



The Worst Aspects of the Current Health Reform Proposals: More Taxes, Higher Costs, More Government Control, and Less Individual Freedom

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Executive Summary

The House and Senate health care bills are riddled with policies that will be bad for America and threaten our health care freedom. By centralizing an unprecedented amount of power in the hands of Washington bureaucrats, both bills dramatically expand the government's control over one-sixth of the nation's economy. No legislation built on a foundation of handouts, earmarks, and shameless payoffs can be expected to coherently address the long-term drivers of health care costs. While there are countless bad policies contained in thousands of pages of legislation, several aspects of the existing bills are particularly problematic.

Due to deceptive accounting and budgetary gimmicks, the bills' estimated costs are far below what their actual impact will be. Such out-of-control spending will add to the deficit, worsening the national debt. For many Americans, health insurance premiums will rise. Americans will begin paying for health care reform legislation immediately, through higher taxes, fees and penalties, but don't actually begin receiving benefits until 2014.

Both bills contain a plethora of new taxes to defray the costs of this national health care takeover. There is agreement on the general scope of taxes—individual mandates, employer mandates, taxes on medical device manufacturers, taxes on medical cabinet goods, caps on flexible spending accounts, higher penalties for health savings account withdrawals, and a slew of other penalties on vulnerable industries. However, conference negotiations are likely to hit a sticking point on their main funding mechanism. The Senate bill plans to impose a 40 percent tax on “Cadillac” health insurance plans valued at \$8,500 per individual or \$23,000 per family; the House bill plans to tax the wealthy, imposing a 5.4 percent surtax on individuals earning over \$500,000, or couples earning over \$1 million filing jointly.

A slew of new regulations are set to be imposed on the insurance industry, which will drive premium costs even higher for consumers. From guaranteed issue to community rating to ending coverage caps, these provisions interfere with the health insurance market, raising costs for the young and healthy in order to cover the sick and elderly. To force individuals to carry this overpriced insurance, draconian mandate policies will be imposed on individuals and employers—carrying penalties up to and including jail time.

Any final bill is certain to include an expansion of Medicaid, much to the chagrin of governors on both sides of the aisle. Rightly seen as an unfunded mandate, states will be forced to raise income, sales, and property taxes on residents to cover these new bills. Meanwhile, Medicare's budget will be cut, with savings ostensibly coming from streamlining services and eliminating waste. But in reality, these Medicare cuts we lead to reduced access to and quality of care.

No legislation built on a foundation of handouts, earmarks, and shameless payoffs can be expected to coherently address the long-term drivers of health care costs.



There are better ways to address the nation's health care woes without a wholesale government takeover. In the long-term, the only way to truly bend the cost curve is by providing consumers with ownership and control over their health care dollars so that they will make smart, conscious choices. These bills, and their many provisions, are not in the best interest of the nation's health, nor long-term fiscal outlook. Should legislators truly be interested in addressing the nation's health care woes, they will scrap these bills entirely and begin anew.

Talking Points

- Any final health care bill is certain to cost more than initial estimates, and will add to our already historic debt.
- These bills contain half a trillion dollars in tax increases on health insurance, small businesses, and medical treatments. Americans will begin paying for health care reform legislation immediately, through higher taxes, fees and penalties, but don't actually begin receiving benefits until 2014.
- Additional regulations and mandates on health insurance, some of questionable constitutionality, will drive up the cost of premiums. A government-run "public option" will not create additional competition in the system, but rather disadvantage private companies and drive them out of business.
- Medicaid expansion will further strain overextended state budgets, forcing states to raise taxes and slash services.
- Medicare cuts could force as many as one in five health care providers into insolvency—resulting in fewer providers to treat an increasing number of retiring baby boomers. Cost savings, allegedly accomplished through greater efficiencies, are more likely to reduce access and diminish the quality of care.



Introduction

The House of Representatives passed its version of health care reform (H.R. 3962, the Affordable Health Care for America Act) on November 7, 2009 by a vote of 220-215.¹ The Senate bill (H.R. 3590, the Patient Protection and Affordable Care Act) passed on December 24, 2009 by a vote of 60-39. Both bills will now have to be merged in a conference committee, whose final product must be re-approved by both chambers by a simple majority before being sent to the President's desk for signature.

The two bills contain numerous provisions that will hurt American consumers—both financially and by lowering the quality of care. House Speaker Nancy Pelosi's (D-CA) bill weighs in at a whopping 1,990 pages and was scored by the Congressional Budget Office at \$894 billion over a ten-year, horizon,² just under President Obama's arbitrary cap of \$900 billion. Alas, Pelosi's efforts were bested (or, perhaps more accurately, "worst-ed") by Sen. Harry Reid (D-NV), whose amended bill totals 2,733 pages and was scored at \$871 billion over ten years.³ If nothing else, Congress deserves credit for their multifaceted approach to health care reform: injure the reader when they try to lift the bill, then provide them with approximately enough reading material to occupy them while they endure the longer wait times that are sure to result from such a bill.

Although it is difficult to determine which provisions will prove the most detrimental to the American public, several are bad enough to merit special attention. This policy brief focuses on those areas that should create the greatest concern for the American public. It describes how these provisions work and how they would affect Americans, both in terms of the medical system they will have to use and the costs associated with supporting the system. The brief argues that these provisions are the wrong direction for America and that Congress should go back to the drawing board in order to create legislation that will actually improve the health care system.

The two bills contain numerous provisions that will hurt American consumers both financially and by lowering the quality of care.



Big Government: The Fundamental Problem with this Health Care Legislation

Before examining any specific aspect of the bill, it is important to consider the bigger picture and to recognize that at its core this legislation is a massive, unconstitutional expansion of government, which is being advanced through a grossly distorted political process.

The scope of the House and Senate reform bills are unprecedented, representing a bold attempt to take over one-sixth of the American economy almost entirely on party lines. Despite claims of “covering the uninsured,” “bending the cost curve,” and “helping our fellow Americans,” the proposals on the table do none of the above—because that is not their design. The underlying theme of both the House and Senate bill is the same: to shift control of an individual’s health care from him or her to the government. In the words of IWF chair-

woman Heather Higgins, “These proposals are yet another manifestation of the no-growth, redistributionist mindset, combined with an elitist, authoritarian philosophy of government. To buy into them and ignore the reality they’ve produced elsewhere is to love humanity more than human beings, and value utopian ideals of equity over the tremendous individual costs they inflict.”⁴ This plan fundamentally redefines Americans’ relationship with the government, turning many more citizens into wards of the state.

That the bills are premised on power, and not on principle, can be seen from the shake-down that occurred throughout passage of the Senate bill. As Majority Leader Reid alternated between threatening his colleagues (example: considering a closure of Offutt Air Force Base in Nebraska to punish Sen. Ben Nelson if he declined to support the bill⁵) and buying their support (example: setting aside \$100 million for Louisiana to benefit Sen. Mary Landrieu for her vote⁶), a bill was cobbled together whose only consistent theme was the naked expansion of government.

Accordingly, no amount of tinkering can fix the proposals currently on the table, because they are based on such flawed premises. Bob Moffit, Director of the Heritage Foundation’s Center for Health Policy Studies, commented: “If the public option goes, it will have only a marginal influence on the substance of the bill. The whole bill is a public option: a massive transfer of power and control over health benefits and financing to Washington.”⁷

The American people should consider carefully the effect of allowing government to expand in this manner. Allowing the federal government to control so many of our personal decisions and to assume financial responsibility for our collective health will inevitably lead to even greater intrusions and loss of liberty as government seeks to “protect” the public interest by forcing citizens to assume certain behaviors. This massive expansion of government’s role in our lives should alarm anyone who values individual liberty.

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The True Cost of these Bills

The media focuses much attention of the cost estimates provided by the Congressional Budget Office. Those projections (that the legislation would cost around \$900 billion a year) should concern all of us, given the already high levels of debt and taxation. This expansion of government's outlays will strain the economy and add to an already bloated federal budget.

Yet the public should also consider that both the House and Senate bills are almost certain to cost far more than have been forecast. Health care bills are notoriously difficult to predict, as the Senate's Joint Economic Committee documented in its July 2009 policy brief "Are Health Care Reform Cost Estimates Reliable?" In 1967, the House Ways and Means Committee estimated that the Medicare program would cost approximately \$12 billion in 1990; actual spending in 1990 was \$110 billion, almost ten times higher. In 1972, Congress created a universal entitlement program for kidney dialysis for sufferers of end stage renal disease, which ended up costing \$229 million in 1974, only two years later—more than double the initial analysis of \$100 million per year.⁸

To be fair to budget analysts, this is due in part to the nature of their jobs—they can only provide cost estimates of what the government says it will do, and cannot guess beyond that, despite indications that bills may snowball out of control. Given that Senator Tom Harkin (D-IA) called the Senate bill a "starter house,"⁹ it is doubtless that health care reform will quickly expand past its original incarnation.

Americans will begin paying for health care reform legislation immediately, through higher taxes, fees and penalties—but they won't actually begin receiving benefits until 2014.¹⁰ In a floor statement, Senator George LeMieux asserted, "Imagine you're going to buy a substantial purchase—a house or a car. And they show you the house, and they say 'here's what your mortgage payment's going to be and you're going to live in the house for ten years. Start paying today, but you can't move in until 2014. That's what this bill does.'"¹¹

Benjamin E. Sasse, former U.S. assistant secretary of health, and Jeffrey H. Anderson, director of the Benjamin Rush Society, point out, "fully 99.9 percent of the Pelosi bill's costs would hit from 2013 onward. Similarly, 98.3 percent of Reid's spending would come after 2014. If you start the tally when the bills' spending would actually start (in 2013 for the House bill and 2014 for the Senate bill), then the bills' real 10-year costs become clear—and are remarkably similar. The CBO reports that, in their true first 10 years, the House bill would cost \$1.8 trillion, and the Senate bill would cost \$1.7 trillion."¹²

Upon taking office in November 2008, President Obama set a cap of \$900 billion for the ten-year cost of any health care reform bill, saying he would not sign any legislation that

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cost more than that. To fit this arbitrary guideline, both the House and the Senate engaged in a fair amount of legislative sleight-of-hand to squeak by under this limit.

One such budgetary trick employed by Congress is the so-called “doc fix.” In the 1990s, Congress created the Sustainable Growth Rate (SGR), a formula used to calculate reimbursements to doctors to treat Medicare patients. Payment was linked to the economy’s growth rate; unfortunately, the formula did not work in practice, because health care costs tend to grow faster than the rest of the economy. Should the formula be applied as intended, many doctors would receive less than the cost of their services, which would cause many providers to drop out of the Medicare program entirely.¹³

To prevent this catastrophe, Congress passes a short-term fix each year to rescind the scheduled rate cuts. Rather than address the problem in the long-term as a part of “health care reform,” both the House and the Senate bill assume that these cuts will actually take place in the future, sharply reducing projected Medicare spending. Officially, both bills cut Medicare fees for doctors by 20 percent in 2011. The House passed a separate bill, H.R. 3961, to rescind the formula for ten years, while the Senate’s version of the doc fix failed altogether. As such, the doc fix’s costs are not factored into either health care bill’s total cost. Legislators may be comforted by their ability to shift costs from one bill to the next and arbitrarily meet spending caps for individual pieces of legislation, but this should be of no comfort to taxpayers who will ultimately foot all of government’s costs.

A recent Lewin Group study commissioned by the Peterson Foundation found that adding the doc fix to the Senate bill would add \$196 billion to the deficit in the first 10 years.¹⁴ Their estimate is very close to the Congressional Budget Office’s estimate of the doc fix on the House side, which would increase direct spending by \$210 billion from 2010 to 2019.¹⁵ As the Heritage Foundation points out, however, the damage does not end there. Andrew J. Rettenmaier and Thomas R. Saving write, “Medicare is a never ending entitlement program, so the real pain caused by the left’s free spending will be felt for decades to come. According to the latest report from the Medicare Trustees, the 75-year cost of allowing doctor payments to match the percentage change in the medical economic index is \$1.9 trillion in more debt.”¹⁶

Studies by the Center for Medicare and Medicaid Services, the agency in charge of running Medicare and Medicaid, find that both the House and Senate health bills will raise overall health care spending in the United States. The House bill would raise national health expenditures by \$289 billion¹⁷ and the Senate bill would raise them by \$234 billion.¹⁸

Despite the Obama Administration’s claims that health care reform would save the average family \$2,500 per year,¹⁹ the CBO confirmed that the Senate legislation will raise health care costs for middle-class families, resulting in non-group premium increases of \$300 per year for individuals and \$2,100 for families.²⁰ Premiums under individual plans are expected to rise 10 to 13 percent. And while health care reform proponents promise taxpayer-funded subsidies to offset those higher costs, 43 percent of those in the individual market will not receive any subsidies at all. Large group plan premiums are expected to change +1 to -3 percent. This does not take into account the moral hazard that will be created from people consuming more services than they originally would have.



Taxes

Americans for Tax Reform has maintained comprehensive, up-to-date lists of all tax hikes in both the House and Senate plans. Several taxes are similar in both bills:

	House ²¹	Senate ²²
Individual Mandate Tax	(Page 296): If an individual fails to obtain qualifying coverage, he must pay an income surtax equal to the lesser of 2.5 percent of modified adjusted gross income (MAGI) or the average premium. MAGI adds back in the foreign earned income exclusion and municipal bond interest.	(Page 324, manager's amendment page 71): Starting in 2014, anyone not buying "qualifying" health insurance must pay an income surtax according to the higher of the following: 0.5 percent AGI in 2014, 1 percent in 2015, 2 percent in 2016+; or \$495 per individual, \$990 per couple, or \$1485 for 3+ persons.
Individual Mandate Tax	(Page 275): If an employer does not pay 72.5 percent of a single employee's health premium (65 percent of a family employee), the employer must pay an excise tax equal to 8 percent of average wages. Small employers (measured by payroll size) have smaller payroll tax rates of 0 percent (<\$500,000), 2 percent (\$500,000-\$585,000), 4 percent (\$585,000-\$670,000), and 6 percent (\$670,000-\$750,000).	(Page 348): 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 \$750 for all full-time employees. Applies to all employers with 50 or more employees. If the employer requires a waiting period to enroll in coverage of 30-60 days, there is a \$400 tax per employee (\$600 if the period is 60 days or longer).
Medicine Cabinet Tax	(Page 324): Non-prescription medications would no longer be able to be purchased with pre-tax dollars from health savings accounts (HSAs), flexible spending accounts (FSAs), or health reimbursement arrangements (HRAs). Insulin excepted.	(Page 1997): Non-prescription medications would no longer be able to be purchased with pre-tax dollars from health savings account (HSAs), flexible spending account (FSAs), or health reimbursement arrangements (HRAs). Insulin excepted.
FSA Cap	(Page 325): Imposes cap on FSAs of \$2500 (currently uncapped).	(Page 1999, page 363 of manager's amendment): Imposes cap on FSAs of \$2500 (currently uncapped). Indexed to inflation after 2011.
Tax on Medical Device Manufacturers	(Page 339): Imposes a new excise tax on medical device manufacturers equal to 2.5 percent of the wholesale price. It excludes retail sales and unspecified medical devices sold to the general public.	(Page 2020, manager's amendment page 364): \$2 billion annual tax on the industry imposed relative to shares of sales made that year. Exempts items retailing for <\$100. Rises to \$3 billion annually in 2017.
HSA Withdrawal Tax Hike	(Page 326): Increases additional tax on non-medical early withdrawals from an HSA from 10 to 20 percent. This disadvantages HSAs relative to other tax-free accounts (e.g. IRAs, 401(k)s, 529 plans, etc.) which remain at 10 percent.	(Page 1998): Increases additional tax on non-medical early withdrawals from an HSA from 10 to 20 percent. This disadvantages HSAs relative to other tax-free accounts (e.g. IRAs, 401(k)s, 529 plans, etc.) which remain at 10 percent.



There are numerous additional taxes found in the Senate bill, including an excise tax on charitable hospitals calculated on the amount generally billed by a hospital; starting in 2010, a tax on the medical device manufacturer industry that raises \$2 billion per year, imposed on firms relative to sales; a tax on the insurance industry to raise up to \$10 billion per year—fully assessed on companies with \$50 million in profits, assessed on a pro-rated basis to other insurance companies based on profits, and exempting the non-profit insurance plans; a tax on innovator drug companies that raises \$2.3 billion annually, imposed relative to share of sales made that year; and, a ten percent tax on indoor tanning services. Medicare payroll taxes will be increased from 2.9 percent to 3.8 percent for wages and self-employment income above \$200,000 (\$250,000 for those who are married). The tax deduction for employer-provided retirement prescription drug coverage in coordination with Medicare Part D will be eliminated.

The Senate bill has several new regulations as well, including requiring employer reporting of insurance on W-2 forms as a precursor to taxing health benefits on individual returns; requiring that 1099-MISC forms be issued to corporations as well as persons for trade or business payments; and a \$500,000 annual executive compensation limit for health insurance executives.

The House bill includes provisions such as a denial of tax deductions for employer health plans coordinating with Medicare Part D, further eroding private sector participation in delivery of Medicare services; requiring that 1099-MISC forms be issued to corporations as well as persons for trade or business payments; delaying for nine years the worldwide allocation of interest, a corporate tax relief provision from the American Jobs Creation Act; empowering the IRS to disallow a perfectly legal tax deduction or other tax relief merely because the IRS deems that the motive of the taxpayer was not primarily business-related; increasing taxes on U.S. employers with overseas operations looking to avoid double taxation of earnings; and raising standards on penalties for publicly-traded partnerships and corporations with annual gross receipts in excess of \$100 million.

The main point of difference between the two bills, however, lies in the fact that the Senate plan's primary funding mechanisms is a tax on high-end insurance plans, also known as "Cadillac" plans.²³ Individual plans valued at over \$8,500 per year and family plans valued at over \$23,000 per year will be taxed at 40 percent—forcing companies either to pass the additional costs on to consumers, or to reduce the value of plans to avoid the tax. The Senate bill provides for a higher threshold (\$9,850 single/ \$26,000 family) for early retirees and high-risk professions. Such a tax has raised the ire of labor unions in particular, who gained such benefits through years of collective bargaining.

The House plan relies on surtax on the wealthy, penalizing high-achieving and productive members of society. The House bill imposes an income surtax of 5.4 percent on individuals earning over \$500,000 or married couples earning over \$1 million who file jointly.²⁴ Not only is this cap not indexed for inflation—meaning that over time, many more people will be subject to the tax—but unfortunately, this will impact many small business owners who file taxes on their personal income tax returns.



At a time of double-digit unemployment, the Senate bill contains \$518.5 billion in tax increases on health insurance, small businesses, and medical treatments. Goods and services from tanning beds to medical devices will be taxed, penalties that will be passed on to individuals in the form of higher costs on everything from wheelchairs to nebulizers. The Senate's Joint Economic Committee points out the negative effects that increasing the marginal tax rates will have on society, arguing that current proposals create disincentives to work, to purchase services, and to hire workers—in other words impeding an economic recovery and long-term growth.²⁵



Individual and Employer Mandates

A myriad of new mandates are set to be imposed on insurance companies, under the guise of “helping consumers.” Unfortunately, these mandates will do little more than drive up the cost of premiums across the board.

The House and Senate bills take the extraordinary step of allowing the government to define what constitutes acceptable health insurance, through an individual mandate, so that individuals who do not have coverage, or whose coverage is deemed insufficient, must pay a fine. The constitutionality of such a fine has been called into question, as this is the first time that all American citizens would be required to purchase a good (health insurance) merely for the privilege of living in the United States.

Sec. 1501 of the Senate bill states that “an applicable individual shall for each month beginning after 2013 ensure that the individual, and dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.”²⁶

The newly-created Health Benefits Advisory Committee will dictate what “minimum essential coverage” is, and what must be included in health plans. Headed by the Surgeon General, this body will have the power to develop additional minimum benefit requirements, and there is no limit to how extensive future required benefits may be. Americans will be allowed to “grandfather” their current plans for a short period of time, keeping them even if the plans do not meet requirements. However, individuals will be required to switch if they lose their current insurance or “if significant changes are made to existing health insurance plan.” In December, the Congressional Budget Office confirmed that 10 million Americans will be forced out of their current plans should such a provision become law.²⁷ In addition, the CBO found that “relatively few non-group policies would remain grandfathered by 2016,”²⁸ meaning millions of individuals will lose their current plans. Within five years, employer plans will have to satisfy the government’s benefit requirements.

States have created similar insurance mandates, providing a preview of how they will operate at the federal level. In Massachusetts, the “Massachusetts connector” program created a pseudo-marketplace to buy private insurance, but only plans that met strict guidelines were allowed to participate. As a result, many individuals lost their previous private plan and the “connector” program effectively outlawed affordable health insurance. Massachusetts’ mandates have caused health insurance premiums to rise 21 to 46 percent faster than the national average;²⁹ in addition, the program has led to a massive budget deficit, and dramatic increases in waiting times for patients.

The minimum coverage standards proposed in both the House and Senate bills will require Americans to purchase expensive health care plans with high premiums, eliminating affordable options such as high-deductible health insurance plans.



The minimum coverage standards proposed in both the House and Senate bills will require Americans to purchase expensive health care plans with high premiums, eliminating affordable options such as high-deductible health insurance plans. Current proposals would forbid catastrophic insurance and mandate coverage for routine care by setting minimum payout levels for insurance policies. Under the House bill, 70 percent of claims must be covered, while 76 percent of claims must be covered under the Senate bill. Both bills also prohibit any deductibles or co-payments for preventive care. Unfortunately, these rules will effectively outlaw Health Savings Accounts (HSAs), negatively affecting approximately 6 million Americans currently using HSAs.

Minimum coverage standards also open the door to lobbying by health interest groups, who seek to include their procedures and products in the government's definition of "acceptable" plans. Such benefit mandates drive up prices for all consumers. Massachusetts requires 16 specific types of coverage: prescription drugs, preventive care, diabetes self-management, drug-abuse treatment, early intervention for autism, hospice care, hormone replacement therapy, non-in-vitro fertility services, orthotics, prosthetics, telemedicine, testicular cancer, lay midwives, nurses, nurse practitioners and pediatric specialists. It is currently considering more than 70 additional requirements.

In addition to penalizing individuals for not having coverage, both bills also propose an employer mandate, which would punish employers for providing inadequate health insurance to employees. The House bill will tax employers up to 8 percent in additional payroll taxes; the Senate bill will force employers to pay a fine of up to \$750 per employee. Such penalties drive up the cost of hiring workers, disproportionately affecting low-income and minimum wage employees.

Hawaii's experience in employer mandates is instructive in showing what we can expect from such a mandate. In 1974, the state imposed an employer mandate to provide health insurance coverage to all employees working 20 hours or more. The employer mandate encouraged small businesses to cut back employee hours to 19 or less and led many companies to drop their increasingly expensive employer-sponsored private plans, opting instead to cover employees through the cheaper government-managed care. The CBO noted that federal employer mandates "could reduce the hiring of low-wage workers, whose wages could not fall by the full cost of... a substantial pay-or-play fee if they were close to the minimum wage."³⁰ Across the board, however, the economy will take a significant hit; the National Federation of Independent Businesses (NFIB) has estimated that an employer mandate could cost could cost 1.6 million jobs with more than 1 million of those jobs lost in the small business sector.³¹

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Regulations

Several onerous regulations have been proposed in both the House and Senate bills that will significantly affect the insurance market and increase prices for customers.

The first such regulation is what's commonly referred to as "community rating." This provision would prohibit insurers from charging older and sicker customers more for coverage. In practice, however, this policy will amount to a tax on young and healthy policyholders, who will have to pay higher premiums to subsidize their less-healthy counterparts. A study by Oliver Wyman, an actuarial firm, found that such restrictive provisions would increase premiums for the youngest 30 percent of the population by 35 percent.³²

Narrowing price differences for comparable policies, although well-intentioned, will stymie innovation and efficiency in the long run, because prices are one way insurers compete with each other. Companies' profit motives serve as incentive for companies to come up with better ways to serve their customers. Six states currently have community rating regulations in their state, driving up the cost of insurance for all citizens: New York, New Jersey, Maine, Massachusetts and Vermont—and it is no coincidence that their average policy prices are among the most expensive in the country. Two other states, New Hampshire and Kentucky, experimented with this provision, but later repealed their statutes because of poor results.

Another proposed regulation is "guaranteed issue," which prohibits insurers from turning down applicants based on preexisting conditions. In practice, this gives healthy people little incentive to buy insurance until they become ill, because they will not need to buy into a policy as a precautionary measure. Only nine states, including New York and New Jersey, have strict forms of community rating. New York adopted community rating and guaranteed issue in 1993. In the first year, an average healthy 55-year-old man saw his health-insurance premiums fall by 30 percent—while an average healthy 25-year-old saw a premium hike of more than 60 percent.³³ According to the New York Insurance Department, 43,666 individuals dropped their health insurance in the first year, mostly young and healthy people—increasing the average age of policyholders by 3.5 years.³⁴ As the pool grew sicker, premiums began to rise even for older New Yorkers who initially had their premiums cut. In the end, everyone ended up paying more.

A third proposal would cap out-of-pocket expenses. Unfortunately, limiting what patients pay out-of-pocket will lead to increased demand for health care services, as the individual will not bear additional costs for care. As insurance companies are forced to pick up more and more costs, they will pass those costs on to policyholders through higher premiums. Related to this proposed regulation is another that would outlaw lifetime coverage caps. Again, these regulations that prevent insurances from limiting their costs and exposure will lead to higher prices for all policyholders and the over-consumption of medical care.



The Public Option

Aside from the funding mechanism, the major sticking point in any conference negotiation is likely to center around the creation of a “public option,” a government-run health care plan. Such a provision was included in the House bill, but stricken from the final Senate bill. The drawbacks to a public option are many; it is widely viewed as a slippery slope to a single-payer system, as it will almost certainly drive lower-cost private health plans out of business. A government option will receive taxpayer-funded subsidies, both direct and indirect, putting private players at a significant disadvantage.

Like all government programs, the public option will appear more cost effective than it is in reality because it will be able to hide many of its costs by spreading them over a variety of government agencies and departments. Private companies have to factor things like taxes into their bottom line, while the government is exempt from these burdens. The government plan might look lean and mean, but in reality, there’s a lot of excess baggage behind the scenes. According to Michael Cannon of the Cato Institute, “If the government plan’s premiums reflected its full costs—and private insurance premiums reflected only their actual costs—there would be no reason not to let the government enter the market.”³⁵

Companies’ profit margins mean that they are constantly innovating to try to make money. And while proponents of government-run health care demonize private insurers as making money at the expense of the sick and the poor, private insurance companies only have a 2.2 percent profit margin³⁶—hardly the wildly lucrative enterprises that politicians describe in their speeches. Innovation is the driver of quality and efficiency. Should companies be forced out of business because they will not be able to compete with the public option’s artificially low costs, those characteristics will go by the wayside. After all, the government isn’t exactly known for business efficiency and innovation.

Without a doubt, the creation of a public option will affect the market for employer-provided insurance. Many employers are expected to drop their plans altogether, choosing to pay the “employer mandate” fines included in both the House and Senate bills rather than shoulder the burden of employees’ increasingly expensive health care plans. The Congressional Budget Office estimated that the Senate bill will cause up to 10 million Americans to lose their current health care plans.³⁷ Early estimates by the Lewin Group predicted that as many as 114 million Americans will be forced out of their health plans, due to employers simply opting out of the private market altogether.

Prior to revealing the House health care bill, Speaker Pelosi launched a campaign to rename the public option the “consumer option,” or alternatively, the “competitive option.”

The Congressional Budget Office estimated that the Senate bill will cause up to 10 million Americans to lose their current health care plans.



Pelosi told the Associated Press in October 2009 that “When people think of the public option, public is being misrepresented, that this is being paid for with their public dollars.”³⁸ Unfortunately, the bill that Madam Speaker passed does actually pay for the provision with public dollars. Greg D’Angelo at The Heritage Foundation sums up the public option neatly: “The proposed government-run health care plan will be public—but for millions of Americans, it may not be an option.”³⁹

The Senate bill twists this theme slightly, allowing the federal Office of Personnel Management (OPM) to negotiate directly with health care insurers in order to provide national plans to individuals.⁴⁰ These new plans could be purchased through state-administered exchanges, and compete with existing plans offered in-state. According to the Galen Institute’s Grace-Marie Turner, such a plan is as doomed to fail as a pure public option. Writes Turner, “Blue Cross and Blue Shield plans would surely be the dominant players, just as they are in the Federal Employee Health Benefits Program that OPM runs now. The American Medical Association found in a 2007 study that 94 percent of insurance markets in the United States already are highly concentrated. The Blues have a dominant share of the market, and the latest Senate scheme would boost their monopoly power. Because most are non-profits, they would surely get favored treatment, leading to even less competition than we have today.”⁴¹



Medicaid Expansion

One of the ways both the House and the Senate propose covering additional poor Americans is by expanding Medicaid. According to the Kaiser Family Foundation, “One in ten women is covered under Medicaid, the state-federal program for low-income people and women comprise over two-thirds of adult Medicaid beneficiaries. Women are more likely than men to qualify for Medicaid because, on average, women have lower incomes and they are also more likely to fall into one of the program’s eligibility categories: pregnancy, parent of dependent child, over 65, or disabled.”⁴²

Although well-intentioned, Medicaid is a deeply flawed, fiscally insolvent program that should be reformed, not expanded. Medicaid provider payment rates are set by states and vary widely;⁴³ however, on average, reimbursement rates are so low that many providers simply do not participate in the program. Expanding Medicaid increases costs for all patients as providers who participate must charge higher rates to other customers to cover the losses they incur through Medicaid.

The Senate bill would expand Medicaid eligibility to include those with incomes up to 133 percent of the federal poverty line, while the House bill would expand Medicaid to 150 percent of the poverty line, covering almost 15 million additional Americans.⁴⁴ The influx of new Medicaid enrollees will not only add costs to the federal government, but it will also be a new burden to the states. Medicaid is partially funded by states and partially by the federal government. State budgets are already stretched thin, and any discussion of expanding Medicaid is contentious because it is viewed as an unfunded mandate. Unfortunately, further burdening state budgets will only force state legislators to raise state income taxes, property taxes, and sales taxes—yet again, hurting the state’s economies and working families.

The increased costs will also force states to make decisions about the quality of health care and the level of access to care that is provided through Medicaid. We’ve already seen this dynamic at work: due to budget shortages, MediCal, California’s version of Medicaid, recently reduced women’s access to mammogram screenings (adopting the new reduced recommendations made by the U.S. Preventative Services Task Force), and other states are sure to follow suit in the future. TennCare expanded Medicaid eligibility and allowed those without insurance to buy into their state plan, dramatically increasing the number of enrollments. Unfortunately, moving to managed care proved to overload the system, leading the state to cut payments to doctors by 30 percent and hospitals by 60 percent.⁴⁵ This prompted some surgeons to refuse to participate in the program.

Speaker Pelosi, acknowledging the potential problems associated with forcing a Medicaid expansion on the states, made a token effort to ameliorate the situation with a

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temporary band-aid. Medicaid expansion above current levels will be fully funded by the federal government (with your taxpayer dollars, of course) in 2013 and 2014. From 2015 to 2019, states will pay nine percent and the feds will pay 91 percent. Eventually, that new formula will probably be folded into the general Medicaid funding equation. The Congressional Budget Office estimates that Pelosi’s bill would increase state Medicaid spending by \$34 billion between 2010 and 2019, but increase net federal outlays for the program and the State Children’s Health Insurance Program (SCHIP) by \$425 billion over that same time frame.⁴⁶

In the Senate, Medicaid expansion has proven to be an even more contentious issue. The federal government is set to cover all newly-eligible enrollees through 2016—but after that, states must pick up approximately 10 percent of remaining costs, and slightly more for Children’s Health Insurance Program (CHIP) enrollees. This solution was deemed unpalatable by a number of Senators at the last minute, forcing Senator Reid to include 100 percent funding for Nebraska’s Medicaid program in perpetuity to appease Sen. Ben Nelson (D-NE), while Vermont and Massachusetts were given additional Medicaid funding for the votes of Sen. Bernie Sanders (I-VT) and Sen. Patrick Leahy (I-VT).⁴⁷ Prior to the addition of these “sweeteners,” the CBO pointed out that the Senate bill’s Medicaid expansion provision would force states to bear additional costs of \$26 billion.⁴⁸

A study from the Heritage Foundation points out another very real possibility, however: that states will opt out of the program entirely because of the overwhelming costs and loss of sovereignty. As Dennis Smith and Ed Haislmaier write, “Faced with becoming merely an agent of the federal government, states will likely take the rational and reasoned approach of simply ending the state-federal partnership known as Medicaid.”⁴⁹



Medicare Cuts

The Senate bill makes \$470.7 billion in cuts to Medicare—ostensibly, cost reductions are to be made by eliminating the program’s waste, fraud, and abuse. However, it is unlikely that the government will be able to identify that much unnecessary spending (if they had been able to, why wait until now?) so the more probable outcome will be cuts to the program as a whole. The Center for Medicare and Medicaid Studies estimates that Medicare cuts could force as many as one in five health care providers into insolvency—resulting in fewer providers to treat an increasing number of retiring baby boomers.⁵⁰ The CBO notes that “adjusting for inflation, Medicare spending per beneficiary under the legislation would increase at an average annual rate of roughly 2 percent during the next two decades—well below the roughly 4 percent annual growth rate of the past two decades. It is unclear whether such a reduction in the growth rate could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care.”⁵¹

Both sets of legislation provide for the creation of an even more powerful Medicare Commission of unelected bureaucrats, which would have the authority to set a priority schedule for treatment, which could be used as an indirect method of rationing care.⁵² Interestingly, the manager’s amendment in the Senate bill would necessitate a supermajority vote to eliminate this panel—an unusual, and extraordinary, legislative action that highlights Congress’ determination to permanently codify these new government agencies.

Women will be particularly affected by changes to Medicare. According to the Kaiser Family Foundation, “More than half (56 percent) of all Medicare beneficiaries are women; among those ages 85 and older, 70 percent are women. Women on Medicare have significant health needs and on average live longer and experience higher rates of many chronic health conditions than men. However, the program has relatively high cost-sharing requirements, which can be prohibitive for many seniors, particularly women, who have fewer financial resources than men. In addition to affordability challenges, the Medicare program has some notable gaps in coverage. It has very limited coverage for long-term care and does not cover essential services such as vision and dental care. Furthermore, some preventive benefits important to women’s health, such as mammography, clinical breast exams, bone density tests, and visits for Pap test and pelvic exams, require 20 percent coinsurance. The House and Senate bills propose to eliminate all cost-sharing as well as raise payments for certain proven preventive services under Medicare, such as mammograms, pap smears, and bone density screenings.”⁵³

In lieu of traditional Medicare plans, many seniors have chosen to enroll in private Medicare Advantage plans, which offer more options for care. Such plans are used predominantly by low-income minorities; unfortunately, the Senate plan makes direct cuts to this program of \$118 billion. Without a doubt, this will devastate this fledgling market, forcing over ten million seniors back onto traditional, inadequate plans.



New Government Programs Galore

Speaker Pelosi's health care bill creates 111 new government programs.⁵⁴ Sen. Reid's bill is almost as ambitious, creating more than 70 new government programs.⁵⁵

Some highlights from the House bill include:

- A grant program for community-based overweight and obesity prevention
- A grant program to promote positive health behaviors in underserved communities
- An Interagency Pain Research Coordinating Committee
- A grant program for national health workforce online training

To give legislators the benefit of the doubt, these very well might be worthwhile programs. However, they are certainly not the proper role of the federal government, particularly in light of the federal budget crisis. States and local governments, being closer to their residents and more sensitive to their communities' needs, should have the prerogative to create or facilitate such programs, but these overreaching, one-size-fits-all solutions should not come from Washington, particularly at a time when the country can least afford them. As mentioned earlier, Sen. Reid's bill would require a supermajority to repeal the Independent Medicare Advisory Panel; no other programs currently have such draconian requirements preventing future Congresses from amending their powers, but if history is any guide, it is virtually certain that most of these new government programs will remain in existence for decades, if not in perpetuity.

A recent poll on women's attitudes towards health care, conducted by the polling company, inc. for the Independent Women's Forum, indicated that 77 percent of respondents feel that the government spends money in a mostly inefficient manner.⁵⁶ It is likely that many individuals would rather not pay higher taxes, fees, and health insurance premiums to fund such programs—which are almost certain to be fraught with waste and fraud.

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Conclusion

Health care reform as currently proposed will be an unprecedented expansion of the federal government into the lives of Americans, and give the government significant control over one-sixth of the American economy. Unfortunately, the impact of such a bill on the American economy, both in the short-term and the long-term, is sure to be devastating. Neither the House nor the Senate bill address the underlying drivers of health care costs, and are thus incapable of producing sustainable cost containment. Although well-intentioned, the regulations proposed will lead to higher premiums for all Americans in the future. While the government attempts to mitigate the problems associated with higher premium costs by offering subsidies to lower income Americans, this is a poor solution. Rather, government should pursue policies that control, instead of raise, premium costs by making the health insurance marketplace more competitive and responsive to individual needs.

Money aside, an expanded government-run health care system is sure to cost the nation something it has long prided itself on—self-determination. No longer will health care decisions be made solely by an individual and his or her doctor. Rather, these new health care reform proposals open the door to a bureaucrat-driven system concerned only about the bottom line. Individuals will not be allowed to determine their own care based on what they want, or what they think they need, but by what the government says they can or cannot do. As government's costs spiral higher, access to care will be reduced, and in some cases, denied.

There are better reform options available—ones that will cover more Americans, drive down costs, and provide individuals with greater control over their health care, at far lower prices.

The health insurance market can be tweaked slightly to cover the poorest and most vulnerable citizens without the use of a government-run option or additional government oversight of the industry. The purchase of health insurance over state lines should be allowed to provide Americans with greater choice in policies and benefit levels. This can be done at no additional cost to the government—if anything, it would reduce bureaucratic overhead. Currently, the federal McCarran-Ferguson Act permits states to create their own health insurance mandates and shields them from interstate competition. If this act is repealed and states are forced to compete with each other on price and services offered, consumers will benefit; at the moment, they are held hostage by geography.

The use of high-deductible health plans with catastrophic coverage, in conjunction with health savings accounts, should be promoted and expanded. Such plans provide people with greater control over their health care dollars, while encouraging individuals to

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spend their resources wisely, and to not over-consume unnecessary services. This, too, can be achieved at no cost to the government. If patients use their own money, they will demand quality services and will only use medical treatments that are necessary and sensible investments in their health (and individuals know better than anyone what is a sensible investment and what is not). Patients would vote with their dollars, rewarding providers that meet the needs of their consumers and penalizing those that do not.

The tax treatment of health insurance should be changed so that people who purchase plans on the individual market can enjoy the same pre-tax benefits as those purchased through employer-sponsored plans. This would help control health care costs and make insurance portable while reducing federal tax intake by only a few billion dollars per year. The current system of employer-based health insurance began under wage and price controls during World War II and is archaic in a world where individuals hold many jobs throughout the course of their lives. Equalizing the tax treatment between employer-based and individual health insurance will provide much needed mobility, as well as help part-time workers, by making individual health insurance more affordable and competitive. Decoupling health insurance from one's place of employment not only allows for better, continuous health care, but will also help the economy in general, by making the workplace more dynamic and freeing workers from "job lock" or the desire to keep a job solely to maintain their insurance.

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To address people with preexisting conditions, or those considered "high risk," state experimentation with high-risk pools should be encouraged to temporarily cover individuals who cannot obtain coverage in the private market. This can be done on an as-needed basis at the cost of only a few billion dollars per year to states until those people become eligible for private insurance once more. These programs could provide subsidies, or vouchers, to ensure that individuals are still in control of and vested in the quality of their care and service.

Medicaid and Medicare must be reformed because of their pending fiscal insolvency. Ideally, individuals participating in Medicaid and Medicare should be allowed to purchase policies through a competitive process. This would help control the costs of these programs without resorting to rationing. Means-testing should be implemented, so those patients who are able to pay more for their care shoulder a greater burden through higher deductibles. Physicians and their patients would continue to decide which tests and other services they believe are worth the cost, but excessive testing would be discouraged.

Finally, medical malpractice abuse must be addressed. The fear of lawsuits leads to unnecessary testing. Capping awards for punitive damages would help discourage counterproductive "defensive" medicine. In 2003 and in 2005, Texas enacted a series of reforms to the state's civil justice system. Medical malpractice insurance companies have slashed premiums, saving doctors millions, and⁵⁷ the state has been flooded with doctors wanting to prac-



tice there. An October 2009 Congressional Budget Office study indicated that medical malpractice reform could save the nation \$54 billion over a ten-year period⁵⁸—a significant amount in savings, compared to the money about to be spent on comprehensive reform.

The House and Senate reform bills have been dubbed a “government takeover” of health care, and rightly so. From funding of care to the delivery and frequency of treatments, bureaucrats will be involved in Americans’ health care decisions every step of the way. Innovation, access, and quality are likely to be sacrificed, so that Congress can expand its control over the economy. These bills, and their many provisions, are not in the best interest of the nation’s health, nor long-term fiscal outlook. Should legislators truly be interested in addressing the nation’s health care woes, they will scrap these bills entirely and begin anew.



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Founded in 1992, the Independent Women's Forum is a non-partisan, 501(c)(3) non-profit educational institution. IWF focuses on issues of concern to women, men, and families. Its mission is to rebuild civil society by advancing economic liberty, personal responsibility, and political freedom. IWF fosters greater respect for limited government, equality under the law, property rights, free markets, strong families, and a powerful and effective national defense and foreign policy. IWF is home to some of the nation's most influential scholars—women who are committed to promoting and defending economic opportunity and political freedom.

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