

# Background

No. 2353  
December 18, 2009



Published by The Heritage Foundation

## An Analysis of the Senate Democrats' Health Care Bill

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**Abstract:** *The Senate health care bill would overhaul the entire health care sector of the U.S. economy by erecting massive federal controls over private health insurance, dictating the content of insurance benefit packages and the use of medical treatments, procedures, and medical devices. It would alter the relationship between the federal government and the states, transferring massive regulatory power to the federal government. The bill would also restrict the personal and economic freedom of American citizens by imposing controversial and unprecedented mandates on businesses and individuals, including an individual mandate to buy insurance.*

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The U.S. Senate is locked in an intense floor debate over the Patient Protection and Affordable Care Act (H.R. 3590), a massive 2,074-page health care bill that would directly affect every man, woman, and child in the United States. Its enactment would shape the character and quality of life in America for generations to come.

The Senate bill's complex and sweeping provisions would affect virtually every aspect of the huge health care sector of the U.S. economy.

- Like the House bill,<sup>1</sup> it would transfer massive regulatory authority from the states to the federal government and make enormous changes in the nation's health insurance markets;
- It would dramatically alter the financing and content of employer-provided and individual health

### Talking Points

- The Senate health care bill would affect virtually every aspect of the huge health care sector of the U.S. economy.
- The Senate bill would impose over a dozen new taxes totaling \$406.2 billion. The new taxes range from a tax on branded drugs to a tax on medical devices.
- The bill uses budget gimmicks, unrealistic assumptions, and highly unreliable projected savings to stay under President Obama's \$900 billion threshold and to appear "deficit neutral." More transparent accounting indicates that the bill will cost \$2.5 trillion over the first 10 years.
- Instead of protecting patients, the bill would stifle patient choice by transferring most decision-making authority to a collection of federal agencies, bureaus, and commissions.
- The Senate bill would produce the greatest concentration of political and economic power over a sector of the U.S. economy in the nation's history.

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This paper, in its entirety, can be found at:  
[www.heritage.org/Research/HealthCare/bg2353.cfm](http://www.heritage.org/Research/HealthCare/bg2353.cfm)

Produced by the Center for Health Policy Studies and  
the Center for Data Analysis

Published by The Heritage Foundation  
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Washington, DC 20002-4999  
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insurance and significantly change Medicare and Medicaid;

- It would change how hospitals, doctors, and other medical professionals are paid and how physicians and other medical professionals deliver care; and
- It would impose controversial and unprecedented mandates on businesses and individuals, including an individual mandate to buy insurance,<sup>2</sup> thus restricting the personal and economic freedom of American citizens.

In effect, the Senate bill would produce the greatest concentration of political and economic power over one major sector of the U.S. economy in the nation's history.

It is not surprising that the Senate bill is highly unpopular.<sup>3</sup> For ordinary Americans, the legislative process has definitely not been a demonstration of the way a law is made as portrayed in civics textbooks or the kind of rational deliberation envisioned by the Founding Fathers. Surprising provisions, unintended consequences, and unreliable assumptions characterize this proposal. Key provisions, such as the provision of a "public plan" to compete against private health plans, are particularly controversial, and the Senate leadership is rapidly floating and rejecting new schemes to secure

the 60 votes necessary to end the debate and quickly pass the bill.

Without the benefit of legislative language, hearings, expert testimony, or committee deliberation and debate, various untested proposals have been floated for press and popular consumption. Writing of the latest scheme to secure a compromise, the editors of *The Washington Post* noted, "The only thing more unsettling than watching legislative sausage being made is watching it being made on the fly."<sup>4</sup>

Regardless of one's views of the Senate bill, it does not comport with the broad popular themes articulated by President Barack Obama and the many congressional leaders who have championed these policies. Contrary to the President's repeated promises to the American people,<sup>5</sup> the Senate bill, like its House counterpart, would:

- **Cause many Americans to lose their current health insurance.** The Congressional Budget Office (CBO) estimates that up to 10 million Americans would no longer be covered by their employers.<sup>6</sup> Given the bill's incentives for employers to discontinue job-based coverage, independent analysts expect the loss of employer-based coverage to be much higher.
- **Bend the cost curve up.** According to independent analysts and government actuaries, the bill

1. For an overview of the House-passed bill, see "A Closer Look at the House Democrats' Health Care Bill," Heritage Foundation *WebMemo* No. 2684, November 6, 2009, at <http://www.heritage.org/Research/HealthCare/wm2684.cfm>.
2. While House Speaker Nancy Pelosi (D-CA) dismissed as unserious a question about the constitutionality of imposing a health insurance mandate on individuals, the question is very serious indeed. See Randy Barnett, Nathaniel Stewart, and Todd F. Gaziano, "Why the Personal Mandate to Buy Health Insurance Is Unprecedented and Unconstitutional," Heritage Foundation *Legal Memorandum* No. 49, December 9, 2009, at <http://www.heritage.org/Research/LegalIssues/lm0049.cfm>.
3. The latest CNN poll shows that 61 percent of Americans oppose the bill. See "CNN Opinion Research Poll," December 10, 2009, at <http://i.a.cnn.net/cnn/2007/images/12/10/rel12a.pdf> (December 18, 2009). A new Rasmussen poll found that only 34 percent of Americans say that passing health care is better than passing nothing. See "Just 34% Say Passing Health Care Bill Is Better Than Passing Nothing," December 18, 2009, at [http://www.rasmussenreports.com/public\\_content/politics/current\\_events/healthcare/december\\_2009/just\\_34\\_say\\_passing\\_health\\_care\\_bill\\_is\\_better\\_than\\_passing\\_nothing](http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/december_2009/just_34_say_passing_health_care_bill_is_better_than_passing_nothing) (December 18, 2009). Finally, a Galen Institute survey found that key components of the legislation, particularly the individual mandate, are highly unpopular. See "Galen Institute Releases Poll Showing Overwhelming Opposition to the Individual Mandate and Other Key Components of Congressional Health Care Proposal," October 18, 2009, at [http://www.galen.org/component,8/action,show\\_content/id,71/blog\\_id,1291/type,33/?\\_highlight=survey](http://www.galen.org/component,8/action,show_content/id,71/blog_id,1291/type,33/?_highlight=survey) (December 18, 2009).
4. Editorial, "Medicare Sausage?" *The Washington Post*, December 10, 2009, p. A28, at <http://www.washingtonpost.com/wp-dyn/content/article/2009/12/09/AR2009120903902.html> (December 14, 2009).
5. Barack Obama, "Remarks by the President to a Joint Session of Congress on Health Care," September 9, 2009, at [http://www.whitehouse.gov/the\\_press\\_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care](http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care) (December 15, 2009).

would substantially increase total health care spending instead of reducing it as promised. Richard Foster, Chief Actuary of the Centers for Medicare and Medicaid Services (CMS), recently judged the projected savings from the Medicare updates as “doubtful” and estimated that the total national spending on health care would increase.<sup>7</sup>

- **Impose many new taxes on middle-class Americans.** The Senate bill contains over a dozen new taxes, including a 40 percent excise tax on high-priced health plans and special fees and taxes on insurance, drugs, medical devices, and anyone who violates the new mandates.<sup>8</sup>
- **Reduce many seniors’ access to Medicare benefits and services.** The bill would reduce Medicare payments by an estimated \$493 billion over 10 years,<sup>9</sup> including payment reductions for Medicare Advantage, hospital care, home health care, and nursing homes.
- **Provide federal funding for abortion.** Contrary to the President’s clear statement to Congress and the nation on health care reform,<sup>10</sup> the Senate bill would provide funding for abortion. The House would prohibit using taxpayers’ dollars to finance abortion, but a similar amendment to the Senate bill was tabled without even a floor vote.<sup>11</sup>

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Surveys consistently show that the American people clearly want health care reform but do not support the bills sponsored by the House and Senate leadership. While they want Congress to enact policies that would increase choice and competition, and thereby help to control costs and rectify inequities in the health insurance markets, they do not favor a federal takeover of the health care system. Nor do they want the power to make key health care decisions transferred from individuals, families, and medical professionals to government agencies, departments, commissions, and advisory boards.

Much better options are available. Reform of the tax treatment of health insurance is a top priority. Eliminating the federal tax code’s discrimination against workers who do not or cannot obtain health insurance through the workplace would expand health insurance coverage; today these persons get no tax relief for the purchase of health insurance coverage. Removing the legal barriers to individuals and families who wish to buy health insurance in a state other than their state of residence would also open health insurance markets to real free-market competition. Promoting state-based health

6. “We estimate that between 9 million and 10 million other people who would be covered by an employment-based plan under current law would not have an offer of such coverage under the proposal.” Congressional Budget Office staff e-mail to the Office of Senator Mike Enzi (R-WY), December 7, 2009, at [http://enzi.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore\\_id=24239e66-4ab7-4135-8b66-e84c32056c37](http://enzi.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=24239e66-4ab7-4135-8b66-e84c32056c37) and [http://enzi.senate.gov/public/index.cfm?FuseAction=NewsRoom.NewsReleases&ContentRecord\\_id=6f4cab2a-802a-23ad-4379-5430a0a3bb03&Region\\_id=&Issue\\_id](http://enzi.senate.gov/public/index.cfm?FuseAction=NewsRoom.NewsReleases&ContentRecord_id=6f4cab2a-802a-23ad-4379-5430a0a3bb03&Region_id=&Issue_id) (December 18, 2009).
7. Richard S. Foster, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act of 2009,’ as proposed by the Senate Majority Leader on November 18, 2009,” U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, December 10, 2009, pp. 19–20 at [http://src.senate.gov/files/OACTMemorandumonFinancialImpactofPPAA\(HR3590\)\(12-10-09\).pdf](http://src.senate.gov/files/OACTMemorandumonFinancialImpactofPPAA(HR3590)(12-10-09).pdf) (December 14, 2009).
8. Joint Committee on Taxation, “Estimated Revenue Effects of the Revenue Provisions Contained in the Patient Protection And Affordable Care Act,” November 18, 2009, at <http://jct.gov/publications.html?func=startdown&id=3635>. Also, for a discussion of the taxes proposed in the House and Senate bills, see Curtis S. Dubay, “Taxes Proposed to Pay for Health Care Reform,” Heritage Foundation *WebMemo* No. 2706, November 20, 2009, at <http://www.heritage.org/research/healthcare/wm2706.cfm>.
9. Foster, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act of 2009,’” p. 8.
10. Obama, “Remarks by the President to a Joint Session of Congress on Health Care.”
11. For more discussion, see Chuck Donovan and Robert Moffit, “House Bill Wrong on Values,” *Centre Daily Times* (State College, Pennsylvania), November 23, 2009.

insurance market reforms, designed by state and not federal officials, could dramatically expand coverage, cope with adverse selection in the markets, and secure affordable health insurance under the varying conditions that prevail within the states for the poorest and most vulnerable members of society.

Beyond these options, if Congress were truly serious about “bending the cost curve down,” it should focus on the huge and growing programs under its direct jurisdiction: Medicare and Medicaid. This means initiating serious entitlement reform that goes well beyond modifying administrative payment systems and cutting physician and hospital reimbursements.

### Hiding the True Cost to the Taxpayers

When Senate Majority Leader Harry Reid (D–NV) unveiled his bill, he claimed that the massive reform package would fall under the \$900 billion cost threshold promised by President Obama. But Senator Max Baucus (D–MT) recently conceded that the real cost of the bill was much higher: “Just for a second—health care reform, whether you use a ten year number or when you start in 2010 or start in 2014, wherever you start at, so it is still either \$1 trillion or it’s \$2.5 trillion, depending on where you start.”<sup>12</sup>

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There is a simple reason for this public confusion over cost. The bill uses budget gimmicks, unrealistic assumptions, and highly unreliable projected savings to stay under the stated threshold. Among these are four egregious “budget tricks.”

**The Costly “Doctor Fix.”** Every year, because of congressionally created formulas in Medicare physician payment, Congress must vote to suspend these pre-ordained payment systems that would

automatically cut Medicare payments to physicians. If enacted this year, these cuts would reduce physician payment rates by 21 percent.

Physicians believe, correctly, that unless there is a fundamental reform of Medicare payment, many physicians will reduce their Medicare practice or stop seeing new Medicare patients, thereby reducing the accessibility of Medicare beneficiaries to physician care. Both the House and the Senate have acknowledged this as part of their agendas for health care reform.

However, to make their bills appear less costly, the leadership of both houses has removed the doctor fix and its more than \$200 billion price tag from their health care bills and presented it as a separate bill. This enables Senator Reid to claim that his bill will reduce the deficit, but the CBO estimates that the House bill (H.R. 3961), combined with the “doctor fix” bill (H.R. 3962), would “add \$89 billion to budget deficits over the 2010–2019 period.”<sup>13</sup> The Senate bill plays the same shell game, creating the appearance of deficit reduction by ignoring the inevitable cost of the doctor fix.

**The True Costs of the CLASS Act.** The Senate bill, like the House bill, includes the Community Living Assistance Services and Supports (CLASS) Act, which would create a new government health care program for long-term health insurance. This provision creates a national insurance trust that would provide benefits for seniors and the disabled by creating a payment update in Medicare for skilled nursing facilities and home health care providers.

The CLASS Act is intended to pay for itself with collected premiums. The premiums would produce positive revenues for the government for the first 10 years, appearing to reduce the federal deficit during this time. However, as the CBO points out, while “the program’s cash flows would show net receipts for a number of years, [this would be] followed by net outlays in subsequent decades.”<sup>14</sup> Thus, the CLASS Act appears self-sufficient for the first 10 years but starts running a deficit soon thereafter.

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12. Senator Max Baucus (D–MT) Remarks on the Senate Floor, December 2, 2009.

13. Congressional Budget Office, “Information on Medicare’s Payments to Physicians and the Budgetary Effects of H.R. 3961, the Medicare Physicians Payment Reform Act of 2009,” November 19, 2009, at [http://www.house.gov/budget\\_republicans/press/2007/pr20091119cboscore.pdf](http://www.house.gov/budget_republicans/press/2007/pr20091119cboscore.pdf) (December 14, 2009).

**Delays of Costly Benefits.** The Senate health care bill is paid for by newly enacted taxes and spending cuts. However, to meet President Obama's \$900 billion maximum over the first 10 years, new spending does not begin until years after new taxes and spending cuts are enacted.

This clever design allows Congress to collect revenues (higher taxes, fees, and other offsets) for the full 10-year window but pay out the major benefits over only the last six years. This spending cushion makes the bill appear much less costly than it would

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if 10 years of spending were included. The true costs of the bill would quickly become apparent in the second 10 years of enactment. Moreover, as with most government programs, it will almost certainly cost more than originally promised.

**Unreliable Medicare Cuts.** The Senate bill depends on cutting Medicare to pay for its \$1.2 trillion coverage expansion. Concerning the impact on Medicare enrollees, as CBO Director Doug Elmendorf explained, the bill would require a substantial reduction in the future growth of per capita beneficiary spending over the next 20 years compared to the previous 20 years.<sup>15</sup>

Proponents of the Senate legislation claim that Medicare spending reductions would result in higher efficiencies. But as James C. Capretta, a Fellow at the Ethics and Public Policy Center, argues, "despite all of the talk of 'delivery system reform,' the Senate Democratic plan would not transform

American medicine to make it more efficient."<sup>16</sup> The dramatic savings depend on conventional Medicare provider cuts, not on meaningful Medicare reform. Furthermore, as demonstrated by the ongoing effort to correct the Medicare physician payment formula, it is unlikely that Congress would allow such deep cuts to occur in Medicare.

Moreover, these Medicare cuts include more than \$100 billion in "savings" from changes in Medicare Advantage plans, a move that would directly affect the benefits of millions of seniors. In his analysis of the Senate bill, Foster confirmed that these changes would result in "less generous packages" and that enrollment "would decrease by about 33 percent."<sup>17</sup>

**Bending the Cost Curve Up.** According to the Office of the Actuary, the Senate bill would increase, not decrease, health care spending by \$234 billion between 2010 and 2019.<sup>18</sup> The Senate bill, like its House counterpart, would cost far more than the President's \$900 billion limit, likely running up a tab in the trillions of dollars. Assuming both full funding and spending over the first 10 years and that both are combined, as Senator Baucus conceded, the bill would cost \$2.5 trillion. Capretta estimates the true cost of the bill at \$4.9 trillion over 20 years.<sup>19</sup>

The devil, as always, is in the details.

First, Senator Reid's bill relies on "bracket creep" to raise taxes to pay for its costs. The new 40 percent excise tax on high-cost insurance plans is indexed to general inflation plus 1 percent, which is lower than health care cost inflation.<sup>20</sup> This means that as health care costs grow, more Americans will pay the tax.

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14. Douglas W. Elmendorf, Congressional Budget Office, letter to Senator Harry Reid, November 18, 2009, at [http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid\\_letter\\_11\\_18\\_09.pdf](http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf) (December 14, 2009).

15. Congressional Budget Office, "Preliminary Analysis of the Affordable Health Care for America Act as Introduced in the House of Representatives on October 29," Director's Blog, October 29, 2009, at <http://cboblog.cbo.gov/?p=403> (December 14, 2009).

16. James C. Capretta, "A \$4.9 Trillion Spending Increase," *National Review Online*, November 19, 2009, at <http://healthcare.nationalreview.com/post/?q=OTc1MjEzYjI5NzM0M2Y1YjUwNzZhZmVhZGFhYTQxYjI> (December 14, 2009).

17. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act of 2009,'" p. 10.

18. *Ibid.*, p. 14.

19. Capretta, "A \$4.9 Trillion Spending Increase."

20. *Ibid.*

*Second*, the bill increases the Medicare payroll tax for individuals making \$200,000 and families making \$250,000 per year. This tax hike is not indexed to inflation, which means that inflation will steadily push more middle-class Americans into that tax bracket. Thus, Senator Reid plans to finance \$2.2 trillion of his health care bill by continuously raising taxes on more and more Americans.

In the second 10 years of enactment, the bill's coverage provisions would cost \$3.1 trillion.<sup>21</sup> When the additional Medicare spending for the so-called doctor fix is included in the calculation, the cost over 20 years would total \$4.9 trillion.

Clearly, raising taxes alone will not cover this, so the remainder is expected to be funded by big cuts in Medicare (assuming they actually occur). The Senate bill would require raising taxes on middle-

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class Americans and cutting senior citizens' health benefits by nearly \$5 trillion. As often happens in Washington, D.C., a bill touted for saving money will end up costing the taxpayers a fortune.

## **Reducing Personal Freedom and Imposing Mandates**

In a remarkable twist in public policy, the Senate bill would use taxes and penalties to punish uninsured Americans and companies that hire workers from low-income families.

**The Individual Mandate.** The Senate bill includes an unprecedented act of Congress to force Americans to buy a commodity: health insurance.<sup>22</sup> The "individual responsibility" provision in Section 1501 requires anyone who fails to obtain a qualifying health plan to pay an annual tax penalty of \$750

per adult family member and \$375 per child, up to a maximum penalty of \$2,250 per family. These penalties would be phased in from 2014 to 2016 and then indexed for inflation, which means they would likely increase every year.

Because these new taxes are fixed amounts based on family size, families of the same size will pay the same amount regardless of income, although the poor may qualify for exemptions. This is different from the House bill, which would impose a 2.5 percent tax on modified adjusted gross income above the minimum income at which filing a tax return is required. A family of two adults and two children is actually worse off under the Senate bill if they make less than \$99,350 per year and worse off under the House bill if they make more.

The bill provides for only a few exemptions. For example, a person can be exempt if the lowest available premium for a bare-bones plan, as defined by federal authorities, is more than 8 percent of one's income. However, this would apply only to those making less than \$28,125 per year.

**The Employer Mandate.** Sections 1511–1513 of the Senate bill contain an "employer responsibility" provision that requires companies with more than 50 employees to offer qualified health plans—as defined by government bureaucrats—to their full-time employees or to pay a tax of \$750 per full-time employee. Since the penalty is much cheaper than providing health insurance, employers are likely to just pay the \$750 tax. For employees, however, this means they lose their employer contribution toward their premium costs.

There is another catch. An employer who offers qualifying insurance must pay a penalty of \$3,000 for every employee from a low-income family who qualifies for and accepts a premium subsidy in the "health insurance exchange."<sup>23</sup> The employer's total penalty is capped at \$750 times the total number of

21. *Ibid.*

22. See Barnett *et al.*, "Why the Personal Mandate to Buy Health Insurance Is Unprecedented and Unconstitutional."

23. See Sections 1401–1402, Patient Protection and Affordable Care Act of 2009. The Senate bill provides a generous tax credit and cost-sharing assistances for individuals and families earning between 100 percent of the federal poverty level (FPL) and 400 percent FPL. Premiums would be based on percent of income, ranging from a 2 percent cap to a 9.8 percent cap. The cost-sharing assistance would also be income-based.

full-time employees if more than a quarter of the employees receive the subsidy.

In summary, if a company employs many low-income workers, it can save money by dropping its health plan and paying the \$750-per-employee tax or by reducing as many employees as possible to working part-time. However, if a company has mostly middle-income workers, it faces a \$3,000-per-year penalty for hiring a worker from a low-income family who elects the subsidy. Also, this penalty applies to the employee's family income, not the income that the employee is paid by any particular company.

Therefore, a company would save \$3,000 by hiring someone with a working spouse or a teenager with working parents whose family income is higher instead of a single mother with three children. Even worse, if one-fourth of its employees qualify for a premium subsidy based on income and family size, the company would still pay the \$750-per-employee tax whether it offers insurance or not.

The Senate bill would create many perverse incentives that would encourage companies with many low-income employees to drop their health plans entirely. Unlike the lower-income workers who would qualify for the subsidies, higher-income workers would have to obtain coverage on their own with no assistance.<sup>24</sup>

### Micromanaging Health Insurance

The Senate bill provides for federal micromanagement of all private health insurance. It would subject all private health insurance, whether purchased from an insurance company by employer groups or individuals or provided through an employer or union self-insured plan, to detailed federal regulation. These "insurance reform" provisions amount to a *de facto* nationalization of health insurance, whether or not Congress creates a gov-

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ernment-run health insurance plan. Instead of protecting patients, heavy regulation will stifle choice and competition in the health insurance market.

**Benefit Control.** Of particular concern to patients, the U.S. Department of Health and Human Services (HHS) would decide the details of their health insurance coverage. Americans recently received a foretaste of what such federal regulation would look like when the U.S. Preventive Services Task Force downgraded its recommendation for breast cancer screening (mammography) for women ages 40 to 50 from "B" (recommended) to "C" (not recommended).

Normally, such recommendations would not create controversy, because until now they have merely been suggestions to guide providers and health plans, which make their own decisions for their patients and members. However, the proposed legislation would give such recommendations the force of law because it would require all plans to provide coverage (with no patient co-pays) for "items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force."<sup>25</sup>

Thus, a recommendation on a specific medical service by the heretofore obscure HHS task force would carry the force of law and impose additional costs on insurers and employer health plans. Conversely, a "C" or "D" rating, such as the recent decision on breast cancer screening, would give insurers and employers justification to discontinue coverage.

24. For a more detailed discussion of this unusual set of problems and the inequities created under the Senate bill, see Robert A. Book, "How the Senate Health Bill Punishes Businesses That Hire Low-Income Workers," Heritage Foundation *WebMemo* No. 2716, December 3, 2009, at <http://www.heritage.org/research/healthcare/wm2716.cfm>, and James C. Capretta, "The Senate Health Care Bill's Firewall Creates Disparate Subsidies," Heritage Foundation *WebMemo* No 2730, December 11, 2009, at [www.heritage.org/research/healthcare/wm2730.cfm](http://www.heritage.org/research/healthcare/wm2730.cfm).

25. H.R. 3962 (House Bill), Sections 222(b)(8) and 222(c)(1)(A). Section 1001(1) of the Senate bill (H.R. 3590) amends the Public Health Services Act, including adding these provisions as a new Section 2713(a)(1) in the PHSA.

**Cost Impact.** Over time, the more specific HHS is in its benefit requirements—driving up the cost of coverage—the greater the incentive will be for insurers and employers to control the escalating costs by covering only what federal law requires. The eventual result will be little to no variation among private health insurance plans and little variation in cost. At that point, Congress will effectively have nationalized the entire American health insurance system under HHS supervision without formally setting up another government-run health insurance program.

### **A Federally Designed Health Insurance Exchange for the States**

The original version of the Senate health bill contained a “public option,” a new government-run health plan to “compete” against private health plans within a federally designed system of state health insurance exchanges. Recently, the Senate leadership agreed to remove that provision and replace it with a Medicare expansion—on top of the Medicaid expansion—and a new health plan option sponsored by the U.S. Office of Personnel Management (OPM), the federal agency that runs the Federal Employees Health Benefits Program (FEHBP). Then, in response to political opposition from “moderate” Senate Democrats, the Senate leadership recently announced that they were dropping the Medicare expansion.

**Mandatory State Health Exchanges.** Under Section 1311 of the bill, the Secretary of Health and Human Services would be required to provide states with grants to establish American Health Benefit Exchanges. By 2014, states would be required to establish these exchanges for the purchase of “qualified” health plans. Plans would be qualified only if they met federal rules governing benefit packages, provider networks, “essential community providers,” quality standards and measures of uniformity of enrollment procedures, rating systems, outreach, reinsurance and risk adjustment, and a variety of other requirements.

States could require the qualified health plans to offer additional benefits, which would make the

health plans more expensive, but they could not allow benefit changes that differ from the federal standards. Administration of the exchanges would have to be “self-sustaining,” so the states would be allowed to impose assessments or fees on health plans and enrollees to cover the administrative costs.

Section 1321 requires states to implement standards for the health exchanges by 2014. If a state fails or refuses to implement an exchange in accordance with federal rules, the HHS Secretary is required to intervene in the state, operate an exchange, and unilaterally implement the federal standards.

**Co-ops.** Section 1322 requires the HHS Secretary to award loans and grant monies to “member-run” nonprofits that offer “qualified health plans.” In effect, this would create a federal “co-op” option. The co-ops would make purchasing decisions but could not fix provider payment rates. Under the terms of the bill, neither existing private health insurance companies nor government organizations could set up co-ops. The bill directs the U.S. Comptroller General to appoint an advisory board to oversee this new program and provides \$6 billion in federal funding for start-up costs.

As Heritage analysts have noted, none of this is necessary. A change in federal tax law would allow private-sector co-ops to offer health insurance.<sup>26</sup>

**A Broken Compromise.** Section 1323 of the original version of the bill would have required the HHS Secretary to create a “community health insurance option” to participate through the authorized health insurance exchanges.<sup>27</sup> This is the government-run plan that would compete against private insurance, but states could opt out of offering the prescribed public health plan in the state-based exchanges.<sup>28</sup>

More recently, Senator Reid has proposed a compromise that would replace this government-run plan with a couple of private nonprofit health plans sponsored by the U.S. Office of Personnel Management. According to press accounts, these OPM-sponsored plans would compete nationwide in the

26. See Edmund F. Haislmaier, “Health Insurance Co-ops: How Congress Could Adopt the Right Design,” Heritage Foundation *Background* No. 2290, June 25, 2009, at <http://www.heritage.org/Research/healthcare/bg2290.cfm>.



state-based health insurance exchanges created under the bill just as the recently discarded “public option” would have under the original version of the bill.

The Senate leadership’s OPM proposal is novel. The OPM administers the FEHBP, a consumer-driven system of hundreds of competing private health plans that serve federal workers, federal retirees, and their dependents. As the federal paymaster, the OPM provides federal enrollees with a defined contribution, which they use to purchase the private plans. The OPM acts as an umpire, enforcing the rules of the market competition.

However, Senator Reid and his colleagues apparently would have the OPM play a much different role as the sponsor and overseer of “at least two” nonprofit health plans that would compete against private plans.<sup>29</sup> Presumably, they would compete in the state-based health insurance exchanges.

Two key issues in this proposal need to be clarified: How would the OPM set premiums for the two plans, and would these plans be eligible for taxpayer subsidies to cover any shortfalls? If the OPM could set premiums below market prices to undercut private health plans and access taxpayer subsidies, then the two nonprofit plans could erode private and employer-based coverage much as a Medicare-style public plan would.

Briefly, the Senate leadership also promoted and then quickly jettisoned a major Medicare expansion—expanding eligibility to citizens between the ages of 55 and 64. The reasons for the Senate leadership’s decision to discard the Medicare “buy in” are not hard to fathom. The proposal was burdened by a number of practical difficulties.

*The New York Times* reported that the program would have been quickly initiated in 2011 but restricted to individuals, not families. It would have been financed by premiums, estimated at \$7,600 per person and \$15,200 per couple.<sup>30</sup> But for many persons in that age category, such premiums would have been unaffordable without special government subsidies to offset their costs. This could have added significantly to the cost of the bill. But without such subsidies, premiums for enrollees could have been higher than those obtained in private health plans.

Worse, Medicare is already deficient as a health care plan because it does not cover many needed benefits, such as catastrophic coverage. Nine out of 10 current Medicare beneficiaries rely on private, employer-based, or supplemental coverage as a “wrap-around” plan for Medicare. A common concern among health policy analysts was that the Medicare expansion provision could further erode employment-based coverage among older workers while adding significantly to Medicare costs.

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27. The original version of the bill required the new government-run plan to offer the “essential” health benefits, as defined by federal authorities, but the states could require the plan to offer more benefits in states where the plan competed against private plans. The HHS Secretary would set rates for the government-run plan and be empowered to negotiate the rates for doctors and hospitals. Under the bill, the rates must not be higher than the “average” rates paid to doctors and hospitals by the qualified private health plans. The CBO has estimated that the rates for the government-run health plan would be higher than private-sector rates for a variety of reasons, including “adverse selection,” the likelihood that the public plan would attract proportionally more older or sicker enrollees. Congress would provide start-up funding for the government health plan, but premiums would cover claims, administrative costs, and contingency reserves. The government plan would be subject to both federal and state solvency and consumer protection laws.

28. In its initial analysis of the original version of the Senate’s “public plan,” the CBO estimated that most Americans would live in states with a government plan. But without the imposition of Medicare rates to reduce payments to doctors and hospitals well below those of the private sector and with a low estimated take-up rate (3 million to 4 million according to an earlier CBO projection), some liberal analysts who championed a “robust public option” started to question the point of the Senate’s “public option” proposal. Many liberals, such as Representative Anthony Weiner (D-NY), saw the Senate leadership’s recent proposal to expand Medicare to include persons well below the normal retirement age as a superior way to move toward a single-payer system of national health insurance, but the Senate leadership, as noted, discarded this option as well.

29. David M. Herszenhorn and Robert Pear, “High Premiums in Senate Democrats’ Health Plan,” *The New York Times*, December 10, 2009, at <http://www.nytimes.com/2009/12/11/health/policy/11insure.html> (December 14, 2009).

30. *Ibid.*

**Federal Control.** Beyond the provisions for a “public plan” or its potential substitutes, the Senate bill sets up a federally designed system of health insurance exchanges modeled after the provisions of a bill reported out of the Senate Health, Education, Labor, and Pensions Committee in July. The federal government would control the creation, design, and operation of health insurance exchanges and, depending on whether states opt out, enter as a direct competitor against private health plans. While states would become vehicles of federal health policy, they could pursue independent arrangements in health insurance only by seeking a “waiver” from federal authorities.

Thus, the Senate health care bill would radically centralize power and control over the content of health benefits packages and health insurance in Washington. In other words, the very text of the bill and the powers it would confer on the federal government would, for all intents and purposes, constitute a “public plan” without even the formal creation of such an institution.

### New Middle-Class Taxes

The Senate bill creates a host of new taxes, totaling \$370.2 billion in taxes and another \$36 billion in taxes from the individual mandate penalty over the next 10 years. The government would start collecting many of these taxes in 2010, even as the economy continues to struggle.

The most significant is a 0.5 percent increase in the payroll tax on earnings above \$200,000 for individuals and \$250,000 for couples filing joint returns. The new tax provisions would also permanently sever the link between the Medicare payroll tax and Medicare benefits because the additional revenue would go to the general fund for health care instead of directly to Medicare payments.

This is a bad decision and represents a major policy shift. It means that Medicare taxes would no longer be dedicated solely to social insurance and safeguarding Medicare. Instead, Medicare payroll taxes would be used for other government programs. It is ironic that congressional liberals have proposed this shift because liberal champions of social insurance historically have worried about turning social insurance programs into welfare pro-

grams that redistribute wealth. The Senate payroll tax is a giant step down that road of using social insurance payroll taxes to transfer income.

The Senate bill would also impose an excise tax on “high value” health care plans. This tax is expected to be almost \$150 billion and is very similar to the tax reported earlier out of the Senate Finance Committee, but it uses a higher threshold level. While the health benefits packages of corporate plans may be rich, it does not follow that the subscribers are wealthy. This tax will disproportionately affect middle-income households.

The Senate bill would also impose a host of new taxes on the health insurance industry, ranging from a tax on branded drugs to a tax on medical devices. These new taxes would increase medical costs and premiums for individuals regardless of income. They would only raise the cost of health care because companies would pass these tax increases on to health care consumers.

The bill has over a dozen new taxes, including:

- A 40 percent excise tax on “high value” health care plans of \$8,500 or more for an individual and \$23,000 or more for a couple (\$149.1 billion in new taxes over the next 10 years);
- A 0.5 percent hike in the Medicare payroll tax for single earners over \$200,000 and joint earners over \$250,000 (\$53.8 billion);
- Changes in health savings accounts (HSAs), Archer Medical Spending Accounts, health flexible spending accounts (FSAs), and health reimbursement arrangements (\$5 billion);
- A \$2,500 cap on FSAs in cafeteria plans (\$14.6 billion);
- An increase from 10 percent to 20 percent in the penalty for early non-qualified HSA withdrawals (\$1.3 billion);
- A tax on branded drugs (\$22.2 billion);
- An annual tax on the health insurers<sup>31</sup> (\$60.4 billion);
- A tax on companies that manufacture or import medical devices (\$19.3 billion);
- A 0.5 percent excise tax on cosmetic surgery (\$5.8 billion over 10 years);

- An increase in the floor of the medical expenses deduction from 7.5 percent of adjusted gross income to 10 percent, except for seniors, who will stay at 7.5 percent (\$15.2 billion);
- Elimination of the Medicare Part D (prescription drug) deduction (\$5.4 billion);
- A \$500,000 cap on the tax deduction for the salaries of employees of health insurance companies (\$0.6 billion over 10 years)<sup>32</sup>; and
- A mandate on companies with more than 50 employees to provide health coverage or pay a \$750 penalty per employee for those who obtain coverage through the insurance exchange (\$36 billion over 10 years) and a mandate on individuals to obtain coverage or pay a tax penalty.<sup>33</sup>

### Expanding Medicaid and Long-Term Care Entitlements

The Senate health care bill generally follows the earlier versions, which would expand Medicaid and create a new health care program, the CLASS Act.

**More Welfare.** The Senate bill expands Medicaid eligibility to all Americans below 133 percent of the federal poverty level, changing it to a purely income-based federal entitlement. It also changes the federal matching rates for different populations and states. For example, Section 2006, a special provision aimed at Louisiana, provides a special “disaster recovery” match rate for states that have had a major disaster declared. The CBO estimates that this will increase total Medicaid spending by \$25 billion.

Of course, millions of persons at or below 133 percent of the federal poverty level carry private health insurance. The Senate bill, based on all pre-

vious experience, would further crowd out private health care coverage. It would also encourage employers to drop coverage for employees that would qualify for Medicaid after the expansion, compounding this effect.

**Less State Authority.** States should be alarmed at the aggressive federal encroachment on state authority over the management of Medicaid. Section 2801 is clearly intended to increase the federal government’s direct control of the program. In addition, states would become vulnerable to federal lawsuits by individuals under the expanded definition of medical assistance in Section 2304. This would likely be used to overturn recent federal court decisions won by states that limit private lawsuits against them.

The Senate makes another major exception to current law governing the eligibility of immigrants for welfare benefits. Previously, legal immigrants have been prohibited from receiving public benefits, including Medicaid, until five years after their date of entry into the United States. The Senate bill would reverse this, making legal immigrants immediately eligible for the new federal subsidies upon enactment. This raises an equity issue that has been overlooked: 60 million U.S. citizens would be *excluded* from the generous federal subsidies.

**Class-Based Inequity.** Instead of expanding high-quality coverage to all, the Senate bill would create a rigid, two-tiered health care system. Individuals at the lowest income levels would be forced into Medicaid, while individuals just above the poverty level would qualify for generous subsidies worth more than Medicaid on a per capita basis. The Senate bill further promotes this inequity by

31. This tax would also apply to Medicare Advantage plans and private plans offered in the FEHBP, meaning that seniors and federal employees would also pay higher taxes. For a discussion of the special health insurance premium tax, see Edmund F. Haislmaier, “The Senate Health Bill: Cost of the Insurance Premium Tax to Individuals and Families,” Heritage Foundation *Backgrounder* No. 2350, December 9, 2009, at <http://www.heritage.org/research/healthcare/bg2350.cfm>.
32. Joint Committee on Taxation, “Estimated Revenue Effects of the Revenue Provisions Contained in the Patient Protection And Affordable Care Act.”
33. Under the federal tax code, similar employees with similar incomes are treated very differently in their purchase of health insurance. Those who receive health insurance through employers get unlimited tax breaks for that purchase; those who obtain health insurance outside the workplace receive no tax relief. As noted, the Senate bill includes this strange new provision, which introduces a whole new set of inequities into the health care system. See Book, “How the Senate Health Bill Punishes Businesses That Hire Low-Income Workers.”

giving non-citizens the federal subsidies that are denied to the lowest-income Americans.

**A New Program.** The CLASS Act has been included in the Senate bill despite criticism that it is not fiscally sound over the long term. The CLASS Act would create a new federal program for long-term health care insurance to compete against private insurance. Individuals who pay into the program for five years and experience limitations in their daily activities would become eligible for cash benefits. These limitations do not meet the current disability test, which opens the program to abuse. Perhaps more problematic, according to the CMS, the program is particularly vulnerable to adverse selection, which would make it “unsustainable.”<sup>34</sup>

The CLASS Act also serves as a budget gimmick, enabling the federal government to collect revenues for five years before paying out any benefits. As noted, this up-front revenue collection, along with other taxes and fees, allows the Senate sponsors to claim that the bill is fiscally responsible and offsets the cost of the Senate bill by \$72 billion over the first 10 years. The problem is that the program’s costs will explode when the benefit payouts start to accumulate. As the CMS has indicated, the program will generate *net costs*, not net savings.<sup>35</sup>

## Conclusion

The Senate is engaged in a deadly serious debate on a 2,074-page bill that would overhaul

the entire health care sector of the economy, profoundly affecting the personal lives of 300 million Americans. It would erect massive federal controls over private health insurance, dictating the content of insurance benefit packages and the use of medical treatments, procedures, and medical devices.

The bill would also make major changes in payments to doctors, hospitals, and medical professionals in Medicare, Medicaid, and other programs; establish new federal agencies, bureaus, and commissions to oversee various aspects of the health care system, including how physicians and other medical professionals deliver care; and alter the relationship between the federal government and the states, transferring massive regulatory power to the federal government while reducing the flexibility of state officials to manage Medicaid and limiting their capacity to initiate health insurance reforms within their own states.

The Senate bill would impose enormous costs on the American people, totaling at least \$2.5 trillion for the first 10 years. After the first 10 years, as costs escalated, Congress would need to impose additional major tax increases and impose major cuts in benefits to pay for this health care agenda.

The American people want and need health reform, but the Senate bill is clearly not what they have in mind.

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34. Foster, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act of 2009,’” p. 14.

35. *Ibid.*, p. 13.