The Impact of National Health Care Reform on Washington State

by Roger Stark, MD, FACS
Health Care Policy Analyst

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Key Findings

1. Employers faced with escalating costs and more government regulations will be forced to make an economic decision regarding company-provided health benefits for workers.
2. Every employer and employee will be subject to increased government regulation, higher taxes and fewer personal choices in health care.
3. Ultimately Medicare and Medicaid patients in Washington state and across the country will have less access to health care, less input into their medical decisions and more dependence upon the government.
4. Young adults will have a strong incentive to wait until they are ill or in an accident before buying insurance.
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6. Decreasing Medicare reimbursements and expanding the number of Medicaid patients while decreasing the number of providers will compound the problem of finding a doctor for patients in these government programs.

POLICY BRIEF

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"We have to pass the bill so you can find out what's in it…"
-Speaker Nancy Pelosi, March 9, 2010

Introduction

After fourteen months of debate, and with narrow partisan support and substantial bipartisan opposition in Congress, President Obama signed major health care reform legislation into law. Polls consistently show the Patient Protection and Affordable Care Act is unpopular with the public. At no point in the history of the United States has such broad, wide-sweeping social legislation become law by such a slim political margin.

From now on, the federal government will manage the health care of all Washingtonians. The national health law will affect every person in Washington state, but will have specific consequences for various groups. This Policy Brief examines the new law's impact on businesses, Medicare and Medicaid, young adults and providers in Washington state.

Impact on Business

Washington state has about 193,000 small businesses with less than 20 full time employees, 14,000 moderate-sized companies with 20 to 50 employees, and 8,800 larger firms with more than 50 employees. These companies employ a total of more than 2.8 million people.[1] Although the health care law will affect different groups of workers differently, it does impose some common rules and regulations on all employers. The law will be phased in, and will be fully implemented by 2018.

Starting in 2010, all employer-sponsored group plans must cover employees' adult children up to age 26. Employer plans may not exclude children up to age 19 for pre-existing medical conditions and they must cover preventive care. Small businesses with fewer than 25 employees may qualify for federal subsidy grants if they offer a wellness program.

Phase I of an employer tax credit will begin in 2010. If a small business pays 50 percent of the total health insurance premium cost for employees, that company may qualify for a tax credit up to 50 percent of the premium cost. Basically, the smaller the business, the larger the tax credit it could receive. For companies with fewer than ten workers and an average per-employee wage of under $25,000 a year, the tax credit will be 50 percent.

[1] "Number of Firms and Employment, by Size of Firm," Labor Market and Economic Analysis, Washington Department of Employment Security, September 18, 2009, at www.workforceexplorer.com/admin/uploadedPublications/9944_1Q09_SizeofFirm.xls.

For businesses with fewer than 25 workers and an average per-employee wage of less than $50,000 a year, the tax credit will be a graduated amount from zero up to 50 percent of the cost of health premiums. The business owner cannot count himself or family members when calculating the amount of the tax credit. Employers with more than 25 workers will not be eligible to receive health care tax credits.

The national health care law targets the tanning services industry with a 10 percent excise tax that starts in 2010. Tanning salons will collect the tax from customers and send it to the U.S. treasury, so the tax will function like a federal sales taxes.

In 2011, all employers will be required to enroll their employees in a new national long-term care program. The details are yet to be worked out, but presumably the funding of this program will function like Social Security and Medicare and will be based on a payroll tax. Although employers will be mandated to enroll workers, employees may opt out if they so choose.

In 2011, the new law will require all employers to report the value of employee health benefits on workers' yearly individual W-2 forms. The IRS will maintain a record of every American's health insurance coverage. For individuals, failure to maintain government-acceptable health coverage will be a violation of federal law.

In 2011, the health care law imposes a new excise tax on insurance companies. Although these taxes can be passed on to plan purchasers, the magnitude of the tax and the companies' ability to remain competitive will require insurers to absorb the majority of this tax.

In 2012, all employers who offer health benefits must start filing reports to the Secretary of the Department of Health and Human Services. These reports must show the company is meeting healthy outcomes and prevention targets for workers, and that medical errors are being reduced. Employers will be required to submit details of their health insurance coverage to guarantee they meet federally mandated requirements. Failure to report government-acceptable coverage is a violation of law and subjects the employer to federal penalties.

In 2012, pharmaceutical manufacturers will be required to pay a new excise tax. This industry is not large in Washington state, although the tax may affect retail prices Washington residents pay for prescription drugs.

New Medicare taxes begin in 2013. The Medicare tax on income will go up 0.9 percent a year on wages over $200,000 for individuals and $250,000 for married couples. These same taxpayers will also be required to pay a new 3.8 percent tax on "unearned" income, marking the first time a payroll tax will be applied to non-wage income.

Unearned income will include dividends, capital gains, profits from home sales and rental income. Many business owners in Washington state are in this income bracket and will be subject to the new tax. The earning threshold is not indexed for inflation, so the number of individuals and families hit by this tax will increase each year, as has happened in recent years with the federal Alternative Minimum Tax (AMT).

In 2013, the national health care law will end the tax deduction employers receive for Medicare Part D retiree drug subsidy payments. Federal accounting rules require that businesses immediately write down the cost of ending this deduction, resulting in significant losses in company value. In 2010 The Boeing

Company announced a $150 million charge.[2] Other companies that have announced similar losses to date include:

AT&T	$1 billion
Caterpillar, Inc	$100 million
Deere & Co	$150 million
Verizon	$970 million
3M Company	$90 million
AK Steel Holding Corp	$31 million
Honeywell	$42 million

About one-third of large U.S. companies, including many in Washington, offer the benefit to their employees and retirees. Nationwide an estimated 6.3 million retirees receive drug benefits from their former employers, and are reportedly at risk of losing coverage because of this tax change. The average subsidy amounts to about $665 per plan member.

If employers choose to stop offering the drug benefit in order to reduce costs associated with the national health care law, estimates show 1.5 to 2 million retirees will lose their employer-sponsored coverage and be forced into Medicare, an outcome that works against President Obama's promise that no one who wanted to keep their health coverage would lose it under his plan.

Starting in 2013, Medical device manufacturers will have to pay an excise tax of 2.9 percent on the value of their products. This tax will either be passed on to consumers or will be taken out of company research and development budgets. Massachusetts, home to many medical device makers, will be particularly hard hit, and Minnesota-based Medtronic company reports the tax on medical devices could cost the company up to 1,000 jobs.[3]

Phase II of the employer mandate begins in 2014. For larger companies with more than 200 workers, all employees must be automatically enrolled in a health insurance plan. Workers may individually opt out of the employer plan, however.

Federally mandated, state-based insurance exchanges will begin in 2014. The exchanges will act as an insurance broker, connecting consumers with health coverage. These will not function as open markets, however, because prices and benefit levels will be set by the federal government.

Individuals and families earning up to 400 percent of the federal poverty level ($88,000 for a family of four today and $96,000 for that same family in 2016) can receive federal subsidies for the purchase of health insurance in the state-based exchanges. Employers with fewer than 100 workers will also be allowed to purchase health insurance through the exchanges.

Employers with more than 50 employees will pay a fine of $3,000 for every worker who receives a government subsidy. These same employers will face a fine of $2,000 for every worker if the business owner does not offer a health insurance plan.

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[2]"Boeing, Lockheed Expect Health-Care Charges," by Doug Cameron and Bob Tita, *The Wall Street Journal*, March 31, 2010, at www.online.wsj.com/article/SB10001424052702304252704575155613728130190.html.

[3]"Device makers react to healthcare reform bill's excise tax," by MassDevice staff, MassDevice, March 23, 2010, at www.massdevice.com/news/update-device-makers-react-healthcare-reform-bills-excise-tax.

As an example of how this will work in practice, the owners of a firm with 100 employees which does not offer government-approved coverage and has at least one employee eligible for subsidized coverage will pay a penalty of $140,000 a year to the federal government. The owners of the same firm which *does* offer government-approved coverage to its employees will pay a penalty of $3,000 a year for each employee who is eligible for subsidized coverage.[4]

By 2014, all health plans must comply with a federally mandated minimum benefit package. Federal officials have not yet determined what level of benefits will be required to meet the government-set minimum.

More taxes will be imposed on drug manufacturers ($3.5 billion) and on private insurance companies ($13.9 billion) starting in 2017. These taxes will be followed by a $4.2 billion tax on pharmaceutical companies and a $14.3 billion tax on insurers starting in 2018. Drug companies will have an additional tax of $2.8 billion imposed in 2019.

Starting in 2018 a 40 percent excise tax will be placed on high-value health insurance plans, $10,200 and $27,500 for individuals and families respectively.

Policy Analysis of Business Impacts

Businesses and employment in Washington state will suffer as a result of the national health care law. Employers of all sizes will experience a greater regulatory burden, more government-mandated paperwork, fewer choices in health plans for their employees, and no mechanism to control costs. These provisions will have a severe negative impact on employment. Researchers at Suffolk University's Beacon Hill Institute found that national health care reform as proposed by President Obama would "destroy a total of 120,000 to 700,000 jobs by 2019."[5]

Employers now offer health benefits as a marketing tool to attract the best workers, or because of a moral commitment based on 65 years of employer-sponsored health care in this country.

The landscape has changed dramatically with the passage of the national health care law, however. Employers faced with escalating costs and more government regulations will be forced to make an economic decision regarding company-provided health benefits for workers.

In many cases paying the fine, or tax, for not offering health insurance will cost employers considerably less than paying for employee health coverage. In highly competitive markets, business owners will likely decide to pay the lesser amount in taxation and force their employees into the government-managed insurance exchange plans. As a result, many workers will lose their current health coverage.

New rules mandating community rating, guaranteed issue of insurance and non-denial for pre-existing conditions will greatly impact the private insurance industry. Carriers in Washington state, as well as throughout the country, will become dependent on government revenue, mandated benefit plans, and government subsidies for their customers. Given the extensive web of regulations,

[4] "Health Mandate Cost Calculator," National Retail Federation, Patient Protection and Affordable Care Act, calculated penalties for a firm with 100 employees, May 21, 2010, at www.nrf.com/modules.php?name=Pages&sp_id=1290.

[5] "Killing Jobs through National Health Care Reform," by David G. Tuerck, Ph.D., et al., BHI Policy Study, Beacon Hill Institute at Suffolk University, Boston, Mass., March 2010, at www.beaconhill.org/BHIStudies/HCR2010/BHI-HealthCareReformAsJobKiller10-0317.pdf.

penalties, taxes and oversight, private insurance companies will operate essentially like public utilities.

As it is implemented, the new health care law will dramatically change the health care landscape in Washington state. Every employer and employee will be subject to increased government regulation, higher taxes and fewer personal choices in health care.

Impact on Medicare and Medicaid

Medicare and Medicaid were enacted in 1965 with broad support in both political parties and with broad acceptance by the American public. Since then, Medicare and Medicaid have grown into two of the largest taxpayer-funded programs in the United States.

Medicare for the elderly has about 900,000 enrollees in Washington state, with over 200,000 enrollees choosing to join Medicare Part C, also called the Medicare Advantage program. In addition, almost 300,000 people are enrolled in the government TRICARE program (health coverage for military families) which pays providers at Medicare rates. Aging baby boomers will bring significant increases in Medicare enrollment in the next thirty to forty years, as members of this generation reach age 65.[6]

One half of the funding for the new national health care reform law will come from almost $580 billion in cuts in the Medicare program over the next ten years. These cuts include $271 billion from physicians payments, $180 billion from hospital payments and $80 billion from Medicare Part C, which will virtually eliminate the Medicare Advantage program.

The Medicaid program for low-income families has approximately 1.2 million recipients in Washington state.[7] Under the requirements of the new national health reform law an estimated 280,000 to 360,000 more people will be added to Washington's state Medicaid program.[8] Federal taxpayers will pay for these added Medicaid patients for the first six years of the expansion. State taxpayers will then be required to pay 10 percent of the new costs. Of course, state and federal taxpayers are the same people, so taxpayers in Washington will be helping to pay all the costs of the expanded program.

Starting in 2010, the federal government prohibited new doctor-owned hospitals from participating in Medicare and limited expansion of existing physician-owned facilities. Also starting in 2010, Medicare Part D, the prescription drug program, expanded so that by 2020 all drug benefits will be funded by the program.

Medicare started cutting payments to inpatient psychiatric hospitals in 2010. Last year the federal government also established a new agency, the Federal Coordinated Health Care Office, with the intention of improving care for people receiving both Medicare and Medicaid.

The government increaseed the mandatory Medicaid drug rebate from 15.1 percent to 23.1 percent in 2010. Hence drug manufacturers will pay an additional

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[6] State Health Care Facts, Kaiser Family Foundation: http://www.statehealthfacts.org/profileglance.jsp?rgn=49

[7] Ibid.

[8] No one knows the exact number of new Medicaid enrollees because of the complexity of the new law. There are currently 60 million people enrolled in Medicaid nationally, which means Washington state's 1.2 million people represent 2 percent of the total. Estimates (and they are just that) of new enrollees range from 14 to 18 million. Hence 2 percent would be 280,000 to 360,000 people in Washington state.

eight percent to the states for drugs sold through the Medicaid program. The federal government will also increase the funding and the role of the Medicaid Payment and Access Commission to help manage care for Medicaid enrollees.

The Center for Medicare and Medicaid Services (CMS) will start choosing health care winners and losers in 2011. Hospitals in "low-cost areas" will receive higher reimbursements, and primary care doctors in "shortage areas," along with general surgeons, will receive an annual 10 percent bonus payment for five years.

Cuts in Medicare will start affecting many health services and facilities starting in 2011. General hospitals, nursing homes, inpatient rehabilitation units and long-term care facilities will all experience a reduction in compensation. Home health care workers, physicians, diagnostic laboratories, ambulance services and durable medical equipment suppliers will also see cuts in their reimbursement payments.

In 2011, CMS will establish an Innovation Center to experiment with creative payment schemes and will freeze Medicare Part B means testing at 2010 levels.

Starting in 2011, Medicaid will prohibit payment to providers for services related to health-acquired conditions. In other words, Medicaid will not pay for treating medical complications that arise during treatment.

Medicaid will also begin an effort to change the way health care is administered. CMS, through Medicaid, will provide funds to establish mandatory medical homes for patients, which are the latest variation of health maintenance organizations. Long-term care in non-institutionalized settings and community-based support for people with disabilities will receive more money.

Medicare begins funding Accountable Care Organizations (ACOs) in 2012. These will function as a doctor-hospital partnership so that decreased spending can occur by way of a single check. Doctors will either be employed by hospitals or will enter into a form of health maintenance organization (HMO) relationship with the hospital.

Along with ACOs, Medicare will establish "value-based" purchasing programs in 2012 that must determine reimbursements for hospitals, home health agencies and ambulatory surgery centers. In 2012, Medicaid begins "bundled" payments with a single-capitated reimbursement to doctors and the hospital for an enrollee's specific care. Mental hospitals will receive increased payments for the acute care of Medicaid patients.

Ironically, Medicare will then cut reimbursements to psychiatric hospitals in 2013. Cuts are also scheduled for payment of hospital re-admissions and for hospice care in the Medicare program. Taxpayer subsidies for the purchase of drugs under Medicare Part D are set to increase in 2013.

A new Medicare tax begins in 2013. Single taxpayers earning more than $200,000 per year and couples earning more than $250,000 will see a 0.9 percent increase in their Medicare payroll taxes. Also, these same taxpayers will be required to pay a new 3.8 percent Medicare tax on "unearned" income, that is earnings from capital investments, dividends, rental income and the sale of real property.

State Medicaid programs will increase payments for primary care in 2013. This increase will be funded exclusively by federal taxpayers.

In 2014, Medicare is scheduled to establish an Independent Payment Advisory Board (IPAB) which will make recommendations to reduce the spending growth rate. Further cuts to Medicare Part C and to home health care payments will occur the same year.

In 2014 a huge expansion of state Medicaid programs will occur, as all adults earning less than 133 percent of the federal poverty level become eligible for coverage. Medicaid in Washington state already covers people who earn up to 250 percent of the FPL. Initially federal taxpayers will fund this expansion, but after six years, state taxpayers must pay 10 percent of these new costs. At the same time, Medicaid is scheduled to reduce payments to hospitals that take care of a disproportionate share of Medicaid patients.

In 2015, Medicare will make further cuts to home health services and will decrease hospital reimbursements for hospital-acquired infections.

Starting in 2018, the IPAB must give recommendations for cutting costs in Medicare to Congress, if Medicare per capita spending is greater than the gross domestic product per capita plus one percent. Presumably these cost-cutting recommendations will then be enacted into law.

Policy Analysis of Medicare and Medicaid Impacts

Medicare currently reimburses providers at about 70 percent of what private insurers pay. Medicaid reimburses roughly 40 percent of what Medicare pays. Because of these low payments, fewer providers are willing to see new patients covered by these two government programs. Consequently, Medicare and Medicaid patients have a difficult time finding health care services today. Slashing Medicare reimbursements and greatly expanding Medicaid will only compound this access problem.

According to the last report of the Medicare Trustees, the program already has $89 trillion in unfunded liability. Clearly financial reforms are necessary, but the random cuts mandated by the President's national health reform legislation are not a long-term solution, and they are not in the best interests of the patients.

Instead of allowing patients more control over their health care dollars and treatment decisions, the new law gives the federal government unprecedented control over patients' health care. The federal IPAB will make decisions for providers and patients based not only on perceived "best practices," but also on controlling costs.

The Board may find that a 70-year-old woman is "best treated" by giving her pain medicine rather than a joint replacement procedure. Perhaps heart surgery for anyone over the age of 70 will be prohibited, so medical care can be redirected to younger people. This is exactly the kind of top-down rationing that countries with government-managed medicine, like Great Britain, are now doing through their nationalized health programs.

From a public policy standpoint, the new Medicare tax on "unearned" income is a huge shift in funding for the program. Currently, Medicare, like Social Security, is funded by a payroll tax as a social insurance program. This new 3.8 percent tax uncouples Medicare funding from workers' payroll and makes Medicare a regular welfare program, in which some taxpayers will be forced to pay for another individual's care.

The new costs created by the huge Medicaid expansion are essentially unknown. At current rates, Washington state taxpayers will pay an additional

$680 million to $8.7 billion over the first ten years of the expansion.[9] The second ten years of the expansion will cost closer to the $8.7 billion number if state and federal taxes are combined.

The real unknown is the impact of the individual and employer mandates to purchase health insurance required by the new health care law. Employers will be required to choose between paying for employee health benefits or paying a fine. No one knows how many employers will drop their employee benefits, and force workers into the Medicaid program, because they find paying the fine is cheaper.

Inconsistencies run throughout the new health reform law. Although Medicare and Medicaid are both government-run programs, under the new law Medicare will be cut in such areas as home health and inpatient psychiatric care, whereas Medicaid receives more funding in these areas. The ultimate control of health care funding, however, will be given to federal bureaucrats who will have no knowledge or interaction with individual patients and their providers.

Throughout the implementation of the new health care law, drug companies and medical device manufacturers will face significant tax increases. The cost of these taxes will either be passed on to health care consumers or will be deducted from research and development budgets. The cost of new taxes cannot be passed on to Medicare and Medicaid patients because of government-mandated fixed reimbursements.

The resulting decrease in research and development funding will mean fewer new drugs and devices will be developed, which in turn will have an adverse effect on the medical treatment of Medicare and Medicaid patients. After a century of progress, the new health care law will begin to reduce the ability of American medicine to conquer historically crippling diseases, like cancer, AIDS, Multiple Sclerosis and diabetes.

Ultimately Medicare and Medicaid patients in Washington state and across the country will have less access to health care, less input into their medical decisions and more dependence upon the government.

Impact on Young Adults

Washington state has approximately 1.5 million people ages 18 to 34.[10] This group represents about 23 percent of the state's population.

These 18- to 34-year-olds are the healthiest of all age groups and have the least need for medical care. Many of them are either still living at home, are in school, or are just starting out in the work force in lower paying, entry level jobs. At this stage of their lives, health insurance is a very low priority for them.

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[9] Washington state currently has 1,200,000 people in its Medicaid program and a total cost to state taxpayers of $2.9 billion (this is matched by $2.9 billion of federal money) per year. This works out to approximately $2,417 of state taxpayer dollars per recipient and a total cost (federal plus state) of $4,834 per enrollee. The new health care law is written so that federal taxpayers cover the entire cost of the new Medicaid patients for the first six years and states pay 10 percent of the costs thereafter. Washington state taxpayers would therefore be required to pay $4,834 times 10 percent times 280,000 (or 360,000) per year which equals $135 million (or $174 million). For a ten year period, Washington state taxpayers would be obligated to pay $1.35 to $1.74 billion. If the state/federal ratio for funding new Medicaid patients reverts to the fifty-fifty split as it exists now, Washington taxpayers will be required to pay $4,834 times 50 percent times 280,000 (or 360,000). This would equal $677 million to $870 million per year, and $6.77 billion to $8.7 billion every ten years. Of course, state taxpayers are also federal taxpayers, so Washington state taxpayers will be required to help pay the entire cost of Medicaid expansion, or $13.4 to $17.4 billion over a ten year period.

[10] "Forecast of State Population, Forecasting Division, Office of Financial Management, November 2009, at www.ofm.wa.gov/pop/stfc/stfc2009/stfc2009.pdf.

The new health care legislation redefines "child" as anyone under the age of 26. Starting this year, all family insurance plans must cover everyone up to age 26, and no one under the age of 19 can be denied coverage for pre-existing conditions.

Also starting this year is a new 10 percent tax on tanning services that are arguably used more by young adults than any other age group.

Health savings accounts (HSAs) and flexible savings accounts (FSAs) with high-deductible insurance plans are excellent choices for the young and healthy. Unfortunately, under a provision of the new health care law, starting in 2011, funds from these personal medical accounts cannot be used to purchase over-the-counter medications.

Long-term insurance, much like Social Security, begins in 2011 and obviously the younger generation will have many more work years ahead to pay into this government program before they receive any benefit from it.

New taxes on drug manufacturers begin in 2011. New taxes on medical devices start in 2013 and, like all of the taxes in the new federal health care law, they will be passed on to all consumers regardless of age.

Many of the key features of the federal health care reform begin in 2014. The individual mandate starts in 2014 and will force every adult to buy health insurance or pay a fine or tax of either $695 or 2.5 percent of income per year, whichever is larger.

State-based insurance exchanges begin in 2014. Although states will be responsible for their administration, the federal government must first approve all prices and benefit packages offered by the exchanges. People who earn up to 400 percent of the federal poverty level ($43,200 for a single person and $58,280 for a married couple[11]) will be eligible for federal taxpayer subsidies if they buy insurance through an exchange. The law does allow state exchanges to offer catastrophic coverage for people up to age 31.

The new Medicaid program begins in 2014 and will provide taxpayer-funded health insurance for any adult who makes less than 133 percent of the federal poverty level ($14,400 for a single and $19,400 for a married couple[12]).

Two new insurance regulations start in 2014. Insurance companies must use community rating, where everyone regardless of age and health status pays roughly the same amount for comparable insurance coverage. Insurance companies are also bound by guaranteed issue rules, which means no matter how sick a person is, an insurance company cannot deny that person health insurance. Private insurance plans must also have government-approved "essential benefits."

Taxes on private insurance premiums begin in 2014 and will undoubtedly be passed on by insurance companies to consumers. Employees will be able to receive a 30 to 50 percent rebate on the cost of insurance, if their employer offers a wellness program approved by the government.

An excise tax on high-end private health insurance plans begins in 2018.

[11] "Update of the HHS Poverty Guidelines," Office of the Secretary, Department of Health and Human Services, January 23, 2009, at www.aspe.hhs.gov/poverty/09fedreg.shtml
[12] Ibid.

Policy Analysis of Young Adult Impacts

As a group, young adults are the least likely to need health care. They have survived childhood illnesses and, in general, are not old enough to suffer age-related diseases such as cancer and heart problems.

They represent a high percentage (up to 60 percent[13]) of the uninsured population simply because they are young and healthy and have financial priorities other than buying insurance.

The new federal health care legislation will force all 18- to 34-year-olds who are not covered by a family plan to purchase health insurance or pay a tax. Because of community rating, insurance premiums for young adults will be artificially high, to support older, sicker people in the insurance pool. Young adults will make an economic decision and decide whether it is cheaper to buy insurance or to pay the tax.

Young adults will also consider the fact that insurance companies must sell them policies regardless of pre-existing conditions. Young adults will have a strong incentive to wait until they are ill or in an accident before buying insurance.

The new health care law allows catastrophic insurance policies for people under the age of 31. However, many states, including Washington, have been unwilling to allow catastrophic policies in the past. A low-cost, high-deductible, catastrophic plan coupled with an HSA would provide ideal coverage for most 18- to 34-year-olds, and is one workable solution to the exploding cost of health care. Only time will tell whether the "allowable" catastrophic policies will actually be offered as the new federal law is implemented.

People earning less than 400 percent of the federal poverty level will qualify for taxpayer subsidies in the insurance exchange. The Urban Institute estimates that 80 to 90 percent of 18- to 34-year-olds will qualify for these subsidies.[14] Of course, as these young adults grow older and enter their high-earning years, they will potentially lose that subsidy. Also, many 18- to 34-year-olds will eventually receive high-end insurance policies by 2018, when the excise tax on these plans begins.

All health care users, including young adults, will pay more because of the new taxes on drug manufacturers, medical devices and insurance companies. These taxes will be passed on to consumers in the form of higher drug, device and premium prices.

The biggest impact on the younger generation is the high level of deficit spending by the federal government. Deficits simply pass the government's current cost from the older generation to the younger. The 18- to 34-year-olds are already facing an unfunded liability burden from Social Security and Medicare of more than $100 trillion.[15] The new federal health care law will continue to add to this liability, and will adversely affect the younger generation's standard of living and quality of life.

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[13] "Who are the uninsured?", by Michael Tanner, Senior Fellow, The Cato Institute, August 17, 2009, at www.cato.org/pub_display.php?pub_id=10449.

[14] "Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs and Household Financial Burdens," by Linda J. Blumberg, Matthew Buettgens and Bowen Garrett, Urban Institute, October 1, 2009, at www.urban.org/publications/411970.html..

[15] "Social Security and Medicare Projections," by Pamela Villarreal, Brief Analysis, National Center for Policy Analysis, at www.ncpa.org/pub/ba662.

Impact on Providers

Washington state has nearly one hundred acute care hospitals and almost 1,400 long-term care, rehabilitation and other sub-acute care facilities. Approximately 12,050 physicians, of whom about 6,000 are in primary care, practice medicine in Washington.[16] Even before passage of the health care law, it was estimated that Washington state will need at least 900 more primary care doctors by 2020.[17]

The new health care reform law will start to affect doctors and other health care providers this year. Although there will be some rebalance of Medicare doctor reimbursements across the country, physicians face on average a 21 percent decrease in pay for all Medicare patients. The federal government will start reducing funds for inpatient psychiatric hospitals, long-term care and rehabilitation facilities in 2010.

Under the new health care law, the federal government will establish a Work Advisory Committee to determine health manpower needs. More student scholarships and loans will be available (although the dollar amounts are not specified) and more Medicare funding will go toward training primary care doctors.

A new Patient-Centered Outcome Research Institute (one of some 110 new government agencies included in the legislation) will undertake comparative effectiveness medical research.

By December 31, 2010, the government will ban new physician-owned hospitals and place sharp limits on the growth of existing private doctors' hospitals. Washington state lawmakers imposed a similar prohibition in 2000, but under the health care law the ban on new physician-owned hospitals will be extended nationwide.

Cuts in the Medicare program will continue in 2011. Long term care facilities, home health programs, ambulance services, diagnostic labs and durable medical equipment manufacturers will all experience reductions in government reimbursements.

Federal payments to states for Medicaid services related to "health care acquired conditions" will stop in 2011. In other words, if the federal government determines that Medicaid patients have complications because of their care and not from their diseases, the providers will not be reimbursed for treating these conditions.

Also in 2011, the Center for Medicare and Medicaid Services (CMS) will establish the Center for Medicare and Medicaid Innovation (CMI). This new agency will create payment incentives for delivery models that attempt to improve the quality of care and lower costs. Another new agency will attempt to strengthen emergency room and trauma care services.

Some winners will emerge in 2011. Primary care doctors and general surgeons will receive a 10 percent pay bonus – good for only five years. Community health centers will receive an additional $11 billion over five years. Doctors in so-called Frontier States – North Dakota, Montana, Wyoming, South Dakota and Utah – will receive higher (how much higher is yet to be determined) Medicare reimbursements. Five year "demonstration programs" for tort reform

[16] "Health Care Service Infrastructure," The Health of Washington State, Washington Department of Health, updated January 31, 2008, at www.doh.wa.gov/hws/doc/HS/HS_HCI2007.pdf
[17] "Family Physicians Call for More Residency Slots," Professional Issues, American Medical Association, 2006, at www.amaassn.org/amednews/site/free/prsc1016.htm.

will begin in 2011. Beyond this vague description, no specific or meaningful tort reform program was included in the new law. In 2012 the health care law will impose additional Medicare pay cuts to hospitals, nursing homes, inpatient rehabilitation facilities and dialysis programs.

In 2013 Medicare will start to evaluate "bundled payments" to doctors and hospitals. This means the government will write one check for all the care an individual patient receives. Hospitals and doctors will then be forced to determine how that check is divided. The Medicare program will continue provider cuts to hospices and to hospitals with high patient re-admission rates.

Also in 2013, a program begins that will impose a pay-for-quality policy in federal reimbursements. The criteria have yet to be determined, but will probably include such things as infection rates and the incidence of in-hospital heart attacks. The fewer of these complications a hospital has, the larger the amount of federal money it will receive.

The Medicaid program will increase primary care reimbursements in 2013. Financial relationship disclosures between hospitals, doctors, pharmacists and drug manufacturers must begin the same year.

The Medicare payroll tax will increase 0.9 percent on income greater than $200,000 for individuals and $250,000 for married couples in 2013. A 3.8 percent tax will also be added to "unearned income" for these same taxpayers. Many doctors and hospital administrators are in these income brackets, so in addition to receiving less pay from Medicare, they will be forced to pay more in Medicare taxes.

Starting in 2014, the new health care law tremendously expands the government's day-to-day involvement in health care. Medicaid expands and will include any adult earning up to 133 percent of the federal poverty level (FPL). States must establish insurance exchanges that will function as government-run insurance brokers. The individual mandate requiring every person in the country to buy health insurance starts in 2014. Federal subsidies will be given to people earning up to 400 percent of the FPL ($88,000 for a family of four today and $96,000 for that same family in 2016) if they purchase health insurance through a state-managed exchange.

A Medicare Commission will be established in 2014 with the intention of reducing the per capita rate of growth in the program. Hospitals in general will see further pay cuts for patients with hospital acquired infections, and hospitals with a high percentage of Medicaid patients will experience further reductions in government funds.

The employer mandate to purchase health insurance for employees begins in 2014. Doctors in private practice and all hospitals will be subject to this mandate.

In 2015, physicians will receive a reimbursement differential based on quality of care compared to cost. Government agencies, not patients, will define the meaning of "quality of care." Hospitals with a higher rate of re-admissions (as determined by the government) will see decreased pay from Medicare. Home health programs will experience more Medicare cuts.

By 2016, the bundling reimbursement programs will be implemented, depending on the judgment of the Secretary of the Department of Health and Human Services. The new Medicaid program will revert back to a shared cost basis with states (90 percent federal dollars and 10 percent state dollars). In 2017, all doctors will be subject to the required pay-for-quality program.

Policy Analysis of Provider Impacts

The Congressional Budget Office estimates the minimum cost of President Obama's health care law will be $940 billion over the first ten years. The largest part of the funding will come from $455 billion in cuts to the Medicare program. Included in this $455 billion are a $155 billion cut to hospitals and a $271 billion cut to doctors.

Medicare currently reimburses physicians at 70 to 80 percent of private insurance. Hospital reimbursements are even lower at 65 to 70 percent of what private insurance pays. Medicaid, in general, reimburses about 60 percent of what Medicare pays, or about 40 percent of what private insurers pay. Many doctors are now losing money whenever they see a Medicare patient, let alone a Medicaid patient, and at least 40 percent of Washington state physicians have stopped seeing new Medicare participants.[18]

Consequently, access to health care services, not access to coverage, has become a more significant problem for these government-sponsored patient groups. Decreasing Medicare reimbursements and expanding the number of Medicaid patients while decreasing the number of providers will compound the problem of finding a doctor for these patients.

Many smaller hospitals, especially in rural areas, will have trouble staying open as the government cuts back on Medicare and Medicaid reimbursements. Even larger hospitals will struggle financially. Demand for care will increase as baby boomers reach Medicare age and as the enrollment in Medicaid, as required under the new health care law, increases dramatically. At the same time, reimbursement for these two government programs will go down. Hospitals will need to become very efficient and major facility consolidation will undoubtedly occur, leaving fewer choices for patients.

Physician-owned hospitals have in many cases proved to be more cost efficient while providing a better patient experience. Outlawing these innovative facilities only decreases competition and restricts patient choices.

In addition to the severe decrease in provider reimbursement, the bundling of pay into a single check will dramatically change our health care delivery system. For simplicity and expediency, this bundling will force doctors into financial arrangements with hospitals. It is very likely that most doctors in the future will either be employed by hospitals, rather than maintaining independent practices, or will at least enter into some type of financial partnership with hospitals.

The new health care reform legislation does not address the escalating cost of malpractice insurance for providers. It is estimated that between 10 percent to 20 percent of overall health care costs are due to the legal system and specifically due to the fact that providers practice defensive medicine by ordering additional tests and procedures. Although the new law allows for pilot programs, it does not establish meaningful tort reform.

Massachusetts passed state universal health care law in 2006. It is essentially the template for the national health care law signed by President Obama, including individual and employer mandates, a government-run insurance exchange with state subsidies, community rating and guaranteed issue of insurance.

[18] "Tomorrow's Medicine: A report on the Future of Health Delivery in Washington State," Washington State Medical Association, September 2006, at www.wsma.org/home.pdf/TomorrowsMedicine.pdf.

After passage of the state plan, Massachusetts' uninsured rate dropped from around 10 percent to three percent, but the unintended consequences have been dramatic. Demand for health care exploded, costs exceeded the budget by over $1 billion and access to providers dropped precipitously. Residents in parts of Massachusetts can wait six to twelve months to see a primary care doctor. There is every indication that across the country similar problems with patients gaining access to providers will develop under the new health care reform law.

The fundamental problem with the American health care system is one of increasing cost. This rise in costs is driven by the fact that almost 90 percent of health care in the United States is paid for by a third party – either an employer or a government agency. Patients are therefore disconnected from the true cost of their care and have little or no interest in seeking the most cost-effective treatments. The new health care law magnifies this problem by further disconnecting patients from the cost of the care they receive.

Under the new law, the only way for the government to hold down costs will be to place more regulations and price controls on the health care delivery system. Instead of allowing the free market and consumer choices to stimulate innovation and best practices, President Obama's health care law creates dozens of powerful new government agencies, such as The Patient Centered Outcome Research Institute and The Center for Medicare and Medicaid Innovation, to make health care decisions for patients and providers.

As demand continues to rise, rationing of health care by the government will likely occur. Patients will experience longer wait times to see physicians, will have fewer physicians to choose from and will find their health care decisions made by government program managers, not their doctors, as is already happening in Massachusetts.

Conclusion

The Patient Protection and Affordable Care Act allows the government to take over one sixth of the United States' economy and dictate a top-down, one-size-fits-all health care system for the entire country. In spite of claims made during the debate, the law:

- Will not provide universal health insurance coverage.
- Will not allow people to keep their existing health insurance plans.
- Will not eliminate waste, fraud and abuse.
- Will not control costs unless health care is severely rationed.
- Will violate people's fundamental rights by mandating they purchase a private product.

This country was founded on individual choice, personal responsibility and the rights of states over the federal government. The new health care law will adversely impact and severely restrict choices for virtually everyone in Washington state.

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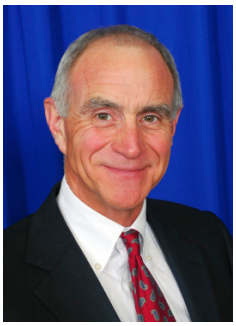

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