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New Taxpayer Subsidies: The Impact of the House and Senate Health Bills

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Under the House and Senate bills, taxpayers are going to pay more for health insurance.

Health insurance is supposed to provide individuals access to quality health care and ensure protection against financial calamity due to a catastrophic illness or injury. But as the cost of insurance rises as a percentage of a family's budget, so does the rate of uninsurance. To make insurance more affordable, the cost of care needs to be lowered or subsidies will need to be provided (or some combination thereof).

Higher, Not Lower, Costs. In February, President Obama stated, "the cost of health care has weighed down our economy." But despite the President's recognition that there is already plenty of money in the current health care system, Congress wants to spend even more. It is now clear that the major legislation being considered in the House and Senate will not lower the cost of health care.

Douglas Elmendorf, director of the Congressional Budget Office (CBO), testified before the Senate Budget Committee that none of the bills he had seen contain "the sort of fundamental changes that would be necessary to reduce the trajectory of federal health spending by a significant amount." This sentiment has been echoed by Michael O. Leavitt, the former secretary of health and human services, Professor Ken Thorpe of Emory University and a former official in the Clinton Administration who worked on the ill-fated Clinton health plan, and Dr. Glenn Hackbarth, head of the Medicare Advisory Committee.[1]

The problem in the current health care system is not cost *per se* but excess cost. Excess cost occurs from under-utilization and over-utilization of services. Simply putting more money into the existing system governed by existing incentives rewards excess cost and will not meet Americans' expectations that these bills would lower unnecessary health care spending.

Moreover, Medicare and Medicaid already serve about 90 million people. Making another 41 million people dependent on government assistance through further expansion of Medicaid and public subsidies will have widespread political and social consequences.

More Public Dependency. In fact, the proposals would worsen the bleak outlook on health care costs. Because the overall cost of health care is not being reduced, expansion of coverage—largely through new government programs—will require even more taxpayer subsidies.

Over the period 2010–2019, the House bill would spend $438 billion to expand Medicaid to all individuals with incomes up to 150 percent of the federal poverty level,[2] or FPL ($16,245 for an individual, $33,075 for a family of four) and $773

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billion to provide new public subsidies to individuals between 150 percent and 400 percent of the FPL ($43,320 for an individual, $88,200 for a family of 4).[3]

Poorly Targeted Spending. The Urban Institute estimated that people who were uninsured in 2008 spent about $30 billion in out-of-pocket costs and received another $56 billion in uncompensated care.[4] Most of these individuals can contribute at least something to the cost of their care, as 71 percent of the uninsured have incomes above 125 percent FPL.[5]

If the cost of their care was just $86 billion in 2008, then why will the subsidies and additional Medicaid spending be over $163 billion in 2015? Medical inflation, estimated to average 6.2 percent annually, does not account for the difference.

The increased federal spending will not go only to individuals who are uninsured. Funds will be used to supplant existing *private* spending among both currently insured as well as uninsured. Unfortunately, the CBO estimates do not provide how much of the new federal spending will simply replace current dollars.

Creating New Inequities. The House and Senate bills use different formulas for deriving the amount of subsidies to be provided on a sliding scale based on income, but both use approaches designed to make coverage "affordable."

Under the House version, the approximate average subsidy per subsidized enrollee is $4,600 in 2014, increasing to $6,000 in 2019.[6] Under the Senate version, the average subsidy per enrollee is $4,700 in 2014 and $6,100 in 2019.[7]

The CBO has not provided the dollar amount range by income level nor how much support a family could receive. Is there public support for providing a family of three with $15,000 in tax free benefits? Are the benefits too generous that will encourage over-utilization? Individuals currently paying for their own health insurance through their employers will not be eligible for assistance, creating new inequities in which lower-income families will not receive assistance while a family at a higher income level does.

It is also important to understand that determining eligibility on adjusted gross income may in many cases mean that a family of four making $100,000 will receive a subsidy. The CBO should provide spending and enrollment estimates for lower eligibility thresholds. Can the same enrollment levels be achieved at a lower cost?

Tighter Government Control. In providing these new subsidies, the federal government will also control how they are used. As such, this legislation represents a tremendous increase in the power of the federal government, including, for the first time, the regulation of private health insurance.

Individuals will not be free to use the subsidies in current employer health plans or to purchase private health plans that do not meet new federal requirements. This will mean that individuals will almost certainly be forced into choosing health plans that cover controversial procedures or services they may find morally objectionable, such as abortion. The only alternative is to refuse the coverage, which would forfeit the subsidy (worth $4,700 per individual on average) and—because of the

1. David S. Broder, "Obama's Turning Point," *The Washington Post*, July 19, 2009.
2. Section 1701 provides eligibility up to 133 percent FPL, but when current law income and expense disregards are factored in, Medicaid coverage will, in effect, go up to 150 percent FPL. The Senate HELP Committee assumes Medicaid expansion to 150 percent FPL.
3. Douglas W. Elmendorf, director of the Congressional Budget Office, letter to Charles B. Rangel, chairman of the Committee on Ways and Means, July 17, 2009.
4. Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs*, Web Exclusive, August 25, 2008, w399.
5. Hadley *et al.*, w412.
6. Elmendorf, letter to Rangel.
7. Douglas W. Elmendorf, director of the Congressional Budget Office, letter to Senator Edward Kennedy, chairman of the Senate Committee on Health, Education, Labor, and Pensions, July 2, 2009.

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mandate for each individual to have health coverage—subject the individual to a penalty.

Individuals will not be permitted to use their subsidies to purchase coverage that does not meet the definition of "essential health benefits." Health plans that do not meet the definition of a "qualified health plan" over time will not be permitted to enroll new customers. The Department of Health and Human Services (HHS) is given broad authority to regulate these benefits and health plans. Although the legislation itself does not fully define the benefit package, amendments to exclude abortion coverage have been defeated in both the House and the Senate committees considering health reform legislation.[8]

In the House bill, because so much authority is left up to HHS and the new commissioner who will administer the national health insurance exchange, it is not possible to determine, with any specificity, what "essential health benefits" would be for Americans with health insurance today.

Mass Confusion. The interaction between Medicaid, the new public subsidies, and penalties for noncompliance will likely result in widespread confusion.

Eligibility for the public subsidies will be determined on an individual's income from the previous year; meanwhile, Medicaid eligibility is determined on current income. There is also a Medicaid standard of allowing states 45 days for determining eligibility. Since an individual is required to enroll in Medicaid if eligible, a person may not know whether he or she is eligible for Medicaid or a subsidy. Moreover, individuals are required to pay the government back for receiving the wrong amount of subsidy.[9]

Bail Out, Take Over. Additional details are needed to obtain an accurate picture of who will be receiving public subsidies and why. Further, a federal takeover of the insurance market is not needed in order to provide subsidies to individuals in need of such assistance. The CBO has made it clear that the new gateways, exchanges, and government health plans will not lower the cost of care. So what is the purpose?

The goal of lower health care costs has been abandoned for an entirely different goal of making more Americans dependent upon the federal government.

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8. The House definition of essential health benefits includes coverage that "provides payment for the items and services…in accordance with generally accepted standards or medical or other appropriate clinical or professional practice" (America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong., 1st Sess., Section 121). In the Senate bill, government-funded "gateways," to be established in the states, are created to connect people with subsidies to health plans. In the Senate bill, for example, a health plan that is not a "qualified health plan" is prohibited from participating in the Senate-created gateways. The gateways will determine whether a health plan is "in the interests" of individuals and employers.
9. See Section 3111 ("Provision on Overpayments") of the Senate HELP Committee bill.