MINORITY VIEWS

HEALTH CARE RECONCILIATION: A BROKEN PROCESS WITH COSTLY CONSEQUENCES

INTRODUCTION

Through this grossly distorted process, the Democratic Majority will attempt to force onto the American public a sweeping government takeover of health care without a shred of bipartisan support, and in spite of *opposition* by a majority of the people Congress has been elected to serve. They will do so by twisting budgetary and legislative procedures to win a political victory at any cost, by any means – because they cannot do it any other way. The arrogance, the paternalism, the condescension of this action are breathtaking.

The key factors in this extraordinary step are the following:

- *A Flawed Health Care Bill*. The legislation being driven through Congress will lead to further government intrusion in the doctor-patient relationship. It will cause costs to rise and quality to deteriorate, and inevitably lead to rationing of health care, one of Americans' most valued and personal services.

- *Worsening a Fiscal Crisis.* Making all this worse, these contorted procedures are being used to expand Federal entitlements when the government already faces a potentially disastrous fiscal path – one that threatens to overwhelm the budget and smother the economy – from programs that already exist.

- *Extraordinary Abuse of Procedure*. The Majority is doing all this by distorting budget reconciliation in unprecedented ways. The process has *never* been used to force through a government expansion of this magnitude – leveraged on a token savings amount, in the face of trillion-dollar deficits, and on a deliberate party-line vote.

- *Starting Over*. There is broad agreement on the need to reform health care. But what is needed is a different vision of how to meet the problems in health care, one that truly addresses the central problem of cost while maintaining a sturdy safety net for those who need it. Such approaches have been available, and still are – and they could lead to a truly bipartisan consensus on reforms that would address the most important and widely acknowledged problems.

Ideology, Not Health Care

From the beginning, the Democratic Majority envisioned a centralized, controlling government role in the provision and financing of health care. They failed to focus sufficiently on the underlying problem – unconstrained growth in health costs, which puts health insurance out of reach for many. In the end, their ideology leads to an inevitable chain of additional government mandates, spending, and taxes. The result is that even without the so-called "public option," their health care bill is an outright government takeover of health care. Some examples:

- The measure creates a Health Insurance Rate Authority, a Washington-controlled price-setting board. This will usurp State governments' role in regulating insurance and premiums, and will further smother the normal market forces that would otherwise encourage innovation and cost-saving efficiencies. It also ignores the real cost drivers in health care: the third-party payment system, which promotes overconsumption; the rising costs of health care services; and the payment mechanisms that encourage doctors to provide more services, not necessarily better outcomes.

- It lets Washington decide what kind of health insurance will be available. The proposal gives the Secretary of Health and Human Services [HHS], and a new Health Benefits Advisory Committee – an unelected group of Federal bureaucrats – unprecedented Washington-centered power to create and change the requirements for "acceptable coverage." This will in turn restrict competition, stifle innovation, and limit the kinds of coverage that will be available to Americans.

- It gives the U.S. Preventive Services Task Force (the group that recently made the controversial recommendations regarding mammograms) new powers to further limit patient choice, allowing the Secretary of Health and Human Services to unilaterally deny payment for prevention services contrary to Task Force recommendations.

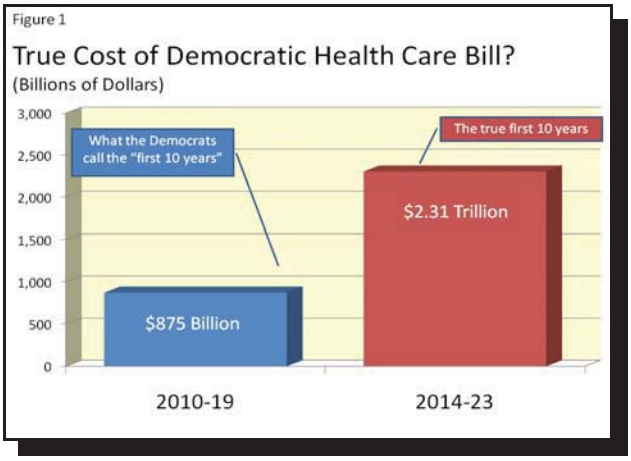
- It empowers a "comparative effectiveness board," created by last year's "stimulus" bill, that will restrict providers' decisions about what treatments are best for their patients.

Gaming the Budget Estimates

The Senate bill is the base legislation for the Majority's health care strategy. It does not control costs. It does not reduce deficits. It adds a new health care entitlement at a time when Congress and the President have no idea how to finance the entitlements that already exist.

The Majority claims the legislation reduces deficits by $118 billion over 10 years, as scored by the Congressional Budget Office [CBO]. But CBO can only score the legislative language presented to it – and in this case the language was contorted to produce a misleading outcome. the Democrats have hidden the true costs of their bill behind a wall of heavy blue smoke and a maze of mirrors. Some examples:

- The bill imposes 10 years of taxes and 10 years of Medicare cuts to offset just 6 years of spending. If the taxes and Medicare reductions were matched year for year with the spending, the real cost of the bill would be $2.3 trillion.[1]



- The Medicare reductions, totaling nearly a half trillion dollars over 10 years, are not used to enhance the program's solvency, but instead to finance an entirely new entitlement. The administration's chief Medicare actuary has said up to 20 percent of Medicare providers may go bankrupt or stop taking Medicare patients as a result. Millions of seniors who have chosen Medicare Advantage will lose the coverage they now enjoy.[2]

- It claims $53 billion in "savings" from increased Social Security payroll taxes. But these revenues already are committed to future Social Security beneficiaries – so either they are being double-counted, or the authors of the bill do not intend to pay the benefits.[3]

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[1] Senate Budget Committee, *Budget Perspective: The Real Deficit Effect of the Health Bill*, 22 December 2009.

[2] Memorandum from the Office of the Chief Actuary, Centers for Medicare and Medicaid Services, 8 January 2010.

[3] Senate Budget Committee Republican Staff, op. cit.

- It takes $70 billion intended as premiums for the long-term care insurance provisions – the Community Living Assistance Services and Supports [CLASS] Act – and counts those as offsets too.[4] The Senate Budget Committee Chairman called this "a ponzi scheme that would make Bernie Madoff proud."[5]

- It authorizes approximately $70 billion in new discretionary spending, according to the Congressional Budget Office – an amount not considered in the estimated cost of the bill.

When the gimmicks and double-counting are stripped away, the health care legislation increases the deficit by $460 billion over the first 10 years and $1.4 trillion over the second 10 years.[6] But that does not count rescinding the effects of the sustainable growth rate formula – the so-called "doc fix" – which is estimated to add $371 billion to the health care overhaul, according to the administration's Office of Management and Budget.[7] The Majority decided simply to remove this provision and deal with it in a stand-alone bill.

But the most damning assessment – again from Medicare's chief actuary – is that the legislation fails in what should have been its most important task: to slow the growth of health care spending. Instead, it bends the cost curve *upward*, increasing national health spending by $222 billion above current estimates.[8]

Student Loans

Further abusing the reconciliation process, the Majority has added to this vehicle a government takeover of all Federal college loans, using the projected savings – assuming they materialize – to expand government now.

The legislation, titled the Student Aid and Financial Responsibility Act [SAFRA] abolishes the 40-year-old Federal Family Education Loan Program [FFELP] as of 1 July 2010. FFELP is a guaranteed lending program, and the largest source of student aid, that has leveraged hundreds of billions of dollars in *private* capital to help students go to college. Under SAFRA, the program will be replaced by 100-percent

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[4] Ibid.

[5] "Proposed Long-Term Insurance Program Raises Questions," *The Washington Post*, 27 October 2009.

[6] Senate Budget Committee Republican Staff, op. cit.

[7] Office of Management and Budget, *Budget of the U.S. Government – Fiscal Year 2011*, Table S-7.

[8] CMS Actuary, op. cit.

government-run lending. The Direct Loan [DL] program will issue and profit from all new loans, which will be financed with Treasury borrowing. The bill then spends about half of its estimated savings toward increasing Pell Grant vouchers, and uses the remaining amounts to create a number of new entitlement programs that do not directly benefit students and will require future spending by the Federal and State governments.

Proponents claim SAFRA will reduce the deficit, but this is an illusion created through the use of budget gimmicks.

First, under the original cost estimate, SAFRA claims to save $87 billion, and then spends slightly more than $79 billion, yielding ostensible deficit reduction of $7.8 billion.[9] But this does not take into account the $13.5 billion worth of increased administrative costs (for both the Direct Loan and Pell Grant programs) that the bill shifts to the discretionary category, where the CBO cannot count them as direct spending. When this gimmick is removed, the bill *increases* the deficit by at least $5.7 billion.

Second, SAFRA's claimed savings are highly uncertain. Recently, CBO released an updated estimate that reduced SAFRA's savings by $20 billion, from $87 billion to $67 billion,[10] and increased the estimated cost of the Pell Grant add-on by $16 billion.[11] It is unclear whether these updated estimates will be applied to the legislation brought to the House floor.

But even more disconcerting is the way CBO was required to calculate SAFRA's savings in the first place. Unless otherwise directed by Congress, CBO must calculate loan savings under the Federal Credit Reform Act of 1990, which requires "scoring" government loans using a simple net present value calculation based on a discount rate. This does not take into account "market risk" – the risk that the value of the loan will decrease due to changes in market factors.

Incorporating market risk to cost estimates more accurately reflects how much a loan program will generate. That is why Congress started including the effect in recent legislation dealing with Federal loans, such as the Troubled Asset Relief Program, among others. SAFRA's authors did not direct CBO to account for market risk when obtaining an official score for the legislation. Nevertheless, CBO noted in a letter to

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[9] Congressional Budget Office, cost estimate for H.R. 3221, The Student Aid and Fiscal Responsibility Act of 2009, 24 July 2009.

[10] CBO Memorandum, *March 2010 Baseline Projections for the Student Loan and Pell Grant Programs*, 5 March 2010.

[11] CBO Preliminary Estimate, *Comparison of the Pell Grant Mandatory Add-On in H.R. 3211 Under March 2009 and March 2010 Baselines*, 8 March 2010.

Senator Gregg that if market risk were applied to SAFRA, it would reduce claimed savings by $22 billion over 10 years.[12]

In an April 2009 letter to the House and Senate Budget Committees, a former Office of Management and Budget director, a bipartisan group of former Budget Committee Members, and a former staff director for the Senate Budget Committee rightly warned: "Using the reconciliation process to spend tens of billions in the next few years under the assumption that future offsetting savings will materialize seems fiscally irresponsible due to the limitation of budget-scoring in this area, and the inherent unpredictability of the projections."[13]

Beyond adding to deficits and debt, there are additional concerns with SAFRA. First, eliminating the current guaranteed lending program will result in the loss of tens of thousands of private-sector jobs associated with the industry, during a period of high unemployment. Meanwhile, many schools have expressed concern that they will be unable to transition in time to meet SAFRA's 1 July 2010, deadline, which is likely to deprive some students of financial support.

Further, because the Federal Government will have to borrow the money to supply the new volume of Direct Loans, the shift will cause a dramatic increase in debt at a time when the country is already taking on dangerous levels of debt to pay for historic levels of spending. If loan origination volumes rise as expected to $100 billion per year, Federal borrowing could grow to over $1 *trillion* over 10 years.

The advantage of the FFELP federally guaranteed student loan option is that, except for extreme circumstances, it uses *private* capital. It also provides students with choice and ever improving service, a feature some complain is lacking with the Direct Loan program.

WORSENING A FISCAL CRISIS

The new $1-trillion entitlement in the health care legislation is being heaped onto a potentially disastrous fiscal path already facing the Federal Government – one that threatens to overwhelm the budget and smother the economy. To summarize:

- *The Current Fiscal Path is Unsustainable*. Federal deficits are projected to reach unprecedented levels, and if reforms are not made soon, the Federal debt will rise uncontrollably, with painful economic consequences. Untenable tax rates will be needed to service a huge and ever-growing debt, and high interest rates will be required to attract new borrowing.

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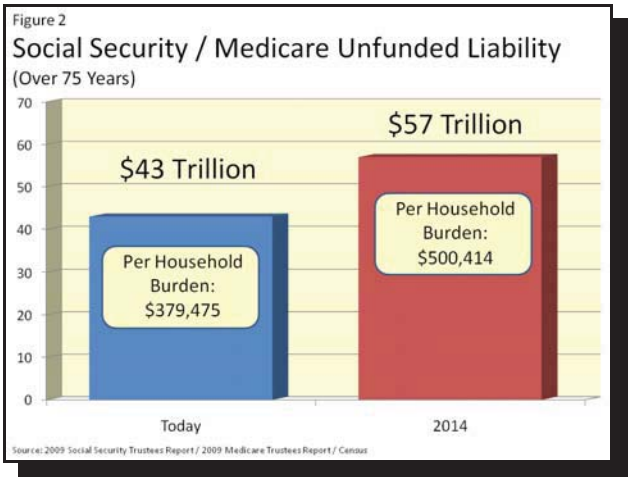
[12] CBO letter to Senator Gregg, 15 March 2010.

[13] Letter from former Budget Committee Ranking Member Frenzel et. al., 24 April 2009.

- *Entitlement Programs are the Root of the Problem.* Over the next 75 years, Medicare and Social Security are promising benefits equal to $43 trillion (in 2009 dollars) more than they can finance as currently structured – a gap often called the programs' "unfunded liabilities." Medicare is responsible for 88 percent (or $38.1 trillion) of the unfunded entitlement costs, versus about 12 percent (or $5 trillion) for Social Security. In the next 5 years, the combined unfunded liabilities for these two programs will increase by an estimated $14 trillion, to $57 trillion. Medicaid is projected to grow by 23 percent this year (partly due to "stimulus" funding), and 11 percent next year, suffocating State budgets.



- *This Course Threatens Both the Budget and the Economy.* Due to their drain on economic resources, the spending and debt levels now unfolding will dry up the prosperity of future generations and lead to declining standards of living.[14] This will further deprive the government of resources needed to support its commitments.

- *The President's Budget Worsens the Problem*. The vast spending ambitions in the President's budget add to the problem, doubling the debt over the next 5 years, and tripling it over the next 10 years, compared with 2008 levels. By the end of the decade, the debt as a share of the economy approaches levels of the 1940s, reaching 90 percent of gross domestic product [GDP]. This approaches the 1046 high-water mark of 108.7 percent of GDP. Interest payments become one of the largest spending categories in the budget, more than quadrupling over the next decade – from $209 billion this year to $916 billion in 2020.

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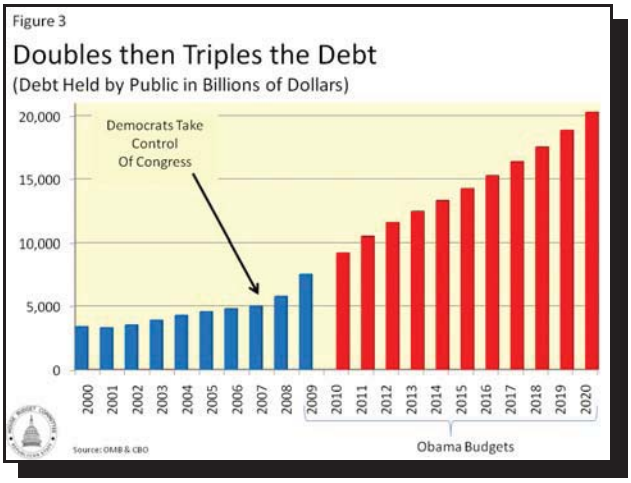
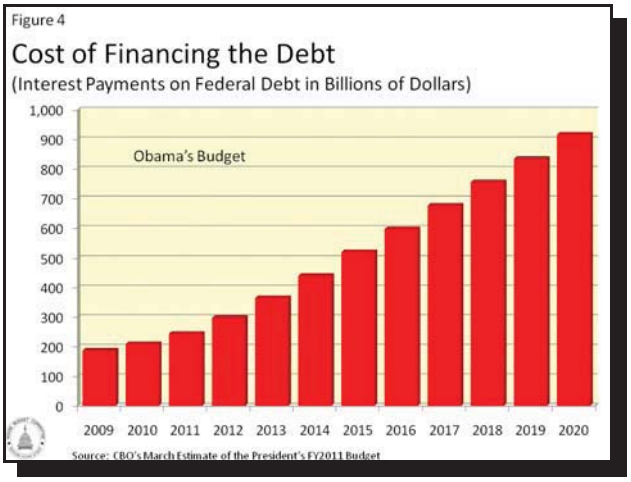
[14] CBO has concluded in several publications that skyrocketing debt levels resulting under current policies will have devastating economic consequences. See pages 16 through 18 of CBO's *The Long-Term Budget Outlook*, June 2009.

The President's answer is to hand off the problem to a "Fiscal Commission," which may or may not agree on solutions to recommend. But before the commission reports in December, the President and Democratic Majority are seeking to add their new trillion-dollar health care entitlement.





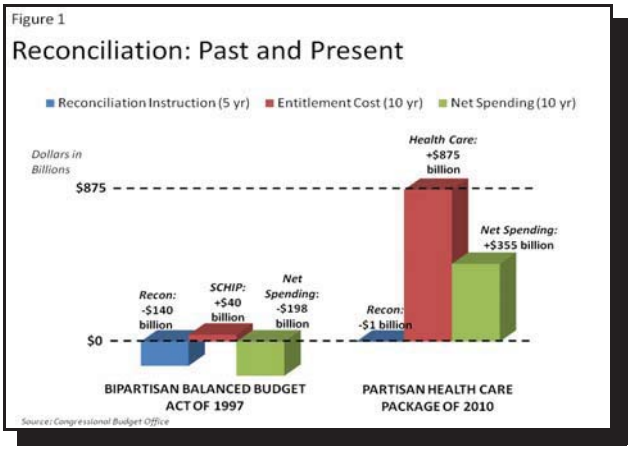
AN EXTRAORDINARY ABUSE

With all the fiscal and economic hazards this legislation invites, the method of pushing it forward is equally troubling. While budget and legislative process are complicated, it is critical to understand the nature and magnitude of the abuse taking place.

Proponents have tried to portray this undertaking a simple and not uncommon use of the budget reconciliation process. It is nothing of the kind. This is an extraordinary contortion, employed to force through sweeping changes in health care delivery and financing that lack adequate support in either the public or the Congress.

- *Nothing Typical*. Reconciliation originally was intended to expedite changes in spending and tax laws to make them align – to *reconcile* them – with levels in the budget resolution. Over time, it came to be used mainly to reduce budget deficits or, more broadly, to limit the growth of government.

  The process has never been used to push through a $1-trillion expansion of government, to seize control of one-sixth of the U.S. economy, and to reshape the way all Americans receive and pay for their health care. Nor has it ever leveraged such a vast social change based on a token $1 billion in savings over 5 years[15] in the face of a $1.5-trillion budget deficit this year alone – and doing so on a deliberate party-line vote, when the only bipartisanship lies *in opposition* to the legislation in question.



  Proponents have tried to defend their actions by citing previous instances in which reconciliation bills have contained substantive policy changes. But the comparisons weaken upon examination. For example, the Welfare Reform legislation of 1996 was bipartisan and reduced spending by $54 billion over 6

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[15] Section 202(a) of the budget resolution for fiscal year 2010 (S.Con.Res. 13) instructed the Committees on Ways and Means, Energy and Commerce, and Education and Labor to report legislation by 15 October 2009 reducing the deficit by $1 billion for fiscal year 2009-14, ostensibly for health care reform. Under section 202(b), the Education and Labor Committee was instructed to achieve $1 billion in deficit reduction for fiscal year 2009-14, ostensibly for education. The same instructions were given to the Senate Committee on Finance and the Committee on Health, Education, Labor, and Pensions.

years. The 1997 creation of the State Children's Health Insurance Program was part of the bipartisan Balanced Budget Act, which reduced Federal spending by $198 billion over 5 years.

With respect to taxes, the first reconciliation bill reduced taxes by $6 billion (at a time when total spending was $332 billion, total revenue was $279 billion, and total gross domestic product was $1.6 trillion).[16] Nor was either of the recent tax relief bills, in 2001 and 2003, used for such a vast expansion of government.

But even if one agreed that these prior cases were improper, none of them matched the scope and magnitude of this abuse. Further, as Senator Byrd has said: "Whatever abuses of the budget reconciliation process which have occurred in the past, or however many times the process has been twisted to achieve partisan ends does not justify the egregious violation done to the Senate's Constitutional purpose."[17] Nor would it justify expanding on such abuses to this unprecedented degree.

- *Mocking the Committee System*. Never before has the House committee process been reduced to such a charade.

  In response to their reconciliation instructions, two committees – Ways and Means, and Education and Labor – submitted thousands of pages of health care legislation to the Budget Committee, to be packaged and reported, as the process requires. (The Energy and Commerce Committee did not submit.)

  Immediately after the Budget Committee's markup, however, all the health care provisions were to be stripped out and replaced with an entirely new bill, written by a handful of people under the cover of the Rules Committee. The new text will not consist of health care legislation, but will instead contain modifications to the Senate-passed health care bill, applicable after that measure is passed by the House. In other words, the health care portion of the bill that reaches the floor as a result of this process will bear no resemblance to the provisions reported by the committees of jurisdiction. It will not have gone through the reconciliation process per se; it will be reconciliation in form only. The Democratic Majority needs to do this because they cannot pass the Senate bill without securing votes through the back-room deal that this vehicle will carry.

  It is common practice for the Committee on Rules to amend legislation before it reaches the floor. But this is a wholesale substitution. It renders the work of the committees of jurisdiction, and the Budget Committee, irrelevant.

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[16] Frumin, Alan S., *Riddick's Senate Procedure*, 1992, pages 622-3.

[17] Statement of Senator Byrd, 29 April 2009.

- *Not a Small Adjustment*. This is not just a simple "fixer" bill, or "sidecar," either.[18] It is the *keystone* on which the entire policy depends. If this process fails, the whole health care house of cards collapses.

- *An Equally Convoluted Rule*. Just as bizarre is the rule being contemplated for consideration of this legislation. The potential rule – fashioned by Rules Committee Chairwoman Slaughter – would "deem" passage of the Senate health care bill. At the same time, it will make in order consideration of the legislative language that will be substituted into this reconciliation vehicle, replacing the language the Budget Committee has reported.

  There are several motivations for this. First is plausible deniability: the rule allows a kind of hands-off passage of the Senate bill with all its shortcomings – the "Louisiana Purchase," the "Cornhusker Kickback," and so on – while Members brand it merely a *procedural* vote, not a substantive one. The strategy will fail, of course: anyone who votes for the rule votes for the Senate bill – there is no getting around it. Further, it stands in direct contradiction to the Majority's ostensible aim of seeking "a simple, up-or-down vote" on health care.

  Second, tying the Senate bill together in a rule with the substitute "reconciliation" language is aimed at allowing Members to claim they passed the first only on the condition that it *will* be modified by the second. This too will fail, because it still provides no guarantee that the Senate will ever take up the reconciliation measure. Expecting Senators to be bound by a House rule is laughable, and would violate a critical constitutional principle: that each House determines its own rules.[19]

  All this assumes that the "deeming" gambit is even a legitimate way to make a law. According to Article I, Section 7 of the Constitution, for a bill to become law it "shall have passed the House of Representatives and the Senate" and be "presented to the President of the United States" for signature or veto. There is no provision for legislation that is "deemed" to have passed by an indirect vote.[20]

The bottom line is this: the House cannot pass the Senate bill on a straight up-or-down vote, and the Senate can no longer pass its own bill again; hence the House Majority has fashioned this extraordinary, unprecedented, and remarkably arrogant

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[18] This is the claim Senator Conrad used – in *The Washington Post* on 6 March 2010 – to justify his change of heart about the use of reconciliation in this context.

[19] Article I, Section 5.

[20] See "The House Health-Care Vote and the Constitution," *The Wall Street Journal*, 15 March 2010. Judge McConnell is now a professor and director of the Constitutional Law Center at Stanford Law School and a senior fellow at the Hoover Institutoin.

set of tactics to circumvent the regular order, and to win a political victory at any cost, by any means necessary.

AN IMPERIOUS MAJORITY

The Reason for Rules

It is also crucial to understand that the design of Congress's legislative procedures – including Senate rules that exist for good reason. They are intended to prevent an overzealous Majority from suppressing a Minority – and to protect the public from national laws and policies arrived at through haste.

Whatever its advantages as a budgetary tool, reconciliation's fast-track procedures[21] clash with the Senate's constitutional role as a forum for thorough and thoughtful deliberation – a place intentionally designed to slow the creation of laws that will affect all Americans.[22]

The Framers were well aware of the hazards of what Tocqueville termed the "tyranny of the majority," and could trace the problem back to America's classical foundations. "If a majority be united by a common interest, the rights of the minority will be insecure," Madison wrote.[23] Ironically, in this case it is not a majority of the people – most of whom now oppose this huge and sweeping government intrusion in their health care – but only the Majority in Congress, who are acting *despite* the people's will.

It demonstrates another of Madison's warnings: "A dependence on the people is, no doubt, the primary control on the government; but experience has taught mankind the necessity of auxiliary precautions."[24] Indeed, the very existence of a bicameral legislature is designed to protect the governed, and Madison's commentary on this point was prescient:

> It is a misfortune incident to republican government, though to a less degree than to other governments, that those who administer it may forget their obligations to their constituents to their constituents and prove unfaithful to

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[21] Reconciliation limits Senate debate to 20 hours; prohibits non-budgetary, or "extraneous" matters from the legislation; and imposes strict germaneness rules on amendments. Because a Legislation taken up under reconciliation can be passed by a simple majority of 51 Senators. Thus, in today's Senate, a reconciliation bill can pass even if all the Republicans and nine Democrats oppose it, with the Vice President breaking the tie vote.

[22] See Senator Byrd's statement, 29 April 2009; and Senator Orrin G. Hatch, "A Health Care Reform Tactic That Degrades Democracy," *The Washington Post*, 2 March 2010.

[23] *Federalist* No. 51.

[24] Ibid.

> their important trust. In this point of view a senate, as a second branch of the legislative assembly distinct from and dividing the power with a first, must be in all cases a salutary check on the government. It doubles the security to the people by requiring the concurrence of two distinct bodies in schemes of usurpation or perfidy, where the ambition or corruption of one would otherwise be sufficient.[25]

This is why Senators are elected statewide (and presumably why, until 1913, they were chosen by State legislatures), and why each State has two: "No law or resolution can now be passed without the concurrence, first, of a majority of the people, and then of a majority of the States."[26]

All these are reasons why the violation of the reconciliation process – and the regular order of legislative procedures – is an alarming development, undertaken by a clearly desperate Majority. It is even worse considering the stakes: promoting a government takeover of health care – one of the most valued and personal services Americans have – and creating a new trillion-dollar entitlement that will accelerate the Nation's march toward fiscal and economic decline.

Major Social Change by a Paper-Thin Margin

One of the strongest and most respected proponents of bipartisanship was the late Senator Daniel Patrick Moynihan; but his views were not simplistic: he understood partisan debate had an appropriate place: "For the most part, I think you want the clash of ideas – you get the best from both that way."[27] But major social legislation, Senator Moynihan believed, required broad consensus in both Congress and the public. David R. Gergen, writing a day after the Blair House health care "summit," recently described the Senator's views as they would apply to the current debate.

> Moynihan, a Democrat, told me that there were two essential pre-requisites to passing major social reform in this country. The first, he said, was that landmark social legislation should be passed with significant, bipartisan support from both sides of the aisle – otherwise, there would always be trouble with it. He sent me the vote tallies to show how at least a half dozen or more Senators from the opposition party voted for big social initiatives stretching back to the New Deal – from Social Security in the 1930s, the civil rights bills of the mid-1960s, and Medicare and Medicaid bundled together in 1965.

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[25] *The Federalist*, No. 62.

[26] Ibid.

[27] Speaking at a forum at The Center on Congress at Indiana University, aired on C-SPAN 16 February 2001.

> Secondly, he said, landmark social legislation should enjoy solid support from the public before it is passed.[28]

The current health care legislation, Mr. Gergen noted, passes neither test. Only one Republican supported the House bill, and he has since changed his mind. No Republicans voted for the Senate measure – not even the moderates who wanted to move it forward. Over the past year, public support has declined, to the point where most Americans oppose the legislation being pursued.

Mr. Gergen concludes: "I wish Pat Moynihan were at Blair House to whisper in the President's ear."[29]

If this convoluted process succeeds, it will be unfortunate in two ways: first, by allowing this huge change in policy to be enacted; and second, by creating a perverse temptation for future Congresses, Republican or Democratic, to use it as a precedent for future legislation, including reconciliation.

STARTING OVER

There is broad agreement on the need to reform health care. Skyrocketing health care costs are driving families, businesses, and governments to the brink of bankruptcy – and leaving millions without adequate coverage. There is a need to address pre-existing conditions, to realign the incentives of insurance companies with patients and doctors, and to root out waste, fraud, and abuse.

But what is also needed is a different vision of how to meet the problems in health care, one that truly addresses the central problem of cost while maintaining a sturdy safety net for those who need it. Alternative approaches have been available, and still are – and they could lead to a truly bipartisan consensus on reforms that would address the most important and widely acknowledged problems.

When the House Majority brought its health care bill to the floor in November, the Republican Minority offered a substitute – a plan that would lower health care premiums; establish universal access to coverage for persons with pre-existing conditions; prevent insurers from unjustly cancelling policies; encourage small-business coverage; promote innovative State health plans; allow Americans to buy health insurance across State lines; enhance Health Savings Accounts; and reform malpractice law to prevent costly, frivolous lawsuits.[30]

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[28] Gergen on the Anderson Cooper 360 blog, 24 February 2010.

[29] Ibid.

[30] For a summary see: http://gopleader.gov/UploadedFiles/Summary_of_Republican_Alternative_Health_Care_plan_Updated_11-04-09.pdf

There have been numerous other proposals introduced by individual Members of the Minority during the past year, bringing their own perspectives to the issue. These have included the following (listed by the date of introduction):

- The Patients' Choice Act of 2009, introduced by Representative Ryan of Wisconsin on 20 May 2009.
- The Small Business Health Fairness Act of 2009, by Representative Johnson of Texas on 21 May 2009.
- The Help Efficient, Accessible, Low-Cost, Timely Healthcare [HEALTH] Act, a medical liability reform bill introduced by Representative Gingrey of Georgia on 6 June 2009.
- The Medical Rights and Reform Act, introduced on behalf of the Tuesday Group, by Representatives Kirk of Illinois and Dent of Pennsylvania, 16 June 2009.
- The Improving Health Care for All Americans Act, introduced by Representative Shadegg of Arizona, 14 July 2009.
- The Empowering Patients First Act, introduced by the Republican Study Committee on 30 July 2009.
- The Promoting Health and Preventing Chronic Disease Through Prevention and Wellness Programs for Employees, Communities, and Individuals Act of 2009, introduced by Representative Castle of Delaware, 31 July 2009.
- The Improved Employee Access to Health Insurance Act of 2009, an auto-enrollment bill introduced by Representative Deal of Georgia, 15 October 2009.
- The Health Insurance Access for Young Workers and College Students Act of 2009, a measure to improve coverage of dependents, introduced by Representative Blunt of Missouri, 21 October 2009.

None of these pretends to offer the perfect and complete solution to every problem. But all represent alternative approaches that should be considered – especially when the quality and affordability of Americans' health care is at stake.

Other elements worthy of consideration are the following:

- *Reforming the Tax Treatment of Health Care.* Addressing the discriminatory tax treatment of health insurance would lower health costs. Currently, coverage is linked to employment by the tax exclusion for employer-sponsored health insurance. This tax treatment effectively discriminates against workers and families who do not have job-based coverage. Linking the tax benefit to the individual would help put American families and their doctors back in control of their health care needs.

- *Greater Opportunity for Small-Business Coverage*. The proposal would create an alternative for small businesses to offer health benefits. Currently, unless a business can afford to offer a full-scale health insurance plan, its options are limited. The refundable tax credit model allows employees to take responsibility for purchasing their own health care with the credit, but also allows small businesses to make defined contributions to accounts – such as Health Savings Accounts [HSAs] – to help fund their employees' health care expenses.

- *High-Risk Pools*. State health insurance high-risk pools would offer affordable coverage to individuals who would otherwise be denied coverage due to pre-existing medical conditions. This would make coverage affordable for those currently deemed "uninsurable."

- *One-Stop Marketplace for Health Insurance*. Each individual would have an opportunity to choose the plan that best meets his or her needs through a State-based Exchange.

- *Simple Auto-Enrollment.* An Exchange would make it easy for individuals to obtain health insurance by providing new and automatic opportunities for enrollment through places of employment, emergency rooms, the Division of Motor Vehicles, and the like. If individuals did not want health insurance, they would not be forced to have it. Research has shown that auto-enrollment mechanisms have achieved near universal levels of coverage. An auto-enrollment mechanism has also been demonstrated to increase the percentage of employee-participation in employer provided 401(k) plans by 70 percent – from 20 percent of new employees enrolled after 3 months under self-employment, to 90 percent of new employees participating under auto-enrollment.

- *Interstate Purchasing.* Another reform worthy of consideration is interstate purchasing. Individuals could be allowed to use the refundable tax credit toward the purchase of health insurance in *any* State. This would greatly expand the choices of coverage available to the consumer, and also would encourage broader competition and diversity among insurers, who would be able to sell their policies to individuals and families in every State, as other companies do in other sectors of the economy.[31]

- *Medical Liability Reform.* Medical lawsuits and excessive verdicts increase health care costs and result in reduced access to care. Indefensible mistakes do happen, and when they do patients have a right to fair legal representation and fair compensation. But the current tort litigation system often serves the interests of lawyers while driving up costs and delaying justice. One solution to limit

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[31] Government Accountability Office, *Federal Employee Health Benefits Program: Competition and Other Factors Linked to Wide Variation in Health Care Prices*, August 2005.

lawsuit abuse without limiting legal justice by implementing a cap on non-economic damages, and assisting States in establishing solutions to medical tort litigation. By enabling each State to tailor a solution to its own needs, the plan ensures the accessibility of health care for everyone by stopping the unreasonable costs for medical malpractice litigation.

Again, these proposed reforms should not be taken as a perfect and complete solution. Further, they could be pursued incrementally – doing what can be done, step by step, to control costs and expand access to quality health coverage. But they can point the way to real answers that can gain bipartisan support in Congress, backed by a broad consensus of the American public.

CONCLUSION

The United States stands at a precipice, where entitlements are pushing Federal spending to levels that will overwhelm the budget and smother the economy. The deepening deficits and debt will drain the U.S. economy of resources needed for growth and rising standards of living.

In the face of this fiscal challenge, the Democratic Majority is proposing to enact sweeping legislation creating a new $1-trillion entitlement, seizing control of one-sixth of the U.S. economy, and fundamentally altering the way Americans receive and finance their health care.

The Majority intends to enact this legislation through a convoluted process that involves abuse of House rules and the Budget Act's reconciliation process. Despite growing opposition to their plan – increasingly expressed over the past year, and culminating in January's Massachusetts Senate election – the Majority will exercise their raw political power to enact this bill, which will increase health care costs, diminish health care quality, impose taxes during the worst recession since the Great Depression, and increase spending, deficits, and debt.

This partisan debacle has been a tragic missed opportunity for true, patient-centered reform. Republicans will continue to pursue reforms that promote the central role of patients and doctors in health care.