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Key Questions for Senator Tom Daschle, Nominee for Secretary of Health and Human Services

Robert E. Moffit, Ph.D.

The United States Senate will soon render its advice and consent to the nomination of former Senator Tom Daschle (D–SD) as the new secretary of the United States Department of Health and Human Services (HHS).

Media reports have already indicated that Daschle, if confirmed, would be the new Administration's "health care czar" and would play a key role in the reform of the nation's health care system, potentially affecting the financing and delivery of care for every American.

Among the broad policy initiatives endorsed by both Daschle and President-elect Obama are the creation of a new public plan to compete with private health insurance in a new national pool, the creation of a new federal agency with broad authority to determine the value and effectiveness of medical treatments and procedures. These are key pillars of a major expansion of federal regulatory authority over health care financing and delivery. In giving its advice and consent, Senators should explore these initiatives and determine how they would be implemented and how they would affect the 300 million Americans that they represent.

In making their own evaluations, Senators should note that Daschle has provided some valuable insights into his own views on these matters with the recent publication of his book *Critical: What We Can Do About the Health-Care Crisis*.[1] It is an excellent resource for the Senate and the public. Based on that volume, consider some preliminary questions.

Question #1: The Future of the Doctor-Patient Relationship. On page 199 of your book, in discussing the powers of your proposed Federal Health Board, you write, "Doctors and patients might resent any encroachment on their ability to choose certain treatments, even if they are expensive or ineffective compared to the alternatives. Some insurers might object to new rules that restrict their coverage decisions." *Could you elaborate on your belief that the reform of America's health care system must deny to doctors the right to prescribe, or the right of patients to choose, medical treatments or procedures that they deem best for their particular medical condition even if an appointed government panel deems them to be too "expensive"?*

Answer: The right answer is that a key goal of health care reform should be to restore the traditional doctor-patient relationship. Ideally, doctors and patients should be able to contract freely with each other in a system governed by personal choice and provider and plan competition. While widespread availability of sound clinical information should be available to doctors and patients alike from a variety of professional sources, in no case should the federal government, through its regula-

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214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

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tory power, monopolize such information or interfere with medical practice.

Daschle's proposal is incompatible with the traditional Hippocratic Oath, the 2,500-year-old body of ethical rules that provide the foundation of the traditional doctor-patient relationship.[2] The tacit assumption of the Daschle proposal is that a special class of government officials should standardize medical treatment for very diverse patients who have the same medical condition. Such a direct repudiation of the professional independence and integrity of the medical profession and the traditional doctor-patient relationship is rare among American public officials.

Daschle's proposal is also incompatible with Americans' personal liberty. American citizens should be free to spend their own money on medical treatments and procedures they wish to secure, offered in a health plan or by a physician of their choice, regardless of whether or not political appointees believe that these treatments are too expensive. Moreover, health insurers should be able to innovate in the coverage of medical services without waiting for permission from a special class of political appointees.

Question #2: Recourse for Patients Denied Care. On page 200 of your book, once again discussing the powers of your proposed Federal Health Board and its appointees, you write, "When the Federal Reserve Board sets interest rates, it affects people's money. But when the Federal Health Board makes coverage decisions, it will affect people's lives." Then, on page 201, discussing the power of the board members, you add, "They will be political appointees, chosen by the president and confirmed by the Senate. The board will derive its authority from Congress, and Congress can dismantle it whenever it wants. Congress will have the power to overturn a board decision or remove a board member for good cause, although I hope it will use this power sparingly, if ever." *If an individual patient were denied a medical treatment, procedure or drug as a result of a decision of the board, what would be their recourse short of an act of Congress? Would there be an appeals process, like Medicare, or access to the federal courts, or both?*

Answer: The right answer is that Congress should not even contemplate such a vast concentration of government power, as Daschle proposes, over the lives of ordinary Americans.

Daschle makes it clear that the board would be making some difficult decisions. He also makes it clear (on page 199) that it would enable Members of Congress to escape direct responsibility for tough decisions affecting Americans, even though they vote the taxpayers money to pay the "insulated" political appointees to make them: "I suspect that most members of Congress would be glad to be rid of their responsibility for controversial health policy decisions. If the Federal Health Board fulfills its mission, it will have to reduce or deny payment for new drugs and procedures that aren't as effective as the current ones."[3]

Obviously, Congress can alter or destroy what it creates. The issue is what are the practical options for doctors and patients who believe that a decision of the board hurts them or in some way damages their health. It would appear that Congress would have to create some sort of appeals process for doctors and patients, similar to today's Medicare appeals process for claims for services denied, which can take literally months. For ordinary Americans, this would not be a pleasant prospect. Perhaps Daschle would have a better idea.

Another key issue, of course, is whether the board would enjoy sovereign immunity from litigation by injured patients or their doctors. For all practical purposes, it is not clear. Congress may decide to provide an avenue of suit against the board in a court of law. So medical issues would

1. Tom Daschle, with Scott S. Greenberger and Jeanne M. Lambrew, *Critical: What We Can Do About the Health-Care Crisis* (New York: Thomas Dunne Books, 2008).
2. For the text of the Hippocratic Oath and a discussion of its relevance to modern medical treatments, see Robert E. Moffit, Jennifer A. Marshall, and Grace V. Smith, "Patients Freedom of Conscience: The Case for Values-Driven Health Plans," Heritage Foundation *Backgrounder* No. 1933, May 12, 2006, pp. 8–11, at *www.heritage.org/research/healthcare/bg1933.cfm.*
3. Daschle, *Critical*, p. 199.

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become matters for lawyers and judges, not congressional deliberation. Based on Daschle's own description, the board would instead appear to function like a "Supreme Court of Health." It is worth noting that in the prototype of this proposal, the "National Health Board" elemental to the ill-fated Clinton health plan of 1993, all the board decisions relating to the imposition of "caps" on health insurance premiums for reasons of "cost control" were to be exempt from either administrative or judicial review.[4]

Question #3: Creating a Public Plan. On page 171 of your book, you write, "The Federal Health Board would also work with Medicare to develop a public insurance option for the (national) pool, designing it to compete with the private health insurance plans on the FEHBP menu." Based on the robust findings in the professional literature, the creation or expansion of public health programs invariably "crowds out" private health insurance coverage, particularly as employers drop health coverage and enroll their employees in government programs.[5] *In your policy role as an Administration official, how would you guarantee President Obama's promise to Americans that if they are enrolled in private health plans, nothing would change for them?*

Answer: It would be an astonishing feat for the Obama Administration to expand public coverage without displacing or destroying existing private coverage. Aside from the "crowd-out" phenomenon, such a promise could not be kept if the Administration were to adopt anything like Daschle's proposed Federal Health Board and then expand its jurisdiction to private coverage imposing tax penalties on noncompliant health plans, as Daschle has suggested in his book.[6] In other words, a lot would *have* to change.

Much depends on the unknown details, such as the payment rates adopted by the public plan, the scope of eligibility for enrollment in such a plan, or the tax rates imposed on employers elemental to the employer mandate endorsed by the President-elect. The Lewin Group concluded that the number of Americans that would be transitioned out of private health insurance coverage would range from anywhere between 10.4 million and 118.5 million Americans.[7]

Question #4: The British Experience with NICE. On page 127 of your book, you write, "In other countries, national health boards have helped to ensure quality and rein in costs in the face of these challenges. In Great Britain, for example, the National Institute for Health and Clinical Excellence (NICE), which is part of the National Health Service (NHS), is the single entity responsible for providing guidance on the use of new and existing drugs, treatments, and procedures." If that British agency determines that a treatment is cost effective, it must then be available within the NHS, but it also denies reimbursement for treatments, making them practically unavailable for patients. *Based on your assessment of the record of NICE, would you like to see similar results for doctors and patients in the United States?*

Answer: The right answer is that Americans should never have to endure anything remotely like the centralized, bureaucratic health care decision-making process that characterizes the British National Health Service.

Increasingly, the British media is reporting on the consequences of the role of NICE, and those results

4. The Health Security Act, Title V, Section 5232. For a more detailed discussion of the enormous powers of Clinton's proposed " National Health Board," see Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993, at *http://www.heritage.org/research/healthcare/tp00.cfm*.
5. For an excellent summary of some of the key findings, particularly the pioneering work of Jonathan Gruber of MIT, see Andrew M. Grossman and Greg D'Angelo, "SCHIP and Crowd Out: How Public Program Expansion Reduces Private Coverage," Heritage Foundation *Webmemo*, No. 1518, June 21, 2007, at *www.heritage.org/research/healthcare/wm1518.cfm.*
6. Daschle, *Critical*, p. 179.
7. For a summary of the most recent findings on this subject by the Lewin Group, see "Opening a Buy-In to a Public Plan: Implications for Premiums, Coverage and Provider Reimbursement," presentation to Republican staff of the Senate Finance Committee, December 5, 2008, at *http://www.lewin.com/content/publications/OpeningBuyInPublicPlan.pdf* (December 18, 2008).

are nasty.[8] For example, *The Telegraph* of London reports that NICE denied access to Velcade, a new drug for the treatment of cancer.[9] Jacky Pickles, a 44-year-old mother with the disease, made a direct plea to Britain's health secretary for coverage of the medication. Ms. Pickles, working in the British system as a midwife for 25 years, said, "I am going to give them the last years of my life. I've got to go to work in a Health Service that won't support me when I most need it. I have given my life to the NHS, but it is a system that won't give me something I need to save my life."[10] Britain's health secretary would not intervene to help Ms. Pickles, and NICE officials refused to comment, noting that while the drug for cancer treatment is "clinically effective" compared to chemotherapy, they deemed it not to be "cost effective." If members of the incoming Administration and the Congress really want such a system, they should thoroughly brief ordinary Americans what it would entail.

Question #5: Tax Policy. Senator Max Baucus (D–MT), chairman of the Senate Finance Committee, has said that Congress should re-examine the federal tax treatment of health insurance, noting that there is a strong, bipartisan consensus among economists and policymakers that the existing tax policy governing health insurance is both unfair and economically efficient. *Do you believe that this growing consensus is sound and that persons who do not or cannot get health insurance at work should be penalized by the tax code if they buy it on their own?*

Answer: The consensus among economists and policymakers is sound, ranging from the views of the late Nobel Laureate Milton Friedman of the University of Chicago to Professor Uwe Reinhardt of Princeton University. There are a variety of ways to accomplish the change, ranging from a total replacement of the existing tax exclusion to more incremental steps, such as a cap on the current tax exclusion on the value of the health benefits provided at the place of work.[11] Baucus has suggested an incremental step of capping the existing employment based tax breaks as a means of financing help for uninsured persons.[12] More ambitiously, Senators Ron Wyden (D–OR) and Robert Bennett (R–UT) have co-sponsored legislation that would repeal the existing tax policy and replace it with a refundable health tax credit (which would function like a voucher for low income persons), guaranteeing every American access to affordable health insurance coverage.[13] Jason Furman of the Brookings Institution, who recently served as an economic adviser to President-elect Barack Obama, has also proposed replacing the current system with a universal, progressive health care tax credit, making it refundable to guarantee direct financial assistance help to low income persons.[14]

Health care reform entails reform of the health insurance markets. But there can be no reform of the health insurance markets without a reform of the federal tax treatment of health insurance.

8. For a recent summary of some of the more notable examples, see Jeet Guram and Robert E. Moffit, Ph.D., "The Concept of a Federal Health Board: Learning from Britain's Experience," Heritage Foundation *WebMemo* No. 2154, December 4, 2008, at *www.heritage.org/research/healthcare/wm2154.cfm.*
9. Graeme Wilson, " Hewitt Faces Fury of Cancer Patients 'Given Death Penalty,'" *Telegraph*, September 28, 2006, at *http://www.telegraph.co.uk/news/uknews/1530000/hewit-faces-fury-of-cancer-patients-given-death-penalty.html* (December 3, 2008).
10. Graeme Wilson, " Bar on Cancer Drug Will Shorten Lives," *Telegraph*, October 21, 2006, at *http://www.telegraph.co.uk/news/uknews/1531893/bar-on-cancer-drugs-'will-shorten-lives'.html* (December 3, 2008)
11. For a brief overview of the issue, see Jason Roffenbender, 'Employer-Based Health Insurance: Why Congress Should Cap Tax Benefits Consistently," Heritage Foundation *Backgrounder* No. 2214, December 5, 2008, at *www.heritage.org/research/healthcare/bg2214.cfm.*
12. Senator Max Baucus, *Call to Action: Health Reform 2009*, November 12, 2008 at *http;//finance.senate.gov/healthreform2009/home.html* (January 7, 2009).
13. The Healthy Americans Act (S. 334). The Wyden-Bennett bill would abolish the existing tax exclusion in favor of a new system of income-based subsidies for low-income persons and a new tax deduction for middle and upper income persons.
14. See Jason Furman, "Health Reform Through Tax Reform: A Primer," *Health Affairs* , Vol. 27, No. 3, (May/June 2008), pp. 622–632.

Reform the Right Way. There is little debate over the need to improve America's health care system, and many of the specific goals of the participants in this national debate are widely shared. Where there is sharp disagreement is over the means to achieve those goals. Those means should not deny Americans the ability to maintain private health insurance that they want; the benefits, medical treatments, and procedures that they want; or the relationship with the physician that they value. Meanwhile, government officials should not be in the business of driving out private health insurance while pretending to champion individual choice and market competition.

—Robert E. Moffit, Ph.D., is Director of the Center for Health Policy Studies at The Heritage Foundation.

For More Information

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