The Optimist's Guide to Repeal and Replace

Patient-Centered Health-Care Reform for the 21st-Century

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Remarks As Prepared For Delivery

Thank you very much for that introduction. It was kind of you to invite me – and not hold it against me that I steal so many ideas from you guys.

It's true. I steal monetary policy ideas from John Taylor, rule-of-law stuff from Richard Epstein… I even tried to steal some wit and humor from Peter Robinson during a taping of his show this morning, but I'm not sure that worked.

If this speech falls flat – blame Robinson.

I'm here today to talk about health care, which is a subject that I find it hard to be funny about – especially since the Democrats stole all the health care jokes and enacted them into law.

Unfortunately, the consequences of this law are no joke. The first step toward true, patient-centered health care reform must be a full repeal of the President's disastrous new law.

If we engage the nation in a serious debate, and put forward a principled reform agenda, then I think the odds are good that the Republican party will soon find itself with the opportunity to do just that.

But we cannot stop at repeal. We also have a responsibility to fix the broken network of government policies that have made such a mess of health care in America.

If that is a prospect that excites you, it should. We have the right ideas on health care, and a change of power in Washington would bring with it an opportunity to turn these ideas into good public policy.

But if that prospect worries you… well, I can understand why. The political hurdles that stand in the way of real, structural health-care reform are daunting. And while Republicans have advanced many good ideas on health care, it is my candid opinion that the party as a whole has yet to coalesce around a complete reform agenda aimed at dealing with the underlying problem – which is runaway inflation in the cost of health care.

Today, I will attempt to make the case for optimism. Specifically, I come bearing three pieces of good news.

The first piece of good news is this: The urgent need to repeal and replace the President's health-care law, coupled with the urgent need to deal with the drivers of our debt, will present us with an unavoidable time for choosing, allowing us to confront health-care inflation head-on.

The second piece of good news is this: Thanks to the tireless work of health-policy scholars here at Hoover and elsewhere, we know what works and what doesn't. Simply put, badly designed government policies are to blame for much of what is wrong with health care today, and the solution is clear: We need to transition from the open-ended, defined-benefit approach of the past… to market-oriented, defined-contribution reforms that promote choice and competition.

And the third piece of good news is this: Though the political hurdles are high, we know we can win these fights – within the conservative movement, across party lines, and across the nation. The challenge will be to summon the courage and the ability to offer the nation a true choice of two futures on health care, which is a choice they deserve.

Let's take each of these reasons for optimism in order.

An Opportunity for Reform

First, we know we will have the ***opportunity*** to enact reforms. Even before the President's law made matters worse, Americans faced serious problems in health care – and we cannot simply revert to the status quo.

In the wake of repeal, we must be ready to advance solutions. To get the prescription right, we need to properly diagnose the problem – starting with the reasons that the President's law is such a failure.

At its core, the health care problem is one of inflation, driven by the overutilization of services, dramatic underpayments, and massive inefficiency.

If you look closely, the reason is easy to see: The health care sector lacks most of the basic building blocks of a functioning market.

For one thing, markets require transparent prices, so that consumers can discover value. But in health care, the "consumer" is usually either a big insurance company, or the government. Health care providers have no incentive to provide transparent prices to their patients, because the patients don't pay directly – it's the government bureaucrat or the insurance company bureaucrat who pays the bills.

Second, markets do not function well when consumers are insulated from marginal costs. We're all paying more for health care, through much higher premiums and taxes. But the share we pay at the doctor's office has plunged. The system that shields us from the cost of services, has actually left us paying much more.

Rather than tackle these root drivers of the problem, the President's law goes in the other direction. It expands broken government programs, enhances bureaucratic control, and imposes flawed mandates that will continue to drive up the cost of health care.

Where there were cost-containing tools that help patients reduce their exposure to exploding costs, such as health savings accounts, the President's health law essentially dismantled them.

But the law's new open-ended entitlement programs are its biggest failure. One has been described as a classic "insurance death spiral," and the other requires an additional trillion in new federal spending. Both are fiscally unsustainable, and estimates suggest the costs could be much higher than initially projected.

And that ultimately is where President's health law falls short. If you look at our debt-and-deficits problem, it really is a health-care spending problem. Today, excluding interest, approximately one-fourth of federal spending goes toward government health-care programs, such as Medicare and Medicaid.

By the time my kids are my age, the non-partisan Congressional Budget Office projects that the share of federal spending going to pay just for health care programs will reach 45 percent.

And the new health law does nothing to address the pressure that escalating health care costs are putting on the federal budget. CBO Director Doug Elmendorf has stated that the new law, "does not substantially diminish that pressure."

Instead, it doubles down on the flawed design of open-ended, subsidized government health care. The result? A health-care system characterized by overutilization and inefficiency, in which costs are rising at 2 to 3 times the growth rate of GDP.

As any family on a budget can tell you, when one-fourth of your budget is growing three times faster than your income, you are in deep trouble – all other priorities get squeezed as you fall deeper into debt.

That is exactly the situation our government faces today.

There is no serious dispute – on either side of the aisle – that health-care inflation is the primary driver of our unsustainable deficits. As President Obama put it, "If you look at the numbers, Medicare in particular will run out of money, and we will not be able to sustain that program no matter how much taxes go up."

And Democratic officials will even admit that the primary driver of health-care inflation is the current structure of government programs. As HHS Secretary Kathleen Sebelius recently testified regarding Medicare's flawed fee-for-service structure, "I would say that the current fee-for-service system, yes, is unsustainable."

So the disagreement isn't really about the problem. It's about how best to control costs in government health care programs. And if I could sum up that disagreement in a couple of sentences, I would say this: Our plan is to empower patients. Their plan is to empower bureaucrats.

Just last week, the President rolled out a deficit-reduction plan that doubled down on his bureaucratic approach to controlling Medicare costs, first advanced in his health-care law last year.

The law empowers a board of 15 unelected officials – the Independent Payment Advisory Board, or IPAB – to hold the growth of Medicare spending to GDP plus 1 percent by reducing reimbursements to health-care providers. Unless overturned by a supermajority in Congress, the recommended cuts dictated by this board become law.

The President's latest proposal simply called for letting IPAB cut deeper. This board of bureaucrats will now be tasked with holding Medicare's growth rate to GDP plus half a percent. To put that in context, Medicare is currently growing at 6.3 percent per year.

Medicare's non-partisan chief actuary, Richard Foster, has been clear on this point: Going from 6 percent growth down to the President's targets, using only the blunt tools that his law gives to IPAB, would simply drive Medicare providers out of business, resulting in harsh disruptions and denied care for seniors.

In fact, the deterioration in seniors' care that is projected to occur under IPAB would be so untenable, the board is unlikely to yield any savings at all. Future Congresses would be under tremendous pressure to undo the cuts, just as past Congresses have time and again reversed scheduled cuts to physicians' pay.

Pain cannot be sustained. You cannot control ***costs*** by using ***price*** controls, which impose painful cuts within a fundamentally broken framework. Instead, you have to revisit the structure of federal health policy and change the incentives – something that many leading Democrats, with their unwavering commitment to early 20th Century social insurance models, remain totally unwilling to do.

A Better Way Forward

That leads me to my second piece of good news: We know there is a ***better way forward*** – a way that accounts for both the benefits ***and*** the failures of those 20th Century models, and builds upon the good while reforming with the bad.

The House-passed budget offers a better way to strengthen Medicare and save it from insolvency. Instead of using cram-downs that simply pay providers less while jeopardizing seniors' care, our budget proposes real reforms designed to slow the growth of health-care costs economy-wide by promoting true choice and competition. Empowering seniors, not bureaucrats, is the best way to save and strengthen Medicare.

At a House Budget Committee hearing last July, Chief Actuary Foster gave evidence in support of this point, quote: "We've estimated for many years that competition among plans in a premium-support setting like this could have advantages and lead to somewhat

lower costs for Medicare. It can get you to the lowest cost consistent with good quality of care."

And not just in Medicare. Choice and competition are critical to controlling costs throughout the health-care system, while improving quality for patients. And yet, across the federal landscape, choice and competition are undermined by poorly designed programs and tax policies.

In Medicare, the government reimburses all providers of care according to a one-size-fits-all formula, even if the quality of the care they provide is poor and the cost is high. This top-down delivery system exacerbates waste, because none of the primary stakeholders has a strong incentive to deliver the best-quality care for the lowest cost.

In Medicaid, a flawed federal-state matching formula is blowing out state budgets. There is no limit on the federal government's matching contributions to state spending, so state governments spend most of their energy devising ways to maximize how much they can get from the federal government, rather than focusing on delivering high quality, cost-effective coverage for their most vulnerable citizens.

Beyond these two programs, our current tax code provides additional fuel for runway health care inflation. Under current law, employer-sponsored health insurance plans are entirely exempt from taxation, regardless of how much an individual contributes to their policy.

This tilts the compensation scale toward benefits, which are tax-free, and away from higher wages, which are taxable. It also provides ways for high-income earners to artificially reduce their tax-able income by purchasing high-cost health coverage – which in turn can fuel the overuse of health services.

The new health law's attempts to deal with this problem won't work – they merely add a layer of taxation to a flawed tax structure, when what we need is to change the structure from the bottom up.

All of these structural flaws push affordable coverage out of reach for millions of Americans. Programs designed to shelter individuals from the price of health care have backfired. Instead, these programs have the unintended consequence of increasing health-care costs for all Americans – causing rising premiums to erode workers' paychecks, and leaving many Americans with no coverage at all.

The solution in each of these areas is to move away from defined-benefit models and toward defined-contribution systems. Under a reformed approach, the government would make a defined contribution to the health-care security of every American, rather than continue to offer open-ended, well-intentioned, but ultimately empty promises.

The growth of these defined contributions should be capped, to reduce the inefficiencies that have led health-care costs to spiral out of control. But they should be adjustable so

that more help goes to the poor and the sick, while less financial support goes to those who are fortunate enough to need it the least.

In other words, defined contributions should underpin a system driven by patient choice and centered on patient needs – one that offers real security instead of empty promises.

In Medicare, patient-centered reform means premium support. This is the approach advanced in the House-passed budget, and also on a bipartisan basis with Alice Rivlin and other Democrats who understand the need to move toward increased choice and competition in health care.

In Medicaid, patient-centered reform means block grants to state governments, so that they are freed from onerous federal mandates and empowered to design Medicaid programs that meet the unique needs of their citizens. Many governors wrote to us after we included this reform in the House-passed budget, to thank us for advancing an idea whose time has come.

And with regard to health insurance for working Americans, patient-centered reform means replacing the inefficient tax treatment of employer-provided health care with a portable, refundable tax credit that you can take with you from job to job, allowing you to hang onto your insurance even during those tough times when a job might be hard to find.

We should empower patients, not only with resources and choices, but also with information. Patient-centered reform must promote transparency on price ***and*** quality – and give patients the incentives to act on this information. By putting the power into the hands of individuals, we can let competition work in health care just as it does everywhere else.

The Case for Political Courage

We know that the first step toward real, bipartisan advances in health policy must start with a full ***repeal*** of the President's partisan law. But the case for repeal must be matched with even greater intensity by a case for ***replace*** – replacing the law with structural reforms and real solutions to the problems Americans are facing in health care.

The three reforms I've just outlined – premium support for Medicare, block grants for Medicaid, and tax reform to correct the inefficient tax treatment of health insurance – must be present in our "replace" agenda.

If we end up with a replace agenda that fails to fix the problem, then we will lose hard-won credibility on the health-care issue as a result.

Look, I understand how daunting the politics of these issues are. I've lived them, so I know that the political hurdles to real reform are great. ***But we can clear these hurdles*** if we combine political courage and clarity of purpose with faith in the American people.

I'll be honest with you: When I first put out my Roadmap for America's Future years ago, if you had asked me to bet on whether premium support in Medicare would make it into the budget this year – well, I would have needed pretty good odds to take that bet. One of my own staffers who helped me write the thing recently reminded me, "I would have laughed out loud if you'd told me that."

Yet here we are. All but four Republican members of the House – and all but six Republican members of the Senate – voted for our *Path to Prosperity* budget – Medicare reforms and all. And, though we took a few dings at first, we survived.

The Democrats' tried the same old scare tactics for a few months, and in the first special election that took place after our budget passed, we learned a costly lesson. We learned that unless we back up our ideas with courage, and defend them in the face of attacks, we will lose.

But once we learned that lesson and started to get our message out… well, a funny thing happened: People listened. They learned that our plan did not affect those in or near retirement… that it guaranteed coverage options like the ones members of Congress enjoy… and that choice and competition would drive costs down and quality up. They also learned more about the Democrats' plans for Medicare, and they didn't like what they heard.

And the scare tactics stopped working.

Look at what just happened earlier this month in the recent special elections next door in Nevada and out in New York. The Democrats threw every scare tactic they could think of at the Republican candidates running in two special elections for vacant House seats. But the attacks failed to connect with voters hungry for solutions. The Republican candidates prevailed.

Now, certainly, there were some mitigating factors in these races. The economy is unquestionably at the forefront of the nation's concerns, and the President's unpopularity definitely played a role. And in Brooklyn – the race to replace former-Congressman Anthony Weiner – well, I don't want to get into all the factors that influenced ***that*** race. As Peter Robinson reminded me this morning before we taped his program, "If you want to talk about the New York race, just remember that this is a family show."

But the point is that we should not fear false attacks again in 2012. Fear and demagoguery are the last refuges of an intellectually bankrupt party – and the moment calls for leaders who are not afraid to be honest with people about how they would solve the problems we face.

In health care, we owe the American people a defining choice, and that choice is: Who is in charge: The government or the patient?

What we need in health care is more efficiency and productivity, so that the pace of rising costs slows in coming years. How will that come about? Certainly not with more

bureaucratic control. HHS can't engineer a more efficient health care system from Washington, D.C. They have been trying for decades, and they have only made things worse.

What ***will*** work is empowered consumers looking for value. Giving patients and consumers control over health care resources would make all Americans less dependent on big business and big government for our health security… give us more control over the care we get… and force health care providers to compete for our business.

So those are my three pieces of good news:

We have a great opportunity to enact real reform in health care.

The wisdom of our leading thinkers has shown us how to do it.

And our budget has demonstrated that we can survive the demagoguery and the attacks if we gather our courage, stay true to our guiding principles, and contrast our approach with the same old, failed policies offered by the defenders of a bankrupt status quo.

This is how we were able to defend our *Path to Prosperity* budget… it is how we were able to defuse Mediscare attacks in two special elections… and it is how we will unite the country to do what's right, both for this generation… and for the next.

Thank you.