the American Society of Anesthesiologists said that doctors could take "a big hit"**

  - In a Jan. 26, 2011, article, *Politico* reported, "Under the five-year exemption negotiated by hospitals, doctors and drugmakers will bear the brunt of Medicare reductions, according to officials from those groups. Doctors could take 'a big hit,' said Mark Warner, president of the American Society of Anesthesiologists. "And we are already under-reimbursed."[48]

- **"So 15 sages sitting in a room with the power of the purse will evidently find ways to control Medicare spending that no one has ever thought of before and that supposedly won't harm seniors' care, even as the largest cohort of the baby boom generation retires and starts to collect benefits"**

  - In an April 14, 2011, editorial, *The Wall Street Journal* wrote, "Mr. Obama said that the typical political proposal to rationalize Medicare's gargantuan liabilities is that it is 'just a matter of eliminating waste and abuse.' His own plan is to double down on the program's price controls and central planning. All Medicare decisions will be turned over to and routed through an unelected commission created by ObamaCare—which will supposedly ferret out 'unnecessary spending.' Is that the same as 'waste and abuse'?

    "Fifteen members will serve on the Independent Payment Advisory Board, all appointed by the President and confirmed by the Senate. If per capita costs grow by more than GDP plus 0.5%, this board would get more power, including an automatic budget sequester to enforce its rulings. So 15 sages sitting in a room with the power of the purse will evidently find ways to control Medicare spending that no one has ever thought of before and that supposedly

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[46] Robert Pear, "Bipartisan Objection to Panel to Curb Medicare Cost," *The New York Times*, April 20, 2011, http://www.nytimes.com/2011/04/20/us/politics/20health.html
[47] Robert Pear, "Bipartisan Objection to Panel to Curb Medicare Cost," *The New York Times*, April 20, 2011, http://www.nytimes.com/2011/04/20/us/politics/20health.html
[48] Bara Vaida, "Health groups rise against panel," *Politico*, http://www.politico.com/news/stories/0111/48166.html, Jan. 26, 2011,

won't harm seniors' care, even as the largest cohort of the baby boom generation retires and starts to collect benefits."[49]

- **Organizations of Medicare beneficiaries and providers said that IPAB would "greatly limit the ability of Medicare beneficiaries, advocates and providers to work with Congress to improve the program, making it especially difficult to include coverage of new and better treatments, procedures and technologies"**

  - According to a Jan. 11, 2010, letter to Senate Majority Leader Harry Reid (D-Nev.) and then-Speaker of the House Nancy Pelosi (D-Calif.) from organizations of health care providers and Medicare beneficiaries, "The Independent Payment Advisory Board would essentially assume authority over the Medicare program. This Board of officials appointed by the President would be required to make recommendations to reduce per capita Medicare spending regardless of whether it was growing faster than general health care inflation. Replacing elected officials with political appointments from the President does not remove 'politics' from the equation. Indeed, we are concerned that this construct would create a body that is not accountable to anyone but the President.

    "The proposal usurps Congressional authority over the Medicare program. IPAB would also greatly limit the ability of Medicare beneficiaries, advocates and providers to work with Congress to improve the program, making it especially difficult to include coverage of new and better treatments, procedures and technologies."[50]

- **The Congressional Budget Office reported that the package would cost nearly $1 trillion and would also reduce federal deficits by $143 billion,…**

  - According to the non-partisan Congressional Budget Office in a March 20, 2010, letter to Speaker Nancy Pelosi, the gross costs of the full health care package would be $938 billion.[51]

  - In a March 20, 2010, letter to Speaker Nancy Pelosi, the non-partisan Congressional Budget office wrote, "CBO and JCT estimate that enacting both pieces of legislation—H.R. 3590 and the reconciliation proposal— would produce a net reduction in federal deficits of $143 billion over the 2010–2019 period as result of changes in direct spending and revenue."[52]

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[49] Editorial, "The Presidential Divider," *The Wall Street Journal*, http://online.wsj.com/article/SB10001424052748703730104576260911986870054.html, April 14, 2011,
[50] Letter to Senator Harry Reid and Rep. Nancy Pelosi, "Organizations unite in opposition to the establishment of the Independent Payment Advisory Board," National Committee to Preserve Social Security and Medicare (NCPSSM), http://www.ncpssm.org/news/archive/letter_independent_payment/, Jan. 11, 2010,
[51] Douglas W. Elmendorf, "Letter to Nancy Pelosi," Congressional Budget Office, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf, March 20, 2010
[52] Douglas W. Elmendorf, "Letter to Nancy Pelosi," Congressional Budget Office, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf, March 20, 2010,

- **In May 2010, the Congressional Budget Office reported that the health care law could potentially add another $115 billion over 10 years to government health care spending, pushing the 10-year cost of the overhaul over $1 trillion**

  - In a May 14, 2010, article, the Associated Press reported, "Congressional budget referees say President Barack Obama's new health care law could potentially add another $115 billion over 10 years to government health care spending.

    "If Congress approves all the additional spending, that would push the 10-year cost of the overhaul above $1 trillion — an unofficial limit the Obama administration set early on.

    "The Congressional Budget Office said Tuesday the added spending includes $10 billion to $20 billion in administrative costs to federal agencies carrying out the law, as well as $34 billion for community health centers and $39 billion for American Indian health care."[53]

- **For most people, premiums would not change significantly under the legislation**

  - According to a March 19, 2010, non-partisan Annenberg Public Policy Center (Factcheck.org), article, "The battle over what happens to insurance premium costs under the bill was most pronounced during President Obama's health care summit Feb. 25. Obama and Republican Sen. Lamar Alexander of Tennessee argued over whether premiums would increase (Alexander's view) or decrease (Obama's), compared with what premiums would do in the absence of legislation. The truth is that for most people, premiums wouldn't change significantly."[54]

  - In an April 13, 2010, article, the *Los Angeles Times* reported, "Public outrage over double-digit rate hikes for health insurance may have helped push President Obama's healthcare overhaul across the finish line, but the new law does not give regulators the power to block similar increases in the future.

    "And now, with some major companies already moving to boost premiums and others poised to follow suit, millions of Americans may feel an unexpected jolt in the pocketbook.

    "Although Democrats promised greater consumer protection, the overhaul does not give the federal government broad regulatory power to prevent increases."[55]

- **Under the legislation, the average premiums for those who buy insurance on their own would go up by 10 percent to 13 percent**

  - According to a March 19, 2010, non-partisan Annenberg Public Policy Center (Factcheck.org), article, "The Congressional Budget Office estimated that for those in the

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[53] "Health overhaul law potentially costs $115B more," CBS News, http://www.cbsnews.com/stories/2010/05/11/politics/main6473640.shtml, May 14, 2010,
[54] Lori Robertson, "A final weekend of whoppers?," Annenberg Public Policy Center http://www.factcheck.org/2010/03/a-final-weekend-of-whoppers/, March 19, 2010
[55] Noam N. Levey, "Healthcare overhaul won't stop premium increases," *Los Angeles Times*, http://articles.latimes.com/2010/apr/13/nation/la-na-health-premiums13-2010apr13, April 13, 2010

group market – those who get insurance through their employers – premiums would largely stay the same. The change in the average premium in the large group market would be between 0 percent and a 3 percent decrease, for instance, compared with where they'd be under current law in 2016. The average premiums for those who buy insurance on their own would go up, however, by 10 percent to 13 percent. The reason is that benefits would become a lot better for this market under the bill. Also, most people buying their own coverage would receive subsidies that make their net costs for these plans substantially lower than they otherwise would be."[56]

- **Young adults that buy their own insurance could see their premiums rise by 17 percent or about $42 a month and will carry a heavier burden of the medical costs of older Americans**

  - In a March 29, 2010, article, the Associated Press reported, "Under the health care overhaul, young adults who buy their own insurance will carry a heavier burden of the medical costs of older Americans— a shift expected to raise insurance premiums for young people when the plan takes full effect.

    "Beginning in 2014, most Americans will be required to buy insurance or pay a tax penalty. That's when premiums for young adults seeking coverage on the individual market would likely climb by 17% on average, or roughly $42 a month, according to an analysis of the plan conducted for The Associated Press. The analysis did not factor in tax credits to help offset the increase."[57]

- **"Nearly one in 10 midsize or large employers expects to stop offering health coverage to workers" because of the democrats' health care overhaul**

  - In an Aug. 24, 2011, article, the Associated Press reported, "Nearly one in 10 midsize or large employers expects to stop offering health coverage to workers once federal insurance exchanges start in 2014, according to a survey from a large benefits consultant.

    "Towers Watson also found in a survey completed last month that an additional 20% of companies are unsure about what they will do.

    "Another big benefits consultant, Mercer, found in a June survey of large and smaller employers that 8% are either 'likely' or 'very likely' to end health benefits once the exchanges start.

    "Employer-sponsored health insurance has long been the backbone of the nation's health insurance system. But the studies suggest some employers, especially retailers or those paying low wages, feel they will be better off paying fines and taxes than continuing to provide benefits that eat up a growing portion of their budget every year.

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[56] Lori Robertson, "A final weekend of whoppers?," Annenberg Public Policy Center http://www.factcheck.org/2010/03/a-final-weekend-of-whoppers/, March 19, 2010
[57] Carla K. Johnson, "Health premiums may rise 17% for young adults buying own insurance," ABC News, http://www.usatoday.com/news/health/2010-03-29-insurance-premiums_N.htm, March 29, 2010

"The exchanges, devised under health care overhaul, may offer an alternative for workers. These exchanges aim to provide a marketplace for people to buy insurance that can be subsidized by the government based on income levels."[58]

- **The democrats' health care overhaul could make the current national doctor shortage even worse by as many as 150,000 doctors in the next 15 years**

  - In an April 12, 2010, article, *The Wall Street Journal* reported, "The new federal health-care law has raised the stakes for hospitals and schools already scrambling to train more doctors.

    "Experts warn there won't be enough doctors to treat the millions of people newly insured under the law. At current graduation and training rates, the nation could face a shortage of as many as 150,000 doctors in the next 15 years, according to the Association of American Medical Colleges."[59]

  - In a March 28, 2010, article, the Associated Press reported, "The new law goes beyond offering coverage to the uninsured, with steps to improve the quality of care for the average person and help keep us well instead of today's seek-care-after-you're-sick culture. To benefit, you'll need a regular health provider.

    "Yet recently published reports predict a shortfall of roughly 40,000 primary care doctors over the next decade, a field losing out to the better pay, better hours and higher profile of many other specialties. Provisions in the new law aim to start reversing that tide, from bonus payments for certain physicians to expanded community health centers that will pick up some of the slack."[60]

- **Taxpayers earning less than $200,000 a year will pay roughly $3.9 billion more in taxes in 2019 alone**

  - In an April 12, 2010, article, *The Hill* reported, "Taxpayers earning less than $200,000 a year will pay roughly $3.9 billion more in taxes — in 2019 alone — due to healthcare reform, according to the Joint Committee on Taxation, Congress's official scorekeeper.

    "The new law raises $15.2 billion over 10 years by limiting the medical expense deduction, a provision widely used by taxpayers who either have a serious illness or are older."[61]

  - The article also reported, "Once the law is fully implemented in 2019, the JCT estimates the deduction limitation will affect 14.8 million taxpayers — 14.7 million of them will earn less

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[58] Tom Murphy, "Survey: Almost 10% of employers may end health insurance," *USA Today*, http://www.usatoday.com/money/industries/health/story/2011-08-24/Survey-Almost-10-of-employers-may-end-health-insurance/50120998/1, Aug. 24, 2011

[59] Suzanne Sataline and Shirley S. Wang, "Medical Schools Can't Keep Up," *The Wall Street Journal*, http://online.wsj.com/article/SB10001424052702304506904575180331528424238.html, April 12, 2010

[60] Laura Neergaard, "Health shortage likely to strain doctor shortage," AOL News, http://www.aolnews.com/2010/03/28/health-care-overall-likely-to-strain-doctor-shortage/, March 28, 2010

[61] Jay Heflin, "JCT: Healthcare law to sock middle class with a $3.9 billion tax increase in 2019," *The Hill*, http://thehill.com/blogs/on-the-money/domestic-taxes/91669-healthcare-law-socks-middle-class-with-a-39-billion-tax-increase, April 12, 2010

than $200,000 a year. These taxpayers are single and joint filers, as well as heads of households."[62]

[62] Jay Heflin, "JCT: Healthcare law to sock middle class with a $3.9 billion tax increase in 2019," *The Hill*, http://thehill.com/blogs/on-the-money/domestic-taxes/91669-healthcare-law-socks-middle-class-with-a-39-billion-tax-increase, April 12, 2010

H.R. 3962: THE HOUSE-PASSED HEALTH CARE REFORM BILL

Early in 2009, following passage of the economic stimulus package, it was made clear that health care reform legislation would be a top agenda item for President Obama and the Democrats in the 111th Congress. Even as the economy continued to spiral downward and the public's cries for action to promote the economy and job growth grew louder, President Obama and Congressional Democrats pushed forward with health care reform legislation that grew more unpopular the more people learned about it. President Obama and the Democrats in Congress spent a shocking amount of time and energy, and most of their "political capital," on a fanatical quest to pass a health care bill that most people either do not understand, do not want or do not think should be the priority of the federal government particularly during a time of economic downturn.

In July 2009, three House committees began formally considering a health care overhaul bill (H.R. 3200) in an effort to increase health care coverage to the uninsured and to reduce health care costs. Democrats, however, quickly found themselves bitterly divided over key aspects of the bill. Specifically, inter-party debates broke out over the overall costs of the legislation, provisions regarding a government-run insurance option, which critics say would kill the private health care insurer market instead of providing a more competitive environment to drive costs down, and over the potential of federal funding of abortion.

The three House committees with jurisdiction over the bill – Ways and Means, Education and Labor (now called Education and Workforce) and Energy and Commerce – each approved a version of the legislation in late July 2009. Democrat leaders had hopes of taking a Floor vote on a final House version of the bill before the August recess, a deadline demanded by President Obama.

In the committees, Republicans fought hard to scale down the bill by offering amendments that would eliminate a government-run insurance plan, eliminate a requirement for employees to provide coverage to workers or face tax penalties and to prevent the government from using research on the comparative effectiveness of treatments to make coverage decisions on the basis of cost. Amendments were also offered by GOP members to remove all of the tax increases from the legislation, require states to limit medical malpractice lawsuits, order Members of Congress to enroll in the "public" insurance plan and prevent abortions from being covered under a proposed "essential benefit package" that would be determined by the federal government under the bill.

After months of wrangling within their own party and missing several self-imposed deadlines, House Democrat leaders introduced a final bill (H.R. 3962) on Oct. 29, 2009. The bill was nearly 2,000 pages long and had a final cost of at least one trillion dollars. It contained a public insurance option for which the government would negotiate rates with health care providers, along with a mandate on individuals that they must purchase coverage subject to a tax penalty and a mandate on businesses that they offer coverage to their employees. The bill would be financed in part by a surtax on the wealthiest Americans. In a move to reduce the cost of the bill that has been compared to a "shell game," the legislation does not include a proposal to repeal a Medicare payment formula that sets doctors' payment rates. Under the House plan, this situation would be handled through separate legislation.

Editor's Note: *For further information regarding the payment formula for doctor's payment rates, please refer to the Medicare and Medicaid chapter of the 2012 NRCC Issues Book.*

While Democratic leaders struggled to round up the 218 votes needed for passage, the House eventually passed the bill by a vote of 220-215 on Nov. 7, 2009, with 39 Democrats voting "no." See how they voted here.

During Floor consideration of H.R. 3962, Members also adopted an amendment (known as the "Stupak Amendment")from then-Rep. Bart Stupak (D-Mich.) that would prevent federal funding of abortion by forbidding insurance plans that receive federal subsidies from covering elective abortion services. It would also prohibit the public option from covering the procedure at all, except in cases of rape or incest or when continuing the pregnancy threatens the woman's life. See how they voted here.

Editor's Note: *For further information regarding abortion and the Stupak Amendment, please refer to the Social Issues chapter of the 2012 NRCC Issues Book.*

Selected voted hits on Democrats who voted for H.R. 3962:

- **On Nov. 7, 2009, House Democrats passed H.R. 3962, the Affordable Health Care for America Act, the Democrats' health care overhaul legislation with a government-run public option**
    - On Nov. 7, 2009, House Democrats passed a bill that would overhaul the nation's health insurance system and require most individuals to buy health insurance by 2013. It would create the Health Choices Administration tasked with establishing a federal health insurance exchange, including a government-run public health insurance option, to allow individuals without coverage to purchase insurance. Those that do not obtain coverage would be subject to an excise tax. Excluded from the mandate would be those exempt from filing income tax and others with a hardship waiver. Employers would be required to offer health insurance to employees or contribute to a fund for coverage. Businesses that fail to provide coverage could face penalties of up to 8 percent of their payroll. It would provide tax credits to certain small businesses for providing coverage; provide subsidies to individuals making up to four times the federal poverty level, excluding illegal immigrants; and allow states to enter into compacts to facilitate coverage purchase across state lines. The bill would bar the use of federal funds to provide abortions, except in cases of rape, incest or if the woman's life is in danger. It also would bar insurance companies from denying or reducing coverage based on pre-existing medical conditions. (Passed by a vote of 220-215, D: 219-39, R: 1-176)[63]

- ***The Washington Post*** **said the bill, "does not do enough to address rising health-care costs and is not financed in a sensible, sustainable way"**
    - In an Oct. 30, 2009, editorial, *The Washington Post* wrote, "The fundamental aims of the health-care bill unveiled Thursday by House Speaker Nancy Pelosi (D-Calif.) -- covering the uninsured and reforming insurance markets to end abusive practices -- are laudable. But the legislation, while creating an expensive new entitlement program (subsidies to purchase health insurance) and dramatically expanding an existing one (Medicaid), does not do enough to address rising health-care costs and is not financed in a sensible, sustainable way."[64]

[63] H.R. 3962, CQ Vote #887, Nov. 7, 2009
[64] Editorial, "The House's health-reform bill," *The Washington Post,* Oct. 30, 2009

- ***The Wall Street Journal*** **called the bill the "biggest expansion of the federal government since the New Deal" and "a breathtaking display of illiberal ambition, intended to make the middle class more dependent on government through the umbilical cord of 'universal health care.'"**

    - In a Nov. 9, 2009, editorial, *The Wall Street Journal* wrote, "Speaker Nancy Pelosi defied policy logic and public opinion late Saturday night, ramming through the House a nearly 2,000-page health-care leviathan that counts as the biggest expansion of the federal government since the New Deal. As President Obama likes to say, this was a 'teachable moment' about our current government."[65]

    - The editorial went on to say, "The bill is instead a breathtaking display of illiberal ambition, intended to make the middle class more dependent on government through the umbilical cord of 'universal health care.' It creates a vast new entitlement, financed by European levels of taxation on business and individuals. The 20% corner of Medicare open to private competition is slashed, while fiscally strapped states are saddled with new Medicaid burdens. The insurance industry will have to vet every policy with Washington, which will regulate who it must cover, what it can offer, and how much it can charge."[66]

- **In a separate editorial entitled, "The Worst Bill Ever,"** ***The Wall Street Journal*** **called the bill "among the worst bills Congress has ever seriously contemplated"**

    - In a Nov. 1, 2009, editorial entitled, "The Worst Bill Ever," *The Wall Street Journal* wrote, "Mr. Obama rode into office on a wave of 'change,' but we doubt most voters realized that the change Democrats had in mind was making health care even more expensive and rigid than the status quo. Critics will say we are exaggerating, but we believe it is no stretch to say that Mrs. Pelosi's handiwork ranks with the Smoot-Hawley tariff and FDR's National Industrial Recovery Act as among the worst bills Congress has ever seriously contemplated."[67]

- **The total cost of the bill is at least $1.1 trillion over the next 10 years**

    - In a Nov. 7, 2009, article, *The New York Times* reported, "After a daylong clash with Republicans over what has been a Democratic goal for decades, lawmakers voted 220 to 215 to approve a plan that would cost $1.1 trillion over 10 years"[68]

    - In a Nov. 2, 2009, article, The Associated Press reported, "The health care bill headed for a vote in the House this week costs $1.2 trillion or more over a decade, according to numerous Democratic officials and figures contained in an analysis by congressional budget experts, far higher than the $900 billion cited by President Barack Obama as a price tag for his reform plan.

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[65] Editorial, "The lords of entitlement," *The Wall Street Journal*, Nov. 9, 2009
[66] Editorial, "The lords of entitlement," *The Wall Street Journal*, Nov. 9, 2009
[67] Editorial, "The worst bill ever," *The Wall Street Journal,* Nov. 1, 2009
[68] Carl Hulse and Robert Pear, "Sweeping Health Care Plan Passes House," *The New York Times*, Nov. 7, 2009

"While the Congressional Budget Office has put the cost of expanding coverage in the legislation at roughly $1 trillion, Democrats added billions more on higher spending for public health, a reinsurance program to hold down retiree health costs, payments for preventive services and more.

"Many of the additions are designed to improve benefits or ease access to coverage in government programs. The officials who provided overall cost estimates did so on condition of anonymity, saying they were not authorized to discuss them.

"House Speaker Nancy Pelosi has referred repeatedly to the bill's net cost of $894 billion over a decade for coverage."[69]

- **H.R. 3962 uses budget gimmicks to hide hundreds of billions of dollars in additional costs, and costs could rise as high as $2 trillion over 10 years and continue to grow**
  - In a Nov. 1, 2009, editorial, *The Wall Street Journal* wrote, "Even so, the House disguises hundreds of billions of dollars in additional costs with budget gimmicks. It 'pays for' about six years of program with a decade of revenue, with the heaviest costs concentrated in the second five years. The House also pretends Medicare payments to doctors will be cut by 21.5% next year and deeper after that, 'saving' about $250 billion. ObamaCare will be lucky to cost under $2 trillion over 10 years; it will grow more after that."[70]
  - In a Nov. 9, 2009, editorial, *The Detroit News* wrote, "Above all else is the cost. Democrats estimate the cost at $1.2 trillion over the next decade, but have worked feverishly to repress credible, contrary estimates that the true expense will be $2 trillion or more. The plan will levy taxes for 10 years to pay for six years of benefits, suggesting that in the second decade the annual costs will explode."[71]
- **As of Nov. 5, 2009, costs for the bill have not been adequately "scored" and could climb even higher**
  - In a Nov. 5, 2009, letter to Rep. John Dingell, Chairman Emeritus of the House Energy and Commerce Committee, the non-partisan Congressional Budget Office (CBO) wrote, "CBO has not completed a comprehensive estimate of the discretionary costs that would be associated with H.R. 3962, incorporating the manager's amendment. Total costs would include those arising from the effects of H.R. 3962 on a variety of federal programs and agencies, as well as from a number of new and existing programs subject to future appropriations."[72]

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[69] David Epso, "AP sources: House health bill totals $1.2 trillion," The Associated Press, Nov. 2, 2009
[70] Editorial, "The worst bill ever," *The Wall Street Journal,* Nov. 1, 2009
[71] Editorial, "Narrowly passed House health care bill lacks broad support," *The Detroit News,* Nov.9, 2009
[72] Douglas W. Elmendorf, "Letter to the Honorable John Dingell," Congressional Budget Office, Nov. 5, 2009

- **H.R. 3962 could take the United States closer to bankruptcy, causing the most harm to the poor and vulnerable**

  - In a Nov. 9, 2009, opinion, Fred Hiatt, editorial page editor of *The Washington Post,* wrote, "Here is the dilemma: The bill also could take America a step closer to bankruptcy. And for progressives in particular -- for those who believe that government has a mission to help the poor and protect the vulnerable -- that prospect should be alarming. If federal debt continues rising on its present path, hastened by a $1 trillion health-care bill, it is the poor and vulnerable who will be most harmed."[73]

- **The day before the vote occurred, it was announced that the national unemployment rate reached 10.2 percent, which is a 26 year high**

  - In a Nov. 6, 2009, article, *The Hill*, reported, "The national unemployment rate jumped higher than expected in October, reaching a 26-year high at 10.2 percent."[74]

- **The bill would create a new government-run public health insurance option**

  - According to *Congressional Quarterly's* summary of H.R. 3962, the bill "Creates a government-run public health insurance option within the exchange, but administered by the Health and Human Services (HHS) Department, which would have to meet the same requirements as private plans. The public option would negotiate with providers to determine reimbursement rates. The option would receive start-up money from the government, but would be dependent on premiums. CBO estimated that 6 million people would likely be covered by the option, about 2% of the population."[75]

- **H.R. 3962 includes several tax increases that would cost taxpayers at least $700 billion over the next 10 years**

  - In a Nov. 6, 2009 WebMemo, The Heritage Foundation wrote, "The new House health care plan includes several tax increases that would cost taxpayers $700 billion over the next 10 years. In addition to the surtax, employer mandate, and individual mandate provisions found in the original bill, H.R. 3962 adds on several new taxes."[76]

- **The bill requires individuals to have health insurance by 2013, or pay an excise tax, equal to 2.5 percent of gross income**

  - According to *Congressional Quarterly's* summary of H.R. 3962, the bill contains an individual mandate that "Requires nearly all individuals to have health insurance by 2013, or pay an excise tax, equal to 2.5% of gross income, capped at the amount of the average premium under the health insurance exchange. The measure, however, provides a hardship exception

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[73] Fred Hiatt, column, "A high price for health reform," *The Washington Post*, Nov. 9, 2009
[74] Sam Youngman, "Unemployment jumped to 26-year high in October at 10.2 percent," *The Hill*, Nov. 6, 2009
[75] CQ House Action Report, "No. 1121, Health Insurance Overhaul," *Congressional Quarterly,* Nov. 5, 2009
[76] Staff Writers, "A Closer Look at the House Democrats' Health Care Bill," The Heritage Foundation, Nov. 6, 2009

and exemptions for religious beliefs. The measure allows parents to maintain coverage for their children until their 27th birthday."[77]

- **If an individual did not comply with the individual mandate and did not pay the excise tax, they could face fines up to $250,000 and up to five years imprisonment**

  - In a Nov. 5, 2009, letter to Rep. Dave Camp (R-MI), ranking member of the House Ways and Means Committee, the non-partisan Joint Committee on Taxation wrote, "You asked that I discuss the situation in which the taxpayer has chosen not to comply with [sic] individual mandate and not to pay the additional tax. The Code provides for both civil and criminal penalties to ensure complete and accurate reporting of tax liability and to discourage fraudulent attempts to defeat or evade tax." [78]

  - The letter goes on to say, "'If the government determines that the taxpayer's unpaid tax liability results from willful behavior, the following penalties could apply.'

    "Criminal penalties
    Prosecution is authorized under the Code for a variety of offenses. Depending on the level of the noncompliance, the following penalties could apply to an individual:

    - Section 7203 – misdemeanor willful failure to pay is punishable by a fine of up to $25,000 and/or imprisonment of up to one year.

    - Section 7201 – felony willful evasion is punishable by a fine of up to $250,000 and/or imprisonment of up to five years."[79]

- **Under H.R. 3962, most employers are mandated to provide health insurance coverage to their employees or face an 8 percent payroll tax**

  - According to a Nov. 9, 2009, article, *The Wall Street Journal* reported, "All but the smallest employers would be required to provide insurance and pay for most of the premium, or they would face a fine of up to 8% of their payroll."[80]

- **Under H.R. 3962, most employers would be required to cover 72.5% of premiums for individuals and 65% for families**

  - According to *Congressional Quarterly's* summary of H.R. 3962, the bill contains an employer mandate that "requires most employers to offer health insurance to their employees, or pay a tax in lieu of such coverage equal to 8% of payroll. Businesses with payrolls of less than $500,000 would be exempt from the payment, and there would be reduced rates for those with payrolls between $500,000 and $750,000. Employers that offer coverage would have to cover 72.5% of premiums for individuals and 65% for families."[81]

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[77] CQ House Action Report, "No. 1121, Health Insurance Overhaul," *Congressional Quarterly,* Nov. 5, 2009
[78] Thomas A. Barthold, Chief of Staff, Joint Committee on Taxation, "Letter to the Honorable Dave Camp," Nov. 5, 2009
[79] Thomas A. Barthold, Chief of Staff, Joint Committee on Taxation, "Letter to the Honorable Dave Camp," Nov. 5, 2009
[80] Janet Adamy and Naftali Bendavid, "Health Bill Faces Senate Heat," *The Wall Street Journal,* Nov. 9, 2009
[81] CQ House Action Report, "No. 1121, Health Insurance Overhaul," *Congressional Quarterly,* Nov. 5, 2009

- **H.R. 3962, imposes new costs on businesses whether they provide coverage or pay the tax penalty**
    - In a Nov. 5, 2009, WebMemo, The Heritage Foundation wrote, "The plan imposes new costs on businesses, regardless of whether they decide to offer health insurance coverage or pay the assessment penalty. It explicitly states that these additional payments for health insurance cannot be directly taken out of an employee's wages, and any employer-based coverage must meet the Pelosi plan's minimum coverage requirements."[82]

- **These additional costs on businesses would create a strong disincentive to increase compensation or to hire new employees**
    - In a Nov. 5, 2009, WebMemo, The Heritage Foundation wrote, "Recently unveiled health care reform legislation known as the "Pelosi plan" would impose new costs on small businesses. This legislation would create an employer penalty system that would apply to small firms--even those with 25 or fewer workers. Businesses expanding total annual payroll to $500,000 would face a $10,000 marginal penalty; this penalty rises to $19,200 for small firms expanding total wages to $750,000. This additional cost would create a strong disincentive for small firms to increase compensation or hire additional employees."[83]

- **Should the tax penalty be less than the cost of providing insurance, some employers could choose not to offer health plans, which would disrupt coverage for employees**
    - In a Nov. 6, 2009 WebMemo, The Heritage Foundation wrote, "Furthermore, since the amount of this tax would be lower than the cost of providing health insurance (especially for low-income workers), many employers would opt to pay the tax and not offer health plans, disrupting their employees' existing coverage."[84]

- **H.R. 3962 imposes a 5.4 percent surtax on those with adjusted gross incomes of more than $500,000 for an individual or $1 million for a joint return. The bill does not index those dollar amounts for inflation, meaning that the surtax would apply to more taxpayers as inflation affects income levels**
    - According to *Congressional Quarterly's* summary of H.R. 3962, "The measure raises an estimated $460.5 billion through FY 2019 by imposing a surtax on those with adjusted gross incomes of more than $500,000 for an individual or $1 million for a joint return. The bill does not index those dollar amounts for inflation, meaning that the surtax would apply to more taxpayers as inflation affects income levels. The surcharge would be 5.4% of the portion of gross income that exceeds the $500,000 and $1 million amounts, and would apply to tax years that begin after Dec. 31, 2010."[85]

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[82] John L. Ligon, "The Pelosi Health Care Plan: Employer Mandate Penalties on Small Businesses," The Heritage Foundation, Nov. 5, 2009
[83] John L. Ligon, "The Pelosi Health Care Plan: Employer Mandate Penalties on Small Businesses," The Heritage Foundation, Nov. 5, 2009
[84] Staff Writers, "A Closer Look at the House Democrats' Health Care Bill," The Heritage Foundation, Nov. 6, 2009
[85] CQ House Action Report, "No. 1121, Health Insurance Overhaul," *Congressional Quarterly,* Nov. 5, 2009

- **By not indexing the tax thresholds for inflation, this tax could resemble the current debacle with the Alternative Minimum Tax (AMT). The original thresholds for the AMT in 1969 were $500,000 for individuals filing as singles and $1 million for joint filers. Today, without annual congressional action, tax filers with taxable income as low as $75,000 would be forced to pay the AMT**

    - In a Nov. 6, 2009, WebMemo, The Heritage Foundation wrote, "The threshold of the surtax is not indexed for inflation, which means that more and more taxpayers will be affected as incomes rise. This is the latest form of bracket creep: paying higher taxes on income over time because a tax does not account for inflation. This means that if a taxpayer's income only keeps up with inflation, he or she will be poorer despite having the same level of purchasing power every year.

      "To illustrate how dangerous this can be, consider the current debacle with the AMT: It was originally conceived in 1969 as a tax to affect only approximately 1 percent of taxpayers who were seen as avoiding some tax payments. However, since it was not indexed to inflation, more and more middle-class taxpayers have been in the AMT bracket. As a result, Congress must enact legislation year after year to 'patch' the inflation to make sure millions of tax filers are not suddenly forced to pay the AMT. Without the patch, tax filers with taxable income as low as $75,000 would be forced to pay the AMT.

      "The original thresholds for the AMT in 1969 were $500,000 for individuals filing as singles and $1 million for joint filers."[86]

- **The surtax within H.R. 3962 is a direct surtax on hundreds of thousands of small businesses and could force successful small businesses to make cutbacks and layoffs**

    - According to an Oct. 28, 2008, report, the Tax Foundation reported, "An under-appreciated feature of the U.S. tax system is that most small businesses are not required to pay the corporate income tax. Instead, small business income "flows through" to the owners who report it on their individual income tax returns. About 35 percent of business taxes are paid in this manner by the owners of sole proprietorships, partnerships and S corporations."[87]

    - In a Nov. 6, 2009, WebMemo, The Heritage Foundation wrote, "However, the surtax as currently proposed would have an even more direct affect on jobs--because it would be a direct surtax on hundreds of thousands of small businesses. These small businesses are the engine of new job creation in the economy. Right when the U.S. needs this job creation the most, the surtax would force successful small businesses to make cutbacks and layoffs.

      "Out of the approximately 300,000 joint tax filers earning over $1 million, about 90 percent have small business income. Thirty percent earn more than half their income from their small business. These small business tax filers would face a sudden increase in their tax burden. In addition, those businesses earning less would be less likely to expand because

[86] Rea S. Hederman, Jr. and Guinevere Nell, "Pelosi Health Care Plan: Who Pays the Surtax?," The Heritage Foundation, Nov. 6, 2009

[87] Robert Carroll, "Small Business and Personal Income Tax Rates," The Tax Foundation, Oct. 28, 2008

their risk-taking would be offset by a much lower reward. This surtax is a tax on the major jobs creation engine of the U.S. economy. There could not be a worse time to propose it."[88]

- **H.R. 3962 imposes a new 2.5 percent excise tax on the sale or lease of medical devices such as prosthetic limbs and defibrillators**

  - According to *Congressional Quarterly's* summary of H.R. 3962, "The bill also imposes a 2.5% excise tax on the sale or lease of medical devices to raise $20 billion over 10 years."[89]

  - In a Nov. 7, 2009 article, *Congressional Quarterly* reported, "To help pay for the cost of expanding health care coverage to millions of uninsured Americans, the bill (HR 3962) would impose a 2.5 percent excise tax on the sale or lease of medical devices, such as prosthetic limbs and defibrillators. The provision would raise an estimated $20 billion over 10 years."[90]

- **Despite President Obama's promise that Americans would be able to keep their current health insurance plan, under H.R. 3962, within five years, all health insurance plans would have to meet new requirements defined by a new Health Choice Commissioner**

  - In his remarks before a joint session of Congress on Sept. 9, 2009, President Obama said, "Here are the details that every American needs to know about this plan. First, if you are among the hundreds of millions of Americans who already have health insurance through your job, or Medicare, or Medicaid, or the VA, nothing in this plan will require you or your employer to change the coverage or the doctor you have. Let me repeat this: Nothing in our plan requires you to change what you have."[91]

  - In a Nov. 6, 2009 WebMemo, The Heritage Foundation wrote, "Furthermore, health plans would have to meet new requirements defined by the new Health Choices Commissioner. Insurers and employer-based plans would have five years to bring their plans into compliance. The commissioner could require coverage of services people do not want (increasing premiums) and then in the name of "cost containment" prohibit plans from covering services people want but that the commissioner does not want."[92]

- **H.R. 3962 contains the largest expansion of Medicaid in history, potentially adding as many as 18 million people to the program, and increases the current Medicaid spending burden for states**

  - According to *Congressional Quarterly's* summary of H.R. 3962, "The bill expands eligibility under Medicaid to anyone with income at or below 150% of the federal poverty line who is not eligible for Medicare, and provides a 100% federal share of costs for newly covered people in 2013 and 2014, and 91% in subsequent years. The bill also requires states to cover

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[88] Rea S. Hederman, Jr. and Guinevere Nell, "Pelosi Health Care Plan: Who Pays the Surtax?," The Heritage Foundation, Nov. 6, 2009
[89] CQ House Action Report, "No. 1121, Health Insurance Overhaul," *Congressional Quarterly,* Nov. 5, 2009
[90] Joseph J. Schatz, "Bargaining Chip: Tax on Medical Devices," *Congressional Quarterly,* Nov. 7, 2009
[91] Office of the Press Secretary, "Remarks by the president to a joint session of Congress on health care," The White House, Sept. 9, 2009
[92] Staff Writers, "A Closer Look at the House Democrats' Health Care Bill," The Heritage Foundation, Nov. 6, 2009

preventive services without charging deductibles or co-payments, reduces Medicaid disproportionate share hospital payments by $10 billion over a three-year period from FY 2017 through FY 2019, and extends increased matching payments under the stimulus law. CBO estimates that state spending on Medicaid would increase by $34 billion over 10 years as a result of these changes."[93]

- In a Nov. 6, 2009, WebMemo, The Heritage Foundation wrote, "The Speaker's mammoth health legislation includes the largest Medicaid expansion in history, adding as many as 18 million people to the program. Not only will childless adults become eligible for Medicaid for the first time in the history of the program, but approximately 5 million children who have been served under the successful and popular State Children's Health Insurance Program (SCHIP) will also be transferred into Medicaid."[94]

- **H.R. 3962 cuts more than $400 billion from future Medicare spending**

  - In a Nov. 8, 2009, article, The Associated Press reported, "To pay for the expansion of coverage, the bill cuts Medicare's projected spending by more than $400 billion over a decade. It also imposes a tax surcharge of 5.4 percent on income over $500,000 in the case of individuals and $1 million for families."[95]

  - The article goes on to say, "Democrats lined up a range of outside groups behind their legislation, none more important than the AARP, whose support promises political cover against the cuts to Medicare in next year's congressional elections."[96]

  - According to *Congressional Quarterly's* summary of H.R. 3962, "The measure would raise $460.5 billion through FY 2019 by imposing a 5.4% surtax on income over $500,000 for an individual, and $1 million for couples. As introduced, it would also reduce mandatory spending under Medicare, Medicaid, and other health programs by an estimated net $426 billion through FY 2019, primarily through changes in payment rates."[97]

- **H.R. 3962 cuts $170 billion from Medicare Advantage, private plan options that currently enroll 20 percent of Medicare beneficiaries**

  - In a Nov. 1, 2009, editorial, *The Wall Street Journal* wrote, "All this is particularly reckless given the unfunded liabilities of Medicare—now north of $37 trillion over 75 years. Mrs. Pelosi wants to steal $426 billion from future Medicare spending to 'pay for' universal coverage. While Medicare's price controls on doctors and hospitals are certain to be tightened, the only cut that is a sure thing in practice is gutting Medicare Advantage to the tune of $170 billion. Democrats loathe this program because it gives one of out five seniors private insurance options."[98]

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[93] CQ House Action Report, "No. 1121, Health Insurance Overhaul," *Congressional Quarterly*, Nov. 5, 2009
[94] Staff Writers, "A Closer Look at the House Democrats' Health Care Bill," The Heritage Foundation, Nov. 6, 2009
[95] David Epso, "House narrowly passes landmark health care bill," The Associated Press, Nov. 8, 2009
[96] David Epso, "House narrowly passes landmark health care bill," The Associated Press, Nov. 8, 2009
[97] CQ House Action Report, "No. 1121, Health Insurance Overhaul," *Congressional Quarterly,* Nov. 5, 2009
[98] Editorial, "The worst bill ever," *The Wall Street Journal,* Nov. 1, 2009

- In its summary of H.R. 3962, *Congressional Quarterly* wrote, "Yet the characterization of these government programs is somewhat incomplete. Medicare has private plan options (Medicare Advantage plans) that now enroll 20% of Medicare beneficiaries, and Medicaid has commercially managed care plans. In both cases, the private plans are publicly financed and closely regulated, but participants often have choices that are characteristic of private coverage. In turn, private insurance is regulated more than other consumer products, including requirements and restrictions on benefits, pricing, and marketing when sold as commercial insurance and tax code and ERISA rules when employers self-insure."[99]

[99] CQ House Action Report, "No. 1121, Health Insurance Overhaul," *Congressional Quarterly,* Nov. 5, 2009

HEALTH CARE OVERHAUL IMPLEMENTATION TIMELINE

Editor's Note: *There are numerous timelines which have been compiled by various organizations and groups – whether it be the law's tax provisions, regulatory provisions or all of its provisions, in general. For the sake of space, this section will only provide a timeline put together by The Heritage Foundation which can be found here. Links to other timelines that are available will be compiled at the end of this chapter so that candidates are able to get a wide swath of perspectives on the law's provisions.*

Implementation of the Major Provisions of Obamacare: The Timeline

Federal Insurance Regulations

- Prohibits lifetime limits on coverage, restricts rescission of policies, and provides health coverage for persons with pre-existing conditions through a national high risk pool.
- Establishes a requirement to provide coverage for non-dependent children up to age 26 to all existing health insurance plans starting six months after enactment.
- Requires that all new group health plans in the individual health insurance market must provide first dollar coverage for preventative services.

New Taxes and Tax Credits

- Provides a tax credit for small businesses for up to 35% of their contribution to purchasing health insurance for their employees. Estimated at $40 billion over 10 years.
- Imposes a 10% tax on indoor tanning.
- Provides for the adoption tax credit and increases the adoption assistance exclusion by $1,000. Credit is refundable and extended through 2011.

Medicare

- Provides a $250 rebate for all Medicare Part D enrollees who enter the "donut hole" in 2010.

Medicaid

- Allows States to cover parents and childless adults up to 133% of the Federal Poverty Level and receive Federal Medical Assistance Percentage (FMAP).

Other Miscellaneous Provisions

- Physicians are prohibited from referring patients to hospitals they own. The law will provide a limited exception to hospitals that treat the highest percentage of Medicaid patients in their county and are not the sole hospital.
- The law establishes a new temporary reinsurance program for companies that provide early retirees health benefits for those aged 55-64.
- The law also provides $5 billion in federal taxpayer funding for health insurance coverage through high-risk pools for eligible individuals.

Federal Insurance Regulations

- The law will limit health plans to medical loss ratios of less than 85% and will require health insurance companies to provide rebates below this limit.

Medicare

- Pharmaceutical manufacturers must provide a 50% discount on "brand name" prescriptions filled in Part D coverage gap. It completely closes the "donut hole" (a congressionally created gap in coverage) with federal subsidies to provide 75% discounts on brand-name and generic drugs by 2020.
- The law freezes Medicare Advantage payments.
- The law will provide a 10% Medicare bonus payment for primary care physicians and general surgeons.

New Taxes

- The law will impose a pharmaceutical industry fee on sales of brand name pharmaceuticals for use in government health programs ($2.5 billion for 2011, $2.8 billion per year for 2012 and 2013, $3.0 billion per year for 2014 through 2016, $4 billion for 2017, $4.1 billion for 2018, and $2.8 billion for 2019 and thereafter).
- The law will increases the additional tax for Health Savings Accounts withdrawals prior to age 65 that are not used for qualified medical expenses from 10% to 20%.

Community Health Centers

- The law will provide for increased federal taxpayer funding for community health centers to $11 billion over five years (FY 2011 – FY 2015).

Medicare

- The federal benchmark payment to Medicare Advantage plans that now cover an estimated 20 percent of seniors will be reduced. Further payments changes then will be phased-in over several years.

Medicaid

- The law will require that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in 2013 and 2014. It will further provide 100% federal taxpayer funding for the incremental costs to States of meeting this payment requirement.

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Implementation of the Major Provisions of Obamacare: The Timeline (continued)

New Taxes

- The law will impose an annual limitation on contributions to a health Flexible Spending Account (FSA) to $2,500 per year, indexed to inflation as measured by the Consumer Price Index (CPI).
- The law will impose a 2.3% excise tax on medical device manufacturers. It will exempt eyeglasses, contact lenses, hearing aids, and any device that is generally purchased by the public at the retail level. Estimated to raise $20 billion.
- The law will eliminate the existing deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.
- The law will increase the income threshold for claiming the itemized tax deduction for medical expenses from 7.5% to 10%. Individuals over 65 would be able to claim the itemized tax deduction for medical expenses at 7.5% of adjusted gross income through 2016.
- The law will increase the Medicare Part A hospital insurance tax rate by 0.9 percentage points on an individual taxpayer earning over $200,000 ($250,000 for married filing jointly). It will expands the taxable base to include net *investment income* in the case of taxpayers earning over $200,000 ($250,000 for joint returns). This is a new category of income for Medicare taxation.

Other Miscellaneous Provisions

- The law will require that health insurance plans must adopt and implement uniform standards and business rules for the electronic health information.
- The law will allow states to create a Basic Health Plan for uninsured individuals between 133%-200% of the federal poverty line (FPL) in lieu of these individuals receiving premium subsidies to purchase coverage in the state based health insurance exchanges.

Federal Insurance Regulations

- The law will prohibit health plans from imposing annual limits on the amount of coverage an individual may receive.
- The law will extend the prohibition on excessive waiting periods to existing health plans.

Medicare

- The law will cut federal payments to Disproportionate Share Hospital (DSH) program, but it will lower the ten-year reduction by $3 billion.

Medicaid

- Provides federal Medicaid matching payments for the costs of services to expansion populations at the following rates in all states: 100% in 2014, 2015, and 2016; 95% in 2017; 94% in 2018.
- Lowers the reduction in federal Medicaid DSH payments from $18.1 billion to $14.1 billion.

New Taxes and Tax Credits

- The law will impose a new insurance industry fee (the scheduled increase will be: $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, $14.3 billion in 2018, and indexed to medical cost growth thereafter).
- The law will provide "tax credits" available through the health insurance exchange system for people with incomes above Medicaid eligibility but below 400% of the federal poverty level (FPL) who are not eligible for or offered other acceptable coverage.
- The law will require persons to obtain "acceptable" health insurance coverage (the individual mandate) or pay an annual penalty. Families will pay half the amount for children, up to a cap of $2,250 per family. After 2016, dollar amounts of the penalty for disobedience are indexed.

Federally Mandated Health Insurance Exchanges

- The law will create state-based American Health Exchanges and Small Business Options Program (SHOP); SHOP is, in effect, a form of a health insurance exchange for individuals and small businesses with up to 100 employees.

The Employer Mandate and Penalties Begin

- The law will impose an employer mandate; businesses must either offer an acceptable level of health insurance coverage or pay a penalty. The law increases the fee to $2,000 for each full-time employee for businesses with more than 50 employees that do not offer coverage. Up to 30 employees are exempt when calculating the fine. It provides for a fine of $3,000 for each low-income employee receiving federal taxpayer subsidies for insurance in those instances *where employers already offer coverage.*

The Individual Mandate Penalties

- The law provides a phase in for the individual mandate and its penalties: $95 penalty or 1.0% of individuals' income. It rises to $325 or 2.0% of income in 2015, and $695 or 2.5% of income in 2016.

The Federal Premium Subsidies for Insurance

- Premium subsidies begin. The federal cap on insurance cost as a percent of a person's income is to be 2% for up to 133% of the Federal Poverty Level, 3-4% of income for those up to 150% of FPL, 4-6.3% of income for those up to 200% of FPL, 6.3-8.05% of income for those up to 250% of FPL, 8.05-9.5% of income for those up to 300% of FPL, 9.5% of income for those up to 400% of FPL.
- The law will impose federal limits on any individual contribution to cost-sharing. Health insurance plans are to cover 94% of costs for persons who have incomes at 100-150% of FPL, 87% for those with incomes up to 200% of FPL, 73% for those with incomes up to 250% of FPL, and 70% for those with incomes up to 400% of FPL.

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Implementation of the Major Provisions of Obamacare: The Timeline (continued)

State Options for Small Businesses
States may allow businesses with more than 100 employees to purchase insurance in the Exchanges/SHOP.

New Taxes
- The new law will impose a 40% excise tax on "high-value" or "Cadillac" health insurance plans. The threshold for the imposition of the new tax will be $10,200 for individual plans and $27,500 for family coverage; this is to be increased to $30,950 (family) and $11,850 (single) for retirees and employees in "high risk" professions.

INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The Independent Payment Advisory Board (IPAB) is current law. It was created by the 2010 Democrats' health care overhaul law as a way to address the long-term solvency of Medicare. Under the law, IPAB's 15 members are chosen by the President and confirmed by the Senate. Beginning in 2014, IPAB members are required to make annual proposals to reduce Medicare spending if the program's expenditures exceed a targeted growth rate. Their first recommendations will be due Jan. 15, 2014. These proposals automatically take effect the following year unless Congress is able to pass legislation that reduces costs by an equal or greater amount than IPAB's proposal.

It should be noted that IPAB is specifically prohibited in the law from, "…rationing, reducing Medicare benefits or eligibility, or increasing premiums or cost-sharing…" in any of its proposals. It is also barred from cutting hospital reimbursement rates until 2020. These restrictions narrow IPAB's options to reducing Medicare payment levels for private health and prescription drug plans and cutting doctor reimbursement rates.

While these proposals would not directly ration care, many medical associations and advocacy groups (including the AARP and the American Medical Association) argue that by targeting medical providers, the IPAB's proposals will result in a de facto rationing of care by reducing reimbursements to levels where providers will simply stop offering certain procedures and plans or stop seeing Medicare patients all together. IPAB's critics cut across party lines with Democrat Representatives Allyson Schwartz and Pete Stark, among others, opposing the Board on grounds that it will risk senior's access to medical care.

Editor's Note: *Please refer to the above-compiled selected hits on the final health care overhaul package for specific hits regarding IPAB.*

In spite of IPAB's numerous detractors, in an April 13, 2011, speech, President Obama proposed "strengthening" the Board as a way to slow the growth of Medicare costs.

COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT (CLASS) ACT

The Community Living Assistance Services and Support Act (CLASS Act) is a voluntary, government-run, long-term-care insurance policy created as part of the Democrats' health care law designed to provide coverage for elderly and disabled people who require long-term-care and assistance performing daily tasks. The specifics of the program created by the CLASS Act are as follows:

- The Dept. of Health and Human Services (HHS) is required to submit full rules and regulations for the new program in October of 2012 (One month before the 2012 elections)

- Coverage will be offered on a voluntary basis and will initially be offered to employees whose employers choose to participate. HHS is also required to develop a mechanism to allow the self employed and workers whose employers do not offer CLASS coverage to sign up for the plan.

- Coverage is available to any working individual over the age of 18 who chooses to enroll. The Congressional Budget Office (CBO) estimates that 5 to 6 percent of those eligible to enroll will choose participate.

- Premium payments are expected to average $123 a month with older enrollee's paying more and younger enrollee's paying less.

- Daily benefits cannot be lower than $50 on average according to the law but HHS will set the final amount when it implements the program (the CBO assumed an average daily benefit of $75 for its estimate). The payments can be used to purchase non-medical services such as living assistance and has no lifetime cap on benefits.

- Participants are subject to a 5-year vesting period which requires them to pay premiums for 5 years before they are eligible to collect benefits. Additionally, participants must be employed for at least 3 of 5 the years in the vesting period in order to qualify.

- Benefits would be triggered when a fully vested enrollee needs assistance with 2 to 3 activities of daily living (ADL's). Examples of ADL's are eating, bathing, dressing, using the toilet, transferring from bed to chair to wheelchair, continence care, etc.

- Underwriting is specifically prohibited by the law so premiums will remain constant regardless of preexisting conditions. This includes disabled individuals who already require long-term-care. (Though they will still be subject to the 5 year vesting period before benefits will be paid out.)

Additionally, the law states that funding for the CLASS Act will come solely from premiums paid by the plans participants. HHS is required to perform an annual review to establish premium rates and make necessary adjustments in order to ensure the programs solvency. Enrollees would be subject to the premium increases set by HHS, however, enrollees who are over 65, who have paid premium for 20 years or more, or who are not actively employed would be exempt from the increases.

Concerns with CLASS

Unsustainable Funding: The CLASS Act was passed as a part of the larger democrat heath care law and its provisions are estimated to save the government $70 billion over the next 10 years, according to the CBO. These cost savings are only possible in the short term due to the five year vesting period that is required before enrollees become eligible to receive benefits. Since the program will begin in the later part of 2012 or early 2013, benefits to the earliest enrollees would not be paid until 2017. At that point, the financial viability of the program could diminish quickly as enrollee's start collecting benefit payments. In fact, the CBO estimates that benefit payments under the CLASS Act are expected to exceed premium payments by the year 2030 under its initial premium estimate of $123 a month. This means that the program would only be solvent for 13 years unless adjustments to the program are made. President Obama's own Commission on Fiscal Responsibility and Reform recognized the inherent problems with funding in the CLASS Act and wrote:

> "The program attempts to address an important public policy concern – the need for non-institutional long-term care – but it is viewed by many experts as financially unsound. The program's earliest beneficiaries will pay modest premiums for only a few years and receive benefits many times larger, so that sustaining the system over time will require increasing premiums and reducing benefits to the point that the program is neither appealing to potential customers nor able to accomplish its stated function. Absent reform, the program is therefore likely to require large general revenue transfers or else collapse under its own weight, Commission advises the CLASS Act be reformed in a way that makes it credibly sustainable over the long term. To the extent this is not possible, we advise it be repealed."

Uniform Premiums Discourage Enrollment: The coverage under the CLASS Act is offered to all applicants at a uniform premium rate that is only allowed to vary by age, specifically prohibiting higher premiums for high risk enrollees. As a result, individuals who are low risk could be discouraged from enrolling in the CLASS Act program since private long-term-care policies will likely be able to offer cheaper premiums. This problem is known as adverse selection and, according to the American Academy of Actuaries, would most likely cause only high risk individuals to enroll in the program which would accelerate its insolvency.

Consequences of Insolvency

Given the challenges facing the CLASS Act program economists and lawmakers have stated that it is all but inevitable that adjustments will need to be made to the CLASS Act to ensure its future solvency. According to the American Academy of Actuaries, this will likely result in some combination of the following policy changes to the law:

- Cuts to benefits
- Increase in premiums
- Taxpayer bailout

Political Concerns

As President Obama's Commission on Fiscal Responsibility and Reform stated, addressing the long-term-care issue is an important public policy concern. Given that beneficiaries of the CLASS Act will primarily consist of the elderly and disabled adults, there is a strong sympathetic appeal to the intent of the program. When speaking about repeal of "Obamacare," which includes the CLASS Act, it is important for candidates and Members to be aware of the emotional component attached to the program. Many constituents will have friends or family members who are in need of long-term-care. According to a poll conducted by the Henry J. Kaiser Family Foundation in January of 2011, 76 percent of Americans support the CLASS Act provision of the health care law. Furthermore, it is likely that the program's start date of October 2012 – one month before the next federal elections – was done by design in order to provide a messaging opportunity for Democrats to highlight a program benefiting seniors when heading into the home stretch of the 2012 campaign season.

Beyond the concerns of whether or not to repeal the program, many policy organizations believe that it would be politically difficult to address insolvency of the CLASS Act, as the options of cutting benefits or raising premiums may be politically unpalatable. This means that an intervention from general revenue funds (a taxpayer "bailout") would be the most likely option to sustain the program as payouts begin to exceed premium payments, thereby creating another unstable entitlement program. Given the CLASS Act's inherent funding instability, the new entitlement would become an increasing burden on the federal budget as the elderly population and life expectancy continue to grow.

Recent Developments

On Oct. 14, 2011, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced that HHS had suspended work on the CLASS program, saying, "…despite our best analytical efforts, I do not see a viable path forward at this time." On the same day, HHS issued a comprehensive analysis of its work on the CLASS program entitled, "Report on the Actuarial, Marketing and Legal Analyses of the CLASS Program." In this report, CLASS Program Administrator Kathleen Greenlee raised concerns with adverse selection, noting, "If healthy purchasers are not attracted to the CLASS benefit package, then premiums will increase, which will make it even more unattractive to purchasers who could also obtain policies in the private market. This imbalance in the beneficiary pool would cause the program to quickly collapse."

The affordability of the program's premiums was also a concern. HHS's analysis projected premiums even higher than had been previously estimated by outside actuaries, noting the basic CLASS benefit plan could cost "$235 and $391 dollars a month, and may cost as much as $3,000 per month."

Editor's Note: *Please refer to the following section regarding legislative action in the 112th Congress dealing with the CLASS Act.*

LEGISLATIVE EFFORTS TO REPEAL, DEFUND AND REPLACE IN THE 112TH CONGRESS

In the current 112th Congress, House Republicans have tackled the Democrats' government takeover of health care law on a variety of fronts. Republicans generally agree that the Democrats' government takeover of health care will cost hundreds of billions that our country cannot afford for a health system that Americans, by and large, do not want. That is why one of the very first votes taken on the House Floor by the 112th Congress was to fully repeal the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care-related provisions contained in the Health and Education Reconciliation Act (P.L. 111-152). While this full repeal effort did not move forward in the Senate and President Obama vowed to veto it if it did reach his desk for signature, other legislative efforts by House Republicans to repeal targeted provisions and to cut and reduce specific funding found in the law have been successful.

In February of last year, Republicans passed funding restrictions to severely limit the President's ability to implement the new law. Furthermore, Republicans have pushed legislation that would eliminate the law's mandatory "slush" funds.

Background on Democrats' Government Takeover of Health Care "Slush" Funds

The Democrats' government takeover of health care contains billions in future "mandatory spending" programs. Rather than one large "slush" fund, this is a compilation of prominent and often controversial provisions in the law, totaling about $105 billion in mandatory spending and fund transfers over ten years. These programs include, but are not limited to:

- $40 billion to fund/extend the Children's Health Insurance Program (CHIP)
- $11 billion for community health centers
- $5 billion to create a temporary high-risk pool for people with preexisting conditions
- $15 billion Prevention and Public Health Fund (PPHF)
- Funding for abstinence education programs
- Funding to support IPAB activities
- Funding for the Patient-Centered Outcomes Research Institute (PCORI) and its comparative effectiveness research activities
- Funding for the Health Care Fraud and Abuse Control (HCFAC) Account which finances investigative, enforcement and Medicare Integrity Program activities

House Floor Action

Below is a compilation of House Floor action (votes) taken this Congress to fight the Democrats' government takeover of health care, as of this writing:

Editor's Note: *It is important to note that more votes are likely to be taken to repeal, defund or replace Obamacare.*

H.R. 2, Repealing the Job-Killing Health Care Law Act: On Jan. 19, 2011, one of the House's first official actions was to repeal the Democrats' government takeover of health care in its entirety and instruct the Committees of jurisdiction to being working on finding common-sense patient-centered replacement legislation. Click here to view the full vote (Passed 245-189; R: 242-0; D: 3-189).

H.R. 1, Fiscal Year (FY) 2011 Full-Year Continuing Appropriations Act: On Feb. 19, 2011, the House passed a full-year appropriations bill (continuing resolution) for FY 2011. During amendment consideration, nine different amendments were added to the underlying bill after passing the House (one amendment passed by voice vote so it did not have an actual Floor vote, but it will be mentioned below) that dealt with severely handicapping implementation of the Democrats' health care overhaul law. Click here to view the full vote for final passage of H.R. 1 (Passed 235-189; R: 235-3; D: 0-186). The amendments to H.R. 1 dealing with the health care overhaul law are detailed below:

- **Rep. Denny Rehberg (R-Mont.) Amendment #575:** Would prohibit payment of any funds made available by H.R. 1 to any employee, officer, contractor or grantee of any department or agency funded by the Labor-HHS-Education portion of H.R. 1 to implement the health care provisions of the Democrats' government takeover of health care. Click here to view the full vote (Passed 239-187; R: 236-2; D: 3-185).

- **Rep. Steve King (R-Iowa) Amendment #267:** Would bar the use of funds made available by H.R. 1 to carry out the Democrats' government takeover of health care. Click here to view the full vote (Passed 241-187; R: 238-0; D: 3-187).

- **King Amendment #268:** Would prohibit the use of funds made available by H.R. 1 to pay the salary of any officer or employee of any federal department or agency with respect to implementing the Democrats' government takeover of health care. Click here to view the full vote (Passed 237-191; R: 234-4; D: 3-187).

- **Rep. Jo Ann Emerson (R-Mo.) #83:** Would bar the Internal Revenue Service (IRS) from using funds to implement or enforce the individual mandate provision of the Democrats' government takeover of health care; would also prohibit the IRS from using funds to implement provisions that require insurance providers to report that they have provided coverage to individuals. Click here to view the full vote (Passed 246-182; R: 238-0; D: 8-182).

- **Rep. Tom Price (R-Ga.) #409:** Would bar the use of funds made available in H.R. 1 to implement or enforce the provision (Medical Loss Ratio provision) in the Democrats' government takeover of health care that stipulates that the federal standard relating to high-risk insurance pools supersedes state laws and standards. Click here to view the full vote (Passed 241-185; R: 238-0; D: 3-185).

- **Rep. Cory Gardner (R-Colo.) #79:** Would bar the use of funds in H.R. 1 to pay the salary of any officer or employee of HHS who develops or promulgates regulations or guidance with regard to health insurance exchanges under the Democrats' government takeover of health care. Click here to view the full vote (Passed 241-184; R: 236-1; D: 5-183).

- **Rep. Michael Burgess (R-Texas) #200:** Would bar the use of funds in H.R. 1 from being used to pay the salary of any officer or employee of the Center for Consumer Information and Insurance Oversight (CCIIO) in HHS. Click here to view the full vote (Passed 239-182; R: 235-1; D: 4-181).

- **Rep. Joe Pitts (R-Pa.) #430:** Would bar funds in H.R. 1 from being used by HHS, Labor or Treasury departments for any action to issue regulations or guidelines defining "essential benefits" as directed by the Democrats' government takeover of health care. Click here to view the full vote (Passed 239-183; R: 235-2; D: 4-181).

- **Rep. Nan Hayworth (R-N.Y.) #567:** Would bar the use of funds to implement IPAB. This amendment passed by voice vote, so there was not an actual vote taken on this amendment. But, since it was added to H.R. 1, a vote for H.R. 1 included this language.

H.R. 4, Comprehensive 1099 Taxpayer Protection and Repayment Exchange Subsidy Overpayments Act: H.R. 4, passed by the House on March 3, 2011, and signed into law by President Obama on April 14, 2011 (P.L. 112-9), repealed the provision in the Democrats' government takeover of health care that required businesses (including small businesses), beginning in 2012, to file an IRS Form 1099 for any payments to corporations that exceed $600 per year per payee. H.R. 4 also repealed a further expansion of the IRS Form 1099 reporting requirements, beginning in 2011, as it relates to real estate rental income. Specifically, this required any person who received rental income, rather than only those in the business of managing property, to file a Form 1099 for any rental property expense payments (this provision was added as an offset to the Democrats' Small Business Jobs Act of 2010). Additionally, H.R. 4 also increased the maximum amount of health care insurance subsidy overpayment that must be repaid on a sliding scale, with those earning more than 400 percent of Federal Poverty Level (FPL) paying back all improper payments.

The premium subsidies (refundable tax credits) are determined based on the most recent tax return, thus an overpayment could occur when actual incomes exceed subsidy eligibility thresholds. Originally, under the Democrats' government takeover of health care, the maximum amount a subsidy recipient was required to repay was $250 for an individual or $400 for a family, even if he/she/they received thousands of dollars in subsidy overpayments. Click here to view the full vote (Passed 314-112; R: 238-0; D: 76-112).

H.R. 1217, to repeal the Prevention and Public Health Fund (PPHF): On April 13, 2011, the House passed H.R. 1217, to repeal the PPHF. The PPHF was established by the Democrats' government takeover of health care with a broad mandate for prevention, wellness and public health activities. The Fund is administered by the Secretary of HHS, who has full discretion on how to spend funds without further congressional action or oversight. This "slush" fund can go towards a variety of programs including jungle gyms, bike paths and even lobbying activities (such as those reported of the Centers for Disease Control encouraging grantees to pursue state tax increases on tobacco products to reduce smoking). Repealing this

slush fund and rescinding any unobligated balances, at the time of the vote, would have saved $16 billion over 10 years, according to CBO. Click here to view the full vote (Passed 236-183; R: 232-0; D: 4-183).

H.R. 1473, FY 2011 Department of Defense and Full-Year Continuing Appropriations Act: H.R. 1473, passed by the House on April 14, 2011, and signed into law (P.L. 112-10) by President Obama on April 15, 2011, tackled two programs created in the Democrats' government takeover of health care. It repealed the Free Choice Voucher program and reduced funding for the Consumer Operated and Oriented Plan (CO-OP) by $2.2 billion. Additionally, H.R. 1473 provided new tools to fight implementation and ensured no increase in IRS funding to hire additional agents to enforce the individual mandate. Click here to view the full vote (Passed 260-167; R: 179-59; D: 81-108).

H. Con. Res. 35, Directing the Clerk of the House to make a correction in the enrollment of H.R. 1473: In addition to the Democrats' government takeover of health care repeal provisions included in H.R. 1473, the agreement reached allowed for two enrollment votes which guaranteed up-or-down Senate votes on key issues. One of the enrollment votes, H. Con. Res. 35, passed by the House on April 14, 2011, would have defunded all mandatory and discretionary spending in the Democrats' government takeover of health care. Click here to view the full vote (Passed 240-184; R: 237-0; D: 3-185).

H. Con. Res. 34, FY 2012 House Budget Resolution: Passed by the House on April 15, 2011, H. Con. Res. 34, in addition to numerous other provisions, would repeal and defund the Democrats' government takeover of health care in full. Click here to view the full vote (Passed 235-193; R: 235-4; D: 0-189).

H.R. 1213, State Insurance Exchanges Funding Repeal: H.R. 1213, passed by the House on May 3, 2011, would repeal a provisions created in the Democrats' government takeover of health care which provides the Secretary of HHS with an unlimited tap on the U.S. Treasury for various activities related to government-mandated health insurance exchanges. It would also rescind unobligated funds made available for the exchanges. Click here to view the full vote (Passed 238-183; R: 233-0; D: 5-183).

H.R. 1214, School-Based Health Centers Funding Repeal: H.R. 1214, passed by the House on May 4, 2011, would repeal mandatory funding in the Democrats' government takeover of health care for school-based health center construction which provided $200 million in mandatory funding through 2014 solely for construction to build and renovate School-Based Health Centers. Click here to view the full vote (Passed 235-191; R: 232-4; D: 3-187).

H.R. 1216, converting funding for Graduate Medical Education (GME) in qualified teaching health centers from direct appropriations to an authorization of appropriations: H.R. 1216, passed by the House on May 25, 2011, would convert $230 million in mandatory spending provided under the Democrats' government takeover of health care for residency programs (GME) to discretionary spending, allowing teaching health centers to receive funding through the regular appropriations process. It also would rescind any unobligated funds that were appropriated by the Democrats' government takeover of health care and authorizes $46 million per year over the 2012-2015 period. Click here to view the full vote (Passed 234-185; R: 231-4; D: 3-181).

H.R. 2576, Health Benefits Eligibility Formula Change: On Oct. 27, 2011, the House passed H.R. 2576, which would count Social Security benefits as income in an eligibility formula for certain health benefits, including Medicaid and subsidies to purchase health insurance on state-run exchanges, established under the Democrats' government takeover of health care. Click here to view the full vote (Passed 262-157; R: 235-0; D: 27-157).

H.R. 674, Contractor Withholding Repeal: On Nov. 16, 2011, the House passed the Senate Amendments to H.R. 674, and President Obama signed into law (P.L. 112-56) on Nov. 21, 2011, which, along with repealing the three percent withholding requirement on certain payments made to contractors doing business with federal, state and local governments, required all Social Security and Tier 1 Railroad Retirement benefits to be included in the calculation of modified adjusted gross income (MAGI) for purposes of determining eligibility for certain health care programs under the Democrats' government takeover of health care (this language was previously passed under H.R. 2576). Without this change, according to CMS' Chief Actuary, a couple earning $64,000 could still qualify for Medicaid. Click here to view the full vote (Passed 422-0; R: 232-0; D: 190-0).

H.R. 3630, Middle Class Tax Relief and Job Creation Act: On Dec. 13, 2011, the House passed H.R. 3630 which, among other things, would have increased the maximum amount of Exchange subsidy overpayments, established under the Democrats' government takeover of health care. H.R. 3630 would also have reduced the funding for the PPHF by $8 billion. Click here to view the full vote (Passed 234-193; R: 224-14; D: 10-179).

Conference Report for H.R. 2055, FY 2012 Consolidated Appropriations Act: H.R. 2055, passed by the House on Dec. 16, 2011, and signed into law (P.L. 112-74) by President Obama on Dec. 23, 2011, in addition to a multitude of other provisions, rescinded $400 million from the CO-OP and $10 million in funds from IPAB, both found in the Democrats' government takeover of health care. H.R. 2055 also reduced IRS funding by $305 million from FY 2011 levels, hampering enforcement of the revenue provisions including the individual mandate and tightened the CDC restriction on using grant money to lobby (i.e. PPHF). Click here to view the full vote (Passed 296-121; R: 147; D: 149-35).

H.R. 1173, Fiscal Responsibility and Retirement Security Act: On Feb. 1, 2012, the House passed H.R. 1173, which would repeal the government-administered long-term care insurance program, the Community Living Assistance Services and Supports (CLASS) Act program, created by the Democrats' government takeover of health care. Click here to view the full vote (Passed 267-159; R: 239-0; D: 28-159).

Conference Report for H.R. 3630, Middle Class Tax Relief and Job Creation Act: On Feb. 17, 2012, the House passed the Conference Report for H.R. 3630, and President Obama signed it into law (P.L. 112-96) on Feb. 22, 2012. This law clawed back a total of $11.6 billion from the Democrat's government takeover of health care including $5 billion in cuts to the PPHF and recouping $2.5 billion by correcting a drafting error that allowed Louisiana to receive excess Medicaid funding via the "Louisiana Purchase." Click here to view the full vote (Passed 293-132; R: 146-91; D: 147-41).

H.R. 5, Protecting Access to Healthcare (PATH) Act: H.R. 5, passed by the House on March 22, 2012, would repeal IPAB and would enact medical liability reform that would save Medicare money through reducing liability insurance and the practice of defensive medicine while still ensuring access to care. Click here to view the full vote (Passed 223-181; R: 216-10; D: 7-171).

H. Con. Res. 112, FY 2013 House Budget Resolution: H. Con. Res. 12, passed by the House on March 29, 2012, would repeal and defund the Democrats' government takeover of health care. Click here to view the full vote (Passed 228-191; R: 228-10; D: 0-181).

H.R. 4628, Interest Rate Reduction Act: H.R. 4628, passed by the House on April 27, 202, would repeal the PPHF to offset extending a lower interest rate of subsidized Stafford Loans for undergraduate students. Click here to view the full vote (Passed 215-195; R: 202-30; D: 13-165).

Potential Political Vulnerabilities in Denying Funding for Democrats' Government Takeover of Health Care Programs

The ability to deny funding to implement the Democrat's government takeover of health care could be more limited than many may realize. Much of the funding contained within the law is actually mandatory, instead of discretionary (which is the funding that Congress controls through the annual appropriations process). This means that funding for many of the high-profile provisions of the health care law, such as the creation of state-based insurance exchanges and expanding Medicaid rolls, will occur automatically outside of the appropriations process. What is left will be a laundry list of what would normally be largely non-controversial programs and policy items such as workforce training programs, grants to test alternatives to the current medical malpractice litigation system (a GOP priority), the Indian Health Service and health professional training programs for doctors and nurses, which have received bipartisan support in the past. Therefore, denying funding to many of the discretionary spending provisions under the Democrats' government takeover of health care could present political opportunities for Democrats to use against Republican Members and candidates.

Just as Democrats are looking to capitalize on the vote to repeal their government takeover of health care law as an opportunity to highlight its popular consumer benefits (such as the coverage of pre-existing conditions, etc. – which would disappear if a full repeal did take place), Republicans should be aware that Democrats could also use the denial of discretionary funding for programs that benefit key groups, constituencies or services as another political opportunity.

The following Jan. 10, 2011, story from *Congressional Quarterly* (*CQ Today*) provides highlights of some of the programs funded through discretionary spending under the Democrats' government takeover of health care. It is easy to see where potential vulnerabilities could emerge based on this list:

> "**Examples of Discretionary Spending in Health Care Law**
>
> "While critics of the health care overhaul are eager to limit funding for the law if they cannot outright repeal it, much of the funding to carry out its provisions is mandatory. Potential discretionary spending under the law is estimated at a minimum of $115 billion over 10 years, out of a total cost of $930 billion. Listed below are some of the programs funded through discretionary spending:
>
> - Grants to centers serving medically under-served populations: Authorized $34.0 billion through FY 2015
>
> - Scholarships and loan repayments for National Health Service Corps participants: $4.0 billion through FY 2015
>
> - Five-year grants to eligible institutions of higher education and nonprofit research institutions that work with depression: $1.3 billion through FY 2020

- Grants to state, local and academic centers for strengthening infectious disease response capacity: $760 million through FY 2013

- Grants for schools that train minority, rural and disadvantaged individuals to work in under-served areas: $625 million through FY 2014

- Grants to states for supporting trauma-related specialties and broadening access to trauma care: $600 million through FY 2015

- Formula grants to enhance state and local programs that protect elderly and disabled adults from abuse and neglect: $400 million through FY 2014

- Funding for programs that recruit and train minorities in the health professions: $300 million through FY 2015

- Grants to employers who provide access to comprehensive workplace wellness programs: $200 million through FY 2015

- Grants to states or medical schools for expanding emergency services for children: $138 million through FY 2014."

HEALTH CARE TALKING POINTS

- We need a fiscally responsible healthcare plan with common sense initiatives to lower healthcare costs without reducing benefits or restricting choices.

- Americans deserve healthcare solutions, but ramming through Congress a partisan, closed-door government takeover of healthcare – as Washington Democrats did – is not the way to solve anything.

- Individual patients, not the government or their board of unelected bureaucrats, should have the freedom to tailor their health plans to their specific needs.

- The Democrats' government takeover of health care:

    - Cuts nearly half a trillion dollars from Medicare
    - Raises taxes by half a trillion dollars
    - Imposes job-killing taxes and regulations
    - Increases health care spending
    - Leaves the door open to the taxpayer funding of abortions

- We should work to repeal the job-killing, big-government policies enacted through this law and to replace it with policies that actually solve our country's healthcare crisis.

ADDITIONAL INFORMATION AND RESOURCES

- Affordable Care Act Tax Provisions, Internal Revenue Service (IRS) - http://www.irs.gov/newsroom/article/0,,id=220809,00.html

- Comprehensive List of Net Tax Hikes in Health Reconciliation Bill, Americans for Tax Reform (ATR) - http://www.atr.org/breaking-comprehensive-list-net-tax-hikes-a4688

- Comprehensive List of Tax Hikes in Government Health Bill to be Voted on by House, ATR - http://www.atr.org/comprehensive-list-tax-hikes-government-health-a4658

- Implementation Timeline, The Henry J. Kaiser Family Foundation - http://healthreform.kff.org/timeline.aspx?source=QL

- Summary of New Health Reform Law, The Henry J. Kaiser Family Foundation - http://www.kff.org/healthreform/upload/8061.pdf

- Timeline of Tax Provisions in the House Health Care Bill, Tax Foundation - http://www.taxfoundation.org/publications/show/26037.html