

ProCon.org presents

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Obamacare: A Nonpartisan Review of What It Is and What It Is Not

This review compiles responses from experts and legislators to 65 frequently asked questions about Obamacare (Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, and Executive Order 13535).

Of the 65 questions, 42 have clear yes or no answers while the other 23 are debated using pro and con responses.

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I. Introduction

Proponents of Obamacare have called it a "historic victory" and "landmark legislation" that reforms the US health care system by reigning in health care costs, making health care more affordable, insuring millions more people, and protecting consumers from unfair insurance practices. They cite the Congressional Budget Office which reports that by 2021, Obamacare will reduce the nation's deficit by about \$210 billion.

Opponents have called Obamacare a "socialist" and "unconstitutional" government takeover of the health care system that will increase the cost of health care, decrease the quality, and entrench a new entitlement. They say the law will increase the nation's deficit \$340-\$700 billion over the next decade. In 2011 and 2012 the House of Representatives voted 36 different times to repeal or replace Obamacare.

Health care is the largest industry in the United States, employing more than 14 million people. Health care expenditures totaled over \$2.5 trillion – 17.9% of the entire US economy – in 2011.

According to the Organization for Economic Cooperation and Development (OECD), a group of 34 nations accounting for three quarters of world trade, the United States spent \$8,508 on health per capita in 2011, two-and-a-half times more than the OECD average of \$3,339 (adjusted for purchasing power parity). The United States, Mexico, and Chile are the only OECD countries where less than 50% of health spending is publicly financed. Compared to OECD per capita averages, the United States has fewer physicians (2.5 per 1,000 vs. 3.2 OECD average), more nurses (11.1 per thousand vs. 8.7), and fewer hospital beds (3.1 per 1,000 vs. 4.8).

In 1960, life expectancy in the United States was 1.5 years higher than the OECD average in 1960. In 2011, at 78.7 years, the US is almost 1.5 years below the OECD average of 80.1 years.

In addition to the 65 questions our report asks and works to answer, there are many other questions about our nation's health care that while outside of the scope of this project may be relevant in discussions about Obamacare and other health care issues. Some of those questions include:

- Should all Americans have the right (be entitled) to health care?
- Why does the US spend about 18% of its GNP on health care but is considered to have average or below average health care compared to the other 33 members of the OECD who spend between 7-12% of their GNP on health care?
- Should middle class Americans pay disproportionately more for health care in order to subsidize the poor who often rely on Medicaid or emergency rooms?

The 964 pages of Obamacare are composed of three documents: HR 3590 [*Patient Protection and Affordable Care Act*](#) (905 pages, signed into law Mar. 23, 2010), HR 4872 [*Health Care and Education Reconciliation Act of 2010*](#) (55 pages, signed into law Mar. 24, 2010), and Executive Order 13535 "[*Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act*](#)" (4 pages, signed into law Mar. 24, 2010). Some experts who have read all the text come away with different conclusions.

Whether people love Obamacare or hate it, ProCon.org believes that a nonpartisan view of Obamacare is important to many of the 300+ million residents of the United States.

We hope that this work helps provide readers with facts about Obamacare and the best pro and con arguments in the debate over what Obamacare is and is not.

II. Summary of 65 Questions and Responses on Obamacare

A. Medical Effects of Obamacare

	YES	NO	DEBATED	PAGE #s
Abortion				
1. Does Obamacare fund abortion services for cases other than rape, incest, or to save the life of the mother?			X	pp. 12-16
Birth Control				
2. Does Obamacare require health insurers to cover birth control?	X			pp. 16-18
3. Are there any exemptions to the Obamacare requirement that health insurance policies cover birth control?	X			pp. 18-20
Emergency Care				
4. Will fewer people rely on emergency rooms for health care under Obamacare?			X	pp. 20-23
Health Insurance Exchanges				
5. Will health insurance exchanges benefit consumers?			X	pp. 23-28
6. Will long term insurance be offered in health insurance exchanges?		X		pp. 28-29
Health Insurance Mandate				
7. Are there any exemptions to the mandatory health insurance requirement?	X			pp. 30-31
8. Are there taxes, penalties, or fines for most individuals who do not have health insurance?	X			pp. 31-34
Home Care				
9. Does Obamacare provide funding for training additional "at home" care professionals?	X			pp. 34-35
Insurance Coverage				
10. Does Obamacare allow people to keep their current coverage?			X	pp. 35-38
11. Does Obamacare cover children with pre-existing conditions?	X			pp. 38-39

	YES	NO	DEBATED	PAGE #s
12. Can adults get health insurance coverage under Obamacare despite having a pre-existing condition?	X			pp. 39-40
13. Under Obamacare, can insurance companies cancel coverage if a person gets sick?		X		pp. 40-41
14. Can children up to age 26 remain on their parent's health insurance?	X			pp. 41-42
15. Does Obamacare require that retiree health plans cover children up to age 26?		X		pp. 42-43
16. Will lifetime or annual limits on health insurance coverage be eliminated?	X			pp. 43-44
17. Does Obamacare require insurers to offer coverage for treatment of mental illness?	X			pp. 44-45
18. Will Obamacare require insurers to offer coverage for substance abuse?	X			pp. 45-46
19. Does Obamacare require dental coverage for children?	X			pp. 46-47
20. Does Obamacare require dental coverage for adults?		X		pp. 47-49
21. Will individuals currently covered by veterans' health benefits be considered covered under Obamacare?	X			p. 49
22. Does Obamacare cover alternative medicine?			X	pp. 50-52
23. Does Obamacare require insurance plans to have a minimum basic coverage level?	X			pp. 52-53
24. Will Obamacare require health insurers to present health insurance information in clear and easily understandable terms?	X			pp. 53-54

	YES	NO	DEBATED	PAGE #s
25. Does Obamacare apply to health plans offered by colleges and universities?	X			pp. 54-55
26. Will Obamacare result in fewer people without health insurance?			X	pp. 55-57
27. Does Obamacare allow individuals to appeal medical service denials?	X			pp. 58-59
Medicare/Medicaid				
28. Does Obamacare do a good thing and save \$716 billion in Medicare expenses (pro side), or does Obamacare do a bad thing and cut \$716 billion from Medicare (con side)?			X	pp. 59-61
29. Will Obamacare’s cuts to Medicare reduce benefits for Part A (hospital care), Part B (outpatient care), and Medicare Advantage Part C?			X	pp. 61-64
30. Will Obamacare’s cuts to Medicare Part C (Medicare Advantage) lead to a decrease in patient benefits?			X	pp. 64-66
31. Does Obamacare close the “doughnut hole” in Medicare’s prescription drug coverage (Medicare Part D)?	X			pp. 67-68
32. Will more people be eligible for Medicaid under Obamacare?	X			pp. 68-69
33. Does Obamacare’s Independent Patient Advisory Board (IPAB) ration Medicare or create “death panels”?			X	pp. 69-73
34. Will the quality of care from public health programs such as Medicare and Medicaid improve?			X	pp. 73-76
35. Will Medicare reduce reimbursements to hospitals with high 30-day readmission rates (“preventable readmissions”)?	X			pp. 76-77

YES	NO	DEBATED	PAGE#s
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Physicians

36. Will Obamacare worsen the primary physician shortage?			X	pp. 78-80
37. Do physicians support Obamacare?			X	pp. 80-82
38. Does Obamacare make any changes to physician payments through Medicare/Medicaid?	X			pp. 82-85

Prevention/Wellness

39. Is free preventive care required under Obamacare?	X			pp. 85-87
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B. Financial Effects of Obamacare

Bankruptcy

40. Will people no longer be at risk of medical bankruptcy?			X	pp. 88-90
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Costs

41. Will Obamacare raise insurance premiums?			X	pp. 90-94
42. Will the government help people who cannot afford mandatory health insurance?	X			pp. 94-96
43. Are there penalties for small businesses (49 or fewer employees) which do not provide insurance for their employees?		X		pp. 96-97
44. Are there taxes, penalties, or fines for large businesses (50 or more employees) which do not provide insurance for their employees?	X			pp. 97-99
45. Does Obamacare place limits on out-of-pocket charges (co-payments and deductibles) that insurance policies can collect?	X			pp. 99-102

Deficit

46. Will Obamacare decrease the federal deficit?			X	pp. 102-107
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YES	NO	DEBATED	PAGE#s
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Employers

47.	Is Obamacare financially burdensome for businesses?			X	pp. 108-111
48.	Will Obamacare lead to decline in employment-based health insurance?			X	pp. 111-116
49.	Does Obamacare create uncertainty for businesses?			X	pp. 116-117
50.	Will Obamacare offer funding for workplace health programs?	X			p. 117

Insurance Industry

51.	Does Obamacare encourage health insurance competition?			X	pp. 118-120
52.	Does Obamacare restrict insurance companies' profits?	X			pp. 120-121
53.	Under Obamacare, are insurance companies still exempt from federal antitrust laws?	X			pp. 121-122
54.	Will Obamacare lead to fewer health insurance agents and brokers (a.k.a. "producers")?			X	pp. 122-124

Taxes

55.	Will Obamacare raise any federal taxes?	X			pp. 124-127
56.	Does Obamacare contain a new tax on "unearned income", including some real estate sales, for individuals with an adjusted gross income of \$200,000 or more?	X			pp. 127-130

Tort Reform/Medical Malpractice

57.	Does Obamacare reform medical malpractice (tort reform) law?		X		pp. 130-131
58.	Does Obamacare add new tools to help fight health care fraud?	X			pp. 131-133

C. Other Effects of Obamacare

YES	NO	DEBATE	PAGE#s
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Congress

59. Are members of Congress and their personal staffs required to purchase their health insurance plans through the Obamacare health insurance exchanges?	X			pp. 133-136
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Constitutionality

60. Is Obamacare substantially constitutional?	X			pp. 136-138
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Privacy

61. Does Obamacare ensure that patient medical data will be protected?			X	pp. 138-140
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Second Amendment

62. Does Obamacare contain provisions related to the Second Amendment and gun ownership?	X			pp. 140-141
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Single Payer Health Care

63. Can states set up their own single payer systems under Obamacare?	X			pp. 141-143
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Socialism

64. Is Obamacare a socialist law?			X	pp. 143-145
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Unauthorized Immigrants

65. Are unauthorized immigrants covered by Obamacare?		X		pp. 145-146
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TOTALS

35	7	23
YES	NO	DEBATED

(35 + 7 + 23 = 65 Questions)

III. Methodology

ProCon.org selected frequently asked questions about Obamacare after reading hundreds of articles, studies, speeches, and reports from diverse sources including the Department of Health of Human Services, Institute of Medicine, Kaiser Family Foundation, Cato Institute, Heritage Foundation, Congressional Budget Office, Centers for Medicare & Medicaid, Harvard School of Public Health, and many more.

We have worked to pose questions in a nonpartisan manner. We framed questions in a way where responses could be categorized as pro (yes), con (no), or not clearly pro or con (debated). Responses to all 62 questions were researched and selected based on:

- **clarity** (We included the most clear and compelling statements that we could find.)
- **directness** (Responses that directly answer our questions.)
- **length** (100-200 word responses were preferred.)
- **most recent** (Given the ongoing understanding of Obamacare, more recent statements were preferred over older ones.)
- **authority of source** (Health care experts and top policy officials were preferred.)
- **diversity** of arguments and sources
- **balance** in number and length of arguments per question

We included some responses that met most but not all of the above criteria when those responses were up to our quality standards and the best we could find.

While we prefer to have the same number and length of pros and cons for each question, in some of the questions, the length of one column may be longer or have one or two more arguments.

All responses include the source's name, his/her advanced degrees (Master's or higher), source's title, date of statement, and where published.

Passages from Obamacare are quoted as "General Reference" responses and include the section number and page number where the quote appears in the official version of the legislation.

Questions were labeled "Debated" when they did not have a clear pro (yes) or con (no) response. Responses to debated questions were put in side-by-side pro and con columns. Questions that did not have debated responses – meaning they had clear pro (yes) or con (no) responses – do not appear in side-by-side format.

Same position responses (pros, cons, etc.) were arranged in random order within the question.

Questions and responses were assembled in a single PDF document for easy distribution to media, legislators, and the general public.

Future revisions to the document (if any) will indicate date last updated.

This review was funded by ProCon.org.

For interviews about this research specifically or ProCon.org in general, please contact Kamy Akhavan, President & Managing Editor of ProCon.org, at 310-587-1407 or kamy@procon.org.

IV. 65 Questions and Responses on Obamacare

A. Medical Effects of Obamacare

--Abortion--

1. Does Obamacare fund abortion services for cases other than rape, incest, or to save the life of the mother? – DEBATED

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1303, "Special Rules," page 50, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(a) STATE OPT-OUT OF ABORTION COVERAGE.—

(1) IN GENERAL.—

A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition...

(A) IN GENERAL.—

Notwithstanding any other provision of this title (or any amendment made by this title)—

(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year...

(B) ABORTION SERVICES.—

(i) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—

The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved."

GENERAL REFERENCE 2

Barack H. Obama, JD, 44th President of the United States, stated in his Mar. 21, 2010 Executive Order 13535, available at www.whitehouse.gov:

"Following the recent passage of the Patient Protection and Affordable Care Act ('the Act'), it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for

abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment. The purpose of this Executive Order is to establish a comprehensive, government-wide set of policies and procedures to achieve this goal...

The Act maintains current Hyde Amendment restrictions governing abortion policy and extends those restrictions to the newly-created health insurance exchanges...

The Act specifically prohibits the use of tax credits and cost-sharing reduction payments to pay for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered) in the health insurance exchanges that will be operational in 2014."

NOT CLEARLY PRO OR CON 1

Jon O. Shimabukuro, JD, Legislative Analyst at the Congressional Research Service (CRS), stated in his July 9, 2012 report "Abortion: Judicial History and Legislative Response," available at www.crs.gov:

"Under ACA, the issuer of a qualified health plan will determine whether to provide coverage for either elective abortions or abortions for which federal funds appropriated for HHS are permitted. It appears that a plan issuer could also decide not to cover either type of abortion. ACA also permits a state to prohibit abortion coverage in exchange plans by enacting a law with such a prohibition.

ACA indicates that an issuer of a qualified health plan that provides coverage for elective abortions cannot use any funds attributable to a premium tax credit or cost-sharing subsidy to pay for such services. The issuer of a qualified health plan that provides coverage for elective abortions will be required to collect two separate payments from each enrollee in the plan: one payment that reflects an amount equal to the portion of the premium for coverage of health services other than elective abortions; and another payment that reflects an amount equal to the actuarial value of the coverage for elective abortions."

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Chris Smith, US Representative (R-New Jersey), stated the following in his Mar. 15, 2012 press release "Obama's Abortion Funding Plan," available at www.chrissmith.house.gov:</p> <p>"This week's Obama abortion funding rule confirms that publicly funded insurance plans WILL include abortion on demand. Using an accounting gimmick, the premium payers will pay the President's abortion surcharge of at least one dollar per month. This separate charge will go directly into an abortion fund.</p>	<p style="text-align: center;">CON 1</p> <p>The White House website posted the following on its webpage "Myths & Facts," available at www.whitehouse.gov (accessed Sep. 6, 2012):</p> <p>"Health insurance reform will NOT use your tax dollars to fund abortions.</p> <p>The health insurance reform legislation maintains the status quo of no federal funding for abortions, except in cases of rape, incest or when the life of the woman is endangered."</p>

Requiring the segregation of funds into allocation accounts—a mere bookkeeping exercise is a cheap political trick designed to circumvent longstanding prohibitions on taxpayer funding of abortion. This is an unprecedented break with longstanding federal policy on funding for abortion...

Undoubtedly many enrollees will be shocked when they get a bill for the Obama abortion surcharge. Once enrolled, even pro-life Americans will be forced to pay for other people’s abortions.”

PRO 2

Americans United for Life stated in its Mar. 29, 2012 newsletter "As the Supreme Court Hears Arguments, AUL Challenges Constitutionality of Abortion Expansion in Obamacare," available at www.action.aul.org:

"Obamacare fails to comprehensively prohibit the use of federal tax dollars for abortions or abortion coverage, and that this loophole can easily be exploited...

Obamacare’s provisions permitting health plans to provide abortion coverage to enrollees through state Exchanges are inconsistent with existing law—the Hyde Amendment...

Americans in these plans will be required to pay a portion of their insurance premium directly into a pot of money used exclusively for abortions. We learned this month that the Obama Administration, as expected, is moving forward with the implementation of this premium scheme...

The ‘preventive care’ mandate in Obamacare could be used to require insurance plans to cover abortions or abortion-inducing drugs. The Obama Administration achieved this by relying on a non-elected advisory committee of abortion advocates...”

PRO 3

CON 2

Erin Shields, a spokeswoman for the Department of Health and Human Services, stated in her Apr. 2, 2012 article, “Obamacare 'Abortion Surcharge': The Facts Behind the Rumor,” available online at www.huffingtonpost.com:

"Under the new health care law, federal funds continue not to be used for abortion services, except those in cases of rape or incest or where the life of the woman is endangered. No one will be required to choose a plan that covers these services and no taxpayer dollars will be spent on them. Before choosing a health plan, consumers will know whether the plan covers these services. And if it does, payments will be made into a separate account to ensure no federal dollars fund these services."

CON 3

Norman K. Moon, JD, Senior US District Judge serving in the Western District of Virginia, stated the following, on Nov. 30, 2010, in his opinion in a lawsuit filed by Liberty University challenging Obamacare:

"...[T]he Act... contains strict safeguards at multiple levels to prevent federal funds from being used to pay for abortion services beyond those in cases of rape or incest, or where the life of the woman would be endangered..."

In plans that do provide non-excepted abortion coverage, a separate payment for nonexcepted abortion services must be made by the policyholder to the insurer, and the insurer must deposit those payments in a separate allocation account that consists solely of those payments; the insurer must use only the amounts in that account to pay for non-excepted abortion services."

CON 4

Barack H. Obama, JD, 44th President of the

The Family Research Council stated in its Mar. 13, 2012: article "ObamaCare: Home of the \$1 Abortions," available at www.frc.org:

"Today, in its final rules on health care exchanges, the administration officially welcomed Americans to the abortion industry. As part of the new regulations on how state health exchanges will work, anyone enrolled in an insurance plan that covers abortion will be responsible for sharing the cost."

PRO 4

Matthew Clark, JD, Associate Counsel with the American Center for Law and Justice (ACLJ) in Media and Government Affairs, stated in his Jan. 18, 2012 article "How ObamaCare Uses Taxpayer Money to Pay for Abortions," available at www.aclj.org:

"...[T]he law specifically provides that state health exchanges may cover abortions unless the state enacts specific legislation prohibiting abortion coverage. Moreover, the law's requirement that insurance providers cover 'preventive services' and preventative care are so broadly defined that they could be used to force coverage of abortions and abortion related drugs. Thus, all Americans are forced to purchase health insurance that could cover abortion and in some cases is required to cover abortion..."

...[T]here is no language in ObamaCare that prevents tax dollars from being used to pay for abortions. The proposed amendment to ObamaCare that would have prevented all taxpayer funding for abortions that was debated in Congress, known as the Stupak-Pitts Amendment, was not included in the final bill signed by President Obama...

...[T]he Executive Order signed by President Obama, which he claimed would 'ensure that Federal funds are not used for abortion services,'

United States, stated the following in his Mar. 24, 2010 executive order 13535 "Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act," available at www.whitehouse.gov:

"Following the recent enactment of the Patient Protection and Affordable Care Act (the 'Act'), it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment..."

The Act specifically prohibits the use of tax credits and cost-sharing reduction payments to pay for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered) in the health insurance exchanges that will be operational in 2014. The Act also imposes strict payment and accounting requirements to ensure that Federal funds are not used for abortion services in exchange plans (except in cases of rape or incest, or when the life of the woman would be endangered)...

The Act establishes a new Community Health Center (CHC) Fund within HHS, which provides additional Federal funds for the community health center program. Existing law prohibits these centers from using Federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered)."

CON 5

Brooks Jackson, Director of FactCheck.org, stated in a July 22, 2010 article, "Taxpayer-Funded Abortions in High Risk Pools," available at www.factcheck.org:

"The claim that the new federal health care law

<p>did not prevent taxpayer funds from being used for abortions...</p> <p>The bottom line is because the law fails to contain any provision actually preventing federal funds from being used to subsidize insurance plans that cover abortions, ObamaCare greatly increases taxpayer funding for abortions."</p> <p style="text-align: center;">PRO 5</p> <p>Erick Cantor, JD, US Representative (R-VA), introduced the Repeal Obamacare Act (HR. 6079) on July 9, 2012. The text of the act, available at thomas.loc.gov, stated in part:</p> <p>"While President Obama promised that nothing in the law would fund elective abortion, the law expands the role of the Federal Government in funding and facilitating abortion and plans that cover abortion. The law appropriates billions of dollars in new funding without explicitly prohibiting the use of these funds for abortion, and it provides Federal subsidies for health plans covering elective abortions. Moreover, the law effectively forces millions of individuals to personally pay a separate abortion premium in violation of their sincerely held religious, ethical, or moral beliefs."</p>	<p>will use taxpayer funds to pay for abortions through 'high-risk pools' originated when the National Right to Life Committee issued a press release July 13. It said that Washington had approved a new insurance program that 'will cover any abortion that is legal in Pennsylvania.' Abortion foes also raised alarms about similar federally subsidized insurance pools being put together in New Mexico and Maryland...</p> <p>State and federal officials have since scrambled to clarify their intentions. Pennsylvania officials issued a statement on July 15 saying that for any abortions performed because of reasons other than rape, incest or a threat to the mother's life, women 'will have to pay for them out their own pocket.' And New Mexico backed down just as quickly, issuing a July 15 statement saying 'elective abortion is not and has never been intended to be a benefit.'...</p> <p>...[W]hatever Pennsylvania officials intended the stated federal policy is now clear: No abortions will be covered by the temporary risk pools except for those in cases of rape or incest, or to save the life of the mother."</p>
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--Birth Control--

2. Does Obamacare require health insurers to cover birth control? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2713, "Coverage of Preventative Health Services," pages 13-14, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

- (1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;
- (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
- (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.
- (5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009."

[Editor's Note: The US Department of Health and Human Services (HHS) commissioned the Institute of Medicine (IOM) to develop a comprehensive list of preventative services for women to be covered under Section 2713, "Coverage of Preventative Health Services," of the Patient Protection and Affordable Care Act (see General Reference 1 directly above).

The IOM released a report on July 19, 2011, "Recommendations for Preventative Services for Women that Should be Considered by HHS," that recommended well-woman visits, screening for gestational diabetes, HPV testing, counseling for STDs and HIV, breastfeeding support, domestic/interpersonal abuse screening and counseling, and the "full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity."

HHS approved the IOM recommendations on Aug. 1, 2011. In accordance with the PPACA, women will have access to birth control without an insurance co-payment, co-insurance, or deductible.]

PRO 1

The *New York Times* reported in its May 21, 2012 "Times Topics" webpage "Contraception and Insurance Coverage (Religious Exemption Debate)," available at www.nytimes.com:

"The 2010 health care law says insurers must cover 'preventive health services' and cannot charge for them and the new rule was issued to spell out the details of this mandate. It requires coverage of the full range of contraceptive methods approved by the Food and Drug Administration. Among the drugs and devices that must be covered are emergency contraceptives including pills known as ella and Plan B. The rule also requires coverage of sterilization procedures for women without co-payments or deductibles.

The administration rejected a request from the Roman Catholic Church for a broad exemption for insurance provided to employees of Catholic hospitals, colleges and charities, although it said it would give such church-affiliated organizations one additional year — until Aug. 1, 2013 — to comply with the requirement. Most other employers and insurers must comply by Aug. 1, 2012."

3. Are there any exemptions to the Obamacare requirement that health insurance policies cover birth control? —YES

GENERAL REFERENCE 1

The US Department of Health and Human Services (HHS) published the following rule on July 2, 2013, "Coverage of Certain Preventive Services Under the Affordable Care Act; Final Rules," available at www.hhs.gov:

"§ 147.131 Exemption and accommodations in connection with coverage of preventive health services.

(a) Religious employers. In issuing guidelines under § 147.130(a)(1)(iv), the Health Resources and Services Administration may establish an exemption from such guidelines with respect to a group health plan established or maintained by a religious employer (and health insurance coverage provided in connection with a group health plan established or maintained by a religious employer) with respect to any requirement to cover contraceptive services under such guidelines. For purposes of this paragraph (a), a "religious employer" is an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(b) Eligible organizations. An eligible organization is an organization that satisfies all of the following requirements:

(1) The organization opposes providing coverage for some or all of any contraceptive services required to be covered under § 147.130(a)(1)(iv) on account of religious objections.

(2) The organization is organized and operates as a nonprofit entity.

(3) The organization holds itself out as a religious organization.

(4) The organization self-certifies, in a form and manner specified by the Secretary, that it satisfies the criteria in paragraphs (b)(1) through (3) of this section, and makes such self-certification available for examination upon request by the first day of the first plan year to which the accommodation in paragraph (c) of this section applies. The self-certification must be executed by a person authorized to make the certification on behalf of the organization, and must be maintained in a manner consistent with the record retention requirements under section 107 of the Employee Retirement..."

PRO 1

The US Department of Health and Human Services (HHS) stated the following in a June 28, 2013 news release “Administration Issues Final Rules on Contraception Coverage and Religious Organizations,” available at www.hhs.gov:

"Today, the Obama administration issued final rules that balance the goal of providing women with coverage for recommended preventive care – including contraceptive services prescribed by a health care provider – with no cost-sharing, with the goal of respecting the concerns of non-profit religious organizations that object to contraceptive coverage...

Today’s final rules finalize the proposed simpler definition of ‘religious employer’ for purposes of the exemption from the contraceptive coverage requirement in response to concerns raised by some religious organizations. These employers, primarily houses of worship, may exclude contraceptive coverage from their health plans for their employees and their dependents.

The final rules also lay out the accommodation for other non-profit religious organizations - such as non-profit religious hospitals and institutions of higher education - that object to contraceptive coverage. Under the accommodation these organizations will not have to contract, arrange, pay for or refer contraceptive coverage to which they object on religious grounds, but such coverage is separately provided to women enrolled in their health plans at no cost. The approach taken in the final rules is similar to, but simpler than, that taken in the proposed rules, and responds to comments made by many stakeholders."

PRO 2

Robert Pear, MPhil, *New York Times* Domestic Reporter, stated the following in his June 28, 2013 article “Contraceptives Stay Covered in Health Law,” available at www.nytimes.com:

"Despite strong resistance from religious organizations, the Obama administration said Friday that it was moving ahead with a rule requiring most employers to provide free insurance coverage of contraceptives for women...

The final rule, issued under the new health care law, adopts a simplified version of an approach proposed by the government in February to balance the interests of women with the concerns of the Roman Catholic Church and other employers with religious objections to providing coverage for contraceptives...

The rule, they said, is very similar to their proposal. An exemption is included for churches. But many Catholic hospitals, schools, universities and other religious institutions will have to take steps so that coverage is available to employees and their dependents...

Among the ‘essential health benefits’ that must be provided [under Obamacare] are preventive services. In particular, the administration says, most health plans must cover sterilization and the full range of contraceptive methods approved by the Food and Drug Administration, including emergency contraceptive pills, like those known as ella and Plan B One-Step.

Under the rule issued Friday, the government said certain ‘religious employers’ — primarily houses of worship — may exclude contraceptive coverage from their health plans for employees and their dependents. In effect, they will be exempt from the federal requirement to provide contraceptive coverage."

--Emergency Care--

4. Will fewer people rely on emergency rooms for health care under Obamacare? — DEBATED

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Barack H. Obama, JD, 44th President of the United States, stated the following in his Aug. 6, 2012 “Presidential Proclamation – National Health Center Week,” available at www.whitehouse.gov:</p> <p>“Health centers play a key role in bringing vital health care services to 20 million Americans from all walks of life. They lift up rural and urban neighborhoods alike, extending community based, patient directed care to those who need it most. Through their work, health centers strengthen our health care system by helping reduce emergency room visits and easing health care burdens for families across America.</p> <p>My Administration is working to empower health centers with the resources they need to provide comprehensive, high quality care for more individuals. Thanks primarily to the Affordable Care Act and the American Recovery and Reinvestment Act, health centers are serving nearly 3 million additional patients.”</p> <p style="text-align: center;">PRO 2</p> <p>Gail Lenehan, EdD, MSN, RN, President of the Emergency Nurses Association, wrote in a June 28, 2012 press release “ENA Applauds Supreme</p>	<p style="text-align: center;">CON 1</p> <p>Avik Roy, Senior Fellow at the Manhattan Institute, stated in his Feb. 2, 2011 article "Myths of the 'Free Rider' Health Care Problem," available at www.forbes.com:</p> <p>"EMTALA [the Emergency Medical Treatment and Active Labor Act] requires that hospitals provide emergency care to anyone who needs it, regardless of citizenship, legal status (i.e. illegal immigrants), or ability to pay...</p> <p>The problem of uncompensated care is one of uncompensated care in the emergency room (and any other care arising from an admission to the ER). But Obamacare’s individual mandate doesn’t allow people to buy inexpensive insurance focused on emergency care: instead, it forces people to buy comprehensive insurance packages with a generous list of basic benefits, benefits far exceeding those required to address the issue of uncompensated emergency room care...</p> <p>It’s pretty simple: if your health care is paid for, you are more likely to see the doctor more, and consume more tests and procedures, than if you are uninsured. Hence, people with insurance consume, on average, twice as much health care as do the uninsured.</p>

Court Decision,” available at www.ena.org:

“Though people will continue to require emergency care, this decision means that millions of people will have access to basic, primary health care and preventive services which should ultimately reduce the numbers of patients seeking routine care in the emergency department. Patients will get the care they need earlier instead of becoming seriously ill and requiring complex, acute care in a hospital emergency department.”

PRO 3

Michael Murphy, CEO of Sharp Healthcare, stated the following during a Mar. 23, 2010 interview on KPBS radio "How Will Health Reforms Affect Community Clinics, Hospitals?," available at www.kpbs.org:

"I think clearly one of the goals of healthcare reform is to get people covered and, clearly, this bill anticipates we'll have 32 million people covered. 16 million of them will be covered by MediCal, 16 million more through the insurance exchange. And the total desire and appropriate thing to happen in this healthcare reform is for those people to get attached to medical home models so that their issues do not become emergency room issues and are treated in the most appropriate and cost effective setting in either community clinics or physicians' offices or ambulatory sites long before they need an emergency room. And, clearly, that should have a positive impact on the emergency room."

PRO 4

Cathy J. Bradley, PhD, Cabell Professor in Cancer Research and Chair of the Department of Healthcare Policy and Research at the School of Medicine, Virginia Commonwealth University, Sabina O. Gandhi, PhD, Assistant Professor in the Department of Healthcare Policy and Research, Virginia Commonwealth University, and David Neumark, PhD, Professor of Economics,

This problem leads to more ER crowding, poorer access to emergency care for the truly vulnerable, and more losses for hospitals...

...[T]he individual mandate is only capable of partially relieving the free-rider [uncompensated care] problem, and simultaneously creates entirely new problems of increased spending, ER overcrowding and limited ER access for the truly needy."

CON 2

John C. Goodman, PhD, President and CEO at the National Center for Policy Analysis (NCPA), stated in his June 18, 2010 article "Emergency Room Visits Likely to Increase Under ObamaCare," published by NCPA on its website, www.ncpa.org:

"More people are likely to turn to the emergency room for their health care and they are likely to do so more frequently under the new health reform legislation. This finding is surprising because an oft repeated argument for insuring the uninsured is that it will allow people to seek less costly and more accessible care elsewhere.

We find that emergency room costs will increase for two reasons: 1) about half the newly insured will enroll in Medicaid and Medicaid patients seek emergency room care more often than the uninsured, and 2) while the newly insured will try to increase their consumption of care, the absence of any program to create more providers will force patients to turn to emergency rooms as the outlet for increased demand."

CON 3

Lynn Massingale, MD, Executive Chairman of TeamHealth, was quoted as stating the following in the June 14, 2012 article "2 Major Implications of the PPACA Ruling for Emergency Departments," available at

University of California at Irvine, et al., stated the following in their Feb. 2012 study "Lessons For Coverage Expansion: A Virginia Primary Care Program for the Uninsured Reduced Utilization and Cut Costs," available at www.content.healthaffairs.org:

"The Affordable Care Act will expand health insurance coverage for an estimated thirty-two million uninsured Americans. Increased access to care is intended to reduce the unnecessary use of services such as emergency department visits and to achieve substantial cost savings.

However, there is little evidence for such claims. To determine how the uninsured might respond once coverage becomes available, we studied uninsured low-income adults enrolled in a community-based primary care program at Virginia Commonwealth University Medical Center. For people continuously enrolled in the program, emergency department visits and inpatient admissions declined, while primary care visits increased during the study period. Inpatient costs fell each year for this group.

Over three years of enrollment, average total costs per year per enrollee fell from \$8,899 to \$4,569—a savings of almost 50 percent. We conclude that previously uninsured people may have fewer emergency department visits and lower costs after receiving coverage but that it may take several years of coverage for substantive health care savings to occur."

PRO 5

Angel Glover Blackwell, Founder and CEO of PolicyLink, wrote in her June 28, 2012 statement "Victory for Equity! Supreme Court Upholds Affordable Care Act," available at www.equityblog.org:

"The law also focuses on prevention, encouraging not only sick people but also healthy individuals to sign up for coverage. Because of the Affordable

www.beckerhospitalreview.com:

"The mere fact that more individuals will be covered by insurance will bring more patients to the ED [Emergency Department], especially since the uninsured population has healthcare needs on reserve. In addition, there is not a primary care practice excess in the country. The odds are that newly insured individuals will not be able to see primary care practitioners and instead will visit an emergency room...

ED patient volumes are historically increasing, particularly as hospitals close and patients are consolidated into fewer ERs. The law and any additional coverage for individuals will only add to the factors of aging population, lack of primary care capacity and the closing of hospitals. These factors all work together to increase patient volume."

CON 4

Douglas Holtz-Eakin, PhD, President of Operation Healthcare Choice at the American Action Forum, and Michael Ramlet, Coordinator of Operation Healthcare Choice at the American Action Forum, stated the following in their Sep. 2010 report "Healthcare Reform and Medicaid: Patient Access, Emergency Department Use, and Financial Implications for States and Hospitals," available at www.americanactionforum.org:

"...[Obamacare is] likely to dramatically expand the use of emergency room care, as Medicaid's low reimbursement rates limit beneficiaries' access to primary care physicians... We estimate that the emergency department impacts alone will generate 68 million visits and add \$36 billion to the nation's healthcare bill...

The Obama Administration's decision to push insurance coverage through a major expansion of Medicaid ensures a greater number of emergency room visits...

<p>Care Act, we can expect fewer emergency room visits for chronic illnesses, and lower costs for preventable and manageable conditions like diabetes, obesity, and asthma.”</p>	<p>Beginning in 2014 with the mandated expansion of Medicaid eligibility, the historical rates of emergency department utilization indicate that policymakers should expect a substantial increase in annual emergency room visits...</p> <p>By 2019, the increased overutilization of the America’s emergency departments stemming from the Obama reform will increase national healthcare expenditures by \$35.8 billion compared to prior law."</p>
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--Health Insurance Exchanges--

5. Will the health insurance exchanges benefit consumers? – DEBATED

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1311, "Part II—Consumer Choices and Insurance Competition through Health Insurance Exchanges," page 55, signed into law on Mar. 23, 2010, available at www.thomas.gov states:

"(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b)."

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>The US Department of Health and Human Services (HHS), stated on its Aug. 23, 2012 posting "Creating a New Competitive Marketplace: Affordable Insurance Exchanges," last updated on www.healthcare.gov:</p> <p>“Affordable Insurance Exchanges will provide individuals and small businesses with a ‘one-stop shop’ to find and compare affordable, quality private health insurance options.</p> <p>Exchanges will bring new transparency to the market so that Americans will be able to compare plans based on price and quality. By increasing</p>	<p style="text-align: center;">CON 1</p> <p>Avik Roy, Senior Fellow at the Manhattan Institute for Policy Research, stated in his Nov. 19, 2012 article titled "What States Should Build Instead of Obamacare's Health Insurance Exchanges," posted at forbes.com:</p> <p>"Obamacare takes [the exchange] concept and distorts it in a critical way, by taking over the insurance market and micromanaging the design of insurance plans that can be sold on the law’s exchanges.</p> <p>...[T]he thrust of Obamacare’s exchanges is to shoehorn consumers into a narrow set of</p>

competition between insurance companies and allowing individuals and small businesses to band together to purchase insurance, Exchanges will help lower costs."

PRO 2

Timothy Stoltzfus Jost, JD, Robert L. Willett Family Professor of Law at the Washington and Lee University School of Law, wrote in his July 2010 article "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues," available at www.commonwealthfund.org:

"Health insurance exchanges are the centerpiece of the private health insurance reforms of the Patient Protection and Affordable Care Act of 2010 (ACA). If they function as planned, these exchanges will expand health insurance coverage, improve the quality of such coverage and perhaps of health care itself, and reduce costs...

One valuable role that exchanges can play is to administer subsidies that assist lower- and middle-income people in purchasing insurance... Exchanges are ideally situated to administer these subsidies, as eligibility can be determined during the enrollment process, and the subsidies can be sent directly to the insurance plan chosen by each person."

PRO 3

The *Los Angeles Times* stated in its Feb. 8, 2012 editorial titled "'Obamacare' Insurance Exchanges: Let's Get Going":

"...[E]ach state should set up an exchange regardless of how its lawmakers feel about 'Obamacare,' because it would help ameliorate the very real problems consumers face in the health insurance market...

The main value for consumers is in the convenience and transparency the exchanges provide. No longer would they have to wander

government-approved products, so as to protect them from making choices that the government deems unwise. The side effect of this approach is to prevent insurers from coming up with innovative products that deliver cost-efficient care...

Imagine if the government required that you could only buy a home that was between 2,000 and 2,500 square feet, with two bedrooms, five electrical outlets, and a solar panel, and you get a sense of what Obamacare's exchanges do."

CON 2

Edmund Haislmaier, Senior Research Fellow of Health Policy Studies at the Heritage Foundation, stated in his Mar. 21, 2011 article "A State Lawmaker's Guide to Health Insurance Exchanges" available at www.heritage.org:

"Health insurance exchanges are a good idea—if they are used to implement patient-centered and market-based health reforms that enhance choices and value for customers. The exchanges prescribed by Obamacare will have the opposite effect...

Rather than serving as a mechanism for expanding health insurance choice, variety, and competition, and for spurring plans and providers to innovate and offer customers better value, Obamacare exchanges will impose new regulations, administer new subsidies, standardize coverage, and restrict consumer choice and insurer competition more than it is already. Thus, in the PPACA Congress has perverted the exchange concept into a bureaucratic tool for federal subsidization, standardization, and micromanagement of health insurance coverage by the Department of Health and Human Services."

CON 3

Ashton Ellis, JD, Contributing Editor at the Center for Individual Freedom, stated in his Mar. 15, 2012 article "ObamaCare Exchanges Consumer Choice

from agent to agent (or website to website) to find out what their options were. Nor would they have to try to translate each insurer's fine print to measure the total value of its policies. Enabling consumers to compare services and prices should remove some of the artificial barriers to competition in insurance and make it harder for companies to raise premiums."

PRO 4

The Robert Wood Johnson Foundation stated in its July 2012 issue brief titled "4 Ways State Health Insurance Exchanges Can Improve Quality," available at rwjf.org:

"1. Exchanges emphasize transparency in information about quality of care. Under the Affordable Care Act, states must ensure that plans participating in the exchange meet certain quality improvement criteria. The exchanges must also provide consistent quality and cost ratings for all participating plans—enabling customers to shop more easily based on quality, price, coverage, etc.

2. Exchanges can help link quality improvement with reimbursement strategies. Exchanges can coalesce insurance purchasers throughout the state—including Medicaid, the Children’s Health Insurance Program, state employee benefits programs, and private employers and their purchasing alliances—so that health plans hear consistent demands for quality that they, in turn, press upon their provider networks, sparking a tighter focus on quality care.

3. Exchanges can help consumers make more informed decisions. Exchanges' Web portals can provide consumers with relevant and actionable information, not just on the availability of affordable plans—but also on quality of care. Displaying easy-to-understand information on the quality of care provided by plans (based on the performance of their provider networks) enables consumers to make informed decisions and promotes quality-driven plans.

and State Sovereignty for Nationalized Healthcare,” available at www.cfif.org:

“The Department of Health and Human Services promises that the creation of government-run health insurance exchanges will give states more flexibility and consumers more choices. But an examination of the rhetoric versus the reality reveals that these claims are just a smokescreen while HHS effectively nationalizes the entire health insurance market...

The initial cost is the loss of state sovereignty. While no state is required to operate a health insurance exchange, if it fails to initiate one by January 1, 2014, ObamaCare authorizes Secretary Sebelius to step in and do so. In the latter scenario, a state would be unilaterally cut out of any policymaking decisions regarding the portion of its residents that fall within the federal exchange’s targeted consumer base...

Health insurance companies must meet certain standards to become qualified participants in the government-run exchange.

But because ObamaCare creates tax incentives and subsidies for purchasing plans on the exchange, many companies rightly fear that failing to qualify as participants will ultimately harm their businesses since those benefits are not extended to plans offered outside the exchange.

Thus, with the advent of government-run exchanges in 2014, the entire health insurance industry will be competing to please Secretary Sebelius and her army of HHS bureaucrats, not the millions of consumers compelled by the tax code to buy a one-size-fits-all health plan.”

CON 4

Michael Cannon, MA, JM, Cato Institute Director of Health Policy Studies, stated in his Mar. 21, 2011 article “Obamacare Can't Be Fixed, and Now Is the Time to Dismantle It,” available at

4. Exchanges can help fuel competitiveness, which in turn can make care more consumer-centered. By offering a choice of plans and equipping consumers with information to better understand and compare options, the exchanges can push plans to compete with each other to provide quality- and value-driven plans that work for consumers."

PRO 5

Families USA stated in its June 2011 article "Why We Need a Health Insurance Exchange," available at www.familiesusa2.org:

"Consumers will greatly benefit once an exchange is in place. Here's why:

Competition: An exchange will make the state's insurance market more competitive. The exchange will force insurers to compete for customers based on value, instead of luring them with the trickiest fine print. The exchange will have an easy-to-use website that allows consumers to make apples-to-apples comparisons when they shop for health plans. On this level playing field, quality insurers of all sizes—not just the largest and most powerful—will be able to compete.

Transparency: Insurers in the exchange will have to use easy-to-understand language to describe their products—a vast improvement over the confusing jargon that consumers face now. And insurers will be required to share information about plan costs and quality in a standardized way so that consumers can truly understand what they're getting.

Affordability: In the exchange, middle-class consumers (those who earn up to nearly \$90,000 for a family of four in 2011) will be eligible for tax credits to help them pay their insurance premiums.

Many people will also receive help with copayments, deductibles, or other cost-sharing.

www.cato.org:

"Running their own exchanges won't empower states to prevent both the most economical and the most comprehensive health plans from disappearing from their markets. Affordable plans will disappear because Obamacare requires all purchasers to buy whatever coverage Sebelius mandates as 'essential,' a definition that will grow ever broader, as such definitions always do. The law's price controls will require insurers to charge everyone of a given age the same premium, regardless of whether an actuarially fair premium might be \$5,000 or \$50,000. Even state-run exchanges would see comprehensive health plans crumble under the weight of too many patients who cost \$50,000 but pay far less. Nor can state-run exchanges prevent other dimensions of quality from eroding. Even in state-run exchanges, the sickest patients would struggle to get their claims paid by insurers who are trying to avoid, mistreat, and dump them, because that is what Obamacare's price controls reward.

States that run their own exchanges will likewise be powerless to prevent HHS from loading health-savings-account (HSA) plans down with mandated benefits."

CON 5

Rita E. Numerof, MSS, PhD, Co-founder and President of Numerof and Associates, stated in her May 2012 article "What's Wrong with Health Insurance Exchanges," available at www.galen.org:

"The health insurance exchanges defined in PPACA won't work, won't increase access to affordable health care, and won't do anything to improve health outcomes or increase value. The solution to affordable coverage isn't to be found in these new bureaucracies, but rather in reducing barriers to competition and consumer choice and removing regulations that make coverage unaffordable today..."

And the exchange will monitor insurers to make sure that they aren't unreasonably increasing their premium rates from year to year."

PRO 6

The Minnesota Office of the Governor, and the Minnesota Departments of Commerce, Health, and Human Services, stated on their webpage "Exchange a Marketplace for Affordable Health Insurance," available at www.mn.gov (accessed Sep. 7, 2012):

"An Exchange can make health care easier to navigate for consumers and small businesses. It can allow Minnesotans to easily compare health insurance options based on cost, quality, and consumer satisfaction. It can also foster fair and equitable competition to encourage insurers and health care providers to place a greater focus on value and affordability..."

An Exchange can help small businesses provide affordable coverage choices to their workers and allow employees to choose the plan that is best for them and their families. Employees will be able to use contributions from one or more employers to purchase coverage for them and their families and keep that coverage if they become self-employed, lose their job, or if they change jobs. An Exchange can also simplify the administration of health insurance for small businesses and allow them to focus on growing their business instead of managing health insurance."

PRO 7

The Center for Consumer Information & Insurance Oversight wrote on a page titled "Affordable Insurance Exchanges," available at www.cciio.cms.gov (accessed Sep. 12, 2012):

"The Affordable Care Act helps create a competitive private health insurance market through the creation of Affordable Insurance Exchanges. These State-based, competitive

PPACA's solution is to combine an individual mandate with health insurance exchanges, forcing consumers to choose from a limited slate of homogenized health plans, with federal subsidies available to some to offset the high cost of the plans.

PPACA's solution is fundamentally flawed and unsustainable: It will limit choice, create new bureaucracies, cost consumers and taxpayers more, and put additional burdens on the states."

CON 6

Rick Scott, Republican Governor of Florida, was quoted in a July 6, 2012 article titled "Gov. Rick Scott Repeats That Florida Will Not Implement Health Care Exchanges," published on www.tampabay.com:

"We're not going to implement the health care exchanges because it's not going to drive down the cost of health care, it's going to raise the cost..."

The problem with the exchanges is the government is going to dictate the type of policies. The policies that will be on there are the kind of policies you might not want to buy..."

CON 7

Twila Brase, President of Citizens' Council for Health Freedom, stated in her Feb. 27, 2013 op-ed titled "The Obamacare Exchanges Aren't 'Marketplaces,'" posted at dailycaller.com:

"Words can deceive, as proponents of federal health reform know well. Calling the proposed state health insurance exchanges 'marketplaces' is nothing but a veiled attempt to use free-market terms to describe a system that is anything but free..."

The reality is that on state insurance exchanges available health insurance plans will be limited by

<p>marketplaces, which launch in 2014, will provide millions of Americans and small businesses with ‘one-stop shopping’ for affordable coverage.</p> <p>In the Exchanges, Americans will also have access to a wide range of customer assistance tools – including information about prices, quality, and physician and hospital networks. The plans offered in the Exchanges will be required to provide at least a basic level of comprehensive benefits...</p> <p>Competitive state Exchanges will keep prices low by:</p> <ul style="list-style-type: none"> • Increasing competition among private insurance plans through improved comparative shopping and more informed consumers • Providing small businesses the same purchasing power in Exchanges as large businesses. <p>Additionally, the increased competition in the Exchanges--combined with provisions in the law to streamline administrative costs by standardizing forms and reducing the amount of paperwork doctors are forced to complete--will reduce average premiums by 7 to 10%, according to the Congressional Budget Office.</p> <p>Provisions in the law that prohibit insurance companies from discriminating against Americans with pre-existing conditions will force insurance companies to provide high-quality benefits at a competitive price.”</p>	<p>a host of federal regulations; personal privacy will be violated, because the exchanges will be connected to various state agencies and a wide variety of federal agencies — including the Department of Justice, the Department of Defense, the IRS, the Social Security Administration and the Department of Health and Human Services — that will share citizens’ data without consent; the federal government will use an individual’s income, tax, employment, medical, family and citizenship data to determine eligibility for coverage and premium subsidies; and it will be impossible to purchase health insurance without federal approval."</p>
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6. Will long term care insurance be offered in health insurance exchanges? – NO

GENERAL REFERENCE 1

[Editor’s Note: The original Obamacare legislation signed into law on Mar. 23, 2010 contained a provision intended to offer long term care insurance through the Community Living Assistance Services and Supports Act or CLASS Act. In Oct. 2011, HHS Secretary Kathleen Sebelius shelved the CLASS Act saying it was financially unsustainable and “We have not identified a way to make Class work at this time.”]

CON 1

The US Department of Health and Human Services, stated on its webpage "Will Long Term Care Insurance Be Offered in a Health Insurance Exchange?" available at www.healthcare.gov (accessed on Nov. 22, 2011):

"No. Affordable Insurance Exchanges will not include information about long term care insurance."

CON 2

Joseph R. Antos, PhD, William H. Taylor Scholar in Healthcare and Retirement Policy at American Enterprise Institute, stated in his July 24, 2012 article "Healthcare Reform after SCOTUS, Hard Decisions Needed to Avoid Health Sector Meltdown," available at www.ahdonline.com:

"We have already seen a major component of the ACA fail because it promised more than it could deliver."

The Community Living Assistance Services and Supports Act (better known as the CLASS Act) was a government long-term care insurance program that could not be made financially solvent and was eventually shelved."

CON 3

Robert Pear, writer for the *New York Times*, stated in his Oct. 14, 2011 article "Health Law to Be Revised by Ending a Program," available at www.nytimes.com:

"The Obama administration announced Friday that it was scrapping a long-term care insurance program created by the new health care law because it was too costly and would not work."

Kathleen Sebelius, the secretary of health and human services, said she had concluded that premiums would be so high that few healthy people would sign up. The program, which was intended for people with chronic illnesses or severe disabilities, was known as Community Living Assistance Services and Supports, or Class...

Advocates for older Americans and people with disabilities expressed disappointment at the decision, and Ms. Sebelius said Americans still had an 'enormous need' for long-term care insurance. 'At \$75,000 a year for a nursing home and \$18,000 a year for home health care, most families cannot afford to pay out of pocket,' she said..."

--Health Insurance Mandate--

7. **Are there any exemptions to the mandatory health insurance requirement? — YES**

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 5000A, "Requirement to Maintain Minimum Essential Coverage," page 126, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—

An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) SHARED RESPONSIBILITY PAYMENT.—

(1) IN GENERAL.—If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (d), there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).

(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer’s return under chapter 1 for the taxable year which includes such month.”

[Editor’s Note: Additional details on the penalty continue from page 126 to page 132. Penalties are also discussed in section 1002 of the Health Care Reconciliation Act of 2010, signed into law on Mar. 30, 2010.]

GENERAL REFERENCE 2

[Editor’s Note: On Aug. 27, 2013, the Obama administration released the final regulations for Obamacare’s individual mandate including how the fines for people who chose not to purchase will be assessed, who it applies to, who is exempt, and the types of insurance that are necessary to meet Obamacare’s health insurance mandate.]

PRO 1

Julie Rovner, NPR Health Policy Correspondent, wrote in her July 6, 2012 article "More Answers to Your Questions About the Health Care Law," available at www.npr.org:

“For starters, if you don't earn enough to have to file a federal tax return, you're exempt. In 2010 that was \$9,350 for an individual, or \$18,700 for a married couple.

You're also exempt if you would have to pay more than 8 percent of your household's income for health insurance, after whatever help you might get from an employer or subsidies from the federal government...

... the VA counts [as having insurance]. So does TRICARE and other military health plans. In fact, just about all government health care program[s], including Medicare and Medicaid, count as well. That's why the Urban Institute estimates that come 2014, only about 7 million people out of the U.S. population of well over 300 million will have to either purchase insurance or be subject to paying the penalty.”

PRO 2

Diane Suchetka, Staff Writer for the *Plain Dealer*, wrote in her June 29, 2012 article “Affordable Care Act's Mandate Does Not Require Everyone to Buy Insurance,” available at www.cleveland.com:

"Who doesn't have to buy insurance?

- American Indians, prisoners and undocumented immigrants.
- Some religious groups. Those that have historically been exempt from the Social Security system, such as the Old Order Amish, are one example. Religious groups whose members pay for one another's health care instead of buying insurance are also exempt.
- Those whose family income is so low they don't have to file a tax return. Those numbers vary depending on several factors, including how old you are, whether you're married and whether you're the head of your household.
- Those who earn so little that health insurance premiums, after federal subsidies and employer contributions, would total more than 8 percent of their income.
- Those who already have insurance through Medicaid, Medicare, an employer or veteran's health program.”

8. Are there taxes, penalties, or fines for most individuals who do not have health insurance? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 5000A, "Refundable Credit for Coverage under a Qualified Health Plan," page 126, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(a) Requirement To Maintain Minimum Essential Coverage- An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared Responsibility Payment-

(1) IN GENERAL- If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (d), there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).

(2) INCLUSION WITH RETURN- Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) PAYMENT OF PENALTY- If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty."

GENERAL REFERENCE 2

[**Editor's Note:** On Aug. 27, 2013, the Obama administration released the final regulations for Obamacare's individual mandate including how the fines for people who chose not to purchase will be assessed, who it applies to, who is exempt, and the types of insurance that are necessary to meet Obamacare's health insurance mandate.]

PRO 1

Diane Suchetka, staff writer for the *Plain Dealer*, wrote in her June 29, 2012 article "Affordable Care Act's Mandate Does Not Require Everyone to Buy Insurance," available at www.cleveland.com:

"Those who aren't exempt or who don't have employer- or government-provided insurance and refuse to buy their own will begin to pay fines in 2014. Those fines will be due with income taxes the following April...

- In 2014, the penalty is either \$95 [annually] for every adult and \$47.50 for every child under the age of 18 in the household (up to \$285 for a family), or 1 percent of taxable income for the household, whichever is larger.
- In 2015, it's \$325 for every adult and \$162.50 for every child (up to \$975 for a family), or 2 percent of taxable income, whichever is larger.

- In 2016, it's \$695 for every adult and \$347.50 for every child (up to \$2,085 for a family), or 2.5 percent of income, whichever is higher.
- After 2016, the penalty increases annually by the cost-of-living adjustment.”

PRO 2

Brooks Jackson, Director of FactCheck.org, wrote in his June 28, 2012 article “How Much Is the Obamacare ‘Tax?’” available at www.FactCheck.org:

“The minimum penalty per person will start at \$95 in 2014, the first year that the law will require individuals to obtain coverage. And it will rise to \$325 the following year.

Starting in 2017, the minimum tax per person will rise each year with inflation. And for children 18 and under, the minimum per-person tax is half of that for adults.

However, the minimum amount per family is capped at triple the per-person tax, no matter how many individuals are in the taxpayer’s household...

The tax would be more for persons with higher taxable incomes...

But the penalty can never exceed the cost of the national average premiums for the lowest-cost ‘bronze’ plans being offered through the new insurance exchanges called for under the law.”

PRO 3

Avik Roy, Senior Fellow at the Manhattan Institute for Policy Research, stated the following in his Aug. 28, 2013 article "White House Publishes Final Regulations for Obamacare’s Individual Mandate – Seven Things You Need to Know," available at forbes.com:

“On Tuesday [Aug. 27, 2013], the Obama administration released the final regulations for Obamacare’s notorious individual mandate - the provision in the health care law that requires most Americans to purchase health insurance, or pay a fine...

If you claim dependents on your tax return, you’re responsible for paying the mandate fines if your dependents don’t have health insurance...

In 2014, the fine for not carrying insurance is the higher of \$95 per person or 1.0 percent of taxable income. In 2015, the fine is the higher of \$325 per person, or 2.0 percent of taxable income. In 2016, it’s \$695 per person or 2.5 percent of taxable income. You’re liable for up to 2 additional dependents, fine-wise...

Section 1501(g)(2) of the Affordable Care Act specifies that the IRS cannot subject taxpayers to ‘any criminal prosecution or penalty’ for refusing to pay the mandate fine. Also, in contrast to normal tax levies, the IRS cannot ‘file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section.’

Basically, the only thing the IRS can do to make you pay the mandate fine is to take it out of your withholding, or withhold it from your tax refund, if you're due one."

--Home Care--

9. Does Obamacare provide funding for training additional "at home" care professionals? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2008, "Demonstration Projects to Address Health Professions Workforce Needs," page 547, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDUCATION, TRAINING, AND CAREER ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS...

(b) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this section, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides."

PRO 1

The Catalog of Federal Domestic Assistance stated in an Aug. 22, 2012 posting "Affordable Care Act (ACA) Personal and Home Care Aide State Training Program (PHCAST)," available at www.cfda.gov:

"Authorization (040):

Section 2008 (b) of the Social Security Act, as added by section 5507 (b) of the Affordable Care Act; and section 4002 of the Affordable Care Act, Public Law 111-148.

Objectives (050):

To train individuals as qualified personal and home care aides to provide care in complex health care environments such as home healthcare services, residential care facilities, and private households. Grants will be made to State entities to conduct demonstration projects for purposes of developing core

training competencies and certification programs for personal and home care aides. The program helps to ensure that we have competent personal and home care aides with acquired skills that would be transportable to any job market in the Nation, thus strengthening the direct-care worker workforce...

Uses and Use Restrictions (070):

Infrastructure training grants are awarded to eligible applicant organizations for projects to strengthen and enhance the capacity of personal and home care aide training programs. This will enable individuals to enter into a personal and/or home care aide position. Funds may be used for the development, evaluation, and demonstration of training programs for personal and/or home care aides on-campus, at alternate sites, and through distance education methodologies."

PRO 2

The Institute on Aging stated on its webpage "Personal and Home Care Aide State Training Program (PHCAST)," available at www.aging.unc.edu (accessed Oct. 8, 2012):

"The PHCAST [Personal and Home Care Aide State Training Program] Project was created as part of the Affordable Care Act. It is a three-year demonstration program to develop core competencies, pilot training curricula, and establish certification programs for personal and home care aides. A total of \$4.2 million was awarded to California, Iowa, Maine, Massachusetts, Michigan, and North Carolina. The six states that are participating in the three-year PHCAST Program are expected to train over 5,100 personal home care aides by 2013."

--Insurance Coverage--

10. Does Obamacare allow people to keep their current coverage? – DEBATED

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1251, "Preservation of Right to Maintain Existing Coverage," page 43, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(a) No Changes to Existing Coverage –

(1) In General.-- Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act."

PRO (yes)	CON (no)
PRO 1	CON 1

Barack H. Obama, JD, 44th President of the United States, stated the following in his June 28, 2012 speech, "Remarks by the President on Supreme Court Ruling on the Affordable Care Act," available at www.whitehouse.gov:

"[T]oday, the Supreme Court upheld the constitutionality of the Affordable Care Act - the name of the health care reform we passed two years ago...

[I]f you're one of the more than 250 million Americans who already have health insurance, you will keep your health insurance - this law will only make it more secure and more affordable."

PRO 2

Harry Reid, US Senator (D-NV), stated the following a June 29, 2012 speech "Congress Can't Afford to Waste Time Refighting Old Battles and Should Renew Focus on Creating Jobs," available at www.reid.senate.gov:

"...[W]hat if you're one of the 250 million Americans who already has insurance? Nothing will change.

Nothing will change except that you'll no longer have to worry that if you lose your job, you'll lose your insurance. Nothing will change except that if you get cancer or have a stroke, your insurance company won't be allowed to deny life-saving care because you reach some arbitrary lifetime cap. Nothing will change except that your checkups and preventive care will be free – a provision that's already helped 54 million Americans with private insurance.

You'll be able to keep your plan and keep your doctor. But now you – not the insurance company – will be in control."

PRO 3

The US Department of Health and Human

Spencer Harris, Policy Analyst for the Center for Health Care Policy with the Texas Public Policy Foundation, wrote in his Dec. 2011 article "Broken Promises of Obamacare," available at www.heartland.org:

"Obama emphatically promised, 'If you like your coverage, you can keep it, no matter what.' That's not true either. The restrictions on cost-sharing adjustments leave companies and individuals with little flexibility to change plan details without losing their grandfathered status. The administration estimates between 49 percent and 80 percent of small-employer plans, between 34 percent and 67 percent of large-employer plans, and between 40 percent and 67 percent of individual plans will not be grandfathered by 2014."

CON 2

Alyene Senger, Research Assistant at the Heritage Foundation's Center for Health Policy Studies, wrote in her July 5, 2012 article "Side Effects: Obama Administration Admits You Can't Keep Your Health Plan," available at www.heritage.org:

"On several occasions during the health care reform debate, President Obama promised the American people, 'If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what.' Now, even the Administration admits that this isn't the case, stating that 'as a practical matter, a majority of group health plans will lose their grandfather status by 2013.' ...

Obamacare puts employers with grandfathered plans in a box. If they make changes to their plans to control increasing costs, they will lose their grandfathered status. Alternatively, if they keep grandfathered status by not making changes, their plans will eventually become unaffordable, forcing them to give them up. Either way, their employees will eventually lose their current coverage..."

Services (HHS) stated the following in its June 14, 2010 press release "US Departments of Health and Human Services, Labor, and Treasury Issue Regulation on 'Grandfathered' Health Plans under the Affordable Care Act," available at www.hhs.gov:

"The new regulation protects the ability of individuals and businesses to keep their current plan while providing important consumer protections that give Americans – rather than insurance companies – control over their own health care..."

The new regulation also provides stability and flexibility to insurers and businesses that offer health insurance coverage as the nation transitions to a more competitive marketplace in 2014 when businesses and consumers will have more affordable choices through exchanges...

While the Affordable Care Act requires all health plans to provide important new benefits to consumers, under the law, plans that existed on March 23, 2010 are exempt from some new requirements. The 'grandfather rule' issued today makes it clear that these plans can continue to innovate and contain costs by allowing insurers and employers to make routine changes without losing grandfather status. Plans will lose their 'grandfather' status if they choose to significantly cut benefits or increase out-of-pocket spending for consumers – and consumers in plans that make such changes will gain new consumer protections."

PRO 4

Paul Krugman, PhD, Professor of Economics and International Affairs at Princeton University, stated the following in his Mar. 18, 2012 article "Hurray for Health Reform," available at www.nytimes.com:

"To understand the lies, you first have to understand the truth. How would ObamaRomneycare change American health care?"

CON 3

Grace-Marie Turner, President of the Galen Institute, wrote in her Dec. 2011 article "Millions to Lose the Health Coverage They Have Now," available at www.galen.org:

"...[M]illions of people are losing 'the coverage they have now,' and tens of millions more surely will follow..."

The Obama administration expects that by 2013, between one-third and two-thirds of the 133 million people with coverage through large employers will lose their grandfathered status. Up to 80 percent of the 43 million people in small employer plans will lose their grandfathered protection. Up to 70 percent of those with coverage in the individual market would be forced to comply with expensive new federal rules within a year. Few of them are likely to lose coverage in the short term, but most will lose the coverage they have now."

CON 4

Elizabeth Weeks Leonard, JD, Associate Professor of Law at the University of Georgia School of Law, stated in her Apr. 22, 2011 article "Can You Really Keep Your Health Care Plan? The Limits of Grandfathering under the Affordable Care Act," available at www.ssrn.com:

"The Affordable Care Act's 'grandfather rule' (Section 1251, 'Preservation of Right to Maintain Existing Coverage') purports to uphold the 'you can keep your health plan' promise. But the regulatory requirements for plans to retain grandfathered status are nearly impossible to abide under existing market conditions. As a result, most plans will fairly quickly relinquish grandfathered status. When they do, the plans will have to come into full compliance with the Affordable Care Act's host of new requirements for health plans. At that point, 'your plan' will necessarily change."

For most people the answer is, not at all. In particular, those receiving good health benefits from employers would keep them."	
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11. Does Obamacare cover children with pre-existing conditions? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1255, "Amendment to the Public Health Service Act," page 36, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(2) the provisions of section 2704 of the Public Health Service Act (as amended by section 1201), as they apply to enrollees who are under 19 years of age, shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act."

GENERAL REFERENCE 2

The Public Health Service Act, Section 2704 [42 U.S.C. 300gg–3], "Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status," page 8, signed into law on May 24, 2010, available www.housedocs.house.gov, states:

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage."

PRO 1

Barack Obama, 44th President of the United States, in a Mar. 18, 2012 posting, "The President's Record on Health Care," available at www.barackobama.com, provided the following information:

"Fact: Before the Affordable Care Act, insurance companies could deny coverage to children with medical conditions. Thanks to the Affordable Care Act, as many as 17 million children with pre-existing conditions can no longer be denied health insurance."

PRO 2

Kate Thomas, New Media Campaign Coordinator at the Service Employees International Union (SEIU), posted in her Mar. 23, 2012 article "Children with Pre-existing Conditions Can No Longer Be Denied the Care They Need," available at www.seiu.org:

"Since September 23, 2010, children living with pre-existing health conditions can no longer be denied benefits or coverage by insurance companies, or even be limited in their treatment for a pre-existing condition."

PRO 3

The US Department of Health and Human Services stated in its Aug. 2, 2012 posting "Children's Pre-Existing Conditions," available at www.healthcare.gov:

"Under the Affordable Care Act, health plans cannot limit or deny benefits or deny coverage for a child younger than age 19 simply because the child has a 'pre-existing condition' — that is, a health problem that developed before the child applied to join the plan.

Until now, plans could refuse to accept anyone because of a pre-existing health condition, or they could limit benefits for that condition.

Now, under the health care law, plans that cover children can no longer exclude, limit, or deny coverage to your child under age 19 solely based on a health problem or disability that your child developed before you applied for coverage.

This rule applies to all job-related health plans as well as individual health insurance policies issued after March 23, 2010. The rule will affect your plan as soon as it begins a plan year or policy year on or after September 23, 2010."

12. Can adults get health insurance coverage under Obamacare despite having a pre-existing condition? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Part I - Health Insurance Market Reforms, "Sec. 2704 Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status," page 36, signed into law on Mar. 23, 2010, available at www.thomas.gov:

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.”

PRO 1

The Centers for Medicare and Medicaid Services (CMS) stated in their Feb. 23, 2012 annual report "Covering People with Pre-existing Conditions: Report on the Implementation and Operation of the Pre-existing Condition Insurance Plan Program," available at www.cciio.cms.gov:

“The law [PPACA] ends discrimination against people with pre-existing conditions. Insurers can no longer deny coverage to children because of a pre-existing condition and starting in 2014, refusing to cover anyone with a pre-existing condition is prohibited.”

PRO 2

Abby Matienzo, Communications Specialist at the National Academy of Elder Law Attorneys (NAELA), wrote in a Mar. 23, 2012 press release "National Academy of Elder Law Attorneys Celebrates Two-Year Anniversary of Affordable Care Act," available at www.naela.org:

"Coverage despite pre-existing conditions: In 2014, health insurance companies will no longer be able to deny coverage to beneficiaries due to a preexisting condition. Protections are already in place for certain individuals with pre-existing conditions, with the ACA's sponsorship of high-risk health insurance plans for individuals with pre-existing conditions. As of November 2011, 450,000 individuals were participating in these plans."

13. Under Obamacare, can insurance companies cancel coverage if a person gets sick? – NO

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2712, "Prohibition on Rescissions," page 13, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage."

CON 1

Sabrina Corlette, JD, Research Professor at the Health Policy Institute at Georgetown University, stated the following in an American Cancer Society pamphlet "Insurance Market Reforms," available at www.ascan.org (accessed Sep. 25, 2012):

"PPACA prohibits all health plans, including grandfathered plans, from rescinding a health insurance policy once an enrollee is covered, unless the enrollee has committed fraud or made an 'intentional misrepresentation of material fact' in his or her application. Before PPACA was enacted, health plans could — and often did — rescind policies when an enrollee became sick, if he or she — or her employer — made an unintentional mistake in filling out the paperwork.

PPACA also requires plans, if they do rescind a policy, to provide a minimum 30 days' notice to the enrollee."

CON 2

Mary Agnes Carey and Padmananda Rama, National Public Radio (NPR) reporters, stated in their July 28, 2012 article "Health Care Law Upheld: Now What?," available at www.npr.org:

"Health insurance providers can't cancel your coverage once you get sick – a practice known as 'rescission' – unless you committed fraud or intentionally withheld facts about your health when you applied for coverage."

14. Can children up to age 26 remain on their parent's health insurance? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2714, "Extension of Dependent Coverage," page 14, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age."

PRO 1

Jeremy A. Lazarus, MD, President of the American Medical Association, stated the following in his June 28, 2012 article "AMA: Supreme Court Decision Protects Much-Needed Health Insurance Coverage for Millions of Americans," available at www.ama-assn.org:

"The American Medical Association has long supported health insurance coverage for all, and we are pleased that this decision means millions of Americans can look forward to the coverage they need to get healthy and stay healthy..."

This decision protects important improvements, such as ending coverage denials due to pre-existing conditions and lifetime caps on insurance, and allowing the 2.5 million young adults up to age 26 who gained coverage under the law to stay on their parents' health insurance policies."

PRO 2

The *Huffington Post* stated in its June 28, 2012 article "Health Care Reform Ruling Means Young Adults Can Stay on Parents' Plans," available at www.huffingtonpost.com:

"As part of its landmark decision to uphold most of President Obama's health care law, the Supreme Court kept a provision that allows adult children to stay on their parents' health plans up until the age of 26..."

The measure covering adult children, one of the most recognizable elements of Obama's bill, would provide relief to young adults struggling to afford health insurance on their own."

**15. Does Obamacare require that retiree health plans cover children up to age 26? —
NO**

CON 1

The Segal Company, a consulting firm, stated in its Apr. 25, 2012 posting "Proposed Rule on the Affordable Care Act's Comparative Effectiveness Research Fees," available at www.segalco.com:

"...[R]etiree-only plans do not have to comply with many provisions in the Affordable Care Act (e.g., the group health plan standards, such as continuing coverage for dependent children to age 26)..."

CON 2

Maurice Hinchey, US Representative (D-NY), posted in his Nov. 1, 2011 press release "New Hinchey Bill Would Allow Parents with Retiree Health Plans to Extend Insurance Coverage to Children Up to Age 26," available at www.hinchey.house.gov:

"Retiree-only plans were exempted from many of the provisions of the Affordable Care Act, including the dependent coverage provision that allowed children to stay on their parents' health care plan through age 26."

CON 3

Annie L. Mach, Analyst in Health Care Financing at the Congressional Research Service, and Bernadette Fernandez, Specialist in Health Care Financing at the Congressional Research Service, wrote in their Nov. 1, 2011 study "Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)," available at www.crs.gov:

"...[F]or certain plans the ACA market reforms, as well as other federal health reforms, do not apply. For example, retiree-only health plans are not required to comply with federal health insurance requirements, such as the dependent coverage requirement..."

CON 4

Ellen E. Schultz, Investigative Reporter for the *Wall Street Journal*, and Jessica Silver-Greenberg, Money & Investing Reporter for the *Wall Street Journal*, wrote in their Oct. 9, 2010 article "Health Overhaul Overlooks Retirees," available at online.wsj.com:

"Thanks to a little-noticed clause in a 1996 law, retiree-only health plans are exempt from the Patient Protection and Affordable Care Act that went into effect last month.

That means the rule requiring health plans to extend dependent coverage to age 26, regardless of financial dependency, student status, employment or marital status, doesn't apply to millions of retirees' health benefits..."

16. Will lifetime or annual limits on health insurance coverage be eliminated? — YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2711, "No Lifetime or Annual Limits," page 13, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—
(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or
(2) unreasonable annual limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on the dollar value of benefits for any participant or beneficiary."

PRO 1

Health Reform in Minnesota stated the following in a Nov. 14, 2011 posting "Restrictions on Annual and Lifetime Limits," available at www.mn.gov:

"Health reform eliminates lifetime dollar maximums on most health plan benefits and places restrictions on annual dollar limits. The changes to annual limits are phased in over several years..."

No annual dollar limits are allowed on most covered benefits effective January 1, 2014.

The requirement to eliminate lifetime dollar limits applies to all plans. The annual limit restrictions apply to employer-based health plans, and to individual health insurance plans issued after March 23, 2010. Some plans are eligible for a waiver from the rules concerning annual dollar limits. To get the waiver, plans must show that increasing their annual limit would require a significant increase in premiums or decreased access to coverage."

PRO 2

The White House stated the following in its Mar. 16, 2012 article "Health Care & You," available at www.whitehouse.gov:

"End to Limits on Care: In the past, some people with cancer or other chronic illnesses ran out of insurance coverage because their health care expenses reached a dollar limit imposed by their insurance company. Under the health care law, insurers can no longer impose lifetime dollar limits on essential health benefits and annual limits are being phased out by 2014. More than 105 million Americans no longer have lifetime limits thanks to the new law."

17. Does Obamacare require insurers to offer coverage for treatment of mental illness? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1302, page 45, "Essential Health Benefits Requirements," signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories...

(E) Mental health and substance use disorder services, including behavioral health treatment."

PRO 1

Richard A. Friedman, MD, Professor of Psychiatry at Weill Cornell Medical College, wrote in his July 9, 2012 article "Good News for Mental Illness in Health Law," available at www.nytimes.com:

"Americans with mental illness had good reason to celebrate when the Supreme Court upheld President Obama's Affordable Care Act. The law promises to give them something they have never had before: near-universal health insurance, not just for their medical problems but for psychiatric disorders as well...

One of the health care act's pillars is to forbid the exclusion of people with pre-existing illness from medical coverage. By definition, a vast majority of adult Americans with a mental illness have a pre-existing disorder... These people have specifically been denied medical coverage by most commercial insurance companies — until now...

The Affordable Care Act treats psychiatric illness like any other and removes obstacles to fair and rational treatment."

PRO 2

Amanda K. Sarata, Specialist in Health Policy at the Congressional Research Service (CRS), stated in her Dec. 28, 2011 report "Mental Health Parity and the Patient Protection and Affordable Care Act of 2010," available at www.crs.gov:

"The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as modified by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010) contains a number of provisions that generally combine to extend the reach of existing federal mental health parity requirements. Prior to 1996, health insurance coverage for mental illness had historically been less generous than that for other physical illnesses. Mental health parity is a response to this disparity in insurance coverage, and generally refers to the concept that health insurance coverage for mental health services should be offered on par with covered medical and surgical benefits...

PPACA expands the reach of federal mental health parity requirements to three main types of health plans: qualified health plans as established by the ACA; Medicaid non-managed care benchmark and benchmark-equivalent plans; and plans offered through the individual market."

18. Will Obamacare require insurers to offer coverage for substance abuse? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1302, page 45, "Essential Health Benefits Requirements," signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories...

(E) Mental health and substance use disorder services, including behavioral health treatment."

PRO 1

The Arapahoe House, a non-medical detoxification facility, stated in its July 5, 2012 post "What Healthcare Reform and the Affordable Care Act Means for Arapahoe House, Colorado's Leading Nonprofit Provider of Drug and Alcohol Treatment," available at www.arapahoehouse.org:

"For the first time in history, the Affordable Care Act ensures that mental health and substance abuse treatment services are required benefits in all basic health insurance packages...

One of the biggest barriers to alcohol and drug treatment is lack of health insurance. With the individual mandate and expansion of Medicaid coverage upheld by the Supreme Court, the Affordable Care Act is a paradigm shift for substance use disorder treatment."

PRO 2

Deni Carise, PhD, Chief Clinical Officer of Phoenix House, stated in her July 2, 2012 article "Affordable Care Act Upheld: A Big Win for Addiction Treatment," available at www.huffingtonpost.com:

"...[T]he Affordable Care Act will help the addiction and recovery community in several significant ways. In sum, it comes down to one word: choice. Millions of previously uninsured Americans will now have health care coverage..."

PRO 3

The White House stated the following on its webpage "Substance Abuse and the Affordable Care Act," available at www.whitehouse.gov (accessed Sep. 6, 2012):

"The ACA includes substance use disorders as one of the ten elements of essential health benefits. This means that all health insurance sold on Health Insurance Exchanges or provided by Medicaid to certain newly eligible adults starting in 2014 must include services for substance use disorders.

By including these benefits in health insurance packages, more health care providers can offer and be reimbursed for these services, resulting in more individuals having access to treatment. The specific substance abuse services that will be covered are currently being determined by the Department of Health and Human Services, and will take into account evidence on what services allow individuals to get the treatment they need and help them with recovery."

19. Does Obamacare require dental coverage for children? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1401, "Refundable Tax Credit Providing Premium Assistance for Coverage under a Qualified Health Plan," page 97, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan."

PRO 1

The US Department of Health and Human Services, in a fact sheet "Families with Children and the Affordable Care Act," (accessed Oct. 10, 2012), available at www.healthcare.gov, stated:

"Pregnancy and newborn care, along with vision and dental coverage for children, will be covered in all Exchange plans and new plans sold to individuals and small businesses, starting in 2014."

PRO 2

The American Dental Association, in a July 17, 2012 statement, "Affordable Care Act after the Supreme Court Decision: Impact on Dentistry," available at www.vsds.org, wrote:

"The Supreme Court decision allows the federal government to move forward with ACA implementation, including the requirement that health care exchanges be in place in each state by January 1, 2014. As a result, unless federal action changes things, millions more children will have dental coverage from private and public sector health plans in 2014."

PRO 3

The Children's Dental Health Project, in a June 28, 2012 press release, "Supreme Court Upholds Affordable Care Act," available at www.cdhp.org, stated:

"In a landmark decision, the Supreme Court ruled today to uphold the Patient Protection and Affordable Care Act (ACA) by a vote of 5 to 4. This historic decision ensures that affordable health coverage will be made available to millions of Americans, including nearly 8 million children who will be eligible for dental coverage through the state health insurance exchanges free of annual and lifetime caps."

PRO 4

The National Conference of State Legislatures, in an Apr. 19, 2012 newsletter article, "Dental Insurance Coverage for Kids Increases," available at www.ncsl.org, stated:

"The PPACA requires insurance plans in the state health insurance exchanges to provide coverage for children's oral health services as an essential health benefit. Children who receive health coverage through the exchanges will have dental coverage when the exchanges are operational in 2014. States will determine the scope of that coverage, however. In addition, the PPACA allows for both stand-alone dental plans and dental plans that exclusively offer pediatric dental benefits to participate in state health insurance exchanges."

20. Does Obamacare require dental coverage for adults? – NO

NOT CLEARLY PRO OR CON 1

Health Care.gov, a federal government website managed by the US Centers for Medicare & Medicaid Services, stated the following on its webpage, “Can I Get Dental Coverage in the Marketplace?,” available at healthcare.gov (accessed July 31, 2013):

"Under the health care law, dental insurance is treated differently for adults and children 18 and under.

Dental coverage for children is an essential health benefit. This means it must be available to you either as part of a health plan or as a free-standing plan. This is not the case for adults. Insurers don't have to offer adult dental coverage...

In the Marketplace, dental coverage will be included in some health plans. You'll be able to see which plans include dental coverage when you compare them. You'll also see what the dental benefits are. If a health plan includes dental coverage, you will pay one premium for everything. The premium shown for the plan includes both health and dental coverage...

In some cases separate, stand-alone plans will be offered.."

CON 1

The *Los Angeles Times*, stated the following in its July 15, 2013 editorial, “An Obamacare Insurance Exchange Gap,” available at latimes.com:

“The 2010 Patient Protection and Affordable Care Act, better known as Obamacare, requires health insurance policies to cover 10 ‘essential health benefits,’ such as hospital stays, outpatient treatments and maternity care. Those essential benefits also include pediatric — but not adult — dental and vision care.”

CON 2

J. Thomas Russell, DDS, general dentist, on Mar. 5, 2011 wrote in his article "Obamacare Omits Dental Care" on www.soundentistry.com:

"The Regulations determine how the program will be administered, are still being created -- but they only deal with children's dentistry. If you are an adult, to use the President's favorite phrase: ‘You're on your Own.’

The Reform of the US Health Care System, when it is fully implemented, will require everyone to purchase a Medical Insurance Policy. This feature is the so-called Individual Mandate that will insure the medical needs of everyone.

However there is no individual Mandate for DENTAL CARE, only a provision for children's dental care after 2014.”

CON 3

The National Association of Dental Plans stated the following in a Sep. 2011 whitepaper abstract, "Offering Dental in Health Exchanges: A Roadmap for State and Federal Policymakers," available at nadp.org:

"The ACA [Affordable Care Act] expressly allows the offering of standalone dental plans -- both child only and adult policies -- in Exchanges. This reflects the current dental plan market, wherein a vast majority of Americans access dental coverage under a policy that is separate from their medical coverage. While adult dental coverage may be purchased, the premium and cost sharing subsidies included as part of the ACA will only be applied to the purchase of benefits necessary to meet the 'pediatric oral services' requirement of EHBP [Essential Health Benefits Package] in the American Health Benefits Exchange. Adults eligible for subsidies for their medical coverage who wish to purchase dental coverage must pay for the full cost of their dental policies."

21. Will individuals currently covered by veterans' health benefits be considered covered under Obamacare? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 5000A, page 126, "Requirement to Maintain Minimum Essential Coverage," signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(1) IN GENERAL.—The term ‘minimum essential coverage’ means any of the following...

(iv) the TRICARE for Life program...

(v) the veteran's health care program under chapter 17 of title 38, United States Code..."

PRO 1

The US Department of Health and Human Services stated in its Sep. 20, 2011 article "I'm Covered by Veterans Health Benefits. Will I Be Considered Covered in 2014?," available at www.healthcare.gov:

"If you are covered by VA health benefits, you are considered covered under the Affordable Care Act."

PRO 2

The Democratic Policy and Communications Center posted on its webpage "How the Patient Protection and Affordable Care Act Will Help Service Members, Veterans, and Their Families," available at www.dpcc.senate.gov (accessed Sep. 5, 2012):

"The Patient Protection and Affordable Care Act clarifies that those covered by VA health care, TRICARE, or TRICARE for Life meet the individual responsibility requirement, and therefore exempts veterans and service members and their dependents from any penalty."

22. Does Obamacare cover alternative medicine? – DEBATED

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2706, "Non-Discrimination in Health Care," page 42, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(a) PROVIDERS. - A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

NOT CLEARLY PRO OR CON 1

Ankita Rao, Reporter at Kaiser Health News, stated the following in her July 29, 2013 article "Alternative Treatments Could See Wide Acceptance Thanks to Obamacare," available at pbs.org:

"One clause of the health law in particular -- Section 2706 -- is widely discussed in the alternative medicine community because it requires that insurance companies 'shall not discriminate' against any health provider with a state-recognized license. That means a licensed chiropractor treating a patient for back pain, for instance, must be reimbursed the same as medical doctors. In addition, nods to alternative medicine are threaded through other parts of the law in sections on wellness, prevention and research...

...[U]nder the health care law each state defines its essential benefits plan -- what is covered by insurance -- somewhat differently, the language concerning alternative medicine has to be very specific in terms of who gets paid and for what kinds of treatment."

NOT CLEARLY PRO OR CON 2

The American Holistic Health Association posted on its webpage "AHHA Featured Issue July 20, 2012," available at www.ahha.org:

"Will more complementary and alternative medicine (CAM) type healthcare modalities be covered by ACA? This could happen if the healthcare providers are licensed professionals. But this doesn't look very promising. Federal subsidies for state Medicaid programs can only be used for 'essential health benefits,' which are defined as medically necessary services. States will not be reimbursed for CAM services, which at best cover licensed chiropractors and acupuncturists and only for a limited number of visits.

The ACA [Affordable Care Act] is touted as expanding the reach of innovative, preventive and treatments that promote healing and health. A review of the law shows, however, that the only wellness

and preventive items covered are standard medical screenings and immunizations, and these only if delivered by licensed medical personnel."

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>John Weeks, Publisher and Editor of "Integrator Blog News & Reports," wrote in his May 6, 2012 article "The Supreme Court and Health Reform: Much Is at Stake for Integrative Medicine," available at www.huffingtonpost.com:</p> <p>“Over the last 30 years, many so-called complementary and alternative medicine (CAM) or integrative health care practitioners have gained or advanced inclusion in state licensing, state-mandated insurance coverage schemes and other state policies such as pain commissions and loan forgiveness for serving the underserved. Among these are chiropractors, massage therapists, acupuncturists, direct-entry midwives and naturopathic doctors... Section 3502 of the law [PPACA], on patient-centered medical homes (PCMHs), specifically denotes that these multidisciplinary practices may include chiropractors and licensed complementary and alternative medicine practitioners in their community-based, team care models.”</p> <p style="text-align: center;">PRO 2</p> <p>The Consortium of Academic Health Centers for Integrative Medicine (CAHCIM), in an Aug. 13, 2012 article, "Consortium of Academic Health Centers for Integrative Medicine Declares Support for Affordable Care Act's Non-discrimination Section Urged by Licensed CAM Professionals," available at www.integrativepractitioner.com, stated:</p> <p>"The Consortium of Academic Health Centers for Integrative Medicine (CAHCIM) sent a July 6, 2012 newsletter to members in support of the historic Supreme Court ruling upholding the</p>	<p style="text-align: center;">CON 1</p> <p>Erik Goldman, Editor of HolisticPrimaryCare.net,“ was quoted in a July 19, 2012 article "Affordable Care Act and Access to Integrative Medicine-What Does it Really Mean?," by Glen Sabin, Board Member of the Society for Integrative Oncology, available at www.fontherapeutics.com:</p> <p>“It [ACA] really doesn’t provide much fiscal support for holistic services. The health insurance industry has made a miserable hash out of conventional medicine - which already has a reductionist, treat-the-numbers, protocol-driven mindset. One can reasonably expect that this effect will be even worse on holistic/functional/integrative medicine because insurance plan thinking is quite antithetical to holistic, individualized, health-oriented thinking.”</p> <p style="text-align: center;">CON 2</p> <p>Jann Bellamy, JD, Founder of the Campaign for Science-Based Healthcare, in an Oct. 4, 2012 article "Obamacare and CAM [Complementary Alternative Medicine] II: Discrimination (or Not) Against CAM," available at www.sciencebasedmedicine.org, wrote:</p> <p>"...now that everyone will have insurance coverage, I wonder how long it will take patients to figure out that, if they go to an M.D., D.O., or A.R.N.P as their PCP [Primary Care Physician], their diagnosis and treatment is covered, but when they go to an N.D. [Doctor of Naturopathic Medicine] as their PCP, not all of their diagnoses and treatments are covered."</p>

<p>Affordable Care Act' and which 'expands health care coverage to millions of Americans.' The notice shared that one reason for the support is that 'the Act provides third party payer coverage for any health professional licensed in a given state.' (Section 2706, Non-Discrimination in Health Care, would require inclusion of licensed complementary and alternative healthcare professionals in coverage schemes.)</p>	
<p>The CAHCIM newsletter also shared that the vision of the Consortium is aligned with the law's expansion of 'the reach of innovative preventive and treatment approaches designed to help Americans achieve better health through integrated approaches that promote healing and health in every individual and community.'"</p>	

23. Does Obamacare require insurance plans to have a minimum basic coverage level? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1302, "Essential Health Benefits Requirements," page 45, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorder services, including behavioral health treatment.
- (F) Prescription drugs.
- (G) Rehabilitative and habilitative services and devices.
- (H) Laboratory services.
- (I) Preventive and wellness services and chronic disease management.
- (J) Pediatric services, including oral and vision care."

PRO 1

The Congressional Research Service (CRS) stated the following in its Apr. 15, 2010 report "Private Health Insurance Provisions in PPACA," available at www.bingaman.senate.gov:

"PPACA... sets minimum standards for health coverage...

These standards will affect private health insurance in the individual, small group, and large group markets, depending on the standard... and require coverage for specified categories of benefits...

The Secretary will specify the 'essential health benefits' included in the 'essential health benefits package' that QHPs will be required to cover (effective beginning in 2014). Essential health benefits will include at least the following general categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness and chronic disease management; and
- pediatric services, including oral and vision care.

Coverage provided for the essential health benefits package will provide bronze, silver, gold, or platinum level of coverage...

A health plan will be allowed to provide benefits in excess of the essential health benefits defined by the Secretary."

24. Will Obamacare require health insurers to present health insurance information in clear and easily understandable terms? — YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2715, page 14, "Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions," signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(a) IN GENERAL.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholders or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage...

(b) REQUIREMENTS.—The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

(1) APPEARANCE.—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee."

PRO 1

The US Department of Health and Human Services stated its Aug. 17, 2011 article "Providing Clear and Consistent Information to Consumers About Their Health Insurance Coverage," available at www.healthcare.gov:

"Under section 2715 of the Public Health Service Act, created by section 1001 of the Affordable Care Act and implemented in the new rules announced today, health insurers and group health plans will provide clear, consistent and comparable information about health plan benefits and coverage to the millions of Americans with private health coverage. Specifically, the rules ensure consumers receive two key forms that will help them understand and evaluate their health insurance choices:

- A short, easy-to-understand Summary of Benefits and Coverage (or 'SBC'); and
- A list of definitions (called the 'Uniform Glossary') that explains terms commonly used in health insurance coverage such as 'deductible' and 'co-payment.'"

PRO 2

Blue Shield of California stated in its Feb. 9, 2012 "Recent News," available at www.blueshieldca.com:

"The ACA requires that all health carriers use standard definitions and terms provided by HHS to create uniform explanation of coverage documents. These new documents are intended to enable consumers to more easily understand the coverage they already have and help them make 'apples-to-apples' comparisons of available options when purchasing new coverage."

25. Does Obamacare apply to health plans offered by colleges and universities? — YES

General Reference 1

The Patient Protection and Affordable Care Act, Section 1560, "Rules of Construction," page 144, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(c) STUDENT HEALTH INSURANCE PLANS.--Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for

purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law."

PRO 1

The US Department of Health and Human Services stated in its Feb. 9, 2011 press release "New Rule Ensures Students Get Health Insurance Protections of the Affordable Care Act," available at www.hhs.gov:

"A new proposed regulation announced today by the Department of Health and Human Services (HHS) would ensure students enrolled in health insurance coverage through their college or university benefit from critical consumer protections created by the Affordable Care Act. Students enrolled in college plans would have the freedom from worrying about losing their insurance, or having it capped unexpectedly if they are in an accident or become sick..."

The proposed regulation would ensure students enrolled in these plans benefit from important consumer protections created by the Affordable Care Act by clarifying that these plans will be defined as 'individual health insurance coverage.'"

PRO 2

The White House stated in its Mar. 19, 2012 document "The Affordable Care Act Helps Young Adults," available at www.whitehouse.gov:

"The new health care law replaces the patchwork system of regulating student health plans, helping ensure that students enrolled in these plans benefit from important consumer protections in the Affordable Care Act, including preventive services. The new law also helps students better understand what their student health covers, and what other insurance options may be available..."

The new law also restricts the use of annual limits, including on student health plans and bans them completely in 2014..."

26. Will Obamacare result in fewer people with health care insurance? – DEBATED

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Greg Scandlen, Founder of Consumers for Health Care Choices, wrote in his Sep. 6, 2012 article "Will ObamaCare Really Insure the Uninsured?," available at www.healthblog.ncpa.org:</p>	<p style="text-align: center;">CON 1</p> <p>The Congressional Budget Office stated in its July 2012 report to Congress, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court</p>

“Why bother paying for insurance if you can get it instantly if and when you need it? That is just money down the toilet. Why would anybody do that?”

The tax penalties of the ACA are trivial, the subsidies are complicated, and the available plans will provide little value to most people. I don’t need coverage for psych counseling and in vitro fertilization.

This is how many (most?) people think. So, I therefore believe the ACA will result in FEWER people being covered, not more.

We know, for instance, that one-third of the uninsured are already eligible for free coverage through Medicaid or SCHIP. Yet they do not enroll. What has changed to get them to enroll now?

We know that mandates never work. Typically 15% of the population ignores them. This is true of helmet laws, auto insurance laws, child support laws, even taxes. In some cases the penalty for violating them is severe, including jail time for the latter two. Yet still people violate them.”

PRO 2

John Merline, Senior Writer at *Investor's Business Daily*, wrote in his July 25, 2012 article “Could ObamaCare Make the Uninsured Problem Worse?,” available at news.investors.com:

“ObamaCare will likely cover far fewer uninsured than advertised. There's even a chance that, if all goes wrong, it could actually make the uninsured problem worse.

The individual mandate, for example, is a cornerstone of ObamaCare's effort to expand coverage. But tax experts who've studied how the IRS will enforce the mandate conclude that it's likely to be ineffective, because the law makes it

Decision,” available at www.cbo.gov:

"CBO and JCT [Joint Committee on Taxation] now estimate that the ACA, in comparison with prior law before the enactment of the ACA, will reduce the number of nonelderly people without health insurance coverage by 14 million in 2014 and by 29 million or 30 million in the latter part of the coming decade...

The share of legal nonelderly residents with insurance is projected to rise from 82 percent in 2012 to 92 percent by 2022. According to the current estimates, from 2016 on, between 23 million and 25 million people will receive coverage through the exchanges, and 10 million to 11 million additional people will be enrolled in Medicaid and CHIP as a result of the ACA."

CON 2

The US Census Bureau, states in its Sep. 2012 report, "Income, Poverty, and Health Insurance Coverage in the United States: 2011," available at www.census.gov:

"In 2011, the percentage of people without health insurance decreased to 15.7 percent from 16.3 percent in 2010. The number of uninsured people decreased to 48.6 million, down from 50.0 million in 2010.

... Among those aged 18 to 24 in 2010, the rate [of people who were uninsured] decreased to 27.2 percent from 29.3 percent in 2009... These age groups are of special interest because of the Affordable Care Act of 2010. Children under the age of 19 are eligible for Medicaid/CHIP and individuals aged 19 to 25 may be a dependent on a parent’s health plan."

CON 3

Kevin Drum, Writer for *Mother Jones*, wrote in his Sep. 12, 2012 article "Thanks to Obamacare, the Ranks of the Uninsured Fell This Year," available

virtually impossible for the IRS to collect the tax penalty from those who don't pay it...

The problem is that if the mandate doesn't work, ObamaCare could make the uninsured problem worse, at least in the individual insurance market.

That's because ObamaCare's insurance market reforms — called 'guaranteed issue' and 'community rating' — force insurers to cover anyone, regardless of their health status, while forbidding them from charging the sick more than the healthy."

PRO 3

Tony Francis, MD, orthopaedic surgeon, stated in his Aug. 7, 2012 article "ObamaCare the Death Star. Domsday Machine Creating More Uninsured," available at www.boards.medscape.com:

"...there is a distinct possibility that ObamaCare will actually increase the number of uninsured. The Congressional Budget Office (CBO) is projecting there will be 30 million uninsured after the implementation of ObamaCare. What's up with that? I thought for all the effort, we would be insuring everyone. That assumes everything goes according to plan. But it could get worse. Since companies may end up paying a fine of a few thousand dollars, many are itching to dump their workers onto either Medicaid or the exchanges. But with no ability of the feds to make states pay for Medicaid, those workers will be out in the cold. As in 'no insurance.'

...If a company pays \$10,000 dollars to insure a worker, but can pay \$2,000 and dump them on Medicaid, that is what they will do. If the state doesn't have Medicaid, then the worker becomes uninsured."

at www.motherjones.com:

"For the first time in three years, the proportion of Americans with health insurance rose, from 83.7 percent in 2010 to 84.3 percent in 2011.

And what explains the shift? The breakdown by age offers some clues. Relative to last year, the percentage of young adults with health insurance rose by 2.2 percent. That was the largest increase of any group. And it was the second year in a row that coverage among young adults increased.... As you probably know, the Affordable Care Act allows young adults to enroll on their parents' health insurance plans if they have no access to coverage on their own. That provision surely doesn't account for all of the young adults getting coverage. But it almost certainly explains a lot of it."

27. Does Obamacare allow individuals to appeal medical service denials? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2719, page 19, "Appeals Process," signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

- (1) have in effect an internal claims appeal process;
- (2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and
- (3) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.”

PRO 1

The US Department of Health and Human Services stated in its June 15, 2012 posting "Has Your Health Insurer Denied Payment for a Medical Service? You Have a Right to Appeal," available at www.healthcare.gov:

"The Affordable Care Act, the health care reform law passed in 2010, requires many health plans to meet basic standards regarding internal appeals and external review processes...

- **Right to information about why a claim or coverage has been denied.** Health plans and insurance companies have to tell you why they've decided to deny a claim or chosen to end your coverage. They have to let you know how you can dispute decisions.
- **Right to appeal to the insurance company.** If you've had a claim denied or had your health insurance coverage cancelled or rescinded back to the date you initially enrolled, you have the right to an internal appeals process. You may ask your insurance company to conduct a full and fair review of its decision. If the case is urgent, your insurance company must speed up this process.
- **Right to an independent review.** In many cases, you may be able to resolve your problem during the internal appeals process with your insurer. But you have other options if you can't work it out through the internal appeals process. You now have the right to take your appeal to an independent third-party for review of the insurer's decision. This is called 'external review.' External review means that the insurance company no longer gets the final say over many benefit decisions. It also means patients and doctors have more control over health care."

PRO 2

The Federal Registrar stated on its webpage "Internal Claims, Appeals, and External Review Processes Under the Affordable Care Act," available at www.federalregister.gov (last updated Feb. 11, 2011):

"The Affordable Care Act provides consumers with the right to appeal decisions made by their health carrier to an outside, independent decisionmaker, regardless of the State of residence or type of health insurance. Under interim final regulations issued earlier this year, non-grandfathered plans and issuers must comply with a State external review process or the Federal external review process."

--Medicare/Medicaid--

28. Does Obamacare do a good thing and save \$716 billion in Medicare expenses (pro side) or do a bad thing and cut \$716 billion from Medicare (con side)? – DEBATED

[**Editor's Note:** Provisions relating to Medicare funding can be found in The Patient Protection and Affordable Care Act, Title III, "IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE," from page 235-420. Some of the areas in Title III where Medicare funding is discussed include the following: Part I, "LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM," Subtitle B, "Improving Medicare for Patients and Providers," Subtitle D, "Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans," Subtitle E, "Ensuring Medicare Sustainability," and Subtitle G, "Protecting and Improving Guaranteed Medicare Benefits."

In addition to the various provisions pertaining to Medicare funding in Title III, additional changes to Medicare funding are made in Title IV, "Transparency and Program Integrity," in Subtitle E, "Medicare, Medicaid, and CHIP Program Integrity Provisions," starting on page 629.]

NOT CLEARLY PRO OR CON 1

Mary Agnes Carey, MA, Kaiser Health News Staff Writer, stated the following in her Aug. 17, 2012 article "FAQ: Decoding the \$716 Billion in Medicare Reductions," available at www.kaiserhealthnews.org:

"Romney and other Republicans over the past two years have criticized President Barack Obama and Democrats for cutting \$500 billion from the Medicare program over the next decade as part of the 2010 health care law. In the past couple of weeks, the number that Romney is using has grown to \$716 billion..."

...The \$500 billion figure comes from a March 2010 analysis that estimated the 2010 federal health law's effects on Medicare spending and was put together by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT). It covered the budget years 2010-2019.

As part of their efforts to repeal the law, congressional Republicans in July asked the two agencies to estimate the impact of a repeal on Medicare.

That July analysis, which covered the years 2013-2022, determined that the health law is expected to reduce Medicare spending by \$716 billion. It is higher than the previous figure because it covers a later time frame that includes greater Medicare spending reductions...

The July report from CBO and JCT -- in explaining where some of the biggest reductions would occur - found that hospital reimbursements would be reduced by \$260 billion from 2013-2022, while federal payments to Medicare Advantage, the private insurance plans in Medicare, would be cut by approximately \$156 billion. Other Medicare spending reductions include \$39 billion less for skilled nursing services; \$66 billion less for home health and \$17 billion less for hospice. The law does not make any cuts to the amount of benefits beneficiaries receive and adds some new benefits, including closing the 'doughnut hole' gap in Medicare prescription drug coverage, and new preventive services, such as an annual wellness visit with a physician."

PRO (Obamacare saved Medicare money)	CON (Obamacare cut Medicare money)
<p style="text-align: center;">PRO 1</p> <p>Barack Obama, 44th President of the United States, stated the following during the Oct. 3, 2012 Presidential debate in Denver, CO, "Transcript and Audio: First Obama-Romney Debate," www.npr.org:</p> <p>"...[I]n Medicare, what we did was we said, we are going to have to bring down the costs if we're going to deal with our long term deficits, but to do that, let's look where some of the money is going. Seven hundred and sixteen billion dollars we were able to save from the Medicare program by no longer overpaying insurance companies, by making sure that we weren't overpaying providers. And using that money, we were actually able to lower prescription drug costs for seniors by an average of \$600, and we were also able to make a — make a significant dent in providing them the kind of preventive care that will ultimately save money through the — throughout the system."</p> <p style="text-align: center;">PRO 2</p> <p>John E. McDonough, DPH, Director of the Center for Public Health Leadership at the Harvard School of Public Health, wrote in his Aug. 12,</p>	<p style="text-align: center;">CON 1</p> <p>Mitt Romney, JD, Presidential Candidate, stated the following at an Aug. 14, 2102 campaign event quoted by Tim Cohen, CNN Reporter in the Aug. 15, 2012 article "Obama, Romney Spar over Medicare in Battleground States," available at www.cnn.com:</p> <p>"When he ran for office he said he'd protect Medicare, but did you know that he has taken \$716 billion out of the Medicare trust fund -- he's raided that trust fund -- and you know what he did with it... He's used it to pay for Obamacare -- a risky, unproven, federal government takeover of health care -- and if I'm president of the United States we're putting the \$716 billion back."</p> <p style="text-align: center;">CON 2</p> <p>Karl Rove, former Senior Adviser and Deputy Chief of Staff to President George W. Bush, wrote in an Aug. 15, 2012 article "The GOP's Medicare Advantage," available at www.online.wsj.com:</p> <p>"The president's legislation cuts Medicare by \$716 billion to pay for ObamaCare. But because so many baby boomers are turning 65, Medicare is</p>

<p>2012 article “The Republican Candidate Said that President Obama ‘Robbed’ Medicare of \$716 Billion to Pay for ObamaCare/the Affordable Care Act (ACA). Sounds Serious. Is It True?,” available at www.boston.com:</p> <p>“According to Romney, Obama went into the ‘Medicare Trust Fund’ room in the Treasury Department walked out with 716 really, really big ones, and leaving the Trust Fund depleted by that amount, jeopardizing its solvency for more than 40 million senior citizens and disabled persons. Sounds nefarious.</p> <p>Not quite.</p> <p>No money from the ‘Trust Fund’ was withdrawn. By reducing rates paid to hospitals, health insurance plans, and other medical providers (not physicians, by the way -- a mistake being made by media all over the place), the ‘draw’ out of the fund is reduced by \$716 billion between federal fiscal years 2013-22 (it was \$449 billion between 2010-19 when the ACA was signed in Mar. 2010). If the ACA is implemented as passed, then \$716B less will be withdrawn over those ten years, meaning the Medicare Trust Fund will have about eight more years of solvency than if the ACA had not been signed into law.</p> <p>That's the truth. Honest. It's the difference between eating into your savings account (what Romney charges) versus reducing your spending so that you don't have to (what the ACA does).”</p>	<p>going broke. (Thanks in part to ObamaCare cuts, Medicare's hospital trust fund will be insolvent by 2024, according to the Social Security and Medicare Boards of Trustees.)</p> <p>Rather than steal from the health-care program for seniors to finance expanding health care for younger Americans, Mr. Romney would repeal ObamaCare and return that \$716 billion to Medicare to shore up its ragged finances...”</p>
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29. Will Obamacare’s cuts to Medicare reduce benefits for Part A (hospital care), Part B (outpatient care), and Medicare Advantage Part C? – DEBATED

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Betsy McCaughey, PhD, Former Lt. Governor of New York State wrote in her Sep. 12, 2012 article “ObamaCare's Cuts to Hospitals Will Cost Seniors</p>	<p style="text-align: center;">CON 1</p> <p>Sarah Kliff, Health Policy Reporter for the Washington Post, wrote in her Aug. 14, 2012 article “Romney’s right: Obamacare Cuts</p>

Their Lives,” available at www.FoxNews.com:

“President Obama is wooing seniors with promises to protect Medicare as they've known it. On the defensive because of the \$716 billion his health care law takes from Medicare, Obama assures seniors he's cutting payments to hospitals and other providers, not their benefits.

Don't be bamboozled. It's illogical to think that reducing what a hospital is paid to treat seniors won't harm their care. A mountain of scientific evidence proves the cuts will worsen the chance that an elderly patient survives a hospital stay and goes home. It's reasonable to conclude that tens of thousands of seniors will die needlessly each year.

Under ObamaCare, hospitals, hospice care, dialysis centers, and nursing homes will be paid less to care for the same number of seniors than if the health law had not been enacted. Payments to doctors will also be cut."

PRO 2

Paul Ryan, US Representative (R-WI), stated in his Aug. 29, 2012 acceptance speech at the Republican National Convention. The video of the speech is available online at www.politico.com:

"You see, even with all the hidden taxes to pay for the health care takeover, even with new taxes on nearly a million small businesses, the planners in Washington still didn't have enough money. They needed more. They needed hundreds of billions more. So, they just took it all away from Medicare. Seven hundred and sixteen billion dollars, funneled out of Medicare by President Obama. An obligation we have to our parents and grandparents is being sacrificed, all to pay for a new entitlement we didn't even ask for. The greatest threat to Medicare is Obamacare, and we're going to stop it..."

PRO 3

Medicare by \$716 Billion. Here's How,” available at www.washingtonpost.com:

“The Medicare Advantage cut gets the most attention, but it only accounts for about a third of the Affordable Care Act’s spending reduction. Another big chunk comes from the hospitals. The health law changed how Medicare calculates what they get reimbursed for various services, slightly lowering their rates over time. Hospitals agreed to these cuts because they knew, at the same time, they would likely see an influx of paying patients with the Affordable Care Act’s insurance expansion.

The rest of the Affordable Care Act’s Medicare cuts are a lot smaller. Reductions to Medicare’s Disproportionate Share Payments — extra funds doled out the hospitals that see more uninsured patients — account for 5 percent in savings. Lower payments to home health providers make up another 8.8 percent. About a dozen cuts of this magnitude make up [the rest]...

It’s worth noting that there’s one area these cuts don’t touch: Medicare benefits. The Affordable Care Act rolls back payment rates for hospitals and insurers. It does not, however, change the basket of benefits that patients have access to.”

CON 2

Rick Ungar, *Forbes* Contributor, wrote in his Sep. 25, 2010 article "Does Obamacare Really Cut Medicare Benefits to Senior Citizens?," available at www.forbes.com:

“Among the many narratives injected into the public debate over health care reform, I find the most disturbing to be the notion that our senior citizens will experience cuts in their Medicare benefits as a result of Obamacare...

It simply isn't going to happen...

As of September 23, 2010, seniors are entitled –

Alyene Senger, Research Assistant at the Heritage Foundation, wrote in her article “Obamacare Robs Medicare of \$716 Billion to Fund Itself,” published by the Heritage Foundation Blog on Aug. 1, 2012 at www.blog.heritage.org:

“In total, Obamacare raids Medicare by \$716 billion from 2013 to 2022. Despite Medicare facing a 75-year unfunded obligation of \$37 trillion, Obamacare uses the savings from the cuts to pay for other provisions in Obamacare, not to help shore up Medicare’s finances.

The impact of these cuts will be detrimental to seniors’ access to care. The Medicare trustees 2012 report concludes that these lower Medicare payment rates will cause an estimated 15 percent of hospitals, skilled nursing facilities, and home health agencies to operate at a loss by 2019, 25 percent to operate at a loss in 2030, and 40 percent by 2050. Operating at a loss means these facilities are likely to cut back their services to Medicare patients or close their doors, making it more difficult for seniors to access these services.”

PRO 4

Jim DeMint, US Senator (R-SC), wrote in a Aug. 27, 2012 post titled "President Obama's Two-fold Dishonesty on Cutting Medicare Benefits" available at www.demint.senate.gov:

“...the President said that 'I've proposed reforms that will save Medicare money by getting rid of wasteful spending in the health care system. Reforms that will not touch your Medicare benefits.'

There’s only one problem: That statement is flat-out FALSE. The President HAS enacted cuts to Medicare benefits -- namely, additional means-testing in Obamacare --and proposed even more Medicare benefit cuts...

...the fundamental problem is the President’s twofold dishonesty when it comes to cutting

free of charge – to an annual physical along with free diagnostic tests such as mammograms and colonoscopies. No co-payments... no changes in deductibles... no increase in Part B premiums... no need for anything beyond your ‘run of the mill’ Medicare participation...

Let us assume for the moment that, as a result of receiving much lower payment rates from Medicare, some Medicare Advantage programs cease operating or diminish their benefits to the detriment of their customers. What, exactly, will these beneficiaries lose? Medicare Advantage participants may lose their health club memberships, and possibly, their vision and dental, all of which they will still have the opportunity to buy if they are willing to pay an additional premium..."

CON 3

The Kaiser Family Foundation wrote in its issue brief, “Summary of Key Changes to Medicare in 2010 Health Reform Law,” available online at www.kff.org (accessed Sep. 6, 2012):

“...[Obamacare] improves coverage of prevention benefits. Beginning in 2011, no coinsurance or deductibles will be charged in traditional Medicare for preventive services that are rated A or B by the U.S. Preventive Services Task Force (USPSTF). Medicare will cover a free annual comprehensive wellness visit and personalized prevention plan...

Authorizes Medicare coverage of personalized prevention plan services, including an annual comprehensive health risk assessment, beginning January 1, 2011.”

CON 4

The US Department of Health & Human Services on Aug. 20, 2012 wrote in a press release “People with Medicare Save More than \$4.1 Billion on Prescription Drugs,” available online at www.hhs.gov:

<p>Medicare benefits. First, in saying that he hasn't proposed cutting Medicare benefits when he has. Second, and just as importantly, in the way he has proposed cutting those benefits -- all the benefit changes the President proposed in his budget would not take effect until 2017, after he leaves office."</p>	<p>"During the first seven months of 2012, the new health care law has helped nearly 18 million people with original Medicare get at least one preventive service at no cost...</p> <p>Prior to 2011, people with Medicare had to pay extra for many preventive health services. These costs made it difficult for people to get the health care they needed. For example, before the health care law passed, a person with Medicare could pay as much as \$160 for a colorectal cancer screening. Now, many preventive services are offered free of charge to beneficiaries, with no deductible or co-pay, so that cost is no longer a barrier for seniors who want to stay healthy and treat problems early.</p> <p>In 2012 alone, 18 million people with traditional Medicare have received at least one preventive service at no cost to them..."</p>
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30. Will Obamacare's cuts to Medicare Part C (Medicare Advantage) lead to a decrease in patient benefits? – DEBATED

GENERAL REFERENCE 1

Kate Pickert, Staff Writer for *Time*, wrote in her Aug. 16, 2012 article "Fact Check: Obamacare's Medicare Cuts," available online at www.swampland.time.com:

"Under the ACA, the federal government will substantially reduce the amount it spends funding Medicare Advantage, which is privately administered insurance offered to Medicare beneficiaries. About one-quarter of Medicare recipients are enrolled in private Medicare Advantage. In theory, these plans are supposed to manage health care spending better than fee-for-service Medicare. But they don't actually save the federal government any money. They cost, per patient, 14% more than traditional Medicare... The ACA eliminates this subsidy and pegs Medicare Advantage payments to quality metrics."

NOT CLEARLY PRO OR CON 1

Amanda Cassidy, Principal at Meitheal Health Policy, LLC, stated in her May 20, 2010 article "Health Policy Brief: Health Reform's Changes in Medicare," available at www.healthaffairs.org:

"Within several years, for example, some payments to Medicare Advantage plans will be cut, but those plans will be eligible for bonuses if they can show that they provide high-quality health care..."

The federal government pays more for beneficiaries enrolled in these plans than for beneficiaries in fee-for-service Medicare. That additional funding provides enrollees with additional benefits... As the Medicare Advantage payment changes go into effect, beneficiaries may or may not see changes in benefit offerings...”

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Robert A. Book, Senior Research Fellow in Health and Economics at the Heritage Foundation’s Center for Data Analysis wrote in his Oct. 29, 2010 blog post “If You Like Your Medicare Advantage Plan, You Probably Cannot Keep it,” available at www.blog.heritage.org:</p> <p>“...our report found substantial regional variations—benefit losses range from a low of \$2,780 in Montana to a high of \$5,092 in Louisiana...”</p> <p>As a direct result of the Medicare cuts used to pay for a massive Medicaid expansion and subsidy scheme under the new law, senior citizens and disabled Americans will pay more but receive less care, and despite repeated promises that ‘if you like your health plan, you can keep it,’ half of those who like the Medicare Advantage plan they’ve chosen will not be able to keep their plan. Even those who are able to keep their plan will find that it’s not the same plan any more—it will have higher out-of-pocket costs and cover fewer services.”</p> <p style="text-align: center;">PRO 2</p> <p>John Goodman, PhD, President and Kellye Wright Fellow in Health Care at the National Center for Policy Analysis, wrote in his Aug. 22, 2012 article "Ten Myths in the Medicare Ad Wars," available at www.forbes.com:</p> <p>“White House Television talking points stress new benefits for seniors: a free annual wellness exam and the eventual closing of the ‘donut hole’ for drug coverage. What they conceal is that for every</p>	<p style="text-align: center;">CON 1</p> <p>John E. McDonough, DPH, Professor of the Practice of Public Health and Director of the Center for Public Health Leadership at the Harvard School of Public Health wrote in his Aug. 15, 2012 blog entry "Whew! Romney/Ryan Agree on Medicare. Now, Four Questions...," available online at www.boston.com:</p> <p>“The ACA reduces or eliminates no benefit to any Medicare enrollee, and neither does any proposal made by President Obama...”</p> <p>A big part of the ACA's Medicare spending reductions involves lowering payments to private insurance companies that participate in Medicare Advantage (also known as Medicare Part C) -- \$156B between 2013-22. These reductions, decried by Republicans, have caused no noticeable damage to Medicare Advantage -- enrollment in these plans is up, and premiums are down since the ACA took effect...</p> <p>And there's something more. There is a financial interaction between Medicare Part C and Medicare Part B -- the physician services part of Medicare for regular fee-for-service beneficiaries. Turns out, the more Medicare Advantage costs, the higher premiums rise for Part B enrollees. And the lower Medicare Advantage go, the lower the pressure on Part B premiums affecting about 70% of all Medicare enrollees.”</p> <p style="text-align: center;">CON 2</p> <p>Emilie Openchowski, Assistant Editor at the Center for American Progress, wrote in her July 6, 2012 article "Obamacare Is Good for Medicare;</p>

\$1 spent on new benefits, seniors will lose \$9 in other spending — which gives a whole new meaning to the term ‘bait and switch.’

...one in four Medicare beneficiaries is in a Medicare Advantage plan. These plans may be overpaid by Medicare, but they are required to ‘spend’ their overpayments on extra benefits for the enrollees. These include extra drug coverage, dental benefits, etc. Over the next 10 years, ObamaCare will reduce spending on these plans by \$156 billion and this reduction will inevitably lead to a loss of benefits. The remainder of the cuts in Medicare spending will mainly be in the form of reduced payments to providers. Although promised benefits won’t change under orthodox Medicare, in the very act of reducing provider fees, health reform will cause seniors to get less care. So while the White House claim that beneficiaries will not lose benefits may not be technically a lie, surely the FTC would pounce on a private company if it said the same things.

Remember: lower payment to providers means less access and less access means less care.”

PRO 3

Richard L. Kaplan, JD, Professor of Law at the University of Illinois at Urbana-Champaign, wrote in his Spring 2011 article "Older Americans, Medicare and the Affordable Health Care Act: What's Really In It for Elders," available online at www.asaging.org:

“Because Medicare Advantage plans may not discontinue any ‘guaranteed Medicare benefits,’ they are likely to scale back or eliminate many of the extra benefits they provide, such as vision and dental care. Some Medicare Advantage plans may raise premiums for their enrollees, while other plans may cease participating in the Medicare program.”

The Affordable Care Act Helps Our Senior Citizens," available at www.americanprogress.org:

“The Affordable Care Act has also improved the quality of care provided to seniors enrolled in Medicare, while making care more affordable. Those enrolled in Medicare Advantage (Part C) have enjoyed 16 percent lower premiums since 2010. There has also been a 17 percent increase in enrollment in the program and higher numbers of beneficiaries opting for higher-quality plans in this time period. Almost 13 million Americans are enrolled in the program as of February 2012—2 million more than the Congressional Budget Office predicted would join by this time.”

CON 3

Sy Mukherjee, Health Reporter-Blogger for ThinkProgress.org, wrote in his Sep 19, 2012 blog post “Obamacare Strengthened Medicare Advantage to Provide More Low-Income Americans with Affordable Coverage,” available at www.ThinkProgress.org:

“Thanks to the ongoing implementation of the health reform law, low-income Americans should continue to see their Medicare Advantage premiums decrease over time, and they will soon have a wider array of quality-rated plans to choose from.”

31. Does Obamacare close the “doughnut hole” in Medicare’s prescription drug coverage [Medicare Part D]? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 3301, "Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans," page 344, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the ‘program’) by not later than July 1, 2010. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c)(1). The Secretary shall establish a model agreement for use under the program by not later than April 1, 2010, in consultation with manufacturers, and allow for comment on such model agreement."

PRO 1

Ron Pollack, JD, Families USA Executive Director, wrote in a Sep. 6, 2012 article “Why Obamacare Is Good for Seniors and America: Families USA,” available at www.smmirror.com:

“Like a bad dream, however, the doughnut hole is going to fade away. That terrible gap, where seniors have to pay 100 percent of the cost of their prescription drugs until the other side is reached, is getting smaller every year. By 2020, the doughnut hole would have grown to \$6,000 a year; instead, under the Affordable Care Act, by 2020, the doughnut hole will be gone and seniors will only have to pay their copayments. The fact that something so bad is being eliminated is real reform.”

PRO 2

The US Department of Health & Human Services wrote in its Aug. 20, 2012 press release “People with Medicare Save More Than \$4.1 Billion on Prescription Drugs,” available online at www.hhs.gov:

"The health care law includes benefits to make Medicare prescription drug coverage more affordable. In 2010, anyone with Medicare who hit the prescription drug donut hole received a \$250 rebate. In 2011, people with Medicare who hit the donut hole began receiving a 50 percent discount on covered brand-name drugs and a discount on generic drugs. These discounts and Medicare coverage gradually increase until 2020 when the donut hole is fully closed.”

PRO 3

Peter Ubel, MD, Professor of Business and Public Policy at Duke University, wrote in a June 27, 2012 article "Obamacare and Donut Holes Why Donut Holes Raise Cholesterol More Than Donuts," available at www.psychologytoday.com:

"If you thought donuts were bad for your health, consider donut holes. Specifically, the donut hole sitting smack in the middle of Medicare Part D, the program helping senior citizens pay for their

medications. The donut hole is a gap in coverage causing people, once they've received a certain level of financial support for their prescriptions, to have to go it alone for a while, bearing all their medication costs until they've spent so much money that a higher level of financial support kicks in.

According to a study in the June 5th issue of the *Annals of Internal Medicine*... , once patients reach the donut hole, they understandably look for ways to save money on their medications. Pain relievers? Patients aren't likely to scrimp on those pills. After all, no pill, no pain relief. Medications for heart burn? Same basic idea. Daily symptoms are there to remind people of the value of these medicines. Blood pressure and cholesterol pills, on the other hand, are very easy medications to forego. No one feels any different when their cholesterol rises thirty points.

Obamacare, if it remains the law of the land tomorrow, will put an end to the donut hole. It will provide more continuous coverage of Medicare recipients' prescription costs. This is good news for those of us interested in helping patients prevent things like heart attacks, which these blood pressure and cholesterol pills do well."

PRO 4

The Kaiser Family Foundation wrote in its issue brief "Summary of Key Changes to Medicare in 2010 Health Reform Law" on www.kff.org (accessed Sep. 6, 2012):

"The Patient Protection and Affordable Care Act: Gradually phases in coverage in the Medicare Part D drug benefit coverage gap, or 'doughnut hole.' In 2010, Part D enrollees with any spending in the coverage gap will receive a \$250 rebate. Beginning in 2011, enrollees with spending in the coverage gap will receive a 50 percent discount on brand-name drugs, provided by the pharmaceutical industry. The law phases in Medicare coverage in the gap for generic drugs beginning in 2011, and for brand-name drugs beginning in 2013. By 2020, Part D enrollees will be responsible for 25 percent of the cost of both brands and generics in the gap, down from 100 percent in 2010."

32. Will more people be eligible for Medicaid under Obamacare? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2001, "Medicaid Coverage for the Lowest Income Populations," page 153, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking “or” at the end of subclause (VI);

(B) by adding “or” at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k).”

PRO 1

The Henry J. Kaiser Foundation stated in its Mar. 2011 article “Determining Income for Adults Applying for Medicaid and Exchange Coverage Subsidies: How Income Measured with a Prior Tax Return Compares to Current Income at Enrollment,” available at www.kff.org:

“A major goal of the Affordable Care Act (ACA) is to significantly expand coverage and reduce the number of uninsured. Beginning in 2014... Medicaid eligibility will be expanded to a national floor of 138% of poverty [level]... No premiums... Cost sharing limited to nominal amounts for most services”

[Editor’s note: In 2012 138 percent of the US poverty level for an individual is \$15,415; for a family of four it is \$31,809. States make their own decisions regarding whether or not to increase Medicaid eligibility.]

33. Does Obamacare’s Independent Patient Advisory Board (IPAB) ration Medicare or create “death panels”? – DEBATED

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1899A, "Independent Medicare Advisory Board," page 371, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.”

NOT CLEARLY PRO OR CON 1

Paul Ryan, US Representative (R-WI) stated the following on Sep. 22, 2012, during a town hall meeting at the University of Central Florida, available at YouTube.com under the title “Paul Ryan on Death Panels”:

" The death panels, well! That’s not the word I’d choose to use to describe it. It’s actually called... so in Medicare, what I refer to as this board of 15 bureaucrats. It’s called the Independent Payment Advisory Board. It sounds fairly innocuous...

What Obamacare does is it says, no we're going to have price controls and we're going to empower this board of 15 people that the President appoints, six year terms, they can get renewed once... these 15 bureaucrats that President Obama appoints, their job, each and every year, is to cut Medicare payments to providers... What Obamacare does is it takes control of Medicare, one of the most important and valuable programs in our country, the cornerstone of health security for all older Americans, and it takes it out of the control of your elected representatives, and it puts it in the hands of these 15 bureaucrats that are unaccountable that President Obama appoints. That is what the Independent Payment Advisory Board is, and that's I think, the issue that you are talking about..."

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Sarah Palin, former Republican Governor of Alaska, wrote in her June 25, 2012 Facebook post "Death Panel Three Years Later," available online at www.facebook.com:</p> <p>"Though I was called a liar [in 2009] for calling it like it is, many of these accusers finally saw that Obamacare did in fact create a panel of faceless bureaucrats who have the power to make life and death decisions about health care funding. It's called the Independent Payment Advisory Board (IPAB), and its purpose all along has been to 'keep costs down' by actually denying care via price controls and typically inefficient bureaucracy. This subjective rationing of care is what I was writing about in that first post:</p> <p>The Democrats promise that a government health care system will reduce the cost of health care, but as the economist Thomas Sowell has pointed out, government health care will not reduce the cost; it will simply refuse to pay the cost. And who will suffer the most when they ration care? The sick, the elderly, and the disabled, of course. The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama's 'death panel' so his bureaucrats can decide, based on a subjective judgment of their 'level of productivity in society,' whether they are worthy of health care. Such a system is downright evil."</p>	<p style="text-align: center;">CON 1</p> <p>Glenn Kessler, <i>Washington Post</i> Reporter, wrote in his June 27, 2012 column, "The Fact Checker, the Truth Beyond the Rhetoric," in an article titled "Sarah Palin, 'Death Panels' and 'Obamacare,'" available at www.washingtonpost.com:</p> <p>"It is important to note that the IPAB is primarily charged with helping to reduce the rate of growth in Medicare spending — a goal that both parties say they want to achieve. The IPAB, made up of 15 experts subject to Senate confirmation, would also make broader recommendations about controlling health costs.</p> <p>Beginning in 2018, if the targets are not met, the board will submit a plan to the White House and Congress to achieve the necessary cuts. Congress could pass a different set of cuts or reject the IPAB recommendations with a three-fifths vote in the Senate.</p> <p>The health-care law, by the way, explicitly says that the recommendations cannot lead to rationing of health care..."</p> <p style="text-align: center;">CON 2</p> <p>Ira Byock, MD, Director of Palliative Care at Dartmouth-Hitchcock Medical Center, wrote in his July 18, 2012 article "Rational Healthcare, Not Rationing," available at www.articles.latimes.com:</p>

PRO 2

Stanley Kurtz, Writer for the *National Review Online*, wrote in his Apr. 18, 2011 article "IPAB, Obama, and Socialism," available online at www.nationalreview.com:

"...IPAB's price controls will lead to one-size-fits-all rationing. As IPAB caps Medicare payments for various services, the elderly will be unable to obtain many kinds of care, or will experience de facto rationing via long treatment delays and sharp declines in the quality of care."

PRO 3

Steven Ertelt, Founder and Editor of *LifeNews.com*, wrote in his July 31, 2012 article "Obamacare Rationing Begins, States Cut Prescription Drug Benefits," available online at www.LifeNews.com:

"...[Under Obamacare] the department of Health and Human Services (HHS) will be empowered to impose so-called 'quality and efficiency' measures on health care providers, based on recommendations by the Independent Payment Advisory Board, which is directed to force private health care spending below the rate of medical inflation. In many cases treatment that a doctor and patient deem needed or advisable to save that patient's life or preserve or improve the patient's health but which runs afoul of the imposed standards will be denied, even if the patient wants to pay for it.

The law empowers HHS to prevent older Americans from making up with their own funds for the \$555 billion the law cuts from Medicare by refusing to permit senior citizens the choice of private-fee-for-service plans whose premiums are sufficient to provide unrationed care but which HHS, in its unlimited discretion, disallows. The Obama health care law could thus lead to elimination of the only way that seniors will have to escape rationing — by limiting their right to

"Many of the people I care for are incurably ill and need expensive medical care to stay alive. They've heard politicians say 'Obamacare' will take away their choices, rob them of hope for living longer and cast their fate to 'death panels' of faceless bureaucrats. Fortunately, none of this is true..."

The Affordable Care Act advances a new approach, called accountable care, that aligns financial incentives with high-quality treatment. This key feature of the law transforms healthcare by making local health systems — made up of doctors, hospitals, clinics, laboratories and imaging facilities — responsible for the outcomes of care and the costs for the population of people they predominantly serve.

Accountable care has real potential for moving our system toward safer, more effective, and less wasteful treatments. Person-centered services, such as individualized care planning, thorough communication and coordination of care, ongoing monitoring, meticulous medication management and early response to problems, make economic sense...

Reforming healthcare to make it rational is not the same thing as rationing. The best care gives people every chance of living longer and well..."

CON 3

Ben Armbruster, National Security Editor for *ThinkProgress.org*, wrote in his July 1, 2012 article "Republican Senator Says ObamaCare Will 'Sovietize' Health Care," available at www.thinkprogress.org:

Last week, just before the Supreme Court ruled that Affordable Care Act is constitutional, Sen. Tom Coburn (R-OK) told the *Eagle Daily Investor* that what ObamaCare is trying to do 'is Sovietize the American health care system...'

But Coburn really shouldn't fear the Independent Payment Advisory Board — a commission that

spend their own money to save their own lives.”

PRO 4

Wesley J. Smith, Senior Fellow in Human Rights and Bioethics at the Discovery Institute, wrote in his July 6, 2012 article “IPAB: the Part of Obamacare That Can’t be Repealed,” available online at www.dailycaller.com:

“IPAB’s unique ‘fast track’ authority divests Congress of discretion regarding the amount of money to be cut from Medicare once IPAB has submitted its ‘advice.’ Get a load of these legislative handcuffs:

By January 15, 2014, IPAB must submit a proposal to Congress and the president for reaching Medicare savings targets in the coming year.

The majority leaders in the House and Senate must introduce bills incorporating the board’s proposal the day they receive it.

Congress cannot ‘consider any bill, resolution, amendment, or conference report ... that would repeal or otherwise change the recommendations of the board’ if such changes fail to meet the board’s budgetary target.

By April 1, all legislative committees must complete their evaluation. Any committee that fails to meet the deadline is barred from further consideration of the bill.

If Congress does not pass the proposal or a substitute plan meeting the IPAB’s financial target before August 15, or if the president vetoes the proposal passed by Congress, the original Independent Payment Advisory Board recommendations automatically take effect.

Not only that, but Congress cannot consider any bill or amendment that would repeal or change this fast-track congressional consideration process

would make recommendations for lowering Medicare spending to Congress. IPAB’s authority only kicks in if health care spending increases beyond a specific threshold and the board is specifically prohibited from rationing. The Affordable Care Act’s language specifically states that IPAB’s recommendations cannot ‘include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums... increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and co-payments), or otherwise restrict benefits or modify eligibility criteria.’”

CON 4

The Kaiser Family Foundation, stated in a July 7, 2010 article "Kaiser Health Tracking Poll - July 2010" available at www.kff.org:

"...[L]arge shares of seniors mistakenly believe the law includes provisions that cut some previously universal Medicare benefits and creates 'death panels.' Half of seniors (50%) say the law will cut benefits that were previously provided to all people on Medicare, and more than a third (36%) incorrectly believe the law will 'allow a government panel to make decisions about end-of-life care for people on Medicare.'"

CON 5

Aaron E. Carroll, MD, MS, Associate Professor and Vice Chairman of Health Policy and Outcomes Research in the Department of Pediatrics at the Indiana University School of Medicine, wrote in his July 19, 2012 article "Take Another Look at Health Care Act," available at www.cnn.com:

"Surely you've heard about the Independent Payment Advisory Board? This one, too, has cost the administration politically. It's been demonized as an actual ‘death panel’ of unelected, unaccountable people who will ration your Medicare. That's not true. The panel is made up of

without a three-fifths vote in the Senate. And to put the icing on the autocratic cake, implementation of the board's policy is exempted from administrative or judicial review."

PRO 5

Richard Reeb, PhD, former Professor of Political Science, Philosophy and Journalism at Barstow College, wrote in his June 29, 2010 article "Health Care Rationing Is Bound to Come," available at www.desertdispatch.com:

"Critics of Obamacare were severely attacked for using allegedly overheated rhetoric such as 'death panels.' But given the fact that an 18-member Independent Payment Advisory Board will be established to set 'quality and efficiency' standards that doctors will be forced to follow after 2015, that rhetoric does not appear to be so overheated after all."

people who need Senate approval (not easy), and they don't serve for life. Moreover, they have a very specific, limited task."

CON 6

Steve Benen, MA, Producer of The *Rachel Maddow Show*, stated the following in a Sep. 24, 2012 article "Ryan Doesn't Call Them 'Death Panels' But...," available at www.maddowblog.msnbc.com:

"In terms of rhetoric, when Ryan says he's not comfortable with the words 'death panel,' I'm glad, but it's worth remembering that this isn't about semantics; it's about policy. Those who talk about 'death panels' aren't just using the wrong language, they're getting the substance wrong, too..."

As we discussed in June, the Obama administration seeks to solve this problem [rising medical costs] through IPAB - putting the difficult decisions in the hands of qualified medical and health care professionals, free of the political process on Capitol Hill. And why is this necessary? In large part because Congress has failed so spectacularly in its ability to make these choices on its own...

Besides, it's not like the 15 panelists serving on IPAB have some kind of dictatorial rule over Medicare coverage - the law not only gives Congress oversight authority over the panel, but it also empowers Congress to replace savings if lawmakers disapprove of what the board comes up with."

34. Will the quality of care from public health programs such as Medicare and Medicaid improve? – DEBATED

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>David Bazelon, former Circuit Court of Appeals</p>	<p style="text-align: center;">CON 1</p> <p>Betsy McCaughey, PhD, former Lt. Governor of</p>

judge, stated in its July 27, 2010 posting “Medicaid Reforms in the Patient Protection & Affordable Care Act and the Health Care & Education Reconciliation Act,” available at www.bazelon.org:

“The new laws...

- Improve Medicaid home and community-based services through improvements to state plan options and waivers;
- Improve prescription drug coverage;
- Encourage collaborative care through health homes;
- Improve services for individuals who are dually eligible for Medicaid and Medicare; and
- Include a number of provisions designed to improve the quality of Medicaid services...

The law confirms and clarifies that the original intent of Congress in providing ‘medical assistance’ through establishment of the Medicaid program was to ensure that beneficiaries do, in fact, have access to and receive promised services. This provision is effective immediately, and responds to a handful of federal court decisions contending that states are not required to ensure that services are indeed available, only to provide payment for services should they be acquired. The clarification requires states to operate their programs so as to ensure that beneficiaries receive covered services with reasonable promptness, and not simply be reimbursed if they are able to obtain services on their own...

... the Affordable Care Act establishes an Office of Coordination for Dual Eligible Beneficiaries to align Medicare and Medicaid policies for dual eligibles, integrate the two programs’ benefits, improve continuity of care and enhance coordination between the federal and state governments.”

PRO 2

The US Department of Health & Human Services on wrote in a Mar. 31, 2011 press release “Affordable Care Act to Improve Quality of Care for People with

New York, wrote in her Sep. 12, 2012 article “ObamaCare’s Cuts to Hospitals Will Cost Seniors Their Lives,” available at www.FoxNews.com:

“President Obama is wooing seniors with promises to protect Medicare as they’ve known it. On the defensive because of the \$716 billion his health care law takes from Medicare, Obama assures seniors he’s cutting payments to hospitals and other providers, not their benefits.

Don’t be bamboozled. It’s illogical to think that reducing what a hospital is paid to treat seniors won’t harm their care. A mountain of scientific evidence proves the cuts will worsen the chance that an elderly patient survives a hospital stay and goes home. It’s reasonable to conclude that tens of thousands of seniors will die needlessly each year.

Under ObamaCare, hospitals, hospice care, dialysis centers, and nursing homes will be paid less to care for the same number of seniors than if the health law had not been enacted. Payments to doctors will also be cut...”

CON 2

Economic Policies for the 21st Century stated on its page “Medicare,” available at www.ObamacareWatch.org (accessed Sep 20, 2012), wrote:

“ObamaCare cuts a half-trillion dollars from Medicare over the next decade. These cuts are unsustainable and will lead to a reduction in the quality of care for seniors who rely on the program to secure access to needed medical services. The cuts in Medicare Advantage will impose steep costs on millions of Medicare beneficiaries, and will fall disproportionately on low income and minority seniors.”

CON 3

Medicare,” available online at www.hhs.gov:

“By focusing on the needs of patients and linking payment rewards to outcomes, this delivery system reform [Accountable Care Organizations], as part of the Affordable Care Act, will help improve the health of individuals and communities while saving as much as \$960 million over three years for the Medicare program.

Under the proposal, ACOs – teams of doctors, hospitals, and other health care providers and suppliers working together – would coordinate and improve care for patients with Original Medicare (that is, who are not in Medicare Advantage private health plans).”

PRO 3

The Centers for Medicare & Medicaid Services stated in a paper “Affordable Care Act Update: Implementing Medicare Cost Savings,” available online at www.cms.gov (accessed on Sep. 21, 2012):

“The Affordable Care Act includes a series of Medicare reforms that will generate billions of dollars in savings for Medicare and strengthen the care Medicare beneficiaries receive. The new law protects guaranteed benefits for all Medicare beneficiaries, and provides new benefits and services to seniors on Medicare that will help keep seniors healthy. The law also includes provisions that will improve the quality of care, develop and promote new models of care delivery, appropriately price services, modernize our health system, and fight waste, fraud, and abuse.”

PRO 4

Ron Pollack, JD, Families USA Executive Director, wrote in his Sep. 6, 2012 article “Why Obamacare Is Good for Seniors and America: Families USA,” available at www.smmirror.com:

“Reform also means that there are no longer any deductibles or copayments for annual wellness visits

Robert Moffit, PhD, Director of the Center for Health Policy Studies at the Heritage Foundation, wrote in his May 20, 2010 article "Obamacare: Impact on Seniors" available at www.heritage.org:

"...much of the financing over the initial 10 years is siphoned off from an estimated \$575 billion in projected savings to the Medicare program. Unless Medicare savings are captured and plowed right back into the Medicare program, however, the solvency of the Medicare program will continue to weaken. The law does not provide for that. Medicare is already burdened by an unfunded liability of \$38 trillion.

Medicare Advantage plans, which currently attract almost one in four seniors, will see enrollment cut roughly in half over the next 10 years. Senior citizens will thus be more dependent on traditional Medicare than they are today and will have fewer health care choices...

In 2011, the new law provides a 10 percent Medicare bonus payment for primary care physicians and general surgeons in ‘shortage’ areas. This is a tepid response to a growing problem.

With the retirement of 77 million baby boomers beginning in 2011, the Medicare program will have to absorb an unprecedented demand for medical services. For the next generation of senior citizens, finding a doctor will be more difficult and waiting times for doctor appointments are likely to be...

Seniors deserve better than what Obamacare gives them.”

CON 4

Scott Gottlieb, MD, American Enterprise Institute Resident Fellow, wrote in his Apr. 26, 2012 article “Toss Gran in an HMO a Fresh Obamacare Outrage,” available at

<p>and such basic screenings as bone mass measurements; cervical cancer screenings, including Pap smear tests and pelvic exams; mammograms; diabetes screenings; prostate cancer screenings; cholesterol and other cardiovascular screenings; and more. It’s just common sense reform. Removing any disincentive for seniors to get important preventive care helps make Medicare a more comprehensive health care plan—and keeps seniors healthier longer.”</p> <p style="text-align: center;">PRO 5</p> <p>President Barack Obama, JD, 44th President of the United States, stated in his Sep. 21, 2012 remarks to the AARP Convention via satellite, available at www.whitehouse.gov:</p> <p>“...I have strengthened Medicare as President. We’ve added years to the life of the program by getting rid of taxpayer subsidies to insurance companies that weren’t making people healthier. And we used those savings to lower prescription drug costs, and to offer seniors on Medicare new preventive services like cancer screenings and wellness services.”</p>	<p>www.nypost.com:</p> <p>“The latest installment of ObamaCare is a scheme that’s uprooting the elderly poor and disabled who get care under Medicare and herding many into state-run Medicaid plans.</p> <p>All of these folks are dually eligible for both Medicare and Medicaid; they are low-income people who are elderly or have disabilities. But it’s hard to see how they’ll be better off in bare-bones, and sometimes poorly-run state Medicaid plans than by getting access to Medicare options they were entitled to before ObamaCare...</p> <p>Some states have already said they plan to automatically place these folks in existing Medicaid plans — which often aren’t equipped to serve an older, sicker group of patients. That will mean big savings for the state and worse care for the vulnerable.”</p>
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35. Will Medicare reduce reimbursements to hospitals with high 30-day readmission rates (“preventable readmissions”)? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 3025, "Hospital Readmissions Reduction Program," page 290, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

“(q) HOSPITAL READMISSIONS REDUCTION PROGRAM.—

(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and
(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.”

PRO 1

Julie Stone, Specialist in Health Care Financing for the Congressional Research Service, and Geoffrey J. Hoffman, Analyst in Health Care Financing for the Congressional Research Service, wrote in their Sep. 21, 2010 paper "Medicare Hospital Readmissions: Issues, Policy Options and PPACA," available at www.ncsl.org:

“Reductions in hospital readmissions (also referred to as rehospitalizations) have been identified by Congress and President Obama as a source for reducing Medicare spending. The Medicare Payment Advisory Commission (MedPAC) reported that in 2005, 17.6% of hospital admissions resulted in readmissions within 30 days of discharge, 11.3% within 15 days, and 6.2% within 7 days. In addition, variation in readmission rates by hospital and geographic region suggests that some hospitals and geographic areas are better than others at containing readmission rates...

Although readmitting a patient to a hospital may be appropriate in some cases, some policy makers and researchers agree that reducing readmission rates could help contain Medicare costs and improve the quality of patient care.”

PRO 2

Jordan Rau, Kaiser Health News Staff Writer, wrote in his Aug. 13, 2012 article “Medicare to Penalize 2,211 Hospitals for Excess Readmissions,” available at www.kaiserhealthnews.org:

“More than 2,000 hospitals — including some nationally recognized ones — will be penalized by the government starting in October because many of their patients are readmitted soon after discharge, new records show.

Together, these hospitals will forfeit about \$280 million in Medicare funds over the next year as the government begins a wide-ranging push to start paying health care providers based on the quality of care they provide.

With nearly one in five Medicare patients returning to the hospital within a month of discharge, the government considers readmissions a prime symptom of an overly expensive and uncoordinated health system. Hospitals have had little financial incentive to ensure patients get the care they need once they leave, and in fact they benefit financially when patients don’t recover and return for more treatment.

Nearly 2 million Medicare beneficiaries are readmitted within 30 days of release each year, costing Medicare \$17.5 billion in additional hospital bills. The national average readmission rate has remained steady at slightly above 19 percent for several years, even as many hospitals have worked harder to lower theirs.”

--Physicians--

36. Will Obamacare worsen the primary physician shortage? – DEBATED

NOT CLEARLY PRO OR CON 1

Kevin Drum, political blogger for *Mother Jones*, stated in his Aug. 7, 2012 article "Why Obamacare Probably Won't Lead to Doctor Shortages," available at www.MotherJones.com:

“I'm not all that worried about a doctor shortage after Obamacare fully kicks in in 2014. It's not that the fear is totally groundless. If you put a lot more patients into the medical system, that's likely to make hospitals and doctors' offices more crowded. But there's also a lot of evidence for a substantial supply-side effect on medical care: the more doctors a city has, the more treatment people get, whether they need it or not. Likewise, if a hospital buys an expensive piece of equipment, they're highly motivated to keep it in constant use whether it's really necessary or not.

So yes: more patients might cause more crowding. It's a reasonable concern. But there's a pretty good chance that it's mostly going to crowd out a fair amount of unnecessary care, like the stuff HCA [Hospital Corporation of America] is accused of providing. That will eat into bottom lines, but it won't necessarily make it any harder to see a doctor when your kid has an ear infection. We'll just have to wait and see.”

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Suzanne Sataline, writer for <i>The Wall Street Journal</i>, and Shirley S. Wang, Health Reporter and In the Lab Columnist at <i>The Wall Street Journal</i>, wrote in their Apr. 12, 2010 article “Medical Schools Can’t Keep Up,” available at online.wsj.com:</p> <p>“The new federal health-care law has raised the stakes for hospitals and schools already scrambling to train more doctors.</p> <p>Experts warn there won't be enough doctors to treat the millions of people newly insured under the law. At current graduation and training rates, the nation could face a shortage of as many as 150,000 doctors in the next 15 years, according to the Association of American Medical Colleges. That shortfall is predicted despite a push by teaching hospitals and medical schools to boost the</p>	<p style="text-align: center;">CON 1</p> <p>The American College of Physicians (ACP) stated in their Apr. 7, 2010 fact sheet "Ensuring an Adequate Supply of Primary Care Internists and Other Specialties Facing Shortages," available at www.acponline.org:</p> <p>"The recently enacted PPACA (H.R. 3590) includes numerous policies to train more primary care physicians and increase the supply of primary care physicians. These policies include: mandatory and increased discretionary funding for the National Health Service Corp (NHSC), reauthorization of Section 747 of Title VII, Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship; creation of a Primary Care Training Extension Program and increased faculty scholarship loans, redistribution of 65% of the current unused Graduate Medical Education slots</p>

number of U.S. doctors, which now totals about 954,000.

The greatest demand will be for primary-care physicians. These general practitioners, internists, family physicians and pediatricians will have a larger role under the new law, coordinating care for each patient.

The U.S. has 352,908 primary-care doctors now, and the college association estimates that 45,000 more will be needed by 2020. But the number of medical-school students entering family medicine fell more than a quarter between 2002 and 2007."

PRO 2

Grace-Marie Turner, President of the Galen Institute, wrote in her July 30, 2012 blog post, "Good Luck Finding a Doctor under Obamacare," available at www.nationalreview.com:

"The health overhaul law expands health insurance to millions more people without significantly increasing the number of physicians or other providers. And Obamacare has exacerbated the physician shortage because many are considering leaving the practice of medicine altogether rather than practice under the dictates of Washington bureaucracies..."

The supply of doctors will dwindle as demand for services reaches an all-time high. Fewer of those in private practice are taking patients on Medicare, and even fewer can afford to see the millions of new patients likely to be enrolled in Medicaid.

By increasing demand for care without a comparable increase in the supply of doctors to treat the additional infusion of patients, the law will exacerbate the current physician shortage..."

PRO 3

Pete Olson, JD, US Representative (R-TX), in an Aug. 1, 2012 blog post, "Obama's Reforms Will

to primary care and general surgery and allowing residents to count their time spent in ambulatory settings to count towards their residency requirements, such as physician offices and community health centers; and the establishment of Teaching Health Centers, creating primary care residency programs in non-hospital settings."

CON 2

Kaiser Family Foundation's Apr. 15, 2011 "Focus on Health Reform: Summary of New Health Reform Law," available at www.kff.org, explains:

"[The Patient Protection and Affordable Care Act will] improve workforce training and development:

- Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. (Appointments made by September 30, 2010)
- Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for payments for the expenses associated with operating primary care residency programs. (Funds appropriated for five years beginning fiscal year 2011)
- Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity

<p>Lead to Ruin," available on www.thehill.com, wrote:</p> <p>"On the patient-care side, while parts of the new law have yet to take effect, negative aspects are already being felt now. The Association of American Medical Colleges estimates that in 2015 the United States will have 62,900 fewer doctors than needed. Compounding this troubling shortage are the results of a recent study by Atlanta-based Jackson Healthcare that indicates 34 percent of physicians say they plan to leave the practice of medicine over the next decade, in part due to low compensation, high costs and a surge in regulations that accompany ObamaCare. This doctor shortage will mean that patient care will involve longer waits for fewer doctors."</p>	<p>building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010)..."</p>
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37. Do physicians support Obamacare? – DEBATED

NOT CLEARLY PRO OR CON 1

Deloitte Center for Health Solutions, in a Dec. 2011 survey "Physician Perspectives about Health Care Reform and the Future of the Medical Profession," available at www.deloitte.com, found:

"44% of all physicians feel the ACA is a good start, while an equal proportion feels it is a step in the wrong direction; 12% don't know."

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Virginia L. Hood, MD, Immediate Past President of the American College of Physicians, in a Mar. 26, 2012 article, "The Present and Future of the Affordable Care Act," available at www.acponline.org, wrote:</p> <p>"The American College of Physicians (ACP), representing 132,000 internal medicine specialists and medical student members, is pleased to report that the Affordable Care Act (ACA) has resulted in major improvements in access and coverage for tens of millions of Americans seen by internal medicine physicians. Considering that it is just a little over two years since the ACA was enacted</p>	<p style="text-align: center;">CON 1</p> <p>Robert E. Moffit, PhD, Senior Fellow of the Heritage Foundation, in a May 11, 2010 Heritage foundation article, "Obamacare: Impact on Doctors," available at www.heritage.org, wrote:</p> <p>"No class of American professionals will be more negatively impacted by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act than physicians. Third-party payment arrangements already compromise the independence and integrity of the medical profession; Obamacare will reinforce the worst of these features. Specifically, physicians will be subject to more government regulation and</p>

into law, and many of its programs are not yet fully effective, the ACA has had notable success in improving health insurance coverage. Looking to the future, the ACA will ensure that nearly all legal residents in the United States will have access to affordable coverage beginning in 2014—if the law is allowed to be fully implemented."

PRO 2

Jeremy Lazarus, MD, President of the American Medical Association, in a June 28, 2012 press release, "AMA: Supreme Court Decision Protects Much-Needed Health Insurance Coverage for Millions of Americans," available at www.ama-assn.org, stated:

"The American Medical Association has long supported health insurance coverage for all, and we are pleased that this decision [Supreme Court decision retaining most of Obamacare] means millions of Americans can look forward to the coverage they need to get healthy and stay healthy.

The AMA remains committed to working on behalf of America's physicians and patients to ensure the law continues to be implemented in ways that support and incentivize better health outcomes and improve the nation's health care system."

PRO 3

American Academy of Family Physicians, in a Mar. 16, 2011 statement to Congress, "Before the Senate Finance Committee Regarding Lessons Learned From a Year of Implementation of the Affordable Care Act," available at www.aafp.org, stated:

"The AAFP supported this legislation [Obamacare] for many reasons, not the least of which is its goal of achieving health coverage for nearly everyone in this country...

No one in this country should delay or forego

oversight, and will be increasingly dependent on unreliable government reimbursement for medical services."

CON 2

Marc Siegel, MD, Associate Professor of Medicine and Medical Director of Doctor Radio at New York University Langone Center, in a Mar. 2012 Fox News article, "What a doctor knows about ObamaCare," available at www.foxnews.com, stated:

"I can tell you as a practicing physician that the regulations and restrictions and red tape of health insurance (all increasing under ObamaCare) hamstringing my office staff and interfere with my ability to take care of you."

CON 3

Adam Frederic Dorin, MD, MBA, anesthesiologist and Founder/President of America's Medical Society, Inc, in a Jan. 17, 2012 Washington Times article, "Doctors vs. Obamacare: Can Your Physician Simply 'Opt-out'?", available at www.washingtontimes.com, wrote:

"A basic tenet of Obamacare is to force doctors to take untenable cuts in pay, all the while absorbing overbearing new regulations and mandates with little or no personal recourse."

CON 4

Jackson & Coker Research Associates, in an Oct. 1, 2012 report "Physicians on the Presidential Election," available at www.jacksoncoker.com, wrote:

"When asked how they felt about the Affordable Care Act, 55 percent [of doctors] said 'repeal and replace' the new law while 40 percent said 'implement and improve' the ACA."

CON 5

<p>needed care because of cost. Instead, we believe that the nation must:</p> <p>Provide health care in the broadest sense rather than focusing only on sick care... Address the factors that drive up costs and lower quality... Build up the primary care physician workforce to meet the requirements of everyone who needs care.</p> <p>The Patient Protection and Affordable Care Act already has made important strides toward achieving these bold and life-saving goals. It will expand insurance coverage by about 30 million people. Although this still falls short of coverage for everyone, the number of uninsured people will be reduced by more than half. It will encourage better health delivery models, emphasize the high value of primary care, support research and demonstrations of what works and what is needed, and it will help evaluate methods for controlling health care costs and improving health care quality.”</p>	<p>The Physicians Foundation, in the Sep. 2012 "Survey of America's Physicians: Practice Patterns and Perspectives," available at www.physiciansfoundation.org, states:</p> <p>"Over 59 percent of physicians indicate passage of the Patient Protection and Affordable Care Act (i.e., 'health reform') has made them less positive about the future of healthcare in America."</p>
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38. Does Obamacare make any changes to physician payments through Medicare/Medicaid? – YES

[Editor's Note: The changes to physician payment discussed in the quotations below can be found in the following sections of the Patient Protection and Affordable Care Act:

- Sec. 3002, "Improvements to the physician quality reporting system," (p.245)
- Sec. 3007, "Value-based payment modifier under the physician fee schedule," (p.255)
- Sec. 3021, "Establishment of Center for Medicare and Medicaid Innovation within CMS," (p.271)
- Sec. 3403, "Independent Medicare Advisory Board," (p.371) and
- Sec. 6301, "Patient-Centered Outcomes Research." (p.609)

The payment changes to Medicaid and Medicare primary care physicians discussed below are found in the Health Care and Education Reconciliation Act of 2010 in "Title I - Coverage, Medicare, Medicaid, and Revenues." (p.2)]

PRO 1

The American Medical Association (AMA) stated the following in its fact sheet "How the Passage of Federal Health System Reform Legislation Impacts Your Practice," available at www.ama-ass.org (accessed Oct. 16, 2012):

"H.R. 3590 includes a number of payment improvements for physicians that, combined, will result in immediate and significant Medicare payment increases for many physicians...

All physicians in family medicine, internal medicine, geriatrics and pediatrics whose Medicare charges for office, nursing facility and home visits comprise at least 60 percent of their total Medicare charges will be eligible for a 10 percent bonus payment for these services from 2011–16...

All general surgeons who perform major procedures (with a 10- or 90-day global service period) in a health professional shortage area will be eligible for a 10 percent bonus payment for these services from 2011–16..."

PRO 2

The US Department of Health and Human Services stated the following in a May 9, 2012 press release "Health Care Law Increases Payments to Doctors for Primary Care," available at www.hhs.gov:

"Primary care physicians serving Medicaid patients would see their Medicaid payments rise under a proposed rule announced today by Health and Human Services (HHS) Secretary Kathleen Sebelius. Through the Affordable Care Act, the increase would bring Medicaid primary care service fees in line with those paid by Medicare. The boost would be in effect for calendar years (CY) 2013 and 2014. States would receive a total of more than \$11 billion in new funds to bolster their Medicaid primary care delivery systems.

Secretary Sebelius also announced today that, in 2011, over 150,000 primary care providers nationwide received almost \$560 million in higher Medicare payments because of the Affordable Care Act. This is another way the Affordable Care Act rewards doctors, nurse practitioners, physician assistants, and other primary care providers who are central to our health care system...

Today's proposed rule would implement the Affordable Care Act's requirement that Medicaid reimburse family medicine, general internal medicine, pediatric medicine, and related subspecialists at Medicare levels in CY 2013 and CY 2014. The increase in payment for primary care is paid entirely by the federal government with no matching payments required of States."

PRO 3

Robert E. Moffit, PhD, Senior Fellow at the Heritage Foundation stated the following in his May 11, 2010 article "Obamacare: Impact on Doctors," available at www.heritage.org:

"Obamacare does not substantially change the general pattern of the government's systems of physician payment but instead expands their reach and adds new regulatory restrictions. For example, beginning in 2010, the new law, with few exceptions, will prohibit physicians from referring Medicare patients to hospitals in which they have ownership.

In 2011, Medicare primary care physicians and general surgeons practicing in 'shortage' areas will receive a 10 percent bonus payment. And primary care physicians participating in Medicaid will get no less than 100 percent of the Medicare payment rates for their services for 2013 and 2014, with the

federal taxpayer making up the difference between Medicaid funding and the higher Medicare payment rates. But there is a catch: There is no provision for continued federal taxpayer funding beyond these two years, so states will have to either increase their own Medicaid expenditures substantially or cut back their Medicaid physician payments...

On top of existing payment rules, regulations, and guidelines, the new law creates numerous new federal agencies, boards, and commissions. There are three that have direct relevance to physicians and the practice of medicine:

1. Under section 6301, Obamacare creates a 'non-profit' Patient-Centered Outcomes Research Institute. It will be financed through a trust fund, with initial funding starting at \$10 million this year and reaching \$150 million annually in fiscal year 2013, with additional revenues from insurance fees. In effect, the institute will be examining clinical effectiveness of medical treatments, procedures, drugs, and medical devices. Much will depend upon how the findings and recommendations will be implemented and any financial incentives, penalties, or regulatory requirements.
2. Under section 3403, there will be an Independent Payment Advisory Board in 2012, with 15 members appointed by the President and confirmed by the Senate. The board would aim to reduce the per capita growth rate in Medicare spending in accordance with specified targets (based initially on measures of inflation and eventually GDP growth) and make recommendations for slowing growth in non-federal health programs. The board's recommendations would go into effect unless Congress enacts an alternative proposal. An unprecedented cap on Medicare spending, the process would doubtless reduce Medicare physician payment.
3. Under section 3002, the law extends the Physician Quality Reporting Initiative. While it provides incentives for the quality of care delivered to Medicare beneficiaries, the program is nonetheless burdened with time-consuming compliance and reporting requirements."

PRO 4

The American College of Surgeons stated the following in its Sep. 26, 2012 article "Physician Value-Based Modifier," available at www.facs.org:

"The Affordable Care Act (ACA) requires that the Centers for Medicare & Medicaid Services (CMS) implement a value-based payment modifier that would apply to Medicare fee-for-service payments starting with some physicians on January 1, 2015, and applying to all physicians and groups by January 1, 2017. The value-based payment modifier is intended to pay physicians differentially based on the quality of care they provide and the cost of that care. It would incorporate the use of Physician Feedback reports, which are confidential reports that quantify and compare the quality of care furnished and costs among physicians and physician group practices, relative to the performance of other physicians."

PRO 5

Laxmaiah Manchikanti, MD, Medical Director of the Pain Management Center of Paducah and Associate Clinical Professor of Anesthesiology and Perioperative Medicine at the University of Louisville, et al., stated the following in their Jan. 13, 2011 article "Patient Protection and Affordable

Care Act of 2010: Reforming the Health Care Reform for the New Decade," available at www.painphysicianjournal.com:

“Another law affecting physicians is the Physician Quality Reporting Initiative, or PQRI. The program is to improve the quality of care delivered to Medicare patients. If doctors report the specified quality data, meaning that they are complying with federal standards in the delivery of care, they get Medicare bonus payments. If they do not reply and do not report the required data, their Medicare payments are cut. By 2015, the law makes participation compulsory for participating physicians in Medicare...

Under the ACA, CMS officials will also be charged with designing 20 new payment systems for physicians. The statute specifically calls for the reduction of Medicare payments away from traditional fee-for-service, which serves about 77% of seniors today, in favor of salaried physician payments."

--Prevention/Wellness--

39. Is free preventive care required under Obamacare? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2713, "Coverage of Preventative Health Services," pages 13-14, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

- (1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;
- (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
- (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.
- (5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening,

mammography, and prevention shall be considered the most current other than those issued in or around November 2009."

PRO 1

HealthCare.gov, a federal government website managed by the US Centers for Medicare & Medicaid Services, stated the following on its webpage "What Are My Preventive Care Benefits?," available at healthcare.gov (accessed Aug. 20, 2013):

"All Marketplace plans and many other plans must cover the following list of preventive services without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible. This applies only when these services are delivered by a network provider...

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Diabetes (Type 2) screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for everyone ages 15 to 65, and other ages at increased risk
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary...
12. Obesity screening and counseling for all adults
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
14. Syphilis screening for all adults at higher risk
15. Tobacco Use screening for all adults and cessation interventions for tobacco users"

PRO 2

Jessica Arons, Director, and Lucy Panza, Policy Analyst with the Women's Health and Rights Program for the Center for American Progress, in their May 24, 2012 Think Progress Health blog post "Top 10 Obamacare Benefits at Stake for Women," available at www.thinkprogress.org, stated:

"Obamacare guarantees coverage of preventive services with no cost sharing. Preventive care promotes health and saves money. Yet many preventive care services are out of women's reach due to high co-pays, deductibles, and co-insurance. More than 50 percent of women have delayed seeking medical care due to cost, and one-third of women report forgoing basic necessities to pay for health care. But under the health reform law, insurers are now required to cover recommended preventive services such as mammograms, Pap smears, and well-baby care without cost sharing. More than 45 million women have already taken advantage of these services. And starting this August more services, including

contraception, gestational diabetes screening, and breastfeeding supports, will be added to the list of preventive care that must be covered at no additional cost."

PRO 3

Barbara Reynolds, DMin, author and ordained minister, in a July 3, 2012 article "'Obamacare': Just What the Doctor Ordered," available at www.washingtonpost.com, stated:

"The Affordable Care Act expands health-care coverage for low-income Americans. It enables everyone to receive recommended preventive services at no cost and expands community-based primary and preventive care...

Moreover, since the law was passed, 2.4 million black seniors with Medicare have received preventive services such as diabetes screening and 5.5 million black Americans now have coverage for preventative health care services without additional cost sharing according to reports released by the Department of Health and Human resources.

Beginning in August, women of all income brackets will be able to obtain contraception, annual well-woman visits, screenings for sexually transmitted infections and gestational diabetes, breast-feeding support and supplies, and domestic violence screenings without any co-pays or deductibles."

PRO 4

Carolyn Johnson, BSN, RN, Director of the Coalition of Labor Union Women's Cervical Cancer Prevention Works Program and the Contraceptive Equity Project, in a July 30, 2012 article, "'Obamacare' Means Preventative Care for Women," available at www.peoplesworld.com, wrote:

"Thanks to the Affordable Care Act, starting on August 1, all new health care plans will be required at the start of their plan year to cover a variety of preventive health care services with no co-pay or deductible. That includes a wide range of health care services for women.

Because some preventive benefits are already in place, such as prenatal screenings and mammograms, over 20 million American women have received at least one preventive health care service without having to make a co-payment or pay additional costs."

IV: 65 Questions and Responses on Obamacare (continued)

B. Financial Effects of Obamacare

--Bankruptcy--

40. Will people no longer be at risk of medical bankruptcy? – DEBATED

PRO	CON
<p style="text-align: center;">PRO 1</p> <p>The National Patient Advocate Foundation, in its Sep. 2012 white paper, "Issue Brief: Medical Debt, Medical Bankruptcy and the Impact on Patients," available at www.npaf.org, stated:</p> <p>"When the Patient Protection and Affordable Care Act (PPACA) was signed into law in March 2010 and the Supreme Court of the United States subsequently upheld the constitutionality of the individual mandate, millions of previously uninsured Americans were given a new pathway to access quality, affordable health insurance coverage. The PPACA also included important coverage provisions designed to safeguard all Americans from medical debt crisis and medical expense-related bankruptcy, including the elimination of annual and lifetime limits on coverage and caps on out-of-pocket spending. These key provisions, many of which will be implemented in 2014, will assist patients who are at risk of experiencing a medical debt crisis that could threaten their ability to access care and could result in medical expense-related bankruptcy."</p>	<p style="text-align: center;">CON 1</p> <p>Quentin Young, MD, National Coordinator of Physicians for a National Health Program (PNHP), stated in a Mar. 30, 2010 article "Where We Are Now on Health Reform," available at www.healthcare-now.org:</p> <p>"The main cause of our dysfunctional health system, the for-profit private insurance industry, remains in the driver's seat..."</p> <p>The bill will do little if anything to check the runaway health system costs and their ability to visit bankruptcy and other forms of penury on the American people."</p>
<p style="text-align: center;">PRO 2</p> <p>Steven B. Larsen, JD, Deputy Administrator and Director for the Center for Consumer Information and Insurance Oversight, in his May 9, 2011 testimony before the US House of Representatives Committee on Energy & Commerce and Subcommittee on Oversight & Investigations, available at www.hhs.gov, stated:</p> <p>"With the new coverage options available in the PCIP [Pre-Existing Condition Insurance Plan; part of Obamacare] program, uninsured individuals with pre-existing conditions no longer need to wait and worry that their illness will bankrupt them, or that they will have to choose between a roof over</p>	<p style="text-align: center;">CON 2</p> <p>Megan McArdle, MBA, economics and government policy journalist, in her Sep. 27, 2013 Bloomberg article, "11 Pieces of Obamacare Conventional Wisdom That Shouldn't Be so Conventional," available at www.bloomberg.com, wrote:</p> <p>"You have probably read the studies showing that well over half of all bankruptcies are driven by medical problems. Well, maybe you didn't read the study, but you read the headlines on the articles about the studies. Unfortunately, those studies weren't very good -- they used extremely expansive definitions of 'medical bankruptcies,' which included people with relatively minor medical bills. And those same authors did a study in Massachusetts which found no significant decline in bankruptcies after Romneycare took effect.</p> <p>Don't get me wrong: I think medical bankruptcy is real. But it's complicated, because people who have really severe medical problems often also</p>

their head and paying for the cancer treatment they so desperately need. The PCIP program is another important program that will lead our transition to the new era of health insurance coverage for all Americans, through the Exchanges, in 2014.”

PRO 3

Cathy Sparkman, JD, Director of Government Affairs for the Association of Surgical Technologists, wrote in the May 2010 issue of *Surgical Technologist*:

"[PPACA] makes premium tax credits available through the Exchange to ensure people can obtain affordable coverage. Credits will be available for people with incomes above Medicaid eligibility and below 400 percent of poverty who are not eligible for or offered other acceptable coverage. Tax credits will apply to premiums and cost-sharing to ensure protection against bankruptcy due to medical expenses. Effective 2014."

PRO 4

Xavier Becerra, JD, US Representative (D-CA), posted on his webpage "Affordable Health Care for America," available at www.becerra.house.gov (accessed Sep. 28, 2012):

"The days when your family could be plunged into devastating medical debt and bankruptcy because of a serious medical condition are becoming history. The Patients' Bill of Rights puts you and your doctor back in charge of your health care-- and puts the insurance company bureaucrats in check."

PRO 5

Harry Reid, JD, US Senate Majority Leader (D-NV), stated in his May 15, 2013 press release "Remarks on House Republican's 37th Vote to Repeal Obamacare," available at reid.senate.gov:

"Thanks to the Affordable Care Act, insurance

have really severe income loss, which gives them a really severe mismatch between their debt payments and their ready funds. Getting rid of the medical bills helps -- I don't trust that latest study any more than the earlier ones -- but while I expect that Obamacare will somewhat reduce the number of people who end up in bankruptcy after a major illness, you'll still have a lot of sick people who end up bankrupt as well as ill. Canada still has Medical bankruptcies, despite a very comprehensive single-payer system."

CON 3

Don McCanne, MD, Senior Health Policy Fellow for Physicians for a National Health Program, in a Mar. 8, 2011 comment on a Mar. 2011 *American Journal of Medicine* article, "Reform in Massachusetts Fails to Reduce Medical Bankruptcies," available at www.pnhp.org, stated:

"Even with subsidies, insurance premiums are ever less affordable, and for those who need health care, out-of-pocket spending creates significant financial hardships. Since reform under the Affordable Care Act closely mirrors that of Massachusetts, their current experience with medical bankruptcy portends the future of medical bankruptcy throughout the United States.

The Massachusetts experience shows that merely providing insurance coverage to the majority of the population is not enough. The quality of the insurance coverage is crucial. In 2009, 89% of Massachusetts debtors and all their dependents had health insurance at the time of filing, yet the insurance was not effective in reducing the rate of medical bankruptcy below levels that already existed before the full implementation of the Massachusetts health reform program."

CON 4

Claudia Chaufan, MD, PhD, Professor of Sociology and Health Policy at University of California at San Francisco's Institute for Health

companies can no longer set arbitrary lifetime caps on benefits, putting millions of Americans one car accident or heart attack away from bankruptcy.”

PRO 6

Mark Perriello, President and CEO of the American Association of People with Disabilities (AAPD), stated in an Aug. 17, 2012 article "The Affordable Care Act Means That a Medical Diagnosis Like MS Is Not a Precursor to Bankruptcy," available at www.AAPD.com:

"Believe it or not, even some with health insurance have fallen into bankruptcy over medical bills. That's because before the Affordable Care Act (ACA) passed, insurance companies could drop people with disabilities and chronic illnesses from coverage. They could also impose 'lifetime caps' on people with MS, cancer, or other illnesses—*that means that they could stop paying medical expenses for an insured person who continues to pay premiums and is still ill.*

...The added risk of bankruptcy is something that [no] family should have to endure. That's one of the many reasons AAPD supports the Affordable Care Act, and why we will continue to do all we can to preserve this law."

and Aging, wrote in her July 2, 2010 article "A Second Opinion on US Health Care Reform," available at www.pnhp.org:

"...nearly 78 percent of personal bankruptcies in 2007 that were linked to medical debt involved persons who were insured at the onset of their illness or injury. PPACA [Patient Protection and Affordable Care Act], by allowing the sale of premiums for policies that will cover only 60 percent of health expenses, will do predictably little to change this state of affairs."

CON 5

Ryan Sugden, JD, stated in his July 14, 2012 article "Sick and (Still) Broke: Why the Affordable Care Act Won't End Medical Bankruptcy," available at digitalcommons.law.wustl.edu:

“In effect, by eschewing comprehensive, single-payer universal health insurance and leaving virtually untouched the fundamental structure of our country’s private health insurance industry, the Affordable Care Act has guaranteed that even medically insured individuals will continue to be on the hook for thousands of dollars of medical expenses...

Because the Affordable Care Act retains the — ‘competitive’ private structure of the health care industry, an industry that increasingly relies on consumer sensitivity to out-of-pocket expenses, the Affordable Care Act cannot and will not completely eliminate medical bankruptcy.”

--Costs--

41. Will Obamacare raise insurance premiums? – DEBATED

NOT CLEARLY PRO OR CON 1

Douglas W. Elmendorf, PhD, Director of the Congressional Budget Office (CBO), stated in a Mar. 30, 2011 testimony before the House Subcommittee on Health Committee on Energy and Commerce

"CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010." The transcript is available at www.cbo.gov:

"Under PPACA and the Reconciliation Act, premiums for health insurance in the individual market will be somewhat higher than they would otherwise be, CBO and JCT estimate, mostly because the average insurance policy in that market will cover a larger share of enrollees’ costs for health care and provide a slightly wider range of benefits. The effects of those differences will be offset in part by other factors that will tend to reduce premiums in the individual market; for example, purchasers in that market will tend to be healthier than they would have been under prior law, leading to lower average costs for their health care. Although premiums in the individual market will be higher on average, many people will end up paying less for health insurance—because the majority of enrollees purchasing coverage in that market will receive subsidies via the insurance exchanges.

Premiums for employment-based coverage obtained through large employers will be slightly lower than they would otherwise be; premiums for employment-based coverage obtained through small employers may be slightly higher or slightly lower."

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Gigi A. Cuckler, Andrea M. Sisko, PhD, and Sean P. Keehan, Economists in the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), et al., stated the following in their Sep. 2013 article “National Health Expenditure Projections, 2012-22: Slow Growth until Coverage Expands and Economy Improves, published in <i>Health Affairs</i>:</p> <p>“On a per enrollee basis, growth in private health insurance premiums is expected to accelerate to 6.0 percent, up from 3.2 percent in 2013.</p> <p>This acceleration is driven by expected increases in utilization for those covered through the Marketplaces. For these people, the availability of new, or potentially more generous, coverage through the Affordable Care Act’s coverage expansion—as well as the presence of premium and cost-sharing subsidies that partially offset the cost of care—is expected to lead to increased spending relative to their current status.”</p> <p style="text-align: center;">PRO 2</p>	<p style="text-align: center;">CON 1</p> <p>Christine Eibner, PhD, Economist at the RAND Corporation, and Amado Cordova, PhD, Senior Engineer at RAND Corporation, et al., stated the following in their Aug. 2013 report "The Affordable Care Act and Health Insurance Markets: Simulating the Effects of Regulation," available at rand.org:</p> <p>"Our estimates indicate that, on average, out-of-pocket premium spending for nongroup enrollees will fall due to new federal tax credits available after the Affordable Care Act takes full effect...</p> <p>In our main estimates, which assume that the individual and small group markets are split for the purposes of risk pooling, we find little to no change in small group premiums as a result of the law. For nine out of ten states considered, and for the United States overall, we find virtually no difference in age - , actuarial value - , and tobacco use – standardized small group premiums in scenarios with and without the Affordable Care Act. Of course, individual firms may experience an increase or decrease in premiums, depending on the health status of their enrollees. However,</p>

Drew Gonshorowski, MA, Policy Analyst in the Center for Data Analysis at The Heritage Foundation, stated the following in his Oct. 16, 2013 Issue Brief #4068, "How Will You Fare in the Obamacare Exchanges?," available at heritage.org:

"Individuals in most states will end up spending more on the exchanges. It is true that in some states, the experience could be the opposite. This is because those states had already over-regulated insurance markets that led to sharply higher premiums through adverse selection, as is the case of New York. Many states, however, double or nearly triple premiums for young adults. Arizona, Arkansas, Georgia, Kansas, and Vermont see some of the largest increases in premiums...

Many individuals will experience sticker shock when shopping on the exchanges. It is clear that many policies and cross-subsidization within Obamacare will lead to upward shifts in premiums...

...[T]he claims of savings on premiums for the average participant is a fantasy."

PRO 3

Paul Howard, PhD, Director and Senior Fellow at the Center for Medical Progress of Manhattan Institute for Policy Research, stated in his Aug. 1, 2012 article "Making Health Care Worse," available at www.nationalreview.com:

"Health-insurance costs have already risen significantly since the passage of Obamacare, albeit at a slower rate than before, owing to a stagnant economy. Since the law imposes heavy costs on the insurance industry — through taxes and onerous regulations that force insurance companies to spend more on health expenses — insurance premiums will likely continue to rise."

PRO 4

overall, we find no evidence to suggest that small premiums will systematically change as a result of the law."

CON 2

Barack Obama, JD, 44th President of the United States, stated the following during a July 16, 2012 campaign event "Remarks by the President at a Campaign Event," available at www.whitehouse.gov:

"You should know that once we have fully implemented [Obamacare], you're going to be able to buy insurance through a pool so that you can get the same good rates as a group that if you're an employee at a big company you can get right now - - which means your premiums will go down."

CON 3

The US Department of Health and Human Services stated in its Sep. 23, 2011 report "Reducing Costs, Protecting Consumers: The Affordable Care Act on the One Year Anniversary of the Patient's Bill of Rights," available at www.healthcare.gov:

"This report outlines how the Affordable Care Act is strengthening the health care system for all Americans and helping to control health care costs. The report finds that the Affordable Care Act's reforms have helped reduce premiums and hold insurance companies more accountable, and the Administration's anti-fraud efforts alone will save \$1.8 billion through 2015...

The MLR [Medical Loss Ratio] provision is already forcing insurance companies to carefully evaluate their rates, slow the rate of premium growth and, in some cases, decrease premiums..."

CON 4

David M. Cutler, PhD, Otto Eckstein Professor of Applied Economics at Harvard University, Karen

Douglas Holtz-Eakin, PhD, President of the American Action Forum, wrote in his Mar. 9, 2011 paper "Higher Costs and the Affordable Care Act," available at www.americanactionforum.org:

"Objective analysts have uniformly concluded that the new law raises – not lowers – national health-care spending. The rising bill for national health care spending will produce sustained upward pressures on health insurance premiums.

In addition, the law’s array of insurance market reforms will increase premiums. Barring limits on annual and lifetime out-of-pocket spending, coverage of children’s pre-existing conditions and the ability for children to stay on parents’ policies are all initiatives that enhance benefits. These benefits must necessarily be covered by higher premiums."

PRO 5

Chris Carlson, Fellow of the Society of Actuaries and Actuarial Principal at the consulting firm Oliver Wyman, wrote in his Oct. 31, 2011 report "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans," available at www.ahipcoverage.com:

“Our analysis estimates that the insurer fees [under Obamacare] will increase premiums in fully insured coverage markets by an average of 1.9% to 2.3% in 2014. The impacts generally increase over time such that we estimate by 2023, the fees will ultimately increase premiums by an average of 2.8% to 3.7%. For small group coverage, this will on average increase the cost to cover an individual by about \$2,800, and a family by about \$6,800 over a 10-year period, beginning in 2014."

PRO 6

Drew Altman, PhD, President and CEO of the Kaiser Family Foundation (KFF), wrote in his Sep. 27, 2011 article "Rising Health Costs Are Not Just a Federal Budget Problem," available at

Davis, PhD, President of The Commonwealth Fund, and Kristof Stremikis, MPP, MPH, Senior Research Associate for Commonwealth Fund, wrote in their May 21, 2010 report "The Impact of Health Reform on Health System Spending," available at www.commonwealthfund.org:

"We estimate that, on net, the combination of provisions in the new law will reduce health care spending by \$590 billion over 2010–2019 and lower premiums by nearly \$2,000 per family. Moreover, the annual growth rate in national health expenditures could be slowed from 6.3 percent to 5.7 percent..."

Reducing insurer administration and modernizing the delivery of health care services will each result in reductions in private insurance premiums. Private premiums might be affected by other provisions as well. For example, an excise tax on high-premium health insurance plans, set to take effect in 2018, will introduce a strong financial incentive for insurers to trim benefits and reduce costs below a tax-free threshold of \$10,200 for individual coverage and \$27,500 for family coverage. Indexing this cap to the overall rate of inflation in the economy plus one percentage point will encourage insurers to seek out value and efficiency continually, thus placing downward pressure on premiums over time."

CON 5

Tom Harkin, US Senator(D-IA), stated in his Apr. 20, 2010 speech to the Health, Education, Labor, and Pensions Committee "Statement of Chairman Tom Harkin (D-IA)," available at www.harkin.senate.gov:

“Those significant premium savings [under Obamacare] are the result of bringing everyone into the insurance pool, as well as administrative savings from larger purchasing pools and prohibiting medical underwriting for health status and pre-existing conditions. And of course, the Affordable Care Act includes an array of reforms

<p>www.kff.org:</p> <p>“...[R]egardless of how you feel about the Affordable Care Act, its effect on premiums this year is modest. Most of the law’s provisions don’t go into effect until 2014. The two biggest changes this year allow young adults up to age 26 to stay on their parents’ insurance policies and require some insurance plans to cover preventive services at no cost to patients. These are popular provisions that provide real benefits, and combined they account for about one to two percentage points of this year’s premium increase.”</p> <p style="text-align: center;">PRO 7</p> <p>Jim DeMint, MBA, US Senator (R-SC), stated in his May 16, 2012 posting "How ObamaCare Is Raising Premiums & Costs," available at www.demint.senate.gov:</p> <p>“ObamaCare's Exchanges will actually RAISE premiums, not lower them. The Administration claim that Exchanges will lower premiums ignores the fact that ObamaCare's new benefit mandates will increase individual market insurance premiums overall -- by an average of \$2,100 per family, according to the Congressional Budget Office.</p> <p>...[Obamacare] requires the purchase of benefit packages that are more comprehensive than what many Americans would otherwise buy. These more generous benefit packages may mean higher premiums.”</p>	<p>to reward quality and value, which will reduce health care costs over the long term.”</p>
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42. Will the government help people who cannot afford mandatory health insurance? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 36B, "Refundable Credit for Coverage under a Qualified Health Plan," page 95, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(a) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.”

PRO 1

The White House Office of the Press Secretary stated in its June 28, 2012 press release "FACT SHEET: The Affordable Care Act: Secure Health Coverage for the Middle Class," available at www.whitehouse.gov:

"Tax Credits for Middle Class Families and Small Businesses: Millions of Americans will soon be eligible for tax credits to ensure that their health insurance is affordable. Under today's ruling, having health insurance is and will continue to be a choice. If you can't afford insurance or you're a small business that wants to provide affordable insurance to your employees, you'll get tax credits that make coverage affordable."

PRO 2

Consumer Reports stated in its June 2012 posting "Update on Health Care Reform," available at www.consumerreports.org:

"If you buy on an exchange as an individual, you may qualify for a subsidy in the form of an advance tax credit if your household income is between 100 percent and 400 percent of the federal poverty level. (The tax system already subsidizes people who have coverage through a job by excluding the cost of their health plan from income taxes.)"

PRO 3

The Kaiser Family Foundation, stated the following in its Aug. 14, 2013 article "Quantifying Tax Credits for People Now Buying Insurance on Their Own," available at kff.org:

"A number of states have recently released information on what premiums will be in the individual insurance market in 2014, when significant changes in that market take effect due to the Affordable Care Act (ACA)..."

However, these premiums are in effect 'sticker prices' that many people will not pay because they will be eligible for federal tax credits under the ACA to offset the cost of insurance...

Premium subsidies (in the form of federal tax credits) will be available for people buying their own insurance in new marketplaces or exchanges who have incomes from 100% up to 400% of the poverty level (about \$24,000 to \$94,000 per year for a family of four in 2014). Those with access to affordable employer-provided insurance or Medicaid are ineligible for tax credits.

The amount of the tax credit is based on a benchmark premium, which is the cost of the second-lowest-cost silver plan in the area where a person lives. The tax credit equals that benchmark premium minus what the individual is expected to pay based on their family income (which is calculated on a sliding

scale from 2% to 9.5% of income).

Here is how the calculation might work for a 40-year-old individual making \$30,000 a year:

Estimated benchmark premium for a 40-year old = \$3,857 per year (which will vary from area to area)

Person is responsible for paying 8.37% of their income = \$2,512

Tax credit = \$1,345

The tax credit can be used in any plan offered in the health insurance marketplace, so the person would end up paying less than \$2,512 to enroll in the lowest cost silver plan or a lower cost bronze plan, and more to enroll in a higher cost plan.”

43. Are there penalties for small businesses (49 or fewer employees) which do not provide insurance for their employees? – NO

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1513, "Sec. 4980.H Shared Responsibility for Employers Regarding Health Coverage," page 136, signed into law on Mar. 23, 2010, available at www.thomas.gov:

"(2) APPLICABLE LARGE EMPLOYER.—

(A) IN GENERAL.—The term ‘applicable large employer’ means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

(B) EXEMPTION FOR CERTAIN EMPLOYERS.—

(i) IN GENERAL.—An employer shall not be considered to employ more than 50 full-time employees if—

(I) the employer’s workforce exceeds 50 fulltime employees for 120 days or fewer during the calendar year, and

(II) the employees in excess of 50 employed during such 120-day period were seasonal workers."

CON 1

Matthew Yglesias, Business and Economics Correspondent for *Slate*, in his July 2, 2012 article "Should Small Businesses Really Fear Obamacare?" available at www.slate.com, wrote:

“Firms with fewer than 50 employees are also exempt from the ‘employer responsibility’ provision of the law... [T]he law stipulates that companies whose employees receive subsidies to buy exchange plans must pay a financial penalty. That is supposed to deter firms from responding to the law by simply

dropping existing insurance coverage. But the ACA doesn't make small businesses pay that penalty.”

44. Are there taxes, penalties, or fines for large businesses (50 or more employees) which do not provide insurance for their employees? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1513, "Sec. 4980.H Shared Responsibility for Employers Regarding Health Coverage," page 135, signed into law on Mar. 23, 2010, available at www.thomas.gov:

"(a) LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.—

If—

(1) any applicable large employer fails to offer to its fulltime employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee, then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month."

GENERAL REFERENCE 2

Valerie Jarrett, JD, Senior Advisor and Assistant to the President for Intergovernmental Affairs and Public Engagement, stated the following in her July 2, 2013 posting on the White House Blog, "We're Listening to Businesses about the Health Care Law," available at whitehouse.gov:

"As we implement this law, we have and will continue to make changes as needed. In our ongoing discussions with businesses we have heard that you need the time to get this right. We are listening. So in response to your concerns, we are making two changes...

...[W]e are giving businesses more time to comply. As we make these changes, we believe we need to give employers more time to comply with the new rules. Since employer responsibility payments can only be assessed based on this new reporting, payments won't be collected for 2014. This allows employers the time to test the new reporting systems and make any necessary adaptations to their health benefits while staying the course toward making health coverage more affordable and accessible for their workers."

[**Editor's Note:** The Obamacare mandate requiring employers with 50 or more employees to provide coverage for their workers or pay penalties will not begin to be enforced until 2015.]

PRO 1

Elizabeth MacDonald, Stocks Editor for Fox News, wrote in her June 29, 2012 article "SCOTUS Ruling Means Bigger, More Intrusive IRS," available at www.foxbusiness.com:

"The health-reform law exempts all small businesses with fewer than 50 employees from the law's 'shared responsibility requirement,' which begins in 2014. But beginning in 2014, employers with 50 or more employees that do not offer health insurance coverage will pay a fine of \$2,000 per full-time worker if any of their employees turn around and get premium tax credits through the new health insurance exchanges.

Even if the small business has 51 workers, and that one worker gets a tax credit to help them buy insurance -- a tax credit provided under health reform -- the small business still has to pay a fine."

PRO 2

The US Department of Health and Human Services wrote in a January 2012 brochure titled "For Small Businesses: The Facts on the New Health Care Law," available online at www.healthcare.gov:

"...starting in 2014, a large employer may have to pay an assessment if it does not offer affordable insurance and one of its employees gets tax credits to purchase insurance in the Exchange. These assessments do not apply to businesses with less than 50 employees.

Large employers that do not offer health benefits coverage at all may be required to pay an assessment of \$2,000 per year for each fulltime employee, excluding the first 30 full-time employees. Larger employers that do offer health benefits coverage that is unaffordable or lacks minimum value may be assessed a payment of \$3,000 per year for each full-time employee receiving federal financial assistance. However, this payment cannot exceed the assessment the business would pay if it did not offer health care coverage. Note: the U. S. Department of Health and Human Services estimates that fewer than 2% of large American employers will have to pay these assessments."

PRO 3

Peter Schiff, *Forbes* Contributor, wrote in his July 31, 2012 article "Justice Roberts Is Right, Obamacare Won't Work," available at www.forbes.com:

"...the burdens placed on employers with more than 50 workers are complex, onerous and unpredictable. Those that don't offer insurance would be subject to substantial (and open ended) penalties if at least one employee receives an insurance tax credit or a government subsidy to an insurance exchange.

If they do offer insurance, they will also be subject to substantial (and open ended) penalties if the plan fails to cover 60% of employee health expenses, or if premiums for any employee are more than 9.5% of family income.”

PRO 4

The US Department of Labor, stated in its Feb. 9, 2012 Technical Release No. 2012-01 “Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods,” available at www.dol.gov:

“The employer shared responsibility provisions, contained in section 4980H of the Internal Revenue Code (Code), provide that an applicable large employer (for this purpose, an employer with 50 or more full-time equivalent employees) could be subject to an assessable payment if any full-time employee is certified to receive an applicable premium tax credit or cost-sharing reduction payment. Generally, this may occur where either:

1. The employer does not offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; or
2. The employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that either is unaffordable relative to an employee’s household income or does not provide minimum value.

For purposes of section 4980H, a 'full-time employee' is an employee who is employed on average at least 30 hours per week.”

45. Does Obamacare place limits on out-of-pocket charges (co-payments and deductibles) that insurance policies can collect? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1302(c), "Requirements Related to Cost-Sharing," page 47-48, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(1) ANNUAL LIMITATION ON COST-SHARING.—

(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount

and the premium adjustment percentage under paragraph (4) for the calendar year; and (ii) in the case of other coverage, twice the amount in effect under clause (i). If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(2) ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS.—

(A) IN GENERAL.—In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—

(i) \$2,000 in the case of a plan covering a single individual; and (ii) \$4,000 in the case of any other plan. The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).

(B) INDEXING OF LIMITS.—In the case of any plan year beginning in a calendar year after 2014—

(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and (ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i). If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.”

GENERAL REFERENCE 2

[Editor's Note: On Feb. 20, 2013, the US Department of Labor (DOL) announced a delay of the implementation of the cost-sharing limits for group health plans or group health insurance issuers that use more than one service provider to administer benefits. Instead of taking effect on Jan. 1, 2014, the implementation has been delayed until Jan. 1, 2015.]

PRO 1

Robert Pear, MPhil, *New York Times* Domestic Correspondent, stated the following in his Aug. 12, 2013 article “A Limit on Consumer Costs Is Delayed in Health Care Law,” available at nytimes.com:

"...[T]he administration has delayed until 2015 a significant consumer protection in the law [Patient Protection and Affordable Care Act] that limits how much people may have to spend on their own health care.

The limit on out-of-pocket costs, including deductibles and co-payments, was not supposed to exceed \$6,350 for an individual and \$12,700 for a family. But under a little-noticed ruling, federal officials have granted a one-year grace period to some insurers, allowing them to set higher limits, or no limit at all on some costs, in 2014...

Under the policy, many group health plans will be able to maintain separate out-of-pocket limits for benefits in 2014. As a result, a consumer may be required to pay \$6,350 for doctors' services and hospital care, and an additional \$6,350 for prescription drugs under a plan administered by a pharmacy benefit manager.

Some consumers may have to pay even more, as some group health plans will not be required to impose any limit on a patient's out-of-pocket costs for drugs next year. If a drug plan does not currently have a limit on out-of-pocket costs, it will not have to impose one for 2014."

PRO 2

The United Methodist Church General Board of Pension and Health Benefits stated the following in its Mar. 19, 2013 publication "Health Care Reform – Essential Health Benefits, Cost-Sharing Limits and Minimum Value," available at gbophb.org:

“Annual Deductible Limit: Beginning in 2014, the annual deductible for a health plan in the individual or small group market may not exceed \$2,000 for self-only coverage and \$4,000 for family coverage. For plans using provider networks, an enrollee's cost-sharing for out-of-network benefits does not count toward the annual deductible limit. HHS will increase the annual deductible limits annually. This annual deductible limit applies only in the fully-insured individual and small group markets. Thus, the limit does not apply to HealthFlex, other self-insured annual conference plans or fully-insured annual conference plans in the large group market (large group plans typically cover more than 50 employees).

Out-of-Pocket Maximum: Beginning January 1, 2014, the ACA places annual limits on total participant cost-sharing for EHBs [essential health benefits]. Once the limitation on cost-sharing (i.e., the out-of-pocket maximum) is reached for the year, the participant is not responsible for additional cost-sharing for the remainder of the year. The ACA's out-of-pocket maximum applies to all non-grandfathered health plans and group health plans. This would include, for example, self-insured health plans and fully-insured health plans of any size in any market. The out-of-pocket maximums will apply to HealthFlex and self-insured annual conference plans.”

PRO 3

The US Department of Labor (DOL) stated the following in its Feb. 20, 2013 “FAQs about Affordable Care Act Implementation Part XII,” available at dol.gov:

"[T]he Affordable Care Act, provides that a group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under section 1302(c)(1) and (c)(2) of the Affordable Care Act. Section 1302(c)(1) limits out-of-pocket maximums and section 1302(c)(2) limits deductibles for employer-sponsored plans...

The HHS final regulation on standards related to essential health benefits implements the deductible provisions described in section 1302(c)(2) for non-grandfathered health insurance coverage and qualified health plans offered in the small group market, including a provision implementing section 1302(c)(2)(C) so that such small group market health insurance coverage may exceed the annual deductible limit if it cannot reasonably reach a given level of coverage (metal tier) without exceeding the deductible limit...

The Departments recognize that plans may utilize multiple service providers to help administer benefits (such as one third-party administrator for major medical coverage, a separate pharmacy benefit manager,

and a separate managed behavioral health organization). Separate plan service providers may impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums...

The Departments have determined that, only for the first plan year beginning on or after January 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums under section 2707(a) or 2707(b), the Departments will consider the annual limitation on out-of-pocket maximums to be satisfied if both of the following conditions are satisfied:

The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and

To the extent the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), such out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302(c)(1)."

--Deficit--

46. Will Obamacare decrease the federal deficit? – DEBATED

GENERAL REFERENCE 1

Source & Date / View on Obamacare	Increase / Decrease in Deficit	Time Period	Average Per Year	Details
2013				
1a. US Government Accountability Office Published Jan. 31, 2013 Nonpartisan on Obamacare	0.7% of GDP (increase)	75 years	N/A	"[This calculation] assumed cost containment mechanisms specified in PPACA were phased out over time while the additional costs associated with expanding federal health care coverage remained."
1b. US Government Accountability Office Published Jan. 31, 2013 Nonpartisan on Obamacare	1.5% of GDP (decrease)	75 years	N/A	"[This calculation] "assumes both the expansion of health care coverage and the full implementation and effectiveness of the cost-containment provisions over the entire 75-year simulation period."

2.	White House Accessed Oct. 9, 2013 PRO Obamacare	\$200 billion (decrease)	10 Years	\$20 billion (decrease)	N/A
2012					
3.	Congressional Budget Office Published July 24, 2012 Nonpartisan on Obamacare	\$109 billion (decrease)	2013-2022	\$10.9 billion (decrease)	"In constructing projections of budget outcomes, CBO takes existing law as it stands and does not attempt to predict changes that might be made by the Congress in the future." <i>Source: CBO, "Our Processes," cbo.gov (accessed Oct. 11, 2013)</i>
4.	Charles Blahous, Mercatus Center Published Mar. 3, 2012 CON Obamacare	\$340-530 billion (increase)	2012-2021	\$34-53 billion (increase)	The budgetary conclusions of this report were based, in part, upon the assumption that "several of the ACA's provisions may not be enforced as currently specified." The costs of health exchanges may be higher than projected; revenue from new surcharges/taxes may be lower than projected; Congress may gut IPAB; and the CLASS program was shelved by HHS. <i>Source: Mercatus Center, "Brief Summary: The Fiscal Consequences of the Affordable Care Act," mercatus.org, Apr. 2010</i>
2011					
5.	Congressional Budget Office Published Feb. 2011 Nonpartisan on Obamacare	\$210 billion (decrease)	2012-2021	\$21 billion (decrease)	"In constructing projections of budget outcomes, CBO takes existing law as it stands and does not attempt to predict changes that might be made by the Congress in the future." <i>Source: CBO, "Our Processes," cbo.gov (accessed Oct. 11, 2013)</i>
6.	Michael Tanner, CATO Institute Published Jan. 19, 2011 CON Obamacare	\$700 billion (increase)	10 years	\$70 billion (increase)	This paper arrived at its deficit estimation by including the "implementation costs" of Obamacare and by assuming that the reductions in Medicare spending called for under Obamacare will not happen.
2010					
7.	Douglas Holtz-Eakin, Health Affairs Published June 2010 CON Obamacare	\$562 billion (increase)	10 years	\$56.2 billion (increase)	The budgetary conclusions of this report were arrived at by "[r]emoving the potentially unrealistic annual savings, reflecting the full costs of implementing the programs, [and] acknowledging the unlikelihood of raising all of the promised revenues."
8.	Congressional Budget Office Published Mar. 2010 Nonpartisan on Obamacare	\$143 billion (decrease)	2010-2019	\$14.3 billion (decrease)	"In constructing projections of budget outcomes, CBO takes existing law as it stands and does not attempt to predict changes that might be made by the Congress in the future." <i>Source: CBO, "Our Processes," cbo.gov (accessed Oct. 11, 2013)</i>

GENERAL REFERENCE 2

The US Government Accountability Office (GAO) stated the following in its Jan. 31, 2013 report, "Patient Protection and Affordable Care Act: Effect on Long-Term Federal Budget Outlook Largely Depends on Whether Cost Containment Sustained," available at gao.gov:

"The effect of the Patient Protection and Affordable Care Act (PPACA), enacted in March 2010, on the long-term fiscal outlook depends largely on whether elements in PPACA designed to control cost growth are sustained [such as productivity adjustments for Medicare payments, the Independent Payment Advisory Board, and the Medicare Shared Savings Program]. There was notable improvement in the longer-term outlook after the enactment of PPACA under GAO's Fall 2010 Baseline Extended simulation, which assumes both the expansion of health care coverage and the full implementation and effectiveness of the cost-containment provisions over the entire 75-year simulation period...

The Fall 2010 Alternative simulation assumed cost containment mechanisms specified in PPACA were phased out over time while the additional costs associated with expanding federal health care coverage remained. Under these assumptions, the long-term outlook worsened slightly compared to the pre-PPACA January 2010 simulation...

...[T]he long-term fiscal outlook improved in our Baseline Extended simulation. The primary deficit declined 1.5 percentage points as a share of GDP over the 75-year period in this simulation. On the spending side, about 1.2 percent of GDP of this improvement was attributable to PPACA [Obamacare]. In contrast... the primary deficit under our Alternative simulation increased by 0.7 percent of GDP during this time period, due largely to increased spending on Medicaid, CHIP, and exchange subsidies."

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>The Congressional Budget Office (CBO), in testimony delivered by its Director, Douglas W. Elmendorf, PhD, stated the following during a Mar. 30, 2011 hearing before the Subcommittee on Health of the US House Committee on Energy and Commerce, available at cbo.gov:</p> <p>"In March 2010, CBO and JCT [Joint Committee on Taxation] estimated that enacting PPACA and the Reconciliation Act would produce a net reduction in federal deficits of \$143 billion over the 2010–2019 period...</p> <p>In February 2011, CBO and JCT estimated that repealing PPACA and the health related provisions of the Reconciliation Act would produce a net increase in federal deficits of \$210 billion over the 2012–2021 period... Therefore, CBO and JCT effectively estimated in February [2011] that PPACA and the health-related provisions of the Reconciliation Act will produce a net decrease in federal deficits of \$210 billion over the 2012–2021</p>	<p style="text-align: center;">CON 1</p> <p>Douglas Holtz-Eakin, PhD, former Director of the CBO, and Michael J. Ramlet, former Director of Health Policy at American Action Forum, stated the following in their June 2010 publication "Health Care Reform Is Likely to Widen Federal Budget Deficits, Not Reduce Them," published in <i>Health Affairs</i>:</p> <p>"The final score of the Patient Protection and Affordable Care Act with reconciliation amendments was released publicly 20 March 2010. The CBO and the Joint Committee on Taxation estimated that the act would lead to a net reduction in federal deficits of \$143 billion over ten years, with \$124 billion in net reductions from health reform and \$19 billion derived from education provisions...</p> <p>Is it really likely that a large expansion of public spending will reduce the long-run deficit? The answer, unfortunately, hinges on provisions of the legislation that the CBO is required to take at face</p>

<p>period...</p> <p>The difference between the two estimates is primarily attributable to the different time periods they cover...</p> <p>Over the eight years that are common to the two analyses—2012 to 2019—enactment of PPACA and the health-related provisions of the Reconciliation Act was projected last March to reduce federal deficits by \$132 billion, whereas the February 2011 estimate shows that those provisions will reduce deficits by an estimated \$119 billion...</p> <p>On the basis of its February 2011 analysis, CBO projected that PPACA and the Reconciliation Act would reduce federal budget deficits during the 2022–2031 period by an amount that is in a broad range around one-half percent of GDP, assuming that all provisions of the legislation were fully implemented."</p> <p>[Editor's Note: The CBO and JCT have also confirmed that the PPACA will reduce the deficit via their July 24, 2012 and May 15, 2013 letters referenced below.</p> <p>In a July 24, 2012 letter to Speaker of the House John Boehner (R-OH), the CBO and JCT estimated that HR 6079, the Repeal Obamacare Act, would increase the federal deficit by \$109 billion over the 2013-2022 period. The letter stated that "the estimated budgetary effects of repealing the ACA by enacting H.R. 6079 are close to, but not equivalent to, an estimate of the budgetary effects of the ACA with the signs reversed."</p> <p>In a May 15, 2013 letter to the Chairman of the Committee on the Budget Paul Ryan concerning HR 45, another bill to repeal Obamacare, the CBO and JCT stated that they were unable to estimate the budgetary effects of HR 45 due to time constraints, however they stated that they "anticipate a similar result" as their estimation on the effects of HR 6079 - an increase in the federal</p>	<p>value and not second-guess.</p> <p>A more realistic assessment emerges if one strips out gimmicks and budgetary games and reworks the calculus...</p> <p>What is the bottom line? Removing the potentially unrealistic annual savings, reflecting the full costs of implementing the programs, acknowledging the unlikelihood of raising all of the promised revenues, and preserving premiums for the programs they are intended to finance produces a radically different bottom line. The act generates additional deficits of \$562 billion in the first ten years. And because the nation would be on the hook for two more entitlement programs rapidly expanding as far as the eye can see, the deficit in the second ten years would approach \$1.5 trillion."</p> <p style="text-align: center;">CON 2</p> <p>Jeff Sessions, US Senator (R-AL), stated the following during his Sep. 26, 2013 speech on the Senate floor, available at www.budget.senate.gov:</p> <p>"A report issued in February at my request by the Government Accountability Office revealed that under a realistic set of assumptions the health care law is projected to increase the federal deficit by 0.7% of GDP over the next 75 years, an amount that is equivalent to \$6.2 trillion in today's dollars. This estimate excludes debt service costs. This is an enormous sum...</p> <p>This report is crucial. It clearly answered the question. It sank any validity to the President's claim that his plan would not add 'one dime to our deficits, now or anytime in the future, period'...</p> <p>So, despite what we were told by proponents of this law, the truth is the President's health care law will further increase the cost of health care, add to our already unsustainable deficits and debt."</p> <p>[Editor's Note: The "February" Government Accountability Office (GAO) report referenced in</p>
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deficit of \$109 billion over the 2013-2022 period.]

PRO 2

Robert Greenstein, President of the Center on Budget and Policy Priorities, stated the following in his July 26, 2011 testimony before the Senate Committee on Finance, available at cbpp.org:

"In the long run, the single largest contribution to deficit reduction will need to come from slowing the rate of growth of health care costs throughout the U.S. health care system...

The recently enacted health reform law includes most of the steps we know how to take now to reduce expenditures in these areas; that is how the Affordable Care Act is able to produce modest deficit reduction even as it extends coverage to 34 million uninsured Americans...

To help address the need to slow systemwide cost growth, the Affordable Care Act contains an extensive array of demonstration projects, pilots, and research to test and identify cost-saving reforms in health care delivery and payment systems that could produce substantial savings throughout the health care system. (It also includes important mechanisms, including the Independent Payment Advisory Board, to help assure implementation of cost-saving reforms.)"

PRO 3

The Council of Economic Advisers, an agency within the Executive Office of the President, stated the following in their Feb. 2012 publication "The Annual Report of the Council of Economic Advisers," available at nber.org:

"Health care legislation passed in 2010 is a key factor to gains in longrun deficit reduction. The Affordable Care Act addressed the Nation's most profound long-run budget challenge by limiting the growth in health care costs in several ways...

the above quote by Senator Jeff Sessions is the Jan. 31, 2013 GAO report referenced in our chart and general reference quote at the top of this page. Unlike the CBO, the GAO is allowed to explore alternative scenarios at congressional request. Senator Sessions requested that the GAO prepare both a baseline scenario and an alternative scenario which assumed various cost containment provisions in Obamacare would be eliminated by Congress over time including productivity adjustments for Medicare payments, the Independent Payment Advisory Board, and the Medicare Shared Savings Program. The GAO's baseline report found that Obamacare would decrease the federal deficit by 1.5% of GDP over 75 years while the alternative scenario report found Obamacare would increase the federal deficit by 0.7% over 75 years.]

CON 3

Charles Blahous, Senior Research Fellow at the Mercatus Center at George Mason University, stated in his Mar. 3, 2012 study "The Fiscal Consequences of the Affordable Care Act," available at www.mercatus.org:

"Over the years 2012-21, the ACA is expected to add at least \$340 billion and as much as \$530 billion to federal deficits while increasing federal spending by more than \$1.15 trillion over the same period and by increasing amounts thereafter... Roughly two-thirds of the law's subsidies for health insurance exchanges must be eliminated to avoid worsening federal deficits and the entirety of their costs eliminated to avoid further increasing federal health care financing commitments."

CON 4

Michael Tanner, Senior Fellow at the Cato Institute, stated the following in his Jan. 19, 2011 article "Five Myths about New Health Care Law," published in the Orange County Register:

"Myth: The health care law reduces the deficit.

The Act includes Medicare payment reforms that will restrain spending growth by rewarding improvements in health care productivity. It established the Center for Medicare and Medicaid Innovation, which will fund and test new strategies for providing high-quality care more efficiently, and the Independent Payment Advisory Board, which will recommend policies to reduce the growth in Medicare spending, without limiting beneficiaries' access to care.

...[I]n the absence of recent health care reform, long-run budget projections would be substantially worse."

PRO 4

The White House stated on its webpage "Deficit-Reducing Health Care Reform," available at www.whitehouse.gov (accessed Oct. 9, 2013):

"In keeping with the President's pledge that reform must fix our health care system without adding to the deficit, the Affordable Care Act reduces the deficit, saving over \$200 billion over 10 years and more than \$1 trillion in the second decade. The law reduces health care costs by rewarding doctors, hospitals and other providers that deliver high quality care and making investments to fund research into what works.

Rising health care costs are a major driver of our long-term deficits, and getting them under control is crucial if we want to grow the economy, create jobs and compete in the world economy. "

It is true the CBO has officially 'scored' the health care bill as costing \$950 billion and warns that repealing it would add \$230 billion to the deficit. However, those numbers do not tell the whole story, nor do they reveal the bill's true cost.

For example, CBO estimates do not include roughly \$115 billion in implementation costs, such as the cost of hiring new IRS agents to enforce the bill's individual mandate.

The CBO estimate also assumes Congress will not repeal an anticipated 23 percent reduction in Medicare spending (the so-called 'doc-fix'). But Congress already has postponed those cuts by a year, and no one seriously expects them to remain intact.

A true accounting of all the bill's costs suggests that repeal could actually reduce the budget deficit by as much as \$700 billion over 10 years."

CON 5

Mitt Romney, JD, Republican Presidential candidate and former Governor of Massachusetts, stated in a June 28, 2012 press release, available at www.mittromney.com:

"Obamacare raises taxes on the American people by approximately \$500 billion. Obamacare cuts Medicare, by approximately \$500 billion. And even with those cuts, and tax increases, Obamacare adds trillions to our deficits and to our national debt and pushes those obligations on to coming generations."

--Employers--

47. Is Obamacare financially burdensome for businesses? – DEBATED

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>The International Franchise Association (IFA) wrote in its Sep. 2011 report "The Effects of the Patient Protection and Affordable Care Act on the Franchise Industry," available at www.franchise.org:</p> <p>"Our report shows that the new health care law will have negative effects on the franchising industry's ability to grow and create much-needed jobs for the U.S. economy. We estimate that the law will negatively affect tens of thousands of franchise businesses, adding more than \$6.4 billion in increased costs, not including the cost of regulatory compliance. Further, we estimate that the jobs of more than 3.2 million full-time employees in franchise businesses would be put at risk.</p> <p>These effects can best be described cumulatively as anti-small business growth. The health care law unintentionally discourages franchisees from owning and operating multiple locations. The law creates a competitive disadvantage for franchisees who do own more than one or two locations. The employer mandate in the law provides an incentive for franchisors and franchisees to replace fulltime workers with part-time and temporary workers. It imposes another layer of regulatory burden on business owners as they attempt to understand and comply with the new law. It increases the cost of doing business for tens of thousands of business owners who are struggling to recover from the deepest recession since the Great Depression. The law ultimately creates barriers to entrepreneurs who are looking to capitalize on the franchise business model to grow their business."</p>	<p style="text-align: center;">CON 1</p> <p>Steny Hoyer, JD, US Representative (D-MD), stated in his Mar. 20, 2012 article "Myth Versus Fact: How the Affordable Care Act Provides Patient Protections, Lowers Health Care Costs," available at www.democraticwhip.gov:</p> <p>"GOP Myth: Health care reform will hurt our economy and small businesses.</p> <p>Fact: Our economy has continued to see private sector job growth, and small and large businesses are benefiting from provisions that help them provide quality, affordable health care coverage to their employees.</p> <ul style="list-style-type: none"> • Since the Affordable Care Act was signed into law, the economy has created 3.5 million private sector jobs, including 488,000 jobs in the health care industry. The unemployment rate is 8.3%, lower than it was in March 2010. • 360,000 small businesses have taken advantage of tax credits that are making health insurance more affordable for 2 million workers. As many as four million small businesses are eligible for these credits. • And over 2,800 employers are participating in the Early Retiree Reinsurance Program, which is helping provide coverage to 13 million early retirees who are not yet eligible for Medicare." <p style="text-align: center;">CON 2</p> <p>Jason Furman, Assistant to the President for</p>

PRO 2

Leonard Steinberg, MBA, Principal of Steinberg Enterprises, LLC, stated in his Apr. 18, 2012 testimony before the House Committee on Small Business, available at www.smallbusiness.house.gov:

"Regardless of how the U.S. Supreme Court rules on the constitutionality of the Affordable Care Act, many small business entrepreneurs are concerned with the new taxes and regulations that the law imposes. Some employers have expressed concerns that they may not be able to afford to keep their employees..."

The proposed tax increases in the Affordable Care Act will alter the way small businesses view each expenditure and cause them to be risk averse. Businesses will stagnate since business owners will be unsure of what additional rules and regulations will be promulgated by the U.S. Secretary of Health and Human Services. This uncertainty takes money out of the worker's pockets, reduces job creation and will lead to a decline in the overall economy since there will be fewer dollars available for disposable income and less risk-taking overall."

PRO 3

Robert F. Graboyes, MSHA, PhD, Senior Healthcare Advisor at the National Federation of Independent Business, wrote in his Mar. 31, 2010 blog entry "Health Care Rx: Not an Ending, Only a Beginning," available at www.washingtonpost.com:

"For small business, the new health-care law begins a long struggle against cost increases, uncertainty and perverse incentives. Traditionally, small business produces over two-thirds of America's new jobs, but this bill jeopardizes that role."

Economic Policy and Principal Deputy Director of the National Economic Council, wrote in his June 29, 2012 article "Upholding the Affordable Care Act Is a Win for Small Businesses," available at www.whitehouse.gov:

"The Supreme Court's decision this week to uphold the Affordable Care Act is a historic win for the nation's 6 million small businesses and their 54 million employees who will see fewer administrative headaches, pay lower premiums, and receive help to make the cost of covering employees more affordable. Those who claim that the law will place new burdens on small employers misunderstand and misrepresent how it will actually work – putting small businesses on a more competitive footing with larger firms."

CON 3

Matthew Yglesias, *Slate* Business and Economics Correspondent, wrote in his July 2, 2012 article "Should Small Businesses Really Fear Obamacare?," available at www.slate.com:

"The bill [PPACA] in fact contains substantial benefits (some might even say giveaways) for small businesses. That starts with a program already under way to offer special subsidies to firms with fewer than 25 employees that want to offer health benefits. As long as your employees earn less than \$50,000 on average... you can get a tax credit to defray 35 percent of the cost of the insurance if you're a for-profit firm, and 25 percent if you're a nonprofit. When the law really gets rolling in 2014, those subsidies rise to 50 percent for for-profits and 35 percent for nonprofits..."

Firms with fewer than 50 employees are also exempt from the 'employer responsibility' provision of the law that otherwise constitutes the biggest business burden in the legislation....

Put the special subsidies and the exemption together, and the result is a law that's pretty clearly

Premium increases will dominate the near-term horizon... Millions of people will begin gaining insurance, with no commensurate increase in the number of doctors and other providers; this will push medical fees upwards...

Premium hikes won't be limited to small business. Based on only one of the myriad new tax provisions, AT&T, John Deere, Caterpillar, 3M, and other companies are setting aside billions of dollars for anticipated losses. They can't spend these dollars on jobs, products, and investment. Small businesses who sell to these companies will feel the secondary effects of this contraction...

Small business will fight every day to survive this bill."

PRO 4

The Detroit News stated the following in a Sep. 18, 2013 editorial article titled "Obamacare Hurts Michigan Businesses," available at detroitnews.com:

"Kalamazoo-based, medical-products maker Stryker Corp. says Obamacare's 2.3 percent medical device tax will cost the company \$100 million this year, reducing its research and development budget by over 20 percent — meaning a loss of 1,000 workers. The Fortune 500 company is just one of many Michigan employers being negatively impacted, making the state a witness to the national economic harm that Obamacare has wrought..."

PRO 5

Michael F. Cannon, MA, JM, Director of Health Policy Studies at the Cato Institute, stated the following in his Aug. 17, 2010 article titled "ObamaCare: The Burden on Small Business," available at cato.org:

"These mandates are a double-whammy for our small-business owner. He already faces some of

a good deal for small businesses."

CON 4

Gene Marks, columnist, author, and small business owner, stated the following in his Mar. 21, 2012 article titled "Why Healthcare Reform Is Great (And Terrible) For Small Business," available at huffingtonpost.com:

"...[I]f you have less than fifty employees (like I do) than you're exempt from the law. You don't have to do anything. You can have a health insurance plan. Or you don't have to have a health insurance plan. It's completely up to you..."

And what if you have more than fifty employees? Well, you're required to have a health insurance plan. If you don't than you have to eventually pay a fine/fee/penalty ... tax of \$2,000 per employee. That sounds like a lot. But it's actually not as much as you think. When you dig down in the calculation, you'll see that the first 30 employees are exempt from the tax. And then when you compare the tax to what you're probably now paying for health insurance (which averages between \$8,000-\$11,000 per employee according to some studies), you may find that not carrying insurance and just paying the tax is way less expensive than carrying the insurance...

Because we're promised lower insurance rates and a state-run competitive exchange of products we may also find ourselves avoiding that annual anxiety attack when we're told how much our rates are going up that year. Theoretically, health insurance, previous subject to 15-20% annual increases, should now be more under control and easier to budget. At least that's what we're told. And that's another great thing for small businesses."

CON 5

Joan McCarter, Senior Political Writer for Daily Kos, wrote the following in her Dec. 9, 2012

the highest premiums out there. Yet he also provides some of the least comprehensive health plans. So his premiums will rise more than larger employers' premiums will...

If our small-business owner has 50 or more employees — or fewer full-time employees and lots of part-timers — he faces the prospect of tens of thousands of dollars in penalties under ObamaCare's employer mandate if he does not provide 'adequate' coverage to his workers.

The worst part is that these penalties will be triggered by factors that are unpredictable, unobservable, and totally beyond the control of our small-business owner."

PRO 6

The US Chamber of Commerce, wrote in its Apr. 26, 2010 white paper "Critical Employer Issues in the Patient and Protection and Affordable Care Act," available at www.uschamber.com:

"The basic premise of the law fundamentally shifts the foundation of employer-sponsored benefits in America. What has been a voluntary and flexible system will now be a one-size-fits-some landscape... Because of the mandatory nature of the law, employers may find it more difficult to offer affordable coverage, may become competitively disadvantaged, and may drop coverage altogether in an effort to stay in business."

article titled "What Obamacare Means for Businesses: Facts vs. Fiction," available at dailykos.com:

"...[B]ecause of a lack of good public education about the Affordable Care Act from the administration and supportive members of Congress, other business owners, especially small business owners, are left with the idea that maybe this Obamacare is just going to be too expensive and too burdensome. That's a big problem, especially for employees of small businesses. Because for those businesses there are some pretty good deals.

The smallest employers are not only exempt from any potential fine for not providing insurance, if they do or want to provide insurance to employees, they can get tax credits to help do that. That's in effect now for companies with few than 25 employees and wages below \$50,000 each. If they offer insurance and pay at least half the premiums, they can receive a tax credit of up to 35 percent of their contributions. After 2014, the tax credit goes up to 50 percent if the business buys coverage through the insurance exchange. Companies that have up to 50 employees and who do not provide health care benefits are not subject to any fines for not providing that coverage. Their employees will be able to get their coverage in the health exchanges the law creates starting in 2014.

Here's one of the greatest things for small business owners: they can afford health insurance for themselves!"

48. Will Obamacare lead to a decline in employment-based health insurance? – DEBATED

NOT CLEARLY PRO OR CON 1

John E. Dicken, Director of Health Care Issues at the Government Accountability Office (GAO), wrote in his July 13, 2012 report "Estimates of the Effect on the Prevalence of Employer-Sponsored Health Coverage," available at www.gao.gov:

"The five studies GAO reviewed that used microsimulation models to estimate the effects of the Patient Protection and Affordable Care Act (PPACA) on employer-sponsored coverage generally predicted little change in prevalence in the near term, while results of employer surveys varied more widely. The five microsimulation study estimates ranged from a net decrease of 2.5 percent to a net increase of 2.7 percent in the total number of individuals with employer-sponsored coverage within the first 2 years of implementation of key PPACA provisions, affecting up to about 4 million individuals... Longer-term predictions of prevalence of employer-sponsored coverage were fewer and more uncertain, and four microsimulation studies estimated that from about 2 million to 6 million fewer individuals would have employer-sponsored coverage in the absence of the individual mandate compared to with the mandate."

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Jessica Banthin, PhD, economist, and Paul Jacobs, PhD, analyst, for Congressional Budget Office's (CBO) Health and Human Resources Division, wrote in their Mar. 15, 2012 report "The Effects of the Affordable Care Act on Employment-Based Health Insurance," available at www.cbo.gov:</p> <p>"CBO [Congressional Budget Office] and the staff of the Joint Committee on Taxation (JCT) continue to expect that the Affordable Care Act (ACA)—the health care legislation enacted in March 2010—will lead to a small reduction in the number of people receiving employment-based health insurance...</p> <p>As reflected in CBO's latest baseline projections, the two agencies now anticipate that, because of the ACA, about 3 million to 5 million fewer people, on net, will obtain coverage through their employer each year from 2019 through 2022 than would have been the case under prior law."</p> <p>[Editor's Note: A table from the CBO's updated "May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage" explains that "the change in employment-based coverage is the net result of projected increases in and losses of offers of health insurance from employers and changes in enrollment by workers and their families. For example, in 2019, an estimated 11 million people</p>	<p style="text-align: center;">CON 1</p> <p>Ezra Klein, Columnist at the Washington Post and contributor for MSNBC, wrote in his May 24, 2013 article "Everything You Know about Employers and Obamacare Is Wrong," available at washingtonpost.com:</p> <p>"There's real concern that companies will see the Affordable Care Act as an opportunity to drop health insurance for their employees and let taxpayers pick up the tab. For those with more than 50 full-time workers, that'll mean paying a \$2,000 to \$3,000 penalty for each one, but that's a whole lot cheaper than paying for health insurance... But people simply misunderstand why employers offer health-care benefits. They're not doing it as a favor to employees. And they're not doing it because anyone is making them... Employers offer health insurance because employees demand it. If you're an employer who doesn't offer insurance and your competitors do, you'll lose out on the most talented workers. An employer who stopped offering health benefits would see his best employees immediately start looking for other jobs...</p> <p>There are a couple other reasons to expect that employers won't be eager to drop coverage. First, because employer-provided health benefits are not taxed, employers can pay their workers more by paying them partly in health-care benefits. Let's say an employer decides to stop offering health</p>

who would have had an offer of employment-based coverage under prior law will lose their offer under current law, and another 3 million people will have an offer of employment-based coverage but will enroll in health insurance from another source instead. These flows out of employment-based coverage will be partially offset by an estimated 7 million people who will newly enroll in employment-based coverage under the Affordable Care Act.”]

PRO 2

The House of Representatives Ways and Means Committee stated in its May 1, 2012 report "Broken Promise: Why ObamaCare Will Force Americans to Lose the Health Care Coverage They Have and Like," available at www.waysandmeans.house.gov:

“As a result of the Democrats’ employer mandate, many employers who offer coverage to their employees will be left with a choice: continue offering health insurance (which is expected to become more expensive because of the Democrats’ health care law) to their employees or pay a penalty for not offering such coverage. Unfortunately... it will be far cheaper for employers to simply drop their health insurance and pay the fine, because the costs of meeting the burdensome mandates required for health insurance plans far exceed the price of the fine...

The Democrats’ health care law contains a number of policies that create perverse financial incentives for employers to stop offering health insurance to their employees, perhaps none more so than the employer mandate."

PRO 3

Douglas Holtz-Eakin, PhD, President of the American Action Forum and former Director of the Congressional Budget Office, and Cameron Smith, MPP, Chief Operating Officer of the American Action Network, stated in their May 27,

benefits but, in a bid to keep employees happy, promises to give them the cash value of their coverage. The employer would have to spend more on the wages than it spends on the benefits, as the wages are taxed. . . Second, the fraction of employers actually affected by the health law’s mandate is very small.

Which is all to say that, for most companies, the Affordable Care Act won’t bring much change at all, and so there’s little reason to expect their behavior will change, either. And if it does change, it might not change in the direction we expect.”

CON 2

Christine Eibner, PhD, Economist at RAND, Federico Girosi, PhD, Senior Policy Researcher at RAND, Carter C. Price, PhD, Associate Mathematician at RAND, Amado Cordova, Senior Engineer at RAND, Peter S. Hussey, PhD, Policy Researcher at RAND, Alice Beckman, Policy Researcher at RAND, and Elizabeth A. McGlynn, PhD, Director of the Kaiser Permanente Center for Effectiveness and Safety Research, stated in their Sep. 3, 2010 study "Establishing State Health Insurance Exchanges: Implications for Health Insurance Enrollment, Spending, and Small Businesses," available at www.rand.org:

CON 3

Towers Watson, global human resources consulting firm, stated in its Mar. 2012 report "17th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care," available at www.towerswatson.com:

"Amid the political, legislative and judicial uncertainty, most employers are steadfast in their commitment to keeping active health care benefits as a central component of their employee value proposition. Through 2015, most employers will remain focused on optimally managing the design and delivery of their programs...

2010 article “Labor Markets and Health Care Reform: New Results,” available at americanactionforum.org:

"The Patient Protection and Affordable Care Act (PPACA) will have profound implications for U.S. labor markets. The PPACA is fiscally dangerous, raising the risk of higher labor (and other) taxes at a time when the job market is struggling. It provides strong incentives for employers - and their employees – 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..."

PRO 4

Shubham Singhal, Director of McKinsey & Company's Detroit office, Jeris Stueland, Consultant in the New Jersey office, and Drew Ungerman, Principal in the Dallas office, wrote in their June 2011 study "How US Health Care Reform Will Affect Employee Benefits," available at www.mckinseyquarterly.com:

"Overall, 30 percent of employers will definitely or probably stop offering ESI [employer-sponsored insurance] in the years after 2014.

Among employers with a high awareness of reform, this proportion increases to more than 50 percent, and upward of 60 percent will pursue some alternative to traditional ESI.

At least 30 percent of employers would gain economically from dropping coverage even if they completely compensated employees for the change through other benefit offerings or higher salaries...

The propensity of employers to make big changes to ESI increases with awareness largely because shifting away will be economically rational not only for many of them but also for their lower-income employees, given the law's incentives."

While many employers are considering their options after the Exchanges open in 2014, the majority of large companies today remain committed to the optimal design and delivery of their health care programs...

In the end, few companies plan to either discontinue their health care programs or shift strategy to a defined contribution option by 2014 or 2015. All signs indicate that companies will continue to focus on the most effective ways to control rising costs and improve employee health and well-being."

CON 4

Kathryn L. Moore, JD, Professor of Law at the University of Kentucky, wrote in her Aug. 1, 2011 article “The Future of Employment-Based Health Insurance after the Patient Protection and Affordable Care Act,” available at the Nebraska Law Review website:

"The Patient Protection and Affordable Care Act (PPACA) does not eliminate the system’s reliance on employment-based health insurance. Instead, it builds on, and arguably strengthens, the employment-based system... Health care in the United States has long been financed principally through employment-based health insurance. At least in the short run, the PPACA is unlikely to disturb that balance. PPACA’s incentives with respect to employment-based health insurance are unlikely to change significantly the number of employers who elect to offer employment-based health insurance. The penalty under the large employer pay-or-play mandate, though low relative to the cost of health insurance premiums, is unlikely to affect employers’ willingness to offer health insurance, at least in the short run. The small employer tax credit may encourage some employers that do not already offer health insurance to offer health insurance."

CON 5

PRO 5

The Lewin Group, a health care and human services policy research and management consulting firm, said in its June 8, 2010 working paper “Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers,” available at [lewin.com](http://www.lewin.com):

"The availability of the expanded Medicaid program and premium subsidies for lower wage workers [under the PPACA] is likely to cause some employers to discontinue coverage. This is particularly true of low-wage employers where workers can obtain publicly subsidized coverage for less than it costs the employer to provide the same coverage... [W]e estimate an overall reduction in the number of people with employer sponsored coverage of 2.8 million people. This includes about 17.2 million people in firms that will discontinue their plans under the Act. This loss of coverage is largely offset by an increase in ESI of about 14.4 million people in firms that decide to start offering coverage..."

Stacey McMorro, PhD, Research Associate, Linda J. Blumberg, PhD, Senior Fellow, and Matthew Buettgens, PhD, Senior Research Methodologist in the Health Policy Center at the Urban Institute, stated in their June 2011 report "The Effects of Health Reform on Small Businesses and Their Workers," available at www.urban.org:

“We find little evidence that the ACA will negatively affect small firms, and, instead, we find evidence of significant benefits for these employers and their workers. The law expands coverage options for small firms while limiting the new requirements imposed on this group. The smallest firms will see a significant increase in offer rates under the ACA, and firms of all sizes will see substantial savings on premium contributions."

CON 6

Avalere Health LLC stated in its June 17, 2011 report “The Affordable Care Act’s Impact on Employer Sponsored Insurance: A Look at the Microsimulation Models and Other Analyses,” available at avalerehealth.net:

"Our analysis suggests that the employer sponsored insurance (ESI) market will be fairly stable after 2014 when key Affordable Care Act (ACA) coverage provisions go into effect. The microsimulation models estimates from RAND, the Urban Institute, the Lewin Group and the Congressional Budget Office (CBO) show net changes to ESI ranging from -0.3 percent to + 8.4 percent compared to baseline projections without ACA implementation - not major changes in the market. Similarly, large-scale employer surveys and analyses conducted by benefits consultants, investor groups, and other consulting firms also confirm that most employers will remain committed to providing coverage. Stability in ESI is driven by expectations that large firms, whose policies cover more people than small- and

	<p>medium-firm policies combined, will continue offering health benefits. Moreover, small businesses that will benefit from new economies of scale in the small business exchanges are likely to offer coverage for their employees through the exchange and possibly newly offer coverage if they previously did not."</p>
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49. Does Obamacare create uncertainty for businesses? – DEBATED

PRO (yes)	CON (no)
<p>PRO 1</p> <p>Jeff Cox, Senior Writer for CNBC, wrote in his June 28, 2012 article "What Businesses Didn't Get from the Health-Care Ruling," available at www.cnbc.com:</p> <p>"For American businesses, uncertainty over the health-care law is anything but over...</p> <p>GOP candidate Mitt Romney vowed again Thursday to repeal the act if elected, while President Barack Obama said he would move forward in implementing it.</p> <p>That means businesses will have a hard time budgeting for health-care costs and are likely to delay hiring even further...</p> <p>U.S. corporations are sitting on more than \$1.2 trillion in cash — \$3.5 trillion counting the financial sector — that has not been deployed, in large part due to anxiety over health care."</p> <p style="text-align: center;">PRO 2</p> <p>Steve Austria, US Representative (R-OH), stated in his July 11, 2012 press release "Congressman Austria Votes to Repeal Obamacare," available at www.austria.house.gov:</p> <p>"Business leaders will tell you that government red tape and regulations creating uncertainty for business expansion is the biggest detriment to job</p>	<p>CON 1</p> <p>Betsi Fores, <i>Daily Caller</i> Reporter, stated in her July 29, 2012 article "Businesses Find Certainty After Health Care Ruling," available at www.dailycaller.com:</p> <p>"The ruling on the Affordable Care Act may provide the stability and certainty businesses need to hire. With the veil of uncertainty lifted, businesses can move forward with planning, and take steps needed to comply with the law, and potentially hire new workers...</p> <p>With the ruling from the Supreme Court in place, businesses have a much better picture of future costs and regulatory burdens they will endure. With a more certain landscape of the future, business can make a better assessment of cost and regulatory burdens imposed by the health care law."</p>

creation. One of the biggest contributors to this uncertainty is the president's health care plan... Quite simply, Obamacare has become a job killer.”	
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50. Will Obamacare offer funding for workplace health programs? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 10408, "Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs," page 859, signed into law on Mar. 23, 2010, available at www.thomas.gov:

"(a) ESTABLISHMENT.—The Secretary shall award grants to eligible employers to provide their employees with access to comprehensive workplace wellness programs (as described under subsection (c))...

(c) COMPREHENSIVE WORKPLACE WELLNESS PROGRAMS.—

(1) CRITERIA.—The Secretary shall develop program criteria for comprehensive workplace wellness programs under this section that are based on and consistent with evidence-based research and best practices, including research and practices as provided in the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry for Effective Programs...

(e) AUTHORIZATION OF APPROPRIATION.—For purposes of carrying out the grant program under this section, there is authorized to be appropriated \$200,000,000 for the period of fiscal years 2011 through 2015. Amounts appropriated pursuant to this subsection shall remain available until expended."

PRO 1

The Centers for Disease Control and Prevention stated in their Jan. 13, 2012 article "Comprehensive Workplace Health Programs to Address Physical Activity, Nutrition, and Tobacco Use in the Workplace," available at www.cdc.gov:

"The Affordable Care Act's Prevention and Public Health Fund is supporting a \$9 million national initiative to establish and evaluate comprehensive workplace health programs to improve the health of workers and their families...

Based on employee needs, companies will establish a core set of three to five interventions from an available menu of options that include a mix of program (education and coaching), policy, and environmental supports and that target physical activity, nutrition, and tobacco use in the employee population."

--Insurance Industry--

51. Does Obamacare encourage health insurance competition? – DEBATED

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>The Bipartisan Policy Center (BPC) stated in its Aug. 24, 2012 report "Primer: Understanding the Effect of the Supreme Court Ruling on the Patient Protection and Affordable Care Act," available at www.bipartisanpolicy.org:</p> <p>"To address the unaffordability of insurance premiums in the individual and small-group markets, the ACA established health insurance exchanges that are designed to provide one-stop-shopping platforms in which consumers can compare and purchase insurance online. Offering consumers transparency in insurance pricing and product information should help promote competition and affordability...</p> <p>As a result of the Supreme Court decision, approximately three million additional individuals—primarily those between 100 and 138 percent of FPL—are now expected to enroll in the insurance exchanges. This influx of people may have a positive impact on the functioning of those exchanges. More consumers create more competition, and a competitive marketplace that makes insurance more affordable is one of the key principles underlying the insurance exchange concept."</p> <p style="text-align: center;">PRO 2</p> <p>The Federal Registrar stated in its Mar. 27, 2012 rule announcement "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," available at www.federalregister.gov:</p>	<p style="text-align: center;">CON 1</p> <p>Barak D. Richman, JD, Professor of Law and Business Administration at Duke University, wrote in his June 15, 2012 report "Beyond Repeal and Replace Ideas for Real Health Reform," available at www.aei.org:</p> <p>"The Patient Protection and Affordable Care Act of 2010 (PPACA) does little to address the monopoly problem and may even worsen it. The highly regulated and heavily subsidized regime ahead under the PPACA already has triggered a feverish scramble among health industry firms (insurers, pharmaceutical manufacturers, physician practice groups, and device makers, as well as hospitals) to get bigger market share and also become better connected politically to ensure that they will be among the politically dependent survivor incumbents in the years ahead...</p> <p>The PPACA poses some additional barriers to more vigorous competition in health services. Its 'minimum medical loss ratio' rules for insurers may superficially appeal to some insurance purchasers but could further disarm payers in aggressive price negotiations with providers and stifle insurers' investments in innovative monitoring and improvement of health care delivery...</p> <p>Unless a more effective competition policy can be implemented in the health sector, many millions of additional Americans will soon carry exactly the kind of health coverage that currently serves provider and supplier monopolists so well."</p> <p style="text-align: center;">CON 2</p>

"This final rule will implement the new Affordable Insurance Exchanges ('Exchanges'), consistent with title I of the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. The Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses."

PRO 3

Families USA stated in its Oct. 11, 2011 report "The Bottom Line: How the Affordable Care Act Helps America's Families," available at www.familiesusa.org:

"...[T]he Affordable Care Act will promote transparency, accountability, and competition among health insurance companies through both the new state exchanges and new standards for reviewing how premiums are set by insurers. By promoting greater competition and accountability, the Affordable Care Act will motivate insurance companies to hold down health care costs and premium increases while improving quality of care."

PRO 4

The Pennsylvania Health Access Network (PHAN) stated in its Nov. 11, 2011 posting "Protecting Pennsylvania's Health: Standing Up for the Affordable Care Act," available at www.pahealthaccess.org:

"The law authorizes states to create a new, competitive marketplace where those without job-based coverage can easily shop for quality,

Joel Albers, Pharm.D, PhD, Clinical Pharmacist and Health Economics Researcher at the Minnesota Universal Health Care Action Network, stated in his July 18, 2012 article "Affordable Care Act Ensures Monopoly of Health Insurance Companies, Banks," available at www.medicine.virginia.edu:

" the ACA will further consolidate control of health care into fewer and even more powerful health insurance companies,...

Also, health insurance companies are NOT REQUIRED to sell health insurance policies within the Health Insurance Exchange... This invalidates the premise of the 'Exchange,' which is to standardize policies and create a competitive market by allowing consumers to compare prices, benefits, and quality thereby forcing insurers to compete. For decades just the opposite has occurred– monopoly– and more of the same is expected under the ACA."

CON 3

Scott Gottlieb, MD, Resident Fellow at the American Enterprise Institute, wrote in his May 22, 2010 article "Patients Left with Fewer Options," available at www.aei.org:

"Insurers are... pulling out of the individual insurance market because of new regulations that fix their profit margins and impose mandates on how they have to spend their revenues..."

The vertical integration among insurers will leave many markets with little or perhaps no choice among health plans...

Insurers and providers are making these defensive business decisions largely because better competitive options are foreclosed to them by the Obama plan."

CON 4

<p>affordable coverage--and receive a tax credit (based on their income) to help make coverage affordable. This new competitive insurance marketplace will allow for real competition among insurers and will finally give people purchasing insurance the kind of quality, high-value and easy-to-compare options that have been out of reach for years."</p>	<p>Karl Rove, former Senior Adviser and Deputy Chief of Staff to President George W. Bush, wrote in his June 17, 2010 article "The Bad News About ObamaCare Keeps Piling Up," available at online.wsj.com:</p> <p>"Health-care plans that existed before the new law are 'grandfathered' with regard to some of its provisions...</p> <p>Health plans would no longer be grandfathered if a business changes insurance companies, raises deductibles more than 5%, drops any existing benefits, or even increases co-pays by as little as \$5...</p> <p>Complying with these new rules would raise costs for companies who provide coverage [and] reduce competition among health insurance companies."</p>
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52. Does Obamacare restrict insurance companies' profits? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2718, page 18, "Bringing Down the Cost of Health Care Coverage," signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the issuer on activities described in subsection (a)(3) exceeds—

(A) with respect to a health insurance issuer offering coverage in the group market, 20 percent, or such lower percentage as a State may by regulation determine; or

(B) with respect to a health insurance issuer offering coverage in the individual market, 25 percent, or such lower percentage as a State may by regulation determine, except that such percentage shall be adjusted to the extent the Secretary determines that the application of such percentage with a State may destabilize the existing individual market in such State."

PRO 1

The Centers for Medicare and Medicaid Services stated in their Dec. 2, 2011 posting "Medical Loss Ratio: Getting Your Money's Worth on Health Insurance," available at www.cciio.cms.gov:

"Beginning in 2011, the law requires insurance companies in the individual and small group markets to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities. Insurance companies in the large group market must spend at least 85 percent of premium dollars on medical care and quality improvement activities. Insurance companies must report their MLR data to HHS on an annual basis so that residents of every State will have information on the value of health plans offered by different insurance companies in their State. Insurance companies that do not meet the MLR standard will be required to provide rebates to their consumers. Insurers will make the first round of rebates to consumers in 2012. Rebates must be paid by August 1st each year."

PRO 2

Emily Berry, Writer for *American Medical News*, wrote in her Feb. 27, 2012 article "Insurers Think Outside the Policy," available at www.ama-assn.org:

"Health plans typically operate under single-digit profit margins overall. The Patient Protection and Affordable Care Act requires them to spend at least 80 cents of every premium dollar on patient care, beginning with 2011, or pay rebates to customers the following year."

PRO 3

William Lazonick, PhD, Director of the University of Massachusetts Lowell Center for Industrial Competitiveness, stated in his Sep. 23, 2010 article "High Health Care Costs Eminate from Business, Not Government," available at www.huffingtonpost.com:

"[The PPACA] takes steps to limit the boundless profiteering that has become customary in the U.S. health care system..."

States have two new tools to prevent health plans from gouging consumers. First, 46 states have received grants from the US Department of Health and Human Services to investigate premium rate increases. This funding will give states the resources to review the complicated actuarial explanations filed by insurance companies and to judge whether premium increases are justified. In addition, plans will now be required to devote a minimum percentage of their premium revenue to medical care instead of administration, executive salaries, profits, lobbying and administrative waste. Plans will owe their customers rebates if they fail to spend at least 80 percent (individual and small group) or 85 percent (large group) of premium dollars on medical expenses."

53. Under Obamacare, are insurance companies still exempt from federal antitrust laws? – YES

[Editor's Note: The antitrust exemption for insurance companies existed prior to the passage of Obamacare. Although a House bill did contain language removing the exemption, the Senate version of the bill that was signed by President Obama to become law on Mar. 21, 2010 did not contain the language removing the exemption and it thus remained in effect.]

PRO 1

Michelle Andrews of the *New York Times* wrote in her Apr. 23, 2010 article "Are Insurance Companies Still Exempt From Antitrust Laws?," available at prescriptions.blogs.nytimes.com:

"The new health reform law did not include language that ended the insurance industry's exemption from antitrust law. It was included in the House health bill but did not appear in the final Senate bill that became law."

PRO 2

Robert Reich, JD, Professor of Public Policy at the University of California at Berkeley and former Secretary of Labor under President Bill Clinton, wrote in his May 24, 2010 blog "Obama's Regulatory Brain," available at www.robertreich.org:

"The final health care act doesn't even remove the exemption of private insurers from the nation's antitrust laws."

54. Will Obamacare lead to fewer health insurance agents and brokers (a.k.a. "producers")? – DEBATED

NOT CLEARLY PRO OR CON 1

Timothy Stoltzfus Jost, JD, Robert L. Willett Family Professors of Law at the Washington and Lee University School of Law, wrote in his Mar. 13, 2012 article "Implementing Health Reform: A Final Rule on Health Insurance Exchanges," available at www.healthaffairs.org/blog:

"The role of agents and brokers within the exchange has been hotly contested. Many agents and brokers have seen insurers cut their commissions in recent years and attribute the cuts to the medical loss ratio provisions of the ACA. They had hoped that they would make up for this lost income by playing a major role in marketing insurance to the millions of new health insurance customers brought in through the exchanges. The final rule contains good news and bad news for agents and brokers.

First, it seems likely that their role as navigators will be more limited than some might have hoped. Under the ACA, navigators will educate and inform health insurance consumers and assist them in navigating the exchanges. The final rule considerably sharpens the focus of the navigator program. Although agents and brokers can be navigators, the rule prohibits states from requiring navigators to be licensed agents and brokers or to carry errors and omissions insurance, typically carried by agents and brokers...

On the other hand, the rule recognizes that agents and brokers—including web-based agents (sometimes called private exchanges), but also traditional 'mom and pop' agents and brokers—can play an active role

in marketing exchange products. The ACA explicitly recognizes that agents and brokers have a role in marketing exchange products. Experience has shown that support from agents and brokers is vital if exchanges are to succeed."

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Mark Newsom, MS, Director of the Division of Payment Reconciliation (Medicare Plan Payment Group), wrote in his Oct. 10, 2010 report "Health Insurance Agents and Brokers in the Reformed Health Insurance Market," available at www.achp.org:</p> <p>"Health insurance agents and brokers, collectively called 'producers' by insurance companies, assist consumers and small employers in choosing and enrolling in health insurance products...</p> <p>The additional regulation of producers and alternative health insurance information (e.g., the online insurance portal) and assistance services available to consumers [under Obamacare] may limit the traditional demand for producers' services.</p> <p>PPACA also has a minimum medical loss ratio provision requiring plans to pay rebates to their members if a certain percentage of their premiums are not spent on medical costs. This provision may provide an incentive for health insurance companies to reduce their compensation to and/or utilization of producers as they seek to reduce their administrative costs in relation to their medical costs."</p> <p style="text-align: center;">PRO 2</p> <p>Robert Miller, MS, MA, President of the National Association of Insurance and Financial Advisors, wrote in his Jan. 11, 2012 article "Obama's Health-Care Law Is Hurting Insurance Agents and Millions of Consumers," available at www.csmonitor.com:</p>	<p style="text-align: center;">CON 1</p> <p>The National Association of Insurance Commissioners (NAIC) stated in its 2011 report "The Comparative Roles of Navigators and Producers in an Exchange: What Are the Issues?," available at www.naic.org:</p> <p>"In looking at the historical background of producers in the health insurance marketplace and issues surrounding the establishment of a navigator program under the ACA, it is clear that determining the future role of producers is a vital part of the implementation process for the Exchanges. States must consider not only what role producers will play in the start-up and day-to-day operations of an Exchange but how producers will work together with navigators to educate, engage and provide needed assistance to individuals, families and business owners. There are many issues in this regard, but experience has shown that all issues must be considered with the firm belief that producers, as well as navigators, can be crucial players in the success or failure of an Exchange... there are also segments of the individual market that are better reached and represented by producers rather than consumers or industry groups. Producers who are accountable and trained on the functions of the Exchange and the products and services available can increase public awareness of the Exchange and increase consumer traffic to the Exchange websites."</p> <p style="text-align: center;">CON 2</p> <p>BlueCross and BlueShield of North Carolina wrote in its Oct. 17, 2011 statement "In the Spotlight: Health Care Reform and Insurance Brokers," available at www.bcbsnc.com:</p>

<p>“If you’ve never heard of the law’s medical loss ratio (MLR) provision, you’re certainly not alone. This simple calculation has had the effect of radically reducing what health insurance agents earn. That, in turn as greatly restricted their ability to help million of Americans navigate the maze of approvals needed for medical procedures and processing claims. It has also had a devastating effect on these agents’ businesses and is disrupting the insurance market.</p> <p>As agents deal with the consequences of the MLR, many are finding that the cost of servicing clients now exceeds their income. They are cutting back on services to customers and laying off support staff. Some are leaving the health insurance business altogether...”</p>	<p>"The Affordable Care Act (ACA) makes many broad, overarching changes to the way health insurance is purchased. New requirements on medical spending for insurers, exchanges, and changing roles for traditional health insurance agents will all contribute to a very different health care insurance landscape. Brokers will be at the forefront of these changes, as the primary actors between health insurance issuers and consumers...</p> <p>Blue Cross and Blue Shield of North Carolina (BCBSNC) is supportive of brokers continuing to play their essential role in serving customers and businesses. We believe that health care reform must result in preserving this role and ensuring that the system enables brokers to adapt and thrive."</p>
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--Taxes--

55. Will Obamacare raise any federal taxes? – YES

[Editor's Note: In the June 28, 2012 5-4 US Supreme Court decision to uphold the constitutionality of the PPACA, Chief Justice John G. Roberts in his majority opinion wrote, "the mandate... [is] just another thing the Government taxes, like buying gasoline or earning income. And if the mandate is in effect just a tax hike on certain taxpayers who do not have health insurance, it may well be within Congress's constitutional power to tax." The "penalty" in the PPACA for not having health insurance is, therefore, a new federal tax. Additional taxes in Obamacare are listed below.]

GENERAL REFERENCE 1

The Health Care and Education Reconciliation Act of 2010 (HR4872), Section 4980I, "Excise Tax on High Cost Employer-Sponsored Health Coverage," page 730, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(a) IMPOSITION OF TAX.-If- "(1) an employee is covered under any applicable employer sponsored coverage of an employer at any time during a taxable period, and "(2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit."

GENERAL REFERENCE 2

The Health Care and Education Reconciliation Act of 2010 (HR4872), Section 4959, "Taxes on Failures by Hospital Organizations," page 739, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to \$50,000."

GENERAL REFERENCE 3

The Health Care and Education Reconciliation Act of 2010 (HR4872), Section 5000B, "Imposition of Tax on Elective Cosmetic Medical Procedures," page 754, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(a) IN GENERAL.-There is hereby imposed on any cosmetic surgery and medical procedure a tax equal to 5 percent of the amount paid for such procedure (determined without regard to this section), whether paid by insurance or otherwise."

GENERAL REFERENCE 4

The Health Care and Education Reconciliation Act of 2010 (HR4872), Section 5000B, "Imposition of Tax on Indoor Tanning Services," page 902, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

(a) IN GENERAL.-There is hereby imposed on any indoor tanning service a tax equal to 10 percent of the amount paid for such service (determined without regard to this section), whether paid by insurance or otherwise."

GENERAL REFERENCE 5

The Health Care and Education Reconciliation Act of 2010 (HR4872), Section 9015, "Additional Hospital Insurance Tax on High-Income Taxpayers," page 752-753, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(2) ADDITIONAL TAX.--In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) a tax equal to 0.5 percent of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2012, and which are in excess of—
(A) in the case of a joint return, \$250,000, and
(B) in any other case, \$200,000"

PRO 1

Lori Robertson, Managing Editor at FactCheck.org, stated in her June 28, 2012 article "Romney, Obama Uphold Health Care Falsehoods," available at www.factcheck.org:

"It's certainly true that the health care law would raise taxes on some Americans, particularly those with higher incomes. The law includes a Medicare payroll tax of 0.9 percent on income over \$200,000 for individuals or \$250,000 for couples, and a 3.8 percent tax on investment income for those earning that much. The Joint Committee on Taxation estimated that the biggest chunk of revenue — \$210.2 billion — comes from those taxes.

There are other taxes in the health care law — including an excise tax on the manufacturers of certain medical devices and on indoor tanning services. The health care law included \$437.8 billion in tax revenue over 10 years, according to the Joint Committee on Taxation's calculations. Republicans tend to add in fees on individuals who don't obtain health insurance (which the Supreme Court now agrees can be considered taxes) and businesses that don't provide it to bump that up to about \$500 billion.

Some taxes, such as those on medical devices, may or may not be passed on to consumers in the form of higher prices, but a large majority of Americans would not see any direct tax increase from the health care law."

PRO 2

William Perez, MA, tax accountant, in a July 3, 2012 article, "Tax Impacts of the Supreme Court's Health Care Decision," available at about.com, stated:

"The Supreme Court's decision leaves all the tax provisions in PPACA intact. Those tax provisions include:

- the requirement for individuals to maintain health insurance coverage beginning in 2014 or else pay a tax penalty;
- individual premium assistance tax credits to help low- and middle-income families purchase health insurance on state-run insurance exchanges;
- an increase in the threshold for deducting medical expenses as an itemized deduction from the current 7.5% to 10% starting in 2013;
- an increase in the tax penalty to 20% for non-qualifying distributions from Health Savings Accounts, Flexible Spending Accounts or Archer Medical Savings Accounts;
- an additional 0.9% Medicare hospital insurance tax on wages and self-employment income over \$200,000 for unmarried persons and over \$250,000 for married couples starting in 2013;
- an additional 3.8% Medicare hospital insurance tax, also starting in 2013, on investment income or modified adjusted gross income over \$200,000 for unmarried persons and over \$250,000 for married couples;
- an increase in the adoption tax credit and making this credit fully refundable, effective for the years 2010 and 2011;
- an excise tax of 10% on indoor tanning services;
- the requirement that health insurance plans cover dependents up to age 26 on their parent's plan;
- a tax exclusion for student loan repayment assistance programs for health professionals to work in underserved localities;
- a shared responsibility payment on large employers who fail to provide adequate health insurance plans for their full-time employees effective starting in 2014;
- a tax credit for small employers ranging from 25% to 50% for providing health insurance coverage to their employees, effective for the years 2010 through 2015;
- a decrease from \$5,000 to \$2,500 in the amount that can be saved pre-tax through a healthcare flexible spending account, effective starting 2013 and with the amount inflation-indexed for subsequent years;

- restriction of the definition of qualified medical expenses for healthcare flexible spending accounts, health savings accounts, health reimbursement accounts and Archer medical savings accounts so that only prescribed medications and insulin are eligible for tax-qualified disbursements, effective since 2011;
- a business tax credit of 28% of covered drug costs for employers who provide health plans offering prescription coverage for retired employees, effective beginning in 2013;
- limitations in the amount that health insurance companies can deduct for any one employee's compensation to \$500,000 effective beginning in 2013;
- a new economic substance penalty of either 20% or 40% for tax transactions after March 30, 2010, that do not involve a substantial change in a person's economic situation or have a substantial business purpose;
- a new excise tax of 40% on high-cost health insurance plans offered by employers starting in 2018;
- an annual fee on manufacturers and importers of brand-name prescription medicines;
- an excise tax of 2.3% on medical devices starting in 2013."

56. Does Obamacare contain a new tax on “unearned income”, including some real estate sales, for individuals with an adjusted gross income of \$200,000 or more? – YES

GENERAL REFERENCE 1

The Health Care and Education Reconciliation Act of 2010 (HR 4872), Section 1402, "Unearned Income Medicare Contribution," page 32, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(a) INVESTMENT INCOME.—

(1) IN GENERAL.—Subtitle A of the Internal Revenue Code of 1986 is amended by inserting after chapter 2 the following new chapter:

“SEC. 1411. IMPOSITION OF TAX.

"(a) IN GENERAL.—Except as provided in subsection (e)—

(1) APPLICATION TO INDIVIDUALS.—In the case of an individual, there is hereby imposed (in addition to any other tax imposed by this subtitle) for each taxable year a tax equal to 3.8 percent of the lesser of—“(A) net investment income for such taxable year, or
 (B) the excess (if any) of—
 (i) the modified adjusted gross income for such taxable year, over
 (ii) the threshold amount...

(1) IN GENERAL.—The term ‘net investment income’ means the excess (if any) of—

(A) the sum of—

- (i) gross income from interest, dividends, annuities, royalties, and rents, other than such income which is derived in the ordinary course of a trade or business not described in paragraph (2),
- (ii) other gross income derived from a trade or business described in paragraph (2), and

(iii) net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property other than property held in a trade or business not described in paragraph (2), over
(B) the deductions allowed by this subtitle which are properly allocable to such gross income or net gain."

PRO 1

The National Association of Realtors stated in their Feb. 16, 2012 article "New Medicare Tax on 'Unearned' Net Investment Income," available at www.realtor.org:

"The 2010 health care legislation did create a new 3.8% tax, but it applies only to a limited group of taxpayers..."

The new 3.8% tax will apply to the 'unearned' income of 'High Income' taxpayers. The new Medicare tax on unearned income will take effect January 1, 2013. Proceeds from the tax will be allocated to shoring up the Medicare fund...

Those whose tax filing status is 'single' will be subject to the new unearned income taxes if they have Adjusted Gross Income (AGI) of more than \$200,000. Married couples filing a joint return with AGI of more than \$250,000 will also be subject to the new tax. (The AGI threshold for married filing separate returns is \$125,000.)"

PRO 2

Bill Bischoff, CPA, MBA, Contributing Editor of SmartMoney.com, stated in his June 28, 2012 article "What Obamacare Means for Your Taxes," available at www.smartmoney.com:

"...[S]tarting in 2013, all or part of the net investment income, including long-term capital gains and dividends, collected by higher-income folks can get socked with an additional 3.8% "Medicare contribution tax..."

The additional 3.8% Medicare tax will not apply unless your adjusted gross income (AGI) exceeds: (1) \$200,000 if you're unmarried, (2) \$250,000 if you're a married joint-filer, or (3) \$125,000 if you use married filing separate status.

The additional 3.8% Medicare tax will apply to the lesser of your net investment income or the amount of AGI in excess of the applicable threshold. Net investment income includes interest, dividends, royalties, annuities, rents, income from passive business activities, income from trading in financial instruments or commodities, and gains from assets held for investment like stock and other securities. (Gains from assets held for business purposes are not subject to the extra tax.)"

PRO 3

Kenneth R. Harney, Managing Director of the National Real Estate Development Center, stated in his July 15, 2012 article “Healthcare Law's Surtax Could Affect a Few Home Sellers in 2013,” available at www.latimes.com:

“Yes, there is a new 3.8% surtax that takes effect Jan. 1 on certain investment income of upper-income individuals — including some of their real estate transactions. But it's not a transfer tax and not likely to affect the vast majority of homeowners who sell their primary residences next year.

In fact, unless you have an adjusted gross income of more than \$200,000 as a single-filing taxpayer, or \$250,000 for couples filing jointly (\$125,000 if you're married filing singly), you probably won't be touched by the surtax at all...

Even if you do have income greater than these thresholds, you might not be hit with the 3.8% tax unless you have certain types of investment income targeted by the law, specifically dividends, interest, net capital gains and net rental income. If your income is solely ‘earned’ — salary and other compensation derived from active participation in a business — you have nothing to worry about as far as the new surtax.

Where things can get a little complicated, however, is when you sell your home for a substantial profit, and your adjusted gross income for the year exceeds the \$200,000 or \$250,000 thresholds. The good news: The surtax does not interfere with the current tax-free exclusion on the first \$500,000 (joint filers) or \$250,000 (single filers) of gain you make on the sale of your principal home. Those exclusions have not changed. But any profits above those limits are subject to federal capital gains taxation and could also expose you to the new 3.8% surtax.”

PRO 4

Roy Oppenheim, JD, Co-founder and Senior Partner of Oppenheim Law, stated in his July 3, 2012 article “The Truth About Obamacare’s Real Estate Sales Tax (It Doesn’t Exist),” available at www.southfloridalawblog.org:

“When ‘Obamacare’ was first passed the blogosphere was up-in-arms that the AHA included an additional 3.8% tax on any real estate sale, and claimed, ‘that’s \$3,800 on a \$100,000 home.’...

But just like Bloody Mary or death panels, it’s just another urban legend that just won’t go away.

So kids once more with feeling, ‘There is no real estate sales tax in Obamacare.’

Now there is an additional capital gains tax included in the Affordable Care Act, and yes it will affect a narrow field of real estate transactions...

There is a new tax on investment income which will cover the income from interest, dividends, rents, as well as capital gains. It’s not a transfer tax on real estate sales.

While the sale of a home can be subject to this tax, it is only if a number of criteria are met.

If you are a married couple making less than \$250,000 or an individual making less than \$200,000, then you cannot be taxed.”

--Tort Reform/Medical Malpractice--

57. Does Obamacare reform medical malpractice (tort reform) law? – NO

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 6801, "Sense of the Senate Regarding Medical Malpractice," page 686, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims."

CON 1

Michael Lavyne, MD, Clinical Professor of Neurological Surgery at Weill Medical College, Cornell University, stated in his Nov. 19, 2012 article, "Obamacare Will Fail Without Tort Reform: Malpractice Insurance Costs Are Crippling Medicine," available at www.nydailynews.com:

"I am what you call a successful neurosurgeon, and I have nothing against ‘socialized medicine’ as such. Everybody deserves good health care. But I am nonetheless worried about President Obama's health care reform, because without tort reform as part of the package, it can't address the labor shortage we face in my specialty.

Tort reform is crucial because it would curtail the threat of frivolous malpractice lawsuits, reward all patients who have been injured by medical mishaps, not just the wealthy with access to high-powered lawyers - and reduce the anxieties faced by young doctors going into medicine in the first place, especially those entering high-stakes fields like my own.

...[M]alpractice insurance... creates a very high cost of entry into this field. Unfortunately, the health care reforms of the Obama administration have done little to curb costs. These costs are imposed by hospital inefficiencies as unpoliced by government-run insurance plans and by the price of malpractice insurance undisciplined by tort reform.

I believe that tort reform is the key to reducing both kinds of cost, because the malignant threat of malpractice haunts the hospitals as well as the physicians."

CON 2

Anthony Tarricone, JD, President of the American Association for Justice (AAJ), stated the following in a Mar. 26, 2010 letter to the members of the AAJ, "AAJ's Healthcare Campaign in Review," available at www.justice.org:

"For over a year, AAJ has been intimately involved in the health care legislation to ensure the rights of injured patients were protected. It was a long and difficult journey, with twists and turns no one expected. Despite your personal ideology or political belief, this legislation is historic in its scope and the impact it will have on all Americans.

I am very pleased to report that the health care bill is clear of any provisions that would limit an injured patient's rights concerning medical negligence claims. While there is a provision for demonstration projects, it provides an absolute opt-out clause for plaintiffs at any time. While some states may embark on demonstration programs we find objectionable, the opt-out provision for plaintiffs minimizes this concern...

AAJ was fighting tort reform in the halls of Congress...

That health care has passed unfortunately does not mean our fight is over. Undoubtedly, lawmakers will need to revisit health care in the months and years to come, and that may lead to future battles on medical malpractice. We will remain vigilant and ensure the voices of patients are heard."

58. Does Obamacare add new tools to help fight health care fraud? – YES

[Editor's Note: The Patient Protection and Affordable Care Act includes three sections on fraud:

- Sec. 6504. "Requirement to report expanded set of data elements under MMIS to detect fraud and abuse" (page 658)
- Sec. 6604. "Applicability of State law to combat fraud and abuse" (page 662)
- Sec. 10606. "Health care fraud enforcement" (page 888)

The word "fraud" or "fraudulent" appears in the law over 70 times.]

PRO 1

The US Department of Health and Human Services stated in its Mar. 15, 2011 fact sheet "New Tools to Fight Fraud, Strengthen Federal and Private Health Programs, and Protect Consumer and Taxpayer Dollars," available at www.healthcare.gov (last updated on July 26, 2012):

"The Obama Administration's fight against health care fraud now includes a ground-breaking partnership among the federal government and several leading private and state organizations to prevent health care fraud on a national scale. To detect and prevent payment of fraudulent billings, the partnership seeks to share information and best practices. A longer-range goal is performing sophisticated analytics on a healthcare industry-wide data set that will detect and predict fraud schemes...

The Affordable Care Act takes historic steps toward combating health care fraud, waste and abuse by providing critical new tools to crack down on entities and individuals attempting to defraud Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and private insurance plans.

The Centers for Medicare & Medicaid Services (CMS) is using state-of-the-art technology review claims before they are paid to track fraud trends and flag suspect activity. New power to fight fraud, granted in the health reform law, will also help decrease the rate of improper payment claims in the traditional Medicare program."

PRO 2

The National Hispanic Council on Aging (NHCOA) posted in its Apr. 5, 2012 blog entry "The Affordable Care Act Works: Winning the Fight Against Medicare Fraud," available at www.nhcoa.org:

"For the second year in a row, the departments' anti-fraud activities through the Health Care Fraud Prevention and Enforcement Action Team (HEAT) have recovered more than \$4 billion. This is thanks to new tools provided through the Affordable Care Act, which include:

- Tougher sentences for people who commit health care fraud
- Expanding the search for waste, fraud, and abuse to Medicaid, Medicare Advantage, and Medicare Part D programs
- Greater information-sharing capabilities between key government agencies, states, the Centers for Medicare & Medicaid Services (CMS), and law enforcement partners to suspend payments if providers and suppliers are suspected of engaging fraudulent activity.

In addition, the Affordable Care Act also directly helps Medicare beneficiaries by making it easier to detect, prevent, and report Medicare fraud themselves. The Medicare Summary Notices were recently re-designed to be more reader-friendly, which makes it easier for beneficiaries to detect and report

discrepancies or errors, which could be a result of fraudulent activity."

IV: 65 Questions and Responses on Obamacare (continued)

c. Other Effects of Obamacare

--Congress--

59. Are members of congress and their personal staffs required to purchase their health insurance plans through the Obamacare health insurance exchanges? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1312, "Consumer Choice," page 64, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(D) MEMBERS OF CONGRESS IN THE EXCHANGE.-

(i) REQUIREMENT.-Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are-

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) DEFINITIONS.-In this section:

(I) MEMBER OF CONGRESS.-The term 'Member of Congress' means any member of the House of Representatives or the Senate.

(II) CONGRESSIONAL STAFF.-The term ‘congressional staff’ means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.”

GENERAL REFERENCE 2

[**Editor's Note:** On Aug. 7, 2013 the United States Office of Personnel Management (OPM) issued a rule to implement the Obamacare requirement that members of congress and staff employed by the

"official office of a Member of Congress" must obtain health insurance plans through the Health Insurance Exchanges beginning on Jan. 1, 2014.

According to an Aug. 28, 2013 article in The Hill, the OPM rule "does not appear to apply to staffers who work in leadership or committee offices." These staffers may be able to continue to participate in the Federal Employees Health Benefits program (FEHB).

Members of Congress and their personal staff who are required to purchase their health insurance plans through the Obamacare health insurance exchange will continue to receive a government contribution of up to 75% of the cost of their health insurance premium – the same contribution they previously received to help pay the cost of their former health insurance plan under the Federal Employees Health Benefits program (FEHB).]

GENERAL REFERENCE 3

The United States Office of Personnel Management (OPM) stated the following in its Aug. 7, 2013 "Fact Sheet: Health Insurance Coverage: Members of Congress and Congressional Staff," available at www.opm.gov:

"The Affordable Care Act includes a provision which requires that Members of Congress and congressional staff employed by the official office of a Member of Congress may only obtain coverage by health plans created under the Act or through coverage offered via an Affordable Insurance Exchange (Exchanges)...

Members of Congress and their staff will no longer be eligible for FEHB [Federal Employees Health Benefits] coverage as of January 1, 2014.

The Act defines 'congressional staff' as all full-time and part-time employees employed by the official office of a Member of Congress.

Because there is not an existing statutory or regulatory definition, OPM believes Congress is best able to make the determination as to whether an individual is employed by the 'official office' of the Member of Congress...

Members of Congress and their staff who are no longer eligible to enroll in an FEHB health plan will continue to receive a government contribution toward the cost of their premiums for qualified health plans purchased on the Exchanges. This contribution will be based on the government contribution provided for FEHB coverage. OPM will apply the employer contribution amounts up to 75 percent of the total cost of the health plan premium on the Exchange plan premium, the same as for an FEHB health plan premium..."

PRO 1

Rick Newman, columnist for Yahoo! Finance, stated the following in his Oct. 4, 2013 article "That Congressional Exemption From Obamacare? Another Myth," available at finance.yahoo.com:

"Of all the misconceptions surrounding the new health reform law known as Obamacare—and there are many—one of the newest and most infuriating is the idea that Congress made itself 'exempt' from a law that puts onerous new burdens on many other Americans. That contention is totally false. In fact, members of Congress, along with their personal staffers, are required to participate in Obamacare, which is a more stringent requirement than employees of many big companies face...

The confusion is understandable. Earlier this year, Congress did, in fact, consider passing legislation that would amount to an exemption, though that never happened...

Up until now, members of Congress, like all federal employees, have been able to select insurance from a government plan...

The government, on average, pays about 75% of the premiums for members of Congress and other federal workers, while workers pay the other 25%. That's comparable to what big firms kick in for coverage...

With members of Congress and their staffs being forced to buy insurance on the exchanges beginning in 2014, the real question regarding Congress is how the government can continue to offer some sort of health care benefit for those federal employees, the way most big employers do...

The Office of Personnel Management, which is the government's HR department, finally decided this summer that the government will give Congressional employees a tax-free subsidy roughly equivalent to the value of the benefit they've been getting until now. That will help offset the unsubsidized cost of insurance bought through an exchange."

PRO 2

Patrick Leahy, JD, US Senator (D-VT), in the "Fact vs. Fiction" section of his "Health Care Reform" webpage, available at www.leahy.senate.gov (accessed Oct. 8, 2012), stated:

"Fiction - Members of Congress are exempt from the health care reform law.

Fact - No one has received a special exemption from the Affordable Care Act. In fact, the health care reform law explicitly includes language regarding the health insurance plans for Members of Congress and their staff.

As a United States Senator, Senator Leahy's health plan options are the same options offered to all federal employees. Included in the Affordable Care Act, was a provision that requires that 'the only health plans that the Federal Government may make available to Members of Congress and Congressional staff shall be health plans that are created under this Act or offered through an Exchange established under this Act.' Members of Congress and their staffs can only purchase health insurance coverage from the health insurance exchanges that are made available for uninsured Americans. The full text of this provision is available on pages 80-81 in section 1312 of the Affordable Care Act."

PRO 3

Ada S. Cornell, Information Research Specialist for the Congressional Research Service, in a May 3, 2012 report, "Health Benefits for Members of Congress," available at www.waxman.house.gov, stated:

"The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) requires health benefit exchanges to be established in every state by January 1, 2014. A provision in ACA requires that the only health plans available to Members of Congress and certain congressional staff as a benefit of their federal employment are health plans created under the ACA or offered through health insurance exchanges, as created by the ACA. The language implies that Members of Congress and certain congressional staff will no longer be eligible to enroll in FEHBP [Federal Employees Health Benefits Program]."

PRO 4

Annie L. Mach, Analyst in Health Care Financing, and Ada S. Cornell, Information Research Specialist for the Congressional Research Service, in their Sep. 19, 2012 report, "Laws Effecting the Federal Employees Health Benefits Program (FEHBP), available at www.fas.org, stated:

"Patient Protection and Affordable Care Act (P.L. 111-148, as amended), March 23, 2010

Beginning in 2014, Members of Congress and congressional staff may only enroll in health plans created under ACA, or offered through an exchange. Congressional staff, for the purpose of this requirement, will be limited to those part-and full-time employees who are employed by the official office of a Member of Congress (i.e., in a 'personal office')."

--Constitutionality--

60. Is Obamacare substantially constitutional? – YES

[**Editor's Note:** On Thursday June 28, 2012 the US Supreme Court upheld the constitutionality of most of the Patient Protection and Affordable Care Act in a 5-4 ruling. The majority opinion was written by Chief Justice John Roberts and joined by Ruth Bader Ginsburg, Stephen Breyer, Sonia Sotomayor, and Elena Kagan. Justices Samuel Alito, Anthony Kennedy, Antonin Scalia, and Clarence Thomas dissented.]

PRO 1

In the three cases against the Patient Protection and Affordable Care Act (decided June 28, 2012), the US Supreme Court, in a 5-4 majority decision written by Chief Justice John G. Roberts, JD, held that:

"The Government advances two theories for the proposition that Congress had constitutional authority to enact the individual mandate. First, the Government argues that Congress had the power to enact the mandate under the Commerce Clause... Second, the Government argues that if the commerce power

does not support the mandate, we should nonetheless uphold it as an exercise of Congress's power to tax...

The Framers gave Congress the power to regulate commerce, not to compel it, and for over 200 years both our decisions and Congress's actions have reflected this understanding. There is no reason to depart from that understanding now...

The individual mandate forces individuals into commerce precisely because they elected to refrain from commercial activity. Such a law cannot be sustained under a clause authorizing Congress to 'regulate Commerce...

Because the Commerce Clause does not support the individual mandate, it is necessary to turn to the Government's second argument: that the mandate may be upheld as within Congress's enumerated power to 'lay and collect Taxes.' Art. I, §8, cl. 1...

The Affordable Care Act's requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness."

PRO 2

Akhil Amar, JD, Sterling Professor of Law and Political Science at Yale University, and Todd Brewster, Don E. Ackerman Director of Oral History at West Point and Director of the Peter Jennings Project for Journalists and the Constitution, stated in their Mar. 19, 2012 article "Rejecting Affordable Care Act Is Rejecting Constitution," available at blog.constitutioncenter.org:

"Next week, while the Republicans continue their search for a candidate to stand against President Obama in the fall election, the president's central legislative triumph – the Patient Protection and Affordable Care Act of 2010 – will come before the Supreme Court. The justices have the power to declare the law unconstitutional and thereby kill 'Obamacare' before it even leaves the birthing chamber. While some believe that such an outcome would be proper, we disagree. A court decision overturning the Affordable Care Act would be an egregious misreading of the Constitution.

The critics' central constitutional claim is that the 2010 law's individual-mandate provision exceeds Congress' regulatory authority. In essence, this provision requires a broad swath of Americans to procure health insurance conforming to certain federal standards. Those who do not procure this insurance must generally pay a 'penalty' to the IRS.

Had the bill explicitly used the word 'tax' instead of 'penalty,' the fatal flaw of the constitutional challenge would be obvious to all. The Constitution undeniably gives Congress sweeping power to tax. And if Congress can tax a person, and then use that tax money to buy a health-care package for that person's benefit, why can't it simply direct the person to procure the package himself, or else pay a higher tax?...

Once we see that the 'penalty' is a tax and that Congress has the power to tax, the constitutional case against the law collapses.

But even if the law were not a tax, it still easily passes muster as an exercise of a second key power of Congress – the power to regulate interstate commerce...

The federal government represents voters, so it can tax voters and impose mandates on voters, whether these mandates oblige constituents to join militias or buy muskets (as did the Militia Act of 1792, signed into law by President George Washington), to serve on juries, or buy health-care insurance."

--Privacy--

61. Does Obamacare ensure that patient medical data will be protected? – DEBATED

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 3101, page 81, "Data Collection, Analysis, and Quality," signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(1) PRIVACY AND OTHER SAFEGUARDS.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that—
 (A) all data collected pursuant to subsection (a) is protected—
 (i) under privacy protections that are at least as broad as those that the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033); and
 (ii) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary; and
 (B) all appropriate information security safeguards are used in the collection, analysis, and sharing of data collected pursuant to subsection (a).
 (2) DATA SHARING.—The Secretary shall establish procedures for sharing data collected pursuant to subsection (a), measures relating to such data, and analyses of such data, with other relevant Federal and State agencies including the agencies, centers, and entities within the Department of Health and Human Services specified in subsection (c)(1).”

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Edwin Park, JD, Vice President for Health Policy at the Center on Budget and Policy Priorities, in a Dec. 12, 2011 article "Allowing Insurers to Withhold Data on Enrollees' Health Status Could Undermine Key Part of Health Reform," available</p>	<p style="text-align: center;">CON 1</p> <p>Tim Huelskamp, PhD, US Representative (R-KS), stated in his Sep. 24, 2011 press release "Obamacare HHS Rule Would Give Government Everybody's Health Records," available at www.huelskamp.house.gov:</p>

at www.cbpp.org, stated:

"Insurance companies that want the federal government to let them withhold data on the health status of their enrollees claim that requiring them to provide such data would endanger enrollees' privacy. But their claims do not withstand scrutiny. Medicare already collects, uses, and protects such data for tens of millions of beneficiaries.

In addition, strong privacy protections would apply to risk adjustment data collection under the ACA, and the entities administering risk adjustment would not collect personal identifiers like names, addresses, and Social Security numbers. Policymakers should not weaken risk adjustment by depriving states and the federal government of the data they will need to administer it effectively."

"With its extensive rule-making decrees, ObamaCare has been an exercise in creating authority out of thin air at the expense of individuals' rights, freedoms, and liberties.

The ability of the federal government to spy on, review, and approve individuals' private patient-doctor interactions is an excessive power-grab...

No matter what the explanation is, however, this type of data collection is an egregious violation of patient-doctor confidentiality and business privacy. It is like J. Edgar Hoover in a lab coat."

CON 2

Elizabeth Lee Vliet, MD, Preventive and Climacteric Medicine Specialist and President of International Health Strategies, Ltd., wrote in her Oct. 24, 2011 article "Your Medical Privacy—Another Obamacare Casualty," available at www.aapsonline.org:

"[Y]our privacy is another casualty of the damage caused by Obamacare's new rules and regulations governing health professionals.

The U.S. Department of Health and Human Services (HHS) recently released new federal regulation that requires private health insurance companies to give health records of every person they insure to the government.

Although government jargon in the HHS rules distracts from their real goal, the end result is clear: government bureaucrats would have access to the health records from all private insurance companies—including yours—whether you want them to or not.

Under the new rules, the Federal government will own and control your medical records, without your permission. The government will be your new 'overlord' controlling your medical information on federal computers in a federal

	database. You will no longer be able to control who sees your medical information.”
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--Second Amendment--

62. Does Obamacare contain provisions related to the Second Amendment and gun ownership? –YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 2716, "Prohibition on Discrimination in Favor of Highly Compensated Individuals," page 766, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“(c) PROTECTION OF SECOND AMENDMENT GUN RIGHTS.—

(1) WELLNESS AND PREVENTION PROGRAMS.—

A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to

(A) the presence or storage of a lawfully possessed firearm or ammunition in the residence or on the property of an individual; or the lawful use, possession, or storage of a firearm or ammunition by an individual.

(2) LIMITATION ON DATA COLLECTION.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to the lawful ownership or possession of a firearm or ammunition;

(B) the lawful use of a firearm or ammunition; or

(C) the lawful storage of a firearm or ammunition.

(3) LIMITATION ON DATABASES OR DATABANKS.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

(4) LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE.—A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon

(A) the lawful ownership or possession of a firearm or ammunition; or

(B) the lawful use or storage of a firearm or ammunition.

(5) LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS.

No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to (A) the lawful ownership or possession of a firearm or ammunition; or (B) the lawful use, possession, or storage of a firearm or ammunition.”

PRO 1

Gun Owners of America stated in their Dec. 10, 2010 article “The Gun Control in ObamaCare,” available at www.gunowners.org:

“What about the Second Amendment protections in the bill?...

This language appears on the face to prohibit the use of any data collection with regard to use firearms. Does this section provide adequate protection for gun owners, and specifically for veterans?

Answer: This language (section 2716) prohibits the use of the federal database for storing information about who has a gun (based on questions asked by a physician with respect to gun ownership).

It does not prohibit the use of the database to determine who has a psychological ‘disorder’ like ADHD or PTSD. And it does not prohibit the ATF from trolling the database for persons with ADHD and PTSD (independent of any issue of gun ownership) — and sending their names to the FBI’s database of prohibited persons because they are ‘mental defectives’ (18 U.S.C. 922 (g)). HIPAA would not prohibit this ‘law enforcement function,’ and ObamaCare may significantly broaden the list of people whose determination is an ‘official’ determination similar to the VA psychiatrists who have disarmed 150,000 veterans.

To say that the health care database would never be used this way is to ignore history. Who ever thought in 1993 — when the Brady Law was passed — that the federal government would soon begin denying military veterans their right to own a gun ... not for any crimes committed, but because of a psychiatrist’s determination that such veterans suffered from PTSD?”

--Single Payer Health Care--

63. Can states set up their own single payer systems under Obamacare? – YES

GENERAL REFERENCE 1

The Patient Protection and Affordable Care Act, Section 1332, “Waiver for State Innovation,” page 85, signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

“SEC. 1332. WAIVER FOR STATE INNOVATION.
(a) APPLICATION.—

- (1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph
- (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—
- (A) be filed at such time and in such manner as the Secretary may require;
- (B) contain such information as the Secretary may require, including—
- (i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and
- (ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and
- (C) provide an assurance that the State has enacted the law described in subsection (b)(2).”

PRO 1

Public Citizen, in a report by Taylor Lincoln, Research Director of the Congress Watch division of Public Citizen, stated the following in its July 10, 2013 publication "A Road Map to 'Single-Payer'" available at citizen.org:

"The law's prescriptions would be a roadblock to states endeavoring to establish universal care systems [single payer systems] but for its inclusion of a section permitting states to apply for a 'waiver of all or any requirements...with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017.'

The criteria for receiving a state innovation waiver include demonstrating that a proposed alternative will provide coverage at least as comprehensive and as affordable as called for in the Affordable Care Act, that coverage will be provided to at least as many people as under the act, and not impose extra costs on the federal government. The waiver provision calls for the federal government to make payments to the state equaling those that the government would otherwise have made pursuant to the Affordable Care Act.

...The standards called for in the waiver provision in the Affordable Care Act appear to be easily attainable by a state that wishes to establish a universal care system."

PRO 2

Margaret Flowers, MD, Co-Director of Its Our Economy, stated the following in her Mar. 2, 2011 publication "State Health Law Waivers: Where Will They Take Us," available at pnhp.org:

“The federal health bill [Obamacare] requires that any state seeking a waiver from the health insurance exchange must at a minimum provide coverage comparable to that specified by the federal bill (Section 1332). It is left to the discretion of the secretary of health and human services to determine if a state meets this requirement.

States that put in place a single-payer health system will surpass the coverage of federal law. A single-payer health system, improved Medicare for all, would be universal and would provide the necessary cost controls and savings that would fund comprehensive coverage, including much-needed mental health, dental and vision care.

States such as Vermont and California...appear to be closer than any others to enacting a state single-payer health system...”

PRO 3

Linda Bergthold, PhD, Research Associate at the Center for Health Policy at Stanford, stated the following in her Sep. 17, 2013 article "Single Payer: Alive and Still Remarkably Well," available at huffingtonpost.com:

“...[T]he ACA encourages individual states to experiment with single-payer universal health care. States can apply for an innovation 'waiver' and start implementing their own plans starting in 2017. Vermont Governor Peter Shumlin led the way when he signed Green Mountain care into law in 2011, establishing a road map for a state-level single-payer system.”

--Socialism--

64. Is Obamacare a socialist law? – DEBATED

PRO (yes)	CON (no)
<p style="text-align: center;">PRO 1</p> <p>Sean Hannity, host of Fox News Channel’s <i>Hannity</i> show, stated the following during a Mar. 25, 2010 interview with CNSnews, available at www.cnsnews.com:</p> <p>"Obama is a socialist. If you take over banks, if you take over car companies, if you take over financial institutions, the way that he has - now the health care system. If you're going to use every crooked deal that you can come up with to get a bill like that passed - most recently the health care bill - that is by definition, if you look up the dictionary definition of socialism, this is it.”</p> <p style="text-align: center;">PRO 2</p> <p>Newt Gingrich, PhD, former Speaker of the US House of Representatives and Senior Fellow at the American Enterprise Institute, stated the following during a May 24, 2010 interview with Tom</p>	<p style="text-align: center;">CON 1</p> <p>Quentin Young, MD, National Coordinator of Physicians for a National Health Program (PNHP), stated the following in an Aug. 11, 2010 email to ProCon.org:</p> <p>"No, the Patient Protection and Affordable Care Act of 2010 is not 'socialized medicine' or a 'government takeover' of U.S. health care. Quite the contrary: the new legislation enhances the central role of private, for-profit corporations in our health system.</p> <p>In fact, by forcing thousands of businesses and millions of individuals to buy health insurance from private corporations, and by subsidizing the purchase of this (often shoddy and inadequate) coverage, the new law is throwing an economic lifeline to a decidedly market-based model of financing care – one that puts profit maximization above the nation’s health.</p>

Schaller titled "Gingrich Slams Paulson, Obama, Sarbanes-Oxley and Even W (a little)," available at www.fivethirtyeight.com:

"Obama is committed to socialism. I mean socialism in the broad sense. I'm not talking about a particular platform adopted by the International Socialist Movement in the late 19th century. I'm talking about a government-dominated, bureaucratically-controlled, politician-dictated way of life. Not only have we taken over GM, Chrysler and AIG, but there's a czar in the White House who believes he can establish the pay scale for 30 companies he's never been in, for hundreds of people he's never met. They just nationalized the student loan program. They designed Obamacare so there's a backdoor road to socialized medicine because it creates an incentive for companies to drop their employees. There's evidence that hundreds of companies may drop millions of employees from their health insurance and have them go buy individual insurance. So there are a lot of different practices that would lead us to believe this is a socialist operation."

PRO 3

Michelle Bachmann, JD, LLM, US Representative (R-MN), stated the following during her June 14, 2010 speech at the Luce Policy Institute "2010 Conservative Leadership Seminar," available at www.c-spanarchives.org:

"...[S]ocialized medicine, or the government takeover of healthcare, really is the lynchpin of socialism in any nation, that's what the threat of Obamacare is for America, because it completely re-tools the way we do business in this country."

PRO 4

Louie Gohmert, JD, US Representative (R-TX), was quoted as stating the following in a Mar. 27, 2012 article "Obamacare Is Socialism: Reps. Louie Gohmert, Steve King Attack," available at www.huffingtonpost.com:

The new legislation was decisively shaped by the insurance and pharmaceutical companies. These firms lavished hundreds of millions of dollars on Congress in the form of lobbying and campaign contributions over the past several years to make sure their profit-making enterprises were protected under any reform..."

CON 2

Martin J. Keenan, JD, practicing attorney, stated the following in his Mar. 23, 2010 article "Health Care Bill Is Not Socialism," available at www.kansasfreepress.com:

"...in Socialism, the government owns the company providing the goods or services and also controls the company. Nothing in the health care bill is Socialism, as defined by Webster.

In a socialistic medical system, the government would nationalize the entire industry. All hospitals, clinics and other health care facilities would be owned by the government. Also, all the employees (including the doctors) would be government employees...

Obama's health care plan is not Socialism, because Socialism is when the government owns and controls the hospitals and hires the doctors and nurses. Obama's plan keeps our current private sector system, but makes it more accessible."

CON 3

Milos Forman, Academy Award-winning Director for the films *One Flew Over the Cuckoo's Nest* and *Amadeus*, wrote in his July 10, 2012 article "Obama the Socialist? Not Even Close," available at www.nytimes.com:

"I hear the word 'socialist' being tossed around by the likes of Rick Perry, Newt Gingrich, Rick Santorum, Sean Hannity, Rush Limbaugh and others. President Obama, they warn, is a socialist.

"How much more socialist can you get than a government telling everybody what they can do, what they can't do, how they can live..."

In order to make Obamacare to work, the IPAB [Independent Payment Advisory Board] must look and say, 'This costs so much, this costs so much. This works over here and will save a lot of people, but this one will save more. So since we're the government and we bought into the socialist notion that the greatest good for the greatest number of people reigns -- no longer individual liberty reigns -- therefore we've got to let these people die and these people live.'"

PRO 5

Steve King, US Representative (R-IA), in a Mar. 27, 2012 *Huffington Post* interview, "Obamacare Is Socialism: Reps. Louie Gohmert, Steve King Attack," available at www.huffingtonpost.com, stated:

"Just think of this: Is it socialism to nationalize a company? Is it socialism to take over banks, insurance companies, car companies? Is that socialism? The socialists say it is... It's control of the means of production... Owning the means of production is Marxism. Controlling the means of production is more in the realm of socialism."

The critics cry, 'Obamacare is socialism!' They falsely equate Western European-style socialism, and its government provision of social insurance and health care, with Marxist-Leninist totalitarianism. It offends me, and cheapens the experience of millions who lived, and continue to live, under brutal forms of socialism...

Whatever his faults, I don't see much of a socialist in Mr. Obama or, thankfully, signs of that system in this great nation."

CON 4

Mormons for Obama stated in their Sep. 1, 2012 article "Myth Romney and the Real Truth About Obamacare," available at www.mormonsforobama.org:

"Myth 4: Obamacare is a socialist program. (FALSE)

Reality: Socialism is a system under which the government directly runs a nation's industries. Under this standard, New Deal programs like the Works Progress Administration and the Tennessee Valley Authority could, arguably, be considered socialist. After all, they represented instances in which the government directly employed people to build and administer power plants and other public works that generated income. Obamacare, on the other hand, will work through private companies. Rather than directly providing health insurance, either through a national program or through some sort of public option, the government will require that people deal with private insurers. Far from competing with private industry, the health care law will likely give it a lot of new customers."

--Unauthorized Immigrants--

65. Are unauthorized ("illegal") immigrants covered by Obamacare? – NO

GENERAL REFERENCE

The Patient Protection and Affordable Care Act, Section 1312, page 64, "Consumer Choice," signed into law on Mar. 23, 2010, available at www.thomas.gov, states:

"(3) ACCESS LIMITED TO LAWFUL RESIDENTS.—If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange."

CON 1

James R. Edwards Jr., PhD, Fellow at the Center for Immigration Studies, stated in his July 2010 article "The Medicaid Costs of Legalizing Illegal Aliens," available at www.cis.org:

"The recently enacted health reform law, in part, expands eligibility for the Medicaid program. Illegal aliens remain ineligible for Medicaid beyond emergency services. However, this could change if they are legalized."

CON 2

The California Immigration Policy Center (CIPC) stated in its Apr. 4, 2012 report "Making the Affordable Care Act Work for Immigrants in California," available at www.caimmigrant.org:

"The Affordable Care Act explicitly excludes unauthorized immigrants from the federally funded Exchange."

V. 19 Taxes, Penalties, Fees, and Deduction Eliminations in Obamacare

In all, Obamacare has 12 new or increased taxes and fees, and seven lowered or eliminated tax benefits and credits. The PPACA contains 12 of those revenue generators, the Reconciliation Act contains four, and three are found in both.

We have listed all 19 taxes, penalties, fees, and deduction eliminations below along with a citation, brief description, and relevant passage from Obamacare.

1. [\\$50,000 tax penalty on 501\(r\)\(3\) charitable hospitals for failure to meet five new requirements](#)
2. [Increased tax penalty \(40%\) for monetary transactions that "merely serve to lower one's tax burden"](#)
3. [Elimination of tax credits for cellulosic biofuel \(black tar\) producers](#)
4. [Annual excise tax on drug manufacturers and importers for sales of non-generic branded pharmaceutical drugs \(varies based on amount sold\)](#)

5. [Tax deduction elimination for health insurance companies that do not spend at least 85% of revenues on clinical services](#)
6. [10% excise tax on indoor tanning services](#)
7. [Removal of reimbursements for over-the-counter medicine \(except insulin\) from people with a health savings account \(HSA\), flexible spending account \(FSA\), or health reimbursement account \(HRA\)](#)
8. [Increased tax penalty \(20%\) for early withdrawal from health/medical savings accounts](#)
9. [3.8% tax on investment income earned in households earning over \\$250,000 per year](#)
10. [0.9% tax for hospital insurance on households earning over \\$250,000 per year](#)
11. [2.3% excise tax on medical device manufacturers](#)
12. [Increase in threshold \(10%\) for itemized tax deduction of medical expenses](#)
13. [Cap on tax-free contributions \(\\$2,500\) to health flexible spending arrangements](#)
14. [Removes tax deductions for employer-provided retirement prescription drug insurance plans through Medicare Part D](#)
15. [Removes executive salary tax deductions for health insurance companies that compensate executives over \\$500,000 per year](#)
16. [Tax penalty for individuals who do not have health insurance \(the mandate\)](#)
17. [Annual \\$2,000 tax on companies with over 50 employees that do not offer health insurance](#)
18. [Annual fee on all health insurance companies \(varies based on amount collected in premiums\)](#)
19. [40% excise tax on “Cadillac” health insurance plans](#)

1. Bill: PPACA

Sec. 9007. Additional Requirements for Charitable Hospitals

Sec. 10903. Modification of Limitation on Charges by Charitable Hospitals

Sec. 4959. Taxes on Failures by Hospital Organizations

Tax Penalty for Non-Compliance

Amends the Internal Revenue Code of 1986 to add additional requirements for hospitals wishing to file as 501(r)(3) charities, and taxes those hospitals \$50,000 if they fail to meet the requirements. The requirements include conducting a community health needs assessment and implementing a strategy to meet those needs; establishing a written financial assistance policy; establishing a policy to provide

emergency care without discrimination; limiting charges for “emergency or other medically necessary care” for individuals eligible for financial assistance.

“If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to \$50,000.”

2. Bill: Reconciliation Act

Sec. 1409. Codification of Economic Substance Doctrine and Penalties

Codifying Existing Common Law Doctrine and Tax Penalty for Non-Compliance

If a taxpayer performs a transaction that the IRS deems to lack “economic substance” or “a business purpose” (i.e. merely to lower one’s tax burden), that transaction is now penalized at a tax rate of 40% if undisclosed (an increase from the existing rate of 20%). The “economic substance doctrine” was a well-established common law doctrine that Obamacare codified in American tax law.

“(5) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

(A) ECONOMIC SUBSTANCE DOCTRINE.—The term ‘economic substance doctrine’ means the common law doctrine under which tax benefits under subtitle A with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose.”

“(1) APPLICATION OF DOCTRINE.—In the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if—

(A) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer’s economic position, and

(B) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction.”

(i) INCREASE IN PENALTY IN CASE OF NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—

“In the case of any portion of an underpayment which is attributable to one or more non-disclosed noneconomic substance transactions, subsection (a) shall be applied with respect to such portion by substituting ‘40 percent’ for ‘20 percent’.”

3. Bill: Reconciliation Act

Sec. 1408. Elimination of Unintended Application of Cellulosic Biofuel Producer Credit

Elimination of Tax Credit

Removes tax breaks for “black liquor,” a byproduct of papermaking used by pulp mills as an alternative energy source for plant operations.

“(a) IN GENERAL.—Section 40(b)(6)(E) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

iii) EXCLUSION OF UNPROCESSED FUELS.—The term ‘cellulosic biofuel’ shall not include any fuel if—

- (I) more than 4 percent of such fuel (determined by weight) is any combination of water and sediment, or
- (II) the ash content of such fuel is more than 1 percent (determined by weight).”

4. Bill: PPACA

Sec. 9008. Imposition of Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers

Bill: Reconciliation Act

Sec. 1404. Brand Name Pharmaceuticals

New Excise Tax

New annual excise tax on sales of non-generic branded pharmaceutical drugs by drug manufacturers and importers. The tax burden varies depending on the amount of drugs sold.

“(a) *IMPOSITION OF FEE.*—

(1) *IN GENERAL.*—Each covered entity engaged in the business of manufacturing or importing branded prescription drugs shall pay to the Secretary of the Treasury not later than the annual payment date of each calendar year beginning after 2010 a fee in an amount determined under subsection (b).

(2) *ANNUAL PAYMENT DATE.*—For purposes of this section, the term ‘annual payment date’ means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) *DETERMINATION OF FEE AMOUNT.*—

(1) *IN GENERAL.*—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount —

(A) the covered entity’s branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

(2) *SALES TAKEN INTO ACCOUNT.*—For purposes of paragraph (1), the branded prescription drug sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

<i>With respect to a covered entity’s aggregate branded prescription drug sales during the calendar year that are:</i>	<i>The percentage of such sales taken into account is:</i>
<i>Not more than \$5,000,000</i>	<i>0 percent</i>
<i>More than \$5,000,000 but not more than \$125,000,000</i>	<i>10 percent</i>
<i>More than \$125,000,000 but not more than \$225,000,000</i>	<i>40 percent</i>
<i>More than \$225,000,000 but not more than \$400,000,000.</i>	<i>75 percent</i>
<i>More than \$400,000,000</i>	<i>100 percent</i>

APPLICABLE AMOUNT.—For purposes of paragraph (1), the applicable amount shall be determined in accordance with the following table:

<i>Calendar year</i>	<i>Applicable amount</i>
<i>2011</i>	<i>\$2,500,000,000</i>
<i>2012</i>	<i>\$2,800,000,000</i>
<i>2013</i>	<i>\$2,800,000,000</i>
<i>2014</i>	<i>\$3,000,000,000</i>

2015	\$3,000,000,000
2016	\$3,000,000,000
2017	\$4,000,000,000
2018	\$4,100,000,000
2019 and thereafter	\$2,800,000,000.”;

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—
(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and
(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).”

5. Bill: PPACA

Sec. 9016. Modification of Section 833 Treatment of Certain Health Organizations

Elimination of Tax Deduction for Non-Compliance

Health insurance companies that do not spend at least 85% of revenues on clinical services will not qualify for existing tax deductions.

“(a) IN GENERAL.—Subsection (c) of section 833 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

(5) NONAPPLICATION OF SECTION IN CASE OF LOW MEDICAL LOSS RATIO.—Notwithstanding the preceding paragraphs, this section shall not apply to any organization unless such organization’s percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85 percent.”

6. Bill: PPACA

Sec. 10907. Excise Tax on Indoor Tanning Services in Lieu of Elective Cosmetic Medical Procedures

New Excise Tax

New 10 percent excise tax on the use of indoor tanning salons.

“(b) EXCISE TAX ON INDOOR TANNING SERVICES.—
Subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new chapter:

CHAPTER 49—COSMETIC SERVICES

SEC. 5000B. IMPOSITION OF TAX ON INDOOR TANNING SERVICES.

(a) IN GENERAL.—There is hereby imposed on any indoor tanning service a tax equal to 10 percent of the amount paid for such service (determined without regard to this section), whether paid by insurance or otherwise.”

7. Bill: PPACA

Sec. 9003. Distributions for Medicine Qualified Only if for Prescribed Drug or Insulin

Elimination of Reimbursements for Over-the-Counter Medicine

Removes reimbursements for non-prescription, over-the-counter medicine (except insulin) from people with a health savings account (HSA), flexible spending account (FSA), or health reimbursement account (HRA).

“(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.”

8. Bill: PPACA

Sec. 9004. Increase in Additional Tax on Distributions from HSAs and Archer MSAs Not Used for Qualified Medical Expenses

Tax Penalty Increase for Early Withdrawal from Health/Medical Savings Accounts

Increases tax penalties from 10 to 20 percent on non-medical early withdrawals from health/medical savings accounts.

“(a) HSAS.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ‘10 percent’ and inserting ‘20 percent’.

(b) ARCHER MSAS.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ‘15 percent’ and inserting ‘20 percent’.”

9. Bill: Reconciliation Act

Sec. 1402. Unearned Income Medicare Contribution

Sec. 1411. Imposition of Tax

New Tax

A new 3.8% tax on investment income earned in households earning over \$250,000 per year (\$200,000 single). This income includes gross income in interest, annuities, royalties, net rents, and passive income in partnerships and S corporations. It does not include municipal bond interest or life insurance proceeds, active trade or business income, fair market value sales of ownership in pass-through entities, or distributions from retirement plans.

“(a) IN GENERAL.—Except as provided in subsection (e)—

(1) APPLICATION TO INDIVIDUALS.—In the case of an individual, there is hereby imposed (in addition to any other tax imposed by this subtitle) for each taxable year a tax equal to 3.8 percent of the lesser of—

(A) net investment income for such taxable year, or

(B) the excess (if any) of—

(i) the modified adjusted gross income for such taxable year, over

(ii) the threshold amount.

(2) APPLICATION TO ESTATES AND TRUSTS.—In the case of an estate or trust, there is hereby imposed (in addition to any other tax imposed by this subtitle) for each taxable year a tax of 3.8 percent of the lesser of—

- (A) the undistributed net investment income for such taxable year, or
- (B) the excess (if any) of—
 - (i) the adjusted gross income (as defined in section 67(e)) for such taxable year, over
 - (ii) the dollar amount at which the highest tax bracket in section 1(e) begins for such taxable year.

- (b) **THRESHOLD AMOUNT.**—For purposes of this chapter, the term ‘threshold amount’ means—
- (1) in the case of a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), \$250,000,
 - (2) in the case of a married taxpayer (as defined in section 7703) filing a separate return, 1/2 of the dollar amount determined under paragraph (1), and
 - (3) in any other case, \$200,000.”

10. Bill: PPACA

Sec. 9015. Additional Hospital Insurance Tax on High-Income Taxpayers

Sec. 10906. Modifications to Additional Hospital Insurance Tax on High-Income Taxpayers

New Tax

An additional tax for hospital insurance on individuals earning over \$200,000 per year and households earning over \$250,000 per year.

“(a) **FICA.**—

(1) **IN GENERAL.**—Section 3101(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking “In addition” and inserting the following:

(1) **IN GENERAL.**—In addition”,

(B) by striking “the following percentages of the” and inserting “1.45 percent of the”,

(C) by striking “(as defined in section 3121(b))—” and all that follows and inserting “(as defined in section 3121(b)).”, and

(D) by adding at the end the following new paragraph:

(2) **ADDITIONAL TAX.**—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) a tax equal to 0.9 percent of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2012, and which are in excess of—

(A) in the case of a joint return, \$250,000, and

(B) in any other case, \$200,000.”.

(2) **COLLECTION OF TAX.**—Section 3102 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

(f) **SPECIAL RULES FOR ADDITIONAL TAX.**—

(1) **IN GENERAL.**—In the case of any tax imposed by section 3101(b)(2), subsection (a) shall only apply to the extent to which the taxpayer receives wages from the employer in excess of \$200,000, and the employer may disregard the amount of wages received by such taxpayer’s spouse.

(2) **COLLECTION OF AMOUNTS NOT WITHHELD.**—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

(3) *TAX PAID BY RECIPIENT.*—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no case relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.’’

(b) *SECA.*—

(1) *IN GENERAL.*—Section 1401(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking “In addition” and inserting the following:

(1) *IN GENERAL.*—In addition”, and

(B) by adding at the end the following new paragraph:

(2) *ADDITIONAL TAX.*—

(A) *IN GENERAL.*—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) for each taxable year beginning after December 31, 2012, a tax equal to 0.9 percent of the self employment income for such taxable year which is in excess of— “(ii) in any other case, \$200,000.

(B) *COORDINATION WITH FICA.*—The amounts under clauses (i) and (ii) of subparagraph (A) shall be reduced (but not below zero) by the amount of wages taken into account in determining the tax imposed under section 3121(b)(2) with respect to the taxpayer.’’

(2) *NO DEDUCTION FOR ADDITIONAL TAX.*—

(A) *IN GENERAL.*—Section 164(f) of such Code is amended by inserting (other than the taxes imposed by section 1401(b)(2)) after section 1401).

(B) *DEDUCTION FOR NET EARNINGS FROM SELF-EMPLOYMENT.*—

Subparagraph (B) of section 1402(a)(12) is amended by inserting “(determined without regard to the rate imposed under paragraph (2) of section 1401(b))” after “for such year”’.

(c) *EFFECTIVE DATE.*—The amendments made by this section shall apply with respect to remuneration received, and taxable years beginning, after December 31, 2012.”

11. Bill: Reconciliation Act

Sec. 1405. Excise Tax on Medical Device Manufacturers

Sec. 4191. Medical Devices

New Excise Tax

New tax on the sales of medical devices, excluding eyeglasses, contact lenses, hearing aids, and “any other medical device determined... to be of a type which is generally purchased by the general public at retail for individual use.”

“(a) *IN GENERAL.*—There is hereby imposed on the sale of any taxable medical device by the manufacturer, producer, or importer a tax equal to 2.3 percent of the price for which so sold.

(b) *TAXABLE MEDICAL DEVICE.*—For purposes of this section—

(1) *IN GENERAL.*—The term ‘taxable medical device’ means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans.

(2) *EXEMPTIONS.*—Such term shall not include—

- (A) eyeglasses,
- (B) contact lenses,
- (C) hearing aids, and
- (D) any other medical device determined by the Secretary to be of a type which is generally purchased by the general public at retail for individual use.”

12. Bill: PPACA

Sec. 9013. Modification of Itemized Deduction for Medical Expenses

Increase in threshold for itemized deduction of medical expenses

Medical expenses in excess of 10% of an individual’s adjusted gross income may be deducted from tax reporting, an increase from 7.5%. The section grants a temporary waiver of the increase from the years 2013-16 for persons over the age of 65.

- “(a) *IN GENERAL.*—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking ‘7.5 percent’ and inserting ‘10 percent.’
- (b) *TEMPORARY WAIVER OF INCREASE FOR CERTAIN SENIORS.*— Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:
- (f) *SPECIAL RULE FOR 2013, 2014, 2015, AND 2016.*—In the case of any taxable year beginning after December 31, 2012, and ending before January 1, 2017, subsection (a) shall be applied with respect to a taxpayer by substituting ‘7.5 percent’ for ‘10 percent’ if such taxpayer or such taxpayer’s spouse has attained age 65 before the close of such taxable year.
- (c) *CONFORMING AMENDMENT.*—Section 56(b)(1)(B) of the Internal Revenue Code of 1986 is amended by striking ‘by substituting ‘10 percent’ for ‘7.5 percent’ and inserting ‘without regard to subsection (f) of such section.’”

13. Bill: PPACA

Sec. 9005. Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans

Sec. 10902. Inflation Adjustment of Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans

Cap on tax deductions for medical expenses

Contributions to health flexible spending arrangements that allow people to set aside money tax free to pay for medical expenses is capped at \$2,500 (the threshold used to be unlimited). The limit will be indexed to inflation and increased by an annual cost-of-living adjustment.

- “(a) *IN GENERAL.*—Subsection (i) of section 125 of the Internal Revenue Code of 1986, as added by section 9005 of this Act, is amended to read as follows:
- (i) *LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.*—
 - (1) *IN GENERAL.*—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement.

(2) *ADJUSTMENT FOR INFLATION.*—*In the case of any taxable year beginning after December 31, 2011, the dollar amount in paragraph (1) shall be increased by an amount equal to—*

(A) *such amount, multiplied by*

(B) *the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting ‘calendar year 2010’ for ‘calendar year 1992’ in subparagraph (B) thereof.*

If any increase determined under this paragraph is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(b) *EFFECTIVE DATE.*—*The amendment made by this section shall apply to taxable years beginning after December 31, 2010.”*

14. Bill: PPACA

Sec. 9012. Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy

Elimination of Tax Deduction

Removes tax deductions for employer-provided retirement prescription drug insurance plans.

“(a) IN GENERAL.—*Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.*

(b) *EFFECTIVE DATE.*—*The amendment made by this section shall apply to taxable years beginning after December 31, 2010.”*

15. Bill: PPACA

Sec. 9014. Limitation on Excessive Remuneration Paid by Certain Health Insurance Providers

Elimination of Tax Deduction for Non-Compliance

Removes tax deductions for health insurance executives that are compensated over \$500,000 per year.

“(a) IN GENERAL.—*Section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:*

(6) *SPECIAL RULE FOR APPLICATION TO CERTAIN HEALTH INSURANCE PROVIDERS.*—

(A) *IN GENERAL.*—*No deduction shall be allowed under this chapter—*

(i) *in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is attributable to services performed by an applicable individual during such taxable year, to the extent that the amount of such remuneration exceeds \$500,000, or*

(ii) *in the case of deferred deduction remuneration for any taxable year beginning after December 31, 2012, which is attributable to services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds \$500,000 reduced (but not below zero) by the sum of—*

(I) *the applicable individual remuneration for such disqualified taxable year, plus*

(II) *the portion of the deferred deduction remuneration for such services which was taken into account under this clause in a preceding taxable year (or*

which would have been taken into account under this clause in a preceding taxable year if this clause were applied by substituting ‘December 31, 2009’ for ‘December 31, 2012’ in the matter preceding subclause (I).”

16. Bill: PPACA

Sec. 1501. Requirement to Maintain Minimum Essential Coverage

Penalty for Non-Compliance

Taxes individuals as a proportion of their income if they choose not to purchase health insurance.

“(b)(1) Section 5000A(b)(1) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

(1) IN GENERAL.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Paragraphs (1) and (2) of section 5000A(c) of the Internal Revenue Code of 1986, as so added, are amended to read as follows:

(1) IN GENERAL.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

- (A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or*
- (B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.*

(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph

(1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

- (i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or*
- (ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.*

(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the taxpayer’s household income for the taxable year:

- (i) 0.5 percent for taxable years beginning in 2014.*
- (ii) 1.0 percent for taxable years beginning in 2015.*
- (iii) 2.0 percent for taxable years beginning after 2015.”*

17. Bill: PPACA

Sec. 1513. Shared Responsibility for Employers

Sec. 4980H. Shared Responsibility for Employers Regarding Health Coverage

Penalty for Non-Compliance

If an employer does not offer health coverage, and at least one employee qualifies for a health tax credit, the employer must pay an additional non-deductible tax of \$2,000 for all full-time employees (applies to all employers with 50 or more employees). If the employer requires a waiting period of 30-60 days to enroll in coverage, a \$400 tax per employee applies (\$600 if the period is 60 days or longer).

“(a) LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.—

If—

- (1) any applicable large employer fails to offer to its fulltime employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer sponsored plan (as defined in section 5000A(f)(2)) for any month, and*
- (2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee, then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.*

(b) LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 30 DAYS.—

(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment, in the amount specified in paragraph (2), for each full-time employee of the employer to whom the extended waiting period applies.

(2) AMOUNT.—For purposes of paragraph (1), the amount specified in this paragraph for a full-time employee is—

- (A) in the case of an extended waiting period which exceeds 30 days but does not exceed 60 days, \$400, and*
- (B) in the case of an extended waiting period which exceeds 60 days, \$600.*

(3) EXTENDED WAITING PERIOD.—The term ‘extended waiting period’ means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 30 days.

(c) LARGE EMPLOYERS OFFERING COVERAGE WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX CREDITS OR COST-SHARING REDUCTIONS.—

(1) IN GENERAL.—If—

- (A) an applicable large employer offers to its fulltime employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and*
- (B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee, then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large*

employer described in subparagraph (B) for such month and 400 percent of the applicable payment amount.

(2) OVERALL LIMITATION.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.”

18. Bill: PPACA

Sec. 9010. Imposition of Annual Fee on Health Insurance Providers

Sec. 10905. Modification of Annual Fee on Health Insurance Providers

Bill: Reconciliation Act

Sec. 1406. Health Insurance Providers

New Fee

Annual fee on health insurance companies relative to the amount collected in premiums during the calendar year. Includes an additional “third party administration agreement” fee.

“(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2013 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ‘annual payment date’ means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to \$6,700,000,000 as—

(A) the sum of—

(i) the covered entity’s net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, plus

(ii) 200 percent of the covered entity’s third party administration agreement fees that are taken into account during the preceding calendar year, bears to

(B) the sum of—

(i) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year, plus

(ii) 200 percent of the aggregate third party administration agreement fees of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—

(A) NET PREMIUMS WRITTEN.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity’s net premiums written during the calendar year that are: The percentage of net premiums written that are taken into account is:

*Not more than \$25,000,000 0 percent
 More than \$25,000,000 but not more than \$50,000,000..... 50 percent
 More than \$50,000,000 100 percent.*

(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—

The third party administration agreement fees that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity’s third party administration agreement fees during the calendar year that are: The percentage of third party administration agreement fees that are taken into account is:

*Not more than \$5,000,000 0 percent
 More than \$5,000,000 but not more than \$10,000,000..... 50 percent
 More than \$10,000,000 100 percent”*

19. Bill: PPACA

Sec. 9001. Excise Tax on High Cost Employer-Sponsored Health Coverage

Sec. 10901. Modifications to Excise Tax on High Cost Employer-Sponsored Health Coverage

Bill: Reconciliation Act

Sec. 1401. High-Cost Plan Excise Tax

New Excise Tax

Beginning in 2018, “Cadillac” health insurance plans will be subject to a 40% excise tax above a certain threshold. The threshold will be higher for early retirees and high-risk professions.

“(a) IMPOSITION OF TAX.—If—

- (1) an employee is covered under any applicable employer sponsored coverage of an employer at any time during a taxable period, and*
- (2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit.*

(b) EXCESS BENEFIT.—For purposes of this section—

(1) IN GENERAL.—The term ‘excess benefit’ means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

- (A) the aggregate cost of the applicable employer sponsored coverage of the employee for the month, over*
- (B) an amount equal to 1/12 of the annual limitation under paragraph (3) for the calendar year in which the month occurs.*

Our review covers a lot of ground, and there may still be more ground to cover. Any suggestions you may have for issues we have missed or got wrong would be greatly appreciated. Please send your feedback – pro or con – to info@procon.org.

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