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*CONGRESSIONAL TESTIMONY*

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**The President's Budget  
And Medicare**

**Testimony before  
Committee on Small Business  
United States House**

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*Mr. Chairman and Members of the Committee:*

My name is Robert E. Moffit. I am the Director of the Center for Health Policy Studies at the Heritage Foundation. I previously served as a Principal Deputy Assistant Secretary of the United States Department of Health and Human Services during the Reagan Administration. The views that I express today are entirely my own, and should not be construed as representing the views of the Heritage Foundation, its officers or its Board of Trustees.

President Barack Obama has outlined an ambitious and far-reaching health care agenda, including major changes in the Medicare program. It should be noted that even before the President held his White House health care summit, the Congress had already enacted key elements of the President's health policy agenda. This includes the expansion of the State Children's Health Insurance Program (SCHIP), estimated to cost approximately \$65 billion over ten years. It also includes health provisions in the recently enacted "stimulus" legislation, including additional funding for Medicaid, COBRA, investments in health information technology, and the establishment of a research program for "comparative effectiveness" into different medical treatments and procedures, drugs and devices. Altogether the estimated 10 year cost of these initiatives amounts to \$136 billion.

**The President's Agenda** In the President's submission, he is asking Congress to adopt a health care funding proposal to create a reserve fund for comprehensive health care reform that would amount to an estimated \$634 billion over ten years. The objective of this proposal is to create systemic changes in the health care system that would lead to universal coverage and also to enact specific health care policies that would result in an annual reduction of \$2500 in the typical American family's health insurance premium costs.

The President is also inviting "good ideas" from across the political spectrum to achieve substantive improvements in the health care system. The President's decision, in this respect, is wise. It is a refreshing departure from the contentious history of previous attempts to forge federal health care policy. Comprehensive health care reform should be a genuine bipartisan undertaking. It should take into account the simple fact that while there are common objectives that all or most Americans sincerely share, there is also strong disagreement among Americans on the best way to achieve reform. When proposals are presented clearly, and the tradeoffs are also presented clearly and honestly, it is not uncommon for support for specific health policy proposals to decline, sometimes dramatically.

Congress should build on points of agreement on goals, and attempt to narrow disagreement on the means. Clearly, there is broad agreement on the need to radically reduce the number of Americans who are uninsured. There is also a widespread recognition of the need to take decisive steps that would result in greater value for the dollars that are spent on health care, as well as to eliminate gaps and inequities in health care coverage, financing and delivery, including racial and ethnic disparities. There is no

widespread agreement on the role of government, or the specific way in which government should influence or control the financing and delivery of health care services.

I would only observe that the decision to start with the financing of the health care reform without a clear understanding of what it is exactly that would be financed beforehand is, at the very least, an unusual approach. I would make two observations. First, while the President may believe that there is enough of an agreement to jump start the process by putting the money up front and hammering out the details later, it is the common experience in this area of public policy that it is the details that drive the broad policy agenda; not the broad policy agenda that necessarily drives the details. Secondly, with funds already committed to the project, there is the danger that existing stakeholders, the representatives of the powerful class of special interests that dominate this sector of the economy( doctors, hospitals, health plans, pharmaceutical and biomedical research interests) will view this entire effort as merely a way to expand existing public and private institutional arrangements, with the ample benefits of additional taxpayers' dollars, rather than a process of securing real, structural change in the health care system: the creation of different ways of improving the financing and delivery of health care for the 300 million Americans who would be the beneficiaries of real reform.

**Financing Reform.** The President's proposed budget outlines in broad terms what methods he will employ to secure the projected \$634 billion health program. It should be noted at the outset that the actual cost of reform is likely to be higher, perhaps exceeding \$1 trillion over ten years. This would follow a familiar pattern: the true costs of health care proposals are invariably higher than the original government projections.

Broadly speaking, the President is proposing to fund health reform by two methods. First, he is proposing tax increases on higher income Americans that would amount to \$318 billion over ten years, He would also secure savings through various delivery reforms, such as the broader use of Health IT and the comparative effectiveness, and changes in the federal entitlements, especially Medicare and Medicaid. Together, these would amount to \$316 billion over ten years.

**Medicare Changes.** The President is proposing major changes to Medicare Advantage, Medicare Part D, and the traditional Medicare fee for service program. Altogether, he is proposing dozen Medicare-related changes. In the limited time available, I would like to focus my remarks on a few key Medicare budget proposals.

Medicare Advantage Plans are increasingly popular and now enroll roughly one out of five senior citizens, and provide richer and more varied packages of benefits than available under traditional Medicare. Richer benefits mean that these plans cost more by an estimated 12 to14 percent compared to traditional Medicare, which is governed by a system of administrative payment. The President estimates this change would account for \$176.6 billion over ten years.

The President proposes instead to have private health plans in Medicare offer bids in geographic area of the country, and then pay the plans on the basis of the average of these bids. This is potentially an attractive change to the Medicare program. Much would depend on how the legislation is crafted, the details of the process and what the Administration means specifically by “competitive bidding”. It is a phrase that can have very different meanings. If the process is a way for the government to pick “winners and losers” among health plans, something akin to a DOD procurement process, it would be incompatible with personal choice and market competition among competing plans. It is well to recall that the provision of that opportunity, particularly for seniors in rural areas, was one of the major reasons why Congress created the Medicare Advantage program in the first place. If it is a way of establishing a more rational benchmark for Medicare payment, and allowing persons to pick richer health plans and pay for the extra benefits, if they wish to do so, or picking less expensive health plans and keeping the savings of those choices, the President’s proposal could be a significant improvement over the current system.

The President is also proposing to make wealthy seniors pay higher premiums for prescription drugs. According to press reports, seniors enrolled in Medicare Part D would pay higher premiums just as seniors do today in Medicare Part B. The President projects that this change would achieve a savings of \$8.1 billion. Congress is faced with a \$36 trillion unfunded liability in the Medicare program over the next 75 years, and within the next three years the first wave of the 77 million baby boom generation will start to retire. This means that the Medicare program will experience the largest demand for medical services in its history. Simply cutting provider reimbursements to control costs, as has been done in the past, are unlikely to maintain the provision of high quality health care to the nation’s senior and disabled citizens. Income-relating Medicare subsidies, as the President has proposed, are a sound alternative.

The Administration wants to change hospital payment by providing a flat fee to hospitals for the first 30 days of hospital care, and lower payments for hospital readmission. This is projected to achieve a ten year savings of \$8.4 billion. The proposal is designed to create incentives for hospitals to provide higher quality care and reduce the need for additional hospitalization. The objective makes a great deal of sense; once again, Congress should study this to make sure that it does not engender any unintended consequences in the provision of hospital care. In health policy, unfortunately, unintended consequences are common and costly.

The Administration also calls for re-evaluation of current provider payment systems, promotes “pay for performance” in accordance with government guidelines, and tougher enforcement and oversight of Medicare payments to doctors and other medical professionals to reduce waste, fraud and abuse. The Medicare “pay for performance” proposals were also promoted by officials of the Bush Administration to secure greater value for health care dollars. But, once again, depending on how they are crafted, they could very easily generate unintended consequences, such as “gaming” by physicians who would have a new economic incentive to focus on certain patients at the expense of others. Likewise, waste, fraud and abuse has been a staple of Medicare cost cutting for

many years, but too often physicians have been audited and investigated for coding errors as well as intentional efforts to defraud the taxpayers. It might be more fruitful for Congress to see what can be done to reduce the regulatory overhead that physicians and other medical professionals must incur in the treatment of Medicare patients.

It should be noted that Medicare savings have previously been proposed as a way to finance broader health care coverage, but with limited success. In 1993, for example, President Clinton proposed shifting \$124 billion out of Medicare, capping Medicare spending over a six year period, to fund his comprehensive health care reform program. Since Medicare currently pays only 81 percent of the cost of private physician payment, for example, it is quite likely that if the President's changes simply result in additional reimbursement reductions, they would aggravate the current level of cost shifting from federal entitlements to private sector health insurance arrangements. Tens of billions of dollars of cost shifting annually does not add one red cent to the value of patient care.

In any case, modifications of Medicare's administrative payment system do not amount to major Medicare reform. That can only be accomplished by changing Medicare financing from defined benefit to defined contribution, and creating a Medicare retirement program that more directly resembles the Federal Employees Health Benefit Program (FEHBP), which is often cited favorably by health policy analysts of many different political persuasions in the media and elsewhere.

**Tax Policy.** As noted, the President is proposing tax increases on those making over \$250,000 annually, and is projected to finance approximately half of the projected health care spending, an estimated \$318 billion. The mechanism would be a reduction in tax deductions for these citizens, including mortgage interest and charitable deductions. Congress will have to decide if the Administration's tax proposals are themselves in the best interest of the country or the best way to secure reform of the health care system under the current economic circumstances.

But renewed discussion of the current tax policy governing health insurance could open up a new opportunity to forge a bipartisan consensus in health policy. From the late President Ronald Reagan and great economists such as the late Professor Milton Friedman to Senator Ron Wyden (D-OR) and Jason Furman, one of President Obama's senior economic advisers, there is an enormous intellectual consensus on the need to reform the inequitable and inefficient federal tax treatment of health insurance.

Today, the federal tax code provides unlimited tax breaks for individuals who get health insurance through the place of work. This tax exclusion for employer-sponsored insurance is a huge, but hidden, tax subsidy. The Joint Committee on Taxation estimates that value of the tax exclusion was \$246.1 billion in 2007 alone, in foregone income and payroll taxes. It is the largest federal tax expenditure as well as the third largest health care expenditure, following only Medicare and Medicaid, the nation's two largest entitlement programs.

Health economists generally agree that existing tax policy is poorly targeted and engenders perverse incentives. It is unfair because only individuals with employer-

sponsored insurance are able to receive tax relief, while individuals without access to such coverage typically pay for health insurance with after-tax dollars and, in effect, face a sizeable tax penalty. It is inefficient and inequitable because the largest tax benefits go to those who need them least: upper income individuals and families. If the goal is to extend coverage to the uninsured, the tax break is poorly targeted because it provides little or no tax relief to those with low incomes, who are most likely to have difficulty getting affordable health insurance.

It also increases health care spending. Of course, the exclusion does encourage individuals to have insurance. As Jason Furman, the President's Deputy Director of The National Economic Council, has noted, the current tax policy also encourages many individuals to have even more insurance than they typically need because the higher the cost of the insurance, and the higher the person's income, the bigger the tax benefit for the individual. Out-of-pocket expenditures, for the most part, do not enjoy a similar tax preference. This incentive reduces the price sensitivity of health care consumers and suppliers and leads to higher prices and greater utilization, which in turn drives up cost and makes health care more expensive for the uninsured.

The best option for reform would be to replace the existing tax exclusion with a universal system of more equitable individual tax relief, leveling the playing field for a robust competition among insurers and creating a level of consumer choice that is routine in every other sector of the American economy.

Short of that, Congress could limit or cap the exclusion, while simultaneously using the new revenue to provide health care tax credits for taxpaying households. Senate Finance Chairman Max Baucus (D-MT) has suggested limiting the current tax exclusion. The Baucus approach is ground for a possible compromise, forging a system of direct assistance to the uninsured through a combination of tax credits and vouchers.

If Congress were to cap the tax exclusion, revenue generated from the value of premiums that either exceeds the cap or is no longer excluded from taxable income could be used exclusively to finance tax credits to individuals and families to offset their federal taxes. The health care tax credits should apply to a significant portion of a health plan's premium, and used to offset some of a taxpayer's income tax liability. In no case should the credit or voucher be used to cover an entire premium, even for very low income persons; it is impossible to get cost control in health care, where financing is notoriously opaque, unless consumers have some skin in the game.

For low income persons who have no tax liability, Congress could provide health care vouchers. For persons with only limited tax liability, some combination of a tax credit and voucher could make health insurance more affordable. The voucher component would be somewhat like a traditional refundable tax credit, like the earned income tax credit, although with a key difference. These health care vouchers should be financed by offsets in the budget, including reductions in existing health programs. Congress can find plenty of options available to finance such direct assistance to low-income persons, and make the trade-offs according to their prudential determination of what should rank as a priority in the public interest. A voucher approach for the education of low-income

schoolchildren is endorsed by Democrats and Republicans alike; there is no reason why Congress could not pursue a similar option in health care.

In any case, Congress should not leave in place the existing tax exclusion for health insurance, the most regressive feature of the federal tax code, which distorts health insurance markets, undercuts consumer choice and competition, and fuels higher health care costs.

These conclude my formal remarks. I would be very happy to answer any questions that the Committee may have.

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