WASHINGTON

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MEMORANDUM FOR THE TAXPAYER

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KeithHennessey.com – Your guide to American Economic Policy

SUBJECT: DEBATING THE PRESIDENT'S PORTSMOUTH PITCH

The President hosted a health care reform town hall in Portsmouth, New Hampshire on Tuesday August 11, 2009. His remarks were extensive and he took questions.

At this town hall meeting the President said:

> *THE PRESIDENT: (L)et me just say there's been a long and vigorous debate about this, and that's how it should be. That's what America is about, is we have a vigorous debate. That's why we have a democracy. But I do hope that we will talk with each other and not over each other — (applause) — because one of the objectives of democracy and debate is, is that we start refining our own views because maybe other people have different perspectives, things we didn't think of.*
>
> *Where we do disagree, let's disagree over things that are real, not these wild misrepresentations that bear no resemblance to anything that's actually been proposed.*

In the spirit of informed and vigorous debate, let's look at what the President said about the pending legislation at the Portsmouth town hall. This memo is a compilation of a series of 20 posts you can find on KeithHennessey.com.

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1. The President's overpromise that everyone can keep their health plan

> *THE PRESIDENT: Now, let me just start by setting the record straight on a few things I've been hearing out here — (laughter) — about reform. Under the reform we're proposing, if you like your doctor, you can keep your doctor. If you like your health care plan, you can keep your health care plan.*

And yet here is what CBO said about the House bill:

> *CBO: In addition, CBO and the JCT staff estimate that nearly 6 million other people who would be covered by an employment-based plan under current law would not have such coverage under the proposal. That figure includes part-time employees, who could receive subsidies via an exchange even though they have an employer's offer of coverage, and about 3 million people who would not have an employer's offer of coverage under the proposal. Firms that would choose not to offer coverage as a result of the proposal*

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would tend to be smaller employers and those that predominantly employ lower-wage workers—people who would be eligible for subsidies through the exchanges—although some workers who were not eligible for subsidies through the exchanges also would not have coverage available through their employers. Whether those changes in coverage would represent the dropping of existing coverage or a lack of offers of new coverage is difficult to determine. (p. 5)

According to CBO, the President's statement is incorrect for a portion of these 6 million people who as a result of the House bill would lose employment-based coverage they would otherwise have under current law. Some of those 6 million people would lose the opportunity to get employment-based coverage, while others would "represent the dropping of existing coverage." CBO reached similar conclusions. Here is a more detailed explanation of this problem that I wrote for an earlier draft of the Kennedy-Dodd bill, under which 10 million people would not have lost the health plan they would otherwise have under current law. CBO dialed this number down to 3 million for a later draft of Kennedy-Dodd.

This is an inevitable consequence of moving away from a system that is so heavily biased toward higher subsidies for employment-based coverage. My preferred plan would have a similar effect. Nonetheless, the President is overpromising, at least relative to CBO's view of the House bill.

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2. Putting the government in charge of your health insurance

THE PRESIDENT: You will not be waiting in any lines. This is not about putting the government in charge of your health insurance.

And yet section 3103 of the Senate HELP Committee bill would give the Secretary of Health and Human Services authority to appoint a *Medical Advisory Council* that would determine what items and services are "essential" for a "qualified health plan," and, by implication, which benefits are *not* essential. The House bill is parallel but less specific, creating an "independent public/private advisory committee," in which the members are chosen by the government. In both cases, the recommendations would be packaged together and approved or disapproved *en bloc* by the Executive Branch and Congress.

These bills would give government officials, or people chosen by the government, authority to determine benefit packages, copayments and deductibles, relative premiums, as well as health plan expenses and profits. They would, in effect, turn health insurance into a utility, run by private companies, but with policies and rates set by the government. While privately-owned firms would be implementing the decisions, the key decisions would be made by government officials or people chosen by government officials.

THE PRESIDENT: I don't think government bureaucrats should be meddling, but I also don't think insurance company bureaucrats should be meddling. That's the health care system I believe in.

Resources are constrained, and so someone has to make the cost-benefit decision, either by creating a rule or making decisions on a case-by-case basis. Many of those decisions are now made by insurers and employers. The House and Senate bills would move some of those

decisions into the government. Changing the locus of the decision does not relax the resource constraint. It just changes who has power and control.

The health care system I believe in moves no more decisions into the hands of the government, and instead creates incentives for people to control more of these decisions and make these hard tradeoffs for themselves. Insurance would evolve from pre-paid medical care, as it is today for many, to a more traditional catastrophic protection model, as we now have for other kinds of insurance.

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3. Waiting in line

(In response to a gentleman's question about Medicaid forcing him to take a generic equivalent for Lipitor):

> *THE PRESIDENT: Now, I want to be absolutely clear here: There are going to be instances where if there is really strong scientific evidence that the generic and the brand name work just as well, and the brand name costs twice as much,* ***that the taxpayer should try to get the best deal possible, as long as if it turns out that the generic doesn't work as well, you're able to get the brand name****.*

The proxy for the taxpayer is the government bureaucrat running the program. At least for this Medicaid patient, he President is in effect saying that, "if there is really strong scientific evidence" of medical equivalence, then a government official, on behalf of the taxpayer, should make the decision for you "to get the best deal possible."

It's hard to square this with his earlier statement that "This is not about putting the government in charge of your health insurance."

Continuing with this same case, the President said:

> *THE PRESIDENT: So the basic principle that we want to set up here is that — if you're in private insurance, first of all, your private insurance can do whatever you want. If you're under a government program, then it makes sense for us to make sure that we're getting the best deal possible and not just giving drug makers or insurers more money than they should be getting. But ultimately, you've got to be able to get the best care based on what the doctor says.*

And it sounds like that is eventually what happened. It may be that it wasn't as efficient — it wasn't as smooth as it should have been, but that result is actually a good one.

The questioner said "And I had to go through two different trials of other kinds of drugs before it was deemed that I was able to go back on the Lipitor through the New Hampshire Medicaid system." The President responded, "It may be that it wasn't as efficient – it wasn't as smooth as it should have been, but the result is a good one."

This man had to wait in a line. Earlier the President said about reform, "You will not be waiting in any lines," and yet in this case, "The result is a good one."

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4. Government-mandated benefits

*THE PRESIDENT: And finally – this is important – **we will require** insurance companies to cover routine checkups and preventive care, like mammograms and colonoscopies … (later) And I would like to see a mental health component as part of a package that people are covered under, under **our plan**.*

In this case, "we" and "our plan" mean "the government." I can't see how he squares that with "This is not about putting the government in charge of your health insurance." And yet the President is talking about the government mandating specific benefits.

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5. Preventive care does not save money (in the aggregate)

*THE PRESIDENT: … because there's no reason we shouldn't be catching diseases like breast cancer and prostate cancer on the front end. That makes sense, it saves lives; **it also saves money** – and we need to save money in this health care system.*

Here is the key sentence from CBO Director Dr. Douglas Elmendorf in a letter he sent to Rep. Nathan Deal last Friday:

CBO: Although different types of preventive care have different effects on spending, the evidence suggests that for most preventive services, expanded utilization leads to higher, not lower, medical spending overall.

Dr. Elmendorf eloquently explains why:

CBO: But when analyzing the effects of preventive care on total spending for health care, it is important to recognize that doctors do not know beforehand which patients are going to develop costly illnesses. To avert one case of acute illness, it is usually necessary to provide preventive care to many patients, most of whom would not have suffered that illness anyway. Even when the unit cost of a particular preventive service is low, costs can accumulate quickly when a large number of patients are treated preventively. Judging the overall effect on medical spending requires analysts to calculate not just the savings from the relatively few individuals who would avoid more expensive treatment later, but also the costs for the many who would make greater use of preventive care. As a result, preventive care can have the largest benefits relative to costs when it is targeted at people who are most likely to suffer from a particular medical problem; however, such targeting can be difficult because preventive services are generally provided to patients who have the potential to contract a given disease but have not yet shown symptoms of having it.

Finally, Dr. Elmendorf makes a key point (also on his blog):

CBO: Of course, just because a preventive service adds to total spending does not mean that it is a bad investment.

The President could have correctly said, "Preventive care saves lives. It increases spending, but I think it's worth it." He was incorrect when he said "It also saves money – and we need to save money in this health care system."

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6. The House bill would increase short-term, 10th year, and long-term budget deficits

> *THE PRESIDENT: And we will do this without adding to our deficit over the next decade, largely by cutting out the waste and insurance company giveaways in Medicare that aren't making any of our seniors healthier.*
> *(later) First of all, I said I won't sign a bill that adds to the deficit or the national debt. Okay? So this will have to be paid for.*

And yet:

- CBO says the House bill would increase federal deficits by $239 B over the next ten years.
- CBO says the House bill would increase the deficit in 2019 by $65 B, meaning the bill fails the President's "10th year test."
- CBO says the House bill would result in increasing deficits beyond 2019, because the new spending would grow faster than 8% per year, while the offsets would grow only about 5% per year.
- The House bill would not just slow Medicare growth, but would also raise taxes on high-income individuals and small business owners.

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7. The President was incorrect – AARP opposes the bill

> *THE PRESIDENT: We have the AARP on board because they know this is a good deal for our seniors.*
>
> *(later) AARP would not be endorsing a bill if it was undermining Medicare, okay?*

After the town hall, AARP issued a statement including the following sentence:

AARP: While the President was correct that AARP will not endorse a health care reform bill that would reduce Medicare benefits, indications that we have endorsed any of the major health care reform bills currently under consideration in Congress are inaccurate.

A political observation: With this statement AARP embarrassed the President. It is a huge deal for a left-leaning interest group like AARP to directly and immediately contradict the President on his top policy priority. I infer that AARP's leadership is more afraid of their members attacking them for perceived support of these bills than they are of infuriating the President and his staff.

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8. The bills would take Medicare savings needed for solvency and spend them on a new entitlement

> *THE PRESIDENT: [If we do nothing] our deficit will continue to grow because Medicare and Medicaid are on an unsustainable path. Medicare is slated to go into the red in about eight to 10 years.*

This statement is true. But the President and his budget director have lowered their bar to say only that health care reform must not increase the deficit, not that it must reduce the deficit. If legislation “cuts” Medicare spending and turns right around and re-spends those funds to create a new rapidly growing health care entitlement, then the underlying deficit problem is unresolved. The legislation being developed in both the House and the Senate just barely meets this condition.

The President’s budget director argues that other reforms in legislation will “bend the cost curve down.” The nonpartisan Congressional Budget Office disagrees, and says the House bill will increase long-term budget deficits relative to current law.

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9. Medicare is not a good example of government-run health care because Medicare is fiscally unsustainable

> *THE PRESIDENT: And so I do think it’s important for particularly seniors who currently receive Medicare to understand that if we’re able to get something right like Medicare, then there should be a little more confidence that maybe the government can have a role — not the dominant role, but a role — in making sure the people are treated fairly when it comes to insurance.*

But Medicare is fiscally unsustainable. The President already said that earlier in the discussion. So Medicare is not a successful model for a new system, because we can’t afford it.

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10. Even if the public option drops out of legislation, other parts of these bills would put private insurance under government control

> *THE PRESIDENT: We also want to make sure that everybody has some options. So there’s been talk about this public option. This is where a lot of the idea of government takeover of health care comes from.*

The President is correct that “a lot of the idea of government takeover of health care comes from” the public option. Many of the critics are missing that, even if the public option drops out of legislation, other provisions in these bills will effectively put insurance under government control, even while it is offered by private firms.

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11. The President says the public option will keep private insurers honest at the same time he proposes cutting payments to private insurers competing with the Medicare public option

> *THE PRESIDENT: And I do think that having a public option as part of that would keep the insurance companies honest, because if they’ve got a public plan out there that they’ve got to compete against, as long as it’s not being subsidized by taxpayers, then that will give you some sense of what — sort of a good bargain for what basic health care would be.*

… We do think that systems like Medicare are very inefficient right now, but it has nothing to do at the moment with issues of benefits. The inefficiencies all come from things like paying $177 billion to insurance companies in subsidies for something called Medicare Advantage that is not competitively bid, so insurance companies basically get a $177 billion of taxpayer money to provide services that Medicare already provides. And it's no better — it doesn't result in better health care for seniors.

On the one hand, the new public option would "keep the insurance companies honest" and be something "that they've got to compete against." On the other hand, where that competition exists today in Medicare, he argues the government should cut payments to private plans that are competing with the Medicare "public option." This is one reason I fear the public option. A future President could easily make the arguments that President Obama made Tuesday about Medicare Advantage plans, and seek to tilt the playing field toward the public option.

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12. The pending bills would move more cost-benefit decisions from insurers to people chosen by the government

THE PRESIDENT: Another way of putting this is right now insurance companies are rationing care. They are basically telling you what's covered and what's not. They're telling you: We'll cover this drug, but we won't cover that drug; you can have this procedure, or, you can't have that procedure. So why is it that people would prefer having insurance companies make those decisions, rather than medical experts and doctors figuring out what are good deals for care and providing that information to you as a consumer and your doctor so you can make the decisions?

The quote takes on a whole new meaning if you insert a legislative detail that the President omitted. I'll put it in brackets:

So why is it that people would prefer having insurance companies make those decisions, rather than medical experts and doctors ***[chosen by the government]*** *figuring out what are good deals for care and providing that information to you as a consumer and your doctor so you can make the decisions?*

In a world of limited resources, we cannot just make decisions about medical care based on whether an additional treatment provides a medical benefit. Someone must instead decide whether that benefit is worth the cost. The third MRI on the sprained wrist may provide more up-to-date and useful information, but the benefit is probably small compared to the additional cost. Someone must have authority to decide whether additional care is "worth it." That person must control the dollars. Ultimately, the health policy debate comes down to the question: Who should make the cost/benefit decision? The pending legislation would move some of those decisions from insurers to the government.

I think it's a mistake to have government make more cost-benefit decisions on our behalf in part because people are different. The President is talking about government policymakers (who would also happen to be medical professionals) making determinations about "what are good deals for care." But cost-benefit tradeoffs depend on the particular medical conditions, situation, and preferences of the individual. I would like more of these decisions to be pushed away from

insurers to individuals and families, rather than to people chosen by the government to make those tradeoffs for us.

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13. Guaranteed renewal and guaranteed issue

> *THE PRESIDENT: Under the reform we're proposing, insurance companies will be prohibited from denying coverage because of a person's medical history. Period. (Applause.) They will not be able to drop your coverage if you get sick. (Applause.) They will not be able to water down your coverage when you need it. (Applause.) Your health insurance should be there for you when it counts — not just when you're paying premiums, but when you actually get sick. And it will be when we pass this plan. (Applause.)*

These are two separate issues. *Guaranteed renewal* is the ability to keep and renew your insurance coverage when you are diagnosed with a long-term medical condition that causes your risk of future medical costs to increase. This is "They will not be able to drop your coverage if you get sick," and "Your health insurance should be there for you when it counts."

Guaranteed issue combined with community rating is the ability to buy insurance that you do not already have and pay premiums that are independent of your health status.

These are very different concepts. The first is an attempt to address a market failure — nobody sells long-term health insurance contracts, and yet when we're healthy we would like to insure against the risk that we are diagnosed with a long-term disease. I would like the market to be able to address this flaw, and am not sure why it hasn't. As a matter of personal policy preference, I can live with the government mandating guaranteed renewal (until and unless someone shows me an effective market-based solution).

Guaranteed issue with community rating is more problematic, as was discussed in Wednesday's *Wall Street Journal* editorial. If you allow people to buy insurance after they get sick, then many people will "free ride," pay no premiums, and buy insurance only when they need the care. Imagine if you could buy fire insurance for your home while your home is on fire. Who would buy fire insurance in advance and pay the premiums?

Because of this perverse incentive, if you have guaranteed issue and community rating, and if insurance purchase is voluntary, then premiums jump up because only sick people are buying insurance. Everyone else is waiting until they get sick. This is what happened in New Jersey. The only way to mitigate this is to force everyone to buy insurance — an individual mandate. In doing so, people with predictably high expenses (e.g., those who already have cancer) will benefit. People who are healthy, or are only temporarily sick or injured, will pay higher premiums than they would without these policy changes. Oversimplifying as I am wont to do:

Guaranteed issue + community rating + individual mandate = hidden income/wealth redistribution from the generally healthy to the generally sick.

People will differ on whether this income/wealth distribution is a good or bad thing. Note that healthy/sick does not mean rich/poor. Most people are relatively healthy, and these policies would raise premiums for all people, including a lot of relatively healthy poor/middle class people. You decide whether you think it's worth it.

An internal analysis done during the Bush Administration showed that, controlling for other factors, in New Jersey these policies in were associated with premiums that were **more than 90% higher than in other states**. Note that "were associated" is weaker than "were caused by." Still, these policies would make insurance available and result in affordable premiums for those with persistent medical conditions and/or high risk of future high medical expenses, while also raising premiums significantly for those who have relatively low expected medical expenditures.

This is an incredibly important and underdiscussed element of the policy debate. There is no right or wrong answer — it's a painful tradeoff. It appears I am somewhat of an outlier on this one, compared to many members of *both* parties. I oppose guaranteed issue, community rating, and an individual mandate. I am trying to understand whether this is because a policy consensus has developed on the difficult tradeoff and I'm just in a different place, or if instead Congress is just ignoring the tradeoff. I question whether support for guaranteed issue and community rating would be so high if Congress understood that it would mean large premium increases for the overwhelming majority of Americans with private insurance. The President certainly isn't mentioning that cost as he pitches this policy change.

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14. The President says "we may be able to get even more than" the $80 B of budgetary savings that the pharmaceutical industry thought was a ceiling promised by the White House.

> *THE PRESIDENT: Now, in terms of savings for you as a Medicare recipient, the biggest one is on prescription drugs, because **the prescription drug companies have already said that they would be willing to put up $80 billion in rebates** for prescription drugs as part of a health care reform package.*
>
> ***Now, we may be able to get even more than that.** But think about it.*

Huh. So much for that secret deal that the drug companies had with the White House that their savings would not exceed $80 B over 10 years. "We may be able to get even more than that." Hmm…

Even after 15 years of working in economic policymaking, I continue to be surprised at the naivete of some American business leaders. Almost three weeks ago I sounded an initial warning:

Hospitals: You're the deep pockets. Insurers, Business **and** Pharma: They can make you villains again if they need to cut you more to make the budget numbers work.

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15. The President says he's not "promoting" a single-payer plan, but the only concern he raises is a disruptive transition.

> *THE PRESIDENT: A single-payer plan would be a plan like Medicare for all, or the kind of plan that they have in Canada, where basically government is the only person — is the only entity that pays for all health care. Everybody has a government-paid-for plan, even though in, depending on which country, the doctors are still private or the hospitals might still be private. In some countries, the doctors work for the government*

and the hospitals are owned by the government. But the point is, is that government pays for everything, like Medicare for all. That is a single-payer plan.

I have not said that I was a single-payer supporter because, frankly, we historically have had a employer-based system in this country with private insurers, and for us to transition to a system like that I believe would be too disruptive. So what would end up happening would be, a lot of people who currently have employer-based health care would suddenly find themselves dropped, and they would have to go into an entirely new system that had not been fully set up yet. And I would be concerned about the potential destructiveness of that kind of transition.

All right? So I'm not promoting a single-payer plan.

This is interesting – he seems not to object to government being "the only entity that pays for all health care" as a desirable endstate. The only concern he raises is that the transition would be disruptive. He also does not say that he opposes single-payer, merely that he is not promoting it.

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16. Many examples suggest that the government cannot compete on a level playing field with private firms.

THE PRESIDENT: Now, I recognize, though, you make a legitimate — you raise a legitimate concern. People say, well, how can a private company compete against the government? And my answer is that if the private insurance companies are providing a good bargain, and if the public option has to be self-sustaining — meaning taxpayers aren't subsidizing it, but it has to run on charging premiums and providing good services and a good network of doctors, just like any other private insurer would do — then I think private insurers should be able to compete. They do it all the time.

Hypothetical follow-up question: Mr. President, are you confident that current and future policymakers won't try to give the public option advantages over private plans? Look at all the cases where that has happened:

- Fannie Mae and Freddie Mac crowded out private firms in the mortgage securitization business because they had government-provided advantages.
- Only the government offers flood insurance, because private firms cannot compete.
- Only the government offers terrorism reinsurance above a certain amount, because private firms cannot compete.
- The Tennessee Valley Authority has no competitors, because the government has granted TVA market protections and advantages.
- You are proposing cutting Medicare payments to private plans that compete with the Medicare "public option."
- Congressional Democrats argue that the government should save money by directly negotiating drug prices with pharmaceutical companies, a negotiation in which the government has most of the power.
- The Federal Housing Authority is crowding out private forms that offer mortgage insurance.

- The government is about to start crowding out private lenders who offer guaranteed student loans, in favor of direct student loans offered by the government.

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17. The President trashes the U.S. Postal Service and undermines the case that government can run a complex health system.

> *THE PRESIDENT: I mean, if you think about — if you think about it, UPS and FedEx are doing just fine, right? No, they are. It's the Post Office that's always having problems.*

I think the President was using this example to demonstrate that private firms can compete with the government. It came out wrong. He undermined the case for more government control, and especially for a public option, by pointing out that the government cannot deliver the mail and stay on budget.

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18. The President understates the annual cost of new spending by a factor of two.

> *THE PRESIDENT: So it's about a hundred billion dollars a year to cover everybody and to implement some of the insurance reforms that we're talked about.*

I assume this is just an honest arithmetic error, in which he assumed that a trillion dollars of new spending would be spread out over 10 years. Since the spending doesn't start until year 4, and isn't fully phased-in until year 6, the actual spending is much higher. The House bill would increase federal spending by $202 B in 2019, the 10th year of the estimate, twice the President's stated figure.

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19. The President says that 2/3 of the offsets come from Medicare and Medicaid spending, while the only public estimate (for the House bill) shows 21% instead. He also advocates a tax proposal that Congressional Democrats killed last Winter.

> *THE PRESIDENT: About two-thirds of those costs we can cover by eliminating the inefficiencies that I already mentioned. So I already talked about $177 billion worth of subsidies to the insurance companies. Let's take that money, let's put it in the kitty. There's about $500 billion to $600 billion over 10 years that can be saved without cutting benefits for people who are currently receiving Medicare, actually making the system more efficient over time.*
>
> *That does still leave, though, anywhere from $300 billion to $400 billion over 10 years, or $30 billion to $40 billion a year. That does have to be paid for, and we will need new sources of revenue to pay for it. And I've made a proposal that would — I want to just be very clear — the proposal, my preferred approach to this would have been to take people like myself who make more than $250,000 a year, and limit the itemized deductions that we can take to the same level as middle-class folks can take them.*

Maybe the President knows something about the Baucus bill that isn't public. In the House bill only 21% of the savings come from Medicare and Medicaid, not two-thirds.

Congressional Democrats rejected the President's proposal to limited itemized deductions last winter. The House bill would instead raise income tax rates on high-income individuals and successful small business owners.

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20. There are 46 million people who are technically uninsured, but the target population is probably one-third to one-half that size.

> *THE PRESIDENT: I don't have to explain to you that nearly 46 million Americans don't have health insurance coverage today. In the wealthiest nation on Earth, 46 million of our fellow citizens have no coverage. They are just vulnerable. If something happens, they go bankrupt, or they don't get the care they need.*

But of those 45.7 million people:

- 6.4 million are enrolled in Medicaid or S-CHIP and just gave the Census taker the wrong answer. I'm serious. This is called the *Medicaid undercount*.
- Another 4.3 million are eligible for Medicaid or S-CHIP and have not enrolled. If they need care, the hospital or clinic generally enrolls them. They are protected against risk even though they don't show up on the rolls as insured.
- Another 9.3 million are non-citizens. Different people come to different conclusions about what portion of this group should receive taxpayer-subsidized health insurance.
- Another 10.1 million have income more than three times the poverty line.
- Leaving about 15.6 million remaining uninsured, of whom about 5 million are childless adults.

The 46 million figure is technically correct, but it dramatically overstates the size of the population that many Americans would conclude is deserving of additional taxpayer subsidies.

I wrote about this topic in early April: How many uninsured people need additional help from taxpayers?

I hope find this memo to be a positive contribution to a vigorous and well-informed policy debate. Please share it with your friends and colleagues. You can find similar policy analysis on a wide range of economic policy topics at KeithHennessey.com. Here are some posts to give you a feel for the breadth:

- Six month economic policy status update
- Are we pointed in the right direction yet?
- What is reconciliation? (3-part series)
- Understanding the President's CAFE announcement
- Understanding the GM bankruptcy
- 20 Questions for the President's press conference
- Will the stimulus come too late?
- The China/India hole in the American climate strategy
- Understanding second quarter GDP
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