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The House Health Care Bill: A Blueprint for Federal Control

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The U.S. House of Representatives leadership recently unveiled a mammoth 852-page blueprint for overhauling Americans' health care: the draft "Tri-Committee Health Reform Bill." It is the product of three major House Committees with jurisdiction over health policy—Education and Labor, Energy and Commerce, and Ways and Means. If enacted, this comprehensive legislation would amount to federal control of the health care sector of the economy, with the implementation of far-reaching policies impacting doctors and patients in the public as well as the private sector.

Like the U.S. Senate Health, Education, Labor and Pensions Committee bill,[1] the House bill would create a new public plan to compete with private health insurance in a national health insurance exchange; impose mandates on individuals and businesses to buy health insurance coverage or be subject to tax penalties; and allow the federal government to control, standardize, and regulate health insurance, defining what is and is not "acceptable coverage" for American citizens.

The "Public" Plan. The bill would require the secretary of health and human services (HHS) to establish a "public health insurance option" to compete against private health plans on a "level playing field" in a national health insurance exchange. It would also expand eligibility for the existing Medicaid program up the income scale to 133 percent of the federal poverty level.

The public plan's payment to providers would be based on Medicare payment rates plus 5 percent. The Lewin Group estimates that, by using the Medicare payment rates and opening up the plan to all employees, as the bill would provide, the House bill could result in up to 113.5 million people losing private coverage.[2] Lewin estimates that cost shifting to private plans from the public plan would amount to an additional $460 per person for those remaining in private insurance,[3] while physician and hospital revenues, under such a scenario, would decline significantly.

Contrary to the House sponsors' claims, it is hard to imagine a "level playing field" where Congress creates a special government plan to compete against private health plans while also creating the rules for its competitors.

While the House bill would set up an account within the Treasury for the deposit of startup funds and premiums, the bill would also require taxpayers to retain the risks and depend on congressional restraint in the appropriation of additional taxpayer funds for the public plan. In light of recent congressional bailouts of automakers and financial institutions, belief in such restraint would amount to a triumph of imagination over experience.

A National Health Insurance Exchange. The bill would create a National Health Insurance

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Exchange in order to "facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable quality health insurance, including a public insurance option."

Champions of state-based health reform have proposed a health insurance exchange to serve as a *state-based* administrative body—not a regulatory body—to provide comparative information on prices, plans and benefits; facilitate enrollment of individuals and employees; collect and transmit premiums payments; and thus reduce the administrative costs for small businesses and the individuals and families employed by them.[4] It would facilitate a defined contribution on the part of employers for their employees, enabling them to choose their own plan while securing the existing tax advantages of group health insurance.

This would enable individuals to buy and own the health plan they determine is best for them and thus be able to take it with them from job to job. This added portability in health insurance would, in and of itself, result in a dramatic reduction in the number of the uninsured, most of whom lost coverage due to changes in their employment situation. For some states, a health insurance exchange may be an appropriate remedy for a dysfunctional health insurance market.

But in the House bill, the health insurance exchange, governed by a commissioner, would be a national institution and function as a powerful regulatory agency. Combined with federal benefit setting and a public plan, it would effectively limit personal choice and reduce competition, as the federal government would erode private coverage and limit the kind of plans that could enter and compete in the market. States could only set up a state-based exchange with federal permission.

Under the House bill, Congress would not forge a federal–state partnership; rather, it would enact federal domination of the states. It would also undermine, not advance, state innovation in the provision of new health insurance options.

Federal Benefit Setting. The House bill would require every American to have health insurance coverage that Congress would define as "acceptable coverage." Under the terms of the bill, existing coverage at the time of enactment would be "grandfathered," but health plans would be legally required to conform to federal standards over time. Eventually, health insurance in the individual market would no longer be considered "acceptable coverage."

Because Congress would centralize decision-making over health insurance in Washington, taxpayers can expect a replay of the frenzied special-interest lobbying that characterizes benefit mandate decisions in state legislatures and agencies.

In addition, government health benefit decisions often include coverage of controversial items such as abortion. A number of House Democrats are concerned that the House bill would become a vehicle for taxpayer subsidization of abortion coverage.[5]

1. Ror a description of the key elements of the Senate bill, see Stuart M. Butler and Robert E. Moffit, "Why the Kennedy Health Bill Would Wreck Bipartisan Reform," Heritage Foundation *WebMemo* No. 2481, June 12, 2009, at *http://www.heritage.org/Research/HealthDare/wm2481.cfm*.
2. John Sheils, "The Impact of The House Health Reform on Coverage and Provider Incomes," testimony before the Energy and Commerce Committee, U.S. House of Representatives, June 25, 2009, p. 1.
3. *Ibid.*, p. 12. The assumption is that all employees would be eligible for enrollment in the public plan and that the plan would use Medicare payment rates.
4. For a discussion of the purpose and function of the state-based health insurance exchange options, see Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at *http://www.heritage.org/Research/HealthCare/wm1230.cfm*. Some analysts describe the Federal Employees Health Benefits Program (FEHBP) as a national exchange, but in sharp contrast to the House bill, there is a wide variety of private benefit options(ranging from traditional plans to health savings accounts) and there is no government plan competing with private health insurance.
5. "Without an explicit exclusion, abortion could be included in a government subsidized health care plan under general health care." Representative Dan Boren (D–OK) *et al.*, letter to the Honorable Nancy Pelosi, Speaker of the House of Representatives, June 25, 2009.

Mandates on Individuals and Businesses. The bill contains both an individual and an employer mandate. Under the terms of the bill, an individual would be required to enroll in an "acceptable" health plan or face a tax penalty. The only exception would be "hardship" cases. For an individual, the tax would be equal to 2 percent of their income up to the "national average premium amount." Such a mandate would amount to an unprecedented restriction on personal liberty.

"Medium and large" employers would be required to offer an "acceptable" health plan, under the terms and conditions of the House bill, or pay an "assumed" 8 percent payroll tax.[6] As economists generally note, the costs of an employer mandate are invariably passed onto employees in the form of wage or compensation reduction or even job loss. There is yet to be an econometric analysis of the impact of these provisions of the House bill.

Promises, Promises. The President has said repeatedly that if Americans like their private health insurance coverage, they would be able to keep it. But in fact, the incentives built into the House bill—a combination of mandates and the provision of a public plan—would guarantee that millions of Americans would lose their private coverage, regardless of their personal preferences.

In the Senate, the leading bill would add $1 trillion to the deficit over 10 years, while pushing millions of Americans out of their employer-based coverage. While the President insists that health care reform should be "deficit neutral," the cost of the House bill—both quantifiable and not—is yet unknown.

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6. Shiels, p. 4.