BAD MEDICINE

A check-up on the new federal health law

United States Senate
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Senator Tom Coburn, M.D.
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Prognosis: Grim Consequences

Introduction

One hundred days after the new federal health care law was passed, Americans remain anxious about how it will impact them and their families. In fact, many Americans still want to know what is in the nearly 3,000 pages of legislation that might represent real health reform for them.

Unfortunately, when measured against the Administration's own stated goals, the new health law fails to address the top health care concerns of the American people. According to a March 2009 report released by Health and Human Services, a majority of Americans identified cost as their top concern with American health care.[1]

Independent experts have found that the new health law will increase the cost of health insurance and health care services. According to the nonpartisan Congressional Budget Office (CBO), premiums for millions of American families in 2016 will be 10-13 percent higher than they otherwise would be.[2] This represents a $2100 increase per family, compared with the status quo.[3]

And, according to a recent memo from the Actuary of the Centers for Medicare and Medicaid Services, the medical device and pharmaceutical drugs fees and the health insurance excise tax will "generally be passed through to health consumers in the form of higher drugs and device prices and higher insurance premiums, with an associated increase in overall national health expenditures…."[4]

This is not the only bad news. According to the same memo, the new health care law bends the cost curve upward and increases national health spending. In other words, health care will cost more because of this new law.

Contrary to the promise that Americans who like their current health plan can keep it, the Administration published a regulation regarding "grandfathered health plans" – plans that are exempt from the changes under the law.[5] According to the published regulation, as many as seven out of every 10 businesses across the country will lose their "grandfathered health plan."[6] This means that about half of the more than 150 million Americans enrolled in employer plans will lose their current plan and either remain without employer coverage, or see the cost of that employer-provided coverage increase due to government mandates and regulation.

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[1] U.S. Department of Health and Human Services, "America Speaks on Health Reform: Report on Health Care Community Discussions," page 101, March 2009, http://www.healthreform.gov/reports/hccd/report_on_communitydiscussions.pdf .

[2] Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, " page 4, November 30, 2009, http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

[3] Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, " page 4, November 30, 2009, http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf. On page 6: "Average premiums per policy in the nongroup market in 2016 would be roughly $5,800 for single policies and $15,200 for family policies under the proposal, compared with roughly $5,500 for single policies and $13,100 for family policies under current law."

[4] Foster, Richard, Chief Actuary for the Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfefd0.

[5] Federal Register, "Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule," Vol. 75, No. 116, June 17, 2010. http://frwebgate3.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=6U63MK/1/2/0&WAISaction=retrieve

[6] Federal Register, "Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule," Vol. 75, No. 116, June 17, 2010. See page 34551: "In total, approximately 66 percent of small employers and 48 percent of large employers made a change in either cost sharing or premium contribution during 2009 that would require them to relinquish grandfather status if the same change were made in 2011." Also see Table 3 on page 34553. http://frwebgate3.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=6U63MK/1/2/0&WAISaction=retrieve

Additionally, the CBO estimates 23 million people will still be without health coverage at all. The dramatic cuts to Medicare could cause some providers to "end their participation in the program," and could jeopardize access to care for beneficiaries.[7]

In fact, according to a recent *USA Today* story, "the number of doctors refusing new Medicare patients because of low government payment rates" is already increasing, "setting a new high, just six months before millions of Baby Boomers begin enrolling in the government health care program."[8]

A majority of Americans opposed the law when it was being considered in Congress. Four separate polls conducted around the time the bill was signed into law showed that a majority of Americans opposed the bill.[9]

Since passage, each week has brought new information about the unintended consequences of Congress' government-takeover of health care. Health plans are changing. Premiums are increasing. Physicians are dropping out of Medicare.

Recent polls fair no better for the law's proponents, with a more recent poll showing 6 in 10 Americans now believe the law will likely increase the federal deficit, with only about 1 in 10 saying the law will reduce the deficit as claimed.[10]

In its recent analysis of the long-term forecast of the federal budget, the Congressional Budget Office (CBO) analyzed the impact of the new health law. In its projection, the CBO incorporated "several changes to [the new health] law that are widely expected to occur or that would modify some provisions of law that might be difficult to sustain for a long period."[11]

In other words, in its projection of future federal spending, CBO determined that, based on previous congressional behavior, deficit-reducing provisions – such as reducing Medicare's payments to physicians – were unlikely to be fully implemented by Congress. Therefore, they concluded the deficit would increase and "federal debt would grow much more rapidly."[12]

As supporters of cost-effective, common-sense health reform, but staunch opponents of the legislation that passed Congress earlier this year, this report presents the American people with a check-up about the side effects and the implications of the Patient Protection and Affordable Care Act as it begins to be implemented.[13] The passage of this law will exacerbate current problems in health care and could make them even worse.

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[7] Foster, Richard, Chief Actuary for the Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfefd0.

[8] Wolf, Richard, "Doctors Limit New Medicare Patients," *USA Today*, June 21, 2010, http://www.usatoday.com/news/washington/2010-06-20-medicare_N.htm.

[9] Quinnipiac University Poll, 3/22-23/10, http://www.quinnipiac.edu/x1295.xml?ReleaseID=1437; Bloomberg National Poll, 3/19-22/10, page 1, http://media.bloomberg.com/bb/avfile/rfvr13o8CUiA; CBS News Poll, 3/18-21/10, page 4, http://www.cbsnews.com/htdocs/pdf/poll_health_care_032210.pdf?tag=contentMain;contentBody; CNN Opinion Research Poll, 3/19-21/10, page 2, http://i2.cdn.turner.com/cnn/2010/images/03/22/rel5a.pdf.

[10] Rasmussen Reports, "Health Care Law," June 28, 2010, http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/march_2010/health_care_law.

[11] Congressional Budget Office, "The Long Term Budget Outlook," June 2010, page x, xi. http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf

[12] Congressional Budget Office, "The Long Term Budget Outlook," June 2010, page x, xi. http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf

[13] Public Law 111-148, http://www.opencongress.org/bill/111-h3590/show; Public Law 111-152, http://www.opencongress.org/bill/111-h4872/show.

The intention of this report is to highlight some of problems with the law and its consequences. Here are a few examples examined in the report:

- Sixteen million Americans are forced into Medicaid, a program that denies care and yields lower health outcomes for patients, and for which there are minimal physicians to deliver care.

- American citizens will be forced to purchase costlier health care or pay a tax; illegal immigrants will continue to get free care and those costs will be shifted onto Americans.

- Uninsured Americans will now be considered violators of the law and could face harassment by the IRS.

- The new health law increases the cost of health care and insurance.

- Millions of Americans will lose their current health plan as employers either drop coverage or purchase more expensive, government-dictated health insurance.

More than a year ago, our country began a national conversation about how to best reform our nation's health care system. We were both early advocates for real health reform that would lower costs, empower patients, and increase access. We proposed health reform ideas that would ensure all Americans had access to affordable coverage.[14]

The passage of the new law is a lost historic opportunity. However, we hope the American people will not give up on their desire for sustainable health reform but will hold their elected leaders accountable to work together to craft common-sense, bipartisan, step-by-step reforms. We believe that real reform begins with replacing the new law with sensible provisions that will lower costs, increase patient control, and put affordable, high quality coverage within the grasp of every American.

Tom Coburn, M.D. and John Barrasso, M.D.
U.S. Senators

[14] Coburn, Tom, "Legislation & Issues: Health Care," http://coburn.senate.gov/public/index.cfm/?p=Healthcare.

Health Costs Skyrocket

Lowering the cost of health care and health insurance is the primary objective most Americans cite when asked about health care. Costs are rising at an unacceptable rate—more than doubling over the last 10 years, which is more than three times the rate of wage growth.[15] In late 2008, Gallup found that a majority of Americans believed that the cost of health care is the most pressing health concern in the country.[16]

When asked a week after the passage of the new health care law in what ways the new law would impact them, Gallup again found cost was the key concern, saying "Americans remain worried about the bill's effect on costs." This poll revealed that a "majority of Americans say healthcare costs in the U.S. and the federal budget deficit will get worse as a result of the bill. Half of Americans believe that healthcare costs for themselves and their families will get worse."[17]

The new health law is not effective at reigning in climbing premium costs because it fails to address the underlying driver of health insurance costs – the cost of medical care. A primary reason premiums are rapidly increasing is because Americans are increasingly using more medical care and are choosing more costly care. Government data confirms this. According to government data, from 2000 to 2008, the growth in premiums tracked with the growth in underlying medical costs.[18]

Despite this, proponents of the new law claim that new federal subsidies will make health insurance more affordable. However, according to the nonpartisan Joint Committee on Taxation (JCT) *only about seven percent* of American households will be eligible to receive the subsidies.[19] This means that nine in 10 households will receive no subsidy or tax benefit for health insurance under the new law, and will continue to experience premium costs rising at or above their current rate of increase.

To make matters even worse, one in four Americans with the subsidy will still see their taxes increase, even after taking the subsidy into account.[20] To accomplish "savings" for seven percent of Americans, the new law redistributes nearly $800 billion generated from increasing taxes and cutting Medicare for millions of other Americans.[21]

Most importantly, the law increases the cost of health care itself. According to an April 2010 memo from the Actuary of the Centers for Medicare and Medicaid Services (CMS), the medical device and pharmaceutical drug fees and the health insurance excise tax will "generally be passed through to health consumers in the form of higher drug and device prices and higher insurance premiums, with an

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[15] Kaiser Family Foundation, "Wages and Benefits: A Long-Term View," November 2009, http://www.kff.org/insurance/snapshot/chcm012808oth.cfm.
[16] Jones, Jeffrey, Gallup Poll: "Healthcare Access, Cost are Top Health Concerns," December 1, 2008, http://www.gallup.com/poll/112516/Healthcare-Access-Cost-Top-Health-Concerns.aspx.
[17] Newport, Frank, Gallup Poll: "Americans Remain Concerned About Costs of Healthcare Bill," March 30, 2010, http://www.gallup.com/poll/127037/Americans-Remain-Concerned-Costs-Healthcare-Bill.aspx.
[18] Center for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, Table 12: "Private Health Insurance Premiums, Benefits, and Net Cost, Selected Calendar Years 1960-2008," http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.
[19] Joint Committee on Taxation, "Only 7% of Americans Receive Insurance Subsidy Under New Health Law," June 20, 2010, http://coburn.senate.gov/public/index.cfm/2010/6/joint-committee-on-taxation-only-7-of-americans-receive-insurance-subsidy-under-new-health-law
[20] Joint Committee on Taxation, "Only 7% of Americans Receive Insurance Subsidy Under New Health Law," June 20, 2010, http://coburn.senate.gov/public/index.cfm/2010/6/joint-committee-on-taxation-only-7-of-americans-receive-insurance-subsidy-under-new-health-law
[21] Congressional Budget Office, Table 1: "Summary of Preliminary Analysis of Health and Revenue Provisions of Reconciliation Legislation Combined with H.R. 3590 as Passed by the Senate," March 18, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf.

associated increase in overall national health expenditures…."[22] The JCT has also confirmed that many of the new taxes included in the health care reform law will be passed on directly to consumers, including the $60 billion tax on health plans, the $20 billion tax on medical devices, and the $27 billion tax on prescription drugs.[23]

Passage of the new health care law means millions of Americans will be forced to pay higher health insurance premiums and pay more for health care. As we noted, the Congressional Budget Office (CBO) found, under the law, premiums for millions of Americans purchasing coverage on their own will be 10-13 percent higher than they otherwise would be. [24] This represents a $2,100 increase for families purchasing coverage on their own.[25]

Premiums will also increase due to a new fee health insurance companies will have to pay to sell plans in the federally-mandated, regulated exchanges. CBO estimates plans would have to pay a surcharge to sell in the exchange, which could add about 3 percent to premiums.[26]

Premiums will increase because the new health law contains new federally-mandated rating rules that will cause premium costs for younger Americans to spike dramatically. About half of the uninsured are ages 19-34.[27] The new law offers these Americans two choices: face a financial penalty for not purchasing health insurance, or purchase health insurance that is *more* expensive than the status quo. Insurance for younger Americans will be more expensive because of new rating rules in the law that allow a smaller difference between the premiums an insurance company can charge a younger person compared with an older person. Unsurprisingly, independent actuaries and private sector experts estimate that, in most states, premiums for the youngest third of the population could increase by 35 percent under the new tight age bands under the law.[28]

Many younger, healthier Americans will make a rational economic decision to pay a new $695 tax – the penalty for not complying with the individual mandate to buy insurance – rather than pay up to 35 percent more for costly insurance they may never need. Older, sicker Americans who consume more health care will purchase health insurance, but others will simply wait until they get sick to buy health insurance. Because millions of young, healthy Americans will not participate in the insurance risk pool, this will cause premiums to increase even more rapidly for those with insurance.

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[22] Foster, Richard, Chief Actuary for the Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," page 17, April 22, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfefd0.

[23] Joint Committee on Taxation, "Technical Explanation of the Revenue Provisions of the 'Reconciliation Act of 2010,' as Amended, In Combination with the 'Patient Protection and Affordable Care Act,'" March 21, 2010, http://www.jct.gov/publications.html?func=startdown&id=3673.

[24] Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, " November 30, 2009, http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

[25] Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, " November 30, 2009, http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf. See page six: "Average premiums per policy in the nongroup market in 2016 would be roughly $5,800 for single policies and $15,200 for family policies under the proposal, compared with roughly $5,500 for single policies and $13,100 for family policies under current law."

[26] Elmendorf, Douglas, Director of the Congressional Budget Office, Letter to the Honorable Max Baucus, September 22, 2009, http://www.cbo.gov/ftpdocs/106xx/doc10618/09-22-Analysis_of_Premiums.pdf.

[27] U.S. Census Bureau, "People Without Health Insurance Coverage by Selected Characteristics: 2007 and 2008," http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2008/p60no236_table7.pdf

[28] Grau, Jason and Giesa, Kurt, "Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets, December 1, 2009, http://www.oliverwyman.com/ow/pdf_files/YBS009-11-28_PPACA120309.pdf.

Premiums will also increase because of changes to Medicare and Medicaid. Because both programs already reimburse doctors and other providers less than private insurance companies, many hospitals and clinics cover the difference by shifting some costs from under-reimbursing Medicare and Medicaid patients onto individuals who have private health insurance. A 2008 study found that the cost-shifting already accounts for an additional cost of almost $1,800 per family policy each year.[29] The new health care law will make this even worse.

The new law forces 16 million more Americans in Medicaid and cuts almost $529 billion from the Medicare program.[30] This means that many providers will be paid less for the care they deliver and could increasingly shift costs onto individuals who have private health insurance. Unfortunately, this cost-shift dynamic could be severe, because the new law does little to permanently address Medicaid's or Medicare's inadequate reimbursement rates to physicians and hospitals.

The cost-shift could also get worse as more Medicaid patients fill emergency departments across the country. According to a recent report, Medicaid patients already are more than twice as likely as the uninsured or privately insured to visit the ER in a year's time.[31]

Tragically, the new health law also increases costs to the federal taxpayer. The CMS Actuary has stated the new health care law bends the federal spending curve upward "by a net total of $251 billion" over the next decade.[32] The Actuary said the new health care law increases national health spending by $311 billion during calendar years 2010-2019.[33]

Not only is the cost curve heading in the wrong direction, but the costs to the government could easily spiral upward when Congress adds or modifies provisions of the new law. This point was underscored by CBO in their original price estimate, when they noted that claims of deficit-reduction "assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation."[34]

One way that federal costs could skyrocket is for employers to drop their employees' health coverage. Many employees would then be automatically eligible for subsidies to purchase coverage in the new health exchanges. If this phenomenon occurs on even a moderate scale, costs to the federal government will soar.

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[29] Fox, Will and Pickering, John, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," December 2008, http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf.

[30] Elmendorf, Douglas, Director of Congressional Budget Office, Letter to the Honorable Nancy Pelosi, Table 2: "Preliminary Estimate of the Effects of the Insurance Coverage Provisions of the Reconciliation Legislation Combined with H.R. 3590 as Passed b the Senate," March 18, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf. Also see Senate Finance Committee GOP staff compilation of final total of cuts to Medicare over 10-year window, http://coburn.senate.gov/public/index.cfm/rightnow?ContentRecord_id=FF5FA031-2706-4CE3-9345-66D3A0A6F0FF.

[31] Marcus, Mary Brophy, "Study: Uninsured don't go to the ER more than insured," *USA Today*, March 19, 2010. http://www.usatoday.com/news/health/2010-05-20-emergency20_st_N.htm.

[32] Foster, Richard, Chief Actuary for the Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," page 17, April 22, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfefd0.

[33] Foster, Richard, Chief Actuary for the Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," page 17, April 22, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfefd0.

[34] Elmendorf, Douglas, Director of Congressional Budget Office, Letter to the Honorable Harry Reid, November 18, 2008, http://www.cbo.gov/doc.cfm?index=10731.

According to one health policy expert, the new law "creates powerful financial incentives for employer to drop coverage – paying a small fee to dump employees in the exchange….the financial incentives for employers to move workers in to the exchanges are most powerful when it comes to middle-income wage-earners."[35] Other experts agree.

Former CBO director, Doug Holtz-Eakin, recently noted the new law provides strong incentives for employers to "drop employer-sponsored health insurance for as many as 35 million Americans, perhaps leading to widespread turmoil in labor compensation and employee insurance coverage – and raising the gross taxpayer cost of the subsidies to roughly $1.4 trillion in the first 10 years."[36]

As CBO pointed out, the "legislation would put into effect a number of procedures that might be difficult to maintain over a long period of time," but the "long-term budgetary impact could be quite different if key provisions of the bill were ultimately changed or not fully implemented." Given Congress' record on spending, it is not surprising that a majority of Americans expect for costs to continue increasing under the new law.

[35] Gottlieb, Scott, "O's Middle-class squeeze: President is wrong to claim health reform only hurts rich," *New York Post*, March 18, 2010, http://www.nypost.com/p/news/opinion/opedcolumnists/middle_class_squeeze_XqHUhXIjnjVB48DYLXhRDK.

[36] Holtz-Eakin and Smith, Cameron, "Labor Markets and Health Care Reform: New Results," May 2010, http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf?utm_source=&utm_medium=&utm_campaign.

Millions Could Lose Their Current Health Plan

While tens of millions of Americans are uninsured or have poor health care coverage, more than eight in 10 Americans already have health insurance they are satisfied with and upon which they depend.[37] Americans were repeatedly promised the new health law would allow anyone who wanted to keep their current health plan to do so.[38] However, as the new law is being implemented, millions of Americans are in danger of losing their current health insurance.

Some Americans have already lost their health coverage. Danny and Zina Robbins of Altus, Oklahoma, received a letter in June from their insurer that their plan would not be renewed in December.[39] The letter stated that "after careful consideration of the recent health care legislation," the insurance company had decided to "withdraw from the individual and small group health benefit plan markets" in 48 states. Danny is not yet sure what he and Zina, who is battling lymphoma, will do next.

Millions of Americans Who Like Their Current Plan Will Lose It

Danny and Zina are not the only Americans facing such challenges. While many businesses struggle to adapt under the new law, some are unable to survive its impact. According to a recent report, "a Virginia-based insurance company says 'considerable uncertainties' created by the…health care overhaul will force it to close its doors by the end of the year." This means that "100 small-business contracts providing policies to 'thousands' of subscribers" could be terminated.[40]

The Congressional Budget Office (CBO) expects about 9 million Americans will lose their current health insurance.[41] According to the Actuary of the Centers for Medicare and Medicaid Services (CMS), the new health care law will result in approximately 14 million people losing their employer coverage by 2019 as smaller employers terminate coverage and workers who currently have employer coverage become enrolled in Medicaid.[42]

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[37] Politifact.com, "Will says that 95 percent of people with health insurance are satisfied with it," February 2010, http://www.politifact.com/truth-o-meter/statements/2010/mar/10/george-will/will-says-95-percent-people-health-insurance-are-s/.

[38] (1) U.S. Senator Barack Obama, October 7, 2008: "If you've got health care already, and probably the majority of you do, then you can keep your plan if you are satisfied with it." (2) President Obama, Remarks on Health Care and the Senate Vote on F-22 Funding, July 21, 2009: "If you like your current plan, you will be able to keep it. Let me repeat that: if you like your plan, you'll be able to keep it." http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-on-Health-Care-and-the-Senate-Vote-on-F-22-Funding
(3) President Obama, Address to a Joint Session of Congress, September 9, 2009: "Nothing in our plan requires you to change what you have." http://www.whitehouse.gov/the_press_office/remarks-by-the-president-to-a-joint-session-of-congress-on-health-care/
(4) President Obama, Remarks on Health Care Reform, March 15, 2010: "So if you like your plan, you can keep your plan." http://www.whitehouse.gov/the-press-office/remarks-president-health-care-reform-strongsville-ohio.

[39] Constituent correspondence to U.S. Senator Tom Coburn, available at www.coburn.senate.gov. Confirmed business decision to withdraw from market with Stephen Way, managing director of Southwest Insurance Partners (SWIP), the holding company for National Health Insurance Company, http://www.nhic.com/. SWIP does not maintain a website, but more information is available here: http://www.hoovers.com/company/Southwest_Insurance_Partners_Inc/rkyxytjc-1.html.

[40] Kliff, Sarah, "First Victim of Health Overhaul?", *Politico*, June 7, 2010, http://www.politico.com/news/stories/0610/38194.html#ixzz0qrAiriQe.

[41] Elmendorf, Douglas, Director of Congressional Budget Office, Letter to the Honorable Nancy Pelosi, Table 2: "Preliminary Estimate of the Effects of the Insurance Coverage Provisions of the Reconciliation Legislation Combined with H.R. 3590 as Passed b the Senate," March 18, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf.

[42] Foster, Richard, Chief Actuary for the Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," page 17, April 22, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfefd0.

Seniors Who Like Their Current Plan Will Lose It

The CMS Actuary also noted that the number of seniors enrolling in Medicare Advantage plans will be reduced by half by 2017, and the payment cuts in the new law will cause Medicare Advantage plans to reduce the benefits they provide, including assistance with co-insurance, lower premiums and extra benefits like vision and dental care. "The new provisions will generally reduce [Medicare Advantage] rebates to plans and thereby result in less generous benefit packages," the Actuary said.[43]

This and other changes to Medicare in the new law will directly impact senior's access to care. The CMS Actuary forecasts that **"**providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and … might end their participation in the program (possibly jeopardizing access to care for beneficiaries)."[44] In other words, doctors will drop out of the Medicare program.

Retirees Who Like Their Current Plan Could Lose It and the Government Could End Up Paying More

A single tax change buried in the new federal health care law could cause thousands, and perhaps even millions of seniors, to lose their current drug coverage. The provision in question, Section 9012, increases federal taxes on employer-provided prescription drug plans for retired workers. This provision changed how the federal government taxes employers who provide prescription drug coverage to their employees who are otherwise eligible for Medicare prescription drug coverage.

As part of the legislation that created the new Medicare prescription drug benefit, employers receive a federal subsidy equal to 28 percent of the costs of providing prescription drug coverage to their retired workers.[45] Employers were then able to deduct the full cost of these plans, including the subsidy, from their corporate taxes as a normal business expense.[46] The purpose of this federal incentive was to shift some of the costs for retiree coverage to the private sector, rather than have Medicare absorb the full cost of covering retirees.

However, to help pay for the new health care law, this subsidy was changed. Employers are now required to pay taxes on the subsidy, rather than being able to exempt it from taxation along with the rest of their employee drug benefit costs.[47] According to the nonpartisan Joint Committee on Taxation, this provision –Section 9012 of the Senate bill –will result in employers paying $4.5 billion in new taxes over the next 10 years.[48] Unfortunately, the seemingly innocuous changes are having wide-reaching, immediate, negative consequences for businesses, retirees, and taxpayers.

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[43] Foster, Richard, Chief Actuary for the Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," page 11, http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf#page=11.

[44] Foster, Richard, Chief Actuary for the Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," page 9, http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf#page=9.

[45] 42 U.S.C. Sec. 1395w-132.

[46] Joint Committee on Taxation, "Technical Explanation of the Revenue Provisions of the 'Reconciliation Act of 2010,' as Amended, In Combination with the 'Patient Protection and Affordable Care Act," Item K, page 94, March 21, 2010, http://www.jct.gov/publications.html?func=startdown&id=3673.

[47] Joint Committee on Taxation, "Technical Explanation of the Revenue Provisions of the 'Reconciliation Act of 2010,' as Amended, In Combination with the 'Patient Protection and Affordable Care Act," Item K, page 94, March 21, 2010, http://www.jct.gov/publications.html?func=startdown&id=3673. "This refers to Section 9012 as amended by section 1407 of the reconciliation bill."

[48] Joint Committee on Taxation, "Estimated Revenue Effects of the Amendment in the Nature of a Substitute to H.R. 4872, the 'Reconciliation Act of 2010,' as Amended in Combination with the Revenue Effects of H.R. 3590, the 'Patient Protection and Affordable Care Act (PPACA),' as passed by the Senate, and Scheduled for Consideration by the House Committee on Rules on March 20, 2010, March 20, 2010, http://www.jct.gov/publications.html?func=startdown&id=3672.

Troublingly, this new tax will have a dramatic affect on prescription drug coverage for retirees. According to a senior official at the AFL-CIO and the President of the American Benefits Council, the provision will be "highly destabilizing for retirees who rely upon employer sponsored drug coverage."[49] Because the loss of the deduction will increase the costs associated with providing prescription drug coverage, many employers are likely to no longer offer such plans to their retired workers. An estimated 1.5 to 2 million retired workers could lose their current prescription drug plans as a result of this new tax increase as employers either increase premiums or drop coverage altogether.[50]

As it turns out, this provision may end up costing the taxpayers rather than saving federal dollars. The problem is that the revenues generated by this provision could be canceled out by increased costs in Medicare as are a direct result of this very change. This provision could lead employers to drop coverage of retiree prescription drug plans, causing federal costs to skyrocket as seniors will seek drug coverage through Medicare.

A recent analysis by an employer benefits research group highlighted how it costs the federal government substantially more money to pay for an individual to receive drug coverage through a Medicare Part D plan than it does for a retiree plan offered by an employer.[51] The report concludes that the increase in the cost of retiree drug benefits will cause employers to re-evaluate whether they should continue to offer retiree drug coverage.

The authors of the report go on to note that the net result of employers deciding to drop their coverage and enroll their retirees in Medicare Part D will result in an additional cost to the government of $544 per retiree. If 1.5 to 2 million retirees lost their coverage, the tax change could erase savings and actually increase federal costs by several billion dollars.

[49] Klein, James and Samuel, William, American Benefits Council, Letter to the Honorable Harry Reid re Proposed Change to the Tax Treatment of Retiree Drug Subsidies, December 10, 2009, http://www.americanbenefitscouncil.org/documents/afl-cio-letter12-10-09.pdf.
[50] The Moran Company, "Assessing the Coverage and Budgetary Implications of Legislation Modifying the Deductibility of Retiree Drug Spending Eligible for Subsidies, March 16, 2010, http://www.americanbenefitscouncil.org/documents/hcr_rds-report_031610.pdf.
[51] Fronstin, Paul, Employee Benefit Research Institute, "Implications of Health Reform, for Retiree Health Benefits," January 2010, http://www.ebri.org/pdf/briefspdf/EBRI_IB_01-2010_No338_RetHlth1.pdf.

16 Million Americans Forced Into Government Program That Denies Care

The new health law will force half of currently uninsured Americans –16 million people – into Medicaid. Medicaid is a federal-state government health program that is already bankrupting states and denying patients access to care and yielding poorer heath outcomes.

Carol Vliet, 53, has experienced how Medicaid denies patients care. Carol "began a punishing regimen of chemotherapy and radiation, [she] found a measure of comfort in her monthly appointments with her primary care physician, Dr. Saed J. Sahouri, who had been monitoring her health for nearly two years."[52] But Carol, who lives near Flint, Michigan, was devastated when Dr. Sahouri told her he could no longer provide care for her because he stopped taking Medicaid patients. Dr. Sahouri sadly explained his reason was "reimbursements from Medicaid were so low — often no more than $25 per office visit….he was losing money every time a patient walked in his exam room." [53]

However, under the new law, Carol, and every low-income American meeting certain eligibility criteria will be essentially locked into Medicaid – the worst delivery system in America. Under the new law, all states are *required* to enroll every American in Medicaid who has income at or below 133% of the federal poverty level ($14,403 individual/ $29,326 family of four).[54]

President Obama once seemed to affirm that locking low-income Americans into Medicaid did not constitute real health reform. "It is not sufficient for us simply to add more people to Medicare or Medicaid to increase the rolls, to increase coverage in the absence of cost controls and reform," he said in June 2009.[55] "If we don't get control over costs, then it is going to be very difficult for us to expand coverage. These two things have to go hand in hand. . . . We can't simply put more people into a broken system that doesn't work."

Unfortunately, the new law enrolls half of the uninsured into a system that denies access to care and is financially stressing state budgets. And the cost for this Medicaid expansion balloons to $386 billion in the first decade, according to the Congressional Budget Office (CBO).[56]

Medicaid is a program for low-income Americans. Medicaid "is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care to more than 64 million people at an estimated annual cost to the federal and state governments of roughly $352 billion" each year according to the Congressional Research Service (CRS).[57]

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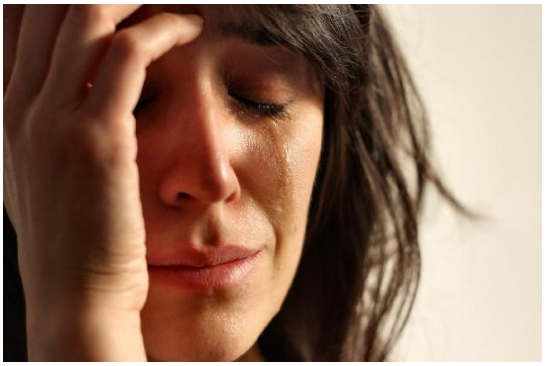
[52] Sack, Kevin, "As Medicaid Payments Shrink, Patients Are Abandoned," *New York Times*, March 15, 2010, http://www.nytimes.com/2010/03/16/health/policy/16medicaid.html?pagewanted=all.
[53] Sack, Kevin, "As Medicaid Payments Shrink, Patients Are Abandoned," *New York Times*, March 15, 2010, http://www.nytimes.com/2010/03/16/health/policy/16medicaid.html?pagewanted=all.
[54] Center for Medicaid and State Operations, et al., "2010 Poverty Guidelines," https://www.cms.gov/MedicaidEligibility/Downloads/POV10Combo.pdf.
[55] President Barack H. Obama, "Remarks Prior to a Meeting with Senate Democrats to Discuss Health Care Reform and an Exchange with Reporters," June 2, 2009, http://www.gpoaccess.gov/presdocs/2009/DCPD-200900422.htm.
[56] Elmendorf, Douglas, Director of Congressional Budget Office, Letter to the Honorable Harry Reid, March 11, 2010. See table 3. http://www.cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf.
[57] Herz, Elicia J., Congressional Research Service, Medicaid: A Primer, February 25, 2010, http://crs.gov/Pages/Reports.aspx?Source=search&ProdCode=RL33202 .

Medicaid Denies Patients Access to Care

Access to a government program is not access to health care. As Dr. Coburn and Dennis Smith, former Director of State Operations at the Centers for Medicare and Medicaid wrote, Medicaid patients have a hard time accessing care:

> "Medicaid reimburses health providers [only…] cents on the dollar. As a result, about 40 percent of physicians do not accept Medicaid patients. Any state Medicaid director in the nation will concede those who are on Medicaid face barriers to access; limiting access or delaying care are forms of rationing. Moreover, the perverse incentives in the program have caused Medicaid recipients to use the emergency room at twice the rate of those with private insurance and see medical and surgical specialists at half the rate of those with private insurance."[58]

A physician recently said that "'high Medicaid utilization [of the emergency department] is no surprise; many patients have difficulty finding primary care providers who take Medicaid, so the ER is the only alternative.'" [59] A recent report from the Centers for Disease Control and Prevention detailing Medicaid patients' use of emergency departments highlights this problem.[60] In 2007, about one in three Medicaid patients under 65 visited the emergency department at least once, compared to less than one in five patients without insurance, or with private health insurance. Even worse, Medicaid patients were about twice as likely as the uninsured or insured to visit an emergency department at least twice. [61]



Medicaid Yields Lower Health Outcomes for Patients

Patients on Medicaid have poorer health outcomes compared to others. As Dr. Scott Gottlieb, a former senior official at the Centers for Medicare and Medicaid Services (CMS), explains:

> "Accumulating medical data shows that Medicaid recipients' poor health outcomes aren't just a function of their underlying medical problems, but a more direct consequence of the program's shortcomings....One study published in the Journal of the American College of Cardiology (2005) found that Medicaid patients were almost 50% more likely to die after coronary artery bypass surgery than patients with private coverage or Medicare.... Another study in the journal *Ethnicity and Disease* (2006) showed that elderly Medicaid patients with unstable angina had worse care, partly because they were less likely to get timely interventions or be treated at higher quality hospitals…..[and] a study of adults with cancer published in the journal Cancer (2005) found that patients on Medicaid were two to three times more likely to die from the disease even after researchers corrected for differences in the location of the tumor and its stage when diagnosed."

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[58] Coburn, Tom and Smith, Dennis, "Expanding the Medicaid Status Quo Is Not Health Reform," *National Review Online*, October 19, 2009, http://healthcare.nationalreview.com/post/?q=NzMwZjk3ZDlmY2VlZjQyODlhNmMwYTc3YmZlYjBkYTg=.

[59] Marcus, Mary Brophy, "Study: Uninsured Don't Go To The ER More Than Insured," *USA Today*, May 19, 2010, http://www.usatoday.com/news/health/2010-05-20-emergency20_st_N.htm?loc=interstitialskip.

[60] Marcus, Mary Brophy, "Study: Uninsured Don't Go To The ER More Than Insured," *USA Today*, May 19, 2010, http://www.usatoday.com/news/health/2010-05-20-emergency20_st_N.htm?loc=interstitialskip.

[61] Marcus, Mary Brophy, "Study: Uninsured Don't Go To The ER More Than Insured," *USA Today*, May 19, 2010, http://www.usatoday.com/news/health/2010-05-20-emergency20_st_N.htm?loc=interstitialskip.

Government data explains the barriers to accessing care. A 2002 government survey found that "'approximately 40% of physicians restricted access for Medicaid patients,'" because payment rates are so low. [62] As Gottlieb explained, "only about half of U.S. physicians accept new Medicaid patients, compared with more than 70% who accept new Medicare patients.[63]

With such restrictions on access to care, patients on Medicaid experience higher rates of infant mortality. Several states have compared infant mortality rates (IMR) for Medicaid patients with the IMR of patients without insurance or with private insurance.

The nonpartisan CRS conducted a data analysis of the IMR in four states.[64] In one state with an IMR higher than the U.S. average, researchers found that "births covered by Medicaid had worse outcomes when compared to births covered by private insurance…. When compared to private insurance, Medicaid mothers received less prenatal care" and had nearly twice as high rate of infant mortality. [65]

Unfortunately, the states below the national average did not fare much better. The State of Hawaii found "that rates of IMR and low birth weight were significantly higher among those with Medicaid when compared to births covered by private or military insurance." The State of Minnesota found that the IMR was about a 50 percent higher for Medicaid covered births than for births covered by other insurance sources. The State of Washington found that the IMR for Medicaid covered births was twice the rate for non-Medicaid covered births.[66]

In addition to poorer health outcomes, Medicaid patients have a limited selection of health care providers. According to a 2009 poll of 110,000 practicing physicians who were asked about insurance market reforms, only one in 4 responding physicians identified enrolling the uninsured in Medicaid as the best change for patients and physicians, so all Americans can have health insurance and insurance companies are held accountable. [67] Nearly half of physicians in the same poll said government health programs, including Medicaid, are ineffective or very ineffective at responding to the individual needs of patients and empowering physicians and providers to provide quality care. About two-thirds of physicians said increased federal control over health care would decrease their ability to provide high quality care to patients.

Medicaid is Bankrupting States and Taxpayers

So why did Congress force more Americans into a system that delivers poor health outcomes for patients, and denies patients access to care? As a former director at the Centers for Medicare and Medicaid wrote, "Washington politicians find a Medicaid expansion appealing because it is a federal program which states help pay for. States pay on average 43 percent of Medicaid's cost. CBO accounting says Medicaid coverage is the cheapest way to provide coverage — it

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[62] Gottlieb, Scott, "What Medicaid Tells Us About Government Health Care," *The Wall Street Journal*, January 8, 2009, http://online.wsj.com/article/SB123137487987962873.html.
[63] Gottlieb, Scott, "What Medicaid Tells Us About Government Health Care," *The Wall Street Journal*, January 8, 2009, http://online.wsj.com/article/SB123137487987962873.html.
[64] Heisler, Elayne J., "Infant Mortality Rates," Congressional Research Service, October 14, 2009, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=5d0b18f4-af13-4d84-85fd-b44c58895933.
[65] Heisler, Elayne J., "Infant Mortality Rates," Congressional Research Service, October 14, 2009, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=5d0b18f4-af13-4d84-85fd-b44c58895933.
[66] Heisler, Elayne J., "Infant Mortality Rates," Congressional Research Service, October 14, 2009, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=5d0b18f4-af13-4d84-85fd-b44c58895933.
[67] Poll Results, "From Sen. Coburn, MD: Your input on Insurance Market Reforms," February 8, 2010, http://www.sermo.com/results/posts/41286_from_senator_coburn_md_your_input_on_insurance_reform/survey_results.html.

can push costs onto the states, thereby lowering the price tag at a federal level." [68] While the federal government may absorb the costs for most of the newly enrolled Medicaid beneficiaries, very few health policy experts believe this situation is fiscally sustainable.

Even worse, just because Medicaid costs are shifted to states which lowers the federal price tag, it does not make it affordable for states. The same former official noted that "most states cannot afford their current share of Medicaid costs. Many states spend more on their share of Medicaid than they do on K-12 education statewide."[69] Under the new law, states are required to maintain their current Medicaid programs.

Congress has expanded an unaffordable system. Yet, since the passage of the health law, Congress has already considered legislation in the Senate that would add a quarter of a trillion dollars to the debt to send more Medicaid funding to states.

This is another danger with the Medicaid expansion in the new health care law. Medicaid spending is now the fastest growing budget line item in virtually every state in the country. In 2006, Medicaid spending accounted for almost one quarter of the average state budget. In many states, spending on Medicaid outpaces spending on all K-12 education.[70] According to the National Association of State Budget Officers, Medicaid costs will grow much faster than state revenue growth for the foreseeable future. This threatens to bankrupt state or result in higher taxes and cuts to other essential state services.

At an average annual growth rate of eight percent, Medicaid is the fastest growing federal entitlement program.[71] According to one private study, "since 1970, Medicaid's *costs have risen 35 percent more, per patient*, than the combined costs of all health care in America apart from Medicare and Medicaid." [72] This is the case, "despite costs shifted from Medicaid to the Medicare prescription drug benefit and to SCHIP, and despite generous assumptions favoring Medicaid."[73]

This runaway growth in Medicaid (and Medicare) spending – coupled with an increase in the number and average age of beneficiaries – is why CBO said federal spending on health care constitutes the "single greatest threat" to our nation's budget stability.[74] According to CBO, last year, one out of every five federal dollars was spent on either Medicare or Medicaid. Reforming Medicaid is a central challenge to ensuring our country's economic growth, as outlays for entitlement programs (Medicaid, Medicare, and Social Security) will "climb to 80 percent of mandatory spending" by 2020 according to CBO. [75]

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[68] Coburn, Tom and Smith, Dennis, "Expanding the Medicaid Status Quo Is Not Health Reform," *National Review Online*, October 19, 2009, http://healthcare.nationalreview.com/post/?q=NzMwZjk3ZDlmY2VlZjQyODlhNmMwYTc3YmZlYjBkYTg=.

[69] Coburn, Tom and Smith, Dennis, "Expanding the Medicaid Status Quo Is Not Health Reform," *National Review Online*, October 19, 2009, http://healthcare.nationalreview.com/post/?q=NzMwZjk3ZDlmY2VlZjQyODlhNmMwYTc3YmZlYjBkYTg=.

[70] Stark, Dr. Roger, Washington Policy Center, "A Review of the Medicaid Program: Its Impact in Washington State and Efforts at Reform in Other States," May 2009, http://www.washingtonpolicy.org/Centers/healthcare/policybrief/Medicaid.html.

[71] Stark, Dr. Roger, Washington Policy Center, "A Review of the Medicaid Program: Its Impact in Washington State and Efforts at Reform in Other States," May 2009, http://www.washingtonpolicy.org/Centers/healthcare/policybrief/Medicaid.html.

[72] Anderson, Jeffrey H., Pacific Research Institute, "Medicaid's Costs, Like Medicare's, Have Risen Far More Than the Costs of Private Health Care," July 2009, http://www.pacificresearch.org/docLib/20090714_HPPv7n07_0709.pdf.

[73] Anderson, Jeffrey H., Pacific Research Institute, "Medicaid's Costs, Like Medicare's, Have Risen Far More Than the Costs of Private Health Care," July 2009, http://www.pacificresearch.org/docLib/20090714_HPPv7n07_0709.pdf.

[74] Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2010 to 2020," January 2010, http://www.cbo.gov/ftpdocs/108xx/doc10871/01-26-Outlook.pdf.

[75] Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2010 to 2020," January 2010, http://www.cbo.gov/ftpdocs/108xx/doc10871/01-26-Outlook.pdf.

Medicaid is Rife with Waste, Fraud, & Abuse

Medicaid loses tens of billions of taxpayer dollars each year to waste, fraud and abuse. The new health law does little to combat this growing problem.

The Department of Health and Human Services' Office of the Inspector General said last year that the Medicaid Statistical Information System (MSIS) – the only source of nationwide Medicaid claims and beneficiary eligibility information – failed to capture many of the data elements that can assist in the detection of waste, fraud, and abuse.[76] In fact, the IG's report determined that the MSIS data was on average about a year-and-a-half old in many cases. The report made clear that the use of "timely, accurate, and comprehensive MSIS data can contribute to more effective health care fraud, waste, and abuse identification and prevention." [77]

Absent specific measures, Medicaid's improper payment rate is the most objective estimate of taxpayer dollars lost to fraud. An improper payment occurs when taxpayer funds are used to pay for a good or service not authorized, or when an entity receives an incorrect amount of funds, or an entity uses federal taxpayer dollars in a wrongful manner. The national average improper payment rate ranges between 8.7% and 10.5%. Medicaid's improper payment rate is more than three times the average improper payment rate of other federal agencies of 3.5 percent.[78] Many states have far higher rates. In Washington, D.C. for example, nearly one out of five Medicaid dollars is improperly spent.[79]

President Obama was right when he said it is "not sufficient for us simply to add more people" to Medicaid or "to increase coverage in the absence of cost controls and reform."[80] Unfortunately, the new health law he signed does precisely that. Our current Medicaid program is in deep need of reform, because it is unaffordable for federal and state taxpayers, it is untenable to give low-income Americans second-class access to care, and it is rife with waste, fraud, and abuse.

[76] Wright, Stuart, Memorandum Report: "MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse," OEI-04-07-00240," August 26, 2009, http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf.
[77] Wright, Stuart, Memorandum Report: "MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse," OEI-04-07-00240," August 26, 2009, http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf.
[78] Hatch, Garrett, and McMurtry, Virginia, "Improper Payments Information Act of 2002: Background, Implementation, and Assessment," Congressional Research Service, May 7, 2010, http://apps.crs.gov/products/rl/html/RL34164.html.
[79] HHS Secretary Kathleen Sebelius's correspondence to Sen. John Cornyn, February 25, 2010, provides improper payment rates listed by state. http://cornyn.senate.gov/public/index.cfm?p=HealthCareRetirement.
[80] President Barack H. Obama, "Remarks Prior to a Meeting with Senate Democrats to Discuss Health Care Reform and an Exchange with Reporters," June 2, 2009, http://www.gpoaccess.gov/presdocs/2009/DCPD-200900422.htm

Patients with Pre-Existing Conditions Still Face Care Restrictions

Julie Kramer is a self-employed writer from the Chicago-area with a pre-existing condition. Julie "is feeling a bit cheated" by the new federal health care law. [81] Unfortunately, she is not alone. According to the Congressional Budget Office (CBO), about 500,000 Americans with pre-existing conditions find themselves in a similar position, since they will not be able to obtain coverage in a new federal high risk pool.[82]

What is a High Risk Pool?

According to the Congressional Research Service, high risk pools "generally cover people who have sought health coverage in the individual (nongroup) market, but have been denied coverage, received quotes from insurers that are higher than the premiums offered by the high risk pools, or received offers from insurers that permanently exclude coverage of preexisting health conditions."[83]

More than 30 states already have some form of a high risk pool and such pools are one of the options states could use in *The Patients' Choice Act* to provide coverage for Americans. In fact, high risk pools boast wide bipartisan support as a way to ensure coverage for Americans with pre-existing conditions.

What is the New Federal High Risk Pool?

The administration advertised the law's newly-created $5 billion high risk pool as a program that will help all Americans with preexisting conditions before the more robust insurance reforms are instituted in 2014. Unfortunately, the Chief Actuary of the Center for Medicare and Medicaid Services estimates the funding for this program will run out in 2011 or 2012. [84] The new law capped total spending on the program at $5 billion between now and 2014, but CBO found that to meet full demand, an additional $5-10 billion in funding would be required.[85]

According to one report, between five and seven million individuals with pre-existing conditions may be eligible for the new risk pool, while only 200,000 would be able to be covered under existing funds. [86] The question then becomes: what would happen to the patients enrolled in the program when the money runs out?

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[81] Johnson, Carla, "High-Risk Patients May Be Stuck Paying High Rates," May 14, 2010, http://cbs2chicago.com/local/high.risk.patients.2.1694407.html.
[82] Elmendorf, Douglas, Director of Congressional Budget Office, Letter to the Honorable Michael B. Enzi, June 21, 2010, http://cbo.gov/ftpdocs/115xx/doc11572/06-21-High-Risk_Insurance_Pools.pdf.
[83] Fernandez, Bridgett, Congressional Research Service, "Health Insurance: State High Risk Pools," June 23, 2010. http://crs.gov/Pages/Reports.aspx?Source=search&ProdCode=RL31745
[84] Foster, Richard, Chief Actuary for the Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfefd0.
[85] Elmendorf, Douglas, Director of Congressional Budget Office, Letter to the Honorable Michael B. Enzi, June 21, 2010, http://cbo.gov/ftpdocs/115xx/doc11572/06-21-High-Risk_Insurance_Pools.pdf.
[86] Diamond, Dan, "High-Risk Pools May Need Lower Expectations," *California Healthline*, June 2, 2010, http://www.californiahealthline.org/road-to-reform/2010/high-risk-pools-may-need-lower-expectations.aspx; Merlis, Mark, "Health Coverage for the High-Risk Uninsured: Policy Options for Design of the Temporary High-Risk Pool," National Institute for Health Care Reform, http://www.nihcr.org/High-RiskPools.html .

Another concern is that the new law says a patient cannot enroll in the new high risk pool program unless that individual has been uninsured for at least six months. Six months could be too long for many uninsured individuals to wait. Some conditions could evolve from being serious to being life-threatening or even terminal, if left unaddressed for six months. Americans with severe conditions like pancreatic or colon cancers, or even uncontrolled diabetes, certainly cannot wait six months for care.

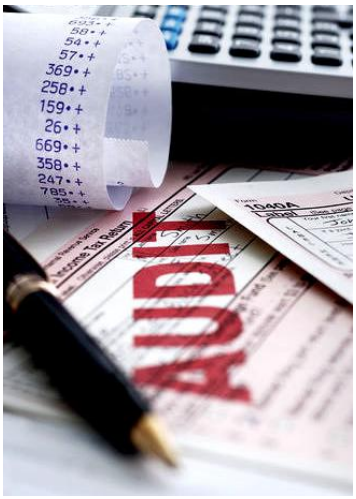
As CBO also pointed out, "most of these enrollees [in the risk pool] would have been uninsured" – because the law requires applicants to have been without insurance for six months.[87] This effectively penalizes responsible Americans who paid premiums to obtain coverage in current risk pools.

Sadly for Julie, and thousands of other Americans with preexisting conditions like cancer, diabetes, and lupus, who are already enrolled in high risk pools, they have discovered they will be denied access to a new system of high risk pools that could offer better benefits at lower costs. The new law mandated the new risk pool program start Monday, June 21, 2010. However, the program is still not operational, leaving hundreds of thousands of Americans with pre-existing conditions waiting access to coverage. For Julie who has been paying high premiums, of about $700 a month, for nearly seven years into Illinois' high-risk pool, "it feels very unfair…[and] it goes against the spirit of what health care reform was supposed to be." [88]

The new law gives the Secretary of Health and Human Services the authority to stop taking new applications from patients. According to reports, it appears that Secretary Sebelius will have to start rejecting applications from thousands of Americans with preexisting conditions as early as 2011. The other possible scenario is the Administration and Congress could pass the buck onto the States. This may be the reason why 20 states are already opting out of participating in the new high risk pool program. [89]

[87] Elmendorf, Douglas, Director of Congressional Budget Office, Letter to the Honorable Michael B. Enzi, June 21, 2010, http://cbo.gov/ftpdocs/115xx/doc11572/06-21-High-Risk_Insurance_Pools.pdf.
[88] Johnson, Carla K., "High-Risk Patients May Be Stuck Paying High Rates," May 14, 2010, http://cbs2chicago.com/local/high.risk.patients.2.1694407.html.
[89] Backus, Jenny, "Next Steps in High-Risk Pool Program," May 3, 2010, http://www.healthreform.gov/forums/blog/high_risk_pools_update.html.

Mandate Will Fail With IRS As Health Care Enforcer, Costs Will Increase



One of the most contentious elements of the health care law is a new requirement –commonly called an "individual mandate"—requiring all Americans, with a few specified exceptions, to have federally-regulated health insurance.

Starting in 2014, it will be illegal for Americans not to purchase health insurance. Never before has the federal government passed a law requiring Americans to purchase any commodity. But, under the new health law, Americans face a choice between buying government-dictated insurance or breaking federal law.

The Congressional Research Service (CRS) has analyzed the Internal Revenue Service's (IRS) enforcement abilities for penalties of noncompliance with the individual mandate in the new health law.[90] The CRS confirms the concern about the ability of the IRS to enforce this provision.[91]

Under the new law, penalties for non-compliance with the mandate "generally are assessed and collected in the same manner as taxes," but without the usual tax-like penalties for noncompliance. Under the new federal health law, relatively low-cost penalties and anemic enforcement will create an incentive for millions of Americans to game the system and only buy health insurance when they are sick.[92]

Absent a stiff penalty, there is no incentive for Americans to comply with the mandate to buy government-approved insurance, at least not until they are sick. In fact, CBO projects that about four million Americans will have to pay a penalty because they choose not to buy government-dictated health insurance,[93] since the penalties for noncompliance will average a about $1,000 apiece in 2016 while the cost of the insurance could be three or four times higher.[94] This gaming of the system will skew the risk pool and increase premiums for other Americans with health insurance.

To see an example of what this will look like, one only need consider what is happening in Massachusetts – the only state with an individual mandate. According to reports, thousands are gaming the system by buying coverage to pay for expensive procedures then dropping coverage. The Massachusetts Division of Insurance recently released a report revealing that the number of people gaming the insurance system by buying coverage only when they are ill quadrupled from 2006 to 2008.[95]

This practice drives up costs for all health care consumers. As the *Boston Globe* reported recently, "thousands of consumers are gaming Massachusetts' 2006 health insurance law by buying insurance

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[90] Pettit, Carol, A. and Liu, Edward C., "The PPACA Penalty Provision and the Internal Revenue Service," Congressional Research Service, April 30, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=2ec1e180-afbf-4a48-ba12-8dea812ac30a.

[91] Block, Sandra, "IRS lacks clout to enforce mandatory health insurance," *USA Today*, April 30, 2010, http://www.usatoday.com/money/perfi/insurance/2010-04-29-healthirs28_CV_N.htm?cid=xrs_rss-nd.

[92] Pettit, Carol, A. and Liu, Edward C., "The PPACA Penalty Provision and the Internal Revenue Service," Congressional Research Service, April 30, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=2ec1e180-afbf-4a48-ba12-8dea812ac30a.

[93] Ohlemacher, Stephen, "Nearly 4M People Could Pay Without Health Coverage," *The Associated Press*, April 22, 2010, http://abcnews.go.com/print?id=10448451.

[94] Kaiser Family Foundation, "Family Health Premiums Reach $13,375 Annually in 2009," September 15, 2009. Note: "employees on average [pay] $3,515." http://www.kff.org/insurance/ehbs091509nr.cfm

95 Welch, Diana and Giesa, Kurt. "Analysis of Individual Health Coverage In Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Nongroup Health Insurance Markets," Report to the Massachusetts Health Care Access Bureau within the Massachusetts Division of Insurance. Oliver Wyman, June 2010. http://www.mass.gov/Eoca/docs/doi/Companies/adverse_selection_report.pdf

when they need to cover pricey medical care, such as fertility treatments and knee surgery, and then swiftly dropping coverage—a practice that insurance executives say is driving up costs for other people and small businesses."[96]

There is good reason to expect the system-gaming under the new federal health care law to be even worse than it is in Massachusetts. Under the Massachusetts law, the state has significant, stringent enforcement powers (including the powers of imprisonment) it can use to force citizens to buy insurance.

But as the CRS makes clear, such beefy enforcement powers are not available to the IRS. "Section 5000A … *limits the means the IRS may employ to collect the penalty established in the section*. First, the taxpayer is protected from either criminal prosecution or penalty for failure to pay the penalty. Second, the IRS is prohibited from either filing a NFTL [notice of federal tax lien] or levying any property in an effort to collect the penalty."[97]

According to the IRS, about 15 percent of Americans refuse to voluntarily pay their taxes on time. [98] CRS found in assessing the penalty, the IRS would likely use current data matching procedures for determining compliance with the law, which means that under the new law, millions of Americans could evade detection.

Under the new law, millions of Americans are required to give personal information to the Secretary of Health and Human Services. According to CRS, "among the information that is to be provided to HHS is information regarding income and family size; the name, address, and employer identification number of the individual's employer, if any; whether the individual is employed full time; whether the employer offers minimum essential coverage; and the cost of the cheapest health coverage options available from the employer and the employee's required contribution."[99]

But while Americans will be sharing sensitive personal information with HHS, federal contractors not compliant with the individual mandate could still receive millions of taxpayer dollars in federally-funded projects. As the memo makes clear, "delinquency in federal taxes is a ground for debarment of a federal contractor. However, debarment is not an automatic process and requires that the contracting agency initiate debarment proceedings against a government contractor."[100]

Under the law, "no additional limits are placed on the IRS using correspondence or phone calls, either through its own employees or through private collection agencies, in an effort to collect the amount

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[96] Lazar, Kay, "Short-term customers boosting health costs," *The Boston Globe*, April 4, 2010, http://www.boston.com/news/health/articles/2010/04/04/short_term_customers_boosting_health_costs/.

[97] Pettit, Carol, A. and Liu, Edward C., "The PPACA Penalty Provision and the Internal Revenue Service," Congressional Research Service, April 30, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=2ec1e180-afbf-4a48-ba12-8dea812ac30a.

[98] The Internal Revenue Service (IRS) collects 96 percent of the government's total receipts, approximately $2.7 trillion in FY 2008. The vast majority of those revenues come from taxpayers who voluntarily report and pay the taxes that they owe. The IRS has estimated the overall voluntary compliance rate to be approximately 84 percent. U.S. Department of the Treasury, "Update on Reducing the Federal Tax Gap and Improving Voluntary Compliance, July 8, 2009, http://www.irs.gov/pub/newsroom/tax_gap_report_-final_version.pdf; The Internal Revenue Service, "The Tax Gap," http://www.irs.gov/pub/irs-utl/tax_gap_facts-figures.pdf .

[99] Pettit, Carol, A. and Liu, Edward C., "The PPACA Penalty Provision and the Internal Revenue Service," Congressional Research Service, April 30, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=2ec1e180-afbf-4a48-ba12-8dea812ac30a.

[100] Pettit, Carol, A. and Liu, Edward C., "The PPACA Penalty Provision and the Internal Revenue Service," Congressional Research Service, April 30, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=2ec1e180-afbf-4a48-ba12-8dea812ac30a.

owed."[101] All this means that while IRS may still harass millions of Americans, the individual mandate will largely be ineffective in broadening the risk pool. Insurance markets are only effective when risks are "pooled" or shared across a large population, thus lower individual costs. Unfortunately, it is likely that millions of Americans will game the system, leaving fewer Americans to shoulder the costs. As a result, premiums will increase even further.

[101] Pettit, Carol, A. and Liu, Edward C., "The PPACA Penalty Provision and the Internal Revenue Service," Congressional Research Service, April 30, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=2ec1e180-afbf-4a48-ba12-8dea812ac30a.

Short-Term Fixes Threaten Seniors' Long-Term Access to Care

The new health care law intentionally omits any changes to a key provision of law that could endanger access to care for millions of seniors and veterans. The missing provision is called the Sustainable Growth Rate (SGR).

What Is The Sustainable Growth Rate (SGR)?

The SGR lies at the heart of a problem of how nearly 100,000 physicians get reimbursed by the government to care for about 40 million seniors. Without ensuring adequate payments to physicians, seniors' health care choices become more limited. What other issue could be more central to health reform, than ensuring we keep our promise to America's seniors so they can have access to a physician?

Janice Jessup may not know what the SGR is, but as a senior on Medicare in Virginia Beach, Va., she will be directly impacted by it.[102] Janice already has a hard time seeing a primary care physician. In fact, when she needed to find a new doctor in recent years, she called dozens of physicians' offices. But, she said, "they weren't taking Medicare patients anymore." Unfortunately for Janice and about 40 million other seniors, the new health law could mean finding a physician in the future will be even more difficult.

How Does The SGR Work?

The Medicare program reimburses 96,000 physicians who provide care for roughly 40 million seniors by using a payment mechanism known as the Sustainable Growth Rate. The SGR is important for ensuring veterans have access to physicians too, because by law, TRICARE – a military medical insurance program – bases its physician reimbursements on the SGR.[103]

Congress established the SGR in 1997 as a funding formula designed to adhere to overall spending targets. The SGR works by effectively decreasing reimbursement levels one year if Medicare reimbursements to physicians another year were higher than a set target.

Designed to rein in Medicare's exploding costs, the SGR was a well-intentioned effort. Though cost-containment is the right goal, the SGR mechanism failed to achieve its goal. In fact, since 2004, Congress has intervened on an almost annual basis to prevent reimbursement reductions that could harm seniors' access to care.

The reason reimbursement cuts could be so damaging is because Medicare pays physicians 20 percent less than private insurance.[104] Severe cuts could jeopardize physicians' ability to cover their costs and

[102] Rovner, Julie, "Medicare Doctor Pay 'Fix' Deadline Looming – Again," *National Public Radio News*, May 6, 2010, http://www.kaiserhealthnews.org/stories/2010/may/06/medicare-doc-pay-fix-npr.aspx.

[103] Jansen, Don. "Military Medical Care: Questions and Answers," Congressional Research Service report RL33537, May 14, 2009. Payment levels for health care services provided under TRICARE are required to be aligned with Medicare's fee schedule 'to the extent practicable.' More than 90% of TRICARE payment levels are currently equivalent to those in Medicare. http://crs.gov/ReportPDF/RL33537.pdf

put their participation in the Medicare program at risk. Should physicians around the country drop out of Medicare because of low reimbursements, seniors and veterans could face a crisis accessing care.

The SGR Needs To Be Fixed

The flawed funding formula is so problematic that most lawmakers agree the SGR needs to be replaced. Yet, there was no SGR provision, no "doc-fix" in the new law. In fact, the authors of the legislation pretended that dramatic Medicare reimbursement cuts would take place, so they could lower the price tag of their bill and claim it would reduce the deficit.

Congressional proponents of the bill could *only* claim the passage of their health bill would lower the federal budget deficit *if* they didn't include the cost of fixing the SGR in the final legislation. Reforming the SGR would cost about $275-330 billion dollars over 10 years, depending on the specific changes made. This cost is well over the alleged "deficit reduction" the bill's authors claimed for the same time period.[105]

So, rather than fixing an issue everyone in Congress agreed was a problem, Congressional leaders left the doc fix out of the final health bill. In fact, in attempt to quiet concerns over the SGR, one Senator introduced legislation what would have frozen Medicare reimbursement levels for a decade. The Senator downplayed the need of addressing the SGR, saying "We've essentially replaced it in the new health care reform bill anyway."[106]

The *Washington Post* exposed this disingenuous tactic saying that while "there is widespread agreement that the original spending formula turned out to be unreasonable….[it] is wrong is to pretend the cost doesn't exist – and to overhaul the health-care system without dealing with this quarter-trillion-dollar expense." [107]

The Congressional Budget Office (CBO) estimated the total budgetary impact of the health reform law and the Democrat-sponsored bill that would replace the SGR (H.R. 3961), and found that the cost of including a "doc-fix" would *increase the deficit by $59 billion.*[108]

Ignoring the SGR had nothing to do with policy; it had everything to do with politics and budgetary shenanigans. At the time of writing, Congress has intervened three times since the passage of the new law to prevent this reimbursement cut from taking effect. But merely leaving the SGR out of health reform to lower the bill's price tag does not really move the costs off the books. As the *Washington Post* noted, "The cost to federal taxpayers remains – no matter how much budgetary smoke and mirrors are used to make it seem to disappear, or to postpone the check-writing." [109]

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[104] Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," page 108, December 2008, http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

[105] Congressional Budget Office, "CBO Estimate of Changes in Net Federal Outlays from Alternative Proposals for Changing Physician Payment Rates in Medicare," April 30, 2010, www.cbo.gov/budget/factsheets/2010b/SGR-menu.pdf.

[106] Stabenow, Debbie, U.S. Senator. "Sens. Schumer and Stabenow Hold News Teleconference on Unemployment Insurance Benefits," *CQ Newsmaker Transcripts*, Congressional Events, April 12, 2010, http://corporate.cqrollcall.com/wmspage.cfm?parm1=81.

[107] Editorial, "Health Reform Shell Game," *The Washington Post*, October 10, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/10/09/AR2009100904189.html.

[108] Elmendorf, Douglas W., Director of the Congressional Budget Office, Letter to the Honorable Paul Ryan, March 19, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11376/RyanLtrhr4872.pdf.

[109] Editorial, "Health Reform Shell Game," *The Washington Post*, October 10, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/10/09/AR2009100904189.html.

Some Physicians Have Already Stopped Accepting Medicare Patients

Many lawmakers, including this report's authors, support a full replacement of the SGR. Allowing reimbursement cuts of over 20 percent will cause many physicians to drop their participation in the program and thus jeopardize access to medical care for seniors on Medicare and veterans with TRICARE. As the Chief Actuary of the Centers for Medicare and Medicaid Services, said in a memo to Congress, physicians "for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program possibly jeopardizing access to care for beneficiaries."[110]

In fact, frustrated with continued failures in the SGR, some physicians have already begun dropping their participation in the program. A recent *Houston Chronicle* story explained that already "Texas doctors are opting out of Medicare at alarming rates, frustrated by reimbursement cuts they say make participation in government-funded care of seniors unaffordable. Two years after a survey found nearly half of Texas doctors weren't taking some new Medicare patients, new data shows 100 to 200 a year are now ending all involvement with the program. Before 2007, the number of doctors opting out averaged less than a handful a year."[111]

According to the Association of American Medical Colleges, the United States already faces a shortage of over 150,000 physicians in the next 15 years.[112] During the coming decade, the number of seniors on Medicare will grow by 15 million. The coming dramatic demand for physicians will reach a crisis level if Medicare did not reimburse physicians at a rate that would cover the costs of providing care to seniors.

A June story in *USA Today* found that twice as many family physicians already did not participate in Medicare last year compared to 2004, while one in three primary care physicians already restrict the number of Medicare patients in their practice.[113] The problem could get even worse.

A March 2010 survey of the American College of Surgeons and 22 other medical organizations revealed that fewer than 1 in 3 physicians would continue to participate in Medicare if the reimbursement cuts assumed by the new health law are allowed to remain.[114] A poll of osteopathic physicians found only four in 10 physicians would "definitely or probably continue seeing their current Medicare patients" if the reimbursement cuts were allowed to occur.[115] Another poll of 110,000 physicians demonstrated similar results. When asked if Medicare reimbursements were merely frozen for the next decade, four in 10 responding physicians said they would reduce the number of Medicare patients in their practice, while a similar number would cease accepting Medicare altogether.[116]

Our country already faces a looming "care crisis" where there could be more need for physicians than there are physicians. Unfortunately, the new health care law does not take the common-sense step forward of reimbursing physicians adequately to ensure seniors and veterans access to care. We believe

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[110] Foster, Richard, Chief Actuary for Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' As Amended," pages 9-10, April 22, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfefd0.

[111] Ackerman, Todd, "Texas doctors opting out of Medicare at alarming rates," *Houston Chronicle*, May 17, 2010, http://www.chron.com/disp/story.mpl/metropolitan/7009807.html.

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

[113] Wolf, Richard, "Doctors limit new Medicare patients," *USA Today*, June 21, 2010, http://www.usatoday.com/news/washington/2010-06-20-medicare_N.htm.

[114] Surgical Coalition, "Survey on Medicare Participation Among Surgeons: Report on the Future of Medicare Physician Payment and the Effect on Surgeons and their Patients," March 2010, http://operationpatientaccess.facs.org/userfiles/file/Surgery%20Medicare%20Particpation%20Survey%20Report.pdf

[115] DO-Online.org, "AOA Poll: Medicare policies negatively impact access to care," May 11, 2010, http://www.do-online.org/index.cfm?au=D&PageId=home_aoapoll.

[116] Poll Results, "From Sen. Coburn MD: Medicare Reimbursements Fixed for 10 years?," February 8, 2010, http://www.sermo.com/results/posts/42288_from_senator_coburn_md_medicare_reimbursements_fixed_for_10_years/survey_results.html.

the SGR cannot be ignored and must be fixed. But the new health law slashes $528.9 billion taxpayer dollars from Medicare and refuses to address the fundamental issue of physician reimbursement in Medicare. The effect of these changes will be to guarantee seniors reduced access to care and higher costs.

New Tax for Insured Americans, Free Care for Illegal Immigrants

Some of the inequities in the new federal health care law mean that Americans face more burdensome requirements under the law than do legal or illegal immigrants, according to a recent analysis from the nonpartisan Congressional Research Service (CRS).

Illegal Immigrants Get Free Health Care, But Americans Either Buy Expensive Insurance, Or Get Taxed

Starting in 2014, Americans will be subject to the individual mandate penalty of $695 annually if they do not purchase federally-dictated health insurance. However, under the new federal law, illegal immigrants will not be forced to purchase health insurance, though they will still be able to receive health care—regardless of their ability to pay—in a hospital's emergency department.

According to CRS, "Unauthorized (illegal) immigrants are expressly exempted from the mandate to have health insurance and, as a result, cannot be penalized for noncompliance."[117] So illegal immigrants get health care without paying for it, but citizens face the choice of either buying expensive health insurance or paying a tax.

The cost of illegal immigrants' health care in the emergency department of hospitals will be shifted to Americans with insurance. As CRS underscored, "the cost of providing uncompensated care to the uninsured was $43 billion in 2008," and, "to pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums on average by over $1,000 a year."[118]

President Obama said in September 2009, there are "more than 30 million American citizens who cannot get [health] coverage."[119] According to the U.S. Census Bureau, there are more than 8 million illegal immigrants in the U.S – constituting between a quarter or third of the uninsured population that President Obama identified.[120]

While the CRS memo said there is "very limited research on the differences in the amount of uncompensated care provided to U.S. citizens and noncitizens," if illegal immigrants use the emergency department for getting health care on a proportional basis, it is possible that they could be the cause of a quarter to a third of the cost of uncompensated care. While the uncompensated care costs may be reduced under the law, according to the Congressional Budget Office, there will still be about 24 million people without health insurance at the end of the decade.

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[117] Siskin, Alison, "Questions about Health Reform and Noncitizens," Congressional Research Service, May 27, 2010, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=ce7e55f4-4290-4442-8ae4-70ce96885171.

[118] Siskin, Alison, "Questions about Health Reform and Noncitizens," Congressional Research Service, May 27, 2010, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=ce7e55f4-4290-4442-8ae4-70ce96885171.

[119] President Barack Obama, "Remarks by the President to a Joint Session of Congress on Health Care," September 9, 2009, http://www.whitehouse.gov/the_press_office/remarks-by-the-president-to-a-joint-session-of-congress-on-health-care/.

[120] Congressional Budget Office, "A Description of the Immigrant Population," page 5, November 2004, http://www.cbo.gov/ftpdocs/60xx/doc6019/11-23-Immigrant.pdf; Robinson, J. Gregory, U.S. Department of Commerce, Bureau of the Census, "ESCAP II: Demographic Analysis Results," October 13, 2001, http://www.census.gov/dmd/www/pdf/Report1.PDF.

Illegal Immigrants Could Fraudulently Obtain New Health Subsidies, And Taxpayers Would Pay For It

Under the new federal health care law, health insurance exchanges – federally-dictated state bureaucracies that will implement the law's mandates – will be in operation by 2014. Under the new law, the verification requirements for getting coverage are likely to be very similar to the current employment eligibility system of E-VERIFY.[121] The memo says that while "the verification system under PPACA has not yet been created….the verification requirements in [the new federal health care law] are most comparable to the employment verification system known as E- VERIFY, because in that system the citizenship status of both U.S. citizens and noncitizens is verified electronically."[122]

This means any structural weaknesses of the E-VERIFY system could also be present under the new law. The memo makes clear that E-VERIFY does not have a good record of catching illegal immigrants who falsify documents to trick the system.

In fact, a 2007 study of the system found "in about half (54%) of queries, the unauthorized immigrants receive an inaccurate finding of being authorized to work, which is primarily due to identity theft….In other words, it is estimated that of the unauthorized immigrants that are run through the system, the system does not identify approximately 54% who are using false documents."[123] If the new verification system for determining eligibility for the health care subsidies is anything like the current government verification program, the system will fail to identify illegal immigrants half the time and taxpayers will pay for it.

Low-Income Immigrants Get A Subsidy And Choice, But Low-Income Americans Only Get Medicaid

America is a nation of immigrants and we strongly support sensible legal immigration. However, the new federal health care law gives preferential treatment to *legal* immigrants over American citizens. Under the new law, legal immigrants who earn less than 133 percent of the federal poverty level ($29,327 for family of four) will be eligible to receive a subsidy and choose what health insurance they want to purchase in a federally-regulated state exchange. However, low-income American citizens will only be eligible for Medicaid.

According to CRS, "due to the fact that they will be eligible for Medicaid in 2014, U.S. citizens with income up to 133% FPL *will not* be eligible for premium credits. In contrast, noncitizens up to 133% FPL who are ineligible for Medicaid (e.g., legal permanent residents subject to a 5-year bar) *will* be eligible for premium credits if they meet all of the criteria specified in PPACA. Importantly, if a person who applies for premium credits in an exchange is determined to be eligible for Medicaid, the exchange will have that person enrolled in Medicaid."[124] Health reform should give all legal residents – American citizens and legal immigrants – more choices in their health care, not merely access to a substandard government program.

[121] U.S. Department of Homeland Security, "E-Verify," http://www.dhs.gov/files/programs/gc_1185221678150.shtm.
[122] Siskin, Alison, "Questions about Health Reform and Noncitizens," Congressional Research Service, May 27, 2010, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=ce7e55f4-4290-4442-8ae4-70ce96885171.
[123] Siskin, Alison, "Questions about Health Reform and Noncitizens," Congressional Research Service, May 27, 2010, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=ce7e55f4-4290-4442-8ae4-70ce96885171.
[124] Siskin, Alison, "Questions about Health Reform and Noncitizens," Congressional Research Service, May 27, 2010, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=ce7e55f4-4290-4442-8ae4-70ce96885171.

New Mandates Increase Families' Health Costs

It might surprise many Americans the new health care law includes a new provision that defines a "child" as an individual who is under 26-years-old. The provision mandates that insurance companies allow adult children under 26 years of age to stay on their parents' health insurance policy as "children."

Under the law, this provision does not kick in until 2011 for most insurers. However, Health and Human Services Secretary Kathleen Sebelius is pressuring insurance companies to make the change earlier than required under the new health care law.

Unfortunately, though semantic gymnastics to redefine "children" in the new federal mandate may marginally benefit some families, they will not protect all Americans from the burdens of hundreds of other provisions under the new law.

New mandates, such as this provision, will increase the costs of health insurance premiums for millions of Americans. Perhaps this is why only about three in 10 Americans believe they personally would be better off as a result of the law's passage according to the same poll. [125]

Families with a combined annual income of about $100,000 could be particularly penalized under the new law. Families in this category will have an income level too high qualify for subsides, but will be forced to buy more expensive insurance, spending an average of $14,700 on health insurance according to estimates from the Congressional Budget Office (CBO). "After income taxes, they'll be spending almost a quarter of their net income for health insurance," according to the estimate of one health policy expert.[126]

Unfortunately, the CBO said health premium costs for 32 million Americans who purchase individual and family policies from insurers will be 10 to 13 percent higher in 2016 than they would be without the new health care law.[127] But it could get even worse.

The changed definition of "child" is just one of a dozen separate new insurance mandates the new health law imposes on health insurance plans. These 12 mandates are effective for annual health insurance policies beginning in just a few months, on September 23, 2010.

The U.S. Department of Health and Human Services recently released a regulation that limits the changes businesses can make to health plans, and still be considered "grandfathered" plans – exempt from many of the new burdensome mandates in the law. [128] Sadly, under the Department's own estimates, by 2013 over half of companies may have to give up their current health coverage under the new law. The Administration estimates more than 176 million Americans currently get their health insurance from their employer. But with this new rule, it looks like almost 90 million Americans could lose their current health plan and instead be stuck with more costly, government-mandated health insurance.

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[125] The Henry J. Kaiser Family Foundation, "Kaiser Health Tracking Poll: May 2010," http://www.kff.org/kaiserpolls/upload/8075-C.pdf.

[126] Gottlieb, Scott, "O's middle-class squeeze," *New York Post*, March 18, 2010, http://www.nypost.com/p/news/opinion/opedcolumnists/middle_class_squeeze_XqHUhXIjnjVB48DYLXhRDK#ixzz0roOgwPmu

[127] Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," November 30, 2009, http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

[128] Federal Register, "Interim Final Rules for Group Health Plans and Health Insurance," June 17, 2010. http://www.gpoaccess.gov/fr/

In a worst case scenario, the Administration foresees that eight in 10 small businesses could lose their current health plans. Employers offering health coverage will face the decision of either dropping coverage altogether, or purchasing more expensive, government-dictated health insurance. Either way, as the *New York Times* reported, this regulation is a staggering admission that the new law falls "short of the sweeping commitments President Obama made while trying to reassure the public in the fight over health legislation."[129]

Americans should be prepared for more changes in weeks and months to come as the Department of Health and Human Services unveils new mandates and regulations that will increase the cost of health insurance. The new regulation pertaining to the 26 year old "children" states that this single federal mandate will increase premium costs by one percent.

Certainly, a one percentage increase may seem small for the benefit. But if each new mandate and regulation has a cumulative impact, premiums for an average American family could increase by over $1,000 above the status quo.[130] The question to consider is, if mandating coverage of 26-year-olds—a relatively healthy, low-cost population—increases premiums, what will the other provisions do? Like so many other provisions in the new health law, there are side effects and unintended consequences.

[129] Pear, Robert, "New Rules on Changes to Benefits," New York Times, June 13, 2010 http://www.nytimes.com/2010/06/14/health/policy/14health.html?pagewanted=print.

[130] Fritze, John, "Average family health insurance policy: $13,375, up 5%," *USA Today*, September 16, 2009, http://www.usatoday.com/money/industries/health/2009-09-15-insurance-costs_N.htm.

New IRS Tax Harming Small Businesses

Buried in the new federal health care law is a new tax reporting requirement that could hurt businesses. This new provision will be especially burdensome on small businesses that generally do not have in-house accounting departments.

Currently, businesses are required report to the IRS payments of more than $600 for services from entities other than corporations on IRS Form 1099 – often merely referred to as "a 1099." Payments to corporations and payments for goods purchased are not required to be reported.

Section 9006 of the new health law made two significant changes to how the Form 1099 is used. Starting in 2012, the provision requires companies to send Form 1099s to the IRS for every business-to-business transaction of $600 or more for both property and services.

Second, the law requires a Form 1099 be issued now to corporations, in addition to the original requirement to issue to individuals. As *CNN* reported, "the stealth change radically alters the nature of 1099s and means businesses will have to issue millions of new tax documents each year."[131]

This is a burdensome tax provision that could overwhelm small businesses with additional paperwork and increase their administrative costs dramatically. Richard Moreno, a California accountant who works primarily with small businesses, thinks "companies would spend hours complying with the new rules and in many cases would have to hire outside accountants." [132] The new tax rules are so burdensome that, "if a freelance designer buys a new iMac [computer] from the Apple Store, they'll have to send Apple a 1099. A laundromat that buys soap each week from a local distributor will have to send the supplier a 1099 at the end of the year tallying up their purchases."[133]

According to the National Federal of Independent Businesses, an average small business spends about $74 per hour on tax compliance.[134] If a small business had to hire an external accountant for just two weeks to meet the new requirement, that small business would pay an additional $6,000 just to handle the paperwork.

In this scenario, that's $6,000 that the company cannot use for employee bonuses, wages, or health care. Tragically, the cost of compliance for some small business could be far greater, ranging in the tens of thousands or hundreds of thousands of dollars.

This provision does nothing to improve health care in America. Over half of Americans work for small businesses and small businesses create two thirds of the new jobs in our country in the past 15 years.[135]

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[131] deMause, Neil, "Health care law's massive, hidden tax change," *CNNMoney.com*, May 5, 2010, http://money.cnn.com/2010/05/05/smallbusiness/1099_health_care_tax_change/?hpt=C2.
[132] Bernstein, Sharon, "Healthcare overhaul's tax provisions have small firms crying foul," *Los Angeles Times*, May 17, 2010, http://articles.latimes.com/2010/may/17/business/la-fi-0517-smallbiz-taxes-20100517.
[133] deMause, Neil, "Health care law's massive, hidden tax change," *CNNMoney.com*, May 5, 2010, http://money.cnn.com/2010/05/05/smallbusiness/1099_health_care_tax_change/?hpt=C2.
[134] National Federation of Independent Businesses, "National Small Business Poll: Paperwork and Record Keeping," 2003, http://www.411sbfacts.com/files/paperwork.pdf.
[135] Small Business Association Office of Advocacy, "Frequently Asked Questions," September 2009, http://www.sba.gov/advo/stats/sbfaq.pdf.

We are in a time of intense economic uncertainty. About one in 10 Americans is unemployed and about one in five is underemployed. Congress should be encouraging growth in small businesses, not saddling them with new burdensome and costly requirements. The nonpartisan Joint Committee on Taxation estimates the new tax rules will increase tax revenues by $17 billion.[136]

[136] Joint Committee on Taxation, "Estimated Revenue Effects of the Amendment in the Nature of a Substitute to H.R. 4872, the 'Reconciliation Act of 2010,' as Amended, in Combination with the Revenue Effects of H.R. 3590, the 'Patient Protection and Affordable Care Act (PPACA),' as Passed by the Senate, and Scheduled for Consideration by the House Committee on Rules on March 20, 2010," March 20, 2010, http://www.jct.gov/publications.html?func=startdown&id=3672.