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Why the Kennedy Health Bill Would Wreck Bipartisan Reform

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Based on the President's description of his health care agenda during the 2008 presidential campaign, Americans believe they were promised three things:

1. If they are satisfied with their current coverage, nothing will change;
2. If they are not satisfied, or have no coverage, they will be offered a plan at least as good as Members of Congress have; and
3. The cost of their family health coverage will fall by an estimated $2,500.

Against that backdrop, the Affordable Health Choices Act, unveiled by Senator Edward M. Kennedy (D–MA), overturns all three of these promises. It is a setback for bipartisan health care reform.

Concentrated Power. The 615-page bill would transfer enormous power over health care to Washington, including regulatory power traditionally exercised by the states over the rules governing health insurance.

Within the federal government, much of the decision-making power would be concentrated in the hands of the secretary of health and human services (HHS), who would be given broad regulatory authority over various aspects of health care financing and delivery.

In contrast to the more broadly worded committee working paper unveiled earlier,[1] in this bill Congress prescribes how exactly the federal government would control and expand private health insurance, how HHS would supervise state health insurance market changes, and how the federal government would determine the kinds of medical benefits and procedures to be covered by "qualified" private health insurance plans.[2]

Opportunities for Consensus. The earlier committee outline contained some health policy proposals that could—depending on the details—attract broad bipartisan support, such as a role for the states in enacting health insurance market reforms (including "the option" for the states to create health insurance exchanges to expand personal choice and coverage) and providing direct assistance to low-income persons to secure coverage.

The earlier bill draft leaked to the media last week outlined the rights of patients to choose their doctors and to retain an "effective" relationship with their physicians, as well as the right of doctors and other medical professionals to judge what is best for their patients.[3]

On these points, there could be broad agreement among liberals and conservatives alike in Congress.

Minefields. Unfortunately, the latest version of Senate Committee bill contains provisions that conflict with bipartisanship and Americans' hopes for reform. Four are particularly controversial and, if pressed, will derail successful reform:

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1. A Public Plan That Would Compete with Private Health Insurance. Under Title I, the bill specifies how the HHS would assist the states in setting up a "gateway," the committee's version of a "health insurance exchange." In establishing a gateway, the states would be required to make "qualified health plans" available to state residents, and in making available that coverage, "a Gateway shall include a public insurance option."[4]

In other words, the committee envisions a government-sponsored plan competing with private plans on a supposedly level playing field. That means government officials would ultimately be responsible for one plan while setting the rules of competition for all plans. It is impossible to believe that government officials would set rules without stacking the deck in favor of their own plan. It is hardly surprising, then, that under the public insurance option, the authors of the Senate bill have a notation: "Policy under discussion."

A public plan conflicts with the assurance that Americans satisfied with their current coverage will not be affected. A public health insurance plan would displace the private coverage of many Americans, regardless of their personal preferences.

An independent analysis by the Lewin Group, for example, shows that a public plan depending on eligibility and payments rates could result in up to 119.1 million Americans being switched by their employers from their existing coverage or transferred to government-sponsored coverage so that employers can reduce benefit costs.[5] Thus a public plan, especially combined with a mandate on employers to offer government-specified coverage or pay a tax, would mean that millions of Americans would be pushed out of the private coverage they have today.

2. Mandates on Businesses and Individuals. The committee bill would impose "a shared responsibility" on both individuals (under Section 161) and employers (under Section 163) to pay for health coverage.[6] These requirements amount to mandates, though the penalties are not spelled out.

An employer mandate would be a regressive tax on business that would be directly shifted to employees in the form of reduced future wages or job losses. It would also spur many employers to drop private coverage, paying the tax rather than having to buy government-specified insurance.

An individual mandate would force Americans to buy a set of health benefits designed by the government or suffer some penalty. Again, mandates without penalties are meaningless, but the penalties are unspecified in the committee bill.

3. Federal Regulation of Health Insurance That Would Undermine State Flexibility. In expanding coverage and improving health care delivery, the federal government and the states should enter into a partnership of equals; the states should not be reduced to mere agencies of federal authority.

Under the committee bill, Congress and federal officials would exert a high degree of control over health insurance, including underwriting and rating rules, and would prescriptively organize the market for competing health plans.[7] That would limit the ability of states to design rules and market rules that fit local conditions.

While the federal government certainly has a role in encouraging states to make health insurance

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1. Briefing paper, "A New Vision for American Health Care: Strengthening What Works and Fixing What Doesn't," Committee on Health, Education, Labor and Pensions, U.S. Senate, 111th Cong., 1st. Sess., May 21, 2009.
2. The Affordable Health Choice Act, S. 325, 111th Cong., 1st. Sess., Title I, Parts I–III.
3. The Affordable Health Choices Act, Section 2. The section was dropped in the most recent version.
4. Affordable Health Choices Act, Title I, Part III, Section 3101(b)(3).
5. John Sheils, the Lewin Group, "The Cost and Coverage Impacts of a Public Plan," testimony before the Committee on Ways and Means, April 29, 2009, at *http://www.lewin.com/content/publications/Testimony_April_29,_2009.pdf* (June 11, 2009). According to the Lewin analysis, the strongest crowd-out of private health insurance would result from the adoption of Medicare payment rates and allowing all employees to enroll in the public plan.
6. Affordable Health Choices Act, Title I, Subtitle D - "Shared Responsibility for Health Care," Sections 161, 162, and 163.
7. Affordable Health Choices Act, Title I, Part III, Section 143.

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accessible and affordable rules for all Americans, because of the radical diversity in state health insurance markets, states rather than Washington are best suited to design policies for universal coverage within their boundaries.

4. Federal Control and Standardization of Health Benefits. Under Title I, Part III, the bill would create a "Medical Advisory Council" (appointed by the secretary of HHS) to make detailed recommendations on the "essential health benefits" to be included in "qualified health plans." HHS would then submit the report for congressional review. HHS's benefit determination would be "applicable" for insurance coverage unless there was a joint resolution of Congress disapproving such a report "in its entirety."[8]

Saving Reform. Senator Kennedy's proposal, understandably at this stage in the process, is an "opening bid" that instead reflects a certain political philosophy and the aspirations of certain constituencies. But Senator Kennedy also seeks serious and lasting reform of the nation's health care system.

For that to happen, the wise next step would be to redraft the legislation in a way that commands broad bipartisan support. That means seeking alternative ways of achieving the goals of those provisions in the current bill that jeopardize a final agreement and will encounter strong opposition from most Americans.

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8. *Ibid.*