Backgrounder

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The Future of Health Care Reform: Paul Ryan's "Roadmap" and Its Critics

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Abstract: *The future of health care in America looks grim—but it does not have to be. Representative Paul Ryan (R–WI) has proposed "A Roadmap for America's Future"—the only comprehensive plan in Washington that deals with the looming fiscal and economic crisis, driven by ever-increasing government spending on health care. Ryan's Roadmap would reduce the deficit, allow Medicare to become truly sustainable, establish equity and efficiency in the federal tax treatment of health insurance, and improve access to health care for middle-class and low-income families. Congressman Ryan's critics have accused him of trying to destroy the Medicare system and claim that the Roadmap will increase the deficit. While they may have honed the harshness of their rhetoric, they have not offered a comparable alternative. Heritage Foundation health policy experts explain how the Ryan Roadmap would really work, and how it would benefit Americans.*

Representative Paul Ryan (R–WI) unveiled an updated version of his comprehensive "Roadmap for America's Future" in January 2010.[1] His is the only comprehensive, pro-growth proposal that has appeared on Capitol Hill to cope with America's looming fiscal crisis, generated largely by the accelerating growth in entitlements. Nonetheless, liberals in Congress and elsewhere have attacked Ryan's proposal. *New York Times* columnist Paul Krugman wrote that "Mr. Ryan has become the Republican Party's poster child for new ideas thanks to his 'Roadmap for America's Future'… But it's the audacity of dopes.

Talking Points

- Deficit spending has put the federal government on an unsustainable path. Representative Paul Ryan's Roadmap for America's Future offers a promising alternative to the status quo and is the only comprehensive plan for reform introduced by any Member of Congress.
- By reducing the deficit, putting Medicare and Medicaid on a fiscally sustainable path, and establishing equity and efficiency in the federal tax treatment of health insurance, the Roadmap would reform America's entitlement programs, and transform and improve the financing and delivery of Americans' health care.
- Ryan's Roadmap for America's Future is the only proposed pro-growth solution that holds the promise for restoring fiscal sustainability to the federal government and improving the fiscal future of our children and grandchildren.

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Mr. Ryan isn't offering fresh food for thought; he's serving up leftovers from the 1990s, drenched in flimflam sauce."[2]

Among serious analysts there is a broad, bipartisan consensus that the federal budget has the nation on the path to disaster. Erskine Bowles and Alan Simpson, co-chairmen of the President's National Commission on Fiscal Responsibility and Reform (Debt Commission), estimate that by 2020, without reform, Americans will be paying $1 trillion annually in interest payments on the national debt.[3] The correct course of action is to control government spending, especially on health care. Large federal entitlement programs—Medicare, Medicaid, and Social Security—threaten to bankrupt the United States if their costs are not curbed, and will become unsustainable due to unabated expansion in years to come.

Entitlement spending currently accounts for 56 percent of total federal spending.[4] As the population ages rapidly in the next three decades, this number will grow. Whereas in 2007 entitlement spending was 8.4 percent of gross domestic product (GDP), by 2050 it will grow to 18.4 percent of GDP. At that point, entitlement programs would consume the entire budget so that other national priorities, such as defense, would be entirely paid for by deficit spending. If entitlement programs are allowed to reach this size, Congress would have to raise taxes another $12,636 per household in 2050 (from an already high $17,879 in 2010) to cover their cost.[5] The only other option would be to add this enormous sum to the national debt, which would invite severe economic consequences.

In sharp contrast to the high-profile promises of President Obama and the congressional leadership concerning their massive health care bill, Representative Ryan's proposal actually delivers on broadly held bipartisan policy goals, such as bending the health care spending curve, expanding access to affordable coverage, preserving personal choice and portability in health care coverage, promoting robust competition in the health insurance markets, and reducing the deficit.

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By refusing to actively work on serious solutions to entitlement and related health policy problems, Ryan's critics lack a clear alternative to a gloomy fiscal future. On their part, this means the continuation of outdated policies, justifying them as necessary to the preservation of an ever-worsening status quo, marked by impending and unavoidable massive tax increases or savage cuts in entitlement benefits.

In sharp contrast, Ryan has outlined a comprehensive plan for reform to cope with the challenge of federal entitlements, particularly health care. His health care policy proposals would reduce the deficit, put health care entitlements, like Medicare, on a sustainable path, and create fairness and equity in the federal tax treatment of health insurance.

1. "Roadmap for America's Future Act of 2010" (H.R. 4529), 111th Congress, introduced by Representative Paul Ryan (R–WI) to limit the size of government, restrain federal spending, and rejuvenate the U.S. economy by reforming Medicare, Medicaid, Social Security, the current tax code, and the health care system at large, at *http://www.roadmap.republicans.budget.house.gov/UploadedFiles/Roadmap2Final2.pdf* (September 1, 2010).
2. Paul Krugman, "The Flimflam Man," *The New York Times*, August 5, 2010, at *http://www.nytimes.com/2010/08/06/opinion/06krugman.html* (August 29, 2010).
3. For a preliminary assessment of the Bowles–Simpson proposal, see Alison Acosta Fraser, "Bowles–Simpson Commission Co-Chair Report: A Good and Welcome First Step," Heritage Foundation *WebMemo* No. 3057, November 10, 2010, at *http://www.heritage.org/Research/Reports/2010/11/Bowles-Simpson-Commission-Co-Chair-Report-A-Good-and-Welcome-First-Step*.
4. Brian M. Riedl, "Federal Spending by the Numbers 2010," Heritage Foundation *Special Report* No. 78, June 1, 2010, at *http://www.heritage.org/Research/Reports/2010/06/Federal-Spending-by-the-Numbers-2010*.
5. *Ibid.*

The Roadmap Reduces Future Deficits

The attacks on this innovative approach fall far short of the mark. This is especially true of the Congressman's efforts to rein in runaway spending and record-breaking deficits.

According to the Congressional Budget Office (CBO),[6] Ryan's proposal would reverse America's course of federal budget deficits, one of the Roadmap's key objectives. It would convert projected deficits under the status quo into a budget surplus of 0.1 percent of GDP by 2063 and pay off the federal debt (projected at 63.6 percent for 2010) [7] by 2080.

Ryan's Roadmap focuses primarily on reducing spending, since projected deficits are caused by federal spending in excess of historical averages, while federal revenue is projected to remain close to and then rise above its historical average.[8] But the Roadmap also includes a major simplification of the federal tax code, replacing many current features of tax law (including exemptions and loopholes) with a broader and simpler tax base that is more encouraging to saving and investment and replacing the multiple rates of current law with just two tax rates. Based on his work with the U.S. Treasury Department and other tax experts, Ryan specifies tax rates that are intended to align projected revenues with the CBO's revenue projections assuming current tax policy is maintained. Then, starting in 2030, revenue would be held constant at 19 percent of GDP.[9] The CBO uses these assumptions in its modeling of the Roadmap plan's budget and economic effects.

Professor Krugman claims that the Roadmap will reduce revenues between 2010 and 2020, increasing the deficit dramatically.[10] He bases his claim on a separate analysis conducted by the Tax Policy Center,[11] a respected group of economists affiliated with the Urban Institute and the Brookings Institution, two prominent liberal think tanks.

But the Tax Policy Center's analysis is limited to a *10-year window*, and, as Ryan clearly explains, "the Roadmap is a long-term plan with spending and revenue projections covering 75 years. As such, the analysis is not consistent with the long-term horizon of the plan."

Aside from the length of the horizon for its projections showing that the Roadmap tax reform would fall short of its revenue target, the Center has another problem: the real revenue levels, reflecting improvements in economic growth, may be closer to the target than the Center's analysis suggests. According to Heritage Foundation tax expert J. D. Foster, the Tax Policy Center ignores the effects that a stronger economy would have on the plan:[12] "A fundamental motivation for tax reform is to improve economic performance, yet the TPC [Tax Policy Center] acknowledges its analysis is essentially static." Furthermore, Foster explains that the Center's analysis "combines a rigorous methodology for assessing the revenue effects from the tax on individuals with a back of the envelope approach to estimating tax revenues from the new Business Consumption Tax (BCT) contained in the Ryan plan." This is a source of further uncertainty in the analysis.

6. Congressional Budget Office, "An Analysis of the Roadmap for America's Future Act of 2010," January 27, 2010, at *http://www.cbo.gov/doc.cfm?index=10851* (August 29, 2010).
7. Office of Management and Budget, *Historical Tables: Budget of the U.S. Government, Fiscal Year 2011*, Table 7.1, at *http://www.whitehouse.gov/sites/default/files/omb/budget/fy2011/assets/hist.pdf* (September 1, 2010).
8. Riedl, "Federal Spending by the Numbers 2010."
9. Congressional Budget Office, "An Analysis of the Roadmap for America's Future Act of 2010."
10. For an account of the Krugman–Ryan controversy, see Megan McArdle, "Paul Krugman Is Wrong on Ryan and the CBO," *The Atlantic*, August 7, 2010, at *http://www.theatlantic.com/business/archive/2010/08/krugman-is-wrong-on-ryan-and-the-cbo/61110* (September 1, 2010).
11. Joseph Rosenberg, "Preliminary Revenue Estimate and Distributional Analysis of the Tax Provisions in *A Roadmap for America's Future Act of 2010*," Tax Policy Center, at *http://www.urban.org/UploadedPDF/412046_ryan_taxplan.pdf* (August 29, 2010).
12. J. D. Foster, "TPC's Hits and Misses on Ryan's Roadmap," The Foundry, March 11, 2010, at *http://blog.heritage.org/2010/03/11/tpc%e2%80%99s-hits-and-misses-on-ryan%e2%80%99s-roadmap*.

Meanwhile, it is worth noting that analysts at the Tax Policy Center repudiated Krugman's charges of Ryan's proposal being a "fraud," calling attention to the CBO's positive estimates on America's debt reduction. Even if, as the Tax Policy Center analysts concluded, Ryan's tax proposals would fall short of his revenue goals, this would merely require an appropriate adjustment of his tax provisions. In this context, the Center's Ted Gayer observes that "[r]easonable people can disagree about whether we should close our long-term fiscal gap primarily through spending reductions or tax increases, but Congressman Ryan's proposal makes a useful contribution to this debate."[13]

There is always a large element of uncertainty when practicing the arts of budgetary or economic projections, especially in health care. Congressman Ryan himself concedes that "Nobody knows…if TPC is right or if the data we got from the Treasury was right." They are both possible models, but Ryan would reasonably expect that the numbers from the Treasury Department are more accurate.[14] Once again, however, even if the Treasury Department analysis is incorrect, Ryan stated that the tax rates in his proposal could easily be tweaked to align taxes and revenues to reduce the federal deficit.

The Roadmap Ensures Sustainable Medicare Reform

Medicare is the hot-button issue in entitlement reform. Representative Louise Slaughter (D–NY) accused Ryan of planning "to phase out Medicare,"[15] and House Speaker Nancy Pelosi (D–CA) lamented that the plan "ends Medicare as we know it."[16] There is, of course, a central intellectual deficiency in this attack: Medicare is already ending "as we know it," and resisting rational reforms to secure affordable health care for the next generation of senior citizens will not change that fact. Indeed, pursuing flawed Medicare policies, which give a superficial appearance to the public of preserving the status quo, will only worsen Medicare's situation, for seniors and taxpayers alike.

First, consider Medicare's payment update policy for hospitals, nursing homes, and home health agencies. Under the Patient Protection and Affordable Care Act of 2010 (PPACA) signed into law by President Obama, Congress enacted massive programmatic changes that will radically transform the Medicare program in a variety of ways. For example, the new law is scheduled to secure an estimated $575 billion in Medicare savings during the first 10 years of its implementation, mostly through reductions in Medicare-provider payment updates and reductions in payments to Medicare Advantage plans. These projected savings will be used to finance entitlement expansions under the new health law, not guarantee Medicare solvency. Nonetheless, taken together, these are enormous changes in Medicare financing.

According to the Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS), the payment reductions to providers will result in "negative" margins for 15 percent of hospitals, skilled nursing facilities, and home health agencies. If Congress does not alter its payment policy, these payment reductions will result in 25 percent of these Medicare providers facing negative profit margins by 2030, and 40 percent by 2050.[17] As the Office of the Actuary observes, "[i]n practice, providers could not sustain continuing negative margins and, absent legislative changes, would have to

13. Ted Gayer, "In Defense of Congressman Paul Ryan," Tax Policy Center, *Tax Vox*, August 6, 2010, at *http://taxvox.taxpolicycenter.org/blog/_archives/2010/8/6/4598007.html* (September 1, 2010).
14. John McCormack, "Ryan Rips Krugman: 'Intellectually Lazy' and 'Bizarre' Attack," *The Weekly Standard*, August 9, 2010, at *http://www.weeklystandard.com/blogs/paul-ryan-krugmans-attack-intellectually-lazy* (August 30, 2010).
15. Congressman Ryan responds to misguided attacks on roadmap before the House Rules Committee, C-SPAN2, March 20, 2010, at *http://www.youtube.com/watch?v=m4qy3bGYii8* (September 1, 2010).
16. Teddy Davis, "GOPer Offers Alternative, Dems Pounce; Pelosi: 'Here They Go Again,'" ABC News, "The Note," February 5, 2010, at *http://blogs.abcnews.com/thenote/2010/02/goper-offers-alternative-dems-pounce-pelosi-here-they-go-again/comments/page/2* (September 1, 2010).
17. John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Centers for Medicare and Medicaid Services, August 5, 2010, p. 6.

withdraw from providing services to Medicare beneficiaries, merge with other provider groups, or shift substantial portions of Medicare costs to their non-Medicare, non-Medicaid payers."[18]

Perhaps such a major reduction in projected payments could be justified if the savings were plowed directly back into the Medicare program to enhance its solvency, particularly the solvency of the Medicare Part A Trust Fund. But, under the terms of the PPACA, these Medicare savings will be used to finance the expansion of new health care entitlements. On paper, the savings are counted toward Medicare solvency; in reality they are not. As the Office of the Actuary carefully noted, "In practice, the improved Part A financing cannot be simultaneously used to finance other federal outlays (such as the coverage expansions under the PPACA) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."[19]

Furthermore, the statutory and programmatic changes to physician reimbursement[20] and other provider payments in the new law also constitute major policy changes. Currently, the vast majority of senior citizens are enrolled in fee-for-service Medicare, sometimes referred to as "traditional" Medicare. This means that doctors and other providers are paid for individual units of medical services or the provision of medical procedures. In many managed-care arrangements, by contrast, doctors and other medical professionals receive "capitated" payments, or salaries for treating patients, regardless of how many people they treat.

While the President and many Members of Congress insist that they have no intention of changing the doctor–patient relationship, the reality is that the legislation authorizes major changes in the way in which physicians are paid under Medicare and Medicaid, which, in turn will directly affect how they treat patients. Under Section 3021 of the PPACA, Congress has created the Center for Medicare and Medicaid Innovation as an office within CMS. Among its many duties is to develop new models of payment for physicians and other providers, including new payment models that "transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment."[21] In other words, Congress has already voted to move away from the traditional Medicare fee-for-service program as we have known it.

Congress has already voted to move away from the traditional Medicare fee-for-service program as we have known it.

Finally, the creation of the Independent Payment Advisory Board is perhaps the most dramatic of all of the Medicare provisions of the PPACA. For the first time in Medicare's history, Congress enacted, and the President signed into law, a hard Medicare spending cap, initially limiting Medicare's per capita spending growth to measures of inflation and later to GDP.[22] Just as the PPACA's initial per capita spending increase tracks inflation growth, statuto-

18. *Ibid.*
19. Solomon M. Mussey, "Estimated Effects of the 'Patient Protection and Affordable Care Act,' as Amended, on the Year of Exhaustion of the Part A Trust Fund, Part B Premiums, and Part A and Part B Coinsurance Amounts," Office of the Actuary, Centers for Medicare and Medicaid Services, April 22, 2010, pp. 1–2. The CMS assessment of this matter was foreshadowed by the Congressional Budget Office. "Unified budget accounting shows that the majority of the HI trust fund savings under PPACA would be used to pay for other spending and therefore would not enhance the ability of the government to pay for future Medicare benefits." Letter to Honorable Jeff Sessions (R–AL), United States Senate from Douglas W. Elmendorf, Director, Congressional Budget Office, January 22, 2010, p. 3.
20. Of course, the sustainable growth rate (SGR) governing the Medicare physician payment updates is not changed at all under the PPACA. The SGR implementation is delayed until December 2010, at which point, the physician payments must either be enforced or delayed again. Over the next three years, according to the Office of the Actuary, Medicare payment rates would be reduced by 30 percent under current law. Shatto and Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," p. 1.
21. The Patient Protection and Affordable Care Act, Title III, Section 3021, (b)(B)(i).

rily determined as a blend of general inflation, as measured by the consumer price index (CPI), and medical inflation, Representative Ryan uses the same formula for indexing the growth of the government contribution to Medicare beneficiaries as part of his overall Medicare reform.[23] In 2010, the congressional Democratic majority, at least on this crucial issue of restraining Medicare spending growth, has enacted a policy at least as stringent, and potentially more so, than Congressman Paul Ryan has proposed. It is possible that many Members, including Ryan's most fervent critics, may not even realize the consequences of what they have already enacted into law.

It is possible that many Members of Congress may not even realize the consequences of what they have enacted into law.

Given the current administrative payment and defined-benefit structure of the Medicare program, Ezra Klein, a *Washington Post* journalist, realizes that Medicare's conventional cost control measures are usually provider payment reductions. But he insists that while Medicare pays doctors and hospitals less, it is more efficient than private insurance.[24] While Klein acknowledges Ryan's plan as an "honest entry into the debate," he is incorrect in holding to a widely held belief in Medicare's superior efficiency.[25] In fact, as Heritage analyst Robert Book explains, when overall costs of delivering services are compared on a per-beneficiary basis, the economic efficiency of private insurance is superior.[26] Examining data over the period 2000 to 2005, Book finds that Medicare's administrative costs per beneficiary were higher than those of the private sector.[27]

Even with the PPACA's extensive provider payment cuts, the Office of the Actuary still projects overall Medicare spending to rise rapidly and, as a percentage of GDP, to jump from 3.59 percent in 2010 to 6.02 percent in 2020, reaching 8.17 percent in 2050.[28] This dramatic rise in spending will likely ignite powerful and politically desperate responses. These could include heavier taxation, sharper beneficiary premium increases or cost sharing, an even greater tightening of provider reimbursement, tougher controls on access to medical services, or an acceptance of mounting debt. Under the trajectory of current policies, not under the market-oriented reforms proposed by Congressman Ryan, Medicare beneficiaries will indeed be vulnerable, and Medicare itself—at least "as we know it"—would be undone.

On one key point, Ryan's critics are correct: The Roadmap would substantially change the rickety 1960s architecture of an outdated and mind-numbingly bureaucratic Medicare program. While current and soon-to-become Medicare beneficiaries would be unaffected, the Roadmap would transform Medicare into a demonstrably superior system for those under age 55. Major changes, in other

22. Patient Protection and Affordable Care Act, Section 3403. For the first five years, the spending target is based on an average of CPI and Medical CPI. Beginning in 2018, the target is changed to an increase in the general economy as measured by GDP plus 1 percent.
23. "When fully phased in, the average payment is $11,000 per year (the average amount Medicare currently spends per beneficiary) and is indexed for inflation by a blended rate of the CPI and the medical care component of the CPI." Ryan, "Roadmap to America's Future," p. 51.
24. Ezra Klein, "Rep. Paul Ryan's Daring Budget Proposal," *The Washington Post*, February 1, 2010, at *http://voices.washingtonpost.com/ezra-klein/2010/02/rep_paul_ryans_daring_budget_p.html* (October 19, 2010).
25. Ezra Klein, "The Virtues of Ryan's Roadmap," *The Washington Post*, August 3, 2010, at *http://voices.washingtonpost.com/ezra-klein/2010/08/the_virtues_of_ryans_roadmap.html* (October 19, 2010).
26. Robert A. Book, "Medicare Administrative Costs Are Higher, Not Lower, Than for Private Insurance," Heritage Foundation *WebMemo* No. 2505, June 25, 2009, p. 1, at *http://www.heritage.org/research/reports/2009/06/medicare-administrative-costs-are-higher-not-lower-than-for-private-insurance*.
27. *Ibid.*, p.3.
28. Shatto and Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," p. 16.

words, would go into effect for enrollees in 2021. The essential change would consist in converting the program from a defined-benefit program to a defined-contribution system, where the government provides generous financial support for the purchase of coverage of personal choice—similar to the kind of system that Members of Congress and federal employees and retirees enjoy today in the popular and successful Federal Employees Health Benefits Program (FEHBP). Like the federal employees and retirees in the FEHBP, future seniors would receive premium support based on current funding to apply to a health plan of their choice, either a Medicare-certified option or any other private plan. In the meantime, Ryan's proposal would also reverse the fiscal dynamics of Medicare, which today faces a long-term unfunded liability of $30.8 trillion.[29] With Ryan's Roadmap, Medicare would be transformed into a fiscally solvent program, rather than an engine of debt and crushing taxation.

Peter Orszag, President Obama's former director of the Office of Management and Budget (OMB), is critical of Ryan's emphasis on a new structure of consumer choice among competing health plans because "such plans would encourage seniors to shop among doctors and treatments and rationally economize on their health care spending. The core problem however, is that the bulk of health care spending is concentrated among those with serious illnesses and high health care costs…."[30]

Orszag's complaint, however, misses the point. No one seriously disputes that those who are gravely ill incur costs well above those who are not. Logically, however, that does not negate the formidable economic advantages, especially cost control, that would be pervasive throughout a reformed system driven by robust market competition and genuine consumer choice. Moreover, Ryan's Roadmap recognizes the need to adjust government assistance for such differences; his proposal explicitly takes into account the health status of retirees. In fact, the Ryan defined-contribution approach would also adjust the government contribution to retiree health coverage to account for income and geography (as costs differ regionally) as well as health status. The central policy objective is to target financial assistance to those who need it most. Wealthier Americans would receive a lower percentage of the full amount, while low-income enrollees would receive additional financial assistance to offset their health care expenditures.

One of the key advantages of Ryan's proposal for competition among plans and providers is that it would, as Orszag concedes, surely encourage Medicare beneficiaries to seek the best value for dollars in meeting their health care needs. If seniors enrolled in health plans which were less expensive than their Medicare contribution, they could apply the remainder to their medical savings accounts and secure their savings. If they instead chose to enroll in a more generous plan, with premiums higher than Medicare's contribution, they would pay the difference. This approach to financing is fair and equitable.

Ryan's general approach has a bipartisan pedigree. In 1980, Representative Richard Gephardt, the Missouri Democrat and future House Majority Leader, joined with Representative David Stockman (R–MI) in cosponsoring the National Health Reform Act. The Gephardt–Stockman bill would not only have created a "voucher" for Medicare beneficiaries to apply to the purchase of private health insurance of their choice, but it also would have provided for the replacement of the current tax exemption for

29. Last year's long-term unfunded liability was estimated to be $38 trillion. The large reduction from the 2009 to 2010 Medicare Trustee report is largely attributable to changes made to the program in the PPACA, which CMS's Chief Actuary warns may be unrealistic and unreasonable. See the Centers for Medicare and Medicaid Services, *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*, August 5, 2010, at *https://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf* (August 30, 2010). See also Shatto and Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," and J. D. Foster, "It's Official: Medicare's Finances Shadowed by Uncertainty," *The Foundry*, August 5, 2010, at *http://blog.heritage.org/2010/08/05/it%e2%80%99s-official-medicare%e2%80%99s-finances-shadowed-by-uncertainty.*

30. Peter Orszag, "Fiscal Accomplishments and Budget Update," speech at The Brookings Institution, July 28, 2010, at *http://www.brookings.edu/events/2010/0728_orszag.aspx* (August 30, 2010).

employer-based coverage with a national system of refundable tax credits for health insurance.[31] Subsequently, the Reagan Administration backed legislation that would have permitted Medicare enrollees to apply, on a voluntary basis, the amount of their Medicare funding for the purchase of private health insurance. The Reagan proposal was, in effect, a voluntary voucher proposal. While Congress never acted on the Reagan initiative, Congress in enacting the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) did provide that HMOs competing for the business of Medicare enrollees accept the full financial risk of covering them, just like private health plans competing for the business of federal retirees in the Federal Employees Health Benefits Program (FEHBP).

Ryan's Medicare proposals are also reminiscent of "premium support" Medicare reforms advocated in the 1990s by top analysts at Brookings and the Urban Institute,[32] as well as embodied in the 1999 majority recommendations of the National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D–LA) and Representative William Thomas (R–CA).[33] The final Breaux–Thomas recommendation concluded that "[w]e believe a premium support system is necessary to enable Medicare beneficiaries to obtain secure, dependable, comprehensive high quality health care coverage comparable to what most workers have today. We believe modeling a system on the one Members of Congress use to obtain health care coverage for themselves and their families is appropriate."

The Reagan Administration proposal was, in effect, a voluntary voucher proposal.

Bipartisan support for moving Medicare to a premium support system has been most recently revived by the recommendations of the Bipartisan Policy Center's Debt Reduction Task Force. Co-chairmen Senator Pete Domenici (R–NM) and Alice Rivlin write that, "Competition among plans will improve the quality of care and increase efficiency."[34] Rivlin and Ryan are both members of the deficit commission convened by President Obama. Together, they proposed a plan for Medicare reform which echoes both the policy recommendations put forth by the Task Force and Ryan's Roadmap.[35]

The FEHBP is an excellent model for Medicare reform.[36] In administering the FEHBP, the federal government makes contributions to health plans chosen by its employees and retirees, and enforces effective rules for marketing, fiscal solvency, and consumer protection. Walton Francis, a prominent Washington-based health care economist, con-

31. Congressman Stockman left the House of Representatives to become President Reagan's Director of the Office of Management and Budget (OMB). Congressman Gephardt again reintroduced his comprehensive health care reform legislation as the National Health Care Reform Act of 1983 (H.R. 850), and secured bipartisan support in the House of Representatives. He became the Democratic House Majority Leader in 1989 and served in that position until 1995.
32. See, for example, Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What is the Next Step?" *Health Affairs*, Vol. 14, No. 4 (1995), pp. 20–22, at *http://content.healthaffairs.org/cgi/reprint/14/4/8?maxtoshow=&hits=10&RESULTFORMAT=&author2=Aaron&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&fdate=11/1/1993&tdate=8/31/1997&resourcetype=HWCIT* (August 30, 2010).
33. National Bipartisan Commission on the Future of Medicare, "Building a Better Medicare for Today and Tomorrow," March 16, 1999, at *http://thomas.loc.gov/medicare/bbmtt31599.html* (September 1, 2010).
34. Senator Pete Domenici and Alice Rivlin, "Restoring America's Future," Bipartisan Policy Center Debt Reduction Task Force, November 2010, p. 17, at *http://bipartisanpolicy.org/sites/default/files/FINAL%20DRTF%20REPORT%2011.16.10.pdf* (November 19, 2010).
35. Alice Rivlin and Paul Ryan, "A Long-Term Plan for Medicare and Medicaid," November 17, 2010, at *http://www.house.gov/budget_republicans/rivlinryan.pdf* (November 19, 2010).
36. Walton J. Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, D.C.: AEI Press, 2009). See also Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Vol. 14, No. 4 (1995), pp. 47–61, and Harry Cain, "Moving Medicare to the FEHBP Model, or How to Make an Elephant Fly," *Health Affairs*, Vol. 18, No. 4 (1999), pp. 25–39.

cludes that "the FEHBP has outperformed original Medicare in every dimension of its performance. It has better benefits, better service, catastrophic limits on what enrollees must pay, and far better premium cost control."[37]

More Patient-Centered Transformations

While putting health care consumers in the driver's seat, the Roadmap also tackles out-of-control growth in overall health care spending. There is a broad intellectual consensus among health care economists that the existing tax treatment of health insurance, specifically the tax exclusion of employment-based health insurance, is a cost-driver; it contributes to the disconnect between health care consumers and the medical services and products they use. By tying group health insurance to the employer and making it an unlimited tax-free benefit, the tax exclusion removes consumers' incentives to control costs.[38] It also undercuts the ability of individuals and families to choose the health plan that suits them best, decide how much of their compensation to dedicate to health care, and achieve portability of coverage, creating a barrier to those who want to keep their health plan if they change jobs.

Ryan's Roadmap eliminates these barriers by replacing the current income tax exclusion for employer-based coverage with a universal, refundable health care tax credit for all Americans to buy the coverage of their choice.[39] The credits amount to $2,300 per individual and up to $5,700 per family in 2010 dollars and could be applied to health insurance either through an employer or purchased independently. Universal health care tax credits, which have enjoyed bipartisan congressional support, can dramatically expand health insurance coverage.

Households, not employers, pay 100 percent of health care costs, even when household members are enrolled in employer plans. The normal trade-off of wages to benefits is well understood: every $1.00 increase in health insurance benefits is offset by a roughly $1.00 decrease in wages and other compensation. So, the employer payment is a mechanism by which employees secure health care coverage as part of their compensation; the employer does not in any way provide a free benefit with the job. As MIT economist Jonathan Gruber explains, "Both economic theory and a large body of economic evidence show that *there are no employer dollars*; the money that employers spend on insurance would otherwise just be spent on worker wages."[40] Employers could offer health benefits as a defined-benefit package or as a defined-contribution package. In a competitive labor market, in trying to attract and retain employees, employers may allocate benefits and wages in different combinations, but a change in those combinations does not automatically mean a change in employees' total level of compensation. From a tax standpoint, however, most employees would be better off with reform.

In the Patients Choice Act of 2009, a legislative embodiment of the health care tax credit sponsored by Representatives Paul Ryan and David Nunes (R–CA), as well as Senators Tom Coburn (R–OK) and Richard Burr (R–NC), almost all households with incomes under $100,000 would benefit from replacing the current tax exclusion with the health insurance tax credit; in other words, they would see net increase in their after-tax incomes.[41] As for employers, an employer receives a regular tax deduction when he offers employees compensation either in the form of wages or benefits, and there is

37. Francis, *Putting Medicare Consumers in Charge*, p. 8.
38. The 40 percent excise tax on "high value" health plans (the "Cadillac plan tax") in the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) is a change in policy, but it will not be effective until 2018. The provision, assuming it survives, is designed primarily as a revenue raiser. It falls far short of a comprehensive reform of the tax treatment of health insurance.
39. Congressman Ryan's broad-based tax reform proposal would generally simplify the federal tax code, creating two marginal tax rates and eliminating most existing tax deductions and credits. The health care tax credit is an exception to this general rule on the use of tax credits; it is more progressive and secures better health policy than the existing system, which ties access to health care tax breaks to the accident of one's employment.
40. Jonathan Gruber, Statement Before the Committee on Finance, United States Senate, July 31, 2008, at *http://finance.senate.gov/imo/media/doc/073108jgtest1.pdf* (emphasis in original) (November 20, 2010).

no change in the tax benefits for employers under the Ryan proposal one way or the other. It is the employee who receives a tax credit to buy health insurance (regardless of whether the employee acquires it through the employer or outside the place of work).

Matt Miller, a senior fellow at the Center for American Progress, a Washington-based liberal think tank, is also a prominent critic of Ryan's Roadmap. Miller seems to assume that government assistance under the tax code should somehow equal the total cost of the insurance eligible for the favorable tax treatment.[42] Such an assumption would only make sense, of course, if one were to harbor the conviction that health care should somehow be a "free" good provided by the government, as in a single-payer system of national health insurance, or that the employer contribution as compensation (in lieu of wages) should be ignored. No responsible proponent of tax credits for health insurance has advanced the argument that a tax break should somehow pay for *all* or most of a person's health insurance costs, making it an exclusively "free good." But Miller says that the "health tax credit of $5,700 per family…won't go far for average Americans when the most popular preferred provider organization family plan enjoyed by Congress today runs about $14,000."[43] As noted, however, most taxpayers will find the health care tax credit to be substantially more generous than the current tax exclusion.

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In his reference to congressional coverage, Miller is doubtlessly referring to the Blue Cross and Blue Shield "standard option," offered through the FEHBP, a plan with a rich level of coverage for an aging but well-paid federal workforce, which covers retirees, and in which the average age of the enrolled pool is around 60. There are many less expensive, but otherwise solid, health insurance plans available; and more would become available in a consumer-driven market, in which insurers tailor their products to the wants and needs of their customers.

Tax breaks for health insurance, including the substantial tax breaks that Americans have today to reduce the cost of employer-sponsored coverage, are designed to make health insurance more affordable. They are designed to *help* offset part of the cost. They are *not* designed to fully subsidize the cost of health insurance for every one or even a substantial proportion of American families. Of course, the issue of whether tax credits are sufficient to secure "affordability" of coverage is not confined exclusively to the use of tax credits to expand private health coverage; the centrality of that issue applies equally to the current law tax exclusion as well as to the expansion of public programs. Note, for example, that congressional liberals have also imposed rigid restrictions on federal assistance for coverage, with an interesting example included in the PPACA: a "firewall" to keep a large majority of those who fall below 400 percent of the federal poverty level from obtaining generous taxpayer subsidies to purchase private health coverage in the yet to be implemented federally designed health insurance exchanges.[44]

A Mainstream Consensus. Congressman Ryan's key policy prescription—a change of the federal tax

41. See Greg D'Angelo, Rea S. Hederman, Jr., and Paul L. Winfree, "How Reforms to the Tax Treatment of Health Insurance Benefit the Middle Class," Heritage Foundation *WebMemo* No.2518, July 1, 2009, at *http://www.heritage.org/research/healthcare/wm2518.cfm*.
42. Matt Miller, "From Paul Ryan, A Plan That Isn't," *The Washington Post*, August 19, 2010, at *http://www.washingtonpost.com/wp-dvn/content/article/2010/08/18/AR2010081802930.html* (August 19, 2010).
43. *Ibid.*
44. James C. Capretta, "The Senate Health Care Bill's 'Firewall' Creates Disparate Subsidies," Heritage Foundation *WebMemo* No. 2730, December 11, 2009, at *http://www.heritage.org/Research/Reports/2009/12/The-Senate-Health-Care-Bills-Firewall-Creates-Disparate-Subsidies*.

treatment of health insurance—puts him squarely in the intellectual mainstream of health care economists, liberal and conservative alike. For example, Jonathan Gruber, professor of economics at MIT, argues that the current tax policy is inefficient and regressive;[45] Uwe Reinhardt, professor of political economy at Princeton, says that it is profoundly unfair;[46] and Katherine Baicker, professor of economics at Harvard University, insists that reform of tax policy is a "key component" of broader health care reform.[47]

While many policy disputes sharply divide health policy analysts, there is an enormous consensus on the need to make tax breaks for coverage more equitable and efficient.[48] Replacing the existing tax exclusion for employer-provided health insurance with a national system of health care tax credits, as in the Ryan Roadmap, has been the preferred policy option of several leading economists with Democratic credentials, including senior appointees of the Obama Administration. For example, Jason Furman, Deputy Director of President Obama's National Economic Council, called for the replacement of the current tax breaks for health insurance with an income-related refundable health care tax credit. As with Ryan's proposal, Furman's objective is to expand coverage while reducing inefficient health care spending.[49] Dr. Sherry Glied, currently Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services (HHS) and formerly a professor of economics at Columbia University, has also written an excellent piece on the need to reform the federal tax exclusion for health insurance.[50] And David Kendall, currently a prominent health policy analyst with "Third Way" and formerly with the Progressive Policy Institute, both "centrist" Democratic think tanks, has long championed the superiority of health care tax credits as an alternative to the existing employment-based federal tax exclusion on health benefits.[51] Among America's top conservative economists—ranging from the late Nobel Laureate Milton Friedman of the University of Chicago to Professors Regina Herzlinger of Harvard and Mark Pauly of the University of Pennsylvania—the necessity of reforming federal tax policy as a key to serious health care reform has long been settled.

Benefiting Middle Class Families. Under the Ryan Roadmap, low-income and middle-income families would receive more federal assistance to purchase insurance than they do now. The Heritage Foundation's Center for Data Analysis examined the Patient's Choice Act[52]—sponsored by Senators Coburn and Burr and Representatives Ryan and Nunes—and, as noted, found that a similar national health care tax credit system would benefit the vast majority of American families:

> [A]lmost all households with incomes under $100,000 would benefit from replacing the current income tax exclusion with a health insurance tax credit. The tax credits…would represent a net tax reduction for these house-

45. See Professor Gruber's testimony before the Committee on Finance, United States Senate, at *http://finance.senate.gov/imo/media/doc/073108jgtest1.pdf* (November 30, 2010. In the interest of both equity and efficiency, Professor Gruber also favors the replacement of the tax exclusion with a flat health care tax credit.
46. Professor Reinhardt's remarks are available at *http://www.pbs.org/healthcarecrisis/Exprts_intrvw/u_reinhardt.htm* (November 30, 2010).
47. Professor Baicker's remarks before the Committee on Finance, United States Senate, are available at *http://finance.senate.gov/imo/media/doc/073108kbtest.pdf* (November 30, 2010).
48. For a good summary of the views of conservative, centrist, and libertarian analysts on the subject, with analysts ranging from the American Enterprise Institute to the Urban Institute, see Grace-Marie Arnett (ed.) *Empowering Health Care Consumers Through Tax Reform* (Ann Arbor: University of Michigan Press, 1999).
49. Jason Furman, "Health Reform Through Tax Reform: A Primer," *Health Affairs*, Vol.27, No. 3 (2008), pp. 622–632, at *http://content.healthaffairs.org/cgi/content/abstract/27/3/622* (November 21, 2010).
50. Sherry Glied, *Revising The Tax Treatment of Employer Provided Health Insurance* (Washington, D.C.: The AEI Press, 1994).
51. David B. Kendall, "A Health Insurance Tax Credit: The Key to Successful Health Care Reform," The Progressive Policy Institute *Backgrounder*, March 1, 2000, at *http://www.ppionline.org/ndol/print.cfm?contentid=605* (November 21, 2010).
52. The Patients' Choice Act, H.R. 2520, 111th Congress, 1st Session.

> holds and, in effect, increase their after-tax incomes. Although compensation in the form of health insurance would now be subject to the federal income tax, the tax credits that would replace the exclusion would, in most cases, more than offset any new federal income tax liability resulting from this change in the tax treatment of health insurance.[53]

Helping Poor Families. Finally, the Roadmap replaces the current Medicaid program, which serves the poor and the indigent, with a new system of health care tax credits and debit cards that could be applied to health insurance premiums, as well as deductibles, coinsurance, and co-payments for low-income families. It is different in a number of details, but the main thrust of the policy change is reminiscent of the innovative 1999 Medicaid reform proposal offered by former Democratic Senator Bill Bradley of New Jersey. Senator Bradley proposed replacing Medicaid altogether with a new system of health care vouchers to allow the low-income uninsured to purchase private health insurance. Bradley's system would have also functioned like the FEHBP.[54] Representative Ryan and Senator Bradley agree that millions of Americans would be better off if they did not have to depend on a poorly performing welfare program.

The current Medicaid program is a budgetary drain for state officials, and has a record of providing beneficiaries with substandard care and inadequate access to doctors.[55] Replacing the current program with a new one that allows America's low-income families to shift to private health insurance of their choice gives them access to the same quality of care their fellow citizens receive in the private market. Unlike the PPACA, which would cover more than half of the newly insured under Medicaid in the first 10 years, the Ryan proposal would reduce dependence on Medicaid and would shift millions of low-income Americans into the private health insurance system that covers their fellow citizens.

Bending the Health Care Spending Curve

A key economic source of skyrocketing health spending is that, as Heritage Foundation analysts have noted, "neither the patient, the doctor, the insurance company, nor any government program has much incentive to spend health care dollars efficiently. A system that determines prices through administrative procedures rather than market processes disconnects the prices paid for health care services and products from both the costs incurred to provide them and their value to patients."[56]

There are a variety of ways to reduce health care spending. The central issue in the American health care debate is whether spending should be controlled by moving toward a free market, relying on competition to secure value for money and economic efficiencies, or through the imposition of various restrictions on the supply of medical goods and services through a centralized government machinery of regulation, administrative payment formulas, and price controls. In various ways, provisions of the PPACA rely on the outdated, top-down approach to limit or control health spending.[57] The

53. D'Angelo, Hederman, and Winfree, "How Reforms to the Tax Treatment of Health Insurance Benefit the Middle Class."
54. Robert Pear, "Health Care Proposals Help Define Democrats," *The New York Times*, December 20, 1999, at *http://www.nytimes.com/library/politics/camp/122099wh-dem-health.html* (August 30, 2010).
55. The literature on Medicaid's substandard care is growing. See, for example, Damien J. Lapar *et al.*, "Primary Payer Status Affects Mortality for Major Surgical Operations," *Annals of Surgery*, Vol. 252, No. 3 (September 2010), pp. 544–551, at *http://www.ncbi.nlm.nih.gov/pubmed/20647910* (August 30, 2010). See also Brian Blase, "Obama's Proposed Medicaid Expansion: Lessons from TennCare," Heritage Foundation *WebMemo* No. 2821, March 3, 2010, at *http://www.heritage.org/Research/Reports/2010/03/Obamas-Proposed-Medicaid-Expansion-Lessons-from-TennCare*, and Jeet Guram and John O'Shea, "How Washington Pushes Americans into Low-Quality Health Care," Heritage Foundation *Backgrounder* No. 2264, April 24, 2009, at *http://www.heritage.org/Research/Reports/2009/04/How-Washington-Pushes-Americans-into-Low-Quality-Health-Care*.
56. Jason Fodeman and Robert A. Book, "'Bending the Curve': What Really Drives Health Care Spending," Heritage Foundation *Backgrounder* No. 2369, February 17, 2010, at *http://www.heritage.org/Research/Reports/2010/02/Bending-the-Curve-What-Really-Drives-Health-Care-Spending*.
57. James C. Capretta, "Why the Obama Health Plan Is *Not* Entitlement Reform," The Galen Institute, July 2010, at *http://www.galen.org/fileuploads/Galen_Entitlement_Reform.pdf* (August 30, 2010).

major spending reductions come from cuts in provider payment updates, reductions in payment to Medicare Advantage plans, and through the bureaucratic imposition of various payment formulas and delivery system reforms to meet bureaucratically set targets. As Heritage analysts note, though "such an approach might control rising spending, it cannot fairly be described as 'bending the cost curve.' The cost of providing any particular service would remain unchanged."[58]

When costs remain unchanged, they are normally not controlled, merely shifted. At the end of the day, cost control through bureaucratic mechanisms shifts costs to patients through reduced access to care. As James Capretta, a former OMB associate director, explains, "Efforts to control costs from the top down have always devolved into price setting and across-the-board payment-rate reductions, which is detrimental to the quality of American medicine. Price controls drive out willing suppliers of services, after which the only way to balance supply and demand is with waiting lists."[59]

By instituting systemic change to the way the health care sector works today, Ryan's Roadmap would convert the sector into a patient-centered, consumer-driven marketplace that drives health prices down while ensuring quality care.

Conclusion

Congressman Paul Ryan has produced a comprehensive proposal that would reform America's entitlement programs, and transform and improve the financing and delivery of Americans' health care. His proposal would reduce the deficit, put Medicare on a fiscally sustainable path, establish a long-awaited equity and efficiency in the federal tax treatment of health insurance, and improve the provision of health care for middle-class and low-income families, particularly those who today have no choice but to rely on a poorly performing Medicaid program, and will have even less choice tomorrow with the implementation of the Patient Protection and Affordable Care Act.

Congressman Ryan's critics have failed to offer a comparable alternative. The simple fact is this: Ryan's Roadmap for America's Future is the only comprehensive, pro-growth solution in the national arena to restore fiscal sustainability to the federal government and improve the fiscal future of our children and grandchildren.

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58. Fodeman and Book, "'Bending the Curve.'"

59. Capretta, "Why the Obama Health Plan Is *Not* Entitlement Reform," p. 17.