



LOWRY HILL

PRIVATE ASSET MANAGEMENT

THE OUTCOMES OF 2010 HEALTH CARE REFORM

Government policy shapes the economies and industries in which we invest. In addition to recent health care reform, Congress will soon debate proposed legislation for several major sectors of the economy, including banking/finance and energy. During this time, we will continue to evaluate the emerging implications for both our clients and related investments. This whitepaper specifically explores the outcomes of the recently signed health care legislation, as well as the implications for taxpayers, business owners and investors.

The *Patient Protection and Affordable Care Act* touches all aspects of the U.S. health care system. The new legislation aims to expand coverage to currently under-served populations while simultaneously slowing cost growth. To this end, the Congressional Budget Office estimates the bill will cost \$938 billion over 10 years. Taxpayers and the health care industry will shoulder the cost of these provisions, as new taxes and fees will raise \$1 trillion to finance reform.

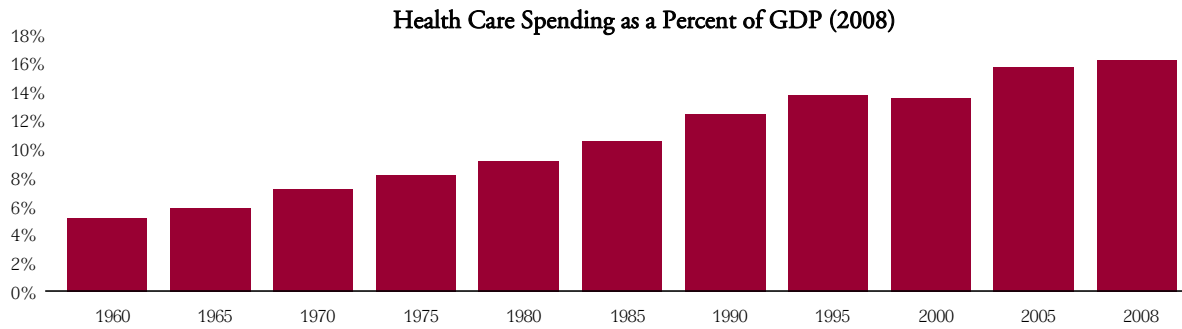
Health care is a large and growing cost to the economy. The legislation is intended to assist millions of the uninsured and others lacking access to care. It also provides a framework for slowing cost growth. However, we are not certain that the provisions are strong enough to lower total costs, particularly given the country's aging Baby Boomers and increasing life expectancies. In the absence of additional payment system reforms, health care costs could continue to rise. The U.S. already spends more on health care than other developed economies, and policy makers will continue to debate an appropriate, sustainable spending level.

In this paper, we provide a timeline of key regulations while outlining how a new tax on investment income and higher marginal rates might influence asset allocation decisions. (As Congress considers additional tax reform, we caution that it may be too early to adjust portfolios.) We also highlight our study of the effect of a health insurance mandate on employers and small business owners. Last, we outline investment opportunities that may result from the legislation.

THE POLICY DECISION

A History of Rising Costs

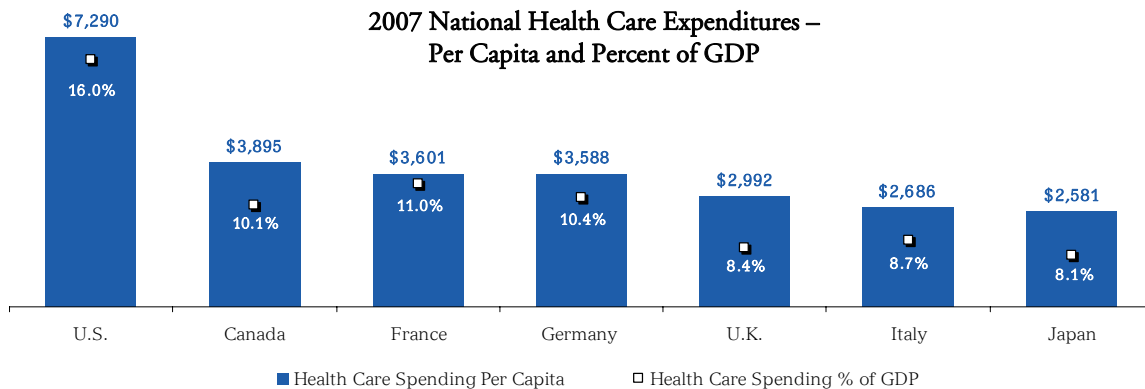
The rate of spending on health care in the U.S. over the last 50 years has exceeded the rate of inflation by a wide margin. A simple formula helps illustrate why: Access + Quality = Cost. Medicare, Medicaid and programs like the *2003 Prescription Drug Act* expanded access to care. Medical advances and technology have improved the quality of care, but they are expensive and tend to add to unit costs. An aging population and rising incomes also contribute to higher spending.



Source: Medicare Trustees Report (2009)

A fee-for-service payment system underpins the rising cost trend. Most doctors and hospitals are paid per test ordered or surgery performed. This incentive structure encourages excessive use of resources, and the industry has allocated capital accordingly. One consequence of this approach is evident in studies of supply-sensitive care. Research from the Dartmouth ATLAS project indicates that regions investing more in health care capacity spend more per patient. In other words, a built hospital bed likely will be filled.

To put costs into perspective, the U.S. spends much more on health care per capita and as a percentage of Gross Domestic Product than other developed countries. Comparing public and private health spending around the world, we see that other governments pay for a larger percentage of total health care costs. Yet, health care consumes a smaller percent of their respective budgets. Despite a higher level of spending, the U.S. system has struggled with issues of access and affordability.



Source: OECD Health Statistics (2007 Data)

Access to Expand

In the wake of the newly passed legislation, the Congressional Budget Office (CBO) estimates that 32 million uninsured individuals will gain new or improved access to the health care system through an employer-sponsored plan, subsidized insurance exchange or expanded Medicaid coverage. Beginning in 2014, all U.S. citizens will be required to buy health insurance or pay a penalty. Individuals will qualify for coverage despite pre-existing conditions. Other access provisions, such as small business tax credits, immediately take

effect. The bill prohibits annual and lifetime benefit caps, and insurers cannot drop participants except in the case of fraud.

Quality Tied to Payment Reform

While the uninsured currently receive basic care through emergency services, the new legislation will shift the load to routine and preventative care. Providers have until 2014, when key access provisions take effect, to prepare for this new level of demand. Focus will be placed on balancing the supply of primary care and specialist physicians, an issue tied to incentives and payment-system reform.

Pilot programs will explore alternatives to a fee-for-service model, including bundled payments and accountable care organizations. The concept of pay-for-quality systems is not new. For example, the Mayo Clinic is organized to provide high-quality care while creating incentives to lower costs. The reform act lays a foundation for payment reform and includes quality in the payment rate equation, although the general fee-for-service model is unchanged. Medicare payments to high-cost areas are 50 percent higher than low-cost regions because reimbursements remain tied to cost rather than value.

Costs to Rise

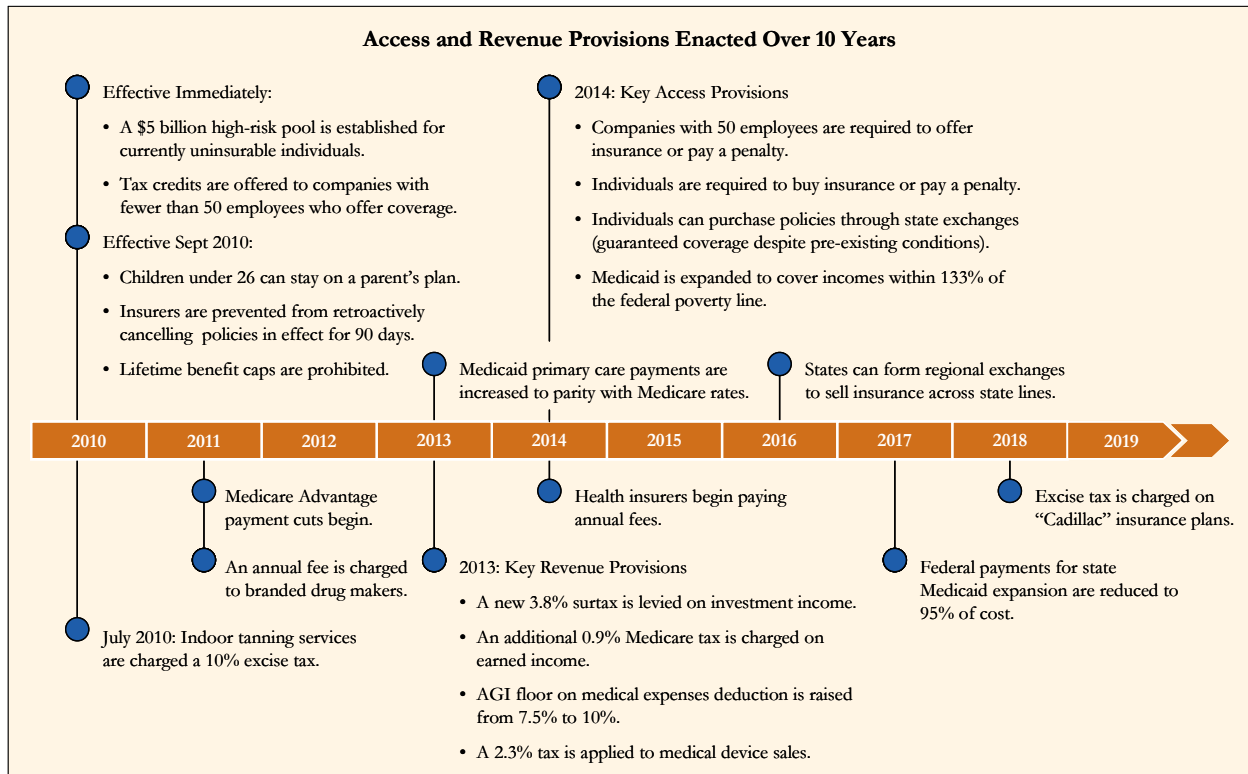
Expanding the number of participants in the health care system while attempting to keep quality fixed will obviously increase the cost to the economy. As the details of this law are worked out in coming years, figuring out the complex interplay of who will bear the burden of increased cost or who will bear the burden of reduced care is likely to spawn much spirited debate. The legislation takes steps to lower costs by controlling reimbursements, but the cost side of health care is difficult to manage. Declining payments could easily change provider behavior, and unintended consequences (e.g., reduced coverage, higher out-of-pocket deductibles, reduced access to care or providers exiting key businesses) could result. Falling payments also could build in disincentives for innovation. If unit and total costs continue to rise, Congress likely will be forced to revisit the percentage of the government's budget allocated to health care. Additional delivery and payment reform might follow.

FINANCIAL IMPLICATIONS

The CBO estimates the *Patient Protection and Affordable Care Act* will cost the U.S. government \$938 billion over the next 10 years. Meanwhile, the legislation builds in new taxes and fees that are projected to raise \$1 trillion to help finance the government's portion of the reform. As written, the CBO projects the legislation would reduce the federal deficit \$143 billion by 2019. We are skeptical of these estimates. CBO projections assume the legislation succeeds at controlling costs. In addition, taxes and spending cuts are unpopular to enact; it is possible that certain revenue provisions will not take effect. Indeed, there is historic precedence for government mandates to be under- or unfunded in subsequent years.

For example, the *Balanced Budget Act of 1997* required Medicare to pay for health care cost increases over the rate of general inflation. To the extent costs rose at a faster rate, reimbursement rates were to fall. By 2003, spending on health care had exceeded the

benchmark rate, and payments to doctors were set to decline. However, Congress opted to defer the cuts for one fiscal year. Then, for each of the next seven years, Congress again voted to defer the cuts. After compounding, doctor payments now would require a 21 percent cut to be in line with the original law's requirement. Provisions in the new law could easily follow a similar course, as Congress grapples with issues such as how to reduce provider payments, increase taxes/fees or restrict access (in order to keep the equation in balance).



A New Tax on Investment Income

The legislation mandates several new taxes and fees. Their start dates are plotted on the timeline above. Significant revenue provisions take effect in 2013, when investors will begin paying a 3.8 percent tax on net investment income. The surtax also applies to trusts and estate income. The bill taxes all income over the top trust and estate income bracket (\$11,200), even if the income is not distributed.

To determine the new tax liability, two values are calculated. The first is modified adjusted gross income (MAGI), which equals adjusted gross income (AGI) from Form 1040 plus a net foreign income exclusion. For many of our clients, AGI will be a close approximation of MAGI. The calculated MAGI then is compared to an income threshold. Individuals and families whose modified adjusted gross incomes do not exceed \$200,000 or \$250,000, respectively, are not subject to the tax.

Investors and trusts with incomes over the threshold values owe surtax on the lesser of investment income or MAGI exceeding the threshold. Net investment income includes passive items (e.g., taxable bond interest, dividends and capital gains) but excludes tax-

exempt income (e.g., interest on municipal bonds). For small business owners, the sale of an active interest in a partnership or S-corporation is also excluded. The tables below illustrate the MAGI and investment income calculations.

Example 1 – Single Filer		Example 2 – Married Couple	
Salary	\$175,000	Pension/IRA RMD	\$275,000
Investment Income	\$25,000	Investment Income	\$50,000
MAGI	\$200,000	MAGI	\$325,000
3.8% Surtax	\$0	3.8% Surtax	\$1,900 = 50,000 x .038

Source: Internal Revenue Service, H.R. Bill 4872 – Sec. 1411

In the first example, the client owes no surtax on the \$25,000 of investment income, since MAGI does not exceed the individual threshold amount (\$200,000). In the second example, MAGI exceeds the family threshold amount, so the couple owes tax on the lesser of investment income (\$50,000) or MAGI above \$250,000 (\$75,000). Beginning in 2013, these clients would owe a surtax of 3.8 percent of \$50,000 (\$1,900), assuming the current legislation remains intact. In the second example, the effect of traditional IRA distributions on the surtax calculation is highlighted. While a traditional IRA distribution is not included in the calculation of investment income, it does increase MAGI. Where income approaches the threshold value, IRA distributions could push MAGI over the top, exposing investment income to the tax.

The Impact of Higher Tax Rates on Investment Strategy

The *2001 and 2003 Tax Relief Reconciliation Acts* lowered the top marginal rate to 35 percent and set capital gains and dividend rates at 15 percent. These cuts expire on December 31, 2010, when tax rates are set to revert to the higher levels that existed prior to the tax cuts. Assuming Congress does not act to change any of the particulars, the trajectory of top-income-bracket rates is illustrated below. Dividends, which are currently taxed at 15 percent, will once again be taxed as ordinary income (i.e., as much as 39.6 percent at the Federal level). In 2013, health care reform will add an additional surtax of 0.9 percent and 3.8 percent to earned and investment income rates, respectively.

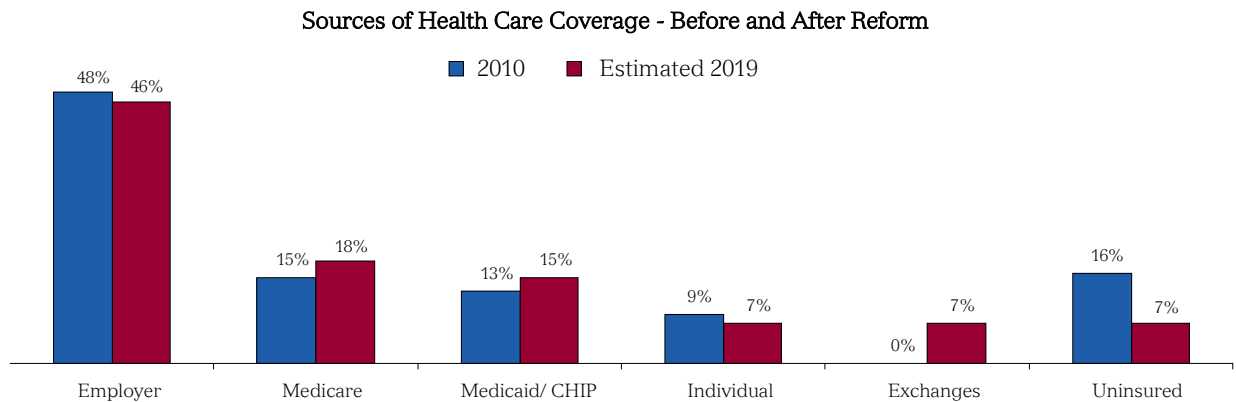
Top Marginal Tax Rate	2010	2011	HC Law	2013
Earned Income	35%	39.6%	+ 0.9%	= 40.5%
Taxable Interest	35%	39.6%	+ 3.8%	= 43.4%
Dividends	15%	39.6%	+ 3.8%	= 43.4%
Long-term Capital Gains	15%	20%	+ 3.8%	= 23.8%

Source: Internal Revenue Service, H.R. Bills 4872, 3590

Because discussions of tax reform are fluid, it may be too early to adjust portfolios based on the potential for future legislation. However, pay-as-you-go rules require Congress to finance any deviation from the rates shown on the previous page. For example, if Congress decided not to let the current 15-percent tax rate on dividends revert to ordinary income tax rates (e.g., by instead stepping it up only in line with the new capital gains rate of 20 percent), it would require higher taxes somewhere else.

Effect on Employers

Businesses provide half of the health insurance coverage in the U.S., dwarfing the number of enrollees in non-group and government health plans. As such, corporate America plays a key role in health insurance reform. Under the new law, individuals are required to purchase health insurance beginning in 2014 (though some already are questioning the constitutionality of this provision). Moreover, large employers are required to provide health insurance—although businesses with fewer than 50 employees are exempt from this mandate. Penalties are charged to individuals and businesses who fail to comply.



Source: Congressional Budget Office

While the full long-run implications of the new taxes, penalties and incentives are hard to project, the new legislation will potentially bring changes in behavior for all involved. For example, firms will likely weigh the cost of insuring more employees against paying the mandated penalty—particularly those bordering on benchmarks such as 50 employees. Employers who do not offer health insurance coverage are charged \$2,000 per employee, after excluding 30 workers. If an employer plan fails to meet a minimum quality standard or premiums exceed 9.5 percent of an employee’s income, the employee can purchase a subsidized policy on the new public exchange. In this case, the penalty increases to \$3,000 per occurrence.








We do not expect the employer mandate to trigger a migration from employer-provided coverage. The CBO estimates a one-percent shift over 10 years. Ninety-eight percent of large businesses already offer coverage, and employer contributions to health insurance are still deductible expenses. While new reporting requirements will increase administrative costs, health insurance will remain a key component of compensation and benefit packages.

Small business owners face a different choice. Because they have less purchasing power, they often pay more for coverage than do large employers. Consequently, fewer small businesses offer health benefits. The legislation exempts companies with fewer than 50 employees to eliminate a burden on bottom lines. It also provides tax credits to encourage small businesses to offer coverage. Firms with 25 or fewer employees that earn an average salary less than \$50,000 are eligible to offset up to 50 percent of health care premiums. We expect some small firms to expand coverage, while others drop plans and send employees to the public exchanges. These exchanges will likely offer similar coverage at an equal or lower cost.

Health Care Stocks

The health care legislation lays out the direct costs or new reimbursement rules health companies will face. However, the impact on sales volumes for products or services is unknown. Although unit sales would not be directly impacted until 2014 when key access provisions take effect, the added costs or lower reimbursements to the companies begin in 2011. The earnings effect of provisions on various industries is illustrated below.

IMPACT OF REFORM ON VARIOUS HEALTH CARE SECTORS

Industry	Key Provisions	Effect on Earnings
Devices	2.3% tax on medical device sales beginning in 2013	 Negative. Most uninsured patients receive basic devices through government programs, so there is no major increase in volume to offset tax.
Drug Retailers	No specific fee or tax	 Positive. Distributors benefit from higher volume and increased capacity utilization.
Hospitals	Cuts to Medicare and Medicaid payments beginning in 2011	  Mixed. Payment cuts will lower profitability, but providers with capacity will run more patients through a high fixed-cost system.
Insurers	Fees and minimum medical loss ratios beginning in 2014	  Mixed. Large companies will look to increase share in the individual markets, though higher medical loss ratios will cap profitability.
Pharmaceuticals	Fees on branded drugs beginning in 2011	 Positive. Drug makers will benefit from a Medicare Part D credit and extended patent protection on biologics.

Health care companies see the need for products and services that will save the system money. Capital is flowing into generic drugs and health care information technology, where potential cost savings and efficiency gains are significant. On the other hand, large pharmaceutical and device companies—long hampered by stiff FDA oversight (which has made the approval of new products difficult) and significant infrastructures (e.g., manufacturing plants, sales overhead)—have relatively weak pipelines. We would not be surprised to see these larger companies buy smaller entities where pipelines are stronger and long-term growth prospects are more promising. Provisions in the legislation, such as the 12-year patent protection for biologics, may reward innovation and spur industry activity in some segments, although getting a drug or device to market is a long and arduous process.

CONCLUSIONS

As the largest purchaser of health care services, prescription drugs, and medical devices, the government will use Medicare payments to influence the growth of health care costs. The legislation charges the newly created Independent Payment Advisory Board with holding the per-beneficiary cost of Medicare below an average of core price growth and medical cost growth. If costs rise above this benchmark, payments will purportedly fall.

Lower payments squeeze margins, and companies may well drop unprofitable products or services. A Medicare Office of the Actuary report estimates enrollment in Medicare Advantage plans will be 50 percent lower by 2017 (when payments are fully phased to parity with fee-for-service providers). Lower reimbursements might also trigger consolidation. One consequence could be higher out-of-pocket expenses for consumers. A second unintended consequence could be reduced access to care, as some providers stop accepting Medicare and Medicaid patients.

The new legislation attempts to address the cost portion of the equation by assessing taxes in a variety of places. As participants seek to minimize tax consequences, these surcharges—and the fact that they are levied against some types of income but not others—could change investor, individual and corporate behavior.

In the absence of payment reform and an alignment of quality and costs, it will be difficult to manage costs across the delivery system. The new law maintains a fee-for-service structure in which payment rates have historically influenced both patient and provider behavior. How quickly will health care costs rise? How much of the economy are we comfortable spending on health care?

Given the massive size and scope of the health care reform bill, it is impossible to project with complete accuracy the *Patient Protection and Affordable Care Act's* full ramifications. Undoubtedly, it will change behavior among investors, consumers, providers and health care manufacturers. The notion that we can provide the current “Cadillac” level of care to all those currently under- or un-served is unrealistic—and would require health care to consume ever larger portions of the already strained U.S. budget. This legislation will inevitably lead to much debate in the months and years to come regarding the appropriate level of care, as well as who is responsible for which costs.

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