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A Closer Look at the House Democrats' Health Care Bill

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The House of Representatives will soon vote on a massive overhaul of America's $2.4 trillion health care system. This amounts to one-sixth of American gross domestic product (GDP), a sector roughly equal to the size of the entire British economy.

To accomplish this task, House Speaker Nancy Pelosi (D–CA) recently unveiled a 1,990-page House health care bill (H.R. 3962). The latest product, which dwarfs the 1,342-page Clinton health plan of 1993, is the result of the merging of three committee versions of the original House health care proposal (H.R. 3200). Like its massive predecessor, H.R. 3962 contains page after page of highly prescriptive legislation that would centralize power over the health care system in Washington. New bureaucracies and government programs, along with the expansion of existing entitlements and higher taxes, would give federal lawmakers ultimate control over what kind of health insurance Americans carry, where they get it, and how much they pay for it.

Federal Control of Health Care. The new House bill would dramatically increase the role of the federal government in health care. H.R. 3962 creates a new minimum federal standard benefit package that would eventually apply to nearly all health plans. It establishes a new "Health Benefits Advisory Committee," housed within the Department of Health and Human Services (HHS), that would make detailed recommendations, which the HHS Secretary would then impose on all private insurers and employers through regulation.

All existing employment-based health insurance coverage would have to be modified or replaced to meet the new federal benefit package by 2018. Starting in 2013, all new individual or employment-based coverage would have to conform to the federal minimum benefit rules.

The bill also limits age rating of premiums to no more than a two-to-one difference between the highest and lowest premium costs. Thus, a 64-year-old could not be charged more than twice the premium of an 18-year-old. However, there is about a five-to-one natural difference in the consumption of medical care between a 64-year-old and an 18-year-old. Thus, the effect will be to significantly increase the cost of health insurance for young adults in their 20s and 30s.

Finally, under H.R. 3962, HHS is given extremely vague orders to "establish a process for the annual review of increases in premiums for health insurance coverage" and further specifies that "the process shall require health insurers to submit a justification for any premium increases prior to implementation of the increase." This is an open invitation to politicized federal insurance rate regulation that could result in insurers being prevented from raising rates

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to cover increased claims costs, potentially forcing insurers into insolvency and leaving policyholders liable for provider claims.

Creating an Uneven Playing Field. The new bill contains a slightly revised version of the "public option," a new government-run health plan designed to compete against private health plans in a "national health exchange." In year one, employers with 25 employees or fewer would become eligible for the exchange. In year two, employers with 50 employees or fewer would become eligible, and in year three, employers with at least 100 employees would become eligible. Starting that year, the "Health Choices Commissioner" would be able to expand employer participation as appropriate, "with the goal of allowing all employers access to the exchange."

To attract moderate Democrats in the House who are concerned about the impact of adopting low Medicare reimbursement to physicians and hospitals, Speaker Pelosi modified the bill to have the government "negotiate" rates with medical providers. The Congressional Budget Office (CBO) predicts that if the public plan were to truly negotiate reimbursement rates, the public plan would actually cost more than private plans. Since the intent of the public plan is to drive down costs, the reality is that "negotiated" rates today will lead to price controls tomorrow. Look no further than the history of Medicare. Medicare was initially designed to pay private rates, but the program now has a complex formula for administered pricing combined with a rigid system of price controls.

In the end, by opening the exchange to more Americans and creating an uneven playing field between the public plan and private plans, more Americans will enroll in the public plan. As enrollment in the public plan soars, private insurers will be unable to keep up with the artificially low cost of the government plan. Worse yet, the public plan's reimbursement rates would not cover the cost of care, forcing many hospitals and physicians to close their doors.

Expanding Medicaid Dependence. The Speaker's mammoth health legislation includes the largest Medicaid expansion in history, adding as many as 18 million people to the program. Not only will childless adults become eligible for Medicaid for the first time in the history of the program, but approximately 5 million children who have been served under the successful and popular State Children's Health Insurance Program (SCHIP) will also be transferred into Medicaid.

For more than 10 years, states have decided whether to run their SCHIP programs as a separate non-Medicaid program or as a Medicaid expansion. A separate SCHIP program provides states with greater flexibility in managing benefits, service delivery, and eligibility.

Under the current SCHIP program, there is no individual entitlement, and eligibility is reserved only for those who were previously uninsured. States had the flexibility to impose a waiting period to protect against families dropping their private coverage. All of this will be overridden under the new legislation. State SCHIP programs will be dismantled.

Lastly, the Centers for Medicare and Medicaid Services, in an analysis of H.R. 3200—where the Medicaid expansion was to 133 percent of the federal poverty level (FPL), not the proposed 150 percent FPL in the current bill—shows that Medicaid spending would surpass Medicare spending and grow nearly twice as fast as spending in employer sponsored insurance. By 2019, one in five health care dollars will be spent through Medicaid. More than half of all health spending would flow through Medicare, Medicaid, or other public spending by 2019.[1]

New Taxpayer-Funded Subsidies. The House bill also extends generous taxpayer-funded subsidies to individuals and families with incomes up to 400 percent FPL (roughly $90,000 for a family of four) for coverage purchased through the new health exchange. In addition to premium subsidies, individuals and families with incomes below 350

1. Richard S. Foster, "Estimated Financial Effects of the 'America's Affordable Health Choices Act of 2009' (H.R. 3200), as Reported by the Ways and Means Committee," U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, October 21, 2009, at *http://www.politico.com/static/PPM145_091021_fratesmemo.html* (October 28, 2009). For a description of the Office of the Actuary's Health Reform Model, see the appendix attached to Foster's memo.

percent FPL (roughly $80,000) could also receive cost-sharing subsidies to cover a portion of their out-of-pocket costs. Premium subsidies would be tied to lowest-cost "basic" plans in the exchange, and for the first two years, those receiving a subsidy could only purchase the basic plan, regardless of their desire to pay for additional services.

CBO estimates an average premium of $15,000 for a "basic" family plan with cost-sharing of about $5,500. Based on the CBO analysis, a family just under 300 percent FPL (roughly $70,000) could receive up to $10,500 in federal subsidies ($8,700 for the premium and $1,800 for cost-sharing) to cover more than half of its health care costs.

Although some Americans would receive lavish subsidies, the bill creates huge inequities. For instance, with the exception of a hardship exemption of 12 percent of income, the bill would exclude those individuals with access to employer coverage from receiving a subsidy. Therefore, a similarly situated family at 300 percent FPL (roughly $70,000) struggling to pay for their current employer-sponsored plan would generally not receive assistance at all. Neither would a family at 200 percent FPL (roughly $45,000) with employer-based coverage.

The bill also excludes individuals from receiving the subsidies if they are eligible for Medicaid. Incidentally, the bill would freeze existing Medicaid eligibility levels at the state level to prevent states from lowering their Medicaid programs in favor of the federal subsidy. Without financial assistance, the only rational option for these low-income Americans is to join Medicaid, a substandard health care program. This situation would perpetuate the two-tiered health care system that permanently segregates lower-income Americans, as well as those often classified as poor, from the rest of America.

New Mandates on Individuals and Employers. The new House bill, like its predecessor, increases the financial burden on low- and moderate-income Americans through individual and employer mandates.

The bill requires the uninsured to pay an extra income tax—2.5 percent of adjusted gross income above the filing threshold, capped at the national average premium. The tax would also apply to persons who have health insurance that does not qualify as "acceptable" coverage under the new federal standards. Those paying this tax would remain uninsured. However, low- and moderate-income individuals and families would have to pay higher premiums than they would otherwise pay for health coverage to avoid the tax. Those premiums would increase rapidly with income, amounting to an additional tax on those with incomes below four times the FPL (about $88,000 per year for a family of four) ranging from 1.5 percent to 12 percent. This tax on low- and moderate-income Americans would be in addition to a "surtax" of up to 5.4 percent on higher incomes.

The bill also imposes a new 8 percent payroll tax on employers who do not cover specified percentages of their employees' health insurance. Employers would have to get the money to pay the tax somewhere, and much of it would come from cutting wages or other benefits. This tax would also not go to pay for any coverage; the bill specifically says that the tax paid by the employer "shall not be applied against the premium of the employee." Furthermore, since the amount of this tax would be lower than the cost of providing health insurance (especially for low-income workers), many employers would opt to pay the tax and not offer health plans, disrupting their employees' existing coverage.

Furthermore, health plans would have to meet new requirements defined by the new Health Choices Commissioner. Insurers and employer-based plans would have five years to bring their plans into compliance. The commissioner could require coverage of services people do not want (increasing premiums) and then in the name of "cost containment" prohibit plans from covering services people want but that the commissioner does not want.

Billions in New Taxes. The new House health care plan includes several tax increases that would cost taxpayers $700 billion over the next 10 years. In addition to the surtax, employer mandate, and individual mandate provisions found in the original bill, H.R. 3962 adds on several new taxes.

The new plan establishes a 5.4 percent surtax on joint filers with over $1 million in adjusted gross income or $500,000 for single filers. This surtax is

not based on final adjusted gross income but instead on modified gross income, thereby increasing the overall effect of the tax.

This surtax is also not indexed to inflation. This would cause more and more taxpayers to be hammered by the surtax even as their real income does not increase. This is one reason the Joint Tax Committee expects the cost of the surtax to more than double in 10 years, from $30.9 billion in 2011 to $68.4 billion in 2021, and that taxpayers will be forced to pay $460.5 billion in higher taxes due to this provision.[2] This is a larger tax increase than the 1993 Clinton income tax increase provisions.

The House bill also limits contributions to flexible spending accounts (FSAs) to $2,500 per year and limits the ability of FSAs or health savings accounts to purchase goods by excluding over-the-counter drugs. It also taxes medical devices and self-insured health plans.

The Real Cost. The CBO's preliminary estimate of H.R. 3962 puts the total cost of the health care coverage provisions at $1.05 trillion (with offsets bringing the net cost down to close to $900 billion).[3] But there are other spending provisions in the bill that the CBO has not accounted for, such as special funding for prevention and wellness, increases in the federal Medicaid matching rate, and Medicaid reimbursement for primary care physicians.

Former CBO Director Donald Marron calculates that these additional provisions would add $217 billion to the total cost of the House health care bill, raising the total cost to almost $1.3 trillion.[4] Moreover, although the score is technically a 10-year score, it is not a 10-year cost under full implementation. A full 10-year cost puts the total close to $2.4 trillion.[5]

The real price tag for taxpayers gets higher when the cost of fixing the scheduled Medicare cuts to physicians is included. While House leaders propose to separate it from the larger bill in order to make their health care spending agenda appear less expensive, the CBO estimates the 10-year cost for this "doc fix" at over $200 billion. As of this writing, it is not clear whether House leaders will find a way to offset the "doc fix" or simply add the extra spending to the already massive increase in deficit spending.

One thing is certain: In the end, the House bill would cost more than the President's promised $900 billion price tag. As with previous health care programs, it will likely cost even more than its current estimated price tag: $1.5 trillion.

Ineffective Treatment. The new House bill is clearly just more of the same. Higher taxes and increased government intervention will not improve health care, and increasing enrollment in costly and troubled government programs will only add to the rising costs of care.

Congress should take a step-by-step approach to fix what is clearly broken in this massive sector of the economy. For doctors and patients alike, it should adopt changes to financing and delivery that would put the country on a path to expanded coverage, higher quality care, and greater innovation. It should tackle the perverse incentives that drive health care costs up, and it should empower individuals and families to control their health care. That is a far superior policy than trying to micromanage and maintain a broken system.

2. Joint Committee on Taxation, "Estimated Revenue Effects of Possible Modifications to the Revenue Provisions of H.R. 3962, the "Affordable Health Care for America Act," October 29, 2009, at *http://jct.gov/publications.html?func=startdown&id=3619* (November 6, 2009).
3. Congressional Budget Office, "Preliminary Analysis of the Insurance Coverage Provisions Contained in H.R. 3962," October 29, 2009, at *http://cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf* (November 6, 2009).
4. Donald Marron, "The House Health Bill Costs Almost $1.3 Trillion," Dmarron.com, October 30, 2009, at *http://dmarron.com/2009/10/30/the-house-health-bill-costs-almost-1-3-trillion* (November 6, 2009).
5. Press release, "Gregg: House Bill Is a Runaway Train to More Debt and a Government Takeover of Our Health System," office of Senator Judd Gregg (R–NH), November 5, 2009, at *http://budget.senate.gov/republican/pressarchive/2009-11-05HouseBill.pdf* (November 6, 2009).

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