Cato's Letter

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# Health Care Reform: The Long-Term Perspective

PAUL RYAN

The president and the Democrats are giving the American people a false choice. We must either choose a public plan option with all the bells and whistles and all the promises—cloaked in the rhetoric of: "If you like what you've got, you can keep it. We just want more choice and competition. We just want to keep those insurance companies honest"—or accept the status quo. They say there are no other options. But they're wrong. There are other ways to fix the problems in health care.

If we do go down the path toward a public option, it will inevitably, mathematically, actuarially, become a government-run monopoly. When the government is put in the position to compete against the private sector, the government is both the referee and the player in the same game.

*Congressman Paul Ryan has represented Wisconsin's First Congressional District for six terms. He is the ranking member of the House Budget Committee and a senior member of the House Ways and Means Committee. This edition of* Cato's Letter *is adapted from a speech Ryan gave at the Cato Institute Conference on Health Care Reform in June.*

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It's a stacked deck against which the private sector cannot compete. The private sector has to pay taxes. It has to pay for salaries and benefits. The private sector can't dictate to the provider network what it's going to pay. We're hearing that this public plan option will base its payments on Medicare, with maybe a modest increase. But keep in mind that Medicare underpays providers by 20 to 30 percent. It is simply a question of when, not if, a public plan option, if set in place, completely displaces the private sector. At least under the status quo, you can fire your insurance company. If the only insurer is the government, you're stuck.

We believe that we have to go to the American people with a better way forward. Sections A through D in Title 1 of the Kennedy bill cost a trillion dollars and buy insurance for 16 million people. That's about $62,500 per person over 10 years.

> "The president and the Democrats are giving the American people a false choice."

And that's just one piece of one title of the bill. The Kennedy bill will cost $4 trillion over 10 years. What we're on the doorstep of doing is creating an entitlement that will rival Medicare. No matter what kind of package is cobbled together to pay for it in the first 10 years, there is no way it's ever going to match the actual cost of the new program. This is a huge problem. It is accelerating the tipping point in America, where more people are dependent upon the government for their livelihood than they are upon themselves.

We already have a little over 40 percent of Americans who are "negative taxpayers," people who receive payments from the government in excess of their income and payroll taxes. We're dangerously close to becoming a social welfare state similar to Europe. When society goes down that road, it loses sight of liberty and becomes more concerned with security—both economic and other forms. When a country becomes a social welfare state, its society stagnates. Standards of living go down. Creativity, innovation, achievement, production, risk—these wash away, leaving high unemployment. We don't want to go down that path.

Health care is much more than having insurance and access to medical care. It is a moral issue. It is an issue about the role of the federal government and which trajectory America is going to take. Will we stick with the American ideal of equalizing opportunity, of protecting our individual rights, or are we going to replace that vision with a European one, where the goal of government is to equalize the results of people's lives instead of equalizing access to opportunity?

This problem can be fixed, not by pushing the market out, but by bringing the market in. One of the

reasons health care is not doing well right now, one of the reasons health inflation is so high, one of the reasons there are so many distortions in health care, one of the reasons millions of Americans don't have access to affordable insurance, is because we've displaced the fundamental tenets of a free market. What are those tenets? Transparency on price, transparency on quality, and an incentive to act on both. Currently, you don't know what services cost, or who's good at providing them and who's bad. Even if you know such things, you're told by your insurance company, HMO, or the government where and who you have to go to to get your care. We don't want to pick a model where the government will ultimately be the single payer. Under that model, you can contain costs, but it requires rationing care. The Institute of Comparative Effectiveness, created in the stimulus package, is the bureaucracy through which that rationing will take place, telling providers, doctors, and physicians that enlightened bureaucrats will decide how best to achieve efficiency and how best to deliver care in America. The only way to quantifiably lower costs is to limit people's access to health care. That's not America. That's not who we are. It offends our sense of individual rights, of freedom and liberty and choice.

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Can we fix the problems in health care without going down this path? Yes. That's exactly what we are attempting to do with the Patients' Choice Act. The Act recognizes the tax distortion that exists, a distortion that helped give rise to our third-party payment system. It's what helped give rise to the system that took the individual out of the game and took the consumer out of the game. We want to equalize tax treatment so we get the individual back in the game. We want the individual to be at least as powerful as the other players in health care. We're not saying, like some Democrats are, that we should tax health benefits and send the money to the government to build a new system and have new mandates and a new public-plan option. We're saying: "Let's equalize tax treatment. Let's take the tax benefit and delink it from the job and reattach it to the worker, so that everybody, regardless of how they get their health insurance, receives the benefit." What makes our bill different from every other on this issue is that the tax

benefit goes back to the taxpayer. We do not use the exclusion money to pay for nontaxpayers, such as refundable tax credits. Under our plan, the money workers get by having deductibility on their employer-sponsored health insurance goes to them in the form of a tax credit: $5,700 for families and $2,700 for individuals. You keep your job, you change your job, you lose your job, you go work for yourself—the tax benefit stays with you. It's portable.

Next, we need to reform entitlements. Let's not continue segregating poor people from the rest of society when it comes to health care. Let's not have Medicaid patients come into the clinic with "poor person" stamped on their forehead and then push them to the back of the line. Where I come from, most doctors won't take Medicaid patients. It underpays them and they don't want it. We'd like to integrate those patients with everybody else by turning Medicaid into a voucher. We'd place $5,000 on a card in addition to the tax credit so a Medicaid family under the poverty line would benefit by about $11,000 dollars. For people up to double the poverty line, that cash benefit phases from $5,000 down to $2,500 dollars.

These Medicaid reforms would save about a trillion dollars. The money that goes to taxpayers comes from the money that taxpayers were getting under the exclusion. The bill is revenue neutral and tax neutral. That's very important. We can fix these problems. We can have universal access to affordable health insurance in America, even for people with preexisting conditions, without having the government take it over, without new taxes, and without new spending.

For insurance, we would set up state-based exchanges. They'd be entirely voluntary—for the individual to participate, for the insurance companies, and for the states. We'd create incentives for states to participate. This way, people can go into the individual market and see an apples-to-apples comparison of what kind of health insurance plans are available. We would also have a mechanism so that the uninsurable—people who had breast cancer eight years ago or had prostate cancer—can also get affordable health insurance. Risk adjustment is the tool we use to do this. Each of these exchanges must have at least a minimum benefit health care plan, without the bells and whistles. The exchanges achieve the same goal as interstate shopping but do it in a

way we believe is easier to pass through Congress.

Health care transparency is also crucial. This is a huge difference between what the White House is proposing and what we're proposing. The notion of having the comparative-effectiveness decisions housed within the Department of Health and Human Services is a regulatory model where enlightened bureaucrats will decide how health care is to be delivered, how transparency will occur, and how best practices will happen. The government—the greatest payer now and probably the single payer later—will make the decisions. Enlightened dictates from bureaucrats are still dictates from bureaucrats. Instead, we'd like to have a market self-regulatory system. We want transparency, so that when we're measuring things—replacing a hip or a knee, doing cataract surgery, or a bypass—the specialists themselves will design the metrics by which we measure effectiveness. The stakeholders in such a structure will come up with standard metrics on price, quality, and best practices. And if you say you're using these metrics and you cook the books, then you will be committing fraud and the government will come and get you. We want to have health innovation, we want to make sure that heart surgeries that are invasive now become less invasive later, and we want breakthrough technologies to be rewarded, not controlled within a government system. That's why we don't want bureaucrats in charge. We want the American College of Cardiology saying, "Here's how we should do it this year and here's how we should do it next year." We want the market standardizing metrics.

> "Enlightened dictates from bureaucrats are still dictates from bureaucrats."

Our plan starts with and revolves around the individual. We take all the money we spend right now—which is two-and-a-half times per person what any other country pays on health care—and don't pass it through bureaucracies or through third parties, but through individuals. Give individuals power. Give them power to get affordable health insurance, give them power in the form of money to buy that health insurance, and give them power in the form of information to make good choices. By empowering the individual, we can fix the problem of cost and everybody can have affordable health insurance, even though they might even have a preexisting condition. And we can do it without new taxes and without new bureaucracies. The nucleus of the system, at the end of the day, is the patient-doctor relationship, not a government bureaucracy.

# *Cato Scholar Profile:* MICHAEL D. TANNER

*Senior Fellow* MICHAEL TANNER *heads research into a variety of domestic policies, with a particular emphasis on health care reform, social welfare policy, and Social Security. He is the author of several books, including* Healthy Competition: What's Holding Back Health Care and How to Free It. *Tanner's writings have appeared in nearly every major American newspaper, including the* New York Times, Washington Post, Los Angeles Times, Wall Street Journal, *and* USA Today.

**You've been quite active in op-ed pages throughout the summer. What is the key message you're trying to get across regarding Obama's health care proposals?**

It is important that people understand what the president and Congress are actually proposing, and the threat it poses to both our liberty and the quality of health care. It is sometimes hard to cut through all the conflicting numbers and terminology about "bending the curve" and "pooling mechanisms." Making matters even worse, some of the spin coming from the administration has been misleading, to put it mildly. For example, despite President Obama's repeated claims, you would not be able to keep your current insurance policy.

In my commentaries and op-eds, I've tried to cut through all that and explain—in plain language—what is actually being discussed. In the end, the American people need to understand that under the reform plans currently making their way through Congress, they will pay more, both in terms of higher taxes and in high premiums, and receive poorer quality health in return.

**The White House has signaled that it's willing to back away from a public option. Does this mean we can breathe a sigh of relief?**

It's much too early to assume that the final bill won't have a public option. The Left has made it clear that they consider a public option the lodestone of any reform bill. And, it is understandable why. Their goal has always been a Canadian-style single-payer system. President Obama said during the campaign that he would prefer one if he thought it could be achieved politically. The so-called public option, really a government-run plan, is the fastest route to such a system. Estimates suggest that as many as 89.5 million Americans would be dumped into the government plan initially. That would make the private insurance market unviable and lead to a complete government takeover.

We should also beware of so called co-ops as an alternative to the public option. These wouldn't be true co-ops. The members wouldn't choose its officers—the president would. Plus, the secretary of Health and Human Services would have to approve its business plan, and thus could force it to offer whatever benefits, premiums, and reimbursement schedules Washington wants. Finally, the federal government would provide start-up, and possibly ongoing, subsidies. A "co-op" run by the federal government, under rules imposed by the government and with federal funding, is simply government-run health insurance by another name. Or, as Senate Majority Leader Harry Reid put it, "We're going to have some type of public option, call it 'co-op,' call it what you want."

**The debate around health care has become heated and often angry. What has been the response to your op-eds and from people you've spoken with about Cato's position on reform?**

Most of my letters and e-mail are surprisingly thoughtful. Even those who disagree with me often ask substantive questions or raise important issues. I try to respond to as many as possible. And, interestingly, most of my mail has been supportive. This is one issue where the American people are ahead of the politicians. I've been through the Hillarycare debate of 1993 and George W. Bush's push for Social Security reform. It's given me a pretty good feel for the public mood. I think the opposition to Obamacare is widespread and intensely felt.

# A PROFILE IN GIVING: R. EVAN SCHARF

Evan Scharf has been a loyal Cato Sponsor since a friend brought him to his first Cato event back in 1989. In the ensuing years, Evan has become intensely involved in public-policy issues and has come to rely on the thoughtful and careful analysis provided by Cato's scholars.

For Evan, economic issues are at the forefront. This is not surprising given that he started his career on Wall Street, first as a financial analyst at Loeb Rhoades and later as a general partner at Wood, Struthers, and Winthrop. Indeed, even after moving to Arizona, he stuck with finance—as a senior vice president responsible for much of Paine Webber's southwestern institutional business for about 20 years.

As Evan sees it, our educational system has "done a good job of making sure that the public doesn't understand the difference between a market and a command economic system." Indeed, he notes that most people have "no independent basis on which to judge economic or historical trends, even as we lurch toward collectivism."

Evan believes that Cato has done a "marvelous job" of educating the public. He points to David Boaz's work on explaining libertarian principles, Dan Mitchell's work on tax competitiveness, and Jerry Taylor's work in exposing the fallacies of cap-and-trade and global warming. Evan also has a special fondness for what he terms the "health care twins": Michael Tanner and Michael Cannon.

Evan believes that it is his personal burden—and Cato's—to "attempt to educate the public in matters economic." To that end, he has supported Cato at the Club 200 level for many years. He is now contemplating a testamentary bequest that would endow an R. Evan Scharf Chair for the Public Understanding of Economics. Evan hopes that this chair will be a powerful voice speaking for personal liberty and property rights—and against the "fascialism" that appears likely to prevail for many years.

Evan's activism is not limited to Cato. He is also a director of the Goldwater Institute and co-founded with John R. Norton III its Scharf-Norton Center for Constitutional Litigation. As Evan puts it, the Center strives to enforce the Arizona and U.S. Constitutions by "taking bureaucrats and politicians to court for overstepping constitutional authority."

Evan has been a wonderful friend and supporter of the Cato Institute, one of the many Sponsors who have allowed us to articulate ideas about small government and the rule of law. As Evan predicts, the future may prove difficult for those who believe in personal liberties and free markets. But that is no reason to stand down. Indeed, it is a reason to intensify the debate.

And so, we thank Evan and all our Sponsors for their support.

If you would like to discuss estate planning or gifting ideas, please feel free to contact **Gayllis Ward,** our director of planned giving at **(202) 218-4631** or **gward@cato.org.**

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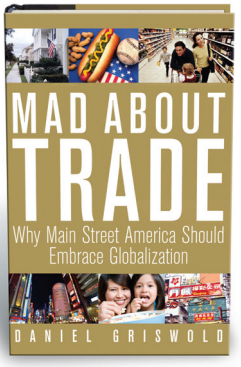


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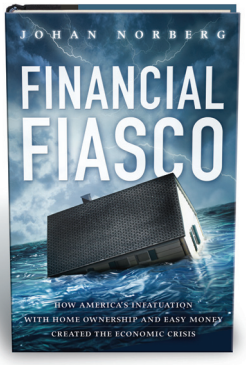


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