Center for American Progress

Still Making Things Worse

An Updated Critique of Conservative Health Policy Proposals

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Introduction

Less than six months after passage of the Affordable Care Act—landmark legislation that will expand coverage to 31 million Americans, reduce the growth of health care spending, and reduce the federal deficit over the coming decade—conservative think tanks, pundits, and politicians are urging Congress to repeal, or repeal and replace, the new law. But how would these pundits and policymakers address the problems of cost, coverage, and access that have festered in our health care system for decades? Would their proposals solve this puzzle?

A careful look makes clear they would not. Most of those who advocate repeal of the Affordable Care Act, or ACA, are really calling for a "do-nothing" approach. Their "solution" is for today's myriad health care problems to continue to fester and grow, saddling future generations of Americans with unsustainable federal budget deficits and leaving the American people paying more each year for health insurance—if they are fortunate enough to have health insurance at all.

Even worse, though, are proposals offered by some conservatives. Whether small or large in scope, these approaches would exacerbate already existing problems in our health care system while failing to rein in ever-rising health care costs. These conservative "solutions" would hurt the average family budget and those left out of our health care system altogether. But let's look at both of these conservative options—simply returning to the status quo of 2009, or doing even more harm—in more detail. Neither approach offers the health care prescription our nation needs.

Preserving the status quo

Prior to passage of the Affordable Care Act, the U.S. health care system was broken. Even after passage of the new law, much work will be necessary to effectively implement this legislation. In the year before passage of comprehensive health care reform, more than 46 million people in our country lacked health care coverage, while health care premiums were growing three times faster than wages and four times faster than inflation.[1] Quality of care varied widely, and many Americans either received too little care or care inappropriate to their needs. And the nation's public health insurance programs—primarily Medicare, Medicaid, and the Children's Health Insurance Program, which provide coverage to more than 90 million people—could not, with their existing eligibility rules, serve as safety nets for millions of low-income, uninsured Americans.[2] Until the new law is fully implemented, many of these dynamics remain.

This scenario, in short, was untenable. Escalating health care costs put health insurance out of reach for many Americans without health coverage. As Congress was considering the new law, four out of five people without health insurance lived in working families, but these families earn too little to purchase coverage on their own. Employers, who provide coverage to 163 million workers and their dependents, struggled to absorb rising health insurance premiums, which have grown 131 percent in the last decade.[3] And individuals who purchased coverage on their own often experienced unpredictable jumps in their health insurance premiums. One high-profile example—Wellpoint's Anthem Blue Cross company in California, which initially tried to increase premiums by up to 39 percent for individual policyholders—emerged during final consideration of the new law.

Nationwide, at the beginning of ACA implementation, we continue to spend more than 17 percent of gross domestic product on health care, and health care costs account for nearly 20 percent of household consumption.[4] Among Americans with below-average incomes, more than half have unmet health care needs due to the high cost of care.[5]

In addition, many individuals and families are unable to purchase health insurance because of insurance company practices. In most states, insurers can deny coverage to people with preexisting conditions or rescind insurance from policy holders who become sick. A recent survey reveals that over the course of three years, insurance companies denied coverage to 12.6 million Americans who sought health insurance in individual market.[6] And for those who are able to get coverage on the individual market, policies can be very costly, particularly

for people with health problems. In many instances, these policies do not cover certain services, and they commonly impose annual or lifetime limits on how much policyholders can spend on care.

The U.S. health care system also is riddled with inefficiency and poor quality care. The Institute of Medicine, part of the National Academies of Science, estimates that up to 98,000 people die each year due to medical errors—more than the number of people who die in motor vehicle accidents, or from breast cancer or AIDS.[7] One in five Medicare beneficiaries have unplanned re-hospitalizations within 30 days of a discharge.[8] Others receive more care than they need—a costly inefficiency the nation can ill afford.

Overutilization of health care services in our country is driven in part by a payment system that rewards the volume and complexity of services rendered rather than the suitability and quality of those services. At the same time, doctors and patients have little information on which treatment, drug, or medical device is best suited for a given condition. Taken together, the prevailing payment system and this dearth of comparative information fuel an inclination to provide the most expensive service or treatment, even if it's no better than an older, cheaper one.

Finally, looming health workforce shortages in nursing and certain physician specialties, such as primary care and general surgery, also threaten future access to basic care. The Health Resources and Services Administration estimates that by 2020 there will be a shortfall of 49,000 physicians and more than 800,000 nurses.[9] Those Americans who lack access to providers—especially primary care providers—often do not receive treatment for preventable conditions. Limited access to primary care providers, in addition to lack of insurance, is a leading cause of nonurgent emergency room utilization.[10]

As bleak as the status quo looked in 2009, the picture only appeared darker when we looked to the future. Researchers estimated that by 2019, many employers would see their health premiums more than double, thus limiting their ability to provide coverage and add workers. Health care benefits would represent 17 percent of total worker compensation, up from roughly 10 percent, and families would face out-of-pocket costs that grow by 35 percent or more. And the ranks of Americans without health insurance would have swollen to more than 65 million.[11]

The ACA took concrete steps to alter these trends and deliver the lower-cost growth, increased coverage, and improved quality necessary for transforming our nation's health care system. In particular, the new law improves the availability

of health coverage by transforming the national health insurance market. Health plans will no longer be allowed to deny coverage or charge higher premiums to people with health problems, or to rescind coverage when policyholders get sick.

At the same time, the new law establishes health insurance exchanges, a new marketplace that will enable individuals and families who do not have coverage through an employer, and who do not qualify for public insurance, to find high quality, comprehensive coverage. In this exchange, consumers will be able to comparison-shop across policies, making apples-to-apples comparisons of benefits, likely out-of-pocket costs, and other important variables.

The ACA also ensures that health coverage is affordable for all Americans. It strengthens and expands the Medicaid program, which previously provided a health care safety net for many, but not nearly all, low-income Americans. It also provides real help with premiums and co-payments for individuals and families who do not have employer coverage and can't afford the full cost on their own.

The new law invests in our healthcare workforce to ensure our nation has enough primary care doctors and nurse-practitioners and the tools these providers need, such as research on which treatments work best and technology that can help them manage care. It also ensures that all Americans enjoy easy access to preventive care, and can develop the knowledge and skills they need to manage their own health.

Finally, provisions of the new law bring a new focus to cost containment, creating real financial incentives for health care providers to improve care for people with chronic conditions by improving the quality and efficiency of care. They combine the market muscle of the Medicare program with the innovation capacity of private payers to prompt greater changes than either sector could manage on its own, and ensure that successful payment reforms and delivery system strategies are duplicated across the country.

Through a Medicare innovation center, and a public-private commission dedicated to reducing growth in health care costs, the ACA ensures that payment innovation will take root and grow. The new law also takes steps to reduce the prevalence of high-end insurance plans and the overuse of services that they encourage through very generous coverage, further enhancing cost-control efforts.

But conservatives who would repeal the law—in particular, Reps. Steve King (R-IA) and Wally Herger (R-CA), as well as Minority Leader John Boehner (R-OH) and other members of the Republican leadership—would return our nation to this untenable status quo. Repealing the Affordable Care Act would enable insurance companies to continue discriminating against individuals with preexisting conditions. Repeal would mean that approximately 15 million Americans would do without the help they need to pay for their health insurance premiums, while another 15 million will be denied Medicaid coverage, simply because their family makeup or modest incomes disqualify them for public health insurance coverage. And repeal would mean that health care costs would continue to grow at an untenable rate, while patients would continue to experience chaotic, episodic, and poorly coordinated care.

In short, repeal means a return to the bad old days that we have only begun to leave behind.

Conservatives' solutions

But what happens if the Affordable Care Act is repealed and conservative policymakers can pursue their own health reform agenda? The elected officials and health policy experts who have offered up policy solutions to this crisis are often criticized for proposing only "small ideas" in response to our nation's serious health care crisis.[12] These criticisms correctly identify a grab bag of ideas, common to virtually all conservatives engaged in health care reform, which are intended to make coverage more affordable for small segments of the population. These proposals do nothing to tackle the large, interconnected problems that plague our current health care system.

Consider conservatives' most cherished reforms: Enabling health insurance companies to sell coverage outside of their licensing state, medical malpractice reform, and enabling small businesses to purchase coverage through business or professional associations. All three proposals are unlikely to make a significant difference in health care costs for the average American family with health insurance or make a meaningful dent in the numbers of Americans without health insurance. And they carry significant risks for patients, small businesses with older and sicker workers, and others.

But these small ideas are not the only ideas advanced by conservative policymakers. Conservative health policy proposals also include some clearly radical ideas, such as changing the tax treatment of health insurance and significantly altering the public health insurance programs that provide coverage today for nearly 90 million people. Taken together, conservative ideas fall into several big themes:

- Promoting the individual health insurance market, where Americans seek coverage on their own instead of benefiting from the buying power of employers and other large groups

- Eliminating the nation's public health insurance programs so that millions of Americans lose guaranteed health care coverage

- Shifting responsibility for health care cost containment to individuals and families, which means paying more for less health care

Let's unpack each of these radical ideas in turn.

Promoting the individual market

A major emphasis of conservative health reform proposals is to move Americans from group coverage—typically employer-sponsored health insurance but also public health insurance programs such as Medicaid—to the individual health insurance market. Conservatives argue that Americans would have greater ability to maintain coverage through changes in employment and work status if individuals and families purchased insurance on their own rather than through an employer.

Critics of this idea note that unpredictable costs, limited benefits, and the discriminatory practices characteristic of the individual insurance market would undermine any advantages related to insurance portability. Millions of Americans would face loss of health insurance coverage through preexisting condition exclusions or lose coverage after falling ill as conservative reform proposals shift Americans to individual coverage through a combination of discrete policy changes.

First of all, conservative policymakers propose to unravel employer-based coverage by either eliminating, or severely limiting, current tax treatment for employer-sponsored health insurance.[13] Today, approximately 163 million workers and their dependents receive health insurance coverage as a tax-free benefit. Under conservative proposals, workers who receive coverage through their jobs would pay income and payroll taxes on some or all of the health insurance premiums

paid by their employers. Yet significant research concludes that treating some or all of employer-covered premiums as taxable income would result in the erosion of employer-sponsored coverage because employers' and employees' incentives for participating in an employer-based system are reduced.[14]

Undeterred, Rep. Paul Ryan (R-WI), Sens. Judd Gregg (R-NH), and Tom Coburn (R-OK) have all proposed some variation of this idea over the last year. Former Speaker of the House Newt Gingrich, conservative health policy analyst John Goodman, and Minnesota Governor Tim Pawlenty have all floated the idea in the national op-ed pages. In addition, Sen. John McCain (R-AZ) made a similar proposal during the 2008 presidential campaign.[15]

A related concept—often offered in tandem with changing the tax treatment of employer-sponsored coverage—would create new tax breaks for individually purchased health insurance policies. This approach would enable individuals and families who purchase coverage on their own to either receive a refundable tax credit or claim an itemized deduction on their individual income taxes. The value of the credit typically ranges from approximately $2,300 for individuals to $5,700 for families, with some variation across plans, while Sen. Gregg's proposal for a tax deduction would limit the deduction to the lower of the actual premium, or $11,500 per family and $5,000 per individual.[16]

The actual value of the deduction when translated into reduced tax liability, however, would be significantly smaller. Higher-income families would reduce their taxes by $4,025 if they took the maximum possible deduction of $11,500, while families in lower tax brackets would receive a smaller benefit. Both the proposed tax credits and the Gregg deduction fall short when compared to the cost of comprehensive coverage through a group plan, which averaged $13,375 in 2009. So these proposed credits and deductions do not come close to covering the full cost of comprehensive coverage.[17]

In addition, the buying power of these credits and deductions would diminish over time, as conservative policymakers typically propose using a growth index that falls well below average growth in health care costs. Sen. Coburn and Rep. Ryan, for example, propose growing their tax credits more than 2 percentage points more slowly than expected growth in health care costs.[18]

Finally, a number of conservative policymakers—notably Sens. Gregg and Coburn and Rep. Ryan—propose to move low-income families from Medicaid coverage to the individual market. Under this approach, low-income families

would, like other Americans, receive tax credits or other help with purchasing health coverage. This coverage is unlikely to be as comprehensive as the Medicaid benefit package and would entail significant out-of-pocket costs through deductibles, copayments, and uncovered services. These proposals include additional subsidies to these families to help with these costs, but even with this supplement low-income families will face higher health care costs.

Moving millions of people out of group coverage and into the individual market raises a number of thorny issues. First, coverage in the individual market is hard to obtain. Except for insurance companies that operate in the handful of states with comprehensive insurance reform, most insurers subject applicants to underwriting tests, examining their health histories in an effort to determine whether they have preexisting conditions and should therefore be denied coverage. In other cases, the insurance company may offer applicants with health problems coverage that excludes particular treatments or body parts, or the insurer may significantly increase the premium cost.[19]

Between 2004 and 2007, nearly three-quarters of all individuals who sought coverage in this market did not end up purchasing a policy—many could not afford the coverage they were offered while others were denied coverage altogether due to a preexisting condition.[20] Insurers in many states may also "rescind" coverage once they have sold a policy and collected premium payments. Insurers in the individual market also charge highly differentiated premiums based on age or gender.

These problems go largely unaddressed by conservative policymakers. And some of their other proposals, such as allowing insurers to sell policies in any state, would undermine strong insurance industry regulations and other consumer protection laws in the states that have made insurance market reforms.

Some conservative policymakers are divided on the extent to which they seek to reform insurance markets. Rep. Wally Herger (R-CA), for example, recently released a so-called repeal-and-replace bill, which would enact a proposal introduced by Rep. Dave Camp (R-MI). Minority leader John Boehner (R-OH) also offered this proposal—the "Common Sense Health Care Reform and Affordability Act"—as the Republican alternative during last year's reform debate. The Common Sense proposal would expand so-called high-risk pools rather than ban preexisting condition exclusions.[21] High-risk pools are arrangements that make some degree of coverage available to individuals with preexisting conditions

who cannot purchase coverage in the individual market. These pools currently cover 200,000 individuals, and often refuse to cover the health problem that makes the enrollee eligible for the high-risk pool in the first place.

The Common Sense proposal also would prohibit annual or lifetime limits on health benefits and would limit insurers' ability to rescind coverage once the policy is in force. Rep. Tom Price (R-GA) of the Republican Study Committee employs a similar strategy.[22]

In contrast, Sen. Coburn and Rep. Ryan would enable health plans to continue using annual and lifetime limits, and continue policy rescissions, but would ban exclusions for preexisting conditions. Sen. Gregg would also end those exclusions and annual and lifetime benefit limits, but he does not address rescissions. None of the conservative proposals restrict rate-setting practices. This means insurers can charge people with chronic illnesses and other preexisting conditions exorbitant rates.

In sum, none of these proposals takes a comprehensive approach to reforming the individual insurance market, which means Americans who must turn to this market for health insurance will face some combination of limited access to coverage, inadequate coverage, and unaffordable premiums.

Finally, this move to the individual market would shift a significant portion of health care costs to individuals and families. Insurance policies in the individual market typically carry higher deductibles and co-payments, while covering fewer health care services compared to comprehensive employer-based coverage. Families covered by these skimpier policies must often pay out-of-pocket for uncovered services, and be prepared to lay down significant resources to meet their annual deductible and cost-sharing requirements.

Undermining the nation's public health insurance programs

Consistent with (and part of) this push toward the individual market, conservative policymakers also propose dismantling critical public health insurance programs, including Medicaid, the Children's Health Insurance Program, and Medicare. These programs provide publicly funded insurance to a range of individuals and families who cannot access affordable, market-based coverage, including senior citizens, people with disabilities, children living in low-income families, low-income pregnant women, and people with long-term care needs.

As noted earlier, legislation proposed by Rep. Ryan and Sen. Coburn would end Medicaid eligibility for low-income children and families, pregnant women, and low-income seniors, offering a tax credit for use in the individual insurance market in place of Medicaid coverage. In both proposals the standard tax credit would be supplemented by additional income-based subsidies for lower-income populations.

These two bills would also convert the remaining Medicaid program—essentially long-term care services and coverage for low-income people with disabilities—to a block grant program. Under this structure, the federal government would make fixed, formula-driven payments to states, which would then be responsible for providing services to individuals with disabilities and people with long-term care needs. But the states could not rely on federal payments that increase with enrollment or service costs. Individuals who currently rely on Medicaid to provide this coverage would no longer have a guaranteed source of payment for their health care needs.

In his "roadmap plan," Rep. Ryan also envisions transforming Medicare coverage into a voucher payment, which people eligible for Medicare can use to purchase an individual health insurance policy. Individuals who become eligible for Medicare after January 1, 2021, would receive vouchers, including those who acquire Medicare eligibility by qualifying for Social Security disability benefits (currently 16 percent of individuals with Medicare coverage), individuals with end-stage renal disease, and those who reach the Medicare eligibility age.[23]

These vouchers, according to the Congressional Budget Office, would have a value equivalent to $5,900 in 2009 dollars—far short of the cost of age-rated insurance policies in the individual market. And Rep. Ryan's legislative language clearly indicates that the disability population would receive vouchers like everyone else, even though the CBO estimate (based on consultation with his staff) assumed otherwise.[24]

These proposals raise a number of serious issues. Low-income individuals who rely on the Medicaid program for comprehensive health insurance coverage would be forced to move to private plans with more limited coverage and higher out-of-pocket costs. And while the Ryan budget roadmap, for example, would provide current Medicaid enrollees with a higher-than-average subsidy to cover premium costs, the total subsidy, $11,000 per year, still falls short of the average premium for comprehensive coverage purchased in the group market.

In some cases, these low-income families may not have the ability to make up the difference between the premium and cost-sharing obligations they would face in the individual market and the help offered to them under this proposal. In addition, the buying power of these subsidies will diminish over time because the subsidy amount typically grows more slowly than expected growth in health care costs.

In addition, without meaningful insurance market reforms, many people with Medicaid, CHIP, and Medicare coverage may experience real difficulty finding a health insurance policy. In 2006, for example, Medicare covered 6.9 million people with disabilities so severe that they cannot work.[25] Unless insurance companies are required to sell a policy to all who seek coverage, and are prohibited from pricing policies based on health status, these individuals are unlikely to find affordable coverage in the individual market. And, as discussed earlier, conservatives typically do not propose such reforms of insurance industry practices.

Finally, proposals to protect the federal government from financial risk related to population growth, economic downturns, and growing health care costs would leave the states extremely vulnerable to unanticipated health care costs. Transforming Medicaid coverage for people with disabilities and Medicaid payment for long-term care costs into a block grant program would leave the states on their own and at financial risk. Medicaid enrollment, for example, grew by 3.3 million individuals from June 2008 to June 2009.[26] The overall Medicaid population would look considerably different under these conservative proposals, but even with enrollment limited to low-income people with disabilities and people with long-term care needs, states could still expect enrollment to grow during economic downturns.

Shifting cost-cutting responsibilities to patients

Conservatives also promote strategies for shifting responsibility for controlling health care costs from insurance companies, public insurance administrators, and health care providers, the latter of whom drive the majority of health care spending through referrals, recommendations, and treatment plans, to patients themselves. In this way, conservatives believe, individual patients will be able to make sophisticated and complex decisions about the costs of their own health care by themselves while also lowering overall health care costs in the United States. They are wrong on both counts.

Consider first conservatives' favorite idea for controlling costs—health savings accounts. For many years, conservatives have touted high-deductible health insurance plans in combination with health savings accounts as a strategy for

reducing health care spending. These arrangements require patients to pay out of their own pocket, or out of their health savings account, until they reach their deductible and full coverage kicks in. This approach will, proponents argue, encourage patients to spend their health care dollars frugally and effectively.

Advocates for health savings accounts believe that paying a greater proportion of their health care spending will drive patients to seek higher-quality providers and shop for lower prices on a given procedure. Today, various conservative policymakers and health policy experts, among them Reps. Herger and Rep. Ryan, propose raising the contribution limits for the savings account component of these arrangements or making other changes to make health savings accounts more attractive to potential enrollees.

Yet to the degree that health savings accounts induce enrollees to reduce their health care spending, these incentives are focused on the health care people use before they meet their deductible. Because 80 percent of all health care spending is dedicated to only 20 percent of the population, this approach will have little impact on total health care spending.[27] The patients who consume most of our nation's health care dollars—people with catastrophic problems or chronic illnesses—use health care services at levels that far exceed a deductible, including the high deductibles featured in health savings account plans.

So instead of addressing the factors that drive the vast majority of health care spending in the United States, such as poor coordination and poor quality of care for people with chronic disease, this approach simply asks very sick people to pay for a larger proportion of their care themselves.

This emphasis on health savings accounts also assumes that patients can shop for health care just as consumers shop for other goods and services. To be savvy health care consumers, patients would need quality and cost information on providers, comparative research on competing treatment plans, and other information that simply does not exist today. This emphasis on "consumerism" to control health care costs also assumes that people are indifferent to any factor other than price—when in fact patients choose physicians based on long-standing relationships, trusted referrals, location and convenience, and intangible attributes such as personality and compassion.

In addition, nearly half of our national spending on health care services is dedicated to institutional payments to hospitals, nursing homes, and other

facilities. In general, when individual consumers need these levels of care, they have very little ability to control the intensity or cost of the services they receive. Their needs are simply too acute or too complex.

Finally, Gingrich and Goodman propose allowing physicians to "repackage and reprice" the services they provide people with Medicare coverage, which would effectively unravel the fee schedule Medicare uses to pay doctors and other providers. This conservative approach is intended to provide some useful flexibility, such as payment for email and telephone consultations, and to create a more price-sensitive market for physician services. But again, this pushes cost-containment responsibility to the consumer.

A flawed approach to health reform

The true challenge of health care policy-making is to address the all-too-real problems of cost, coverage, and quality in our health care system. Improving the availability and affordability of coverage, reining in the growth of health care costs, and making the infrastructure investments necessary to modernize heath care delivery and address developing health care need must be top priorities. To be successful, reforms must offer pragmatic solutions that achieve these goals.

The conservative approach—which promotes the individual insurance market, undermines public health insurance programs, and requires individuals and families to take responsibility for controlling health care costs—fails to meet this standard.

Likely outcomes of conservative proposals

Given the very real problems in our nation's health care system, how would these conservative proposals address our systemic problems, and what would the U.S. health care system look like if they were implemented? It is impossible to develop precise cost and coverage estimates when considering a range of proposals, but existing research points to some clear probabilities.

Providing tax credits or tax deductions in the place of employer-sponsored insurance and public health insurance coverage would result in millions of Americans moving into the individual insurance market—and millions more who will not be able to find affordable coverage in this market. Recent cost

and coverage estimates of these approaches are elusive, but an analysis of Sen. McCain's 2008 health reform proposal, which featured new tax credits for the purchase of health insurance, and the elimination of the tax exclusion for employer-provided health coverage, estimated that 20 million people would lose employer-sponsored coverage.[28]

Because policies in the individual market are less likely to include comprehensive benefits, more families would face high out-of-pocket costs for cost sharing and uncovered services. At the extreme, families may be duped into buying junk insurance, which offers virtually no financial protection but nevertheless proliferates in some poorly regulated markets. Families facing high out-of-pocket costs, or carrying poor insurance, are more likely to face medical bankruptcy, even though they have health insurance.

These conservative proposals also are likely to result in larger numbers of uninsured Americans. Families who previously held coverage through an employer or through the Medicaid and CHIP programs would find that the new tax credits or deductions do not provide enough help for them to purchase coverage on their own. Some small business owners and their employees also are likely to find coverage less affordable because association health plans—which create group purchasing options for small businesses—enable businesses with younger, healthier employees to find advantageous employer-provided health insurance plans, leaving those with older, sicker workers in the current small group market where their premiums will spiral up once the good risks and healthy workers have been siphoned off to association health plans.

Finally, health care costs overall would continue growing at unsustainable rates, since individual patients will have little ability to induce doctors, hospitals, and other providers to improve efficiency, improve coordination for people with chronic illnesses, and upgrade the quality of care they deliver. Nor could individual patients, largely through the dollars they would spend on services they consume before they meet their deductible, create the kind of financial incentives that would induce providers to develop the new types of health care organizations most experts think are needed to truly improve health care delivery and control the growth of health care costs.

A specific example—repeal and replace

The consequences of the conservative approach can be best understood through a thorough examination of one specific proposal—the Common Sense plan. Rep.

Camp introduced this plan on November 6, 2009, and Minority Leader Boehner offered the same language as the so-called House leadership alternative to the Democratic proposal in during floor debate in mid-November. Boehner has since signaled that he would like to replace the law with this plan.[29] In short, the plan has all the main ingredients of the conservative approach to health care reform: it shifts the costs and risks of insurance onto individuals, and divides the already fragmented insurance market into low-cost plans for the healthy and high-cost insurance for the sick.[30]

To insure sicker individuals who are currently uninsured and can't find affordable coverage in the unregulated individual market, the bill requires states to establish high-risk pools with the aid of $15 billion in federal funding. But like most pools designed to insure very sick and costly beneficiaries, these programs would likely try to control costs by denying coverage for certain chronic conditions. The bill does abolish waiting lists and specifies that the pools must provide at least two coverage options (one of which must be a high deductible plan with a health savings account), but it does not require states to cover all preexisting conditions. Given the limited federal funding and the cap on premiums—they could be set no higher than 150 percent of the state average—this cannot be a permanent solution for providing coverage.

For Americans moving from group to individual coverage, the legislation eliminates the Health Insurance Portability and Accountability Act requirement of having creditable coverage in the past 18 months to receive individual insurance. Annual or lifetime spending caps are also eliminated and insurers will no longer be able to rescind coverage. But since insurers could still deny coverage for preexisting conditions and charge very different rates based on gender and age, these plans would only be open to healthier and younger Americans who can survive the tedious underwriting process.

Under this bill, insurers selling products in the individual health care market will no longer be confined by the consumer protections of a particular state. Instead, they will be able to choose their own rules and regulations by declaring a state as their "primary" state. From that locale, issuers can sell to customers in all other states and the District of Columbia. This is the plan's signature proposal and it's worth examining further.

Conservatives claim that they are empowering individuals by giving everyone a choice of plans across the United States. But in reality this provision is a thinly veiled attempted to free insurers from any rules or regulations. The plan not only

undermines state sovereignty by stripping states of their power to set insurance rates and conditions, but also tilts the balance of power in the regulator-issuer-beneficiary relationship toward the issuer.[31]

The Common Sense proposal also explicitly expands the definition of "state" to include not just D.C. and Puerto Rico, but also the Virgin Islands, Guam, American Samoa and the Northern Marianas.[32] Companies can designate the Northern Marianas as the "primary state" for their plan—and then have that island's nonexistent regulatory authority serve as the company's sole regulator. This provision would not only empower the issuer, but it could also set off a race to the bottom among the states, many of which would undoubtedly lower their consumer protections standards to attract businesses and jobs.

In fact, the bill seems to recognize this reality and requires insurers to carry a "buyer beware" label, warning consumers that the plan is "not subject to all of the consumer protection laws or restrictions on rate changes of the state."[33]

The bill's cost-control provisions are even less impressive than its coverage proposals. All in all, the Common Sense proposal would establish state innovation program grants to reward states for lowering the cost of their premiums, build a website to help consumers navigate through their coverage options, cap noneconomic damages in malpractice lawsuits at $250,000, and specify that all claims must be filed within three years.

These efforts would have a minimal impact on health spending and coverage expansion. The Congressional Budget Office found that under this $61 billion proposal, three million Americans would gain coverage, while the total number of uninsured Americans would actually increase to 52 million by 2019, and millions of Americans would continue to pay skyrocketing premiums.[34] The proposal would, however, decrease the deficit by $68 billion over the 2010–2019 period. It would also reduce premiums for healthy Americans who can purchase coverage independently by 10 to 13 percent.

In fact, it's unlikely that Rep. Boehner would be able to find affordable insurance under his own proposal should he choose to give up his government-sponsored plans for his own set of conservative reforms. He is 60 and by virtue of his age is more susceptible to cardiovascular disease, different cancers, high blood pressure, and host of other chronic diseases.

The Common Sense proposal would allow insurers to discriminate against these conditions and price the Republican leader out of the market. Specifically, Rep. Boehner:

Would not find coverage in the individual market

The Common Sense proposal aims to increase access to coverage in the individual market by giving individuals the opportunity to purchase insurance licensed in different states. But it's unlikely that Boehner would be able to find an affordable coverage option, particularly since insurers will now have the option of selecting a deregulated U.S. territory in the Caribbean Sea or Pacific Ocean as their "primary state" and will likely compete on risk selection.

Would not find adequate coverage in high-risk pools

When Rep. Boehner is denied coverage in the individual market, he could apply for insurance in expanded state-based high-risk pools, which typically provide very expensive coverage for the so-called "uninsurables." But his legislation does not adequately fund these pools and would compel states to limit services, deny coverage for preexisting conditions, and impose high cost sharing.

Would not find stable coverage in association health plans

If Rep. Boehner can't purchase affordable coverage from state-run high-risk pools, he could join an association-sponsored plan. Unfortunately, under his own legislation, associations are not required to provide a standard package of benefits and have an incentive to craft skimpy policies that attract healthier applicants. See table for a general comparison of the Common Sense Plan and the Affordable Care Act. His alternative would not provide adequate or affordable coverage to Americans who need it most.

Comparing Health Care Plans

The Affordable Care Act of 2010 versus the Common Sense Plan

	Affordable Care Act	Common Sense Plan
Newly Insured	32 million	3 million
Cost of Bill	$938 billion/10 years	$61 Billion/10 years
Access	• Healthier uninsured will be guaranteed coverage from a regulated exchange. • Sicker uninsured will be guaranteed coverage from a regulated exchange. • Lower-income Americans newly eligible for state Medicaid programs. • Americans with employer-based coverage will keep the coverage they now have.	• Healthier uninsured could find affordable coverage in the individual market. • Sicker uninsured will be denied individual coverage. Could find coverage in high-risk pools. • Lower-income Americans who aren't offered affordable coverage will be uninsured or underinsured. • Americans with employer-based coverage will keep the coverage they now have.
Regulations	• Insurers can't deny coverage because of preexisting conditions or rescind coverage. • Insurers can't apply lifetime or annual limits to coverage. • Insurers will have to offer comprehensive benefit packages that provide adequate coverage to sicker Americans.	• Insurers can deny coverage because of preexisting conditions, but they won't be able to rescind coverage. • Insurers can't impose "arbitrary" lifetime limits and annual limits on coverage. • Insurers don't have to offer comprehensive benefit packages that provide adequate coverage to sicker Americans.
Premiums	• CBO concluded that most Americans will pay the same or less for insurance. • The majority of Americans who purchase coverage would pay premiums that are 56 to 50 percent lower, on average, than the nongroup premiums charged under current law. • Families purchasing coverage in the small group market could save up to $100 annually. • Families purchasing coverage in the large-group market could save up to $200 annually.	• CBO concluded that healthier Americans would pay less for insurance. • CBO concluded that the bill would slightly reduce premiums for healthier Americans who purchase coverage in the individual or small group market, but "would tend to increase the premiums paid by less healthy enrollees."
Small Business	• Small employers can take advantage of large risk pools by purchasing coverage through the bill's state-based exchanges. • Small employers would receive a tax credit to help them provide coverage to their employees.	• Small employers can come together and purchase coverage in associations. Association health plans have sole discretion in selecting specific items and services to cover as benefits. Not required to provide a standard benefit package. Can craft skimpy policies that attract healthier applicants. • Small employers would not receive a tax credit to help them provide coverage to their employees.
Expenditures	The most conservative government estimates conclude that the bill would reduce national health expenditures by at least 0.3 percent by 2019.	Does not reduce national health spending. Establishes state innovation program grants to reward states for lowering the cost of their premiums.

Source: Letter from Congressional Budget Office to Senator Harry Reid, December 01, 2009, available at http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf.
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Conclusion

The Affordable Care Act made landmark improvements in the American health care system. By reforming the health insurance marketplace, creating new coverage opportunities through expanded Medicaid eligibility and new help with private health insurance for moderate income families, and creating a new platform for controlling health care costs by changing payment incentives and improving the delivery system, the new law takes on the fundamental flaws in American health care.

Conservative efforts to repeal this signature achievement, or to replace the new law with either watered-down approaches or dangerous new experiments, threaten the nation's employers, families, and taxpayers. These "solutions" will exacerbate, rather than fix, the persistent problems of access and affordability, cost, and quality. We cannot afford a step backwards into the 2009 status quo. Nor can we run the risk of the escalating costs, more limited coverage, and cost shifting to individuals and families that their approaches promise.

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