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Yes, Mr. President

A Free Market Can Fix Health Care

by Michael F. Cannon

Executive Summary

In March 2009, President Barack Obama said, "If there is a way of getting this done where we're driving down costs and people are getting health insurance at an affordable rate, and have choice of doctor, have flexibility in terms of their plans, and we could do that entirely through the market, I'd be happy to do it that way." This paper explains how letting workers control their health care dollars and tearing down regulatory barriers to competition would control costs, expand choice, improve health care quality, and make health coverage more secure.

First, Congress should give Medicare enrollees a voucher and the freedom to choose any health plan on the market. Vouchers would be means-tested, would contain Medicare spending, and are the only way to protect seniors from government rationing.

Second, to give workers control over their health care dollars, Congress should reform the tax treatment of health care with "large" health savings accounts. Large HSAs would reduce the number of uninsured Americans, would free workers to purchase secure health coverage from any source, and would effectively give workers a $9.7 trillion tax cut without increasing the federal budget deficit.

Third, Congress should break up state monopolies on insurance and clinician licensing. Allowing consumers to purchase health insurance licensed by other states could cover one-third of the uninsured without any new taxes or government subsidies.

Finally, Congress should reform Medicaid and the State Children's Health Insurance Program the way it reformed welfare in 1996. Block-granting those programs would reduce the deficit and encourage states to target resources to the truly needy.

The great advantage of a free market is that innovation and more prudent decisionmaking means that fewer patients will fall through the cracks.

Michael F. Cannon is director of health policy studies at the Cato Institute and coauthor of Healthy Competition: What's Holding Back Health Care and How to Free It.

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Introduction

In March 2009, at the outset of his effort to overhaul America's health care sector, President Barack Obama told a White House summit:

> If there is a way of getting this done where we're driving down costs and people are getting health insurance at an affordable rate, and have choice of doctor, have flexibility in terms of their plans, and we could do that entirely through the market, I'd be happy to do it that way.[1]

This paper explains how a free market can and would control costs, expand choice, improve health care quality, and make health coverage more secure. The key steps that would move America toward a free health care market are Medicare, tax, and regulatory reforms that give consumers control over their health care dollars and free them to choose from a wide variety of providers and health plans.

At present, America's health care sector is far from a free market. Government directly controls nearly half of all health care spending, and indirectly controls most of the remainder.[2] Government controls more than half of the nation's health *insurance* dollars (through Medicare, Medicaid, and other public programs), and delegates control over another third to employers through the preferential tax treatment granted to employer-sponsored health insurance.[3] The federal government imposes an average tax penalty of more than 40 percent on the one market that offers a wide range of health plans and seamless coverage between jobs: the "individual" market, where consumers purchase coverage directly from insurers. (Indeed, that tax penalty may explain much public dissatisfaction with the individual market.[4]) More than half of U.S. health care spending takes place under government price and exchange controls. As President Obama's economic adviser Larry Summers reminds us, "Price and exchange controls inevitably create harmful economic distortions. Both the distortions and the economic damage get worse with time."[5] That is to say nothing of the countless counterproductive regulations that government imposes on clinicians, insurance, medical products, and health care facilities.[6]

As health economist Victor Fuchs explains, most leading health care reforms "aim at cost shifting rather than cost reduction."[7] Whereas the legislation that President Obama is shepherding through Congress attempts to cover the uninsured by pouring more resources into health care, a free market would get more out of America's health care sector. Letting Americans control their health care dollars and breaking up the states' monopolies on insurance and clinician licensing (with "regulatory federalism") would put access to health care within reach of millions of Americans by putting downward pressure on health care prices and health insurance premiums. Those reforms would also dramatically improve quality by allowing various health plans, with various payment systems and delivery systems, to compete on a level playing field.

Controlling Costs

Health care spending is growing unsustainably. Over the past 30 years, health care spending has grown more than 2 percentage points faster than the economy overall,[8] and now stands at 18 percent of GDP.[9]

That would not be a problem if we were getting our money's worth. The most credible estimates, however, suggest an alarming one-third of health care spending does nothing to make patients healthier or happier.[10] In 2009, Americans will waste more than $800 billion—about 6 percent of U.S. GDP—on medical care that provides zero benefit to patients. Americans will waste additional billions on services whose benefits are not worth the cost. That wasteful spending results in higher taxes, higher health insurance premiums, and more uninsured Americans.

Government Failure

Government is largely incapable of eliminating wasteful health care spending, because nobody spends other people's money as carefully as they spend their own. Government tax and entitlement policy denies patients ownership of their health care dollars, and thereby strips them of any incentive to control costs. Due to federal tax policy, for example, Stanford University health economist Alain Enthoven estimates that "less than 5 percent of the insured workforce can both choose a health plan and reap the full savings from choosing economically."[11] Indeed, consumers resist efforts to eliminate wasteful spending, and with good reason. Since they are enjoying health insurance that is effectively purchased with other people's money, consumers receive no direct financial benefit from eliminating wasteful spending, whether through cost-sharing or care management. When Medicare tries to eliminate coverage of low-value services or to reduce excessive provider payments, seniors experience nothing but pain. Workers perceive increased cost-sharing or managed-care controls as cuts in their compensation. Even though these steps should ultimately lead to higher wages and lower taxes, those benefits are not salient to seniors and workers.[12]

That lack of cost-consciousness creates what author David Goldhill describes as "an accidental collusion between providers benefiting from higher costs and patients who don't fully bear them."[13] Former Senate Majority Leader Tom Daschle writes that this results in a politically powerful "patient-provider pincer movement" that blocks efforts to reduce wasteful spending.[14] The patient-provider pincer movement prevents Medicare from considering cost-effectiveness when deciding whether to cover particular services; repeatedly eliminates funding for federal agencies that conduct comparative-effectiveness research;[15] preserves excessive Medicare payments for specialists, insurers, and procedures; blocks competitive bidding for durable medical equipment in Medicare; has made a joke out of the scheduled "sustainable-growth-rate" cuts to Medicare physician payments; and even curtails private-sector efforts to eliminate wasteful spending with managed-care controls.

The end result is that both government- and employer-sponsored insurance waste money in ways that consumers spending their own money never would. If the health reform legislation currently before Congress becomes law, politicians and employers will continue to control Americans' health care dollars, and this government failure will persist.[16]

The Free-Market Alternative

A free market, in contrast, would eliminate wasteful health care spending. Individuals would control their own health care dollars and would therefore benefit directly from reducing waste. A less-regulated market would also free Americans to choose from a wide variety of health plans and providers.

When consumers own and control their health care dollars—in particular, the money that purchases their health insurance—the self-interest of hundreds of millions of Americans will lead them to choose health plans that eliminate wasteful spending, whether through cost-sharing or care management, in exchange for lower premiums. Peter Orszag, President Obama's director of the Office of Management and Budget, testified before Congress on the promise of individual ownership:

> Workers may demand less efficiency from the health system than they would if they knew the full cost that they pay via forgone wages for coverage or if they knew the actual cost of the services being provided.[17]
>
> [I]magine what the world would be like if workers [understood] that today it was costing them $10,000 a year in take-home pay for their employer-sponsored insurance, and that could be $7,000 and they could have $3,000 more in their pockets today if we could relieve these inefficiencies out of the health system. Making those costs more

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transparent may generate demand for efficiency.[18]

Consumers who *own* the money they are spending are a cornerstone of free and functional markets. A free market would reduce wasteful spending with minimal harm because, unlike price controls and other tools of government rationing,[19] markets allocate resources according to consumer preferences, rather than the preferences of politicians, government bureaucrats, or special-interest lobbyists.

Restoring individual ownership to health care will require a two-pronged strategy.

Medicare Reform

For Americans covered by Medicare, Congress should give enrollees a voucher and let them choose any health plan available on the market.[20] To ensure that all beneficiaries can afford a basic health plan, Medicare should give larger vouchers to poorer and sicker seniors and smaller vouchers to healthy and wealthy seniors, using current health-risk-adjustment mechanisms[21] and Social Security data on lifetime earnings.[22]

The amount of each individual's voucher must be fixed, so that enrollees who want to purchase comprehensive coverage would have to pay more for it. Likewise, if a Medicare enrollee chooses an economical policy, she could save the balance of her voucher in an account dedicated to out-of-pocket medical expenses. When enrollees bear the added cost of comprehensive coverage, and reap the savings from more economical coverage, their self-interest will lead them to select health plans that curb wasteful spending. Letting seniors make their own rationing decisions is the only way to protect seniors from government rationing.[23]

Medicare vouchers are the only way to protect seniors from government rationing.

Tax Reform

In the film *Sicko*, director Michael Moore took five Ground Zero rescue workers to Cuba, where they received "free" treatment for the ailments they contracted during the 9/11 rescue effort. All five had employer-sponsored insurance on September 11, 2001, but lost their coverage when they subsequently lost those jobs.[24] Had they been free to purchase coverage directly from an insurance company without penalty, Moore would have had more difficulty finding sick, uninsured Americans.

To give people under age 65 the freedom to control their health care dollars without penalty, Congress must reform the tax code. Employer-provided health insurance currently receives favorable tax treatment compared to health insurance that consumers purchase directly. That tax preference reduces the after-tax price of employer-sponsored insurance by 30 percent on average, which is the equivalent of imposing a 42-percent tax penalty on coverage purchased directly from an insurance company. As a result, some 163 million non-elderly Americans obtain coverage through an employer, while only 18 million purchase coverage directly from an insurance company.[25] The "tax exclusion" for employer-sponsored insurance encourages wasteful health spending by also distorting the after-tax price of medical services relative to other uses of income.[26]

This supposed tax "break" for employer-sponsored health insurance actually operates more like a tax hike, because it denies workers control over a large portion of their earnings as well as their health care decisions. To obtain this tax break in 2009, workers with self-only coverage sacrificed control over more than $4,000 of their earnings to their employers, while those with family coverage sacrificed control of nearly $10,000, on average.[27] Analysts typically call those amounts the "employer contribution" to the cost of health benefits, yet economists agree that employers fund those contributions by reducing workers' wages.[28] In other words, that money is part of each worker's earnings, but the worker does not and cannot control it. This tax break also largely confines workers' coverage choices to the few (if any) options their employer offers. In 2008, 80 percent of covered workers had at most two health insurance options; 47 percent had only one option.[29]

The tax preference for employer-sponsored insurance therefore creates a health insurance "market" that largely resembles a government program. Much like a tax, it denies workers control over their earnings. Much like a government program, it empowers agents—that is, employers—to determine whether consumers will have a choice of health plans, and what those choices will be. As with government programs, federal nondiscrimination rules effectively impose price controls that prohibit insurance premiums from varying according to risk.

Returning those earnings to the workers requires reforming the tax code so that all health insurance—whether purchased through an employer or directly from an insurer—receives the same tax treatment. For example, replacing the current tax exclusion with either health-insurance tax credits,[30] a standard deduction for health insurance,[31] or large health savings accounts[32] would level the playing field between employment-based coverage and other sources of health insurance. Absent any tax preference for employer-sponsored coverage, workers could demand that employers give them their $4,000 or $10,000 as cash, and could use those funds to purchase coverage from any source. A competitive labor market would force employers to comply.[33]

All of which means that eliminating the tax preference for job-based insurance would be an enormous tax *cut*. First and most obvious, the above-mentioned tax reforms would provide tax breaks to all individuals, regardless of where they purchase health insurance. Those reforms would therefore deliver tax relief to individuals who purchase insurance outside an employment setting, and who currently receive no tax break.

Second, and less obvious, eliminating the tax preference for employer-sponsored insurance would result in a massive tax cut for workers with employer-sponsored insurance, because each insured worker would gain control over $4,000 or $10,000 of her earnings that she currently does not control. In 2007, employers contributed more than $532 billion to employee health benefits. In the prior 10 years, aggregate employer contributions grew at an average rate of 8 percent. Assuming that they continue to grow at that rate through 2019, employer contributions to employee health benefits will total $9.7 trillion over the next 10 years.[34]

Eliminating the tax preference for employer-sponsored insurance would therefore shift control over more than $532 billion each year, and $9.7 trillion over the next 10 years, from employers to workers. That effective $9.7 trillion tax cut would not increase the federal budget deficit, and it would more than swamp any small, explicit tax increases that altering the existing tax treatment of employer-sponsored insurance would impose on some insured workers.[35] Unlike other tax reforms, Large HSAs would deliver that tax cut immediately and with greater transparency.

Workers would receive that tax cut even if employers immediately dropped their health benefits. An employer who did not cash out its workers would lose those workers to competing firms who either continue to offer health benefits, or who pay workers the cash equivalent of those health benefits. The CBO writes:

> To be sure, workers' cash compensation might not increase immediately by the full amount of any reduction in employers' payments for health insurance. For that reason, firms that currently contribute toward the costs of their workers' health benefits could temporarily reap some savings in labor costs.[36]

But those savings would not be permanent, because a competitive labor market would force those firms to pay workers the full value of those cancelled health benefits. Again, Large HSAs would make that tax cut immediate and transparent, and all but eliminate the incentive for employers to capture that short-term gain.

Eliminating the tax preference for employer-sponsored insurance would also expand consumers' health plan choices. Workers would be

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free to remain with their company's health plan. Yet they would no longer be confined to the few (if any) choices their employer offers. They could choose any health plan available on the market, including plans with varying benefits, cost-sharing structures, delivery systems, and payment systems. Consumers who value greater physician choice, but who are currently locked into closed-panel managed-care plans, could select a fee-for-service plan. Consumers who value lower premiums more than physician choice could do the reverse.

In the process, consumers' self-interest would eliminate wasteful spending. The Congressional Budget Office writes that "with a fixed-dollar tax credit or deduction . . . employees would capture more of the savings from choosing a cheaper plan. As a result, the CBO estimates that people would ultimately select plans with premiums that are between 15 percent and 20 percent lower than the premiums they would pay under current law."[37] Unlike government efforts to ration medical care, consumers would curb spending in ways that fit their individual preferences.

Medicare reform and tax reform would further reduce costs by spurring greater competition between health plans and providers. With seniors choosing from a menu of private health plans, the market would no longer operate under the stranglehold of Medicare's fee-for-service price and exchange controls. Greater competition would put downward pressure on prices for medical services. Provider competition would also grow as cost-conscious consumers make greater use of mid-level clinicians for basic care, such as through retail clinics and other settings.[38]

Answering the Critics

Few dispute that letting consumers control their health care dollars would reduce wasteful health care spending. The most common criticism of individual ownership is that consumers would restrain spending too much; that many consumers would skimp on care, leading to higher costs down the road. Research suggests that is not the case. The RAND Health Insurance Experiment showed that either cost-sharing or care management can reduce wasteful health care spending without harming overall health.[39] Individual ownership and greater competition could even improve health by expanding access to health plans that emphasize preventive care, coordinated care, information technologies (including electronic medical records), medical-error reduction, and comparative-effectiveness research.[40]

Critics also fear that, in the transition from the current tax preference for employer-sponsored insurance to a level playing field, some workers with high-cost illnesses would be unable to obtain coverage. If enough workers leave an employer's health plan for the individual market, the employer may have to drop its health benefits. The sickest people in those pools would then have difficulty purchasing coverage on their own.

For several reasons, this serious concern should not be an obstacle to letting workers control their own money. First, thousands of workers are already losing their employer-sponsored insurance with every passing day, because employers are either dropping coverage or eliminating jobs.[41] Many have expensive illnesses and are subsequently unable to purchase coverage. They generally receive no tax breaks to help them purchase private health insurance. Tax reform would assist those workers by reducing the after-tax cost of coverage for everyone who purchases insurance on the individual market.

Second, the freedom to purchase health insurance directly from an insurance company—coverage that stays with consumers between jobs—will guarantee that fewer Americans would find themselves in such dire straits. Economists Mark Pauly and Robert Lieberthal found that, for people with high-cost illnesses, the individual market provides coverage as secure as, or more secure than, job-based coverage: "a young male high risk who initially had small-[employer] coverage faces a 44 percent chance of becoming uninsured . . . a risk nearly twice as great as it would be if he initially had individual insurance."[42]

Third, the individual market does a better job of providing health insurance to the sick than conventional wisdom suggests. Pauly, Susan Marquis of the RAND Corporation, and their respective colleagues find that there is significant subsidization of the sick by the healthy in the individual market, and that such pooling increases over time.[43] Contrary to the conventional wisdom, Marquis and colleagues find that in California's individual market, "a large number of people with health problems do obtain coverage."[44]

Fourth, the above-mentioned tax reforms would put relatively more money in the hands of workers with higher medical costs. Economists consistently find that cash wages adjust downward to account for the higher costs that older,[45] obese,[46] and female[47] employees impose on an employer's health plan. Put differently, workers with costly medical conditions accept lower wages than they could otherwise command, in order to obtain health benefits.

Those workers would therefore receive the biggest tax cuts after eliminating the tax preference for employer-sponsored insurance. The fact that those workers currently accept lower wages than they could otherwise command means that they would generally receive more than the average $4,000 or $10,000 annual cash-out. A free market would therefore do exactly what so-called "risk-adjustment" schemes attempt to do: target resources to the people who need them most. Whereas President Obama and congressional Democrats have proposed taxing high-cost health plans, which would hit older, unionized, and female workers the hardest,[48] eliminating the tax preference for employer-sponsored insurance would give those workers the most tax *relief*. Unlike other tax reforms, which would delay that tax cut, Large HSAs would deliver those resources to sick workers immediately. To the extent that those workers are at a higher risk of losing their jobs and their coverage because they fall ill, the freedom to purchase secure, portable coverage is likewise more valuable to them than to other workers.

Finally, Large HSAs would go even further by extending the same tax relief to the uninsurable as to those who purchase insurance—something that no other tax reform proposal would do.

Affordable Coverage and a Choice of Doctors and Health Plans

Making health insurance more affordable requires more than giving consumers control over their health care dollars. Government regulations drive health care costs higher by blocking competition from more-efficient providers, insurance plans, delivery systems—and even more-efficient regulators. Reforming insurance and clinician regulation with "regulatory federalism" would make health insurance more affordable, as well as expand the freedom to choose one's own doctor and health plan.

Monopolistic Insurance Licensing

State health-insurance licensing is a prime example of costly regulation. Each state requires insurers to obtain a license from that state's government in order to sell insurance within that state's borders. Those laws effectively give each state a monopoly over providing consumer protections to insurance purchasers because they prevent employers and individuals from purchasing health insurance licensed and regulated by other states.[49]

Some form of regulation is necessary to ensure that health insurers keep their commitments to their enrollees. Yet monopolistic insurance-licensing laws may be more harmful than helpful. Those laws give government the power to dictate the terms of every health insurance policy sold in the state—a power that is inevitably captured by the health care industry.

As a result, state insurance-licensing laws require consumers to purchase coverage for an average of 42 specific types of health services—whether the consumer wants that coverage or not.[50] Some states also use insurance-licensing laws to enact price controls that tax healthy consumers to subsidize the sick. Those price-

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control laws typically do little to increase risk pooling,[51] but they do create perverse incentives for insurers to avoid the sick[52] and can cause insurance markets to unravel.[53] Physicians have used insurance-licensing laws to protect their incomes from market forces that would otherwise make health care more affordable.[54] The Congressional Budget Office estimates that state health insurance regulations increase health insurance premiums by 15 percent on average.[55] Eliminating just half of that burden could save families $1,000 or more on their premiums.[56]

Monopolistic Clinician Licensing

Regulation increases health care costs by blocking competition between clinicians as well.[57] As with insurance, each state requires clinicians to obtain a license from that state's government in order to practice within its borders. Those clinician-licensing laws define a "scope of practice" for each type of mid-level clinician, such as nurse practitioners and physician assistants. Those laws give government the power to decide what tasks each type of clinician may perform. Again, that power is inevitably captured by the health care industry—in this case, by competing clinicians, especially physicians.

Clinicians' scopes of practice are a perennial battleground for clinician groups who try to block competition for their members by narrowing the range of services that competing clinicians perform, or the settings in which they practice. Ophthalmologists use licensing laws to prevent optometrists from performing surgical procedures. Anesthesiologists use licensing laws to block competition from nurse anesthetists. Physicians use licensing laws to prevent podiatrists from treating the ankle,[58] as well as to restrict nurse practitioners' ability to prescribe drugs and operate retail clinics.[59] Physicians have even used clinician-licensing laws to block competition from health insurers that contain costs by making more extensive use of mid-level clinicians (e.g., physician assistants, nurse practitioners).[60] There is ample evidence that clinician-licensing laws have increased costs by blocking competition, yet there is little or no evidence that such laws have made patients any healthier.[61]

Some type of regulation is necessary to prevent clinicians (including physicians) from practicing beyond their competence. Like monopolistic insurance licensing, however, monopolistic clinician licensing appears to be an inadequate and even counterproductive form of regulation.

Break up Regulatory Monopolies

Consumer protections are ultimately a product. Like all monopolies, the monopolies that state governments hold over licensing clinicians and insurers produce high-cost, low-quality consumer protections. The most promising way to spur cost-saving competition between clinicians and insurers is to break up those monopolies and force regulators to compete to provide the best set of consumer protections.

With regard to insurance, that means preventing states from using their insurance-licensing laws as a barrier to entry for insurance products licensed by other states. An employer or consumer in Michigan, for example, should be allowed to purchase an insurance policy licensed in Connecticut or any other state, so that the only insurance regulations that would govern that relationship would be Connecticut's. Those regulations could be incorporated into the insurance contract, so that the purchaser could enforce Connecticut's consumer protections in Michigan courts, even with the help of Michigan's insurance commissioner.[62] (States courts frequently enforce other states' laws already.[63])

Allowing state-issued insurance licenses to cross state lines would make insurance more affordable. It would give employers and individual purchasers the freedom to choose only the coverage and regulatory protections they want, and to avoid unwanted regulatory costs. A study by Stephen Parente and colleagues at the University of Minnesota estimated that ending those regulatory monopolies could cover an additional 17 million Americans, or one-third of the most commonly cited estimate of the uninsured.[64] Moreover, it would

do so without creating any new taxes or new government subsidies, and would likely reduce the federal deficit.[65]

With regard to clinicians, breaking up regulatory monopolies means preventing state governments from barring entry to clinicians licensed by other states. Physicians and other clinicians licensed by Virginia should be able to practice in Maryland or Maine or Montana under the terms of their Virginia license, while still subject to local malpractice rules. That change would give physicians and mid-level clinicians more freedom to live and practice where they wish.

The primary benefit of ending this regulatory monopoly, however, would likely come from encouraging competition by corporate providers of care,[66] such as retail clinics and health plans like Kaiser Permanente and Group Health Cooperative. Such providers operate their own facilities and employ their own staff of clinicians. Health plans like Kaiser and Group Health strive to make medical care more affordable, in part by using mid-level clinicians to their full competence. Making state-issued clinician licenses portable would enable such organizations to compete nationwide without facing different regulatory obstacles in each state.

Eliminating both types of regulatory monopoly would force states to compete to provide the protections that consumers demand, while avoiding unwanted regulatory costs. States that want to collect licensing fees and premium taxes would face powerful incentives to find the "right" amount of regulation—not too much and not too little—much like Delaware has made itself the go-to state in the market for corporate chartering laws.

Ideally, state legislatures would take the lead by recognizing the clinician and insurance licenses issued by other states. Yet Congress can act as well, using its powers under the Commerce Clause to tear down these barriers to trade between the states.[67]

"Regulatory federalism," as it is called, would expand the array of health-insurance and medical-delivery choices available to consumers—particularly by allowing competition from more efficient providers and health plans that states' regulatory monopolies hold at bay.

Answering the Critics

Critics fear that breaking up states' regulatory monopolies would spur states to gut essential consumer protections in an effort to capture health insurance premium taxes and clinician licensing fees. The result would be a "race to the bottom" where fly-by-night insurance companies and incompetent clinicians do harm to patients.

Yet political factors and competitive market forces would prevent a race to the bottom by restoring vital consumer protections. Suppose that Delaware gutted its consumer protections and began issuing licenses to sketchy insurers and clinicians, in the hope of collecting lots of premium taxes and licensing fees. Could Delaware get away with it? Not likely. First, some of those insurers and clinicians would inevitably harm Delaware residents, who would demand that their politicians restore those essential consumer protections. Second, competitors would discipline the low-quality clinicians and health plans licensed by Delaware. Higher-quality insurers and clinicians would advertise their credentials, including the fact that they comply with the stronger consumer protections demanded by other states. Third, courts in other states would deter Delaware-licensed insurers and clinicians from bad behavior by enforcing contracts and punishing medical negligence. Regulatory federalism would still allow each state to set its own medical malpractice rules, which provide additional (and perhaps superior) protections against incompetent clinicians. Finally, consumers themselves would discipline low-quality insurers and clinicians after learning of Delaware's reputation through the news, *Consumer Reports*, and other media. Whether Delaware eliminated vital consumer protections deliberately or inadvertently, these self-correcting mechanisms would restore those essential consumer protections.

Critics likewise fear that allowing consumers to avoid state-imposed price controls

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on health insurance would lead health insurers to dump patients because they need expensive care. Yet markets offer protections against such behavior. First, Mark Pauly and Johns Hopkins University economist Bradley Herring find that absent price controls, insurers set premiums so as to eliminate any incentive for low-risk consumers to avoid pooling with high-risk consumers.[68] Second, the controversy over rescissions in California's individual market demonstrates both that insurers may shirk their commitments to the sick, but also that the courts, media scrutiny, and the forces of reputation and competition check such behavior.[69] If Americans were free to choose their own health plan, the forces of reputation and competition would be even stronger (while administrative costs in the individual market would fall).[70] Third, University of Chicago economist John H. Cochrane explains that a free market would further discipline insurers by offering products that give even sick patients the freedom to flee a disreputable insurer.[71] Indeed, Cochrane explains, it is government price controls—not market forces—that encourage insurers to avoid sick people, because price controls prevent insurers from charging enrollees a premium that covers their cost to the plan.

Monopoly—not competition—produces a race to the bottom. Regulatory federalism will drive a race to equilibrium by finding the best balance between too little regulation and too much regulation.

Congress should reform Medicaid and the State Children's Health Insurance Program with block grants that give states the ability and the incentive to target those resources to the truly needy.

Helping the Needy

A free market would provide better and more affordable health insurance to more Americans, but it would not provide health insurance to every last person. Many would require subsidized health care, either because they did not purchase health insurance when they could have, or because health insurance was never within their grasp.

The first contribution that a free market would make to alleviate the suffering of the needy would be to reduce the number of Americans who find themselves unable to afford medical care. Through greater price competition and innovation, a free market would put health insurance and medical care within the reach for more low- and middle-income Americans. It would also provide more seamless and secure health insurance coverage, so that fewer Americans would find themselves sick and uninsured.

Moreover, subsidizing the needy need not disrupt the crucial progress that markets can make on reducing costs and improving quality. For example, considerable evidence suggests that government programs like Medicaid and the State Children's Health Insurance Program enroll many non-needy people who could obtain coverage on their own.[72] Better management of those programs would make more resources available for the truly needy.

Congress should build on the success of welfare reform by reforming those programs the same way it reformed the Aid to Families with Dependent Children program in 1996: with block grants that give states the ability and the incentive to target those resources to the truly needy.[73] As markets make health insurance more secure and medical care more affordable, fewer people will fall into this vulnerable situation, and it will be easier to care for those who do.

Conclusion

When President Obama said, "We've got to admit that the free market has not worked perfectly when it comes to health care,"[74] he was doubly correct. The free market hasn't worked perfectly, because it hasn't been given a chance to work at all.

But he was also correct in the sense that a free market would fall short of perfection. Contrary to former Vermont governor Howard Dean's assessment that Obama's reform plan is "perfect," perfection is not an option.[75] Former Senate majority leader Tom Daschle more sensibly observes, "Even if we achieve 'universal' coverage, there will be some percentage of people who still fall through the cracks."[76]

The risk of health care reforms that expand government control over health care—including a new "government option,"[77] mandates,[78] and price and exchange controls—is that they would further reduce innovation and lead to even less-prudent resource decisions, both of which will cause those cracks to widen.

The great advantage of a free market is that it encourages innovation and more prudent resource allocations, which fills those cracks in over time. Many believe health care reform should include a government guarantee of "universal coverage," which even supporters often admit isn't universal in reality. If a free market were to save even more people from falling through the cracks, who would hesitate to support it?

At his March 2009 health care summit, Obama also said, "In this effort, every voice has to be heard. Every idea must be considered."[79] At a town hall meeting in June 2009, he said, "I'm very open-minded. And if people can show me here's a good idea and here's how we can get it done and it's not something I've thought of, I'm happy to steal people's ideas. You know, I'm not ideologically driven one way or another about it."[80]

Letting consumers control their health care dollars and choose from a wide array of competing health plans and providers would make health care better, more affordable, safer, and more secure. Medicare reform, tax reform, and regulatory federalism stand ready to put those cornerstones of a free health care market in place.

They await their champion.

Notes

1. White House Office of the Press Secretary, "Closing Remarks by the President at White House Forum on Health Reform," March 5, 2009, http://www.whitehouse.gov/the_press_office/Closing-Remarks-by-the-President-at-White-House-Forum-on-Health-Reform/.

2. Michael F. Cannon, "Does Barack Obama Support Socialized Medicine?" Cato Institute Briefing Paper no. 108, October 7, 2008, http://www.cato.org/pubs/bp/bp108.pdf.

3. Michael F. Cannon, "A Better Way to Generate and Use Comparative-Effectiveness Research," Cato Institute Policy Analysis no. 632, February 2, 2009, http://www.cato.org/pubs/pas/pa632.pdf.

4. See, for example, Mark V. Pauly and Robert D. Lieberthal, "How Risky Is Individual Health Insurance?" *Health Affairs* Web Exclusive, May 6, 2008, p. w248, http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.3.w242v1.

5. Lawrence H. Summers, "No Short-cuts to Development" (remarks by the Deputy Secretary of the Treasury to the IDB Conference on Development Thinking and Practice, U.S. Department of the Treasury press release, September 4, 1996), http://www.treas.gov/press/releases/rr1247.htm.

6. See Christopher J. Conover, "Health Care Regulation: A $169 Billion Hidden Tax," Cato Institute Policy Analysis no. 527, October 4, 2004, http://www.cato.org/pubs/pas/pa527.pdf. See also James C. Robinson, "The End of Asymmetric Information," *Journal of Health Politics, Policy and Law* 26 no. 5 (October 2001): 1045–53. ("To some within the health care community, the uniqueness doctrine is self-evident and needs no justification. After all, health care is essential to health. That food and shelter are even more vital and seem to be produced without professional licensure, nonprofit organization, compulsory insurance, class action lawsuits, and 133,000 pages of regulatory prescription in the *Federal Register* does not shake the faith of the orthodox.")

7. Victor Fuchs, "Cost Shifting Does Not Reduce the Cost of Health Care," *Journal of the American Medical Association* 302, no. 9 (September 2, 2009): 999–1000, http://jama.ama-assn.org/cgi/content/short/302/9/999.

8. U.S. Congressional Budget Office, "The Long-Term Outlook for Health Care Spending," November 2007, p. 8, http://www.cbo.gov/ftpdocs/87xx/doc8758/MainText.3.1.shtml.

9. U.S. Centers for Medicare & Medicaid Services, "National Health Expenditure Projections 2008–2018," http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf. Were that trend to persist, the United States would spend 100 percent of its GDP on health care by 2082. Peter R. Orszag (testimony before Senate Committee on the Budget, U.S. Congressional Budget Office, January 31, 2008, p. 11), http://www.cbo.gov/ftpdocs/89xx/doc8948/01-31-HealthTestimony.pdf.

10. Elliott S. Fisher, "Expert Voices: More Care Is Not Better Care," *National Institute for Health Care Management* no. 7, January 2005, http://www.ni

hcm.org/~nihcmor/pdf/ExpertV7.pdf.

11. Alain C. Enthoven, "Open the Markets and Level the Playing Field," in *Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice*, ed. Alain C. Enthoven and Laura A. Tollen (San Francisco: Jossey-Bass, 2004), p. 232.

12. See, for example, Peter R. Orszag, "Health Care and Behavioral Economics; A Presentation to the National Academy of Social Insurance," p. 6, http://www.cbo.gov/ftpdocs/93xx/doc9317/05-29-NASI_Speech.pdf.

13. David Goldhill, "How American Health Care Killed My Father," *Atlantic*, September 2009, http://www.theatlantic.com/doc/print/200909/health-care.

14. Tom Daschle, Scott S. Greenberger, and Jeanne M. Lambrew, *Critical: What We Can Do about the Health-Care Crisis* (New York: Thomas Dunne Books, 2008), p. 114.

15. Cannon, "A Better Way to Generate and Use Comparative-Effectiveness Research."

16. See, for example, Michael F. Cannon, "Fannie Med: Why a "Public Option" Is Hazardous to Your Health," Cato Institute Policy Analysis no. 642, August 6, 2009, http://www.cato.org/pubs/pas/pa642.pdf; Michael F. Cannon, "All the President's Mandates: Compulsory Health Insurance Is a Government Takeover," Cato Institute Briefing Paper no. 114, September 23, 2009, http://www.cato.org/pubs/bp/bp114.pdf; Michael Tanner, "Halfway to Where? Answering the Key Questions of Health Care Reform," Cato Institute Policy Analysis no. 643, September 9, 2009, http://www.cato.org/pubs/pas/pa643.pdf; and Michael Tanner, "Obama-Care to Come: Seven Bad Ideas for Health Care Reform," Cato Institute Policy Analysis no. 638, May 21, 2009, http://www.cato.org/pubs/pas/pa638.pdf.

17. Peter R. Orszag, "The Long-Term Budget Outlook and Options for Slowing the Growth of Health Care Costs" (testimony before the Committee on Finance United States Senate, U.S. Congressional Budget Office, June 17, 2008), http://www.cbo.gov/ftpdocs/93xx/doc9385/MainText.2.1.shtml.

18. Quoted in U.S. Senate Republican Policy Committee, "Health Care Costs and Their Impact on Middle-Class Wages," *RPC Bulletin*, October 1, 2008, p. 6, http://rpc.senate.gov/public/_files/BulletinImpactofHealthCostsonMiddleClass100108.pdf.

19. Michael F. Cannon, "How Can I Ration Your Medical Care? Let Me Count the Ways," *Townhall Magazine*, September 2009, p. 51, http://www.cato.org/pubs/articles/cannon-obamacare-townhall-magazine.pdf.

20. See, for example Mark V. Pauly, *Markets without Magic: How Competition Might Save Medicare* (Washington: AEI Press, 2008).

21. See, for example, Melvin J. Ingber, "Implementation of Risk Adjustment for Medicare," *Health Care Financing Review* 21, no 3 (Spring, 2000): 119, http://www.cms.hhs.gov/HealthCareFinancingReview/Downloads/00springpg119.pdf; Gregory C. Pope et al., "Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model," *Health Care Financing Review* 25, no. 4 (Summer 2004): 119, http://www.cms.hhs.gov/HealthCareFinancingReview/Downloads/04Summerpg119.pdf; and John Kautter et al., "Medicare Risk Adjustment for the Frail Elderly," *Health Care Financing Review* 30, no 2 (Winter 2008): 83, http://findarticles.com/p/articles/mi_m0795/is_2_30/ai_n31440029/.

22. See, for example, Andrew Samwick, "Means-Testing Medicare," *Vox Baby*, September 11, 2006, http://voxbaby.blogspot.com/2006/09/means-testing-medicare.html; and C. Eugene Steuerle, "Taxing the Elderly on Their Medicare Benefits," *Tax Analysts*, July 21, 1997, http://www.urban.org/url.cfm?ID=1000109.

23. Michael F. Cannon, "How Can I Ration Your Medical Care?"

24. Personal conversations with Reggie Cervantes, John Graham, and Bill Maher, Washington, DC, June 20, 2007.

25. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey," Employee Benefit Research Institute Issue Brief no. 321, September 2008, p. 5, http://www.ebri.org/pdf/briefspdf/EBRI_IB_09a-2008.pdf. Data are for 2007.

26. Michael F. Cannon, "Large Health Savings Accounts: A Step toward Tax Neutrality for Health Care," *Forum for Health Economics & Policy* 11, no. 2 (Health Care Reform), Article 3 (2008), http://www.bepress.com/fhep/11/2/3/.

27. Gary Claxton et al., "Employer Health Benefits: 2009 Annual Survey," Kaiser Family Foundation/Health Research and Educational Trust, September 15, 2009, pp. 79–80, http://ehbs.kff.org/pdf/2009/7936.pdf.

28. Michael A. Morrissey and John Cawley, "Health Economists' Views of Health Policy," *Journal of Health, Politics, Policy, and Law* 33, no. 4 (August 2008): 712.

29. Claxton et al.

30. For an example of a health-insurance tax credits proposal, see Len Burman et al., "An Updated Analysis of the 2008 Presidential Candidates' Tax Plans: Revised August 15, 2008," Tax Policy Center, updated September 12, 2008, http://www.taxpolicycenter.org/UploadedPDF/411749_updated_candidates.pdf.

31. For an example of a proposal to create a standard deduction for health insurance, see Leonard E. Burman et al., "The President's Proposed Standard Deduction for Health Insurance: An Evaluation," Tax Policy Center, February 15, 2007, http://www.taxpolicycenter.org/publications/url.cfm?ID=411423.

32. Cannon, "Large Health Savings Accounts: A Step toward Tax Neutrality for Health Care."

33. See, for example, Jason Furman, "Reforming the Tax Treatment of Health Care: Right Ways and Wrong Ways," Brookings Institution, February 24, 2008, p. 8, http://www.taxpolicycenter.org/tpccontent/healthconference_furman.pdf. ("Most labor market models have the feature that firms that drop coverage will ultimately pay their workers more, money they could put towards purchasing insurance in the individual market.")

34. The $534 billion figure represents total "employer contributions" toward employee health benefits. "Sponsors of Health Care Costs: Businesses, Households, and Governments, 1987–2007," U.S. Centers for Medicare & Medicaid Services, p. 5, Table 1, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/bhg07.pdf; and author's calculations. If the annual growth in employer "contributions" gradually declines to 3 percent over that period, the 10-year figure would still be more than $8 trillion.

35. Typically, those would be workers with the most expensive employer-sponsored insurance plans and/or those who are in the highest tax brackets.

36. U.S. Congressional Budget Office, "Effects of Changes to the Health Insurance System on Labor Markets," CBO Economic and Budget Issue Brief, July 13, 2009, p. 8, http://www.cbo.gov/ftpdocs/104xx/doc10435/07-13-HealthCareAndLaborMarkets.pdf.

37. U.S. Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, December 2008, p. xvii, http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

38. See, for example, Ateev Mehrotra et al., "Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison Of Patients' Visits," *Health Affairs* 27, no. 5 (2008): 1272–82, http://content.healthaffairs.org/cgi/content/abstract/27/5/1272.

39. See generally, Joseph P. Newhouse et al., *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, MA: Harvard University Press, 1996).

40. Cannon, "A Better Way to Generate and Use Comparative-Effectiveness Research."

41. There are more than 50 million job "separations" in the United States each year. U.S. Bureau of Labor Statistics, "Job Openings and Labor Turnover: January 2009" (press release, March 10, 2009), http://www.bls.gov/news.release/archives/jolts_03102009.pdf. A recent study by the Center for American Progress suggested that during the recent economic downturn, 14,000 U.S. workers joined the ranks of the uninsured each day. That paper relied on two particularly bad months for job losses (December 2008 and January 2009). Applying the paper's methodology to a broader period of rising unemployment (January 2008 through August 2009) produces a figure below 9,000. Center for American Progress Action Fund, "Health Care in Crisis: 14,000 Losing Coverage a Day," February 2009, http://www.americanprogressaction.org/issues/2009/02/pdf/health_care_crisis.pdf; U.S. Bureau of Labor Statistics, "Labor Force Statistics from the Current Population Survey," September 30, 2009, http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?data_tool=latest_numbers&series_id=LNS14000000;and author's calculations. Among those 9,000 workers, many are healthy, and many will regain coverage after a number of months. Nevertheless, the problem of workers with high-cost conditions losing their health insurance and then being unable to afford coverage is very real. See Jonathan Cohn, *Sick: The Untold Story of America's Health Care Crisis—and the People Who Pay the Price* (New York: HarperCollins, 2007).

42. Mark V. Pauly and Robert D. Lieberthal, "How Risky Is Individual Health Insurance?"

43. Mark Pauly, "How Private Health Insurance Pools Risk," NBER Reporter: Research Summary (Summer 2005), http://www.nber.org/reporter/summer05/pauly.html; and M. Susan Marquis et al., "Consumer Decision Making in the Individual Health Insurance Market," *Health Affairs* Web

Exclusive (May 2, 2006): w226, http://content.healthaffairs.org/cgi/content/short/hlthaff.25.w226v1.

44. Marquis et al.

45. Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks* (Washington: AEI Press, 1999), pp. 69–70.

46. Jay Bhattacharya and M. Kate Bundorf, "The Incidence of the Healthcare Costs of Obesity," *Journal of Health Economics* 28, no. 3 (May 2009): 649–58, http://healthpolicy.stanford.edu/publications/the_incidence_of_the_healthcare_costs_of_obesity/.

47. Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *The American Economic Review* 84, no. 3 (June 1994): 622–41, http://aysps.gsu.edu/isp/files/isp_summer_school_2008_erard_incidence_of_mandated_maternity_benefits.pdf.

48. Elise Gould and Alexandra Minicozzi, "Who is Adversely Affected by Limiting the Tax Exclusion of Employment-Based Premiums?" Economic Policy Institute Working Paper no. 281 (March 2009), http://www.epi.org/page/-/pdf/wp281.pdf.

49. Michael F. Cannon, "Health Insurance Regulation," in *Cato Handbook for Policymakers*, 7th ed., ed. David Boaz (Washington: Cato Institute, 2009), p. 167, http://www.cato.org/pubs/handbook/hb111/hb111-16.pdf.

50. Victoria Craig Bunce and J. P. Wieske, "Health Insurance Mandates in the States 2009," Council for Affordable Health Insurance, 2009, http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf.

51. Pauly, "How Private Health Insurance Pools Risk."

52. John H. Cochrane, "Health-Status Insurance: How Markets Can Provide Health Security," Cato Institute Policy Analysis no. 633, February 18, 2009, http://www.cato.org/pubs/pas/pa-633.pdf.

53. Pauly, "How Private Health Insurance Pools Risk."

54. See, generally, Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982 [actually published in January 1983]); and Michael A. Morrissey, "State Health Care Reform: Protecting the Provider," in *American Health Care: Government, Market Processes and the Public Interest*, ed. Roger D. Feldman (Oakland, CA: Independent Institute, 2000), http://www.independent.org/store/book_detail.asp?bookID=33.

55. U.S. Congressional Budget Office, "Increasing Small-Firm Health Insurance Coverage through Association Health Plans and HealthMarts," CBO Paper, January 2000, p. 3, http://www.cbo.gov/ftpdocs/18xx/doc1815/healthins.pdf; and author's calculations.

56. A typical employer-provided family plan cost $13,375 in 2009. Gary Claxton et al., "Employer Health Benefits: 2009 Annual Survey," Kaiser Family Foundation/Health Research and Educational Trust, September 15, 2009, p. 14, http: //ehbs.kff.org/pdf/2009/7936.pdf. If a family plan with that premium could avoid half of the average regulatory burden, the savings would be more than $1,000.

57. Clinicians include physicians; physician assistants; nurse practitioners and other advanced-practice nurses; physical therapists; optometrists; and other medical practitioners.

58. See generally Shirley V. Svorny, "Medical Licensing: An Obstacle to Affordable, Quality Care," Cato Institute Policy Analysis no. 621, September 17, 2008, http://www.cato.org/pubs/pas/pa-621.pdf.

59. See, for example, Illinois State Medical Society, "Doctor's [*sic*] Seek Retail Health Clinic Oversight to Ensure Patient Safety, Adequate Follow-Up Care" (news release, February 19, 2008), http://www.isms.org/NewsRoom/newsreleases/Pages/nr2008_0218.aspx; and U.S. Federal Trade Commission (letter to Hon. Elaine Nekritz, May 29, 2008), http://www.ftc.gov/os/2008/06/V080013letter.pdf.

60. Cannon, "A Better Way to Generate and Use Comparative-Effectiveness Research."

61. Svorny, "Medical Licensing: An Obstacle to Affordable, Quality Care."

62. See Henry Butler and Larry Ribstein, "The Single-License Solution," *Regulation* 31, no. 4 (Winter 2008–2009): 36–42.

63. See, for example, Erin A. O'Hara and Larry E. Ribstein, *The Law Market* (Oxford: Oxford University Press, 2009).

64. Stephen T. Parente et al., "Consumer Response to a National Marketplace for Individual Insurance," Carlson School of Management working paper, June 28, 2008, p. 8, http://www.aei.org/docLib/20080730_National_Marketpla.pdf.

65. U.S. Congressional Budget Office, "H.R. 2355: Health Care Choice Act of 2005" (cost estimate, September 12, 2005), http://www.cbo.gov/ftpdocs/66xx/doc6639/hr2355.pdf. (As more workers opt for individual-market coverage over em-

ployer-sponsored insurance, more of workers' overall compensation would become subject to income and payroll taxes, resulting in an incidental increase in federal revenues.)

66. See Arnold Kling and Michael F. Cannon, "Does the Doctor Need a Boss?" Cato Institute Briefing Paper no. 111, January 13, 2009, http://www.cato.org/pubs/bp/bp111.pdf.

67. U.S. Constitution, Article I, section 8.

68. Bradley Herring and Mark V. Pauly, "Incentive-Compatible Guaranteed-Renewable Health Insurance Premiums," *Journal of Health Economics* 25 (2005): 395–417, http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V8K-4JP9FP6-1&_user=10&_rdoc=1&_fmt=&_orig=search&_sort=d&_docanchor=&view=c&_searchStrId=1030484307&_rerunOrigin=google&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=652644515e80a777202cf2a6e3c279b2.

69. See, for example, Lisa Girion, "Blue Cross Makes Policy About-Face," *Los Angeles Times*, May 11, 2007, http://www.latimes.com/business/la-fi-insure11may11,1,1299206.story.

70. Mark Pauly, Allison Percy, and Bradley Herring, "Individual versus Job-Based Health Insurance: Weighing the Pros and Cons," *Health Affairs* 18, no. 6 (November/December 1999): 28–44, http://content.healthaffairs.org/cgi/content/abstract/18/6/28.

71. Cochrane explains how disease-specific payouts, whose use is legally limited to purchasing health insurance, would enable sick patients to afford whatever premiums the market would charge and thereby free the sick to flee a substandard health plan. John H. Cochrane, "Health-Status Insurance: How Markets Can Provide Health Security," Cato Institute Policy Analysis no. 633, February 18, 2009, http://www.cato.org/pubs/pas/pa-633.pdf.

72. See, for example, Jonathan Gruber and Kosali Simon, "Crowd-out 10 Years Later: Have Recent Public Insurance Expansions Crowded out Private Health Insurance?" *Journal of Health Economics* 27, no. 2, (March 2008): 201–17; Michael F. Cannon, "Medicaid's Unseen Costs," Cato Institute Policy Analysis no. 548, August 18, 2005, http://www.cato.org/pub_display.php?pub_id=4049; Michael F. Cannon, "Sinking SCHIP: A First Step toward Stopping the Growth of Government Health Programs," Cato Institute Briefing Paper no. 99, September 13, 2007, http://www.cato.org/pub_display.php?pub_id=8697; and Stephen A. Moses, "Aging America's Achilles Heel: Medicaid Long-Term Care," Cato Institute Policy Analysis no. 549, September 1, 2005, http://www.cato.org/pubs/pas /pa549.pdf.

73. See Cannon, "Medicaid's Unseen Costs," and Cannon, "Sinking SCHIP."

74. White House Office of the Press Secretary, "Remarks by the President in Town Hall Meeting on Health Care: Southwest High School, Green Bay, Wisconsin," June 11, 2009, http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-in-Town-Hall-Meeting-on-Health-Care-in-Green-Bay-Wisconsin/.

75. Christina Bellantoni, "Dean Says 'Enough' on Limbaugh," *Washington Times*, March 10, 2009, http://www.washingtontimes.com/news/2009/mar/10/dean-touts-perfect-obama-health-plan/. See also Harold Demsetz, "Information and Efficiency: Another Viewpoint," *Journal of Law and Economics* 12, no. 1 (April 1969): 1, http://www.scribd.com/doc/19623869/Demsetz-H-1969-Information-and-Efficiency-Another-Viewpoint. ("The view that now pervades much public policy economics implicitly presents the relevant choice as between an ideal norm and an existing 'imperfect' institutional arrangement. This nirvana approach differs considerably from a *comparative institution* approach in which the relevant choice is between alternative real institutional arrangements.")

76. Tom Daschle, Scott S. Greenberger, and Jeanne M. Lambrew, *Critical: What We Can Do about the Health-Care Crisis* (New York: Thomas Dunne Books, 2008), p. 164.

77. Michael F. Cannon, "Fannie Med."

78. Michael F. Cannon, "All the President's Mandates."

79. "President Obama Speaks at Healthcare Summit," *CQ Transcripts Wire/Washington Post*, March 5, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/03/05/AR2009030501850.html.

80. Mara Liasson, "Obama Pitches Health Care Overhaul in Wisconsin," NPR.org, June 12, 2009, http://www.npr.org/templates/story/story.php?storyId=105285850.

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