



LEGISLATIVE ALERT

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THE HOUSE HEALTH CARE BILL A COSTLY GOVERNMENT TAKEOVER OF AMERICANS' HEALTH CARE (H.R. 3962)

3 November 2009

SUMMARY

The 1,990-page Democratic health care bill, expected to reach the House floor this week, suffers all the predictable failings that result from its true intent: to initiate a central government takeover of the health sector – one-sixth of the U.S. economy and one of the most valued and personal services Americans have. The bill is a costly behemoth that does the following:

- Launches a government takeover of health care that inevitably will increase costs, force rationing of medical care, or both.
- Creates a new \$1.3-trillion health entitlement that will cost more than advertised, worsen the Nation's unsustainable fiscal situation, and drive State governments deeper into the red.
- Imposes heavy taxes and fees on both individuals and businesses, including a burdensome "play-or-pay" tax on businesses that cannot obtain affordable employee coverage.
- Increases the long-term budget deficit, which already is projected to remain at record levels during the next 10 years.
- Makes no sense economically.
- Results in putting *upward* pressure on health care costs, instead of bringing down costs as promised.

KEY POINTS

- **A Government Takeover of Health Care.** The flaws in U.S. health care result mainly from *distortions imposed on the market by government policies*. But the Majority's legislation would *expand* Washington's interference in health care decisions, initiating an

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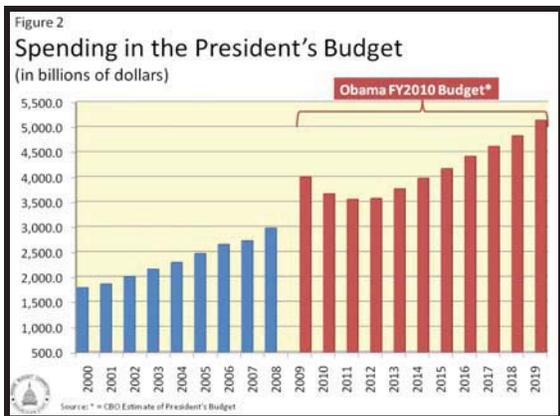
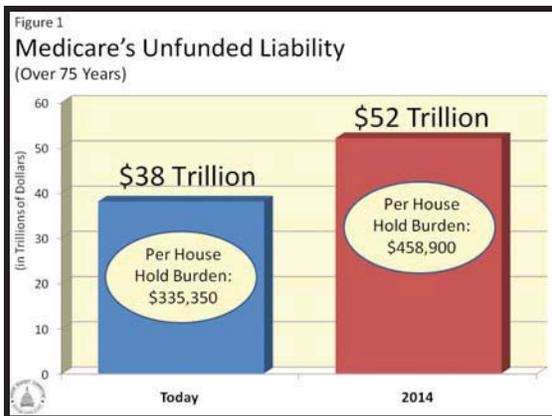
eventual government takeover of health care. This is *not* alarmist rhetoric; the legislation proposes:

- *One-Size Fits All Health Care.* The bill’s rating restrictions, coverage mandates, and benefit requirements will halt innovation and drive individualized health products out of the market. The bill disqualifies Health Savings Accounts, which provide more than eight million people with access to low-cost health care; would cause 64 percent of seniors in Medicare Advantage to lose their coverage in the next 5 years; and would subject plans to approval by a new Health Choices Commissioner, with the authority to audit, review, and penalize any health plan that does not comply with the rules set by this Washington-based office.
 - *Government Rationing.* The bill creates a “Comparative Effectiveness Research” program, giving the Federal Government even greater leverage in deciding which medical treatments are worth paying for and which are not. This will inevitably impose government control over physicians’ medical decisions, and cause private-sector insurers to limit coverage in line with the government’s choices.
 - *Price Setting.* While the legislation suggests providers will be able to negotiate rates with the government, there is nothing to prevent this from becoming a take-it-or-leave-it, price-setting system. Put simply, prices will be dictated to health care providers at rates determined by a cost-wary Federal Government.
- **Another Unsustainable Health Entitlement.** Current challenges in health care are driven largely by fundamental problems in existing Federal Government entitlement programs. These include a \$38-trillion unfunded liability in Medicare (\$335,350 per U.S. household) that will grow to \$52 trillion (\$458,900 per household) in the next 5 years (see Figure 1, next page); and a Medicaid Program that is the leading cause behind State budget crises. But the Majority’s legislation layers on yet another Washington-based medical program – a new \$1.3-trillion health entitlement that will cost \$2.4 trillion when fully implemented.
- *A Faulty “Self-Sustaining” Public Plan.* The bill’s government-run, public health insurance program is intended to be financed by premiums from beneficiaries. As noted by the Congressional Budget Office [CBO], however, the public plan is expected to charge higher premiums than private health insurance – which Congress is unlikely to allow, and which appears to contradict the ostensible goal of boosting “competition” to “keep private insurers honest.”
 - *Budget and Savings Gimmicks.* The legislation’s \$104 billion in deficit reduction projected over the next 10 years is achieved mainly through timing gimmicks and savings from extraneous provisions. First, the Majority dropped a Medicare physician payment increase (the “doc fix”) that was included in its earlier bill (H.R. 3200), with a plan to hide the \$229-billion deficit increase in a separate bill. Second, the government-run plan does not start until 2013, leaving much of its Federal spending hidden from the 10-year budget window; less than 1 percent of the bill’s \$1.05 trillion is spent in the first 3 years after the program

starts, further masking the deficit impact. Third, of the \$104 billion in claimed deficit reduction, \$72 billion comes from extraneous legislation added to the bill after the three House committees marked it up.

- *Driving States Deeper Into the Red.* While CBO reports this bill would reduce the uninsured by 36 million people, nearly half of those would be enrolled in Medicaid, and would not be eligible for private insurance in the new health care exchanges. This would force States to spend an additional \$34 billion over the next 10 years, beyond the unsustainable Medicaid burdens States already face.
- *Ignoring Significant Costs.* The bill assumes a 21-percent reduction in Medicare reimbursements to physicians, with additional cuts throughout the 10-year window. But since 2002, Congress has consistently reversed the scheduled physician payment reductions; and the Majority introduced another such “doc fix” the day it unveiled its health care bill. CBO has estimated this payment change would cost \$229 billion.¹ While the bill does not account for the “doc fix,” it does take credit for \$479 billion in reductions to hospitals, nursing homes, and other providers that will either severely disrupt care, or lead to measures reversing these provisions. (See the appendix to this document.)

- **Long-Term Costs.** The long-term consequences of this legislation are even more severe. Says CBO: “On balance, during the decade following the 10-year budget window, the bill would increase both Federal outlays for health care and the Federal budgetary commitment to health care, relative to the amounts under current law.”² This would add to the unprecedented spending already built into the President’s budget (see Figure 2).



- **Heavy Taxes and Fees on Individuals and Businesses.** To extend coverage to an additional 36 million legal residents, the bill relies heavily on mandates and tax penalties.

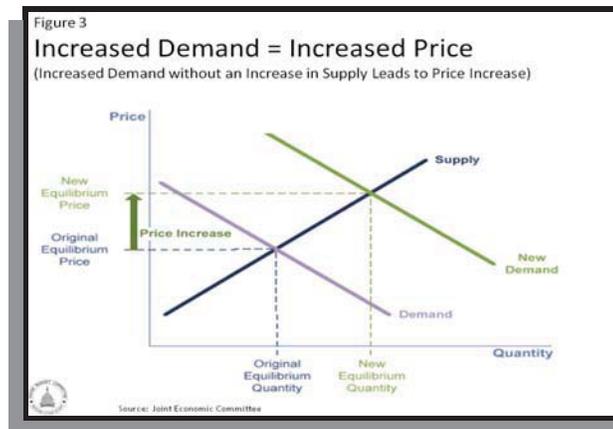
¹ CBO estimate of H.R. 3200, dated 17 July 2009.

² CBO preliminary cost estimate for H.R. 3962, dated 29 October 2009.

CBO estimates that \$729.5 billion in new taxes would be extracted from individuals and employers. Among those tax increases are:

- A total of \$460.5 billion in job-killing small-business surtaxes (section 551).
- Another \$135 billion in employer mandates, including the “play-or-pay” scheme punishing even small companies that cannot provide group health insurance (sections 511-512).
- An additional \$33 billion in individual mandates – including an unprecedented Washington requirement that everyone must buy health insurance or be subject to Federal penalties (section 501).

Twenty-two House Democrats have written to Speaker Pelosi noting the folly of raising small-business taxes in the fragile U.S. economy. As they put it: “Especially in a recession, we need to make sure not to kill the goose that will lay the golden eggs of recovery. By concentrating the cost of health care reform in one area, and in one that will negatively affect small business, we are concerned this will discourage entrepreneurial activity and job growth.”³



- **Economic Illogic.** The Democrats’ health care bill seems to defy economic logic. It aims to 1) greatly expand health coverage through a government-run insurance plan; 2) achieve higher quality care for all Americans; and 3) lower health care costs so these expenditures do not cause unsustainable Federal budget deficits in the future. But the policies in this bill would likely cause the opposite effects – leading, for example, to greater coverage but only at the expense of higher total costs and a lower average quality of care. In short, the plan’s policies and its advertised goals do not add up. Consider:
 - *Supply and Demand.* The bill mandates expanded insurance coverage, which would lead to significantly higher demand for health care services. But it also reduces payments to health care providers, and restricts private health insurance companies so they are forced to operate like highly regulated public utilities

³ Letter to the Speaker from Representatives Polis, Massa, et. al., dated 16 July 2009.

(with mandated rates, prices, and profits). These changes would guarantee the supply of health care services would not keep pace with the new demand. If demand for health care rises, but the supply of health care services remains fixed, then the price of health care in the economy must rise (see Figure 3 above).

- *Government Price Setting.* The bill attempts to suspend this market dynamic by having the government set the price of health care services (i.e. through price controls). But government-imposed price controls would simply lead to shortages (i.e. a gap between supply and demand) and rationing. Under such a system, waiting times essentially replace the role of prices as a means of balancing restricted supply and increased demand: long lines would develop for medical services (similar to the long lines that developed outside gasoline stations when the government imposed cost controls on energy in the 1970s). Quality also would decline as consumers began to face restricted access to the full range of treatment options. Greater regulation and government-imposed ceilings on provider payments would also limit incentives for medical innovation.
- **Failure to Bend Down the Cost Curve.** After all this, the bill does little to limit the overall cost of health care (i.e. bend the cost curve), and might even worsen it. It is not designed, for instance, to increase competition among private health insurers or empower consumers to shop for cost-efficient providers. In other words, the bill is not designed to provide a greater supply of medical services at a lower relative cost.
 - *Mandate Creep.* The cost issue matters because it is likely the government would not allow politically unpopular shortages of medical services. It is more likely the political process would lead to an *increase* in mandated benefits under the government-controlled public plan – so-called “mandate creep.”
 - *Cost Explosion.* In this case, the government would expand coverage, impose price controls, extend subsidies and simply *absorb the residual cost of significantly higher demand for expensive medical services*. This would lead to a cost explosion for the government.
 - *Higher Government Costs.* CBO estimates the bill will increase the Federal Government’s commitment to health care by \$598 billion over the next 10 years. While the public plan would have lower administrative costs than private insurance, it would “engage in less management of utilization by enrollees.”⁴ In other words, the government-run plan would *increase* the rate of health care inflation rather than slow it.

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⁴ CBO preliminary cost estimate for H.R. 3962 dated 29 October 2009.

This document is a product of 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.

APPENDIX
ACTUAL COSTS AND DEFICIT INCREASES FROM H.R. 3962

The data in the table below are based on Congressional Budget Office [CBO] estimates for the 10-year period 2010-19. During the debate on health care, the President said the bill’s cost would not exceed \$900 billion and would “not add one dime to the deficit.” While the administration and the Majority claim the bill meets these two limits, this is only achieved through manipulation of the numbers.

Table A-1 compares the President’s \$900-billion limit to the number the Majority uses. But the Majority gets to a lower number by using revenue increases to offset the cost of coverage. If these revenues are removed, as CBO did in its cost estimate, the total cost rises to \$1.055 trillion. Others have pointed out that this does not show the bill’s full cost.⁵ Finally, the Majority dropped the Medicare physician payment increase (the “doc fix”) from the bill. If the new version of the Medicare physician payment increase that allows the sustainable growth rate to be adjusted upwards by medical inflation, it would add \$229 billion to the cost of the bill over 10 years.

The fully implemented cost of the bill will be much higher than these figures. The Senate Budget Committee Republican staff has estimated, based on CBO data, that the fully implemented cost of the bill for the first decade (2014-23) will amount to \$2.4 trillion.

The second claim by the administration and the House

Majority is that the bill will not increase the deficit. Table A-2 begins with CBO’s preliminary estimate of outlays (spending), revenues, and the deficit for the 10-year period, 2010-19. It then makes adjustments to this scoring to show the actual cost of the bill.

- First, it adds the cost of the Medicare physician payment increase that the Majority has introduced as a separate bill. As noted earlier, the Majority dropped the Medicare physician payment increase from the bill.
- Second, as CBO notes in its cost estimate, the bill includes authorizations for appropriations for the Internal Revenue Service and the Centers for Medicare and Medicaid Services to implement the bill. Because there are no limits on appropriations or a pay-as-you-go requirement for discretionary spending, the costs of administering the bill are added.
- Finally, the bill assumes deep reductions in payments to hospitals, nursing homes, and other providers of health care through the Medicare system. In the past, these savings have not been sustained. The best evidence of that is legislation to reverse the current law reductions in Medicare physician payments. If Congress reverses the provider reductions in the bill, along with the other adjustments previously discussed, the bill increases the deficit by \$618 billion.

Table A-1: Actual Cost of H.R. 3962
(total spending, in billions of dollars)

	2010-19
Obama Proposed Cost	900
House Bill Claimed Cost	894
Revenue Increases	162
Actual Cost (gross cost of expanding coverage, according to CBO)	1,055
Plus Other Health Spending Increases	217
Actual Cost of House Bill as Introduced	1,273
Medicare Physician Payment (“doc fix”)	229
Total Cost	1,502
<hr/> <i>Figures may not add due to rounding.</i> <hr/>	

⁵ See the blog by former CBO Director Donald B. Marron: <http://dmarron.com/2009/10/30/the-house-health-bill-costs-almost-1-3-trillion/>

Table A-2: Likely Deficit Increases from H.R. 3962
(dollars in billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
Outlays - Total	7	18	-16	34	56	95	111	105	107	112	629
Receipts - Total	0	33	35	59	76	90	100	106	114	121	733
Deficit (-)/Surplus	-7	15	50	25	20	-5	-11	1	7	9	104
Adjustments											
Medicare Physician ("doc fix")	7	13	15	18	20	24	28	31	34	38	229
Discretionary Costs ^a	2	2	2	2	2	2	2	2	2	2	15
Deficit Adjusted	16	-1	29	0	-9	-38	-45	-33	-29	-31	-173
Provider Cuts	3	21	27	35	58	56	57	66	75	82	479
Deficit w/o Provider Cuts	-19	-21	7	-29	-60	-86	-97	-98	-104	-112	-618

^a Discretionary costs are averages of ranges provided by the Congressional Budget Office, where known.
Figures may not add due to rounding.