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A Study of Flawed Democrat Solutions on Healthcare



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Despite Obama’s [promise](#) to bring all parties together to negotiate in front of the American people and the shifting political makeup in the Senate, Democrats are continuing to push their flawed agenda through closed door negotiations without any Republican input. Republicans believe that patient-centered health care reform is vital, however a government—takeover of health care is not a positive solution that conservatives can embrace.

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Public Option

Liberal Democrats keep touting the idea of a government-run insurance plan, and President Obama argued in his speech last year before the joint session of Congress that a public option would promote choice and competition. Nothing could be farther from the truth. As John Hoff [explains](#), rather than competing on a level playing field, as President Obama claims, “the ‘competition’ would be rigged,” and the public option would enjoy “a number of advantages.” Among other favored positions, the public option would not face the challenges of taxes, licensing, and tort litigation placed upon private plans. For example, under the House-passed bill, the government-run plan is supposed to “negotiate” payment rates with health care providers. Since there is no definition for negotiate, many fear that the Secretary will follow Medicare and Medicaid by setting reimbursement rates well below cost, allowing the government to lower the price of their plan for consumers. All of these benefits would **allow the government plan to undercut private insurance companies**. In effect many conservatives feel that the public option is a backdoor method of bringing America closer to a single payer system. Hoff [argues](#), “Coupled with the federal regulatory system that the legislation would impose on the remaining private plans, this would clearly by itself constitute a government takeover of health care.”

Although the government-run plan with a state-opt out was removed in the Senate bill, it still allows for the federal government, through the Office of Personnel Management (OPM), to run, oversee and “negotiate” with new “Multi-State” plans offered in State Exchanges and available nationwide. These plans are similar to a government-run plan in that they would not be able to make decisions without first obtaining clearance from OPM, could be given a competitive advantage, and are the only plans that would be able to “compete” at the national level. At least one of the “Multi-state” plans must be non-profit, and at least one plan must not offer coverage of abortions. In order to be “qualified,” a plan must still be licensed in each state and meet all state and federal requirements including newly established standards for medical loss ratios, profit margins, benefits, premiums and other insurance regulations.

For More Information:

John S. Hoff, “The Public Health Insurance Option: Unfair Competition on a Tilting Field,” Backgrounder #2311, The Heritage Foundation, August 26, 2009, <http://www.heritage.org/Research/HealthCare/bg2311.cfm>.

Stuart M. Butler, “The Case Against: The public plan will unfairly crowd out private coverage,” The Heritage Foundation, July 28, 2009, <http://www.heritage.org/Press/Commentary/ed072809e.cfm>.

“The Impact of the American Affordable Health Choices Act of 2009,” Center for Health Policy Studies, The Heritage Foundation, July 28, 2009, http://www.heritage.org/research/healthcare/upload/Lewin_public_plan_National_all.pdf.

Robert E. Moffit, “The Public Health Plan Reincarnated: New-and Troubling-Powers for OPM,” The Heritage Foundation, January 21, 2010, <http://www.heritage.org/Research/HealthCare/bg2364.cfm>

Causes a Drop in Coverage and Quality

One only needs to look at Medicare and Medicaid to see that government health programs provide substandard care. Both are notorious for their lack of coverage. Scott Gottlieb [explains](#), “From 1999 to 2007, Medicare denied access in a third of the treatments it evaluated through its coverage process, taking an average of eight months to complete its reviews. When coverage was granted, in 85% of cases the treatments were restricted, usually to patients with more advanced illnesses.” Furthermore, according to the American Medical Association’s (AMA) [National Health Insurer Report Card](#) for 2008, Medicare, when compared to private plans, is the largest denier of claims. As the Heritage Foundation [notes](#), although the government run-health plan may appear to be less expensive, the extra costs are passed on to doctors “in administrative costs and lower reimbursements.” Because the missing money must come from somewhere, ultimately the costs are passed onto the private insurance industry and private consumers. In fact, [according](#) to Joseph Antos and Grace-Marie Turner, “Providers could not keep their doors open without the higher payments from private insurers.” Milliman, an independent actuarial firm, [estimated](#) that the annual cost shift from Medicare and Medicaid to private insurers was \$88.8 billion. Individual families under a private plan paid an average of \$1,788 more per year to compensate for the underpayment of Medicare and Medicaid. If the [Lewin Group](#) is correct that millions of Americans would end up under the public option, the resulting burden of additional costs would further undermine the private system. **If a majority of Americans enrolled in the public option, it is unlikely that the private system could sustain the extra weight, resulting in a deterioration of health care quality for all Americans.**

For More Information:

“The Public Health Care Plan: What Seems to Be the Problem?” Fact Sheet #29, The Heritage Foundation, May 21, 2009, <http://www.heritage.org/Press/FactSheet/fs0029.cfm>.

Scott Gottlieb, “How the U.S. Government Rations Health Care,” Wall Street Journal, October 1, 2009, reprinted under The American Enterprise Institute for Public Policy Research, <http://www.aei.org/article/101092>.

Grace-Marie Turner and Joseph Antos, “Medicare Is No Model for Health Reform,” *Wall Street Journal*, September 11, 2009, <http://online.wsj.com/article/SB10001424052970204884404574362543878647858.html>.

Will Fox and John Pickering, “Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Players,” Milliman, December 2008, <http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf>.

Michael Cannon, “How Can I Ration Your Medical Care? Let Me Count the Ways,” *Townhall Magazine*, September 2009, available from the Cato Institute, <http://www.cato.org/pubs/articles/cannon-obamacare-townhall-magazine.pdf>.

N. Gregory Mankiw, “The Pitfalls of the Public Option,” *New York Times*, June 28, 2009, available from the American Enterprise Institute, <http://www.aei.org/article/100694>.

The Exchange

Although many conservatives have long touted the benefits of a health insurance market where consumers could shop for various plans across state lines, the Democrat formulation of the “exchange” is fundamentally flawed. The two bills differ (the House bill creates one central national exchange and the Senate bill creates an exchange in each state) but are equally problematic. Under both versions, **the government would not only act as an umpire in the exchange**, setting the rules for competition, but as Heritage scholar Robert Moffit [explains](#), **“It would also enter into the competition as a player.”** There would likely be many incentives for the government to unfairly provide an advantage to its own plan by setting the “plan premiums artificially low” and “reducing or eliminating cost-sharing requirements,” at the expense of private plans.

Giving the government too much control over the rules of the exchange is also problematic. For example, under H.R. 3962 and H.R. 3590, the Health Benefits Advisory Committee and Secretary of Health and Human Services (HHS) respectively are given broad latitude to dictate the benefit packages of plans operating in the exchange. By setting the benefits for all of these plans, in effect the Committee or Secretary, not the consumer, would be the one choosing the health care of millions of Americans. In fact, in order to make competition “[fair](#)” in the exchange, according to Robert Moffit, the government would have to “make sure that the health benefits and payment schedules for the private plans are comparable,” resulting in a “a centralized federal standardization of health benefit offerings on America’s private health plans.”

For More Information:

Robert E. Moffit, “Government as ‘Competitor:’ The Latest Prescription for Government Control of Health Care,” WebMemo #2024, The Heritage Institute, August 14, 2008, <http://www.heritage.org/Research/HealthCare/wm2024.cfm>.

Robert E. Moffit, “A Federal Health Insurance Exchange Combined with a Public Plan: The House and Senate Bills,” Backgrounder #2304, The Heritage Foundation, July 30, 2009, <http://www.heritage.org/Research/HealthCare/bg2304.cfm>.

Thomas P. Miller, “Health Exchanges: Different Political Railroad Tracks to the Same Station?” HealthAffairs.org, September 4, 2009, available from the American Enterprise Institute for Public Policy Research, <http://www.aei.org/article/100984>.

Michael F. Cannon, “Fannie Med? Why a “Public Option” Is Hazardous to Your Health,” Cato Institute: Policy Analysis, July 27, 2009, http://www.cato.org/pub_display.php?pub_id=10382.

Stuart M. Butler, “Exchange We Can Believe In,” The Heritage Foundation, November 14, 2008, <http://www.heritage.org/Press/Commentary/ed111308c.cfm>.

State Co-ops

The Senate and House bills create state Consumer Operated and Oriented Plan (CO-OP) Programs where individuals who do not have insurance through their employers can buy health insurance. Although not as insidious as the Democrats' version of the "public option," this proposal is still problematic. While some conservatives have touted the benefits of independent co-ops, under the proposed legislation, \$6 billion of federal funding will be provided for startup loans and grants for the creation of additional not-for-profit insurance companies. The CO-OPs would only have to pay back the loans or grants plus interest if they violate the terms of the program. Otherwise they are financed on the back of the taxpayer with **no prohibition on the CO-OP from receiving a bail-out if it fails.**

The House and Senate bills also give broad regulatory powers over the co-ops to the Commissioner and HHS Secretary respectively. **By funding and regulating these new co-ops, the government is in essence creating a new federal health insurance program.** As the Heritage Institute Center for Health Policy [explains](#), the co-op legislation "could be a back door to a public plan flying under a different flag."

For More Information:

"The Baucus Health Bill: A First Look," WebMemo #2619, Center for Health Policy, The Heritage Foundation, September 17, 2009, <http://www.heritage.org/Research/HealthCare/wm2619.cfm>.



Individual Mandate

One idea often touted by Democrats is an individual mandate, which they feel is necessary in order to achieve universal coverage. Americans must either purchase health insurance or pay a fine. This provision is a serious imposition on the freedom of all Americans as it forces Americans to purchase “acceptable” health care coverage or face a tax of 2.5% of modified adjusted gross income (MAGI). This mandate will be the first time in our nation’s history that the government has required individuals to buy any good or service as a condition of lawful residence or has regulated Americans simply for existing (taxed for **not** entering into economic activity). In addition to being unconstitutional, **an individual mandate necessitates a government definition of acceptable health care coverage.** Because the benefit packages found in the Democrats’ health care bills are quite large (or in some cases still to be determined by a new Commissioner or “health Czar,” an unelected bureaucratic board or the Secretary of HHS), it is likely that millions of Americans would be unable to keep their existing health care coverage and be forced to pay for more expensive health insurance, participate in a public option, or pay a fine. Especially noteworthy, is the de facto elimination of the private individual market plans and exclusion of most or all Health Savings Accounts from the definitions of acceptable coverage.

In order to enforce an individual mandate, **it is likely that the privacy of all Americans would be further subject to IRS scrutiny.** As Heritage [explains](#), under the Senate bill, individuals, insurers, and employers would be required to submit detailed health insurance information to the IRS, and the IRS in turn would be required to report income data to state exchanges, insurance companies, and employers “because premium credits and out-of-pocket limits would depend on income.”

Penalty schemes for not having health care coverage differ. Under the Senate bill, the penalty is tied to a flat dollar amount (up to \$750 or 2% of taxable income) up to the national average of the “Bronze” (lowest value) plan premium, bringing in \$15 billion in tax revenue. Under the House bill, individuals who do not have qualifying coverage must pay a tax of either 2.5% of modified adjusted gross income, not to exceed the average premium price in the Exchange.

The individual mandate assumes that government is better at determining the needs of individual Americans, than the American citizens themselves. Estimates vary, but [according to](#) Michael Tanner, a senior fellow at the Cato Institute, one quarter of the uninsured are eligible for Medicaid and SCHIP, but have chosen not to enroll. One study [concluded](#) that as many as three-quarters of the uninsured could afford health insurance, but have chosen not to buy it. Michael Cannon [argues](#) that the financial burden placed upon American citizens by an insurance mandate is worse than a public option. CBO [reported](#) that average individual premiums (i.e. insurance not purchased through an employer or group health plan) under the Senate bill, would rise by 10 to 13%. Including an individual mandate is simply another method of giving the government control over the health choices of the American people.

For More Information:

Michael F. Cannon, “All the President’s Mandates: Compulsory Health Insurance is a Government Takeover,” Briefing Paper no. 114, Cato Institute, September 23, 2009, http://www.cato.org/pub_display.php?pub_id=10576.

Robert A. Book, Guinevere Nell, and Paul L. Winfree, “The Baucus Individual Health Insurance Mandate: Taxing Low-Income and Moderate-Income Workers,” Backgrounder #2325, The Heritage Foundation, September 25, 2009, <http://www.heritage.org/Research/HealthCare/bg2325.cfm>.

“The Baucus Health Bill: A First Look,” WebMemo #2619, Center for Health Policy, The Heritage Foundation, September 17, 2009, <http://www.heritage.org/Research/HealthCare/wm2619.cfm>.

Grace-Marie Turner, “Compulsory Insurance Has Consequences,” *The Washington Examiner*, September 25, 2009, available from The Galen Institute, http://www.galen.org/component,8/action,show_content/id,13/blog_id,1281/category_id,9/type,33/.

Michael D. Tanner, “Who Are the Uninsured?” CATO Institute, August 20, 2009, http://www.cato.org/pub_display.php?pub_id=10449.

Kate M. Bundorf and Mark V. Pauly, “Is Health Insurance Affordable for the Uninsured?” *National Bureau of Economic Research*, Working Paper No. W9281, October 2002, available from the Social Science Research Network, <http://ssrn.com/abstract=341850>.

Douglas W. Elmendorf, Letter to the Honorable Evan Bayh providing “an analysis of how proposals being considered by Congress to change the health care and health insurance systems would affect premiums,” Congressional Budget Office, November 30, 2009, <http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf>.



Employer Mandate

While unemployment hovers at 10%, Democrats are finding new ways to place higher costs on businesses. Requiring employers to provide health insurance for their employees is just as problematic as the individual mandate. Varying versions of the so-called “pay or play” mandate exist, placing large burdens on American businesses. Under H.R. 3962, employers would be forced to pay 72.5% of their employees’ “qualified” health insurance premiums (65% of family coverage) or face an excise tax of 8% on wages. The Senate bill, H.R. 3590, requires employers to pay a \$750 fine per full-time employee – if at least one of its full-time employees enrolled in an exchange plan and received a premium subsidy. Furthermore, both bills stipulate that even if an employer offers coverage but an employee decides to opt out and enroll in an exchange plan (if the employer coverage is deemed “unaffordable”), it will still be subject to a penalty. In a time when employers are already facing economic hardship, **an employer mandate simply imposes new costs on businesses, which in turn makes it less likely that they will be able to create new jobs.** As the Heritage Foundation [points out](#), ultimately the costs of an employer mandate will be passed on to employees in the form of lower wages. Rather than encouraging economic growth, the Democrats’ health care bills will further stifle the economy. **Both bills would essentially encourage employers to drop coverage and dump people into an exchange rather than pay the increased rates associated with the costly mandates.**

These new requirements do not just apply to large businesses; **small firms will be affected as well.** Under H.R. 3962, small businesses with payrolls over \$500,000 will be subject to a graduated penalty starting at a minimum of \$10,000. The Heritage Foundation [reports](#) that as many as 330,839 businesses with fewer than 25 workers would be subject to penalties. **Like the individual mandate, the payroll exemption is not indexed and thus over time fewer small businesses will qualify for an exemption.** Under the House and Senate bills, businesses with 25 or fewer employees would receive a graduated tax credit (albeit temporary and insufficient) to help cover the cost of health care. Instead, firms with 50 to 75 employees will experience the most difficulties (the fee placed on employers who do not offer health care applies to businesses with 50 or more employees). By giving tax credits to businesses with 25 or fewer employees, and assessing a penalty on businesses with 50 or more employees who do not provide health care coverage, the Senate bill will create a strong disincentive for small businesses to expand. The added cost of going over 50 employees (or loss if going over 25) will discourage, rather than promote growth.

Finally, implementing an employer mandate does not fix one of the fundamental problems in the current health insurance system— [portability](#). Instead, an employer mandate would only exacerbate the problem. Rather than being able to take their plans with them from job to job, workers would face health insurance change or loss (unless they bought the public option or “qualified” insurance through the exchange).

For More Information:

James Sherk and Robert A. Book, “Employer Health Care Mandates: Taxing Low-Income Workers to Pay for Health Care,” WebMemo #2252, The Heritage Foundation, July 21, 2009, <http://www.heritage.org/Research/HealthCare/wm2552.cfm>.

Robert A. Book and Edmund F. Haislmaier, "Senate 'Free Rider' Penalties: Taxing the Poor to Pay for Health Care," WebMemo #2516, July 1, 2009, The Heritage Foundation, <http://www.heritage.org/Research/HealthCare/wm2516.cfm>.

D. Mark Wilson, "House Health Care Bill Will Hurt small Businesses: A Reply to My Critics," WebMemo #2606, The Heritage Foundation, September 4, 2009, <http://www.heritage.org/Research/HealthCare/wm2606.cfm>.

Grace-Marie Turner, "Employer Health Care Mandate Would Make a Terrible System Worse," New York Daily News, September 3, 2009, available from the Galen Institute, [http://www.galen.org/component.8/action.show_content/id.13/blog_id.1268/category_id.9/type.33/](http://www.galen.org/component/8/action.show_content/id.13/blog_id.1268/category_id.9/type.33/).

John L. Ligon, "The Pelosi Health Care Plan: Employer Mandate Penalties on Small Businesses," WebMemo #2683, The Heritage Foundation, November 5, 2009, http://www.heritage.org/Research/HealthCare/wm2683.cfm#_ftn4.

John L. Ligon, "The Baucus Plan: Implications for Small- and Medium-Sized Firms," WebMemo #2656, The Heritage Foundation, October 20, 2009, <http://www.heritage.org/Research/HealthCare/wm2656.cfm>.

Ryan Ellis, "Comprehensive List of All Tax Hikes in Senate Government Health Bill," Americans for Tax Reform, November 23, 2009, <http://www.atr.org/userfiles/111809pr-comptaxreid%283%29.pdf>.

"Going Out of Business: How ObamaCare Will Hurt American Businesses," Fact Sheet #40, The Heritage Foundation, September 23, 2009, <http://www.heritage.org/Press/FactSheet/fs0040.cfm>.



Reductions in Medicare Advantage

Although House and Senate proposals differ in their changes to Medicare Advantage, both would result in a reduction of seniors' benefits. Currently Medicare Advantage provides a way for seniors to choose privately-owned health plans, instead of relying on traditional Medicare. As Michael Tanner [explains](#), Medicare Advantage plans receive payments “that average 14% more than traditional fee-for-service Medicare, something that Democrats have derided as wasteful.” The higher payments, however, allow private plans participating in Medicare Advantage to offer “benefits not included in traditional Medicare,” such as preventive care, routine eye and ear exams, glasses, hearing aids, greater prescription coverage, and stays in skilled nursing facilities.

Even though Medicare Advantage was originally created to alleviate the problems found under the fee-for-service payment method in traditional Medicare, the House bill changes Medicare Advantage to pay seniors based on the fee-for-service cost level in each county. The Chief Actuary of the Centers for Medicare and Medicaid Services [reported](#) that the bill passed by the House, H.R. 3962, would “reduce MA rebates to plans and thereby result in less generous benefit packages.” By cutting Medicare Advantage, **Democrats would effectively make the choice of additional coverage found under private insurance unfeasible for millions of senior citizens.** Ultimately, CMS [estimated](#) that enrollment under Medicare Advantage would decrease by 8.5 million, which would force many seniors back into traditional Medicare.

The Senate bill also changes the payment system, and [according to](#) CBO, H.R. 3590 would reduce Medicare Advantage spending by \$118 billion. The Senate bill would make benefits offered under Medicare Advantage plans more homogenous, offering seniors less choice rather than more. CBO [reports](#) that the extra benefits (such as vision and dental care) offered by Medicare Advantage plans would be reduced from \$135 to \$49 per month in 2019 under H.R. 3950. **Rather than improving coverage, the Democrat changes to Medicare Advantage would restrict it.**

For More Information:

James Capretta and Robert Book, “The Wrong Medicare Advantage Reform: Cutting Benefits, Limiting Choices, and Increasing Costs,” WebMemo #2671, The Heritage Foundation, October 30, 2009, <http://www.heritage.org/Research/HealthCare/wm2671.cfm>.

Robert E. Moffit, “The Baucus Bill: Medicare Advantage and Medicare Savings Lost to Medicare Reform,” WebMemo #2641, The Heritage Foundation, October 5, 2009, <http://www.heritage.org/Research/HealthCare/wm2641.cfm>.

Douglas W. Elmendorf, Letter to the Honorable Harry Reid on the “estimated changes in direct spending and revenues resulting from the Patient Protection and Affordable Care Act, incorporating the Manager’s Amendment” Congressional Budget Office, December 19, 2009, http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf

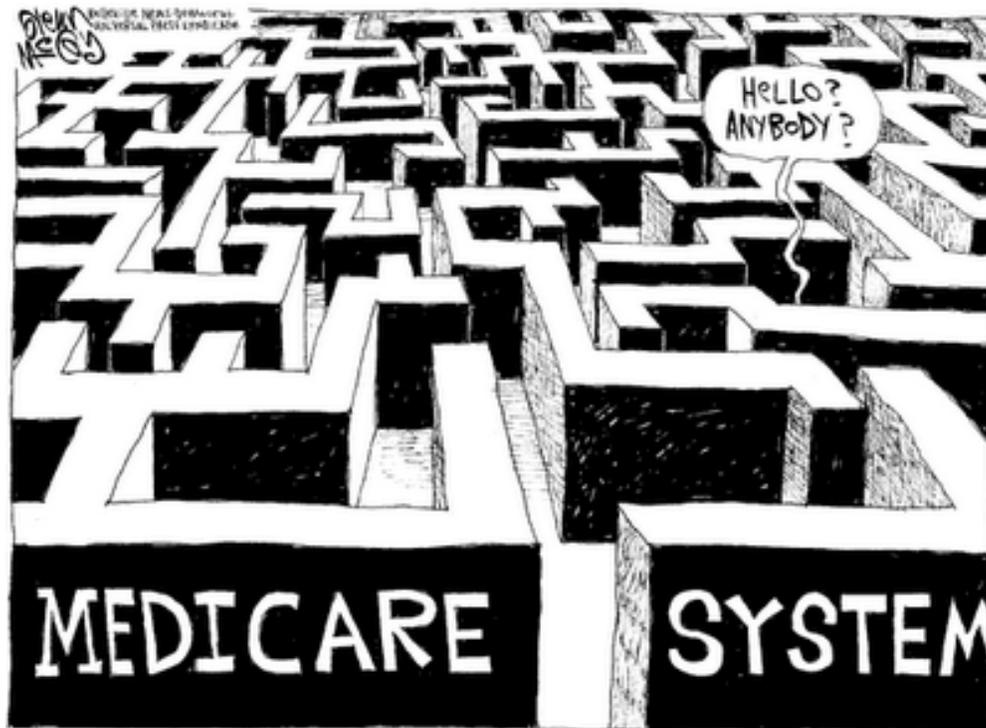
Richard S. Foster, “Estimated Financial Effects of the ‘America’s Affordable Health Choices Act of 2009’ (H.R. 3962), as Passed by the House on November 7, 2009,” U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, November 13, 2009,

http://republicans.waysandmeans.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_H.R._3962_11-13-09_.pdf.

“Comparison of Projected Enrollment in Medicare Advantage Plans and Subsidies for Extra Benefits Not Covered by Medicare Under Current Law and Under the Patient Protection and Affordable Care Act,” Congressional Budget Office, November 21, 2009,.

http://www.cbo.gov/ftpdocs/107xx/doc10731/Effects_of_PPACA_on_MA_Enrollment_and_Extra_Benefits_Not_Covered_by_Medicare.pdf.

Michael Tanner, “Halfway to Where? Answering the Key Questions of Health Care Reform,” Policy Analysis, No. 643, The Cato Institute, September 9, 2009, <http://www.cato.org/pubs/pas/pa643.pdf>.



Medicaid Eligibility Increase

Both House and Senate bills involve massive expansions of Medicaid eligibility levels. Increasing Medicaid eligibility, however, will only extend a faulty program that provides substandard coverage, rather than providing low-income Americans with quality health insurance. Because Medicaid pays health care providers below cost, **many doctors no longer accept Medicaid patients** because they cannot afford to make up the difference. Doctors who do accept Medicaid patients are left unable to meet their expenses, or they pass on the costs to their other patients, placing a burden on private health insurance. Milliman, an independent actuarial firm, [estimated](#) that the annual cost shift from Medicare and Medicaid to private insurers was \$88.8 billion. Individual families under a private plan paid an average of \$1,788 more per year to compensate for the underpayment of Medicare and Medicaid. The expansion of Medicaid, coupled with the other new requirements and costs placed upon the private health insurers found under the Democratic health care bills, makes it unlikely that the private system would be able to sustain the added weight, resulting in a **deterioration of health care quality for all**.

Increasing Medicaid will also place **significant burdens on states** already struggling to meet their budgets. H.R. 3962 increases Medicaid eligibility to 150% of the FPL, an unfunded mandate that will cause states to shell out \$34 billion while dumping 15 million more people onto an already unsustainable entitlement program with poor patient access and care. CBO [estimated](#) that the Senate bill, H.R. 3590, would increase state spending on Medicaid by \$26 billion over the first 10 years to every state but Nebraska, which would receive 100% federal funding indefinitely. If eligibility for Medicaid was increased to only 133% of the federal poverty level (FPL), as under H.R. 3590, the Heritage Foundation [reports](#) that Medicaid populations in 33 states would jump by 30%, while Medicaid populations in 10 states would grow by 50%. While making the states pay more, the expansion of Medicaid found under the House-passed bill takes oversight authority away from states and places it in the hands of the federal government. As Heritage scholar Dennis Smith [explains](#), it would be the federal government that would make the eligibility decisions and create new standards for Medicaid. Providing health care coverage by expanding a flawed program, and taking power way from the states, is not the solution for health care access.

For More Information:

Dennis G. Smith, "Why Congress Wants to Force More Americans into Medicaid," WebMemo #2662, The Heritage Foundation, October 21, 2009, <http://www.heritage.org/Research/HealthCare/wm2662.cfm>.

Dennis G. Smith, "Federalization of Medicaid: Health Reform Bill Would Reduce State Authority," WebMemo #2678, The Heritage Foundation, November 4, 2009, <http://www.heritage.org/Research/HealthCare/wm2678.cfm>.

Grace-Marie Turner and Joseph Antos, "Medicare Is No Model for Health Reform," *Wall Street Journal*, September 11, 2009, <http://online.wsj.com/article/SB10001424052970204884404574362543878647858.html>.

Douglas W. Elmendorf, Letter to the Honorable Harry Reid on the "estimated changes in direct spending and revenues resulting from the Patient Protection and Affordable Care Act, incorporating the Manager's Amendment" Congressional Budget Office, December 19, 2009, http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf

Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Players, Milliman, December 2008, <http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf>.

"The End of Federalism: How Obamacare Will Impact States," Fact Sheet #42, The Heritage Foundation, October 16, 2009, <http://www.heritage.org/Press/FactSheet/fs0042.cfm>.

Grace-Marie Turner, "Medicaid Expansions," The Galen Institute, September 21, 2009, http://www.galen.org/component,8/action,show_content/id,13/blog_id,1279/category_id,15/type,33/.

Edward Miller (Dean and CEO of John Hopkins), "Health Reform Could Harm Medicaid Patients," The Wall Street Journal, December 4, 2009, <http://online.wsj.com/article/SB10001424052748703939404574567981549184844.html?mod=djemEditorialPage>.



Cost

If there was no other reason to oppose the Democrats' health care legislation, the enormous cost should make most people think twice. At a time when the American economy continues to struggle, Democrats want to add trillions of dollars of new spending to an already burdened public. [Based on](#) the CBO score, H.R. 3962 would lead to \$1.052 trillion of new spending for FY2010-2019, but when the Medicare payment (SGR) fix is included, which Democrats separated out of the main bill and the additional discretionary spending for which CBO did not account, the actual cost of the Democrats' health reform is around **\$1.5 trillion**.

According to estimates from the Republican staff on the Senate Budget Committee, the "true cost" for the House bill, once the reforms are fully implemented (FY2014-2023), is [\\$3.04 trillion](#).

As former assistant CBO director Joseph Antos [explains](#), however, the CBO numbers are in many ways a "fiscal fantasy," since CBO only examines the ten-year impact of the bill, and the costliest provisions in the Senate bill do not go into effect until 2014. [According to](#) CBO, the Senate bill, H.R. 3590, increases spending by \$871 billion over ten years, however the "true cost" for the House bill, once the reforms are fully implemented (FY2014-2023), is [\\$2.31 trillion](#).

CBO itself [notes](#) in relation to H.R. 3962, "the bill would put into effect (or leave in effect) a number of procedures that might be difficult to maintain over a long period of time," and "the long-term budgetary impact of H.R. 3962 could be quite different if those provisions generating savings were ultimately changed or not fully implemented." Much of CBO's deficit-reduction estimates are unlikely to actually occur. In fact, the Cato Institute [reports](#) that health legislation could increase ten-year deficits by \$600 billion. As a Wall Street Journal article [points out](#), government programs have a history of exceeding their estimated costs. Today, Medicaid costs 37 times more than it did when it was originally created (and that is after adjusting for inflation). Medicare cost billions more than what was originally projected, largely because enrollment was much higher than expected. Rather than decreasing the deficit, the Democrat health care bills are far more likely to increase the federal debt. Regardless of what version of the Democrats' health care bills may emerge from the closed-door sessions, expect a staggering price tag that will be bore by our children and grandchildren.

For More Information:

"A Closer Look at the House Democrats' Health Care Bill," WebMemo #2684, The Heritage Foundation, Center for Health Policy and Center for Data Analysis, November 6, 2009, <http://www.heritage.org/Research/HealthCare/wm2684.cfm>.

Douglas W. Elmendorf, Letter to the Honorable Harry Reid on the "Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment," Congressional Budget Office, December 19, 2009, http://cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf.

Douglas W. Elmendorf, Letter to the Honorable John Dingell on the "estimate of the direct spending and revenue effects of H.R. 3962, the Affordable Health Care for America Act," Congressional Budget Office, November 6, 2009, http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf.

Douglas W. Elmendorf, Letter to the Honorable Chares Rangel, on “a preliminary analysis of H.R. 3962, the Affordable Health Care for America Act,” Congressional Budget Office, October 29, 2009, <http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf>.

Greg D’Angelo, “Congress’s Health Care Reform Bills: The Unknown Costs,” WebMemo#2646, The Heritage Foundation, October 9, 2009, <http://www.heritage.org/Research/HealthCare/wm2646.cfm>.

Robert E. Moffitt, “The Baucus Bill Grows Big Government,” The Heritage Foundation, October 13, 2009, <http://www.heritage.org/Press/Commentary/ed101309d.cfm>.

Donald Marron (former Acting Director of the CBO), “The House Health Bill Costs Almost \$1.3 trillion, October 30, 2009, <http://dmarron.com/2009/10/30/the-house-health-bill-costs-almost-1-3-trillion>.

Joseph Antos, “Health Reform: A Fiscal Fantasy Land,” *Forbes*, October 15, 2009, <http://www.forbes.com/2009/10/14/health-care-reform-max-baucus-opinions-contributors-joseph-antos.html>.

Stephen J. Entin, “CBO Underestimates Cost of the Senate Finance Health Bill, IRET Congressional Advisory, No. 259, Institute for Research on the Economics of Taxation, October 12, 2009, <http://iret.org/pub/ADVS-259.PDF>.

Lori Montgomery, “In health debate, those numbers are just numbers: The CBO’s price tags are educated guesses, but guesses nonetheless,” *The Washington Post*, October 19, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/18/AR2009101802541.html>.

Daniel Mitchell, “Will Federal Health Legislation Cause the Deficit to Soar?” *Tax & Budget Bulletin*, No. 58, The Cato Institute, November 2009, <http://www.cato.org/pubs/tbb/tbb-58.pdf>.

“Health Costs and History: Government programs always exceed their spending estimates,” *The Wall Street Journal*, October 20, 2009, <http://online.wsj.com/article/SB10001424052748703746604574461610985243066.html#articleTabs%3Darticle>.

Martin Feldstein, “ObamaCare’s Crippling Deficits,” *The Wall Street Journal*, September 8, 2009, available from the American Enterprise Institute, <http://www.aei.org/article/100992>.

Michael D. Tanner, “Despite New Deficit-Cutting Claim, Baucus Bill is Just Tax-and-Spend,” *Investor’s Business Daily*, October 8, 2009, available from the Cato Institute, http://www.cato.org/pub_display.php?pub_id=10622.

Michael Barone, “Conceptual Language’ Hides Health Care’s Cost,” *Washington Examiner*, October 11, 2009, available from the American Enterprise Institute, <http://www.aei.org/article/101155>.

Jeffrey H. Anderson, “ObamaCare’s Ugly Math: The Senate’s \$2.5 trillion bill would create higher taxes and higher premiums with little return,” *The Weekly Standard*, December 3, 2009, <http://weeklystandard.com/Content/Public/Articles/000/000/017/289eptak.asp?pg=1>.

Higher Taxes

The House and Senate bills differ slightly on their taxing mechanisms, but both impose **new taxes that will [hit](#) middle class Americans and small businesses.**

The House bill, H.R. 3962, increases overall taxes by \$745.5 billion over ten years that will harm small businesses and middle-class families. H.R. 3962 relies on \$460.5 billion in new taxes from a 5.4% income surtax on single filers with over \$500,000 in income, and joint filers with over \$1 million in income. What Democrats seem to have forgotten is that many small businesses file as individuals, and a 5.4% tax would place a huge burden on small businesses already struggling to make ends meet. This surtax is not indexed for inflation, so eventually it will affect thousands of middle-class taxpayers, similar to the alternative minimum tax. The individual mandate and so-called “pay or play” employer mandate would collectively raise taxes by \$168 billion through penalty taxes for non-compliance. The House legislation contains numerous other tax provisions including:

- \$56.8 billion in health care related taxes such as a 2.5% tax on medical device manufacturers and limitations on Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs); and
- \$60.2 billion in non-health care related tax increases.

The Senate bill, H.R. 3590, increases taxes by \$518.5 billion. H.R. 3590 increases taxes by:

- \$43 billion in the form of new penalties for not complying with employer and individual mandates;
- \$97.4 billion from taxes on the health care plans, manufacturers and limiting FSAs;
- \$86.8 billion from raising the Medicare payroll tax by 0.9% on individuals making \$200,000 and families making \$250,000 (thus maintaining the marriage penalty); and
- \$148.9 billion through a 40% tax on “Cadillac” (high cost) plans offered by insurers.

What Democrats have [overlooked](#) is that many average Americans have generous health care plans, often paid for by their employers. The excise tax will be passed onto employers and individuals in the form of higher premiums.

However, the Senate bill includes special deal for unions through a protection for “high risk professionals” who are given a higher threshold before the Cadillac tax hits them. This includes law enforcement officers, firemen, medical technicians, paramedics, first-responders, construction, mining, agriculture (not including food processing), forestry, fishing industry workers, workers who repair or install electrical or telephone lines, and Longshoremen.

Placing additional taxes on already struggling individuals and employers is not the prescription for a sound economy. Taxing the businesses that create life-saving drugs or wheel chairs will only discourage them from developing new products. Ultimately higher costs on manufacturers get passed on to consumers who must pay more for their new prescriptions or pacemakers.

For More Information:

Ryan Ellis, "Comprehensive List of All Tax Hikes in Senate Government Health Bill," Americans for Tax Reform, November 23, 2009, <http://www.atr.org/userfiles/111809pr-comptaxreid%283%29.pdf>.

Ryan Ellis, "Comprehensive List of All Tax Hikes in House Government Health Bill (Updated)," Americans for Tax Reform, November 6, 2009, <http://www.atr.org/userfiles/110609pr-househealthhikesupdated.pdf>.

Curtis S. Dubay, "Taxes Proposed to Pay for Health Care Reform," WebMemo #2706, The Heritage Foundation, November 20, 2009, <http://www.heritage.org/Research/HealthCare/wm2706.cfm>.

Rea Hederman, Jr. and Guinevere Nell, "Pelosi Health Care Plan: Who Pays the Surtax?" WebMemo #2687, The Heritage Foundation, November 6, 2009, <http://www.heritage.org/Research/HealthCare/wm2687.cfm>.

Karen Campbell, "High-Income Surtax: How Not to Pay for Health Care," WebMemo #2707, The Heritage Foundation, November 20, 2009, <http://www.heritage.org/Research/Taxes/wm2707.cfm>.

Curtis S. Dubay, "Baucus Health Insurance Excise Tax Misses the Mark," WebMemo #2654, The Heritage Foundation, October 19, 2009, <http://www.heritage.org/Research/HealthCare/wm2654.cfm>.

Robert E. Moffitt, "The Baucus Bill Grows Big Government," The Heritage Foundation, October 13, 2009, <http://www.heritage.org/Press/Commentary/ed101309d.cfm>.



Government Control of Health Care: Quality and Choices

Democrat health care legislation greatly expands the federal regulation of health care. Under the House bill, a Health Choices Commissioner and the Health Benefits Advisory Committee would set benefit standards for qualifying health care plans, establish rules governing the Exchange, and set premiums. Similarly, the Senate bill requires the Secretary of HHS Services to determine the requirements of the “Essential Health Benefits Package.” Since plans that do not meet these new federal standards would be subject to penalties or discrimination (such as not being allowed to cover new treatments) the government will be [dictating](#) the health benefits for the majority of Americans. New or alternative treatments that the government does not view as cost efficient would likely be excluded from coverage. While supporters may claim these bills will allow Americans to keep their existing coverage, in reality **existing plans will be disadvantaged to the point of extinction** unless they comply with the new regulations. By giving the federal government control over benefit standards, Democrats will **restrict the choices** available to individual citizens. In essence, Democrats are assuming that the government knows the needs of the American people better than the American people themselves. This legislation takes power away from the [states](#) and centralizes it in the hands of the federal government—allowing federal bureaucrats to micromanage the health care of millions of Americans.

Both bills create a CMS Innovation Center and mandate federal Comparative Effectiveness Research boards, yet **do not prohibit federal agencies from using this information to ration or prohibit care**. The Senate bill also contains the Independent Medicare Advisory Board, or “MedPAC on Steroids,” made up of non-elected government bureaucrats that are empowered to make arbitrary cuts to Medicare providers that will limit access to care for seniors. Congress would be required to consider legislation implementing the proposal or alternative proposals with the same budgetary impact on a fast track basis. The recommendations of the board would go into effect automatically unless blocked by subsequent legislative action. A 2009 [report](#) by the U.S. Preventative Services Task Force changing the recommended mammogram age from 40 to 50, because the costs of mammograms at an earlier age outweighed the benefits (the American Cancer Society disagrees), highlights the concern with government recommendations. Sometimes the cheapest, most cost-efficient treatment is not always the most effective or best option for that individual patient. A new [study](#) by California [researchers](#) underscored what many Americans already understand—spending more can save lives. Patients and their doctors need to be free to decide what is best for their health needs without any government interference.

Medicare faces deep financial problems that will bankrupt the program if not addressed. Conservatives have proposed various legislative options to improve, or completely bring into balance, Medicare’s long-term outlook (H.R. 4529, the Roadmap for America’s Future Act of 2010, is one example). However, while the Senate- and House-passed bills contain Medicare savings, these savings are more than exhausted by the cost of new health care entitlement spending. While Congressional Democrats acknowledge that it is impossible to solve the long-term budget problem without reforming federal health spending, their proposed solution would *increase* overall government health care spending.

For More Information:

Robert A. Book, “Government-Run Health Care Even Without the Public Option,” WebMemo #2686, The Heritage Foundation, November 9, 2009, <http://www.heritage.org/Research/HealthCare/wm2686.cfm>.

Reed Abelson, “California Hospital Study: Sometimes Spending More Actually Does Save Lives,” *The New York Times*, October 14, 2009, <http://prescriptions.blogs.nytimes.com/2009/10/14/california-hospital-study-sometimes-spending-more-actually-does-save-lives/>.

Michael K. Ong, Carol M. Mangione, Patrick S. Romano, Qiong Zhou, Andrew D. Auerbach, Alein Chun, Bruce Davidson, Theodore G. Ganiats, Sheldon Greenfield, Michael A. Gropper, Shaista Malik, J. Thomas Rosenthal and José J. Escarce, “Looking Forward, Looking Back: Assessing Variations in Hospital Resource Use and Outcomes for Elderly Patients With Heart Failure,” *Circulation: Cardiovascular Quality and Outcomes, Journal of the American Heart Association*, Vol. 2, No. 6, November 2009, published online October 13, 2009, <http://circoutcomes.ahajournals.org/cgi/reprint/2/6/548>.

Tom Feeney, “Preserving Freedom and Federalism: What’s at Stake for Americans in the Health Care Debate,” Backgrounder #2327, The Heritage Foundation, October 13, 2009, <http://www.heritage.org/Research/HealthCare/bg2327.cfm>.

Dennis G. Smith, “Congress Breaks Obama Promise on Government Role in Health Care,” WebMemo #2644, The Heritage Foundation, October 7, 2009, <http://www.heritage.org/Research/HealthCare/wm2644.cfm>.

Michael F. Cannon, “How Can I Ration Your Medical Care? Let me Count the Ways,” *Townhall Magazine*, September 2009, available from the Cato Institute, <http://www.cato.org/pubs/articles/cannon-obamacare-townhall-magazine.pdf>.

Martin Feldstein, “ObamaCare Is All About Rationing,” *Wall Street Journal*, August 19, 2009, available from the American Enterprise Institute, <http://www.aei.org/article/100918>.

Gina Kolata, “Panel Urges Mammograms at 50, Not 40,” *The New York Times*, November 16, 2009, <http://www.nytimes.com/2009/11/17/health/17cancer.html>.

Scott Gottlieb and John Cornyn, “Ration with Caution,” *Forbes.com*, December 3, 2009, available from the American Enterprise Institute, <http://www.aei.org/article/101386>.



Illegal Immigrants

Despite President Obama's promise that his health care plan will not provide health care to illegal immigrants, both bills **fail to explicitly exclude illegal immigrants** from receiving coverage. The House bill, H.R. 3962, fails to adequately address citizen verification for individuals applying for low-income affordability subsidies in the Exchange, or enrolling in Medicaid/CHIP, or enrolling in high risk pools. Furthermore, the House bill **allows** illegal immigrants to purchase insurance through the Exchange using their own dollars. Unlike the House bill, the Senate language will not allow illegal immigrants to purchase coverage through the Exchange using their own dollars. However, because the Senate bill contains the same insufficient and ineffective verification methods as the House, some conservatives may be concerned that it would still allow for illegal immigrants to access the Exchange.

Under the bills, even though illegal immigrants are not eligible for tax credits or subsidies, if employers do not provide health insurance for all their employees (including illegal aliens), they are [penalized](#). Both bills also provide tax credits to small businesses to purchase health care for their employees. Because employers often do not verify the immigration status of their employees, illegal immigrants will likely be covered. At the end of the day, because Democrats do not explicitly exclude illegal aliens, or require stringent verification procedures, illegal immigrants will be receiving subsidized coverage under their legislation.

For More Information:

Robert Rector, "Providing Health Care for Illegal Immigrants: Understanding the House Health Care Bill," Backgrounder #2345, The Heritage Foundation, November 23, 2009, <http://www.heritage.org/Research/HealthCare/bg2345.cfm>.

Stephen Dinan, "Health bills fail to block illegals from coverage: Employers fund insurance," *The Washington Times*, November 30, 2009, <http://www.washingtontimes.com/news/2009/nov/30/health-bills-fail-to-block-illegals-from-coverage/>.

James R. Edwards Jr., "Immigration-Related Provisions of Senate and House Health Reform Bills," Memorandum, Center for Immigration Studies, December 2009, <http://www.cis.org/articles/2009/healthcare-12-01-09.pdf>.

Special Interests

The health care legislation provides prime examples of Democrats carving out special exemptions for various jurisdictions and interest groups. Rather than applying the mandates of H.R. 3962 universally, the bill passed by the House creates special benefits for some states, including:

Connecticut: Senator Chris Dodd’s state was awarded \$100 million for a “Health Care Facility” at a public research university that contains a state’s sole public academic medical and dental school—criteria designed to apply to the University of Connecticut. Furthermore, the bill amends section 508 hospital provisions so that hospitals in Connecticut (as well as Michigan) have the option to benefit under them if it means higher payments.

Florida: Senator Bill Nelson secured a deal to keep [Medicare Advantage](#) plan enrollees in Florida grandfathered in. Notably, when McCain tried to offer an amendment to allow all enrollees to be grandfathered in, [57](#) Democrats voted against it.

Hawaii: The House bill allows Hawaii to be exempt from state penalties imposing greater mandates by making the Hawaii Prepaid Health Care Act a qualified health benefits plan. The Senate bill also singles out Hawaii as the only state to receive a Disproportionate Share Hospital (DSH) extension.

Louisiana (aka the “Louisiana purchase”): Senator Landrieu was one of the first Senators to secure a sweetheart deal, aptly nicknamed the “Louisiana Purchase.” She received a \$300 million increase in Medicaid funding for Louisiana in return for her “yes” vote on the bill. The underlying bill was cryptically written to increase federal Medicaid subsidies for “certain states recovering from a major disaster” during the past 7 years that have been declared a “major disaster area.”

Massachusetts: H.R. 3962 also allows the “optional operation” of state health insurance exchanges if states can demonstrate that they can fulfill all the functions of an exchange (such as negotiating with qualified health benefits plans, enrolling individuals, providing enough local offices to meet the needs of enrollees, and administering affordability credits). Under Sec. 308, however, the bill provides that a state operating an exchange before January 1, 2010 shall be presumed by the Commissioner to meet the required standards. The only state that appears to be eligible for such an exemption is Massachusetts, which enacted health care reform in 2006 and created the Connector, their version of a state health insurance exchange. Additionally, H.R. 3962 provides matching federal grants for states operating their own exchanges. Not only would Massachusetts’s health care system likely be exempt, it would receive federal funding.

The Senate bill, H.R. 3590, contains unfunded mandates to states through the expansion of Medicaid but reserves special treatment for the several states including **Massachusetts**, which will receive a 0.5% FMAP increase for three years, thus receiving an additional \$500 million over ten years.

Michigan: According to reports, like Nelson, Levin [sought](#) an exemption from the \$6 billion annual fee for non-profits, as non-profit insurers make up 76% of industry profits, but drew opposition from liberals. Ultimately, Levin got an exemption from the insurance tax for Michigan non-profit insurers, with language written in a way that applies to Blue Cross Blue Shield Plans (BCBS) of Michigan (and Nebraska). Furthermore, the amendment changes the extension of section 508 hospital provisions so that hospitals in Michigan (as well as Connecticut) have the option to benefit under them if it means higher payments.

Montana: Sen. Baucus secured a pilot program to “provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care” to certain qualified individuals. A qualified individual “is an environmental exposure affected individual...who resides in or around the geographic area subject to an emergency declaration made as of June 17, 2009.” And who might these select few individuals be? Well, according to [EPA](#), “On June 17, 2009, EPA Administrator Lisa Jackson issued a Public Health Emergency (PHE) finding at the Libby Asbestos Superfund site in northwest Montana.” This provision would help residents of Libby by allowing them to sign up for Medicare benefits.

Nebraska (aka the “cornhusker kickback”): Nebraska will receive a 100% FMAP for newly eligibles *indefinitely*, making it the only state where the federal government will pay for all new enrollees. CBO estimated the cost to the federal government (additional funds to Nebraska) would be \$100 million, which may look small compared to the other deals negotiated, yet over the long-term will cost far more, since funding continues indefinitely. Sen. Nelson also secured an exemption from the insurance tax for Nebraska non-profit insurers, with language written in a way that only applies to Mutual of Omaha Insurance Company and Blue Cross Blue Shield Plans (BCBS) of Nebraska (and Michigan). According to [news reports](#), Nelson’s office states that BCBS “would pay between \$15 million and \$20 million less in fees under the Senate bill than it would have without a change.” Finally, Nelson negotiated an exemption from taxes for Medicare supplemental (“Medigap”) insurance providers. Specifically, Mutual of Omaha, will not have to pay taxes on Medigap insurance, while reports also indicate that this tax break will be extended to other companies.

One of the many problems with these “sweetheart” deals, is it leaves the door wide open for more federal involvement and financing of state-based entitlement programs. [Sen. Harkin said it best](#) when he stated “In 2017, as you know, when we have to start phasing back from 100%, and going down to 98%, they are going to say, ‘Wait, there is one state that stays at 100?’ And every governor in the country is going to say, ‘Why doesn’t our state stay there?’ ...When you look at it, I thought well, god, good, it is going to be the impetus for all the states to stay at 100%. So he [Nelson] might have done all of us a favor.”

Vermont: Vermont will receive a 2.2% FMAP increase for 6 years for their entire program, thus receiving an additional \$600 million over ten years. Additionally, the final bill includes a provision pushed by Senator Sanders to provide an additional \$10 billion in funding for community health centers and the National Health Services Corps which [he argues](#) would provide primary care to 25 million more people.

Other States: As noted above, despite \$120 billion in Medicare Advantage cuts, the Manager’s Amendment found a way for [Florida](#) residents, as well as some individuals in **Pennsylvania and New York**, and potentially [Oregon](#), to be grandfathered out of receiving the cuts.

Senator Dorgan and Senator Conrad’s “protections for frontier states” provision would, starting in 2011, establish a 1.0 hospital wage index and geographic practice expense floors for hospitals and physicians located in states where at least 50% of the counties in the state are “frontier”. Not surprisingly, states that qualify and benefit from this increase in Medicare payments to hospitals and doctors are **Montana, South Dakota, North Dakota, Utah, and Wyoming**.

Unions: While the House– and Senate– passed bills were already chock-full of union carve outs (reinsurance subsidy program for retirees, early entrance into the Exchange, provisions to hurt small non-union construction firms, and a higher threshold before the “Cadillac” tax hits for “high risk professionals” such as Longshoremen), apparently that was not enough. According to [reports from the SEUI](#), the White House cut another deal to buy-off union support while harming all other non-union middle class workers. The new “deal” would exempt collectively bargained (union) health plans (including state and local government employees) from the “Cadillac” tax through 2017 while also raising the thresholds to \$24,000 for family coverage (up from \$23,000) and \$8,900 for individuals (up from \$8,500). Dental and vision plans (estimated to be an additional \$1,500 carve out) will be removed from the calculation of the threshold costs for the “Cadillac” tax for union, state and local government employees. Other reports indicate that other thresholds may be tweaked upwards to take into account other factors that may increase the cost of a plan, such as age and gender, which would benefit union plans with high percentages of older workers. If health costs rise faster than expected, the thresholds may be further increased (likely removing a large portion of the expected revenue from the tax). Finally, 17 “high cost” states will have a transition period where they will have a higher threshold than other states.

If Democrat legislation is really the prescription for the ailments of the American health care system, then some conservatives may well ask, why do certain states and favored constituent groups require immunity from its provisions?

For More Information:

Kimberly Strassel, “States of Personal Privilege,” *The Wall Street Journal*, October 9, 2009, <http://online.wsj.com/article/SB20001424052748703746604574461434007876034.html>.

Lisa Mascaro, “Senate bill would cover Medicaid expansion for all states,” *Las Vegas Sun*, November 19, 2009, <http://www.lasvegassun.com/news/2009/nov/19/senate-bill-cover-medicaid-expansion-all-states/>.

Gail Russell Chaddock, “Healthcare’s dealbreakers: Mary Landrieu likes her \$300 million,” *The Christian Science Monitor*, November 24, 2009, <http://features.csmonitor.com/politics/2009/11/24/healthcares-dealbreakers-mary-landrieu-likes-her-300-million/>.

Abortion

Federal funding of abortion has been one of the most controversial issues for the Democrats. While the House bill would have allowed coverage for abortion under the public plan and subsidized private plans covering abortion through the Capps Amendment, this language was removed and replaced with the Stupak-Pitts amendment specifically prohibiting federal funding of any plans that covered abortion.

However, the Senate bill, H.R. 3590, still allows for the funding of abortion, and is very different from the Stupak language that passed the House with the support of 64 Democrats. Specifically Nelson's "compromise" would require those enrolled in a plan that covers abortion to make separate payments into an account that will be used for abortions, therefore creating public and "private" funds. Just because the funds are put into another account does not mean they are not federal dollars subsidizing abortions. Money is fungible and attempts to separate taxpayer dollars and private dollars to pay for an abortion is nothing more than a deceitful shell game.

The Senate bill includes a mandate that every state provide an insurance plan option that does not cover abortion, while giving each state the right to pass a law barring insurance coverage for abortion within state borders (which was already allowed in the underlying bill). However, even if a state chooses to opt out, an individual's tax dollars may go toward plans that cover abortion in other states. Each state through the new government run plan ("Multi-State Plan") overseen by the Office of Management Personnel (OMP) can provide access to two plans – only one of which must exclude abortions. Currently no plan under the Federal Employee Health Benefits Plan (FEHBP), overseen by OMP, provides for abortion coverage.

Additionally, it fails to fix Sen. Mikulski's [amendment](#), which gives the Health Resources and Services Administration (HRSA) the power to require private insurance plans include abortion coverage under the title of "preventive care." And finally, the bill fails to provide adequate conscience protections, as it does not prohibit any government entity or program from discriminating against health care providers that do not want to participate in abortions.

For More Information:

Douglas Johnson, "National Right to Life Committee Rejects Reid Abortion Funding Language as 'Completely Unacceptable,' Calls for Enactment of Stupak-Pitts Amendment," Press Release, National Right to Life Committee, November 18, 2009, <http://www.nrlc.org/AHC/Release111809.html>.

"The Capps Abortion Amendment to Affordable Health Choices Act," InFocus, Family Research Council, September 2009, <http://downloads.frc.org/EF/EF09I20.pdf>.

"Senate Approval of Mikulski Amendment Further Opens Health Care Bill to Massive Federal Funding of Abortion," Press Release, Family Research Council, December 3, 2009, <http://www.frc.org/pressrelease/senate-approval-of-mikulski-amendment-further-opens-health-care-bill-to-massive-federal-funding-of-abortion>.

Additional Resources

House Bill, H.R. 3962:

“Legislative Bulletin: H.R. 3962 – Affordable Health Care for America Act,” Republican Study Committee, November 7, 2009,

http://rsc.tomprice.house.gov/UploadedFiles/LB_110609_HR3962_Updated.pdf.

“RSC Policy Brief: Highlights of H.R. 3962, The ‘Pelosi Government Takeover Bill,’” October 30 2009, Republican Study Committee,

http://rsc.tomprice.house.gov/UploadedFiles/PB_103009_healthcarehighlights.pdf.

Senate Bill, H.R. 3590:

“RSC Policy Brief: Stumbling Blocks to Merging the House and Senate Government Takeover of Health Care Bills,” January 12, 2010, Republican Study Committee,

http://rsc.tomprice.house.gov/UploadedFiles/PB_011210_Stumbling_Blocks_to_Merging_Health_Care_Bills.pdf

“RSC Info Alert: Summary of Major Changes to Senator Reid’s Takeover of Health Care Bill, H.R. 3590 (Patient Protection and Affordable Care Act),” December 21, 2009, Republican Study Committee, http://rsc.tomprice.house.gov/UploadedFiles/PB_122109_HR3590_Changes.pdf

“RSC Info Alert: Special Deals in the Senate Bills,” January 22, 2009, Republican Study Committee, http://rsc.tomprice.house.gov/UploadedFiles/RSC_Info_Alert_Special_Deals_in_Senate_Bill_12.22.09.pdf

“H.R. 3590: The Quality, Affordable Health Care for All Americans Act,” Legislative Notice, No. 28, U.S. Senate Republican Policy Committee, December 2, 2009,

http://rsc.tomprice.house.gov/UploadedFiles/RPC_Summary_of_Reid_Health_Bill.pdf

RSC Health Care Documents:

<http://rsc.tomprice.house.gov/Solutions/RSCHealthCareDocuments.htm>

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