DISSENTING VIEWS ON H.R. 3200

OVERVIEW

H.R. 3200 is fundamentally flawed legislation that threatens to simultaneously do irreparable harm to the health delivery system and add mountains of additional debt on our children and grandchildren. Long before those bills come due, though, Americans with health insurance would pay thousands of dollars more per year for coverage, and a host of new taxes on individuals and businesses would further hamper efforts to revive an already struggling economy if this bill becomes law.

The bill violates oft-repeated promises by the President and others that health care reform won't cause people to lose coverage they like, that taxes won't increase on families with income less than $250,000 and that tax rates won't increase above what they were during the 1990s.

The minority was united in opposition to the bill for five main reasons:

1. It was unnecessarily rushed through the Committee without proper understanding or even a reading of the bill by Members;
2. The massive spending and tax increases will damage an already reeling economy;
3. Americans will lose coverage they have and like;
4. The bill gives the government control over Americans' personal health decisions; and
5. Numerous specific improvements we proposed to the bill were all rejected.

I. BILL SHOULD NOT HAVE BEEN RUSHED INTO AND OUT OF COMMITTEE

While we share the majority's goal of improving the nation's health care system, the issues are too important and the decisions too difficult to act in haste and without the full range of information necessary to make such critical policy choices.

We held only one hearing on the discussion draft released in June, however not one of the witnesses spoke knowledgably about all of the provisions in the bill because they were only given a couple of days to digest it.

The measure approved by the Committee was substantially changed from the June draft, with the last round of edits coming out just after midnight on Thursday, July 16th, a few hours before the one-day markup of the legislation that began at 9 a.m. that morning.

This contrasts starkly with the health care reform debate in 1994. That year, the full Ways and Means Committee spent 17 days over six weeks conducting our markup. And that was only after holding a dozen hearings (eight at Subcommittee, four at full Committee) on the bill after its introduction.

It is also worth pointing out that the Committee refused to act on the Clinton bill in 1994 until nearly three months after the Congressional Budget Office (CBO) released a comprehensive, 104-page analysis and score. We had no such analysis of H.R. 3200 or the Chairman's mark. What we had instead was a very rough estimate on only a portion of the bill based on specifications as outlined by the Majority to CBO, not on actual legislative text. As Director Elmendorf wrote to Chairman Rangel:

"It is important to note, however, that [those] estimates are based on specifications provided by the tri-committee group rather than an analysis of the language released [this week]. For that reason and others outlined below, those figures do not represent a formal or complete cost estimate for the coverage provisions of the draft legislation."

Quite simply, that is not adequate for a bill as important as this, one that will have such far-reaching impacts on every family and business in America. We cannot afford to guess and hope we got it right. This Committee had no business marking up a bill of which CBO cannot tell us its cost or impacts. That view was further confirmed by testimony during the day by Director Elmendorf about the long-term budget impact of this legislation.

II. MASSIVE SPENDING AND TAX INCREASES WILL HURT ECONOMY

What we do know about the bill is that it matches more than a trillion dollars in new spending that grows even faster than the revenues being generated to pay for it, creating a massive, long-term unfunded federal mandate that imperils the fiscal future of this nation. Ironically, despite claims that the United States is already "spending too much on health care," the bill finances even higher spending with more than $820 billion in new taxes that will be paid for by families making as little as $20,000, small businesses, and manufacturers—all while we are in the midst of a recession and with unemployment moving quickly toward 10 percent.

Section 412 of the bill includes a mandate that employers provide health coverage deemed acceptable by the Federal Government or else pay a new payroll tax of eight percent of total payroll (a so-called "pay-or-play" scheme) that will bring the total U.S. federal payroll tax to more than 23 percent. Only the smallest of businesses would get any relief from this job-killing tax. Economists across the political spectrum agree that workers suffer the economic burden of payroll taxes. In a July 13, 2009 report entitled, "Effects of Changes to the Health Insurance System on Labor Markets," the Congressional Budget Office concluded that an employer mandate "is likely to reduce employment," with the effect being most severe for low-wage workers. It is therefore disappointing that the Majority chose to ignore the warnings of leading groups representing businesses in America about the damage this will do to employment and wages in America.

Section 441 of the bill attempts to plug part of the fiscal hole it creates with a new surtax on individuals and small businesses. The 5.4-percent surtax rate, combined with the

already scheduled increase in the top marginal rate to 39.6 percent, would result in an increase in the top Federal income tax rate from 35 percent in 2010 to 45 percent in 2011. Adding in the 2.9-percent Medicare payroll tax and hidden marginal rate increases that operate by phasing out certain deductions, the proposed top Federal rate would jump to about 48 percent, and the average top Federal-State marginal tax rate would be over 52 percent.

While nominally aimed at individuals, the surtax will fall heavily on small businesses, the engine of job creation. According to a Joint Committee on Taxation data projection for 2011, 42 percent of small business income (including the income of sole proprietorships, partnerships, and S corporations) would be subject to the surtax.

Not content to just tax "the wealthy," the bill also imposes large taxes on some of America's poorest families. Effective in 2013, section 401 would impose a tax on individuals without "acceptable coverage", which would hit single filers with incomes as low as $9,350 and married couples with incomes as low as $18,700 (in 2009 dollars). This undermines President Obama's ongoing promise not to raise taxes on families with incomes under $250,000.

Section 442 would prohibit the use of tax-free distributions from Health Savings Accounts (HSAs), Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs) to purchase medicine or drugs other than prescription drugs or insulin. By imposing this restriction on the estimated 47 to 50 million individuals who currently carry coverage that includes either an HSA, FSA, or HRA, the bill violates another of President Obama's pledges: to allow families to keep the coverage they have and like.

In addition, the Majority would impose several unwise tax increases that bear no relationship to the purpose of the legislation other than to fund the move toward nationalization of health care in this country. These tax increases include a provision that appears to violate our tax treaties with our trading partners; a multi-year delay in rules that would allow worldwide American businesses to calculate their interest expense more accurately; and codification of the economic substance doctrine. The delay of the interest expense allocation rules is especially troubling. By terminating this tax increase at the end of the budget window, the Majority seems to be subtly acknowledging that the revenues generated by the bill will further fail to keep pace with its spending in the long-run.

III. AMERICANS WILL LOSE THE COVERAGE THEY HAVE AND LIKE

Independent analysis demonstrates that under H.R. 3200, two out of three Americans will lose the coverage they currently enjoy because it establishes a government-run health plan. It will, over time, force other coverage out of the market, eventually turning the government option into a federal monopoly.

This starts with the creation of a federally subsidized government-run insurance plan that would pay hospitals and doctors at set Medicare rates for services. As Medicare significantly underpays providers, the government-run plan will force private plans to pick up the slack. As a result, the average cost of private coverage for a family of four would be $3,628 more expensive because of the new and existing cost-shift, according to analysis by Milliman and the Lewin Group. Because it is unlikely that providers will willingly accept the government-run plan's low reimbursements, the Secretary of HHS would have the authority to force providers to participate in this plan.

The government-run plan will not have to pay state or federal taxes. It would be exempt from complying with state benefit and provider mandates, which have been shown to increase the cost of health insurance. The plan provides a $2 billion interest free loan from taxpayers. Unlike private insurance plans, who can be sued in state courts, the government-run plan could only be sued in federal court. And finally it will have the full backing of the United States government. Regardless of any assurances to the contrary, the government-run insurance plan will be "too big to fail," almost ensuring that taxpayers will be responsible for any funding shortfalls. This affords the government plan further significant advantage over the plans it is supposed to "compete" against.

To further guarantee that result, all private health plans would be required to conform to benefit mandates, as determined by the federal government. Any employer offering coverage that wasn't approved by the government would be forced to pay a steep tax penalty. Further, individual market plans would be prohibited from enrolling new members and would be prohibited from updating their benefits or cost-sharing arrangements for those currently enrolled. This prohibition on new enrollment will result in a death spiral where insurance costs for a plan climb at an unsustainable rate for all existing health insurance plans. By guaranteeing adverse selection will occur, the bill will ultimately force these plans to close down completely.

The bill further prohibits any new insurance plan from creating health coverage that does not conform to the federal government's requirements, and that insurance plan will not be allowed to exist outside of the government established super-structure, referred to in H.R. 3200 as the Exchange. By prohibiting new insurance plans that don't comply with various new federal requirements, the bill effectively limits choice in the insurance market.

IV. GIVES THE GOVERNMENT CONTROL OVER PERSONAL HEALTH CARE DECISIONS

H.R. 3200 will create a system by which health care decisions will be made in Washington that should be made in doctor's offices by patients and their physicians and at kitchen tables by families. House Democrats would establish a new government-run "Exchange" run by a new "Health Choices Commissioner" nominated by the President and confirmed by the Senate. As the Commissioner is serving at the pleasure of the President, some may be concerned about the lack of independence of this individual. The Commissioner would also be required to work with the Secretary of Health and Human

Services, who oversees the government-run insurance plan described above, creating the potential for a serious conflict of interest that could significantly disadvantage the private coverage that insures more than 170 million Americans today.

Aside from the will of the President, the Commissioner's power would be unchecked. This is extremely troubling given the large scope of responsibility given to the Commissioner. In fact, the Commissioner is so powerful that the title is referenced almost 200 times in H.R. 3200. This government official would have:

- The power to decide which treatments patients could receive and at what cost;
- The power to decide which private plans would be allowed to participate in the Exchange;
- The power to regulate all insurance plans, both in and out of the Exchange;
- The power to determine which employers would be allowed to participate in the Exchange;
- The power to determine how many Americans will be allowed to choose health coverage through the Exchange;
- The power to form and control which physicians and hospitals participate in the government-run plan and in private plan provider networks;
- The power to determine which states are allowed to operate their own Exchange and terminate a previously-approved State Exchange at any time;
- The power to override state laws regarding covered health benefits;
- The power to determine how trillions of taxpayer and employer dollars would be spent within the Exchange;
- The power to determine who qualifies for premium assistance; and
- The power to automatically enroll Americans into the Exchange if they don't have coverage, including potentially forcing these individuals into the government-run plan.

Also troubling is the fact the Secretary of Health and Human Services would decide which prescription drugs are made available in the government plan. Evidence has shown that government officials in other countries have used this power to deny access to needed treatments on the basis of cost.

The bill also contains a new initiative on Comparative Effectiveness Research (CER). This board and its research will significantly harm the patient-doctor relationship if government-run health care uses the research to restrict treatments deemed too expensive. The bill reported by the Committee contains a provision expressly prohibiting the CER board from using its research to make coverage determinations. That may be the biggest of many fig leaves in the bill; in this case, the joke is on us, since the CER board would never make a coverage determination -- it doesn't issue health insurance or pay claims, or have to decide what is covered and what is not.

But those who would make such coverage decisions, like the Centers for Medicare and Medicaid Services (CMS), face no such restrictions on their use of CER data. Peter Orszag, Director of the Office of Management and Budget, has publicly affirmed the

Administration's desire to use CER to "bend the cost curve." As it relates to CER, this means that CMS and the Health Choices Commissioner will be able to deny coverage based on the cost of treatment, or ration access to health care services, for people in Medicare and every American enrolled in insurance plans offered through the Exchange.

V. ATTEMPTS TO IMPROVE THE LEGISLATION WERE REJECTED

Sadly, the foregoing does not constitute a complete review of the flaws of this legislation. During the Committee mark-up, these and other concerns were identified. Republicans attempted to address them through more than three dozen amendments. Those included amendments to: eliminate the government-run health insurance plan that could result in two out of three Americans losing their current coverage; ensure that comparative effectiveness research isn't used to ration care based on cost; terminate the government-run plan if wait times for care become too long; prevent the government from requiring health care providers to serve patients enrolled in the government-run health plan; ensure the Health Choices Commissioner could not deem abortion to be a required benefit; reverse cuts to Medicare Advantage plans, which give seniors access to benefits not found in the government-run Medicare program; and promote medical liability reform, which would help address the impact that the practice of defensive medicine has on health care spending.

Sadly, not a single one of these or the other amendments offered was accepted, reinforcing the widely held belief that this effort is a purely partisan exercise in which additional views and suggestions simply are not welcome.

CONCLUSION

At the outset of the mark-up, the Majority rejected a motion by the Ranking Member to delay consideration of the bill by one week, notwithstanding the fact the bill had been available for only a few hours and that the Committee did not even have a Congressional Budget Office estimate about the short and long-term impact of the package.

We suppose that should have been an indication about what was to come and the futility of trying to improve this deeply flawed product.

Hours after the mark-up ended, the Congressional Budget Office did release a further partial score of the bill (still based on descriptions of what is in the bill rather than on the legislative text itself). The overall conclusion is that the bill adds nearly $240 billion to the deficit this decade, with the bulk of those costs occurring at the end of the budget window. In 2015 alone, the bill will add $40 billion to the federal deficit. By 2019, that figure will rise to $65 billion and the deepening debt impact shows no signs of slowing down in future years. In short, the $240 billion that this adds to the deficit this decade is just the tip of the fiscal iceberg.

We would like to hope that the Majority's mad dash for an arbitrary finish line, regardless of the consequences, will be called off before real and lasting damage is done to our health care system and our economy. But as we write this, the prognosis is not good.

Dave Camp, Michigan

Wally Herger, California

Sam Johnson, Texas

Kevin Brady, Texas

Paul Ryan, Wisconsin

Eric Cantor, Virginia

John Linder, Georgia

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