



REPUBLICAN CAUCUS

THE COMMITTEE ON THE BUDGET

B-71 Cannon House Office Building
Washington, DC 20515
Representative Paul D. Ryan, *Ranking Republican*

Phone: (202)-226-7270
http://www.house.gov/budget_republicans/
Augustine T. Smythe, *Republican Staff Director*

THE COSTLY CONSEQUENCES OF HEALTH CARE ‘REFORM’ A REVIEW OF THE LEGISLATION AS ENACTED

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The Democratic health care legislation enacted last week¹ will enlarge government, increase Federal spending, deficits, and debt, and create a dependence on the Federal Government at odds with America’s historic commitment to individual liberty and personal responsibility. It was muscled through Congress on a purely partisan vote, and through an unprecedented abuse of a specialized budget process intended to control the size of government, not expand it. The principal consequences of the legislation include:

- *It initiates a government takeover of the health care sector (one-sixth of the U.S. economy), intrudes in the doctor-patient relationship, and increases total spending by \$2.6 trillion.*
- *It raises taxes by more than a half-trillion dollars over the next 10 years – the largest tax increase in American history.*
- *It cuts more than a half-trillion dollars from Medicare to finance a new entitlement, and includes a series of additional gimmicks that hide the true cost of the legislation.*
- *It adds to an already unsustainable rate of government spending growth that will overwhelm the Federal budget and sacrifice the Nation’s future prosperity.*

The discussion that follows details these points.

A GOVERNMENT TAKEOVER, AND A SURGE OF NEW SPENDING

Seizing Control of the Health Care Sector

From the beginning, the Democratic Majority pushed legislation that envisioned a centralized, controlling government role in the provision and financing of health care. They failed to focus on the underlying problem – unconstrained growth in health costs – which puts health insurance out of reach for many. In the end, their approach led to an inevitable chain of additional government mandates, spending, and taxes. *Even without the so-called “public option,” their health care bill is an outright government takeover of health care.*

¹ The legislation consists of two bills: the Senate-passed Patient Protection and Affordable Care Act (H.R. 3590), subsequently also passed by the House; and the Reconciliation Act of 2010 (H.R. 4872), which modified the Senate bill. H.R. 4872 also contains changes in Federal student loans.

Contrary to the Majority's claims, the Democratic health care legislation does not reduce deficits; it does not control costs; it will bend the health care cost curve *upward*, increasing national health expenditures by \$222 billion.² It adds a new trillion-dollar health care entitlement when the government cannot pay for the entitlement programs already on the books. It will also expand the Federal budget commitment to health care by \$390 billion over the next 10 years.³

Some key components of the legislation:

- The measure creates a new, open-ended health care entitlement for anyone earning up to 400 percent of the poverty level.
- It imposes an unprecedented Washington mandate that forces everyone to buy health insurance, or pay a fine.
- It essentially eliminates the individual insurance market by prohibiting individuals from using their government health coverage subsidies outside the new federally regulated insurance exchanges.
- Its “play or pay” scheme, sold as a way of encouraging employers to provide coverage, may actually do the reverse if the penalties cost companies less than providing health coverage. As a result, workers may be pushed off their job-based health insurance and forced to buy a government-subsidized plan.
- It expands the Federal workforce – already on track to add 274,000 employees by the end of this year – including legions of Internal Revenue Service agents to monitor its new tax provisions.
- It nationalizes the regulation of health insurance premiums, usurping a State government role and further smothering the normal market forces that would otherwise encourage innovation and cost-saving efficiencies.
- It ignores the real cost drivers in health care, such as 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 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.

² Memorandum from the Office of the Chief Actuary, Centers for Medicare and Medicaid Services, 8 January 2010. The document can be found at: http://www.cms.hhs.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf.

³ Congressional Budget Office cost estimate dated 20 March 2010: <http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager%27sAmendmenttoReconciliationProposal.pdf>.

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- It gives the U.S. Preventive Services Task Force (the group that made the controversial recommendations regarding mammograms) new powers to further limit patient choice, allowing the HHS Secretary 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.
 - It creates a new Medicare commission – the Independent Payment Advisory Board [IPAB] – another group of unelected bureaucrats who will recommend future cuts in Medicare benefits.

Economic Illogic

The underlying top-down approach of the legislation – imposing more layers of management and control on the health care sector – makes it impossible to achieve both of its claimed principal goals: vastly expanding health coverage while at the same time reducing costs. This is especially true considering the legislation’s failure to address the cost drivers and incentives noted above. But economic forces play a role even in a government-dominated system. With the policies in this legislation, those forces will lead to higher costs, or a reduction in the quantity or quality of health care services. Consider:

- *Supply and Demand.* The mandate requiring effectively universal insurance will lead to a higher demand for health care services. But at the same time, the legislation limits the supply of services by constraining payments to providers and suppliers. Hence demand will continue outpacing supply, leading to upward pressure on costs and prices.
- *Government Price Controls.* Instead of promoting real competition – which would moderate costs naturally – the legislation nationalizes the regulation of health insurance premiums. This will lead to shortages and rationing: waiting times will replace prices as a means of balancing limited supply and higher demand. Quality will decline as consumers begin facing restricted access to the full range of treatment options. Greater government regulation also will limit incentives for medical innovation.

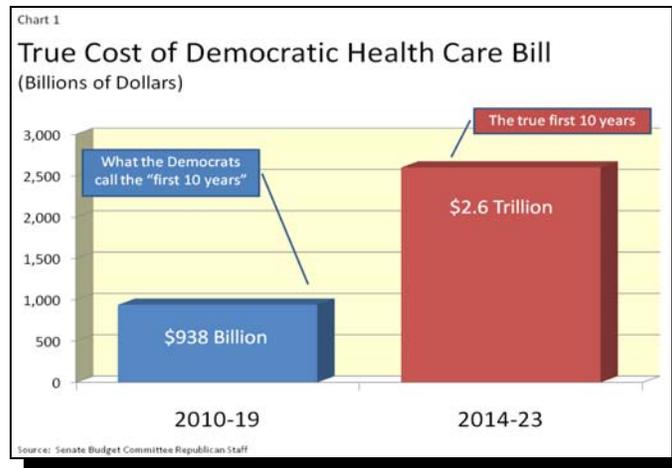
New Spending

In contrast to the Majority’s optimistic claims of deficit reduction and cost control, a thorough analysis of updated Congressional Budget Office [CBO] estimates, coupled with additional information,⁴ shows a huge increase in entitlement spending, and growing budget deficits that will add to the government’s already unsustainable growth of debt.

⁴ This discussion is based on an updated estimate by CBO and the Joint Committee on Taxation of an amendment in the nature of a substitute for H.R.4872, and its effects in combination with the Senate-passed Patient Protection and Affordable Care Act (H.R. 3590), dated 2 March 2010. It differs from CBO’s preliminary estimates, released on 18 March 2010, which applied to an earlier version of the legislation, and it makes certain technical refinements as well. This discussion also reflects CBO’s analysis when certain alternative factors are included, as requested by Budget Committee Ranking Member Ryan, 19 March 2010. The two documents can be found at:
<http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager%27sAmendmenttoReconciliationProposal.pdf>;
<http://www.cbo.gov/ftpdocs/113xx/doc11376/RyanLtrhr4872.pdf>.

- The legislation contains roughly \$2.6 trillion in total spending in the 10-year window once the new entitlement is implemented (2014-23).⁵
- It provides \$464 billion for Federal subsidies to purchase government-run health coverage (\$15 billion in excess spending relative to the Senate bill).
- It adds \$434 billion for Medicaid and the State Children’s Health Insurance Program (\$48 billion in excess spending relative to the Senate bill). Medicaid already is growing by 23 percent this year (partly from the “stimulus” bill), and is projected to grow by about 11 percent next year, increasing the already heavy burdens on State government budgets.

Yet all this additional spending *does not include* \$208 billion over 10 years for the “doc fix,” which was removed by the Democratic Leadership to hide the true cost of the health care legislation. (See further discussion below.)



New Tax Hikes

A summary of the legislation’s larger tax burdens (see Table 3 at the end of this document for a more complete list):

- A total of \$569 billion in new tax increases – representing a new record for the largest tax increase in U.S. history.⁶

⁵ The \$2.6-trillion estimate is from the Senate Budget Committee Republican staff, 21 March 2010: <http://budget.senate.gov/repUBLICan/pressarchive/2010-03-21HealthBill.pdf>.

⁶ The \$569 billion is a gross tax increase figure. CBO also counts a tax reduction against this amount, yielding a net tax increase of \$525 billion for the combination of H.R. 3590 and H.R. 4872 – still the largest tax increase in history. The previous record was established by the Omnibus Budget Reconciliation Act of 1993, which increased revenue by \$241 billion over 10 years, according to CBO estimates (see Table 2-2 in CBO’s 1993 *Update of the Budget and Economic Outlook*: <http://www.cbo.gov/ftpdocs/76xx/doc7670/09-1993-OutlookEntireRpt.pdf>).

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- The largest single tax hike in the bill – \$210 billion – results from a 0.9-percent increase in the Medicare payroll tax on wages for job creators and small businesses, and a *new* 3.8-percent surtax on net investment income.
 - The threshold amounts for these surtaxes are *not* indexed for inflation, meaning that although the taxes are aimed at “wealthy” individuals today, they will reach increasing numbers of middle-income taxpayers over time, just like the alternative minimum tax.
 - For instance, an individual earning \$100,000 today would cross the \$200,000 threshold within 2 decades, assuming a yearly inflation rate of 3.5 percent.
 - These new taxes will be in addition to numerous proposed tax increases for individuals and businesses outlined in the administration’s budget, adding to the total drag on economic growth and job creation just as the economy is struggling to emerge from the worst downturn since the Great Depression.

BUDGET GIMMICKS

The CBO can only make estimates based on the way legislation is written – and what the Majority presented to CBO is full of spending gimmicks and hidden costs. Budget Committee Ranking Member Ryan exposed the smoke and mirrors at the Blair House health care summit on 25 February 2010 – and CBO confirmed many of these gimmicks in its letter of 19 March 2010.⁷

Timing Gimmicks

- The legislation includes 10 years of tax increases and 10 years of Medicare cuts to pay for 6 years of spending. So the estimated \$938-billion cost for health care subsidies, which start in 2014, does not reflect a full 10 years of spending. A true 10-year cost estimate, starting when subsidies begin (2014-23), is \$2.6 trillion.
- In addition, the CBO cost estimate is derived from the March 2009 baseline – instead of the March 2010 baseline, which has been released. The outdated cost estimate hides the true price tag of the legislation.

Other Sleights-of-Hand

The legislation as written double-counts several “savings” items, including the following:

- A total of \$53 billion in “savings” over 10 years (\$29 billion after enactment of the reconciliation bill) from increased Social Security payroll tax revenues is used for the new entitlement.⁸ These funds already are dedicated to future Social Security

⁷ See CBO’s previously cited letter to Ranking Member Ryan dated 19 March 2010.

⁸ CBO estimated the tax on high-end health insurance plans (the “Cadillac tax”) would increase revenues to the Social Security trust fund. This tax is expected to reduce the amount individuals receive in compensation from health care, but increase the amount they receive in wages. This in turn would increase

beneficiaries; using them to offset the cost of this legislation assumes those benefits will not be paid as promised.

- The legislation counts as offsets \$70 billion intended as premiums for the long-term care insurance provisions – the Community Living Assistance Services and Supports [CLASS] Act. Senator Conrad has termed the inclusion of the CLASS Act in the health care bill “a Ponzi scheme of the first order, the kind of thing Bernie Madoff would have been proud of.”⁹
- The measure double-counts \$528 billion in reductions from Medicare – making the false claim of extending Medicare’s solvency while also offsetting costs of the new health care entitlement. For the Medicare Hospital Insurance fund alone, CBO has calculated that \$398 billion in savings over 10 years is being double-counted. The legislation also includes \$202 billion in reductions to the Medicare Advantage Program, representing nearly \$14 billion more in cuts than the Senate-passed bill.
- The CBO estimate does not include at least \$70 billion in appropriations that will be required to implement this vast expansion of government. If all explicit authorized appropriations were extended over 10 years, the additional cost for the legislation would exceed \$100 billion.

After stripping away the double-counting of Medicare cuts, the Social Security payroll tax “savings,” and the CLASS Act, and counting the necessary appropriations, the legislation *increases* the deficit by \$425 billion over the first 10 years. When the “doc fix” is added, it increases the government’s long-term deficits by one-quarter of a percent of gross domestic product [GDP] – which translates to more than \$600 billion in the second decade.¹⁰

Also, the President’s budget claimed \$150 billion in deficit reduction from health care legislation. Even with this effect included, his budget then doubles the debt in 5 years, and triples it in 10 years – reaching 90 percent of GDP by 2020. The health care legislation he signed falls short of his deficit-reduction allowance from health care – so the debt increase will likely be even worse.

The Missing ‘Doc Fix’

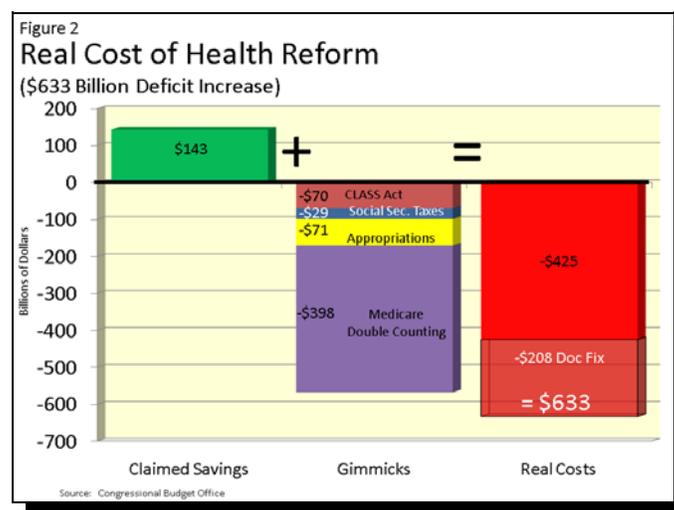
In addition, as noted above, the legislation does not include the “doc fix,” preventing scheduled cuts in Medicare physician payments assumed in current law – even though the provision was included in previous iterations of both the House and Senate health care legislation. Adding this cost, along with correcting the double-counts cited above, increases the total cost of the legislation to \$638 billion over 10 years.

taxable Social Security income, and therefore increase Social Security payroll tax revenue. The reconciliation bill, H.R. 4872, applies the Cadillac tax at a higher insurance premium rate than the previous bill, and phases it in more slowly. This reduces the amount of revenue flowing to Social Security, and also the double-counted “savings” amount.

⁹ Quoted in *The Washington Post*, 27 October 2009:
<http://www.washingtonpost.com/wp-dyn/content/article/2009/10/27/AR2009102701417.html>.

¹⁰ CBO letter to Ranking Member Ryan, 19 March 2010.

- In its letter of 19 March 2010, CBO wrote: “Under current law, Medicare’s payment rates for physicians’ services will be reduced by about 21 percent in April 2010 and by an average of about 2 percent per year for the rest of the decade.”
- Preventing these reductions “would increase those payment rates by 1.2 percent in 2010,” CBO wrote.
- The Majority also would restructure the payment system starting in 2011. Combining this with the physician payment increase, CBO wrote, “would cost about \$208 billion over the 2010-19 period.”¹¹
- The administration’s Office of Management and Budget estimated the cost of the “doc fix” even higher, at \$371 billion.¹²



STUDENT LOANS

A final irony in this package is the inclusion of a government takeover of the student loan industry, using the projected profits – assuming they materialize – to expand government now. Title II of the Reconciliation Act of 2010 (H.R. 4872) contains the main components of the Student Aid and Fiscal Responsibility Act [SAFRA], which abolishes the 40-year-old Federal Family Education Loan Program [FFELP] as of 1 July 2010, and requires that all future Federal student loans be Direct Loans [DL]. This will turn the Department of Education into the seventh largest bank in the Nation.

The Direct Loan program was started in the 1990s by the Clinton administration. Proponents argued this “public option” would provide competition to FFELP, a guaranteed lending program that leverages *private* capital to help students attend college. At its height, the DL program captured about 34 percent of loan volume, but historically it has hovered around 25 percent. In

¹¹ Ibid.

¹² Office of Management and Budget, *Budget of the U.S. Government – Fiscal Year 2011*, Table S-7.

the intervening years, FFELP enjoyed robust popularity with students and schools. When SAFRA was introduced a year into the global credit crisis that crippled capital markets, FFELP loan volumes made up about 67 percent of the market. Now, under the first Democratic administration since President Clinton, the government is eliminating this option for students – not because the Direct Loan program performed better, but because the administration and Congress saw they could increase revenue – from students’ interest payments – by eliminating the competition.

- Beginning this summer, the Direct Loan program will issue and profit from all new loans, which will be financed with Treasury borrowing. The bill immediately spends the estimated \$41.9 billion in future savings on various education items, including: \$13.5 billion to fill the Pell Grant shortfall created by the “stimulus” bill; \$22.6 billion to increase the maximum Pell Grant award; \$1.4 billion for servicing Direct Loans; and \$1.5 billion for the Income Based Repayment [IBR] Plan.
- The education title is then used to cross-subsidize \$8.7 billion of the legislation’s health care provisions, and provide \$10.4 billion for deficit reduction. There is legitimate concern, however, that the projected loan savings will be much lower than anticipated, which could cause the bill to *increase* deficits instead.
 - When SAFRA’s authors required CBO to calculate the savings from the student loan takeover, they did not direct the agency to take into account “market risk” – the risk that the value of the loans would decrease due to changes in market forces.
 - Incorporating market risk to cost estimates more accurately reflects how much a loan program will generate, which is why Congress has started including the effect in recent legislation dealing with Federal loans, such as the Troubled Asset Relief Program [TARP]. CBO noted in a March 2010 letter that if market risk were applied to SAFRA, it would reduce claimed savings by about \$22 billion over 10 years.¹³
- This legislation irresponsibly spends billions of dollars based on the rosiest of scenarios of possible future savings.

A TWISTED PROCESS

With all the flaws described above, it is no wonder the Majority could barely muster enough Democratic votes to pass their health care legislation. In fact, the Senate could not pass its own bill a second time – so House Democrats had to swallow it, and both the House and Senate had to amend it with a budget “reconciliation” bill they could jam through on a purely partisan vote – with no Republican support and barely enough Democratic votes.¹⁴ The Democratic Leadership even seriously considered a convoluted maneuver by which the Senate bill could be passed in the House without a direct vote on it – though they abandoned the idea due to strong resistance from their own Members.

¹³ CBO letter to Senator Gregg, 15 March 2010.

¹⁴ The House vote on the Senate health care bill (H.R. 3590) was 219-212. On the reconciliation bill (H.R. 4872), the vote was 220-211.

Proponents tried to portray this as a simple and not uncommon use of the budget reconciliation process. It was nothing of the kind. It was 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.

- Reconciliation originally was intended to expedite changes in spending and tax laws to align them – to *reconcile* them – with budget resolution levels. Over time, it came to be used to reduce budget deficits or, more broadly, to limit the growth of government.
- The process has *never* been used to push through a \$2.6-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. In contrast, in 1997, the Congress achieved \$198 billion in spending *reductions* over 5 years in a landmark reconciliation bill, the Balanced Budget Act.
- Nor has reconciliation ever leveraged such a vast social change based on a token \$1 billion in savings over 5 years¹⁵ – in the face of a \$1.5-trillion budget deficit this year alone – and done so on a deliberate party-line vote, when the only bipartisanship lay *in opposition* to the legislation in question.
- This reconciliation was not merely a simple “fixer” bill, or “sidecar,” either. It was the *keystone* on which the entire policy depended. If the reconciliation bill failed, the whole health care house of cards would have collapsed.

CONCLUSION

The U.S. health care sector clearly needs reform. But the legislation discussed here is not solely about health care. It really deals with what kind of country America will be in the 21st century: whether government will have a bigger role in making individuals’ deeply personal decisions about their medical care; whether Americans will come to depend more on the government than on themselves for their livelihoods; whether America declines into a culture of dependency, or rejuvenates itself as a culture of initiative, opportunity, and creativity – the principles on which the Nation was founded.

This document was prepared by the Republican staff of the Committee on the Budget, U.S. House of Representatives. It has not been approved by the full committee and may not reflect the views of individual committee members.

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.

Table 1: Health Care/Education Legislation: Summary

(dollars in billions)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
Total Outlays	4	5	-5	-28	6	44	86	92	90	90	384
Total Revenues	-3	3	5	27	57	65	83	89	95	104	525
Deficit	6	1	-10	-56	-51	-20	3	4	-5	-15	-143

Source: Congressional Budget Office, Joint Committee on Taxation.
Totals may not add due to rounding.

Table 2: Health Care/Education Legislation: Major Spending Components

(dollars in billions)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
Spending Increases											
Health Insurance Exchanges	0	2	2	2	20	45	77	97	106	113	464
Medicaid and SCHIP	0	-1	-2	-4	29	56	81	87	91	97	434
Pell Grants	0	5	11	2	5	2	3	4	4	5	42
Medicare Costs	3	9	9	11	18	16	12	9	7	8	101
Total Spending Increases	4	15	20	11	72	119	173	197	208	223	1,041
Reductions and Offsets											
CLASS Act	0	0	-5	-9	-10	-11	-11	-9	-8	-7	-70
Medicare	0	-6	-15	-24	-54	-60	-67	-83	-98	-117	-524
Direct Loans	-1	-6	-8	-7	-7	-7	-7	-6	-6	-7	-61
Total Reductions and Offsets	-1	-11	-27	-40	-71	-77	-85	-98	-112	-130	-654
Total Spending	3	4	-7	-30	0	42	88	98	96	92	384

Source: Congressional Budget Office, Joint Committee on Taxation.
Totals may not add due to rounding.

Table 3: Health Care/Education Legislation: Tax Increases

(dollars in billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
Tax Increase Provisions											
Excise Tax on High-Premium Plans	-	-	-	-	-	-	-	-	12	20	32
Additional Hospital Insurance Tax	-	-	1	21	17	29	33	35	37	39	210
Annual Tax on Insurance Providers	-	-	-	-	6	9	10	11	12	12	60
Penalty Payments by Employers	-	-	-	-	3	8	10	10	10	11	52
Tax on Drug Manufacturers	-	2	3	3	3	3	3	3	4	3	27
Tax on Medical Device Manufacturers	-	-	-	2	3	3	3	3	3	3	20
Info Reporting on Payments to Coprs	-	-	0	3	2	2	2	2	2	3	17
Raise AGI Floor Medical Deductions	-	-	-	0	2	2	2	3	4	4	15
Tax Uninsured Individuals	-	-	-	-	-	2	3	4	4	4	17
Limit FSA	-	-	-	2	2	2	2	2	2	2	13
Eliminate Part D Expense Deduction	-	-	-	0	1	1	1	1	1	1	4
Restrict HSAs, HRAs, FSAs	-	0	1	1	1	1	1	1	1	1	5
Tax Tanning Salons	0	0	0	0	0	0	0	0	0	0	3
Impose Fee on Health Plans	-	-	-	0	0	0	0	0	1	1	3
Increase HSA Penalty	-	0	0	0	0	0	0	0	0	0	1
Exclusion of Black Liquor	-	7	7	6	3	2	0	-	-	-	24
Codify Economic Substance Doctrine	0	0	0	1	1	1	1	1	1	1	5
Other Revenue Effects	(1)	(3)	(4)	(5)	3	10	16	21	14	10	60
Total Tax Increase	(1)	7	8	33	45	74	86	97	106	113	569
Revenue Reductions	-2	-4	-5	-6	-5	-4	-3	-3	-4	-4	-43
Total Net Tax Increase	-3	2	3	27	40	70	83	94	102	108	525

Source: Congressional Budget Office, Joint Committee on Taxation.
Totals may not add due to rounding.