REPLACING OBAMACARE

THE CATO INSTITUTE ON HEALTH CARE REFORM

EDITED BY MICHAEL F. CANNON AND MICHAEL D. TANNER

CATO INSTITUTE

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INTRODUCTION

On March 23, 2010, President Barack Obama signed the Affordable Health Care Act into law.

Renamed ObamaCare at its conception, the Act's 2,700 pages are filled with government price controls, mandates, subsidies, bureaucracies, and regulations. And now, having escaped being struck down by the Supreme Court, the dangers it poses to individuals, families, companies, industries, and our nation as a whole, have to be confronted, halted, and replaced.

The Cato Institute has been a leader in educating the American people about the threats ObamaCare poses to individual freedom, to democracy, and to health care reform. This book assembles the best of our work on ObamaCare, and on how free markets are the only way to make health care better, more affordable, and more secure. As you will note, this book contains the work of over a dozen national experts who have dedicated their professional lives to enabling true, effective, health care reforms. Readers can follow Cato's work at www.cato.org, and the Cato@Liberty blog, www.cato-at-liberty.org.

This book explains why Congress should repeal ObamaCare, and what reforms Congress should then put in its place. But make no mistake. By this book's conclusion, you will understand why "replace" means nothing without "repeal." Repealing ObamaCare—and pursuing the solid, proven solutions we set forth in the following pages—is real health care reform.

Michael F.Cannon
July 4, 2012

SECTION ONE:

A LIBERTARIAN PERSPECTIVE ON HEALTH CARE REFORM

Chapter 1

Health Care

by Michael F. Cannon

Health care represents a special area of public policy for libertarians, although not for the reasons typically offered in support of government intervention. In limited circumstances, a substantial number of libertarians support state-sponsored coercion to prevent the spread of infectious diseases. In the absence of violence, theft, tortious injury, fraud, or breach of contract, however, libertarians reject the use of coercion in health and medicine as immoral and counterproductive.

People can do violence to each other by transmitting contagious diseases. Therefore, most libertarians sanction limited government efforts to identify and contain infectious diseases and punish those who infect others intentionally or negligently. They do so cautiously, however. A 2004 survey published in the journal *Health Affairs* hints at one way such powers could be abused. Amid widespread concern about bioterrorism, roughly equal shares of white and black Americans expressed support for quarantines to contain a serious contagious disease. When subsequently asked whether they would support a compulsory quarantine, where the authorities would have the power to arrest violators, 25% of whites changed their minds, whereas 51% of blacks did, indicating an awareness that these policies would not necessarily be fairly implemented. Just as libertarians advocate limits on government's ability to pursue criminals generally, they closely circumscribe the use of force to protect public health. For example, an outbreak must pose a serious health threat, there must be no feasible alternative to coercion, and the state must use the least coercive measures available. Libertarians reject government intervention to remedy private health problems, such as obesity, diabetes, or addiction.

There exist more unjustified uses of the state's coercive power in health and medicine than in nearly any other area. In the United States, governments routinely forbid competent adults from making medical decisions that affect no one but themselves. Libertarians maintain that such laws are unjust and ultimately counterproductive. For example, the government denies patients, including terminally ill patients, the ability to determine their course of treatment. Proponents argue that such laws exist to ensure the safety and effectiveness of medical products. Libertarians argue that those laws cause more morbidity and mortality than they prevent.

Licensing laws restrict entry into the medical professions, dictate what tasks each profession may perform, and deny patients the right to be treated by the practitioner of their choice. Libertarians agree with a quip that Mark Twain delivered before the New York General Assembly in 1901, as reported in *The New York Times*:

> I don't know that I cared much about these osteopaths until I heard you were going to drive them out of the State; but since I heard this I haven't been able to sleep . . . Now what I contend is that my body is my own, at least I have always so regarded it. If I do harm through my experimenting with it, it is I who suffer, not the State.

Proponents of licensing argue that it enhances the quality of care, but libertarians point to the fact that low-quality care is widespread despite licensing, that licensing does not improve overall quality because it reduces access to care for the poor, and that the chief proponents of licensing are incumbent practitioners who profit by restricting entry. Meanwhile, unregulated markets are extremely likely to develop private quality certification.

Government prohibits the sale of human organs to transplant patients or organ brokers. Proponents of that ban consider it immoral to commodify the human body, but such a ban allows government to assert a property right in the body of every citizen. Further, it makes organs no less valuable a commodity, but merely imposes on them a zero price and consequently creates an artificial shortage that causes thousands of unnecessary deaths in the United States each year.

Governments infringe on the individual's ability to choose whether to purchase health insurance and what type of insurance to purchase. Targeted tax breaks penalize consumers for purchasing the wrong type of health insurance or no insurance. Libertarians note that these laws require adults to buy coverage they do not want and may even consider immoral. Legislatures enact these laws at the behest of the providers of the covered services, which increases the costs of health insurance and the number of uninsured.

Libertarians further object to the government's refusal to honor contracts limiting a provider's liability for malpractice in exchange for reduced-price or free medical care. Proponents of that rule argue that patients harmed by negligent providers might not be able to recover. Opponents say that such rules limit the right of consenting adults to engage in mutually beneficial exchanges that harm no one else and that they reduce access to care among those least able to pay. Finally, regulations of this sort reduce experimentation with malpractice rules that ensure both quality and access.

Government may do the greatest damage to health and personal liberty through its influence over the financing of medical care. Government programs such as Medicare and Medicaid finance nearly half of all medical expenditures in the United States. They devour private health insurance markets and deny adults the ability to choose whether and how to fund their health needs in retirement and how to assist the needy. These programs waste more than $60 billion per year on care that makes patients no healthier or happier. Targeted tax breaks divert even private spending from pursuing high-quality, affordable care and unnecessarily induce millions to become dependent on government. These targeted tax breaks deny workers control over their earnings and their health insurance. They encourage wasteful consumption of medical care and strip workers of their health insurance when they leave a job.

In 1963, Nobel laureate economist Kenneth Arrow wrote that licensure and other features of health care markets can be partially explained by uncertainty about the quality of medical care and the fact that physicians possess more certainty regarding quality than do patients. Many supporters of licensure cite Arrow's analysis when arguing for government intervention to correct the perceived market failures of imperfect and asymmetric information. With respect to Arrow's conclusions, however, health economist James C. Robinson has replied,

> The most pernicious doctrine in health services research, the greatest impediment to clear thought and successful action, is that health care is *indifferent*. . .
>
> To some within the health care community, the uniqueness doctrine is self-evident and needs no justification. After all, health care is essential to heath. 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 . . .

> The central proposition of [Arrow's 1963] article, that health care information is imperfect and asymmetrically distributed, has been seized upon to justify every inefficiency, idiosyncrasy, and interest-serving institution in the health care industry. . . . It has served to lend the author's unparalleled reputation to subsequent claims that advertising, optometry, and midwifery are threats to consumer well-being, that nonprofit ownership is natural for hospitals though not for physician practices, that price competition undermines product quality, that antitrust exemptions reduce costs, that consumers cannot compare insurance plans and must yield this function to politicians, that price regulation is effective for pharmaceutical products despite having failed in other applications, that cost-conscious choice is unethical while cost-unconscious choice is a basic human right . . .

Libertarians do not dispute that health and medicine present unique challenges, but they argue that noncoercive measures are best able to address these challenges.

Further Readings

Arrow, Kenneth J. "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review* 53 no. 5 (December 1963): 941–973.

Cannon, Michael F., Daniel B. Klein, and Alexander Tabarrok. "Do Economists Reach a Conclusion on the Food and Drug Administration?" *Econ Journal Watch*.

Cannon, Michael F., and Michael D. Tanner. *Healthy Competition: What's Holding Back Health Care and How to Free It.* Washington, DC: Cato Institute, 2007.

Conover, Christopher J. "Health Care Regulation: A $169 Billion Hidden Tax." *Cato Institute Policy Analysis* 527 (October 4, 2004).

Epstein, Richard A. "Medical Malpractice: The Case for Contract." *American Bar Foundation Research Journal 1* no. 1 (1976): 87–149.

Epstein, Richard A. *Mortal Peril: Our Inalienable Right to Health Care?* Reading, MA: Addison-Wesley, 1997.

Hamowy, Ronald. "The Early Development of Medical Licensing Laws in the United States, 1875–1900." *Journal of Libertarian Studies* 3 (Spring 1979): 73–119.

Hamowy, Ronald. *Government and Public Health in America.* Northampton, MA: Edward Elgar Publishing, 2007.

Hyman, David A. *Medicare Meets Mephistopheles*. Washington, DC: Cato Institute, 2006.

Kling, Arnold. *Crisis of Abundance: Rethinking How We Pay for Health Care.* Washington, DC: Cato Institute, 2006.

Robinson, James C. "The End of Asymmetric Information." *Journal of Health Politics, Policy, and Law* 26 no. 5 (October 2001): 1045–1053.

Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, 1984.

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Chapter 2

Not Enough Healthcare to Go Around

by Michael D. Tanner

Some say Americans use too much healthcare, that even if reform is achieved, universal access should not mean unlimited access.

Tough choices must be made.

Others worry that the most needy or least able to fight for themselves will be left waiting.

Should healthcare be rationed?

No one can fail to be moved by heartbreaking stories of people suffering and unable to get healthcare they want or need. But compassion is a sentiment, not a policy.

We tend to talk about healthcare in the philosophically abstract. "Is healthcare a right or a privilege?" goes the refrain. In reality, it is neither.

Healthcare is a commodity—and a finite one at that.

There are only so many doctors, hospitals, and, most important, money to go around. After all, every dollar spent on healthcare is one not spent on education, infrastructure, or defense.

President Obama is right about the unsustainable trajectory of healthcare spending.

We spend $2.5 trillion per year for healthcare, 17.5 percent of the gross domestic product. Under current trends, that will increase to 48 percent of GDP by 2050. At that point, government healthcare programs like Medicare and Medicaid alone will consume 20 percent of GDP. Quite simply, we cannot provide all the healthcare everyone might want.

Sure, there are efficiency savings to be had here and there. But savings from things like greater emphasis on preventive care, better evidence as to best practices, and electronic medical records are unlikely to be realized for years, if at all. Any healthcare reform will have to confront the biggest single reason costs keep rising: The American people keep buying more and more healthcare.

At its most basic, no one wants to die.

If a treatment can save our lives or increase quality of life, we want it. Therefore, in the long run, the only way to spend less on healthcare is to consume less healthcare. Someone, sometime, has to say no.

Take just one example. If everyone were to receive a CT brain scan every year as part of an annual physical, we would undoubtedly discover a small number of brain cancers earlier than we otherwise would, perhaps early enough to save a few lives. But given the scan's cost, adding it to all annual physicals would quickly bankrupt the nation.

False hope.

The real debate, therefore, is not about whether we should ration care but about who should ration it. Currently, that decision is often made by insurance companies or other third-party payers. Obama and congressional Democrats want to shift that decision-making power to the federal government. Some, frustrated by the insurance-based rationing of the current system, naively believe that putting the

government in charge would mean unlimited access to the care they need and desire. When Michael Moore, in Sicko, showcased emotional tales of people denied experimental treatment by insurance companies, he implied that a government-run system would certainly pay for it.

The reality, however, is that every government-run healthcare system around the world rations care.

In Great Britain, the National Institute on Clinical Effectiveness makes such decisions, including a controversial determination that certain cancer drugs are "too expensive." The government effectively puts a price tag on each citizen's life—some $44,305 per year, to be exact. That's just a baseline, of course, and, as the British institute's chairman, Michael Rawlins, points out, the agency has at times approved treatments costing as much as $70,887 per year of extended life. But these are approved only if it can be shown they extend life by at least three months and are used for illnesses that affect fewer than 7,000 new patients per year.

Free-market healthcare reformers, on the other hand, want to shift more of the decisions (and therefore the financial responsibility) back to the individual.

People should have the absolute right to spend their own money on whatever they want, including buying as much healthcare as they want. And, if they are spending their own money, they will make their own rationing decisions based on price and value.

That CT scan that looked so desirable when someone else was paying may not be so desirable if you have to pay for it yourself. The consumer himself becomes the one who says no.

Of course, as a compassionate society, we may choose to help others pay for some care. That's a worthwhile debate to have. But our resources are not unlimited. Choices will have to be made. And, therefore, the real question should be: Who will make those choices?

The only way to spend less on healthcare is to consume less healthcare.

This article appeared in the August 2009 issue of U.S. News & World Report.

Chapter 3

The Ethos of Universal Coverage

by Michael F. Cannon

Associated Press photojournalist Noah Berger captured this thousand-word image near the Occupy Oakland demonstrations last month.

(AP Photo/Noah Berger)

Many *Cato@Liberty* readers will get it immediately. They can stop reading now. For everyone else, this image perfectly illustrates the ethos of what I call the Church of Universal Coverage.

Like everyone who supports a government guarantee of access to medical care, the genius who left this graffiti on Kaiser Permanente's offices probably thought he was signaling how important other human beings are to him. He wants them to get health care after all. He was willing to expend resources to transmit that signal: a few dollars for a can of spray paint (assuming he didn't steal it) plus his time. He

probably even felt good about himself afterward.

Unfortunately, the money and time this genius spent vandalizing other people's property are resources that could have gone toward, say, buying him health insurance. Or providing a flu shot to a senior citizen. This genius has also forced Kaiser Permanente to divert resources away from healing the sick. Kaiser now has to spend money on a pressure washer and whatever else one uses to remove graffiti from those surfaces (e.g., water, labor).

The broader Church of Universal Coverage spends resources campaigning for a government guarantee of access to medical care. Those resources likewise could have been used to purchase medical care for, say, the poor. The Church's efforts impel opponents of such a guarantee to spend resources fighting it. For the most part, though, they encourage interest groups to expend resources to bend that guarantee toward their own selfish ends. The taxes required to effectuate that (warped) guarantee reduce economic productivity both among those whose taxes enable, and those who receive, the resulting government transfers.

In the end, that very government guarantee ends up leaving people with less purchasing power and undermining the market's ability to discover cost-saving innovations that bring better health care within the reach of the needy. That's to say nothing of the rights that the Church of Universal Coverage tramples along the way: yours, mine, Kaiser Permanente's, the Catholic Church's . . .

I see no moral distinction between the Church of Universal Coverage and this genius.

Both spend time and money to undermine other people's rights as well as their own stated goal of "health care for everybody."

Of course, it is always possible that, as with their foot soldier in Oakland, the Church's efforts are as much about making a statement and feeling better about themselves as anything else.

This article appeared on February 7, 2012 on Cato@Liberty.org.

Chapter 4

Universal Coverage Means 'Willing to Let You Die Sooner'

by Michael F. Cannon

I cannot disagree with Uwe Reinhardt's response to my previous post at *National Journal*'s Health Care Experts blog. But his response bears clarification and emphasis.

Improving "population health" generally means "helping people live longer."

To paraphrase, Reinhardt then writes:

> If helping people live longer were our objective in health reform, we could do better than universal coverage. But health reform is not (solely or primarily) about helping people live longer. It is (also or primarily) about other things, like relieving the anxiety of the uninsured.

I applaud Reinhardt for acknowledging a reality that most advocates of universal coverage avoid: that universal coverage is not solely or primarily about improving health.

Will Reinhardt go further and acknowledge that, since universal coverage is largely about some other X-factor(s), that *necessarily* means that advocates of universal coverage are willing to let some people die sooner in order to serve that X-factor?

This article appeared on October 21, 2009 on Cato@Liberty.org.

Chapter 5

Rwanda and the Psychic Benefits of Universal Coverage

by Michael F. Cannon

Last week, the *New York Times* published an article subtitled, "In Desperately Poor Rwanda, Most Have Health Insurance." The main theme was the contrast between Rwanda's compulsory health insurance system and the as-yet-non-compulsory U.S. health insurance market:

> Rwanda has had national health insurance for 11 years now; 92 percent of the nation is covered, and the premiums are $2 a year.
>
> Sunny Ntayomba, an editorial writer for *The New Times*, a newspaper based in the capital, Kigali, is aware of the paradox: his nation, one of the world's poorest, insures more of its citizens than the world's richest does.
>
> He met an American college student passing through last year, and found it "absurd, ridiculous, that I have health insurance and she didn't," he said, adding: "And if she got sick, her parents might go bankrupt. The saddest thing was the way she shrugged her shoulders and just hoped not to fall sick."

I don't see anything absurd here, but I do see something remarkable. Rwanda is so poor, its per capita income is about 1 percent that of the United States ($370 vs. $39,000). Its health care sector is an international charity case: "total health expenditures in Rwanda come to about $307 million a year, and about 53 percent of that comes from foreign donors, the largest of which is the United States." That's roughly $32 per person per year, which doesn't buy much. Dialysis is "generally unavailable." As are many treatments for cancer, strokes, and heart attacks, making those ailments "death sentences" more often than in advanced nations. Life expectancy at birth is 58 years, compared to 78 years in the United States. Rwandan children are 15 times more likely to die before their first birthday (7 vs. 107 deaths per 1,000 live births) and 25 times more likely to die before turning five (8 vs. 196 deaths per 1,000 live births) than U.S.-born children. (If you want to meet some Rwandan kids struggling to make it to age 5, read my friend's blog, Life of a Thousand Hills.) And yet, the *saddest* thing is a healthy-but-uninsured American college student.

What the *Times* sees as a paradox isn't really a paradox. Yes, the poorer nation has a higher levels of health insurance coverage. But the wealthier nation does a better job of providing medical care to everyone, insured and uninsured alike. The *Times* reports that Rwanda's national health insurance system isn't fancy, "But it covers the basics," including "the most common causes of death—diarrhea, pneumonia, malaria, malnutrition, infected cuts." Surely, the *Times* must know that anyone walking into any U.S. emergency room with any of those conditions would be treated, regardless of insurance status or ability to pay. The same is true of other acute conditions, like heart attacks and strokes, for which uninsured Americans receive better treatment than insured Rwandans. True, some uninsured Americans end up filing for bankruptcy, but let's be clear: while bankruptcy is no day at the beach, suffering

bankruptcy because you got the treatment is better than suffering death because you didn't. (As for dialysis, the United States already has universal coverage for end-stage renal disease through the Medicare program.) The Healthcare Economist puts it this way: "Would you rather be sick in the United States without insurance or sick with insurance in Rwanda?" You get the point. If there's a paradox here, it's that insurance status does not necessarily correlate with access to medical care: uninsured people in the wealthy nation actually have better access to care than insured people in the poor nation.

An even bigger paradox, though, is Rwandan attitudes toward the United States. The United States generates many of the HIV treatments currently fighting Rwanda's AIDS epidemic, as well as other medical innovations saving lives there and around the world. More than any other nation, we create the wealth that purchases those and other treatments for Rwandans and other impoverished peoples. The United States is probably *closer* to providing universal access to medical care for its citizens—and, indeed, the whole world—than Rwanda. Rwanda's "universal" system leaves 8 percent of its population uninsured. Though official estimates put the U.S. uninsured rate at 15.4 percent, the actual percentage is lower; and again, uninsured Americans typically have better access to care than insured Rwandans. The real paradox is here that Rwandan elites think *the United States* is doing something wrong. Why?

Here's one answer: Rwanda's government explicitly guarantees health insurance to its citizens, and for some people that guarantee has value apart from any health improvements or financial security that may result. Dr. Agnes Binagwaho, "permanent secretary of Rwanda's Ministry of Health," illustrates:

> Still, Dr. Binagwaho said, Rwanda can offer the United States one lesson about health insurance: "Solidarity—*you cannot feel happy as a society* if you don't organize yourself so that people won't die of poverty."

Set aside that a (permanent) third-world bureaucrat is telling the United States how to keep people from dying of poverty. Binagwaho *cannot feel happy* without that government-issued guarantee.

How might such a guarantee increase happiness? It could make people happier by reassuring them that they themselves will be healthier and more financially secure (self-interest), or that others will be (altruism). Yet altruism and self-interest probably cannot explain the "happiness benefits" that people enjoy when governments guarantee health insurance. As I have argued elsewhere, the jury is out on whether broad health insurance expansions like ObamaCare result in better overall health; they may, but it is entirely possible that they would not. The jury is also out on whether ObamaCare will produce a net increase in financial security. It will subsidize millions of low-income Americans, but it will also saddle them with high implicit taxes that could trap millions of them in poverty. Meanwhile, ObamaCare's new taxes will reduce economic growth and destroy jobs. If such a guarantee doesn't improve health or financial security, it's not worth much in terms of altruism or self-interest.

But there's another potential "happiness benefit" that might accrue to supporters of a government guarantee of health insurance: it could make them happier by allowing them to signal something about themselves—e.g., that they are compassionate. If people use a government guarantee of health insurance in this way, that could explain why Rwandan elites feel bad for uninsured Americans. They may feel empathy for uninsured Americans because they perceive the American electorate has not sent uninsured Americans a valuable signal ("We care about you!"). Meanwhile, the act of expressing pity for uninsured Americans allows Rwandan elites to signal something about themselves ("We are compassionate!"). Robin Hanson has a lot to say about why people might use health insurance and medical care to signal loyalty and compassion.

My hunch is that this is an under-appreciated reason why some people support universal coverage: a government guarantee of health insurance coverage provides its supporters psychic benefits—even if it does not improve health or financial security, and maybe even if both health and financial security suffer.

If that's the case, then we're facing the same problem that Charles Murray identified in *Losing Ground*, his seminal work on poverty:

> Most of us want to help. It makes us feel bad to think of neglected children and rat-infested slums . . . The tax checks we write buy us, for relatively little money and no effort at all, a quieted conscience. The more we pay, the more certain we can be that we have done our part, and it is essential that we feel that way regardless of what we accomplish . . .
>
> To this extent, the barrier to radical reform of social policy is not the pain it would cause the intended beneficiaries of the present system, *but the pain it would cause the donors*. The real contest about the direction of social policy is not between people who want to cut budgets and people who want to help. When reforms finally do occur, they will happen not because stingy people have won, but because generous people have stopped kidding themselves.

One thing is for certain. When Rwandan elites pity uninsured Americans, there is something very interesting going on.

While I'm at it, the health-policy advice I offered to China and India also applies to Rwanda:

> Does not the fact that "these countries lack the fiscal resources required for universal coverage because of their . . . low average wages" suggest that many residents have more pressing needs than health insurance? For things that might just deliver greater health improvements? In a profession where universal coverage is a religion, such questions are heresy, I know.
>
> China and India are in the process of a slow climb out of poverty. It is entirely possible that the best thing those governments could do to improve [health care] markets and population health would be to enforce contracts, punish torts, contain contagion, and nothing else.

Of course, if Rwandan elites support universal coverage largely because they want to signal something about themselves, this advice may fall on deaf ears.

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Chapter 6

The Church of Universal Coverage Becomes Self-Aware

by Michael F. Cannon

I have blogged before about the "Church of Universal Coverage," my affectionate term for those whose support for universal health insurance coverage is impervious to reason—or would be, were they to subject it to reason. I read something today that has me wondering whether the Church might be waking up to the fact that it is indeed a religion.

The July/August 2008 issue of the journal *Health Affairs* contains a letter from Mitch Roob, the Indiana official who oversees Gov. Mitch Daniels' (R) health care agenda. Roob writes:

> Like other advocates for children's health, *I have an almost religious conviction* that the State Children's Health Insurance Program (SCHIP) is effective public policy . . . Although *I have no empirical evidence* to support the assertion that SCHIP is a beneficial and effective way to invest in children's health, I worked to expand the program . . . *I was not able to base this expansion on empirical evidence* because there is none . . . *The lack of actual evidence* of the benefits for children is simply damning to the program . . . *Public policymakers need more than just a conviction* that SCHIP works and is worthy of public investment. We need facts. [Emphasis added.]

Wow. I mean, *wow*.

I see three possible outcomes. One, all that cognitive dissonance causes Roob's head to explode. Two, the Church hierarchy dispatches its goons to burn this heretic at the stake for noticing that their god has no clothes. Three, the Left decides "to hell with it," admits that it has a religion, and files for tax-exempt status.

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Chapter 7

Still Don't Think Universal Coverage Is a Religion?

by Michael F. Cannon

In case my last post didn't convince you that universal coverage is a religion, here is its apostle's creed:

> To *believe* in universal health care is to *believe* that we can do more and do better, all at once—that it is possible to have hospitals full of high technology and emergency departments with room for all comers; that it is possible for people to choose their doctors and have a say in their treatments; that it is possible to make the economy more free and more efficient; and that it is possible to do all of this for everybody, not just an economically or medically privileged few, in a way we can all find affordable. [Emphasis added.]

(As delivered by Church of Universal Coverage high priest Jonathan Cohn and chronicled in the book *Sick*, chapter 9, p. 231.)

I may *think* that government often serves the few at the expense of the many, that people respond to incentives, that tradeoffs are unavoidable, that there may be better ways to promote health, and that introducing coercion into human affairs creates more problems than it solves.

But just try telling that to someone who *believes*.

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SECTION TWO:

THE U.S. AND THE WORLD

Chapter 8

The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World

by Michael D. Tanner

Cato Institute Policy Analysis no. 613 (March 18, 2008)

Introduction

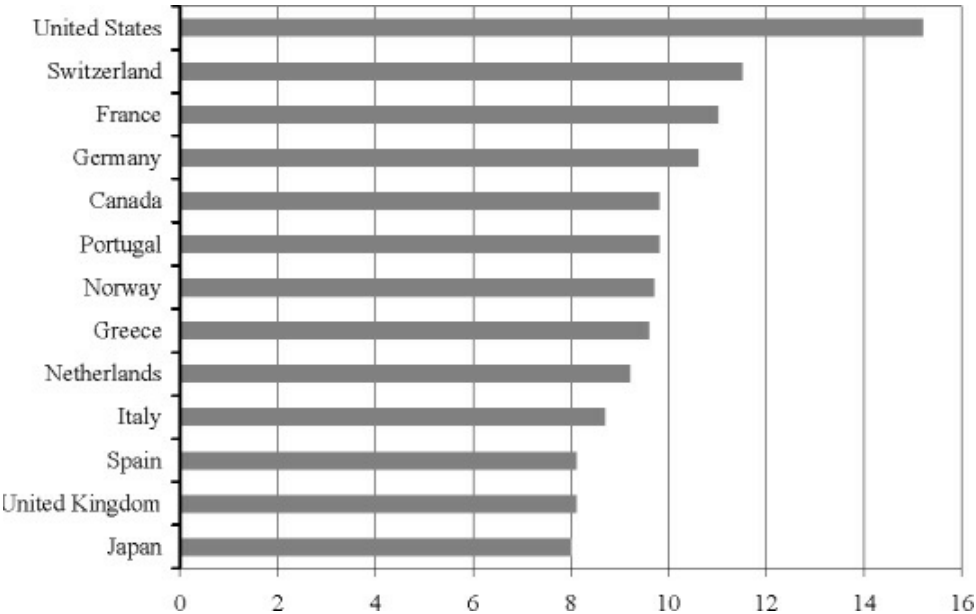
In his movie *SiCKO*, Michael Moore explores problems with the U.S. health care system and advocates the adoption of a government-run, single-payer system.[1] Moore compares the U.S. system unfavorably with those of Canada, Great Britain, and France. Economist and *New York Times* columnist Paul Krugman also thinks the health care systems of France, Britain, and Canada are better than that of the United States.[2] Physicians for a National Health Program points out that the United States is the "only industrialized country without national health care."[3] These and other critics of the U.S. health care system note that countries with such systems spend far less per capita on health care than the United States does and, by some measures, seem to have better health outcomes.

These critics contend that by adopting a similar system the United States could solve many of the problems that currently afflict its health care system. As Krugman says, "The obvious way to make the U.S. health care system more efficient is to make it more like the systems of other advanced countries."[4]

There is no doubt that the United States spends far more on health care than any other country, whether measured as a percentage of gross domestic product (GDP) or by expenditure per capita. As Figure 1 shows, the United States now spends close to 16 percent of GDP on health care, nearly 6.1 percent more than the average for other industrialized countries.[5] Overall health care costs are rising faster than GDP growth and now total more than $1.8 trillion, more than Americans spend on housing, food, national defense, or automobiles.[6]

Health care spending is not necessarily bad. To a large degree, America spends money on health care because it is a wealthy nation and chooses to do so. Economists consider health care a "normal good," meaning that spending is positively correlated with income. As incomes rise, people want more of that good. Because we are a wealthy nation, we can and do demand more health care.[7]

Figure 1
Total Expenditure on Health Care as a Percentage of GDP



Source: Organisation for Economic Co-operation and Development, "OECD Health Data 2007: Statistics and Indicators for 30 Countries," (Paris: OECD, July 2007); 2004 data.

But because of the way health care costs are distributed, they have become an increasing burden on consumers and businesses alike. On average, health insurance now costs $4,479 for an individual and $12,106 for a family per year. Health insurance premiums rose by a little more than 6 percent in 2007, faster on average than wages.[8]

Moreover, government health care programs, particularly Medicare and Medicaid, are piling up enormous burdens of debt for future generations. Medicare's unfunded liabilities now top $50 trillion. Unchecked, Medicaid spending will increase fourfold as a percentage of federal outlays over the next century.[10]

At the same time, too many Americans remain uninsured. Although the number of uninsured Americans is often exaggerated by critics of the system, approximately 47 million Americans are without health insurance at any given time.[11] Many are already eligible for government programs; many are young and healthy; many are uninsured for only a short time.[12] Yet there is no denying that a lack of insurance can pose a hardship for many Americans.[13]

Finally, although the U.S. health care system can provide the world's highest quality of care, that quality is often uneven. The Institute of Medicine estimates that some 44,000–90,000 annual deaths are due to medical errors,[14] while a study in *The New England Journal of Medicine* suggests that only a little more than half of American hospital patients receive the clinical standard of care.[15] Similarly, a RAND Corporation study found serious gaps in the quality of care received by American children.[16]

Many critics of U.S. health care suggest that the answers to these problems lie in a single-payer,

national health care system.[17] Under such a system, health care would be financed through taxes rather than consumer payments or private insurance. Direct charges to patients would be prohibited or severely restricted. Private insurance, if allowed at all, would be limited to a few supplemental services not covered by the government plan. The government would control costs by setting an overall national health care budget and reimbursement levels.

However, a closer look at countries with national health care systems shows that those countries have serious problems of their own, including rising costs, rationing of care, lack of access to modern medical technology, and poor health outcomes. Countries whose national health systems avoid the worst of these problems are successful precisely because they incorporate market mechanisms and reject centralized government control. In other words, socialized medicine works—as long as it isn't socialized medicine.

Measuring the Quality of Health Care across Countries

Numerous studies have attempted to compare the quality of health care systems. In most of these surveys, the United States fares poorly, finishing well behind other industrialized countries. This has led critics of the U.S. health care system to suggest that Americans pay more for health care but receive less.

There are several reasons to be skeptical of these rankings. First, many choose areas of comparison based on the results they wish to achieve, or according to the values of the com-parer. For example, *SiCKO* cites a 2000 World Health Organization study that ranks the U.S. health care system 37th in the world, "slightly better than Slovenia."[18] (See Table 1.)

This study bases its conclusions on such highly subjective measures as "fairness" and criteria that are not strictly related to a country's health care system, such as "tobacco control." For example, the WHO report penalizes the United States for not having a sufficiently progressive tax system, not providing all citizens with health insurance, and having a general paucity of social welfare programs. Indeed, much of the poor performance of the United States is due to its ranking of 54th in the category of fairness. The United States is actually penalized for adopting Health Savings Accounts and because, according to the WHO, patients pay too much out of pocket.[19] Such judgments clearly reflect a particular political point of view, rather than a neutral measure of health care quality. Notably, the WHO report ranks the United States number one in the world in responsiveness to patients' needs in choice of provider, dignity, autonomy, timely care, and confidentiality.[20]

Table 1
WHO Health Care Rankings

Country	Rank	Country	Rank
France	1	Switzerland	20
Italy	2	Belgium	21
San Marino	3	Colombia	22
Andorra	4	Sweden	23

Malta	5	Cyprus	24
Singapore	6	Germany	25
Spain	7	Saudi Arabia	26
Oman	8	United Arab Emirates	27
Austria	9	Israel	28
Japan	10	Morocco	29
Norway	11	Canada	30
Portugal	12	Finland	31
Monaco	13	Australia	32
Greece	14	Chile	33
Iceland	15	Denmark	34
Luxemburg	16	Dominica	35
Netherlands	17	Costa Rica	36
United Kingdom	18	United States	37
Ireland	19	Slovenia	38

Source: World Health Organization, "The World Health Report 2000" (Geneva: WHO, 2000).

Difficulties even arise when using more neutral categories of comparison. Nearly all cross-country rankings use life expectancy as one measure. In reality though, life expectancy is a poor measure of a health care system. Life expectancies are affected by exogenous factors such as violent crime, poverty, obesity, tobacco and drug use, and other issues unrelated to health care. As the Organisation for Economic Co-operation and Development explains, "It is difficult to estimate the relative contribution of the numerous nonmedical and medical factors that might affect variations in life expectancy across countries and over time."[21] Consider the nearly three-year disparity in life expectancy between Utah (78.7 years) and Nevada (75.9 years), despite the fact that the two states have essentially the same health care systems.[22] In fact, a study by Robert Ohsfeldt and John Schneider for the American Enterprise Institute found that those exogenous factors are so distorting that if you correct for homicides and accidents, the United States rises to the top of the list for life expectancy.[23]

Similarly, infant mortality, a common measure in cross-country comparisons, is highly problematic. In the United States, very low birth-weight infants have a much greater chance of being brought to term with the latest medical technologies. Some of those low birth-weight babies die soon after birth, which boosts our infant mortality rate, but in many other Western countries, those high-risk, low birth-weight infants are not included when infant mortality is calculated.[24] In addition, many countries use abortion to eliminate problem pregnancies. For example, Michael Moore cites low infant mortality rates in Cuba, yet that country has one of the world's highest abortion rates, meaning that many babies with health problems that could lead to early deaths are never brought to term.[25]

When you compare the outcomes for specific diseases, the United States clearly outperforms the rest

of the world. Whether the disease is cancer, pneumonia, heart disease, or AIDS, the chances of a patient surviving are far higher in the United States than in other countries. For example, according to a study published in the British medical journal *The Lancet*, the United States is at the top of the charts when it comes to surviving cancer. Among men, roughly 62.9 percent of those diagnosed with cancer survive for at least five years. The news is even better for women: the five year-survival rate is 66.3 percent, or two-thirds. The countries with the next best results are Iceland for men (61.8 percent) and Sweden for women (60.3 percent). Most countries with national health care fare far worse. For example, in Italy, 59.7 percent of men and 49.8 percent of women survive five years. In Spain, just 59 percent of men and 49.5 percent of women do. And in Great Britain, a dismal 44.8 percent of men and only a slightly better 52.7 percent of women live for five years after diagnosis.[26]

Notably, when former Italian prime minister Silvio Berlusconi needed heart surgery last year, he didn't go to a French, Canadian, Cuban, or even Italian hospital—he went to the Cleveland Clinic in Ohio.[27] Likewise, Canadian MP Belinda Stronach had surgery for her breast cancer at a California hospital.[28] Berlusconi and Stronach were following in the footsteps of tens of thousands of patients from around the world who come to the United States for treatment every year.[29] One U.S. hospital alone, the Mayo Clinic, treats roughly 7,200 foreigners every year. Johns Hopkins University Medical Center treats more than 6,000, and the Cleveland Clinic more than 5,000. One out of every three Canadian physicians sends a patient to the Unites States for treatment each year,[30] and those patients along with the Canadian government spend more than $1 billion annually on health care in this country.[31]

Moreover, the United States drives much of the innovation and research on health care worldwide. Eighteen of the last 25 winners of the Nobel Prize in Medicine are either U.S. citizens or individuals working here.[32] U.S. companies have developed half of all new major medicines introduced worldwide over the past 20 years.[33] In fact, Americans played a key role in 80 percent of the most important medical advances of the past 30 years.[34] As shown in Figure 2, advanced medical technology is far more available in the United States than in nearly any other country.[35]

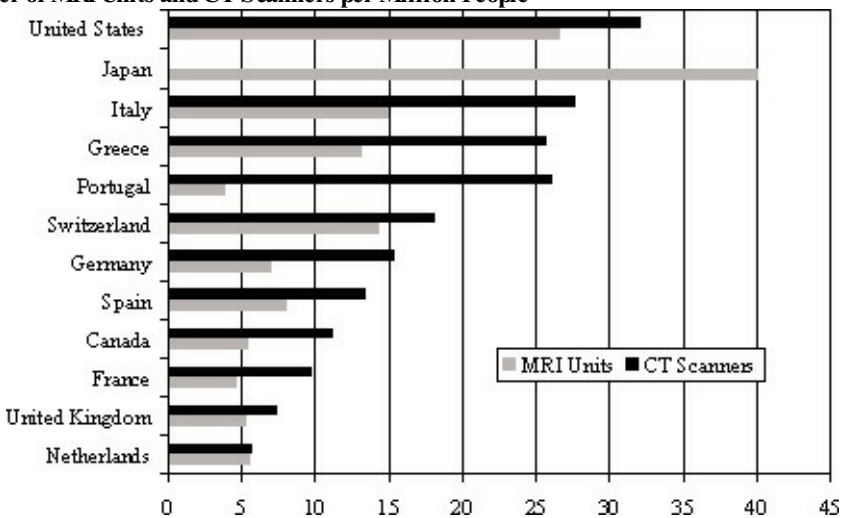
The same is true for prescription drugs. For example, 44 percent of Americans who could benefit from statins, lipid-lowering medication that reduces cholesterol and protects against heart disease, take the drug. That number seems low until compared with the 26 percent of Germans, 23 percent of Britons, and 17 percent of Italians who could both benefit from the drug and receive it.[36] Similarly, 60 percent of Americans taking anti-psychotic medication for the treatment of schizophrenia or other mental illnesses are taking the most recent generation of drugs, which have fewer side effects. But just 20 percent of Spanish patients and 10 percent of Germans receive the most recent drugs.[37]

Of course, it is a matter of hot debate whether other countries have too little medical technology or the Unites States has too much.[38] Some countries, such as Japan, have similar access to technology. Regardless, there is no dispute that more health care technology is invented and produced in the United States than anywhere else.[39] Even when the original research is done in other countries, the work necessary to convert the idea into viable commercial products is most often done in the United States.[40]

By the same token, not only do thousands of foreign-born doctors come to the United States to practice medicine, but foreign pharmaceutical companies fleeing taxes, regulation, and price controls are increasingly relocating to the United States.[41] In many ways, the rest of the world piggybacks on the

U.S. system.

Figure 2
Number of MRI Units and CT Scanners per Million People



Source: Organisation for Co-operation and Development, "OECD Health Data, 2007 Statistics and Indicates for 30 Countries" (Paris: OECD, July 2007).
Note: U.S. Data from2003.

Obviously there are problems with the U.S. system. Too many Americans lack health insurance and/or are unable to afford the best care. More must be done to lower health care costs and increase access to care. Both patients and providers need better and more useful information. The system is riddled with waste, and quality of care is uneven. Government health care programs like Medicare and Medicaid threaten future generations with an enormous burden of debt and taxes.

Health care reform should be guided by the Hippocratic Oath: First, do no harm. Therefore, before going down the road to national health care, we should look more closely at foreign health care systems and examine both their advantages and their problems.

Many of the countries with health systems ranked in the top 20 by the World Health Organization, such as San Marino, Malta, and Andorra, are too small to permit proper evaluation, or their circumstances clearly limit the applicability to the U.S. health care system. Accordingly, this study will look at 12 countries that appear to hold lessons for U.S. health care reforms: 10 ranked in the top 20 by the WHO and 2 others frequently cited as potential models for U.S. health care reform.

Types of National Health Care Systems

National health care, or universal health care, is a broad concept and has been implemented in many

different ways. There is no single model that the rest of the world follows. Each country's system is the product of its unique conditions, history, politics, and national character, and many are undergoing significant reform.

Single-Payer Systems

Under a single-payer health care system, the government pays for the health care of all citizens. It collects taxes, administers the supply of health care, and pays providers directly. In effect, this replaces private insurance with a single government entity. Typically, the government establishes a global budget, deciding how much of the nation's resources should be allocated to health care, and sets prices or reimbursement rates for providers. In some cases, providers may be salaried government employees. In others, they may remain independent and be reimbursed according to the services and procedures they provide. In the strictest single-payer systems, private insurance and other ways to "opt out" of the system are prohibited. This is the type of system advocated by Michael Moore, Paul Krugman, Dennis Kucinich, and Physicians for a National Health Program, among others.

Employment-Based Systems

Countries with employment-based systems require that employers provide workers with health insurance, often through quasi-private "sickness funds." These insurance funds may operate within or across industry sectors, with benefits and premiums set by the government.

Often premiums are simply a form of payroll tax paid directly to the fund. Providers remain independent and reimbursement rates are negotiated with the funds, sometimes individually, sometimes on a national level. Germany has long been the model for an employment-based system.

Managed Competition

Managed competition leaves the provision of health care in private hands but within an artificial marketplace run under strict government control and regulation.[42] In most cases, the government mandates that individuals purchase insurance, though this is often paired with a requirement for employers to provide insurance to their workers. Individuals have a choice of insurers within the regulated marketplace and a choice of providers. Although the government sets a standard benefits package, insurers may compete on price, cost sharing, and additional benefits. Switzerland is the clearest example of a managed-competition approach to universal coverage, although the Netherlands has also recently adopted a similar system. The 1993 Clinton health plan, the 2006 Massachusetts health care reform, and most of the proposals advocated by the current Democratic presidential candidates are variations of managed competition.[43]

Within these broad categories are significant differences. Some countries, such as France and Japan, impose significant cost sharing on consumers in an effort to discourage overutilization and to control costs. Other countries strictly limit the amount that consumers must pay out of pocket. Some countries permit free choice of providers, while others limit it. In some countries there is widespread purchase of alternative or supplemental private insurance, whereas in others, private insurance is prohibited or used very little. Resource allocation and prioritization vary greatly. Japan spends heavily on technology but limits reimbursement for surgery, while France has exceptionally high levels of prescription drug use.

Outcomes also vary significantly. Canada, Great Britain, Norway, and Spain all heavily ration health care or have long waiting lists for care, while France and Switzerland have generally avoided waiting lists. At the same time, France, Italy, and Germany are struggling with rising health care costs and budget

strain, compared with Canada and Great Britain which have done better at containing growth in expenditures. And some countries such as Greece have fallen far short of claims of universal coverage.

With all of that in mind, consider the following prominent national health care systems.

France

Some of the most thoughtful proponents of national health care look to France as a model of how such a program could work. Jonathan Cohn of the *New Republic* has written that "the best showcase for what universal health care can achieve may be France."[44] Ezra Klein of the *American Prospect* calls France "the closest thing to a model structure out there."[45] The French system ranks at or near the top of most cross-country comparisons and is ranked number one by the WHO.[46]

Although the French system is facing looming budgetary pressures, it does provide at least some level of universal coverage and manages to avoid many of the problems that afflict other national health care systems. However, it does so in large part by adopting market-oriented approaches, including consumer cost sharing. Other aspects of the system appear to reflect French customs and political attitudes in such a way that would make it difficult to import the system to the United States.

France provides a basic level of universal health insurance through a series of mandatory, largely occupation-based, health insurance funds. These funds are ostensibly private entities but are heavily regulated and supervised by the French government. Premiums (funded primarily through payroll taxes), benefits, and provider reimbursement rates are all set by the government. In these ways the funds are similar to public utilities in the United States.

The largest fund, the General National Health Insurance Scheme, covers most nonagricultural workers and their dependents, about 83 percent of French residents. Separate insurance plans cover agricultural workers, the self-employed, and certain special occupations like miners, transportation workers, artists, clergy, and notaries public. Another fund covers the unemployed. These larger insurance schemes are broken down into smaller pools based on geographic region. Overall, about 99 percent of French citizens are covered by national health insurance.

The French health care system is the world's third most expensive, costing roughly 11 percent of GDP, behind only the United States (17 percent) and Switzerland (11.5 percent). Payroll taxes provide the largest source of funding. Employers must pay 12.8 percent of wages for every employee, while employees contribute an additional 0.75 percent of wages, for a total payroll tax of 13.55 percent. In addition, there is a 5.25 general social contribution tax on income (reduced to 3.95 percent on pension income and unemployment benefits). Thus, most French workers are effectively paying 18.8 percent of their income for health insurance. Finally, dedicated taxes are assessed on tobacco, alcohol, and pharmaceutical company revenues.[47]

In theory, the system should be supported by these dedicated revenues. In reality, they have not been sufficient to keep the program's finances balanced. The National Health Authority sets a global budget for national health care spending, but actual spending has consistently exceeded those targets.[48]

In 2006, the health care system ran a €10.3 billion deficit. This actually shows improvement over 2005, when the system ran an €11.6 billion deficit.[49] The health care system is the largest single factor driving France's overall budget deficit, which has grown to €49.6 billion, or 2.5 percent of GDP,

threatening France's ability to meet the Maastricht criteria for participation in the Eurozone.[50] This may be just the tip of the iceberg. Some government projections suggest the deficit in the health care system alone could top €29 billion by 2010 and €66 billion by 2020.[51]

In general, the funds provide coverage for inpatient and outpatient care, physician and specialist services, diagnostic testing, prescription drugs, and home care services. In most cases, the services covered are explicitly specified in regulation. However, some "implicit" benefit guarantees occasionally result in conflicts over what benefits are and are not fully covered.[52]

Most services require substantial copay-ments, ranging from 10 to 40 percent of the cost. As a result, French consumers pay for roughly 13 percent of health care out of pocket, roughly the same percentage as U.S. consumers.[53] Moreover, because many health care services are not covered, and because many of the best providers refuse to accept the fee schedules imposed by the insurance funds, more than 92 percent of French residents purchase complementary private insurance.[54] In fact, private insurance now makes up roughly 12.7 percent of all health care spending in France, a percentage exceeded only by the Netherlands (15.2 percent) and the United States (35 percent) among industrialized countries.[55]

The combination of out-of-pocket and insurance payments means that nongovern-ment sources account for roughly 20 percent of all health care spending, less than half the amount spent in the United States but still more than most countries with national health care systems.[56]

The private insurance market in France is in many ways less regulated than the U.S. market. For example, while 20 U.S. states require some form of community rating or put limits on health insurance premiums, private health insurance in France is largely experience rated. No regulations specify what benefits must be included in coverage or mandate "guaranteed issue"; and pre-existing conditions may be excluded. The only significant restriction requires "guaranteed renewability" after two years of coverage.[57] More than 118 carriers currently offer some form of private health insurance coverage.[58]

In general, French patients pay up front for treatment and are then reimbursed by their government health insurance fund and/or private insurance. The amount of reimbursement, minus the copayment, is based on a fee schedule negotiated between health care providers and the national health insurance funds. These fee schedules operate similarly to the diagnostic-related groups (DRGs) under the U.S. system.

Although reimbursement levels are set by the government, the amount physicians charge is not. The French system permits providers to charge more than the reimbursement schedule, and approximately one-third of French physicians do so.[59] In some areas, such as Paris, the percentage of physicians who bill above reimbursement schedules runs as high as 80 percent.[60] In general, however, competition prevents most physicians from billing too far outside negotiated rates; and physicians employed by hospitals, as opposed to those in private practice, do not have the same ability to charge more than the negotiated rate.

The government also sets reimbursement rates for both public and private hospitals, which are generally not allowed to bill beyond the negotiated fee schedules. While fees are restricted, private hospitals (called *cliniques*), which account for 37 percent of all short-stay hospital beds and half of all surgical beds, control their own budgets, whereas public hospitals operate under global annual budgets imposed by the Ministry of Health.

Health care technology that the National Health Authority has categorized as "insufficient medical service rendered" cannot be purchased by public hospitals, and its use at *cliniques* is not reimbursable

through national insurance schemes.[61] Yet in denying reimbursement for such technology, the French government admits that when a product with an insufficient medical service rendered is de-listed from reimbursement, this does not imply that it is not efficient for a given pathology, but simply that the government prefers to commit its resources to other reimbursements which it deems more useful from a collective point of view."[62]

In general, the quality of French health care is high, but there are problem areas. Until very recently, the French have generally had quick access to their primary care physician of choice. Now, a growing problem, *nomadisme medical*, wherein patients go from one doctor to another until they find one whose diagnosis they prefer, is driving up costs to the system.[63] The government has responded by increasing copayments and attempting to limit physician reimbursements.

Much of the burden for cost containment in the French system appears to have fallen on physicians. The average French doctor earns just €40,000 per year ($55,000), compared to $146,000 for primary care physicians and $271,000 for specialists in the United States. This is not necessarily bad (there is no "right" income for physicians) and is partially offset by two benefits: 1) tuition at French medical schools is paid by the government, meaning French doctors do not graduate with the debt burden carried by U.S. physicians, and 2) the French legal system is tort-averse, significantly reducing the cost of malpractice insurance.[64] The French government also attempts to limit the total number of practicing physicians, imposing stringent limits on the number of students admitted to the second year of medical school.[65]

However, French physicians have shown growing resistance to efforts at limiting physician reimbursement with several recent strikes and protests.[66] In the face of growing budgetary problems, future conflict may well be brewing.

More significantly, the government has recently begun imposing restrictions on access to physicians. A 2004 study by the High Council on the Future of Health Insurance raised questions about "the legitimacy of the complete freedom enjoyed by health professionals in setting up their private practice."[67] And in 2005, the government adopted a system of "coordinated care pathways." Under the new system, which operates very much like managed care in the United States, patients are encouraged to choose a "preferred doctor" and to follow the "pathway" suggested by that doctor. The effect is both to lock patients into a choice of primary care physician and to establish a "gatekeeper" who limits access to specialists, tests, and some advanced treatment options.[68]

So far, the new system has been more of a gentle push than a mandate. If the new system is not used, copayments may be slightly higher or reimbursements slightly lower, much like going "out of network" in the United States. But if costs continue to rise, the new system may be extended and made more rigorous.

Of more immediate concern, global budgets and fee restrictions for hospitals have led to a recurring lack of capital investment, resulting in a shortage of medical technology and lack of access to the most advanced care. For example, the United States has eight times as many MRI units per million people and four times as many CT scanners as France.[69] This partially reflects the more technology-reliant way of practicing medicine in the United States, but it has also meant delays in treatment for some French patients. Also, strong disparities are evident in the geographic distribution of health care resources, making access to care easier in some regions than others.[70] Thus, while the French system has generally

avoided the waiting lists associated with other national health care systems, limited queues do exist for some specialized treatments and technologies. In some cases, hospitals in danger of exceeding their budgets have pushed patients to other facilities to save money.[71]

Finally, the government has tried to curtail the use of prescription drugs. The French have long had an extremely high level of drug consumption. French general practitioners (GPs) prescribe on average €260,000 worth of drugs a year.[72] However, the National Health Authority has begun de-listing drugs from its reimbursement formulary.[73] Many French patients have responded by switching to similar, reimbursable drugs, but some patients may not be getting the medicine they need. For example, one study found that nearly 90 percent of French asthma patients are not receiving drugs that might improve their condition.[74]

Government regulation and bureaucracy have also been blamed for rigidity in the French system, preventing it from reacting quickly to changing circumstances. For example, mismanagement and the inability of the system to cope with emergencies were blamed in part for the deaths of 15,000 elderly individuals in the summer of 2003 during the European heat wave; and a shortage of hospital beds occurred in 2004 when a nationwide flu and bronchitis epidemic broke out.[75]

Although the changes made so far do not amount to rationing, 62 percent of French citizens report that they "have felt the effects" of the new restrictions.[76] Slightly less than half consider the waiting time between diagnosis and treatment to be acceptable.[77]

Valentin Petkantchin, a scholar with the Institut Economique Molinari, warns that France is in danger "of joining the group of countries [such as] the UK and Canada, where the existence of rationing of health care and waiting lists raises serious questions of access to treatments by those who need them."[78] And some French health professionals have suggested that waiting times for care have begun to lengthen.[79]

The impact of all these cost containment measures is alleviated to some degree by the ability of French patients to privately contract for care outside the public system. If a drug is removed from the national formulary, patients may still purchase it if they are willing to pay for it themselves. The same is true for technology. Likewise, patients may ignore the "coordinated care pathway" and accept higher prices, paying more for immediate access.

In addition, the added resources from payments by private insurance have increased the supply of health care technology and services. By increasing the overall amount of capital available for investment above and beyond the restrictions imposed by the government system, private insurance payments increase the number of hospital beds and the amount of technology available within the system. The capital infused through private insurance may also increase the number and training of physicians.[80]

In essence, the French system avoids widespread rationing because, unlike true single-payer systems, it employs market forces. Even the OECD says that the "proportion of the population with private health insurance" and the degree of cost sharing are key determinants of how severe waiting lists will be:

> Waiting lists for elective surgery generally tend to be found in countries which combine public health insurance (with zero or low patient cost sharing) and constraints on surgical capacity. Public health insurance removes from patients the financial barriers to access leading to high potential demand. Constraints on capacity . . . prevent supply from matching this demand. Under such circumstances, non-price rationing, in the form of waiting lists, takes over from price rationing as a means of equilibrating supply and demand.[81]

And Ezra Klein praises the French because

> [France's ability to hold down health care costs] is abetted by the French system's innovative response to one of the trickier problems bedeviling health-policy experts: an economic concept called "moral hazard." Moral hazard describes people's tendency to overuse goods or services that offer more marginal benefit without a proportionate marginal cost. Translated into English, you eat more at a buffet because the refills are free, and you use more health care because insurers generally make you pay up front in premiums, rather than at the point of care. The obvious solution is to shift more of the cost away from premiums and into co-pays or deductibles, thus increasing the sensitivity of consumers to the real cost of each unit of care they purchase.[82]

However, the benefits of private insurance are not equally distributed. The wealthy are more likely to be able to pay privately to escape the government system, creating in essence a two-tier system. That has resulted in a disparity in health outcomes based on income.[84] While this is certainly the case in the United States and elsewhere—and there is nothing wrong with the wealthy being able to pay more to receive better care—it demonstrates that the professed goal of entirely equal access is largely unattainable even under this government-run health system.

A 2004 poll showed that the French had the highest level of satisfaction with their health care system among all European countries. This is partly because their hybrid system has avoided many of the biggest problems of other national health care systems. Yet it also stems from French social character. For example, by a three-to-one margin, the French believe the quality of care they receive is less important than everyone having equal access to that care.[85] This means the French experience may not be easily transferable to the United States, which has a far less egalitarian ethic.

While satisfied with their care today, the French do express concern about the future. In particular, they acknowledge the need for greater cost control. This leads to the standard contradiction inherent in government services: most people are opposed to paying more (either through higher taxes or out of pocket), yet they worry that cost-control measures will lead to a deterioration of care in the future. There is no consensus on what French health care reform would look like. Still, some 65 percent of French adults believe that reform is "urgent," and another 20 percent believe reform is "desirable."[86]

Moreover there is growing dissatisfaction with the French welfare state—of which the health care system is a significant part—and the level of taxes necessary to support it. The recent election of French president Nicolas Sarkozy is widely regarded as a reflection of this new attitude.[87] Indeed, the new French government has made a crackdown on health care spending one of its top priorities..[88]

To sum up: the French health care system clearly works better than most national health care systems. Despite some problems, France has generally avoided the rationing inherent in other systems. However, the program is threatened by increasing costs and may be forced to resort to rationing in the future.

The French system works in part because it has incorporated many of the characteristics that Michael Moore and other supporters of national health care dislike most about the U.S. system. France imposes substantial cost sharing on patients in order to discourage over-utilization, relies heavily on a relatively unregulated private insurance market to fill gaps in coverage, and allows consumers to pay extra for better or additional care, creating a two-tier system.

This is clearly not the commonly portrayed style of national health care.

Italy

Italy's national health care system is rated second in the world by the WHO.[89] Yet a closer examination shows the system to be deeply troubled, plagued with crippling bureaucracy, mismanagement and general disorganization, spiraling costs, and long waiting lists.

Generally, the Italian system is similar to the British National Health Service but enjoys more decentralization. The central government sets goals on how money should be spent, monitors the overall health status of the nation, and negotiates the labor contracts of medical staff. The Italian Constitution was changed in 2001 such that the national government now sets the "essential levels of care" regions must meet, but regional governments still control their own autonomous budgets and distribute resources to the local level.

In theory, under the "fiscal federalist" provisions of this reform, discretionary central transfers should have dropped sharply, local tax bases and tax sharing should have increased, and "equalizing" transfers should have been standardized and linked to objectives for controlling costs and increasing quality. However, poorer regions and powerful special interests have strongly resisted these changes. Reform therefore remains incomplete, and financial transfers from the central government are still based on historical spending patterns.[90]

Thus, while the national Ministry of Health continues to outline funding needs based on weighted capitation and past spending, recent reforms have shifted more and more power and responsibility to regional governments who set their own budgets. The regions establish one or more Local Health Authorities, which are responsible for the provision of care either through government-run hospitals and clinics or by contracting with private providers.[91] It should be noted that governance in Italy is often as much art as science, and regions frequently fail to implement rules, guidelines, reimbursement schedules, and budgets set by the central government.[92]

Financing comes from both payroll taxes and general revenues. Payroll taxes have a regressive structure, starting at 10.6 percent of the first €20,660 of gross income and decreasing to 4.6 percent of income between €20,661 and €77,480. The remainder of funding comes from both federal and regional general taxation, including income and value-added taxes.[93] The central government redistributes resources to compensate to some degree for inequalities among regions. Even so, most regional health authorities run significant deficits. Overall, regional deficits top 1.8 percent of GDP.[94]

Inpatient care and primary care are free at the point of treatment. However, copayments are required for diagnostic procedures, specialists, and prescription drugs.[95] The size of such copayments has crept steadily upward over the past decade and now runs as high as 30 percent for some services.[96] Several attempts have been made to impose copayments for a broad range of services, including primary care, but have collapsed in the face of public protests.[97] In addition, nearly 40 percent of the population (the elderly, pregnant women, and children) are exempt from copayments.[98]

Italians have limited choice of physician. They must register with a general practitioner within their LHA. They may choose any GP in the LHA but may not go outside it. Except for emergency care, a referral from a GP is required for diagnostic services, hospitalization, and treatment by a specialist. Despite these limits, Italians enjoy more choice of physician than do the British or Spanish.

Most physicians are reimbursed on a capi-tated basis (i.e., according to the number of patients served

over a given time period rather than the services actually provided), although some hospital physicians receive a monthly salary. Hospitals are generally reimbursed according to DRGs, with rates set by the central government—though regions sometimes disregard those rates and set their own.

Private health insurance is available in Italy but is not widespread. Where offered, it is usually provided by employers. About 10 percent of Italians have private health insurance, below the percentage in most OECD countries. According to the insurance industry, this is partly because it is not possible to opt out of the National Health System and because health insurance premiums are not tax deductible.[99] Private health insurance allows free choice of doctors, including specialists, and treatment in private hospitals. Even without private insurance, however, many Italians use private health resources (and presumably pay out of pocket). Estimates suggest that as much as 35 percent of the population uses at least some private health services.[100]

Although Italy spends a relatively low percentage of GDP on health care, expenditures have been rising rapidly in recent years and have consistently exceeded government forecasts.[101] Between 1995 and 2003, total health care spending rose by 68 percent.[102] The Italian government has taken various steps to try to control costs, such as reducing reimbursement rates, increasing copayments, reducing capital expenditures, contracting with private providers, and limiting prescription drugs. All of these measures have met with protests, including physician strikes, and many have been repealed after only a short time.[103]

The Italian government does not provide official information on waiting lists, but numerous studies have shown them to be widespread and growing, particularly for diagnostic tests. For example, the average wait for a mammogram is 70 days; for endoscopy, 74 days; for a sonogram, 23 days.[104] Undoubtedly, this is due in part to a shortage of modern medical technology. The United States has twice as many MRI units per million people and 25 percent more CT scanners.[105] Ironically, the best-equipped hospitals in northern Italy have even longer waiting lists since they draw patients from the poorer southern regions as well.[106]

If delays become excessive, patients may seek permission from the regional government to obtain treatment from private doctors or hospitals at NHS expense. A recent court decision allows patients whose life would be endangered by delays under the NHS to seek treatment in private hospitals even without prior permission from the regional government.

Italy has imposed a relatively strict drug formulary as well as price controls, and has thereby succeeded in reducing pharmaceutical spending, long considered a problem for the Italian health care system. In 2006, Italian drug prices fell (or were pushed) 5 percent, even as drug prices rose in the United States and much of the rest of the world. However, the savings came at a cost: the introduction of many of the newest and most innovative drugs was blocked.[107]

Conditions in public hospitals are considered substandard, particularly in the south. They lack not just modern technology, but basic goods and services; and overcrowding is widespread. Conditions are frequently unsanitary. For example, one of the largest public hospitals in Rome was recently found to have garbage piled in the hallways, unguarded radioactive materials, abandoned medical records, and staff smoking next to patients.[108] Private hospitals are considered much better and some regions have contracted with private hospitals to treat NHS patients.

Dissatisfaction with the Italian health care system is extremely high, by some measures the highest in

Europe.[109] In polls, Italians say that their health care system is much worse than that of other countries and give it poor marks for meeting their needs. Roughly 60 percent of Italians believe that health care reform is "urgent," and another 24 percent believe it is "desirable." In general, Italians believe that such reform should incorporate market-based solutions. More than two-thirds (69 percent) believe that giving patients more control over health care spending will improve the system's quality. And 55 percent believe that it should be easier for patients to spend their own money on health care.[110]

However, given the general dysfunction of the Italian political system, and the entrenched opposition of special interest groups, substantial reform is not likely anytime soon.

Spain

Spain's national health care system operates on a highly decentralized basis, giving primary responsibility to the country's 17 regions. The Spanish Constitution guarantees all citizens the "right" to health care, including equal access to preventive, curative, and rehabilitative services; but responsibility for implementing the country's universal system is being devolved to regional governments. The degree and speed of devolution is uneven, however, with some regions only recently achieving maximum autonomy.[111]

Coverage under the Spanish system is nearly universal, estimated at 98.7 percent of the population. The system provides primary health care, including general health and pediatric care, outpatient and inpatient surgery, emergency and acute care, long-term disease management, and prescription drugs (although some drugs may require a copayment). Many mental health services, particularly outpatient services, are excluded, as is cosmetic surgery.[112]

The federal government provides each region with a block grant. The money is not earmarked: the region decides how to use it. The block grant itself is based primarily on a region's population with some consideration given to other factors such as the population's demographics. Regions may use their own funds to supplement federal monies.

Not surprisingly, health care spending varies widely from region to region. The differences in expenditures, as well as in spending priorities, lead to considerable variance in the availability of health resources. For example, Catalonia has more than 4.5 hospital beds per 1,000 residents, while Valencia has just 2.8.[113]

Spanish patients cannot choose their physicians, either primary care or specialists. Rather, they are assigned a primary care doctor from a list of physicians in their local community. If more specialized care is needed, the primary care physician refers patients to a network of specialists. Unlike U.S. managed care, it is not possible to go "out of network" unless the patient has private health insurance (see below). This has sparked an interesting phenomenon whereby sick Spaniards move in order to change physicians or find networks with shorter waiting lists.

Waiting lists vary from region to region but are a significant problem everywhere. On average, Spaniards wait 65 days to see a specialist, and in some regions the wait can be much longer. For instance, the wait for a specialist in the Canary Islands is 140 days. Even on the mainland, in Galacia, the wait can be as long as 81 days. For some specialties the problem is far worse, with a national average of 71 days for a gynecologist and 81 days for a neurologist.[114] Waits for specific procedures are also lengthy. The

mean waiting time for a prostectomy is 62 days; for hip replacement surgery, 123 days.[115]

Some health services that U.S. citizens take for granted are almost totally unavailable. For example, rehabilitation, convalescence, and care for those with terminal illness are usually left to the patient's relatives. There are very few public nursing and retirement homes, and few hospices and convalescence homes.[116]

As with most other national health care systems, the waiting lists and quality problems have led to the development of a growing private insurance alternative. About 12 percent of the population currently has private health insurance. (This amounts to double coverage since opting out of the government system is not allowed.[117]) In larger cities such as Madrid and Barcelona, the number of privately insured reaches as high as 25 percent. Overall, private insurance payments account for 21 percent of total health care exenditures.[118] More commonly, Spaniards pay for care outside of the national health care system out of pocket. In fact, nearly 24 percent of health care spending in Spain is out of pocket, more than any European country except Greece and Switzerland, and even more than the United States.[119]

Here again, a two-tier system has developed, with the wealthy able to buy their way around the defects of the national health care system, and the poor consigned to substandard services.[120]

There are also shortages of modern medical technologies. Spain has one-third as many MRI units per million people as the United States, just over one-third as many CT units, and fewer lithotripters.[121] Again, there is wide variation by region. For example, two regions, Ceuta and Melilla, do not have a single MRI unit.[122] The regional variation is important because Spaniards face bureaucratic barriers in trying to go to another region for treatment.

All hospital-based physicians and approximately 75 percent of all other physicians are considered quasi–civil servants and are paid a salary rather than receiving payment based on services provided. Compensation is based on years of practice or the attainment of certain professional credentials, with across-the-board annual increases unrelated to merit, performance, or patient satisfaction.[123]

As a result, Spain has fewer physicians and fewer nurses per capita than most European countries and the United States. The lack of primary care physicians is particularly acute.[124]

Even so, Spaniards are generally happy with their system. Nearly 60 percent describe their system as good, the second highest favor-ability rating in Europe. (France was first.)[125] Accordingly, health care reform does not rank high on the average Spaniard's political agenda. One observer described health care as "conspicuous by its absence as a major issue" in recent elections.[126] Only about 46 percent of Spaniards describe the need for reform as "urgent," while 35 percent see reform as "desirable." And Spaniards are less inclined toward market-based reforms than most other European countries. Only 42 percent of Spaniards believe that it should be easier for patients to spend their own money on health care, and only 58 percent believe that giving patients more control over spending will improve quality. However, Spaniards do want more choice of doctors and hospitals, and they want the government to do a better job of dealing with waiting lists.[127]

Japan

Japan has a universal health insurance system centered primarily around mandatory, employment-

based insurance. On the surface, Japan's national health insurance program defies easy description, comprising some 2,000 private insurers and more than 3,000 government units. However, in a broader sense, the system encompasses four principal insurance schemes.

The Employee Health Insurance Program requires companies with 700 or more employees to provide workers with health insurance from among some 1,800 "society-managed insurance" plans. Nearly 85 percent of these plans cover a single company and can be thought of as similar to the self-insurance plans operated by many large U.S companies. Most of the rest are industry-based. About 26 percent of the population participates in these plans.[128]

Such plans are financed through mandatory employer and employee contributions, effectively a payroll tax. The total contribution averages around 8.5 percent of wages. It is generally split evenly between employer and employee, although some companies assume slightly more than half the contribution. As a result, workers contribute about 45 percent of payments overall.[129] It should be noted that studies have found that the majority of the burden of the employer's contribution to health insurance is borne by the employees in the form of reduced wages.[130]

These contributions are frequently insufficient to operate the insurance plans. In 2003, more than half lost money.[131] A number of companies have responded by dissolving their individual plans and entering larger industry-based plans. However, growing costs continue to pressure many businesses.

Workers in businesses with fewer than 700 workers must enroll in the government-run, small-business national health insurance program. This plan covers about 30 percent of the population and is funded primarily through mandatory contributions, around 8.2 percent of wages, and supplemented by government funds.[132]

The self-employed and retirees are covered under the Citizens Insurance Program administered by municipal governments. Funding comes primarily from a self-employment tax, but additional revenues come from an assessment on the society-managed insurance programs discussed above and the small business program. General revenue contributions from the national government are used to plug shortfalls.

Finally, the elderly are covered through a fund financed by contributions from the other three schemes, as well as contributions from the central government. The elderly do not pay directly into this plan, known as the *Roken*, but contribute to the plan they were enrolled in while employed. The *Roken* is simply a cost-sharing mechanism.[134]

A number of small programs exist to handle special populations such as farmers, fishermen, and government workers. The unemployed remain under their former employers' plan, although they are not required to continue contributing. Private supplemental insurance exists, but very few Japanese carry it. Private health insurance pays for less than 1 percent of total Japanese health care spending.

Benefits under all four schemes are extremely generous, including hospital and physician care, as well as dental care, maternity care, prescription drugs, and even some transportation costs. There are no restrictions on hospital or physician choice and generally no preauthorization or gatekeeper requirements. Significant copayments accompany most services, ranging from 10 percent to, more commonly, 30 percent (capped at $677 per month for a middle-income family). As a result, the average Japanese household pays about $2,300 per year out of pocket.[135] Overall out-of-pocket expenditures amount to roughly 17 percent of total health care spending.

The vast majority of hospitals and clinics in Japan are privately owned, but because the government

sets all fee schedules, the distinction between privately and publicly owned is irrelevant for patients. Reimbursement for both hospitals and clinics is on a fee-for-service basis, with the government setting fees and prescription prices.

The fee schedule is identical for inpatient and outpatient treatment. Because hospitals must absorb both physician and capital costs from the same level of reimbursement, the tendency has been to shift patients to outpatient services.[136] Recently, some attempts have been made to introduce alternate reimbursement mechanisms for hospitals, including DRGs and Diagnosis and Procedure Combinations—classification systems that tie reimbursements more closely to the resources that a particular patient consumes. But the medical establishment has resisted, and only about 80 hospitals participate in the experiment.[137]

Hospital physicians are salaried employees. Nonhospital physicians work in the private sector, and the government sets their reimbursement schedules. Generally, reimbursement is on a fee-for-service basis, although recently some chronic conditions have been "price bundled" into a single fee. Reimbursement schedules are set within the context of an overall global budget on health spending, but the division of resources is the subject of extensive negotiation with providers.

The fee schedule reflects both the Japanese style of medicine and attempts to contain costs. For example, because of a strong cultural bias against invasive procedures, surgery tends to be reimbursed at a much lower rate than nonsurgical procedures.[138]

The fee-setting system has had serious corruption problems. Because the fees for each of more than 3,000 procedures or services are set individually and adjusted every two years on an individual basis, it is possible to manipulate particular fees without attracting much attention.[139] In 2004, a group of dentists was indicted for bribing the fee-setting board.[140]

In addition, the reimbursement schedule for physicians creates an incentive for them to see as many patients as possible. The result is assembly line medicine. Two-thirds of patients spend less than 10 minutes with their doctor; 18 percent spend less than 3 minutes.[141]

On the other hand, the Japanese, like Americans, practice a very technology-intensive style of medicine. Capital investment in technology has been given high priority, and the Japanese have at least as much access to technology such as MRI units, CT scanners, and lithotripters as patients in the United States.[142] Because the government imposes uniform fee schedules on hospitals, there is no price competition. Instead, hospitals attempt to lure patients by having the best technology. While this can benefit patients, it has also led to queues at the best hospitals and a black market with "under the table" payments for faster access.[143]

Some restrictions have been added in the last few years, capping the number of diagnostic imaging procedures that a hospital can perform in a calendar month, as well as reducing the fees for those services.[144] These changes have not led to visible rationing yet but could in the future.

To date, Japan has done a fairly good job of controlling costs without resorting to the rationing common in many universal care systems. This is due in part to factors outside the health care system, such as generally healthy lifestyles, low vehicle accident rates, low crime rates, low rates of drug abuse, and other cultural factors.[145] One study estimated that 25 percent of the difference in health care spending between the United States and Japan is attributable to a lower incidence of disease and 15 percent to less aggressive practice styles.[146] But rationing has also been avoided through the management

of the health care system and the imposition of significant consumer cost sharing.

Nonetheless, spending is beginning to escalate, especially in government-managed programs such as the *Roken*, where there has been less of an attempt at cost sharing and cost containment. As one observer explained:

> We Japanese have a tendency to go to the hospital even when we have only minor ailments such as the flu, headaches, or stomach aches. If medical expenses are not high and we do not feel well, then why not go see a doctor and get some medication. . . . The result, of course, is that waiting rooms of clinics and hospitals are full of people. Everyone is welcome and there are, in fact, regular customers. Sometimes elderly people come to see a friend and the hospital waiting room becomes a sort of salon.[147]

This problem is aggravated by the demographics of a rapidly aging society. By some estimates, the elderly are responsible for 90 percent of the aggregate increase in Japan's health care costs.[148] If current trends continue, Japan will almost triple its government spending on health care in the next 20 years.[149] And the situation will only grow less stable with time.

Japan is expected to lose 35 million workers by 2050, with 35 percent of its population in retirement.[150] This raises questions of how a system that relies on payroll taxes for funding can continue to fund rising costs even as its payroll base shrinks.

Norway

Norway has a universal, tax-funded, single-payer, national health system. All Norwegian citizens, as well as anyone living or working in Norway, are covered under the National Insurance Scheme. Norwegians can, however, opt out of the government system by paying out of pocket. In addition, many Norwegians go abroad for treatment to avoid the waiting lists endemic under the government program.[151]

The system is financed through general tax revenues, with no earmarked or dedicated tax for health care.[152] Thus, health care becomes one large contributor to a tax burden that consumes 45 percent of GDP. Among industrialized countries, only Sweden has a higher tax burden.[154]

Benefits are extensive and include inpatient and outpatient care, diagnostic services, specialist care, maternity services, preventive medicine, palliative care, and prescription drugs. At public hospitals, there are no charges for stays or treatment, including drugs. However, small copayments may be charged for outpatient treatment and for treatment by a general practitioner, psychologist, or psychiatrist. The program also provides "sick pay" and disability benefits.[155] As Michael Moore has noted, the Norwegian system will even pay for "spa treatments" in some cases.[156]

Although the central government retains overall responsibility for and authority over the system, some management and funding responsibilities have devolved to regional and municipal governments. In general, municipal governments are responsible for primary health care, while four regional health authorities are responsible for specialist care.[157] Prior to 2002, public hospitals were run by local or county governments. In the face of chronic problems, notably long waiting lists and rising costs, the central government took direct control of all public hospitals in January 2002.[158] A small number of

private hospitals do exist outside the public system.

The government sets a global budget limiting overall health expenditures, and setting capital investment expenditures for hospitals. Most general practitioners and physician specialists outside hospitals receive a fixed salary, although some specialists working on a contract basis receive both an annual grant and fee-for-service payments. Reimbursement rates are set by the government and balance-billing is prohibited. Most other health care personnel are salaried government employees.[159]

Patient choice of physician is constrained. All Norwegian citizens must choose a general practitioner from a government list. The GP acts as a gatekeeper for other services and providers. Patients may switch GPs, but no more than twice per year and only if there is no waiting list for the requested GP.[160] Specialists may only be seen with a referral from the GP.

The Norwegian health care system has experienced serious problems with long and growing waiting lists.[161] Approximately 280,000 Norwegians are estimated to be waiting for care on any given day (out of a population of just 4.6 million).[162] The average wait for hip replacement surgery is more than four months; for a prostectomy, close to three months; and for a hysterectomy, more than two months.[163] Approximately 23 percent of all patients referred for hospital admission have to wait longer than three months for admission.[164]

The Norwegian government has responded by repeatedly and unsuccessfully attempting to legislate waiting lists out of existence. For example, under the 1990 Patients' Rights Act, patients with a condition that would lead to "catastrophic or very serious consequences" have a right to treatment *within six months*, if the treatment is available.[165] In 2001, after several government reports had documented repeated violations of this policy, the government passed a new mandate requiring that a patient's medical condition be at least "assessed" within 30 days.[166] Despite these paper guarantees, waiting lists have not been substantially reduced.[167]

Moreover, such delays may represent only the tip of the iceberg when it comes to rationing care in Norway. In some cases, care may be denied altogether if it is judged not to be cost-effective. As Knut Erik Tranoy, Professor Emeritus at the Centre for Medical Ethics of the University of Oslo and an original member of the government's Health Care Priorities Commission, explains:

> It is important to see (a) that, in a public health service of the Nordic type, any given amount of resources always has alternative uses. And (b) it is neither medically nor morally defensible to put scarce resources to uses which will fore-seeably yield less favorable outcomes than other uses—save fewer lives, cure fewer patients.[168]

Tranoy differentiates between Norwegian-style systems of national health care and "a health care system where patients buy services in a market, and where justice means equality of opportunity to buy what you need. Decisions about alternative use are then (largely) patients' decisions."[169]

While Norwegians generally report that they are "fairly satisfied" with the way their health care system is run, there has been growing discontent over such issues as the ability to choose a health care provider, involvement in decisions regarding care or treatment, and waiting times—which has been an ongoing issue in Norwegian politics.[170] However, at this time there doesn't appear to be any widespread movement for larger reform.

Portugal

The Portuguese health care system is a classic, universal, centrally run National Health System, a single-payer system funded through taxes with comprehensive benefits provided free or with little cost at the point of service.[171] Also, a number of occupation-related health insurance schemes—originally intended to be integrated into the NHS—now coexist with it.

The primary source of care is the NHS, which is funded primarily through general tax revenues, accounting for approximately 13 percent of all government expenditures.[172] In theory, the NHS operates within an annual global budget for health care spending. In reality, it regularly exceeds this budget by a wide margin, necessitating supplemental funding. Portugal is one of the few OECD countries where public health care spending has been rising as a proportion of total health spending, up more than four percentage points since 1997.[173]

Theoretically, benefits under the NHS include all necessary inpatient and outpatient health care services including specialists, diagnostic tests, mother and child care, and prescription drugs. On paper, no health-related expense is specifically excluded from coverage by the NHS, though in reality services such as dental care and rehabilitation therapy are seldom provided.[174] Copayments are required for diagnostic tests, hospital admissions, consultations with specialists, and prescription drugs, where copayments can run to 40 percent or higher.[175]

Primary care physicians and hospital-based physicians are public employees, paid directly by the NHS. However, NHS doctors are permitted to practice privately as well, and roughly half do so.[176] Specialists are often in private practice and are reimbursed by the NHS on a contractual basis.

About 25 percent of the population, mostly government workers, military, telecommunication workers, and their families, remain under a series of industry or occupation-based insurance schemes, known collectively as "subsystems," which are a legacy of the country's pre-NHS health care system.[177] These plans were originally intended to be incorporated into the NHS, but their powerful constituencies have prevented that from occurring.Participants in the subsystems pay a premium equal to approximately 1 percent of their salary. Benefits are generally superior to those offered through the NHS.[178] Not surprisingly, premiums fall far short of what is needed to finance benefits. The resulting shortfall is shifted to the NHS.

In addition, approximately 10 percent of the population has private insurance, usually through their employer.[179] Private insurance generally pays for hospital and specialty care but not for primary care physicians. Policies are medically underwritten and have no requirement for renewability, meaning insurers can raise premiums or drop customers with extremely high claims.[180]

Choice of provider is heavily constrained under the NHS. Every citizen must choose a primary care physician from a list of those available within a specified geographic area.This area is usually based on the person's area of residence but may be based on the area of employment. The average general practitioner serves as many as 1,500 people, though some may have more than 2,000 patients, leading to long waits and difficulties in getting appointments. People may change GPs only by applying in writing to the NHS and explaining their reasons.[181]

Access to specialists or hospital care, except in emergencies, requires referral from the patient's GP. Since this is often difficult to secure in a timely manner, patients often seek care through hospital

emergency rooms. By some estimates, at least 25 percent of emergency room patients do not need immediate treatment.[182]

Despite guarantees of "universal coverage,"access to care remains a serious problem. Waiting lists are so long and so prevalent that the European Observatory on Health Systems says that they veer toward "de facto rationing."[183] Currently, more than 150,000 Portuguese are on waiting lists for surgery, out of a population of just 10.6 million.[184] However, that may understate the problem in poorer and rural areas, which have fewer health resources and less access to care.[185] Modern health technology is far less available than in the United States. The United States has almost seven times more MRI units per million people, and 20 percent more CT scanners.[186]

To avoid waiting lists, Portuguese patients frequently pay out of pocket to see physicians in private practice. In some cases, Portuguese patients have crossed the border to receive treatment in Spain.[187]

While there appears to be a consensus in Portugal that the system needs some kind of reform, weak governments and strong structural interest groups have combined to prevent the development of any consensus over the direction reform should take.[188] For the moment, Portugal drifts.

Greece

Although ostensibly an employer-based system, the Greek system operates more like a single-payer system in that it is highly centralized and regulated. Virtually every aspect of health care financing and provision is strictly controlled by the Ministry of Social Health and Cohesion.[189] Some attempts have been made to decentralize decisionmaking, with 17 regional organizations having some responsibility for implementing policy and managing the delivery of health care, but most power remains with the central government.

Greek employers must enroll their workers in one of 35 "social insurance funds," funded in part through a payroll tax and in part through general tax revenues. Unlike Germany, where employers have a choice among competing sickness funds, Greek social insurance funds are specific to industry sectors. The range of benefits offered by each fund, the contribution rates, and the types of providers that the insured can access are all determined by the Ministry of Social Health and Cohesion.[190]

Certain funds known as "noble funds," primarily used by government workers, the banking sector, and public utility workers, offer more extensive benefits and require smaller worker contributions. The powerful unions representing workers from these sectors have consistently blocked attempts to merge these funds with other social insurance funds or to allow buy-ins from other industry sectors.[191]

Social insurance funds reimburse doctors in two ways. Some providers are employed directly by the funds at fund-operated clinics and are effectively salaried employees. Others practice privately but contract with funds to provide care. Contract physicians are reimbursed on a fee-for-service basis, but reimbursement rates are extremely low. Balance-billing is prohibited.

In theory, funds provide first-dollar coverage, with no deductibles and low copayments for only a few services. However, as discussed below, most physicians demand "informal"payments in exchange for treatment.

In addition to the social insurance funds, the National Health Service employs physicians and operates

hospitals. The NHS operates parallel to the social insurance funds, acting essentially as a back-up mechanism, although it may be the principal provider of health services in some rural areas. It also provides health care for the uninsured and the elderly.

In addition to NHS hospitals, other public hospitals contract with the social insurance funds. In both cases, the Ministry of Social Health and Cohesion determines not only the hospital's budget, but the number of personnel, the specialties of the personnel, salary levels, number of beds, and the purchase of technology. Budgets are rigidly monitored and hospital administrators have little leeway.[192] Hospitals are reimbursed on a per diem payment system, a type of a fixed charge.[193]

NHS hospitals in particular are considered substandard. Most suffer from severe staffing shortages caused by low pay and poor living conditions in rural areas. It has been estimated that less than half of authorized medical positions are actually filled.[194] Low salaries have also led to personnel shortages in public hospitals associated with social insurance funds.[195]

A series of reforms implemented in 2005 imposed a referral requirement for hospital admissions. Patients seeking free treatment in a public NHS hospital must have a referral from a general practitioner, who acts as a gatekeeper. Private practice physicians may not make referrals to public or NHS hospitals.[196] Unfortunately, general practitioners are in severely short supply. Greece needs an estimated 5,000 general practitioners to meet demand. In actuality it has only around 600.[197]

Despite overlapping health plans, the Greek system falls short of universal coverage. About 83 percent of the population is covered for primary care (on par with the United States), and about 97 percent for hospital care.[198] In theory, the uninsured can always receive treatment by walking into an NHS clinic or hospital. Only about 8 percent of Greeks have private supplemental health insurance, although this percentage has risen substantially in the past few years and further growth is predicted.[199]

Accurate information on waiting lists is difficult to come by. According to the WHO, "although 'patient registries' at the hospital level do exist, there is no systematic data processing available at any level of care," to provide adequate analysis.[200] However, most observers agree that waiting lists are a severe problem at almost every level of care, and particularly bad at both NHS and public hospitals. An examination of waiting lists at Athens hospitals by the *Ta Nea* newspaper found the wait for surgery was as long as six months; for an outpatient appointment with either the hypertension or neurology departments, 150 days. Even simple blood tests required a month-long wait.[201]

The Greek system has developed a level of endemic corruption as patients have sought ways around the system's rationing, bureaucracy, and inefficiencies. For example, Greeks routinely provide physicians with "informal" payments for seeing a patient from a sickness fund that has not contracted with the doctor, for moving a patient up in the queue, or for providing treatment outside government guidelines. In addition, physicians actively attempt to persuade patients to move from a doctor's sickness fund contract to the doctor's private practice. Patients who switch pay out of pocket but receive faster and better care. Even NHS physicians see private patients on the side. (This practice was illegal until 2002 but went on despite the prohibition).[202] Physicians also receive payments for referrals to private hospitals or diagnostic centers. Such informal outof-pocket payments made up 42 percent of total health expenditures in 2002, fully 4.5 percent of GDP.[203] Essentially, the Greek health care system is funded through payroll taxes, general tax revenue, and bribery.

In addition, the health care bureaucracy has become highly politicized. Every staff appointment in the

public health sector must be approved at the ministry level. All hospital administrators and other health officials are appointed on the basis of political affiliation with the governing party, often with little regard for relevant training or other qualifications.[204]

Not surprisingly, Greece has far less modern health care technology than the United States. The United States has more than twice as many MRI units per million people and 20 percent more CT scanners.[205] Much of the state-of-the-art equipment that does exist is clustered in the country's small number of private clinics and hospitals. Indeed, the vast majority of high technology biomedical tests are performed by the private sector.[206]

One study summed up the problems with the Greek health care system this way:

> The Greek health system does not yet offer universal coverage and has fragmented funding and delivery. Funding is regressive, with a reliance on informal payments, and there are inequities in access, supply and quality of services. Inefficiencies arise from an over reliance on relatively expensive inputs, as evidenced by the oversupply of specialists and undersupply of nurses. Resource allocation mechanisms are historical and political with no relation to performance or output; therefore providers have little incentive to improve productivity.[207]

That would appear to be a fairly accurate summary.

Netherlands

Aside from Switzerland, the Netherlands has perhaps the most market-oriented national health care system in Europe. That was the case even before 2006, when a series of reforms introduced even more market mechanisms.

The old pre-2006 Dutch system resembled Germany's. Dutch workers with incomes below €32,600 were required to enroll in one of 30 government-controlled "sickness funds."

Those with higher incomes had the option of enrolling in the funds if they wished, or opting out of the government system and purchasing private insurance. Sickness funds were financed through a payroll tax and a flat-rate, per-capita premium.[208]

The funds provided a uniform package of benefits including physician and hospital care, specialist care, diagnostic tests, prescription drugs, and dental care for children.[209] While consumers could switch funds annually, there was little competition between funds and few consumers actually switched.

The new Dutch system operates on the theory of managed competition like Switzerland (see below). Both the social health insurance program and the alternative private health insurance option were replaced by a requirement that all Dutch citizens purchase a basic health insurance plan from one of 41 private insurance companies. Although a fine may be imposed for failure to comply, there is no comprehensive system for identifying citizens who do not meet the mandate. An estimated 1.5 to 2 percent of the population is currently uninsured.[210]

The required plan, which covers minimum benefits set by the government, includes general practitioner and specialist care, hospital stays, some dental care, prenatal care, some medicines, and travel expenses. In one interesting innovation, most of the required benefits are specified in terms of "functions of care"

rather than by provider category. Thus, "rehabilitation care" is required, but no particular type of rehabilitation provider is mandated.[211] This may mean that the benefits package will be less susceptible to manipulation by provider interest groups, but it is much too early to tell.

The Health Ministry sets premiums, which average around €100 per month for an individual. Insurance companies can offer varying deductibles, ranging from €150 to €1,000 per year, allowing for a small level of price competition. Policies can also offer rebates of up to €225 if a policyholder uses no health services in a given year beyond seeing a primary care physician.[212] About 90 percent of the population also buys supplemental insurance covering services over and above the required standard benefits package.[213]

Employers generally pay half of insurance premiums, with individual workers picking up the other half.[214] Individual premiums are tax deductible.[215] Subsidies, or care allowances, that help low- and middle-income income workers purchase the basic insurance plan are extensive and reach well into the middle class. Currently, 5 million Dutch citizens qualify for some level of subsidy on a sliding scale based on income.[216] Those subsidies are financed through a tax on salaried workers. Because of the high levels of subsidy, the Dutch government remains a large source of health spending, one area of significant difference with the Swiss system.[217]

Insurers negotiate quality, quantity, and price of services with providers. Notably, many insurers require providers to document the quality of the care they provide, frequently relying on evidence-based guidelines and performance metrics.[218]

Some insurers provide care directly, using their own staffs and their own facilities, such as primary care centers and pharmacies. Other insurers contract with a network of providers similar to U.S. preferred provider organizations (PPOs). Patients can go out of network but will receive only partial reimbursement. Most insurers require a referral from a primary care provider before a patient can see a specialist.[219] Pharmaceutical prices are capped nationwide at the average price of medicines in a therapeutic class. Individuals may choose more expensive drugs but must pay the difference out of pocket.[220]

The new system has been in place for only two years, which is not enough time to permit a thorough evaluation. However, preliminary indications suggest that it is an improvement over the pre-2006 system.[221]

Dutch consumers appear to have embraced the reforms. Consumer organizations are participating in negotiations with providers, insurers, and lawmakers. The system is becoming more transparent, with far greater information available regarding both price and quality. Consumers seem willing to make decisions and change insurers on the basis of price and quality.

Price competition under the new system has increased significantly and at least 20 percent of Dutch consumers have switched insurers.[222] When the system was initiated, the Dutch government predicted premiums would cost €1,106 on average. However, competition has forced the average premium down to €1,028, 097.6 percent below the prediction.[223] Overall, the new system is estimated to have increased the purchasing power of Dutch households by as much as 1.5 percent.[224] However, not everyone has been a winner. The community rating requirement has resulted in steep increases in premiums for younger workers who were more heavily subsidized under the old system.[225]

Under the old system, waiting lists were widespread—for example, more than three months for a hip

replacement and two months for a prostectomy or hysterectomy.[226] One study estimated that at least 100 heart patients died each year while on waiting lists.[227] Early evidence suggests that some improvement has come as a result of the 2006 reforms.[228]

Hospitals are beginning to compete by expanding services such as neurosurgery and radiation therapy.[229] Although some experts have expressed concern that smaller hospitals offering these services may not have sufficient utilization rates to ensure quality and efficacy, the expanded availability of services will likely increase access to care and reduce queues.[230]

The new system may even be having a positive impact on health care costs. Since the new system took effect, health care costs have been growing at an annual rate of just 3 percent, compared to more than 4.5 percent in the year before the reforms.[231]

The jury is still out, and the Dutch system still falls well short of a true free market, but the Netherlands appears to have taken a big step in the right direction.

Great Britain

Almost no one disputes that Britain's National Health Service faces severe problems, and few serious national health care advocates look to it as a model. Yet it appears in Moore's movie *SiCKO* as an example of how a national health care system should work, so it is worth examining.

The NHS is a highly centralized version of a single-payer system. The government pays directly for health care and finances the system through general tax revenues. Except for small copayments for prescription drugs, dental care, and optician services, there are no direct charges to patients. Unlike many other single-payer systems such as those in Canada and Norway, most physicians and nurses are government employees.

For years, British health policy has focused on controlling spending and in general has been quite successful, with the system spending just 7.5 percent of GDP on health care.[232] Yet the system continues to face serious financial strains. In fiscal year 2006, the NHS faced a deficit of £700 million, according to government figures, and as much as £1 billion, according to outside observers.[233] This comes despite a £43 billion increase in the NHS annual budget over the past five years.[234] By some estimates, NHS spending will have to nearly triple by 2025 just to maintain the current level of services.[235]

And that level of services leaves much to be desired. Waiting lists are a major problem. As many as 750,000 Britons are currently awaiting admission to NHS hospitals. These waits are not insubstantial and can impose significant risks on patients. For example, by some estimates, cancer patients can wait as long as eight months for treatment.[236] Delays in receiving treatment are often so long that nearly 20 percent of colon cancer patients considered treatable when first diagnosed are incurable by the time treatment is finally offered.[237]

In some cases, to prevent hospitals from using their resources too quickly, mandatory minimum waiting times have been imposed. The fear is that patients will flock to the most efficient hospitals or those with smaller backlogs. Thus a top-flight hospital like Suffolk East PCT was ordered to impose a minimum waiting time of at least 122 days before patients could be treated or the hospital would lose a portion of its funding.[238] As the *Daily Telegraph* explained:

> In a real competitive market, increased demand can allow prices to rise, thus increasing profits, which allow the market to grow. Efficient producers can then reduce their unit costs and their prices, and so give a better deal to the consumer. The prevailing logic is that the more customers who are served—or products that are sold—in a given period of time, the better the business does.
>
> But PCTs have budgets that are predetermined by Whitehall spending limits, and there is no way for them to conjure extra revenue out of the air or to grow their market. As a result, the hospitals that are most successful in providing prompt treatment are running through the finite resources of their PCTs at an unacceptably rapid rate.[239]

The problem affects not only hospitals. There are also lengthy waits to see physicians, particularly specialists. In 2004, as a cost-cutting measure, the government negotiated low salaries for general practitioners in exchange for allowing them to cut back the hours they practice. Few are now available nights or weekends.[240] Problems with specialists are even more acute. For example, roughly 40 percent of cancer patients never get to see an oncology specialist.[241]

The government's official target for diagnostic testing is a wait of no more than 18 weeks by 2008. In reality, it doesn't come close.[242] The latest estimates suggest that for most specialties, only 30 to 50 percent of patients are treated within 18 weeks. For trauma and orthopedics patients, the figure is only 20 percent. Overall, more than half of British patients wait more than 18 weeks for care.[243]

Explicit rationing also exists for some types of care, notably kidney dialysis, open heart surgery, and some other expensive procedures and technologies.[244] Patients judged too ill or aged for the procedures to be cost-effective may be denied treatment altogether.

Recently, the British government introduced some tiny steps toward market-based reforms. Under the experimental London Patient Choice Project, patients who have been waiting longer than six months for treatment are offered a choice of up to four alternate providers. This experiment has been extended nationwide for coronary heart patients who have been waiting longer than six months.[245]

Some proposed solutions are far more radical. David Cameron, leader of the Conservative Party, has proposed that the NHS be allowed to refuse treatment to individuals who don't practice healthy lifestyles, for example, who smoke or are overweight. Then again, he has also proposed that the government pay for gym memberships and subsidize the purchase of fresh fruit and vegetables.[246]

A small but growing private health care system has emerged in the UK. About 10 percent of Britons have private health insurance. Some receive it through their employer, while others purchase it individually. In general, the insurance replicates care provided through the NHS and is purchased to gain access to a wider choice of providers or to avoid waiting lists.[247] Private health insurance is lightly regulated and risk-rating is allowed. The British government treats health insurance more or less the same as other types of insurance.[248]

The British public is well aware of the need for reform. Nearly two-thirds of Britons (63 percent) say that the need for reform is "urgent," while another 24 percent believe it is "desirable." Fully 60 percent of Britons believe that making it easier for patients to spend their own money on health care would improve quality.[249] Yet Britons are also extremely proud of their health care system and wary of any reforms that would "Americanize" it.

Switzerland

Of all the countries with universal health care, Switzerland has one of the most market-oriented systems. Indeed, the Swiss government actually pays for a smaller amount of total health care expenditures than the U.S. government, 24.9 percent versus 44.7 percent.[250] (See Figure 3.)

The Swiss system is based on the idea of managed competition, the same concept that underlay the 1993 Clinton health care plan and Mitt Romney's reforms in Massachusetts.[251] Managed competition leaves the provision of health care and health insurance in private hands but creates a highly regulated artificial marketplace as a framework within which the health care industry operates.[252]

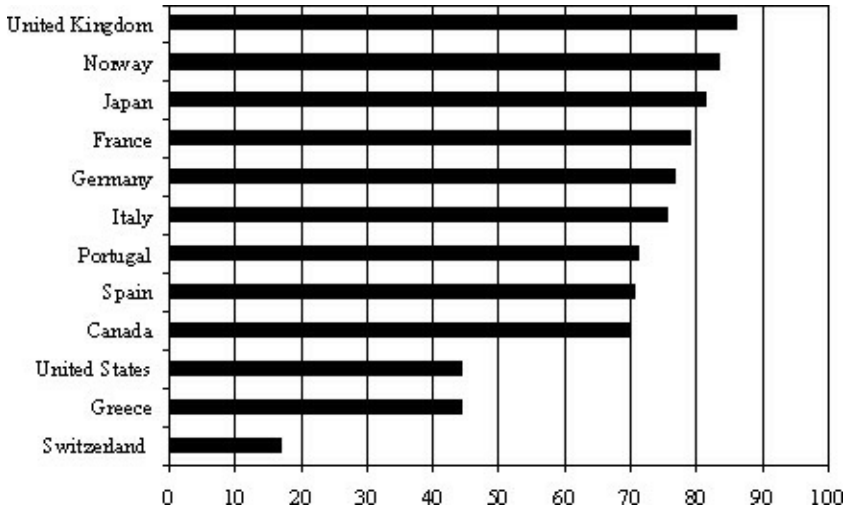
Swiss law requires all citizens to purchase a basic package of health insurance, an individual mandate. Coverage is close to universal, estimated at 99.5 percent.[253] This level of compliance is due in part to the Swiss national character and may not be replicable in the United States where the record of complying with mandates is much more mixed (even if such a mandate were desirable).[254] For example, nearly 100 percent of Swiss drivers comply with their country's mandate for automobile insurance, compared with only 83 percent of U.S. drivers.[255]

The term "basic benefits package" is somewhat misleading since the required benefits are quite extensive, including inpatient and outpatient care, care for the elderly and the physically and mentally handicapped, long-term nursing home care, diagnostic tests, prescription drugs, and even complementary and alternative therapies.[256]

Insurance is generally purchased on an individual basis. Few employers contribute to the purchase or provide insurance.[257] The policies are provided by private insurers. Currently, some 93 insurers operate in Switzerland, although not every insurer operates in every canton, or region.[258] Originally, insurers were required to be nonprofit entities, but that restriction was eliminated in 2002.

Insurers cannot reject an applicant on the basis of health status, and all policies are community rated within a geographic area, meaning that the healthier pay higher premiums to subsidize the less healthy. One exception to community rating is for nonsmokers, who can receive premiums as much as 20 percent lower than smokers. A formula adjusts premiums based on sex and age.[259] The geographic variation can be significant, with premiums differing as much as 50 percent between cantons.[260]

Figure 3
Percentage of Total Health Spending Paid by Government



Source: OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries." Organisation for Economic Co-operation and Development, July 2007; 2004 data.
Note: Switzerland excludes mandatory insurance premiums.

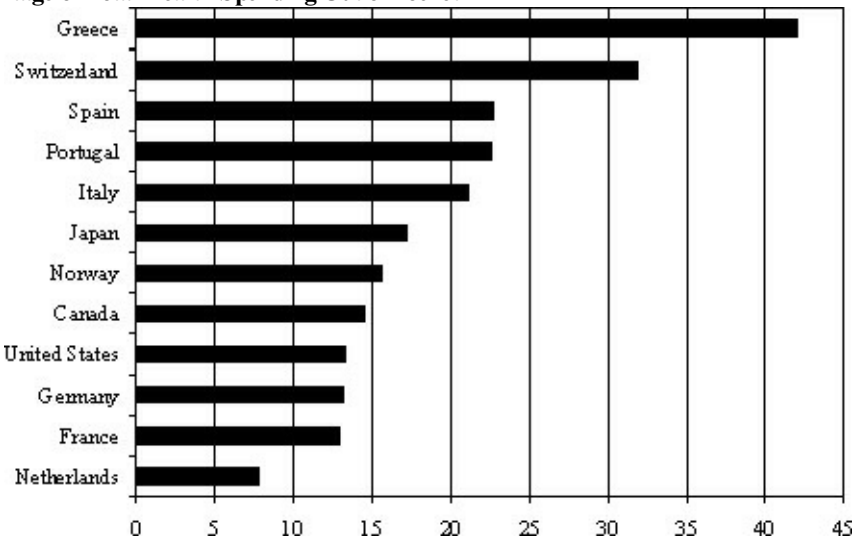
Unable to compete on the basis of managing and pricing risk, and required to offer nearly identical basic benefits packages, insurers compete primarily on price. Since they cannot reduce costs by risk management or benefit design, they generally manage prices by varying the level of deductibles and copayments. Individuals can purchase expensive policies with very low deductibles and copayments, or far less expensive policies with high deductibles or extensive copay-ments. Thus, premiums vary according to their cost-sharing attributes and plan type, running from $1,428 per year for a plan with a deductible of approximately $2,000 to $2,388 for a plan with a $250 deductible.[261]

Because employers do not pay for workers' health insurance, the Swiss are exposed to the full cost of their insurance purchases. As a result, many Swiss have opted for high-deductible insurance. Thus, with high deductibles and extensive copayments, the Swiss pay out of pocket for 31.5 percent of health care, twice as much as in the United States.[262] (See Figure 4.)

Recently, there has also been a growing market in managed care plans that, like those in the United States, offer lower premiums in exchange for limitations on access to specialists and other services. Premiums for such plans run around $1,900 per year.[263]

The Swiss government offers subsidies to low-income citizens to help them purchase a policy. Subsidies are based on both income and assets, and the maximum available subsidy covers the cost of an average premium in the individual's canton. These subsidies are designed to prevent any individual from having to pay more than 10 percent of income on insurance. They do not, however, pay the entire cost of insurance because the Swiss do not want to create an incentive for subsidized individuals to choose the most expensive plan with the lowest deductibles and copay-ments.[264] Roughly one-third of Swiss citizens receive some form of subsidy, and approximately 19 percent of all health insurance premiums are paid with government funds.[265]

Figure 4
Percentage of Total Health Spending Out of Pocket



Source: OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."
Data for France from Simone Sandier, Valerie Paris, and Dominique Polton, *Health Care Systems in Transition: France* (Copenhagen: European Observatory on Health Systems and Policies, 2004).
Data for Greece from the World Health Organization.

Swiss insurers operate as cartels to negotiate provider reimbursements on a cantonal basis. Providers must accept the negotiated payment, and balance-billing is prohibited. If insurers and providers are unable to reach agreement on a fee schedule, canton governments are empowered to step in and impose an agreement. There are no restrictions on where physicians may set up practice, so to some degree providers can vote with their feet, moving to cantons that offer higher reimbursements, a practice that has led to physician shortages in some areas.[267]

The system includes both public and private hospitals.[268] Private hospitals negotiate reimbursement with insurance cartels and physicians in the same manner. Public hospitals are operated by cantons, which negotiate reimbursement rates with insurers and provide subsidies to the hospitals. In some cantons, individuals with only the basic insurance plan must use public hospitals; supplementary insurance (see below) is required for admission to private hospitals.

Recently some providers have begun operating outside the negotiated fee schedules. A separate supplemental insurance market is starting to develop to cover the cost of these providers, which are presumed to offer higher quality or more advanced services. Supplementary insurance also allows access to private hospitals in those cantons that do not permit access under the basic insurance plan. Even within public hospitals, supplementary insurance can be used to pay for services such as private rooms that are not covered under the basic plan. By some estimates as many as 40 percent of Swiss citizens have purchased supplemental insurance.[269]

The Swiss do not impose a global budget on their health care system and have therefore avoided the waiting lists common in other systems. In addition, the Swiss have a high degree of access to modern

medical technology, but it has come at a cost. The Swiss spend 11.5 percent of GDP on health care, second only to the United States.[270]

Since Swiss health care consumers are exposed to the cost consequences of their health care decisions, this trade-off between access and cost can be presumed to reflect the desires of Swiss patients. They have chosen high quality care even though it costs them more. Given that economists consider health care to be a "normal good"—that is, consumption rises along with income—and Switzerland is a wealthy nation, such a decision seems entirely reasonable.[271]

At the same time, it is notable that Swiss health care spending remains below that of the United States for nearly comparable care. Strong evidence suggests that the exposure of Swiss consumers to the cost consequences of their health care decisions has made them more conscious consumers and helped limit overall health care costs. As Regina Herzlinger and Ramin Parsa-Parsi of Harvard have concluded, "Cost control may be attributed to the Swiss consumer's significant role in health care payments and the resulting cost transparency."[272]

The transparency of the system also makes it responsive to consumer preferences. The WHO survey ranked Switzerland second only to the United States in terms of responsiveness to patients' needs for choice of provider, dignity, autonomy, timely care, and confidentiality.[273]

The Swiss generally seem pleased with their system. Earlier this year, Swiss voters overwhelmingly rejected a proposal to replace the current system with a single-payer plan; more than 71 percent of Swiss voters turned down the proposal in a nationwide referendum.[274]

Nonetheless, the Swiss system has its own problems, most of them predictable outgrowths of the individual mandate and the regulation inherent in managed competition. In most markets, consumers impose a certain discipline on prices because they can refuse to buy a product if it costs too much. The individual mandate removes this power since consumers must purchase the product (in this case, insurance) even if they believe the cost outweighs the value. Moreover, the establishment of a government-defined benefits package is an open-ended invitation to special interests representing various health care providers and disease constituencies, who can certainly be expected to lobby for the inclusion of additional services or coverage.[275]

Public choice dynamics are such that providers (who would make money from the increased demand for their services) and disease constituencies (whose members naturally have an urgent desire for coverage of their illness or condition) will always have a strong incentive to lobby legislators for inclusion under any minimum benefits package. The public at large will likely be unaware of the debate or see resisting the small premium increase caused by any particular additional benefit as unworthy of a similar effort—a simple case of concentrated benefits and diffused costs.[276]

That is exactly what has happened in Switzerland, leading to a growing expansion of the basic benefits package. In particular, a powerful hospital and physician lobbying coalition known as the "Blue Front" was able to demand a significant expansion in covered benefits in exchange for a relaxation of "any willing provider" laws so as to permit managed-care contracts.[277]

The expansion of benefits has driven up the cost of insurance, a cost only partially offset by larger deductibles. Although the proportion of health expenditures paid out of pocket remains high, it has decreased by roughly 10 percent in the past decade.[278]

Moreover, the growth in covered benefits has helped drive up costs for the system as a whole, as the Swiss become more insulated from the costs of their health care purchasing decisions. If that trend

continues, it could undermine the cost transparency that is at the heart of the Swiss system." As Uwe Reinhardt has noted, "Over time, the growth in compulsory benefits has absorbed an increasing fraction of the consumers' payment, thus compromising the consumer-driven aspects of the Swiss system."[279]

Evidence shows that the community rating requirements are creating distortions within the Swiss market, leading to the over provision of care to the healthy and the under provision of care to the sick.[280] In addition, the prohibition on risk management discourages the development of new and innovative products. Peter Zweifel of the University of Zurich, a member of the Swiss Competitive Committee which oversees insurance regulation, believes that a return to some degree of risk-rating is essential to the long-term success of the Swiss system.[281] As Zweifel puts it, "Let competition work its magic. Let those who are bad risks get the message that they need to become better risks, if possible. If not possible, [they would] still get a subsidy which [keeps their costs] down to little more than 8–10 percent of taxable income."[282]

Third, the cartel structure for negotiating reimbursement schedules can create a number of distortions. Effectively monopsony purchasers, the cartels have enormous leverage when it comes to negotiations. Not surprisingly, physicians have tended to set up practice in cantons with the highest levels of reimbursement, leading to shortages in other areas. Reimbursement rates have reportedly created wasteful incentives—for example, hospitals shifting patients from outpatient to inpatient care.[283] And the combination of increased demand and low reimbursement has led to the first signs of queues for the most complex surgeries.[284]

In addition, the negotiations freeze in place a pricing structure that inhibits the development of innovative approaches that do not tie payments to specific benefits. This includes both managed care approaches and health services integration.[285]

Finally, Switzerland has some of Europe's strongest regulation of nonphysician health care professionals.[286] As a result, patients are often forced to use more expensive providers where a less expensive professional would do.

All of the above combine to undermine the consumer-driven nature of Switzerland's health system. Despite these problems, the Swiss system provides a useful lesson for the United States about the value of consumer-directed health care. In particular, we can see that when the cost of insurance becomes more transparent, consumers shift their purchasing preferences toward true insurance (spreading catastrophic risk), rather than purchasing prepayment for routine, low-cost services. That gives consumers an overall incentive to make cost-versus-value decisions when purchasing health care, resulting in reduced costs while maintaining individual choice and quality care.

Germany

Germany ranked 25th in the WHO ratings.[287] Despite that low ranking, however, the country is worth examining because it is frequently cited as a model by advocates of national health care.

National health insurance in Germany is part of a social insurance system that dates back to Bismarck. All German citizens with incomes under €46,300 (roughly $60,000) are required to enroll in one of approximately 250 statutory "sickness funds." Those with higher incomes may enroll in the funds if

they wish, or may opt out of the government system and purchase private insurance.[288] About three-quarters of workers with incomes above the statutory limit choose to remain in the sickness funds, which currently cover approximately 90 percent of the population. Overall, insurance coverage is nearly universal. However, the number of uninsured has been rising, roughly tripling in the last 10 years to 300,000 people.[289] About 9 percent of the population purchases supplemental insurance to cover items that are not included in the standard benefits package.[290]

Sickness funds are financed through a payroll tax split equally between the employer and employee. The size of the tax varies depending on which fund the worker has chosen, but averages around 15 percent of wages.[291] Sickness funds are supposed to be solvent and self-supporting, but in reality the system ran a €7 billion deficit in 2006.[292] The German government has proposed a 1 percent increase in the payroll tax, split evenly between employer and employee, starting next year.[293] In addition, general tax revenues finance capital costs for acute care hospitals and many rehabilitative services, especially for retirees.

Benefits are extensive, covering physicians, hospital and chronic care, diagnostic tests, preventive care, prescription drugs, and part of dental care. In addition to the medical benefits, sickness funds provide sick pay to those who cannot work due to illness, ranging from 70 to 90 percent of the patient's last gross salary, for up to 78 weeks.[294]

The central government and state governments split the regulation of the health care system. The central government establishes the national global budget for health care spending, defines any new medical procedures to be included in benefit packages, and sets reimbursement rates for physicians. Some of this is accomplished through legislation, while the rest is handled through negotiations between the National Association of Sickness Funds and the National Association of Physicians. At the state level, state associations of sickness funds and physicians negotiate overall health budgets, reimbursement contracts for physicians, procedures for monitoring physicians, and reference standards for prescription drugs.[295] The bargaining power in these negotiations clearly lies with the sickness funds backed by the government, allowing them to effectively impose fee schedules and other restrictions on providers. The purchasing power of a German physician's wages is now about 20 percent that of a U.S. physician.[296] This has led to physician strikes as recently as 2005.[297]

Although Germany spends less on health care than the United States, both as a percentage of GDP and per capita, expenditures have been rising at an alarming rate in recent years. Friedrich Breyer, an economist from Konstanz University, estimates that health care spending could reach 30 percent of GDP by 2020 unless significant changes are made.[298]

The German government has responded by beginning to cut back on benefits. In 2004, sickness funds stopped covering eyeglasses, lifestyle medications, and all over-the-counter drugs. Copayments were imposed for the first time, such that Germans now pay €10 per quarter to see a general practitioner, €10 per day of hospital stay, €10 per prescription, and for certain specialty services.[299] The highest copayments are 10 percent for prescription drugs. Overall, Germans pay out of pocket for about 13 percent of total health care spending, only slightly less than Americans.[300] Preliminary evidence suggests that the introduction of cost sharing has slightly reduced utilization and spending.[301]

In 2006, Chancellor Angela Merkel proposed a sweeping set of health care reforms that included creating a centralized health fund, shifting financing in part from payroll taxes to general revenues,

trimming benefits, imposing greater cost sharing, and making the system more transparent. She was forced to abandon the package in the face of public and political opposition.[302]

The degree of health care rationing in Germany is the subject of considerable debate. Unlike many OECD countries, the German government does not compile data on waiting lists.[303] One frequently cited study suggests that Germans are no more likely than Americans to wait more than four weeks to see a specialist.[304] The WHO says, "Waiting lists and explicit rationing decisions are virtually unknown."[305]

However, at least one study concludes that rationing is occurring for the elderly and those with terminal illness, and concludes that "the question remains as to whether lives at advanced ages could be saved if age rationing were discontinued and maximum medical treatment were to be applied to everyone, irrespective of their age."[306] In addition, a survey of German hospitals reported that "waiting times were prolonged" due to both a lack of capacity and hospital target budgets that make the treatment of sickness fund patients with serious conditions financially unattractive.[307]

Also, Germans have less access to modern medical technology than Americans. The United States has four times as many MRI units per million people and twice as many CT scanners.[308] The situation would undoubtedly be worse without the existence of the small private insurance sector. Although small as a proportion of total health spending, private insurance puts competitive pressure on sickness funds, pushing them to expand their quality and services. At one time, CT scanners were even rarer in the public system, available only under exceptional circumstances and after long waits, yet relatively common in the private sector. Competition forced the public sector to add more CT scanners.[309]

Some analysts blame price restrictions and reimbursement rates for increasing bureaucratic interference in how German physicians practice medicine. Physicians trying to work within the maze of reimbursement caps and budget restrictions have no financial incentive to provide more than the minimally necessary care. That has led to questions of quality assurance, and the government has responded with ever greater micromanagement of practice standards. The result has been a huge increase in red tape for physicians and a general loss of innovation.[310]

Germans seem aware of the need to reform their health care system. In a 2004 poll, 76 percent of Germans thought health care reform was "urgent," while an additional 14 percent thought it was "desirable." However, Germans are split nearly down the middle about what that reform should be. Roughly 47 percent would like to see an increase in private health care spending, whereas 49 percent would not. Similarly, 45 percent of Germans believe that more patient choice would improve health care quality, whereas 50 percent do not. The reluctance to fully embrace market reforms undoubtedly stems from a long-standing German belief in social solidarity. By a margin of 81 to 18 percent, Germans believe that equal access to the same quality of care for everyone is more important than their own access to the best possible care.[311]

Costs and demographics will eventually force changes in the German system. However, given the failure of Chancellor Merkel's reforms, change is unlikely in the near future.

A Few Thoughts on Canada

Canada is another country that did not make the top 20 health care systems in the WHO rankings (it

finished 30th), and few serious advocates of universal health care look to it as a model. As Jonathan Cohn puts it, "Nobody in the United States seriously proposes recreating the British and Canadian system here—in part because, as critics charge . . . they really do have waiting lines."[312] However, since the press still frequently cites it as an example, it is worth briefly examining.

Although Canada is frequently referred to as having a "national health system," the system is actually decentralized with considerable responsibility devolved to Canada's 10 provinces and 2 territories. It is financed jointly by the provinces and the federal government, similar to the U.S. Medicaid program. In order to qualify for federal funds, each provincial program must meet five criteria: 1) universality—available to all provincial residents on uniform terms and conditions; 2) comprehensiveness—covering all medically necessary hospital and physician services; 3) portability—allowing residents to remain covered when moving from province to province; 4) accessibility—having no financial barriers to access such as deductibles or copayments; and 5) public administration—administered by a nonprofit authority accountable to the provincial government.

Federal financing comes from general tax revenue. The federal government provides a block grant to each province which amounts to around 16 percent of health care spending. However, most funding comes from provincial taxes, primarily personal and corporate income taxes. Some provinces also use funds from other financial sources like sales taxes and lottery proceeds. And some (British Columbia, Alberta, and Ontario) charge premiums, although health services cannot be denied because of inability to pay. The health care system is an enormous part of the Canadian welfare state. On the provincial level, the health care system amounts to between one-third and one-half of all social welfare spending.[313]

Provinces must provide certain benefits, including primary care doctors, specialists, hospitals, and dental surgery. Other benefits, such as routine dental care, physiotherapy, and prescription drugs, are optional. Some provinces offer substantial coverage for these services, some cover them only partially, and some do not cover them at all. Except for emergencies, treatment by specialists or hospital admission requires a referral from a primary care physician.

Provider reimbursement is set by each province, and some provinces restrict overall physician income. In general, however, reimbursement is on a fee-for-service basis. Hospitals are paid a specific pre-set amount to cover all noncapital costs. Capital expenditures must be approved on a case-by-case basis.

An increasing number of Canadians also carry private insurance, most often provided through their employer. Originally this insurance was designed to cover those few services not covered by the national health care system. At one time, all provinces prohibited private insurance from covering any service or procedure provided under the government program. But in 2005, the Canadian Supreme Court struck down Quebec's prohibition on private insurance contracting.[314] Litigation to permit private contracting is now pending in several other provinces.

In addition to the public hospitals covered by the government, many private clinics now operate, offering specialized services. Although private clinics are legally barred from providing services covered by the Canada Health Act, many do offer such services in a black market. The biggest advantage of private clinics is that they typically offer services with reduced wait times compared to the public health care system. Obtaining an MRI scan in a hospital could require a wait of months, whereas it could be obtained much faster in a private clinic.

Waiting lists are a major problem under the Canadian system. No accurate government data exists, but provincial reports do show at least moderate waiting lists. The best information may come from a survey of Canadian physicians by the Fraser Institute, which suggests that as many as 800,000 Canadians are

waiting for treatment at any given time. According to this survey, treatment time from initial referral by a GP through consultation with a specialist, to final treatment, across all specialties and all procedures (emergency, nonurgent, and elective), averaged 17.7 weeks in 2005.[315] And that doesn't include waiting to see the GP in the first place.

Defenders of national health care have attempted to discount these waiting lists, suggesting that the waits are shorter than commonly portrayed or that most of those on the waiting list are seeking elective surgery. A look at specialties with especially long waits shows that the longest waits are for procedures such as hip or knee replacement and cataract surgery, which could arguably be considered elective. However, fields that could have significant impact on a patient's health, such as neu-rosurgery, also have significant waiting times.[316] In such cases, the delays could be life threatening. A study in the *Canadian Medical Association Journal* found that at least 50 patients in Ontario alone have died while on the waiting list for cardiac catheterization.[317] Data from the Joint Canada–United States Survey of Health (a project of Statistics Canada and the National Center for Health Statistics) revealed that "thirty-three percent of Canadians who say they have an unmet medical need reported being in pain that limits their daily activities."[318] In a 2005 decision striking down part of Quebec's universal care law, Canadian Supreme Court Chief Justice Beverly McLachlin wrote that it was undisputed that many Canadians waiting for treatment suffer chronic pain and that "patients die while on the waiting list."[319]

Clearly there is limited access to modern medical technology in Canada. The United States has five times as many MRI units per million people and three times as many CT scanners.[320] Indeed, there are more CT scanners in the city of Seattle than in the entire province of British Columbia.[321]

Physicians are also in short supply. Canada has roughly 2.1 practicing physicians per 1,000 people, far less than the OECD average. Worse, the number of physicians per 1,000 people has not grown at all since 1990. And while the number of nurses per 1,000 people remains near the OECD average, that number has been declining since 1990.[322]

In addition, although national health care systems are frequently touted as doing a better job of providing preventive care, U.S. patients are actually more likely than Canadians to receive preventive care for chronic or serious health conditions. In particular, Americans are more likely to get screened for common cancers, including cancers of the breast, cervix, prostate, and colon.[323]

Canada has been relatively effective at controlling spending. The country spends about 9 percent of GDP on health care, a percentage that has risen only slightly over the last decade. Relative to average OECD expenditures, Canadian health expenditures have declined by 4 percent since 1997.[324] That cost control, however, has clearly come at the expense of access to care.

Canadians' dissatisfaction with the problems in their system has been growing for some time. One survey showed that some 59 percent of Canadians believe that their system requires "fundamental changes," and another 18 percent believe the system needs to be scrapped and totally rebuilt.[325] Still, Canadians are reluctant to embrace market reforms that are associated with the U.S. health care system—a system that Canadians disdainfully reject. As one observer put it:

> Anxiety about Americanization and the constantly reinforced strain of national pride in Canadian health care coexist[s] with considerable uneasiness about the actual state of that care. It is as if, when Canadians look south across the border they swell with pride, but when they look within they shrink back, seeing many problems and feeling uncertainty about the future.

Canadians may jealously guard their system and resist "Americanizing" it, but even advocates of universal health care are coming to recognize that it does not provide a valid model for U.S. health care reform.

Conclusion

The U.S. health care system clearly has problems. Costs are rising and are distributed in a way that makes it difficult for some people to afford the care they want or need. Moreover, although the number of uninsured Americans is often exaggerated, far too many Americans go without health insurance. And while the U.S. provides the world's highest quality health care, that quality is uneven, and too often Americans don't receive the standard of care that they should. But the experiences of other countries with national health care systems show that the answer to these problems lies with more pro-market reform, not more government control.

Of course, there is no single model for national health care systems in other countries. Indeed, the differences from country to country are so great that the terms "national health care" or "universal coverage" can be misleading—as if one collective model shows how other countries deal with health care and health insurance. Each country's system is the product of its unique conditions, history, politics, and national character. Those systems range from the managed competition approach of the Netherlands and Switzerland to the more rigid single-payer systems of Great Britain, Canada and Norway, with many variations in between.

Some countries have a true single-payer system, prohibiting private insurance and even restricting the ability of patients to spend their own money on health care. Others are multi-payer systems, with private competing insurers and varying degrees of government subsidy and regulation. Some countries base their systems around employment, while others have completely divorced work from insurance. Some require consumers to share a significant portion of health care costs through either high deductibles or high copayments. Others subsidize virtually first-dollar coverage. Some allow unfettered choice of physicians. Others allow a choice of primary care physicians but require referrals for specialists. Still others restrict even the choice of primary care doctors.

In fact, about the only system one cannot find is the type of system described by Michael Moore, Physicians for a National Health Program, and other national health care advocates— a system that provides unlimited care with no premiums, deductibles, or copay-ments, from the physician of one's choice. For example, in *SiCKO*, Moore lambastes American insurers for denying coverage for rare and experimental treatments.[327] And, during the New Hampshire primary, John Edwards ran television advertisements highlighting the tragic death of a teenage girl whose liver transplant was rejected by her father's insurer.[328] These stories play effectively on the emotions and drive a desire for change. Yet one searches in vain for a national health care system anywhere that regularly pays for experimental and untested procedures.

Likewise, advocates for national health care tap into the anger many patients (and doctors) feel for the gatekeepers and prior approval required under American managed care. But many if not most foreign systems require similar gatekeepers. Moreover, copayments and other forms of cost sharing are commonplace.

It is also important to realize that no country's system would translate directly to the United States. Americans are unlikely to accept the rationing or restrictions on care and technology that many countries use to control costs. Nor are U.S. physicians likely to accept a cut in income to the levels seen in countries like France or Germany. The politics, economics, and national cultures of other countries often vary significantly from those of the United States. Their citizens are far more likely to have faith in government actions and to be suspicious of free markets. And polling suggests that citizens of many countries put social solidarity and equality ahead of quality and choice when it comes to health policy.[329] American attitudes are quite different. As pollster Bill McInturff notes, "Never, in my years of work, have I found someone who said, 'I will reduce the quality of the health care I get, so that all Americans can get something.'"[330]

Even so, some important lessons can be drawn from the experiences of other countries:

- Universal health insurance does not mean universal access to health care. In practice, many countries promise universal coverage but ration care or have extremely long waiting lists for treatment. Nor does a national health care system necessarily mean universal coverage. Some countries with ostensibly universal systems actually fall far short of universal coverage, and most leave at least a small remnant (1–2 percent of the population) uncovered. Although this is certainly wider coverage than the United States provides, it shows the difficulty of achieving either truly universal coverage or universal access to care.
- Rising health care spending is not a uniquely American phenomenon. Other countries spend considerably less than the United States on health care, both as a percentage of GDP and per capita, often because they begin with a lower base of expenditures.Nonetheless, their costs are still rising, leading to budget deficits, tax increases, and/or benefit cuts. In 2004, the last year for which data is available, the average annual increase for per capita health spending in the countries discussed in this study was 5.55 percent, only slightly lower than the United States' 6.21 percent.[331] As the *Wall Street Journal* notes, "Europeans . . . face steeper medical bills in the future in their cash-strapped governments."[332] In short, there is no free lunch.
- Those countries that have single-payer systems or systems heavily weighted toward government control are the most likely to face waiting lists, rationing, restrictions on the choice of physician, and other barriers to care. Those countries with national health care systems that work better, such as France, the Netherlands, and Switzerland, are successful to the degree that they incorporate market mechanisms such as competition, cost-consciousness, market prices, and consumer choice, and eschew centralized government control.
- Dissatisfaction and discontent with a nation's health care system seems to be universal. Undoubtedly, Americans are unhappy with the current state of our health care system. According to the most recent Commonwealth Fund survey, an astounding 82 percent of Americans believe that our system either requires fundamental change or needs to be completely rebuilt.[333] Not surprisingly, polls suggest health care reform is the top domestic policy issue in the upcoming presidential election.[334] Yet, that same Commonwealth Fund study shows large majorities in every country, ranging from 58 percent in the Nether-lands to 78 percent in Germany calling for fundamental reform or complete rebuilding of their health care systems.[335] Earlier polling by the Stockholm Network found similar levels of unhappiness.[336] Not as bad as in the United States,

perhaps, but certainly no ringing endorsement of their systems.

- Although no country with universal coverage is contemplating abandoning a universal system, the broad and growing trend in countries with national health care systems is to move away from centralized government control and introduce more market-oriented features. As Richard Saltman and Josep Figueras of the World Health Organization put it, "The presumption of public primacy is being reassessed."[337] Alan Jacobs of Harvard points out that despite significant differences in goals, content, and strategies, European nations are generally converging toward market practices in health care.[338] Thus, even as Americans debate adopting a government-run system, countries with those systems are debating how to make their systems look more like that of the United States.

Looking at other countries and their experiences, then, can provide guidance to Americans as we debate how to reform our health care system. National health care is not a monolithic idea, nor is it as disastrous as U.S. critics sometimes portray. Some national health care systems do *some* things well.

Yet, those systems do have serious problems. In most cases, national health care systems have successfully expanded insurance coverage to the vast majority, if not quite all, of the population. But they have not solved the universal and seemingly intractable problem of rising health care costs. In many cases, attempts to control costs through governmental fiat have led to problems with access to care, either delays in receiving care or outright rationing.

In wrestling with this dilemma, many countries are loosening government controls and injecting market mechanisms, particularly cost sharing by patients, market pricing of goods and services, and increased competition among insurers and providers. As Pat Cox, former president of the European Parliament, put it in a report to the European Commission, "We should start to explore the power of the market as a way of achieving much better value for money."[339]

Moreover, the growth of the government share of health care spending, which had increased steadily from the end of World War II until the mid-1980s, has stopped, and in many countries the private share has begun to increase, in some cases substantially. Some evidence shows a growing shift from public to private provision of health care.[340] If the trend in the United States over the last several years has been toward a more European-style system, the trend in Europe is toward a system that looks more like America's.

Therefore, if U.S. policymakers can take one lesson from national health care systems around the world, it is not to follow the road to government-run national health care, but to increase consumer incentives and control. The United States can increase coverage and access to care, improve quality, and control costs without importing the problems of national health care. In doing so, we should learn from the successes—*and the failures*—of systems in other countries.

Notes

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1. *SiCKO*, Dog Eat Dog Films, 2007.

2. Paul Krugman, "The Waiting Game," *New York Times,* July 16, 2007.

3. Physicians for a National Health Program, "Insurance CEOs Fattened on the Suffering of Many," http://www.pnhp.org/news/2006/april/the_healthcare_tipp.php.

4. Paul Krugman and Robin Wells, "The Health Care Crisis and What to Do about It," *New York Review of Books,* March 23, 2006.

5. Organisation for Economic Co-operation and Development, "OECD Health Data 2007: Statistics and Indicators for 30 Countries" (Paris: OECD, 2007).

6. Christine Borger et al., "Health Spending Projections through 2015: Changes on the Horizon," *Health Affairs* 25, no. 2 (2006): w61–w73, http://content.healthaffairs.org/cgi/content/abstract/hlthaff25.w61.

7. Uwe Reinhardt of Princeton University, for example, estimates that nearly half of the difference in spending between the United States and other industrial nations is due to America's higher GDP. Uwe Reinhardt, Peter Hussey, and Gerard Anderson, "U.S. Health Care Spending in an International Context," *Health Affairs* 23, no. 3 (2004): 11–12.

8. Kaiser Family Foundation, "Employer Health Benefits 2007 Annual Survey," Kaiser Family Foundation, September 11, 2007.

9. *2007 Annual Report of the Board of Trustees of the Federal Hospital Insur ance and Federal Supplemental Medical Insurance Trust Funds* (Washington: Government Printing Office, 2007).

10. Jagadeesh Gokhale, "Medicaid's Soaring Costs: Time to Step on the Brakes," Cato Institute Policy Analysis no. 597, July 19, 2007.

11. Carmen DeNavas-Walt et al., "Income, Poverty and Health Insurance in the United States: 2005," *Current Population Reports* (Washington: U.S. Census Bureau, 2006). This number should be approached with a great deal of caution, however. A study for the Department of Health and Human Services suggests that the Current Population Survey "appears to overstate the uninsured substantially compared to other surveys." Cathy Callahan and James Mays, "Working Paper: Estimating the Number of Individuals in the United States without Health Insurance," Actuarial Research Service, prepared for the Department of Health and Human Services (Washington: U.S. Department of Health and Human Services, 2005), p. 22. Other studies put the actual number of uninsured at 21–31 million. Congressional Budget Office, "How Many People Lack Health Insurance and for How Long?" (Washington: Congressional Budget Office, 2003). Moreover, all those estimates include people who could obtain coverage. For example, as many as one-third of Americans without health insurance are eligible for existing government programs such as Medicaid or the State Children's Health Insurance Program but have failed to sign up for the program. BlueCross BlueShield Association, "The Uninsured in America," January 2005, www.coverageforall.org/pdf/BC-BS_Uninsured-America.pdf. Roughly another third live in households with annual incomes above $50,000, suggesting that many could reasonably afford to purchase insurance if they chose to do so. Devon Herrick, "Crisis of the Uninsured: 2007," National Center for Policy Analysis Brief Analysis no. 595, September 28, 2007.

12. "Overview of the Uninsured in the United States: An Analysis of the 2005 Current Population Survey" (Washington: U.S. Department of Health and Human Services, 2005).

13. This is not to say that *universal* coverage should be the goal of health care reform, and certainly not the primary goal. Universal insurance coverage does not necessarily translate into access to care. And, while some evidence indicates that uninsured Americans have somewhat worse health outcomes than insured Americans, the evidence of a direct link between health insurance and health is weak. Nor is expanding insurance coverage necessarily the best or most efficient use of resources for improving health. Helen Levy and David Meltzer, "What Do We Really Know about Whether Health Insurance Affects Health," Economic Research Initiative on the Uninsured Working Paper no. 6, December 2001. Moreover, in many cases, expanding insurance coverage will exacerbate the problems of third-party payment.

14. Cited in Tamar Nordenberg, "Make No Mistake: Medical Errors Can Be Serious," FDA *Consumer Magazine* 34, no. 5 (2000).

15. Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348 (2003): 2635–45.

16. Rita Mangione-Smith et al., "The Quality of Ambulatory Care Delivered to Children in the United States," *New England Journal of Medicine* 357 (2007): 1515–23.

17. See, for example, http://www.michaelmoore.com/sicko/health-care-proposal/ and http://www.pnhp.org.

18. World Health Organization, "The World Health Report 2000" (Geneva: WHO 2000); *SiCKO*, Dog Eat Dog Films, 2007. For a

critical look at the WHO study, see Glen Whitman, "WHO Do You Think You're Fooling: The World Health Organization's Problematic Ranking of Health Care Systems," Cato Institute Briefing Paper, February 28, 2008; Twila Brase, "WHO's Hidden Agenda," *Ideas on Liberty,* Foundation for Economic Education, October 2000.

19. World Health Organization.

20. Ibid.

21. OECD, "Health at a Glance: OECD Indicators, 2005" (Paris: OECD Publishing, 2005), p.11.

22. Census Bureau, *2000 Census* (Washington: U.S. Census Bureau).

23. Robert L. Ohsfeldt and John E. Schneider, *The Business of Health: The Role of Competition, Markets, and Regulation* (Washington: American Enterprise Institute Press, 2006).

24. In Austria and Germany, fetal weight must be at least 500 grams (1 pound) to count as a live birth; in other parts of Europe, such as Switzerland, the fetus must be at least 30 centimeters (12 inches) long. In Belgium and France, births at less than 26 weeks gestation are registered as lifeless. And some countries don't reliably register babies who die within the first 24 hours after birth. For a full discussion of the issue, see Miranda Mugford, "A Comparison of Reported Differences in Definitions of Vital Events and Statistics," *World Health Statistics Quarterly* 36 (1983), cited in Nicholas Eberstadt, *The Tyranny of Numbers: Measurements and Misrule* (Washington: AEI Press, 1995), p. 50. Some, but not all, countries are beginning to standardize figures, and future data may be more reliable.

25. Anthony DePalma, "*SiCKO*, Castro, and the 120 Year Club," *New York Times,* May 27, 2007.

26. Arduino Verdecchia et al., "Recent Cancer Survival in Europe: A 2000–02 Period Analysis of EUROCARE-4 Data," *The Lancet Oncology* 8, no. 9 (2007): 784–96, http://www.thelancet.com/journals/lanonc/article/PIIS1470204507702462/abstract; Nicole Martin, "UK Cancer Survival Rate Lowest in Europe," *Daily Telegraph*, August 24, 2007. Of course, some argue that these figures are skewed by aggressive U.S. testing and diagnostic procedures. In the United States, doctors catch many cancers that would go undetected in other countries. These cancers may be small or slow growing and might not kill the person. That these cancers are diagnosed in the United States but not in other countries makes our survival rate look higher. Jonathan Cohn, "What Jacques Chirac Could Teach Us about Health Care," *New Republic,* April 10, 2007. That theory is worth considering; increased screening likely does affect the figures for slow growing cancers such as prostate cancer (the source of much controversy since Rudy Giuliani raised the issue in his campaign). "Rudy Wrong on Cancer Survival Chances," *Washington Post*, October 31, 2007; David Gratzer, "Rudy Is Right in Data Duel about Cancer," *Investors Business Daily*, November 6, 2007.

As Robert Ohsfeldt and John Schneider concede in their book, *The Business of Health*, "[Many] cancer survival rate estimates . . . do not adjust for cancer stage at diagnosis. This could result in survivor time bias—those with cancers detected at an earlier stage would exhibit longer post diagnosis survival times, even for cancers that are essentially untreatable." Robert Ohsfeldt and John Schneider, *The Business of Health* (Washington: AEI, 2007), pp. 23–24. However, survivor time bias is not as big an issue for cancers that have faster metastasizing times or that strike younger patients. As Ohsfeldt and Schneider go on to note:

> Survivor time bias, however, should not be a significant concern for cancers that respond well to treatment if detected early. For such cancers, early detection makes a substantive contribution to survival time—the longer survival time associated with early detection thus is not a spurious effect of early detection. An example is thyroid cancer. In the United States, virtually all females with thyroid cancer survive for at least five years. The lower survival rates for thyroid cancer in European countries suggest some underperformance in either early detection or post diagnosis management in these countries. In contrast, the differences in survivor rates are less pronounced for cancers that are more difficult to treat, such as lung cancers.

The United States' advantage holds for other cancers, too, including breast, colon, and thyroid cancer among others. Moreover, the benefits of early detection and treatment go well beyond survival rates. Even for prostate cancer, early treatment can significantly affect quality of life. And the United States might simply have more cases of prostate cancer than other countries. (For example, diet could play a significant role. Kyung Song, "Study Links Diet to Prostate Cancer," *Seattle Times,* October 11, 2007.)

Finally, one of the most common arguments for socialized medicine is its capacity to increase screening and preventive care. Indeed, John Edwards actually wants to make testing mandatory for all Americans. "Edwards Backs Mandatory Preventive Care," Associated Press, September 2, 2007.

27. "World Briefing: Berlusconi Has Heart Surgery in US," *New York Times*, December 19, 2006.

28. "Stronach Went to US for Cancer Treatments: Report," CTV, September 14, 2007,

http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070914/belinda_Stronach_070914/20070914.

29. Steve Findlay, "U.S. Hospitals Attracting Patients from Abroad," *USA Today*, July 22, 1997.

30. The two principal reasons for sending a patient abroad were the lack of availability of services in Canada (40 percent) and the length of the wait for certain treatments (19 percent). Robert J. Blendon et al., "Physicians' Perspectives on Caring for Patients in the United States, Canada, and West Germany," *New England Journal of Medicine* 328, no. 14 (1993): 1011–16.

31. John Goodman, "Moore's SiCKO Could Put Lives at Risk," *The Michael Moore Chronicles,* National Center for Policy Analysis, 2007, http://sicko.ncpa.org/moores-sicko-could-put-lives-at-risk.

32. "Nobel Prize in Physiology or Medicine Winners 2007–1901," The Nobel Prize Internet Archive, http://almaz.com/nobel/medicine/medicine.html.

33. Pharmaceutical Research and Manufacturing of America, "R&D Spending by U.S. Biopharaceutical Companies Reaches a Record $55.2 Billion in 2006," February 12, 2007.

34. *Economic Report of the President* (Washington: Government Printing Office, 2004), p. 192.

35. Gerard Anderson et al., "It's the Prices Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (2003): 99.

36. Oliver Schoffski, "Diffusion of Medicines in Europe," paper prepared for the European Federation of Pharmaceutical Industries and Associations," 2002, cited in Daniel Kessler, "The Effects of Pharmaceutical Price Controls on the Cost and Quality of Medical Care: A Review of the Empirical Literature," submitted to the U.S. International Trade Commission.

37. Ibid.

38. For example, some evidence seems to indicate that overuse of CT scans in the United States, especially in children, may actually be increasing the incidence of some cancers. David Brenner and Eric Hall, "Computed Tomography—An Increasing Source of Radiation Exposure," *New England Journal of Medicine* 357, no. 22 (2007): 2277–84. Yet, other evidence suggests that increased use of CT scans may reduce deaths from other cancers such as lung cancer. International Early Lung Cancer Investigators, "Survival of Patients with Stage I Lung Cancer Detected on CT Screening," *New England Journal of Medicine* 355, no. 17 (2006): 1763–71. Robin Hanson of George Mason University has argued that much of U.S. health care spending provides no benefit at all. Indeed, Hanson believes that we could cut health care spending by 50 percent without affecting health outcomes. Robin Hanson, "Cut Medicine in Half," Cato Unbound, September 10, 2007, http://www.cato-unbound.org/2007/09/10/robin-hanson/cut-medicine-in-half/. In contrast, Mark McClellan of Harvard University and economist David Cutler argue that the benefits of increased health care technology vastly overwhelm their costs. David Cutler and Mark McClellan, "Is Technological Change in Medicine Worth It?" *Health Affairs* 20 (2001): 11–29.

39. Ohsfeldt and Schneider, *The Business of Health*. It is true, as Jonathan Cohn points out, that much, though by no means all, of the basic research on health care is funded by the National Institutes of Health. Jonathan Cohn, "Creative Destruction: The Best Case against National Health Care," *The New Republic*, November 12, 2007. However, the vast majority of applied research is funded by the private sector. Overall, roughly 57 percent of all biomedical research spending comes from private industry. From 1989 to 2002, four times as much money was invested in private biotechnology companies in America as in all of Europe. Tyler Cowen, "Poor U.S. Scores in Health Care Don't Measure Nobels or Innovation," *New York Times,* October 5, 2006.

40. Cowen, "Poor U.S. Scores in Health Care Don't Measure Nobels or Innovation."

41. "The Novartis Warning," *Wall Street Journal,* May 8, 2002.

42. See Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs* 12, suppl. 1 (1993): 24–48.

43. Michael Tanner, "No Miracle in Massachusetts: Why Governor Romney's Health Care Reform Won't Work," Cato Institute Briefing Paper no. 97, June 6, 2006.

44. Jonathan Cohn, *Sick: The Untold Story of America's Health Care Crisis—And the People Who Pay the Price* (New York: HarperCollins, 2007), p. 226.

45. Ezra Klein, "Health Care Wrap Up," www.ezraklein.com April 25, 2005; http://www.prospect.org/csnc/blogs/ezraklein_archive?month=04&year=2005&base_name=health_care_wrapup.

46. Mattke et al., "Health Care Quality Indicators Project."

47. Victor Rodwin, "The Health Care Systemunder French National Health Insurance: Lessons for Health Reformin the United States," *American Journal of Public Health* 93, no. 1 (2003): 34. Note that the total tax burden is higher than the health care system's percentage ofGDP because ofthe costs associated with the nonworking population—that is, children, the elderly, and the unemployed.

48. Philippe Manière et al., "Perspectives on the European Health Care Systems: Some Lessons for America," Heritage Foundation Lecture no. 711, July 9, 2001.

49. "French Health Insurance Systemto Post 10.3- Billion-Euro Deficit," *EU Business*, August 6, 2006.

50. "Deficit-Saddled France under Fire over Budget," Reuters, July 5, 2007. Members ofthe Eurozone are required to keep budget deficits below 3 percent ofGDP.

51. "French Health Care Is Badly Run," *BBC News*, August 8, 2006.

52. Martine Bellanger, Veneta Cherilova, and Valerie Paris, "The Health Benefit Package in France," *European Journal of Health Economics* 6, suppl. 1 (2005): 24–29.

53. Simone Sandier et al., "France," in *Health Care Systems in Transition,* eds. Sarah Thomson and Elias Mossialos (Brussels: The European Observatory on Health Care Systems, 2004).

54. Thomas Buchmueller and Agnes Couffinhal, "Private Health Insurance in France," OECD Health Working Paper no. 12, 2004. In this sense at least, French physicians may have more freedomthan American physicians under Medicare, which prohibits balance-billing.

55. Francesca Columbo and Nicole Tapay, "Private Health Insurance in the OECD Countries: The Benefits and Costs for Individuals and Health Systems," OECD Health Working Paper no. 15, 2004.

56. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."

57. Buchmueller and Couffinhal, "Private Health Insurance in France." It is important to note, however, that this deregulated insurance is *supplemental coverage*. No one can be disqualified for health reasons frombasic coverage.

58. Ibid.

59. Rodwin, "The Health Care Systemunder French National Health Insurance."

60. Ibid.

61. Valentin Petkantchin, "Pernicious Myths about Public Health Insurance in France," *Economic Note* (Brussels: Institut Economique Molinari, 2007), http://www.institutmolinari.org/pubs/note20071.pdf.

62. "La Securite Social," Report ofthe French Court of Audit, September 2006.

63. Manière et al., "Perspectives on the European Health Care Systems."

64. Paul Dutton, "Health Care in France and the United States: Learning fromEach Other," Brookings Institution, July 2002.

65. Rodwin, "The Health Care Systemunder French National Health Insurance.

66. Alexander Dorozynski, "French Health StaffStrike over Budget Cuts," *British Medical Journal* 320 (February 2000): 333; Alexander Dorozynski, "French Medical SystemBeset by Strikes," *British Medical Journal* 324 (February 2002): 258.

67. High Council for the Future ofHealth Insurance, "L'Avenir de l'Assurance Maladie: L'Urgence d'un Redressment par la Qualité" (Paris, Ministry ofHealth, 2004).

68. Valentin Petkantchin, "The Ineffectiveness ofHealth Cost Containment Policies in France," *Economic Note* (Brussels: Institut Economique Molinari, 2007); http://www.institutmolinari.org/pubs/note20073.pdf.

69. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."

70. Rodwin, "The Health Care Systemunder French National Health Insurance.

71. Petkantchin, "The Ineffectiveness of Health Cost Containment Policies in France."

72. Norman Ho; "A Long, Hot Summer;" *Harvard International Review* 26 (Summer 2004); "French Health Care Is Badly Run," BBC News, January 23, 2004.

73. Valentin Petkantchin, "Bureaucratic Drug De-listing: The French Example," *EU Reporter,* January– February 2007.

74. Schoffski, "Diffusion of Medicines in Europe."

75. "French Health Care Is Badly Run," BBC News, January 23, 2004.

76. D. Benamouzig and R. Launois, "Rationing Health Care in Europe-France," in *Rationing Health Care in Europe: An Empirical Study,* eds. J. Matthais Graf von der Schulenburg and Michael Blanke (Amsterdam: IOS Press, 2004), p. 16.

77. Helen Disney et al., *Impatient for Change: European Attitudes to Healthcare Reform* (London: Stockholm Network, 2004), pp. 69–86.

78. Institut Economique Molinari, "Health Myths in France—More Competition, Not Cost Containment Is the Solution According to the French Institut Economique Molinari," news release, January 7, 2007, www.institutmolinari.org/pubs/pr20071.pdf

79. Dorozynski, "French Health Staff Strike over Budget Cuts."

80. Columbo and Tapay, "Private Health Insurance in the OECD Countries."

81. Hurst and Luigi Siciliani, "Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries," OECD Health Working Paper no. 6, July 2003.

82. Ezra Klein, "The Health of Nations—Here's How Canada, France, Britain, Germany, and our Own Veterans Health Administration Manage to Cover Everybody at Less Cost and with Better Care than We Do," *American Prospect*, April. 24; 2007.

83. E. van Doorslaer et al., "Income-Related Inequality in the Use of Medical Care in 21 OECD Countries," in *Towards High Performing Health Systems: Policy Studies from the OECD Health Project* (Paris: OECD, 2004).

84. Rodwin, "The Health Care System under French National Health Insurance."

85. Disney et al., *Impatient for Change*, pp. 69–86.

86. Ibid.

87. "Sarkozy's Election Reflects Europe's Right Turn," National Public Radio, May 7, 2007.

88. "Budget 2008: Tighter Controls on Healthcare Spending as French Conservatives Crack Down on Social Security Deficit," Global Insight, 2007, http://www.globalinsight.com/SDA/SDADetail10740.htm

89. Mattke et al., "Health Care Quality Indicators Project."

90. Alexandra Bibbee and• Benoît Bellone, "Economic Survey of Italy, 2007" (Paris: OECD, 2007).

91. Andrea Donatini et al., *Health Care Systems in Transition: Italy* (Copenhagen: European Observatory on Health Systems and Policies, 2001).

92. Franco Reviglio, "Health Care and Its Financing in Italy: Issues and Reform Options," IMF Working Paper 00-166, October 2000.

93. Donatini et al., *Health Care Systems in Transition: Italy*.

94. Reviglio, "Health Care and Its Financing in Italy".

95. Depending on regions and election cycles. Copay-ments for prescription drugs are frequently introduced only to be repealed shortly before elections.

96. Daniel Callahan and Angela Wasunna, *Medicine and the Market: Equity v. Choice* (Baltimore: Johns Hopkins University Press, 2006), p. 98.

97. Donatini et al., *Health Care Systems in Transition: Italy*.

98. Callahan and Wasunna, *Medicine and the Market: Equity v. Choice,* p. 93.

99. Vincenzo Atella and Federico Spandanaro, "Private Health Insurance in Italy: Where We Stand Now," *Euro Observer,* Spring 2004.

100. Callahan and Wasunna, *Medicine and the Market: Equity v. Choice,* p. 97.

101. George France, Francesco Taroni, and Andrea Donatini, "The Italian Health Care System," *Health Economics* 14 (September 2005): 185–202.

102. Alberto Mingardi, "A Drug Price Path to Avoid," *Washington Post*, November 12, 2006.

103. See, for example, "Italy Hit by Double Strike," BBC News, February 9, 2004.

104. Reviglio, "Health Care and Its Financing in Italy."

105. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."

106. Donatini et al., "Health Care Systems in Transition: Italy."

107. Mingardi, "A Drug Price Path to Avoid."

108. Ariel David, "Italian Police Units Inspect Hospitals," *Washington Post*, January 8, 2007.

109. Vittorio Maio and Lamberto Manzoli, "The Italian Health Care System: WHO Ranking versus Public Perception," *PLoS Medicine* 6 (June 2002): 301–03.

110. Disney et al., *Impatient for Change,* pp. 111–19.

111. GuillemLopez-Casasnovas, Joan Coasta-Font, and Ivan Planas, "Diversity and Regional Inequalities: Assessing the Outcomes ofthe Spanish SystemofHealth Care Services," UPF Working Paper no. 745, April 2004.

112. Antonio Duran, Juan Lara, and Michelle van Waveren, "Spain: Health SystemReview," *Health Systems in Transition* 8, no. 4 (Copenhagen: European Observatory on Health Systems and Policies, 2006).

113. Ibid.

114. "Waiting to Be Seen: How the Health Service Varies across Spain," *Expatica*, June 26, 2007.

115. Emilio Cerda, Laura de Pablos, and Maria Rodriguez, "Waiting Lists for Surgery," in *Patient Flow: Reducing Delay in Healthcare Delivery* (Hoboken, NJ: Springer, 2006).

116. Xavier Bosch, "Spain: The Old Frequently Live with Their Families," *British Medical Journal* 324 (June 29, 2002): 1543.

117. There is one exception. Central government civil servants can opt out ofthe public systemand have the government pay for their private insurance. Roughly 91 percent ofcivil servants choose private insurance. Noah Clarke, "Government Health Care: A Universal Failure," *Today's News,* Goldwater Institute, May 10, 2007.

118. Mario Rodriguez, Richard Scheffler, and Jonathan Agnew, "An Update on Spain's Health Care System: Is It Time for Managed Competition?" *Health Policy* 51 (2000): 109–31.

119. Columbo and Tapay, "Private Health Insurance in the OECD Countries."

120. Luis Rajmil et al., "The Quality ofCare and Influence ofDouble Health Care Coverage in Catalonia (Spain)," *Archive of Disease in Childhood* 83 (September 2000): 211–14.

121. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."

122. Duran, Lara, and van Waveren, "Spain: Health Systems Review."

123. Rodriguez, Scheffler, and Agnew, "An Update on Spain's Health Care System"

124. Duran, Lara, and van Waveren, "Spain: Health Systems Review."

125. Disney et al., *Impatient for Change*, pp. 151–60.

126. Alastair Kilmarnock, "Spain: Commentary," in *Impatient for Change: European Attitudes to Healthcare Reform*, eds. Disney et al. (London: StockholmNetwork, 2004), p. 161.

127. Disney et al., *Impatient for Change*, pp. 151–60.

128. Tetsuo Fukawa, "Public Health Insurance in Japan," World Bank Institute Working Paper no. 37201 (2002).

129. Ibid.

130. Kohei Komamura and Atsuhiro Yamada, "Who Bears the Burden of Social Insurance? Evidence from Japanese Health and Long-Term Care Insurance Data," *Journal of Japanese and International Economics* 18 (December 2004): 565–81.

131. "Japanese Health Insurance Industry Faces Winnowing Out," *Medical Insurance News*, March 21, 2004.

132. Noriyuki Takayama, "Japan's Never-Ending Social Security Reforms," *International Social Security Review* 55 (2002): 11–22.

133. Ibid.

134. Adam Wagstaff, "Health Systems in East Asia: What Can Developing Countries Learn from Japan and the Asian Tigers?" *Health Care Economist*, April 18, 2007.

135. Shikha Dalmia, "The UAW's Health-Care Dreams," *Wall Street Journal*, July 27, 2007.

136. M. Ryan Baker, "Japan and Massachusetts: A Comparison of Universal Health Care Systems," Missouri Foundation for Health, Spring 2006.

137. Naoki Ikagami and John Campbell, "Japan's Health Care System: Containing Costs and Attempting Reform," *Health Affairs* 23 (2004): 29–34.

138. Naoki Ikagami and John Campbell, "Health Care Reform in Japan: The Virtues of Muddling Through," *Health Affairs* 18 (Fall 1999): 56–75.

139. Ibid.

140. "The Doctor's Dilemma," *The Economist*, June 10, 2004.

141. Jeong Hyoung-Sun and Jeremy Hurst, "An Assessment of the Performance of the Japanese Health Care System," OECD Labour Market and Social Policy Occasional Paper no. 56, 2001.

142. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."

143. Aki Yoshikawa and Jayanata Bhattacharya, "Japan," in *World Health Systems: Challenges and Perspectives*, eds. Bruce Fried and Laura Gaydos (Chicago: Health Administration Press, 2002).

144. Ikagami and Campbell, "Health Care Reform in Japan: The Virtues of Muddling Through."

145. Bill Ross et al., "International Approaches to Funding Health Care," [Australia] Commonwealth Department of Health and Ageing Occasional Papers, Health Financing Series no. 2, 1999.

146. W. C. Hsiao, "Afterward Costs—The Macro Perspective," *Containing Health Care Costs in Japan* (Ann Arbor: The University of Michigan Press, 1999), pp. 45–52. While this study uses dated data, the general conclusions have been endorsed by more recent authors: Ikagami and Campbell, "Health Care Reform in Japan: The Virtues of Muddling Through"; Ross et al., "International Approaches to Funding Health Care."

147. Rihito Kimura, "Bioethics and Japanese Health Care," *Washington-Japan Journal* 3 (1994): 2.

148 Takayama, "Japan's Never-Ending Social Security Reforms."

149. Christian Hagist and Laurence J. Kotlikoff, "Health Care Spending: What the Future Will Look Like," National Center for Policy Analysis, Study no. 286, June 28, 2006.

150. Booyeon Lee, "Help Wanted: Is Immigration the Answer to the Shrinking Labor Force," *Ashai Shimbun*, December 23, 2003.

151. Waiting lists and rationing in Norway have become sufficiently bad that, in 2000, the government launched the Patient Bridge Project to facilitate the treatment of Norwegian patients in private hospitals in neighboring countries. G. Bottom, S. Grepperud, and S. M. Neiland, "Trading Practices: Lessons from Scandinavia," *Health Affairs* 69 (2004): 317–27.

152. Jan Roth Johnsen, *Health Systems in Transition: Norway* 8, no. 1 (Copenhagen: European Observatory on Health Systems and Policies, 2006).

153. "Tax Revenues on the Rise in Many OECD Countries, OECD Report Shows," *FinFacts*, October 11, 2006; http://www.finfacts.com/irelandbusinessnews/publish/article_10007581.shtml.

154. Ibid.

155. Johnsen, *Health Systems in Transition: Norway*.

156. Michael Moore, Remarks before the Washington, D.C., premiere of *SiCKO*, June 20, 2007.

157. Johnsen, *Health Care Systems in Transition: Norway*.

158. Terje Hagen and Oddvar Kaarboe, "The Norwegian Hospital Reform of 2002: Central Government Takes Over Ownership of Public Hospitals," Health Organization Research Norway (HORN) Working Paper no. 1 (2004).

159. Paul van den Noord, Terje Hagen, and Tor Iversen, "The Norwegian Health Care System," OECD Economics Department Working Paper no. 198, 1998.

160. Johnsen, *Health Care Systems in Transition: Norway*.

161. H. Piene, P. Nyen, and H. Hauge, "Waiting Lists and Hospital Capacity—Analyses Based on Theoretical Queue Models and Empirical Data," Paper presented to the Annual Meeting of the International Society for Technological Assessment of Health Care, Unimed, Norway, 1997.

162. Christine Furuholmen and Jon Magnussen, *Health Care Systems in Transition: Norway* (Copenhagen: European Observatory on Health Care Systems, 2000).

163. Luigi Siciliani and Jeremy Hurst, "Explaining Waiting Times Variations for Elective Surgery across OECD Countries," OECD Health Working Paper no. 7, October 2003.

164. M. Hoel and E. Saether, "Private Health Care as a Supplement to a Public Health System with Waiting Time for Treatment," Ragnar Frisch Center for Economic Research, Oslo, 2000.

165. Quoted in Soren Holm, "Goodbye to the Simple Solutions: The Second Phase of Priority Setting in Health Care," *British Medical Journal* 317 (October 1998): 1000–02.

166. Hagen and Kaarboe, "The Norwegian Hospital Reform of 2002: Central Government Takes Over Ownership of Public Hospitals."

167. Ibid.

168. Knut Erik Tranoy, "Ethical Principles in Public Health Care" in "Scandinavia: With a Remark about Relativism and the Cultural Foundations of Health Care Ethics," in *Bioethics for the People by the People,* ed. Darryl R. J. Macer (Bangkok, Thailand: Eubios Ethics Institute, 1994), p. 57.

169. Ibid.

170. Hagen and Kaarboe, "The Norwegian Hospital Reform of 2002: Central Government Takes Over Ownership of Public Hospitals."

171. Catarina Diogo, "The Reform of the NHS in Portugal," University of York, Department of Management, Working Paper no. 5, 2005.

172. Directorate-General of Health, "National Health Plan, 2004–2010" (Lisbon: Ministry of Health, July 2004).

173. OECD, "Health at a Glance: OECD Indicators, 2005" (Paris: OECD, 2005).

174. Margarida Bentes et al., *Health Care Systems in Transition: Portugal* (Copenhagen: European Observatory on Health Systems

and Policies, 2004).

175. Bentes et al., *Health Care Systems in Transition: Portugal*.

176. Paul Ferrinho, "Dual Practice in the Health Sector: Review of the Evidence," *Human Resources for Health* 2 (2004).

177. Bentes et al., *Health Care Systems in Transition: Portugal*.

178. Ibid.

179. Ibid.

180. Columbo and Tapay, "Private Health Insurance in OECD Countries."

181. Bentes et al.

182. Ibid.

183. Ibid.

184. Catarina Diogo, "The Reform of the NHS in Portugal," University of York, Department of Management, Working Paper no. 5, 2005.

185. Monica Duarte Oliveira and Gwyn Bevan, "Measuring Geographic Inequalities in the Portuguese Health Care System: An Estimation of Hospital Care Needs," *Health Policy* 66 (March 2003): 277–93.

186. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."

187. Mario de Queiroz, "Living in Portugal, Giving Birth in Spain," *InterPress Service*, March 29, 2005.

188. Monica Duarte Oliviera, Jose Magone, and Joao Periera, "Nondecision Making and Inertia in Portuguese Health Policy," *Journal of Health Politics, Policy and Law* 30 (January–February 2005): 211–30.

189. Josep Figueras et al., *Health Care Systems in Transition: Greece* (Copenhagen: World Health Organization, 1996).

190. Figueras et al., *Health Care Systems in Transition:Greece.*

191. Konstantina Davaki and Elias Mossialos, "Plus Ca Change: Health Sector Reforms in Greece," *Journal of Health Politics, Policy, and Law* 30 (February– April 2005): 143–67.

192. Figueras et al., *Health Care Systems in Transition:Greece.*

193. Mary Geitona, "Cost Containment Policies in the Public Sector," Paper presented at International Training Programon Health Economics, Athens, December 2003, http://www.nsph.gr/ecoman/word/costconainmentpolicies.doc

194. Davaki and Mossialos, "Plus Ca Change."

195. Ibid.

196. "Greece Healthcare: Coming under Great Pressure," *The Economist,* June 24, 2005.

197. Figueras et al., *Health Care Systems in Transition:Greece*.

198. WHO, "Highlights on Health: Greece 2004" (Copenhagen: WHO Regional Office for Europe, 2005.)

199. Columbo and Tapay, "Private Health Insurance in OECD Countries"; WHO, "Highlights on Health: Greece 2004."

200. Theodora Zachariadou et al., "The Demolition of Waiting Lists Project," PowerPoint presentation, 2005; http://www.hope.be/04exchange/pro-gramme2006/presentations_participants/greece_2006.pdf

201. Cited in Zachariadou et al., "The Demolition of Waiting Lists Project."

202. Davaki and Mossialos, "Plus Ca Change."

203. WHO, "Highlights on Health: Greece 2004."

204. Figueras et al., *Health Care Systems in Transition:Greece*.

205. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."

206. Geitona, "Cost Containment Policies in the Public Sector."

207. Elias Mossialos, Sara Allin, and Konstantina Davaki, "Analyzing the Greek Health System: A Tale of Fragmentation and Inertia," *Health Economics* S1 (2005): S151.

208. Jessica Hohman, "International Healthcare Systems: A Primer," American Medical Student Association, 2007.

209. Andre den Exter et al., *Health Care Systems in Transition: Netherlands* (Copenhagen: European Observatory on Health Systems and Policies, 2004).

210. G. P. Westert and H. Verkleij, eds., *Dutch Health Care Performance Report 2006* (Bilthoven, The Netherlands: Center for Prevention and Health Services Research, National Institute for Public Health and the Environment, 2006.) A government-run system remains in place to cover long-term care, mental health care, and mental health hospitalization of longer than one year. Kaiser Permanente International, "Selected European Countries' Health Systems," Prepared for a conference on European Systems of Universal Health Care, Washington, October 31, 2007.

211. "Alain Enthoven and Wynand van den Ven, "Going Dutch—Managed-Competition Health Insurance in the Netherlands," *New England Journal of Medicine* 357 (2007): 2421–23.

212. Stefan Greb, Maral Manougian, and Jurgen Wasem, "Health Insurance in the Netherlands," CESifo DICE Report, January 2007.

213. Kaiser Permanente International, "Selected European Countries' Health Care Systems."

214. Willem van Duin, "The Role of Private Insurers in Dutch Health Care: The Vision of Eureko," Paper presented at a conference on European Systems of Universal Health Care, Washington, October 31, 2007.

215. Ibid.

216. "The New Care System in the Netherlands," Ministry of Health, Welfare and Sport, The Netherlands Embassy, May 2006, www.minvws.nl/images/boekje-zorgstelsel—engels_tcm20-107939.pdf.

217. "Health Insurance System," Ministry of Health, Welfare and Sport, The Royal Netherlands Embassy, 2006, www.minvws.nl/en/themes/health-insurance-system/.

218. J. Andre Knottnerus and Gabriel ten Velden, "Dutch Doctors and Patients—Effects of Health Care Reform in the Netherlands," *New England Journal of Medicine* 357 (2007): 2424–26.

219. Van Duin, "The Role of Private Insurers in Dutch Health Care: The Vision of Eureko."

220. Ibid.

221. Knottnerus and ten Velden, "Dutch Doctors and Patients—Effects of Health Care Reform in the Netherlands."

222. Greb, Manougian, and Wasem, "Health Insurance in the Netherlands."

223. Gautam Naik, "Dutch Treatment: In Holland, Some See Model for U.S. Health-Care System," *Wall Street Journal,* September 6, 2007.

224. Greb, Manougian, and Wasem, "Health Insurance in the Netherlands."

225. Ibid.

226. Siciliani and Hurst, "Explaining Waiting Times Variations for Elective Surgery across OECD Countries."

227. J. Plomp et al., "Death on the Waiting List for Cardiac Surgery in the Netherlands in 1994 and 1995," *Heart* 81 (1999) 593–97.

228. Paul Belien, "Two Months of Competition in Dutch Healthcare," *Brussels Journal*, October 23, 2006.

229. Knottnerus and ten Velden, "Dutch Doctors and Patients—Effects of Health Care Reform in the Netherlands."

230. Ibid.

231. Gautam Naik, "Dutch Treatment: In Holland, Some See Model for U.S. Health-Care System," *Wall Street Journal,* September 6, 2007.

232. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."

233. Rudolf Klein, "The Troubled Transformation of Britain's National Health Service," *New England Journal of Medicine* 355 (2006): 409–15.

234. Daniel Martin, "Billions Squandered as NHS Fails to Deliver," *Daily Mail,* September 12, 2007.

235. Ibid.

236. Anthony Browne, "Deadly Rise in Wait for Cancer Care," *London Observer*, March 3, 2002.

237. Anthony Browne, "Cash-Strapped NHS Hospitals Chase Private Patient "Bonanza," *London Observer,* December 16, 2001.

238. "Too Successful: The Hospitals Forced to Introduce Minimum Waiting Times," *Daily Telegraph*, August 7, 2006.

239. Ibid.

240. Martin, "Billions Squandered as NHS Fails to Deliver."

241. John C. Goodman, "Health Care in a Free Society: Rebutting the Myths of National Health Insurance," Cato Policy Analysis no. 532, January 27, 2005.

242. Richard Lewis and John Appleby, "Can the English NHS Meet the 18-Week Waiting List Target?" *Journal of the Royal Society of Medicine* 99 (206): 10–13.

243. David Rose, "Waiting List Crisis as NHS Cuts Costs," *London Times*, June 56, 2007.

244. Callahan and Wasunna, *Medicine and the Market: Equity v. Choice,* p. 93.

245. Lewis and Appleby, "Can the English NHS Meet the 18-Week Waiting List Target?"

246. "NHS Should Not Treat Those with Unhealthy Lifestyles, Say Tories," *Evening Standard*, September 4, 2007.

247. Elizabeth Docteur and Howard Oxley, "Health-Care Systems: Lessons from the Reform Experience," OECD Working Paper no. 9, December 5, 2003.

248. Sarah Thomson and Elias Mossialos, "Regulating Private Health Insurance in the European Union: Implications of Single Market Legislation and Competition Policy," European Health Policy Group, September 2004.

249. Disney et al., *Impatient for Change*, pp. 29–38.

250. Civitas, "The Swiss Healthcare System" (London: The Institute for the Study of Civil Society, 2002), http://www.civitas.org.uk/pdf/Switzerland.pdf. This number differs from the official OECD percentage because the OECD defines government expenditure on health to include government-mandated insurance premiums, even if they are spent on private insurance. Under this definition, all private insurance purchased in Massachusetts under its new compulsory health care plan would be categorized as a public expenditure on health, for example. The cited number excludes mandatory insurance premiums because, though Swiss citizens are required to purchase a basic insurance plan, that plan comes from privately owned and even "for-profit" insurance companies. Individuals have considerable freedom of choice among insurers. Furthermore, premiums are paid directly to the insurers rather than collected directly by the government. For all those reasons the Swiss system differs significantly from, say, Germany, where I believe it is proper to include payments to sickness funds as a governmental rather than a private expenditure.

251. Michael Tanner, "No Miracle in Massachusetts: Why Governor Romney's Health Care Reform Won't Work." However, Regina Herzlinger of Harvard University notes the important distinction that, unlike most systems of managed competition, including both the Clinton and Romney versions, the Swiss system is not employer based (email to author, October 3, 2007).

252. For more on the concept of managed competition, see Enthoven, "The History and Principles of Managed Competition."

253. Association of Swiss Health Insurance Companies and *CIA World Factbook* (Washington: Central Intelligence Agency).

254. Michael Tanner, "Individual Mandates for Health Insurance: Slippery Slope to National Health Care," Cato Institute Policy Analysis no. 565, April 5, 2006.

255. E-mail from Sabine Alder, Communications Manager, Association Suisse d'Assurances, to author, October 4, 2007; Greg Kelly, "Can Government Force People to Buy Insurance?" *Issues and Answers* no. 123, Council for Affordable Health Insurance, March 2004, citing data from the Insurance Research Council, http://www.cahi.org/cahi_contents/resources/pdf/n123GovernmentMandate.pdf.

256. Andreas Minder, Hans Schoenholzer, and Marianne Amiet, Health Care Systems in Transition: Switzerland (Copenhagen: European Observatory on Health Care Systems, 2000).

257. Jim Landers, "In Switzerland, Everyone Is Insured, and Businesses Don't Pay," *Dallas Morning News,* February 7, 2006.

258. Regina Hertzlinger and Ramin Parsa-Parsi, "Consumer-Driven Health Care: Lessons from Switzerland." *Journal of American Medical Association* 292, no. 10 (2004).

259. Ibid.

260. Ibid.

261. Landers, "In Switzerland Everyone Is Insured, and Businesses Don't Pay."

262. Uwe E. Reinhardt, "The Swiss Health System: Regulated Competition without Managed Care," *Journal of the American Medical Association* 292, no. 10 (2004): 1227–31.

263. Hertzlinger and Parsa-Parsi, "Consumer-Driven Health Care: Lessons from Switzerland."

264. Peter Zweifel, "Competitive Mechanisms in Health Care," in *Reinventing Health Care* (London: Stockholm Network, 2000).

265. Hertzlinger and Parsa-Parsi. "Consumer-Driven Health Care: Lessons from Switzerland."

266. Minder, Schoenholzer, and Amiet, Health Care Systems in Transition: Switzerland.

267. Ibid.

268. Civitas, "The Swiss Healthcare System"

269. Ibid.

270. OECD, "Health at a Glance: OECD Indicators, 2005."

271. See Reinhardt, Hussey, and Anderson, "U.S. Health Care Spending in an International Context."

272. Herzlinger and Parsa-Parsi. "Consumer-Driven Health Care: Lessons from Switzerland."

273. Mattke et al., "Health Care Quality Indicators Project."

274. "Swiss Voters Reject Health Insurance Changes," Agence France Presse, March 11, 2007.

275. Tanner, "Individual Mandates for Health Insurance: Slippery Slope to National Health Care."

276. Ibid.

277. Civitas, "The Swiss Healthcare System"

278. Ibid.

279. Reinhardt, "The Swiss Health System: Regulated Competition without Managed Care."

280. Herzlinger and Parsa-Parsi. "Consumer-Driven Health Care: Lessons from Switzerland."

281. Peter Zweifel, "Switzerland," *Journal of Health Politics, Policy, and Law* 25 (2000): 937–44.

282. Zweifel, "Competitive Mechanisms in Health Care."

283. Hertzlinger and Parsa-Parsi, "Consumer-Driven Health Care: Lessons fromSwitzerland."

284. Alphonse Crespo, "Swiss Health Care: A Clockwork Model That Fails to Keep Its Promise," in *The Dangers of Undermining Patient Choice: Lessons from Europe and Canada*, eds. Merrill Matthews, Grace-Marie Turner, and Julian Morris (Dallas: Institute for Policy Innovations, and Alexandria, VA: Galen Institute, 2006), pp. 16–19.

285. Hertzlinger and Parsa-Parsi, "Consumer-Driven Health Care: Lessons fromSwitzerland."

286. Minder, Schoenholzer, and Amiet, *Health Care Systems in Transition: Switzerland.*

287. Mattke et al., "Health Care Quality Indicators Project."

288. David Greene and Benedict Irvine, "Health Care in France and Germany: Lessons for the UK" (London: Civitas, The Institute for the Study ofCivil Society, 2001).

289. Ulla Schmidt, "Health Policy and Health Economics in Germany," Speech given at the conference, *The American Model and Europe: Past-Present-Future*, Washington, January 27, 2006.

290. Kaiser Permanente International, "Selected European Countries' Health Care Systems."

291. Schmidt, "Health Policy and Health Economics in Germany." Roughly 14.2 percent covers standard health insurance, with an additional 0.9 percent going to cover dentures and sick pay. There is also a separate 1.7 percent tax (1.95 percent for childless couples) to cover long-termcare insurance. Kaiser Permanente International, "Selected European Countries' Health Care Systems."

292. Kyle James, "German Health Care Reform: Mission Impossible?" *Deutsche Welle*, March 8, 2006.

293. Ibid.

294. Reinhard Busse and Annette Riesberg, *Health Care Systems in Transition: Germany* (Copenhagen: European Observatory on Health Systems and Policies, 2004).

295. Ibid.

296. Dennis Nowak, "Doctors on Strike—The Crisis in German Health Care Delivery," *New England Journal of Medicine* 355, no. 15 (2006): 1520–22.

297. Ibid.

298. Cited in Annette Tuffs, "Germany at Centre ofRationing Row as Budget in Crisis," *British Medical Journal* 327 (2003): 414.

299. Christian Gericke, Matthias Wismar, and Reinhard Busse, "Cost-Sharing in the German Health Care System," Berlin University ofTechnology, 2004, http://www.ww.tu-berlin.de/diskussionspapiere/2004/dp04-2004.pdf

300. Kaiser Permanente International, "Selected European Countries' Health Care Systems."

301. Boris Augurzky, Thomas Bauer, and Sandra Schaffner, "Copayments in the German Health Care System: Does It Work?" Institute for the Study ofLabor (IZA) Discussion Paper no. 2290, September 2006.

302. "Merkel Announces a Deal, Averts a Crisis," *Der Spiegel*, October 5, 2006.

303. Siciliani and Hurst, "Explaining Waiting Times Variations for Elective Surgery across OECD Countries."

304. K. Davis et al., "Mirror, Mirror on the Wall: An International Update on the Comparative Performance ofAmerican Health Care," The Commonwealth Fund, May 2007.

305. World Health Organization, "Highlights on Health, Germany, 2004, www.euro.who.int/eprise/main/WHO/Progs?CHHDEU/system/200050311-1.

306. Hilke Brockmann, "Why Is Less Money Spent on Health Care for the Elderly than for the Rest ofthe Population? Health Care Rationing in German Hospitals," *Social Science and Medicine* 55 (2002): 593–608

307. Cited in Busse and Riesberg, *Health Care Systems in Transition: Germany.*

308. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."

309. Wilfried Prewo, "Germany: How Not to Organize a Health System," in *The Dangers of Undermining Patient Choice: Lessons from Europe and Canada*, ed. Merrill Matthews, Grace-Marie Turner, and Julian Morris (Dallas: Institute for Policy Innovations, and Alexandria, VA: Galen Institute, 2006).

310. Dieter Braeuninger, "Health Policy in Germany: Health Reforms Need a Dose of Market Medicine," Deutsche Bank Research, June 13, 2006.

311. Disney et al., *Impatient for Change*, pp. 89–97.

312. Jonathan Cohn, "Shtiko: It's No Fun to Agree with Michael Moore," *New Republic*, June 22, 2007.

313. Brett J. Skinner, "Paying More, Getting Less 2005: Measuring the Sustainability of Provincial Public Health Expenditure in Canada," Fraser Institute, October 2005.

314. *Chaoulli v. Quebec* (Attorney General), 2005 SCC 35, [2005] 1 S.C.R. 791.

315. Nadeem Esmail, Michael Walker, and Dominika Wrona, "Waiting Our Turn, 16th Edition: Hospital Waiting Lists in Canada," Fraser Institute, 2006.

316. Ibid.

317. Madhu Natarajan et al., "The Risks of Waiting for Cardiac Catheterization: A Prospective Study," *Canadian Medical Association Journal*, November 26, 2002.

318. Cited in June O'Neill and David O'Neill, "Health Status, Health Care and Inequality: Canada vs. the U.S.," National Bureau of Economic Research Working Paper no. 13429, September 2007.

319. *Chaoulli v. Quebec*.

320. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."

321. "What President Clinton Can Learn from Canada about Price Controls and Global Budgets," Policy Backgrounder no. 129, National Center for Policy Analysis, October 5, 1993.

322. OECD, "Health at a Glance: OECD Indicators, 2005."

323. O'Neill and O'Neill, "Health Status, Health Care and Inequality: Canada vs. the U.S."

324. OECD, "Health at a Glance: OECD Indicators, 2005."

325. Cited in Callahan and Wasunna, *Medicine and the Market: Equity v. Choice*, p. 72.

326. Ibid, p. 69.

327. *SiCKO*, Dog Eat Dog Films, 2007.

328. "Edwards Campaign Unveils New 'Underdog' Television Ad in New Hampshire," John Edwards 08, news release, January 6, 2008, http://www.johnewards.com/news/headlines/20080106-underdog-ad/; Joel Zinberg, "Edwards' Evil Insurance Scam," *New York Post*, January 10, 2008.

329. Callahan and Wasunna, *Medicine and the Market: Equity v. Choice*; Disney et al., *Impatient for Change*.

330. Robin Toner, "Unveiling Health Care 2.0, Again," *New York Times*, September 16, 2007.

331. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 countries."

332. Quoted in Callahan and Wasunna, Medicine and the *Market: Equity v. Choice*, p. 109.

333. Cathy Schoen et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," Health Affairs, October 31, 2007.

334. For example, the CBS News poll, October 12–16, 2007, found 25 percent of Americans choosing health care as the most important issue in this campaign, second only to 26 percent choosing the war in Iraq. Similarly, an NBC/*Wall Street Journal* poll, November 1–5, found 16 percent chose health care, second to the 26 percent who chose Iraq,

http://www.pollingreport.com/prioriti.htm

335. Schoen et al., "Toward Higher-Performance Health Systems."

336. Disney et al., *Impatient for Change.*

337. Richard Saltman and Josep Figueras, "Analyzing the Evidence on European Health Care Reforms," *Health Affairs*, March–April 1998.

338. Cited in Callahan and Wasunna, *Medicine and the Market: Equity v. Choice,* p. 91.

339. "Cox Report on Financing Sustainable Healthcare in Europe Presented to European Commission Today," *Medical News Today*, February 13, 2007.

340. Hans Maarse, "The Privatization of Health Care in Europe: An Eight Country Analysis," *Journal of Health Politics, Policy, and Law* 31e1 (2006): 981–1014.

Chapter 9

WHO's Fooling Who?
The World Health Organization's Problematic Ranking of Health Care Systems

by Glen Whitman

Cato Institute Briefing Paper no. 101 (February 28, 2008)

Introduction

The *World Health Report 2000*, prepared by the World Health Organization, presented performance rankings of 191 nations' health care systems.[1] Those rankings have been widely cited in public debates about health care, particularly by those interested in reforming the U.S. health care system to resemble more closely those of other countries. Michael Moore, for instance, famously stated in his film *SiCKO* that the United States placed only 37th in the WHO report. CNN.com, in verifying Moore's claim, noted that France and Canada both placed in the top 10.[2]

Those who cite the WHO rankings typically present them as an objective measure of the relative performance of national health care systems. They are not. The WHO rankings depend crucially on a number of underlying assumptions—some of them logically incoherent, some characterized by substantial uncertainty, and some rooted in ideological beliefs and values that not everyone shares. Changes in those underlying assumptions can radically alter the rankings.

More Than One WHO Ranking

The first thing to realize about the WHO health care ranking system is that there is more than one. One ranking claims to measure "overall attainment" (OA) while another claims to measure "overall performance" (OP). These two indices are constructed from the same underlying data, but the OP index is adjusted to reflect a country's performance relative to how well it theoretically could have performed (more about that adjustment later). When using the WHO rankings, one should specify which ranking is being used: OA or OP.

Many popular reports, however, do not specify the ranking used and some appear to have drawn from both. CNN.com, for example, reported that both Canada and France rank in the top 10, while the United States ranks 37th. There is no ranking for which both claims are true. Using OP, the United States

does rank 37th. But while France is number 1 on OP, Canada is 30. Using OA, the United States ranks 15th, while France and Canada rank 6th and 7th, respectively. In neither ranking is the United States at 37 while both France and Canada are in the top 10.

Which ranking is preferable? WHO presents the OP ranking as its bottom line on health system performance, on the grounds that OP represents the efficiency of each country's health system. But for reasons to be discussed below, the OP ranking is even more misleading than the OA ranking. This paper focuses mainly on the OA ranking; however, the main objections apply to both OP and OA.

Factors for Measuring the Quality of Health Care

The WHO health care rankings result from an index of health-related statistics. As with any index, it is important to consider how it was constructed, as the construction affects the results. WHO's index is based on five factors, weighted as follows:[3]

1. Health Level: 25 percent
2. Health Distribution: 25 percent
3. Responsiveness: 12.5 percent
4. Responsiveness Distribution: 12.5 percent
5. Financial Fairness: 25 percent

The first and third factors have reasonably good justifications for inclusion in the index:

Health Level. This factor can most justifiably be included because it is measured by a country's disability-adjusted life expectancy (DALE). Of course, life expectancy can be affected by a wide variety of factors other than the health care system, such as poverty, geography, homicide rate, typical diet, tobacco use, and so on. Still, DALE is at least a direct measure of the health of a country's residents, so its inclusion makes sense.

Responsiveness. This factor measures a variety of health care system features, including speed of service, protection of privacy, choice of doctors, and quality of amenities (e.g., clean hospital bed linens). Although those features may not directly contribute to longer life expectancy, people do consider them aspects of the quality of health care services, so there is a strong case for including them.

The other three factors, however, are problematic:

Financial Fairness. A health system's financial fairness (FF) is measured by determining a household's contribution to health expenditure as a percentage of household income (beyond subsistence), then looking at the dispersion of this percentage over all households. The wider the dispersion in the percentage of household income spent on health care, the worse a nation will perform on the FF factor and the overall index (other things being equal).

In the aggregate, poor people spend a larger percentage of income on health care than do the rich.[4] Insofar as health care is regarded as a necessity, people can be expected to spend a decreasing fraction of their income on health care as their income increases. The same would be true of food, except that the rich tend to buy higher-quality food.

The FF factor is not an objective measure of health attainment, but rather reflects a value judgment that rich people should pay more for health care, even if they consume the same amount. This is a value judgment not applied to most other goods, even those regarded as necessities such as food and housing. Most people understand and accept that the poor will tend to spend a larger percentage of their income on these items.

More importantly, the FF factor, which accounts for one-fourth of each nation's OA score, necessarily makes countries that rely on market incentives look inferior. The FF measure rewards nations that finance health care according to ability to pay, rather than according to actual consumption or willingness to pay. In most countries, a household's tax burden is proportional to income, or progressive (i.e., taxes consume an increasing share of income as income rises). Thus, a nation's FF score rises when the government shoulders more of the health spending burden, because more of the nation's medical expenditures are financed according to ability to pay. In the extreme, if the government pays for *all* health care, then the distribution of the health-spending burden is exactly the same as the distribution of the tax burden. To use the existing WHO rankings to justify more government involvement in health care —such as via a single-payer health care system—is therefore to engage in circular reasoning because the rankings are *designed* in a manner that favors greater government involvement. If the WHO rankings are to be used to determine whether more government involvement in health care promotes better health outcomes, the FF factor should be excluded.

The ostensible reason for including FF in the health care performance index is to consider the possibility of people landing in dire financial straits because of their health needs. It is debatable whether the potential for destitution deserves inclusion in a strict measure of health performance *per se*. But even if it does, the FF factor does not actually measure exposure to risk of impoverishment. FF is calculated by (1) finding each household's contribution to health expenditure as a percentage of household income (beyond subsistence), (2) *cubing* the difference between that percentage and the corresponding percentage for the average household, and (3) taking the sum of all such cubed differences.[5] Consequently, the FF factor penalizes a country for each household that spends a larger-than-average percentage of its income on health care. But it also penalizes a country for each household that spends a *smaller*-than-average percentage of its income on health care.

Put more simply, the FF penalizes a country because some households are especially likely to become impoverished from health costs—but it also penalizes a country because some households are especially *unlikely* to become impoverished from health costs. In short, the FF factor can cause a country's rank to suffer because of desirable outcomes.

Health Distribution and Responsiveness Distribution. These two factors measure inequality in the other factors. Health Distribution measures inequality in health level[6] within a country, while Responsiveness Distribution measures inequality in health responsiveness within a country.

Strictly speaking, neither of these factors measures health care performance, because inequality is distinct from quality of care. It is entirely possible to have a health care system characterized by both extensive inequality *and* good care for everyone. Suppose, for instance, that Country A has health responsiveness that is "excellent" for most citizens but merely "good" for some disadvantaged groups, while Country B has responsiveness that is uniformly "poor" for everyone. Country B would score *higher* than Country A in terms of responsiveness distribution, despite Country A having better responsiveness than Country B for even its worst-off citizens. The same point applies to the distribution of health level.

To put it another way, suppose that a country currently provides everyone the same quality of health care. And then suppose the quality of health care improves for half of the population, while remaining the same (not getting any worse) for the other half. This should be regarded as an *unambiguous* improvement: some people become better off, and no one is worse off. But in the WHO index, the effect is ambiguous. An improvement in average life expectancy would have a positive effect, while the increase in inequality would have a negative effect. In principle, the net effect could go either way.

There is good reason to account for the quality of care received by a country's worst-off or poorest citizens. Yet the Health Distribution and Responsiveness Distribution factors *do not do that*. Instead, they measure relative differences in quality, without regard to the absolute level of quality. To account for the quality of care received by the worst-off, the index could include a factor that measures health among the poor, or a health care system's responsiveness to the poor. This would, in essence, give greater weight to the well-being of the worst off. Alternatively, a separate health performance index could be constructed for poor households or members of disadvantaged minorities. These approaches would surely have problems of their own, but they would at least be focused on the absolute level of health care quality, which should be the paramount concern.

Uncertainty and Sensitivity Intervals

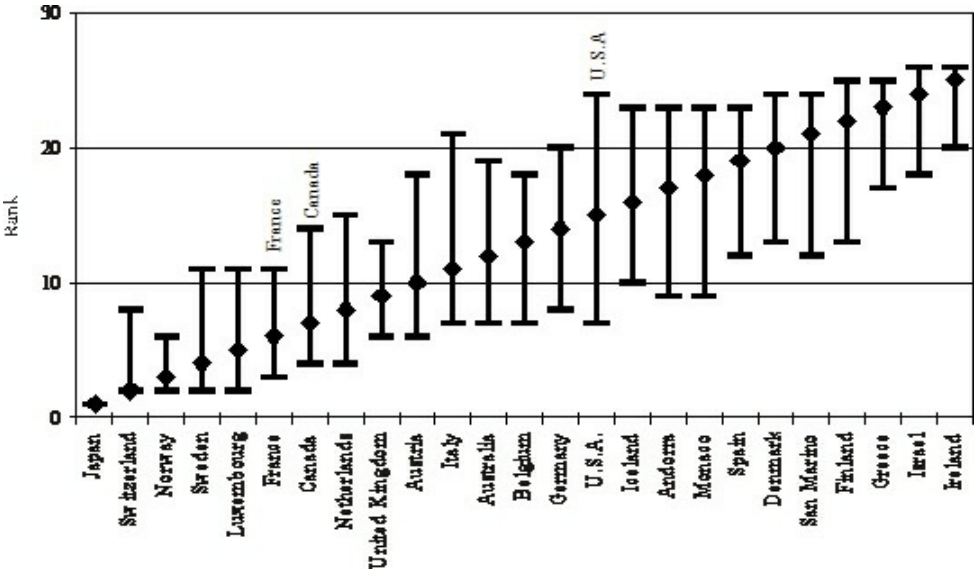
The WHO rankings are based on statistics constructed in part from random samples. As a result, each rank has a margin of error. Media reports on the rankings routinely neglect to mention the margins of error, but the study behind the WHO ranking7 admirably includes an 80-percent uncertainty interval for each country. These intervals reveal a high degree of uncertainty associated with the ranking method.

Using the OA ranking, the U.S. rank could range anywhere from[7] to 24. By comparison, France could range from 3 to 11 and Canada from 4 to 14. The considerable overlap among these intervals, as shown in Figure 1, means one cannot say with great confidence that the United States does not do better in the OA ranking than France, Canada, and most other countries.

These intervals result only from errors associated with random sampling. They do not take into account differences that could result from different weightings of the five component factors discussed earlier. Given that discussion, the proper weight for three of these factors is arguably zero. The authors of the study did not calculate rankings on the basis of that weighting, but they did consider other possible factor weights to arrive at a sensitivity interval for each country's rank.

It turns out that the U.S. rank is unusually sensitive to the choice of factor weights, as shown in Figure 2. The U.S. rank could range anywhere from 8 to 22, while Canada could range from 7 to 8 and France from 6 to 7.[8] These intervals depend on the range of weights considered and would therefore be larger if more factor weights were considered.

Figure 1
Uncertainty Intervals of OA-Based Ranks



Source: Christopher J. L. Murray et al., "Overall Health System Achievement for 191 Countries," Global Programme on Evidence for Health Policy Discussion Paper Series no. 28 (Geneva: WHO, undated), p. 8.

Furthermore, the rank resulting from any given factor weighting will itself have a margin of error resulting from random sampling. That means the two different sorts of intervals (uncertainty and sensitivity) ought to be considered jointly, resulting in even wider ranking intervals. The ranks as reported in the media, without corresponding intervals, grossly overstate the precision of the WHO study.

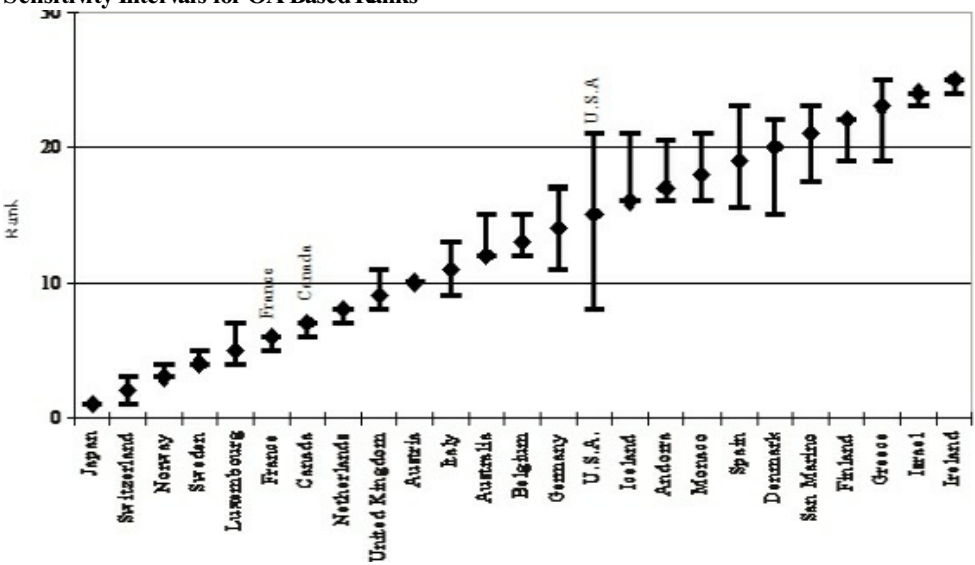
Achievement versus Performance Ranking

As noted earlier, the WHO report includes rankings based on two indices, OA and OP. The OP index, under which the U.S. rank is notably worse, is the WHO's preferred measure. It is worth considering the process that is used to convert the OA index into the OP index.[9]

The purpose of the OA-to-OP conversion is to measure the efficiency of health care systems—that is, their ability to get desirable health outcomes relative to the level of expenditure or resources used. That is a sensible goal. The results of the OP ranking, however, are easily misinterpreted, or misrepresented, as simply measuring health *outcomes* irrespective of inputs. For instance, according to the WHO press release that accompanied the original report, "The U.S. health system spends a higher portion of its gross domestic product than any other country but ranks 37 out of 191 countries according to its performance, the report finds."[10] The implication is that the United States performs badly in the OP ranking *despite* its high expenditures—an implication that has also been drawn by various media

outlets and commentators.[11] A more accurate statement would be that the United States performs badly in the ranking *because* of its high expenditures, at least in part.

Figure 2
Sensitivity Intervals for OA-Based Ranks



Source: Source: Christopher J. L. Murray et al., "Overall Health System Achievement for 191 Countries," Global Programme on Evidence for Health Policy Discussion Paper Series no. 28 (Geneva: WHO, undated), p. 8.

When Costa Rica ranks higher than the United States in the OP ranking (36 versus 37), that does not mean Costa Ricans get better health care than Americans. Americans most likely get better health care—just not as much better as could be expected given how much more America spends. If the question is health outcomes alone, without reference to how much has been spent, the more appropriate measure is the OA ranking, where the United States is 15 and Costa Rica is 45. (Even then, this paper's earlier criticisms of the OA ranking still apply.)

The conversion of OA into OP depends on two constructed variables: first, the *maximum* level of performance a country could potentially achieve; and second, the *minimum* level of performance the country could achieve without a modern health care system. The maximum is estimated on the basis of a country's per capita health expenditure and its level of literacy. The minimum is based on literacy alone. Literacy is used as a proxy for all aspects of a country that might affect health other than the health care system.

Many other variables could have been used to estimate a country's minimum and maximum possible performance, such as average income, crime rate, geography, nutrition, and so on. None of these were included. But Dean Jamison and Martin Sandbu, in a 2001 *Science* article,[12] reconstructed the OP ranking while including just one additional variable: geography.[13] For 79 out of 96 countries for which Jamison and Sandbu were able to recalculate ranks,[14] the resulting rank fell outside—often far outside—the WHO

report's 80-percent uncertainty intervals for those ranks. In other words, inclusion of just one additional variable could drastically affect the resulting ranks. Inclusion of other variables could result in even greater deviations from the reported ranks. For this reason, the OP ranking is even more misleading than the OA ranking, which simply reports health outcomes without a spurious "efficiency" adjustment.

Underlying Paternalistic Assumptions

The WHO rankings, by purporting to measure the efficacy of health care systems, implicitly take all differences in health outcomes not explained by spending or literacy and attribute them entirely to health care system performance. Nothing else, from tobacco use to nutrition to sheer luck, is taken into account.

To some extent, the exclusion of other variables is simply the result of inadequacies in the data. It is difficult to get information on all relevant factors, and even more difficult to account for their expected effects on health. But some factors are deliberately excluded by the WHO analysis on the basis of paternalistic assumptions about the proper role of health systems. An earlier paper laying out the WHO methodological framework asserts, "Problems such as tobacco consumption, diet, and unsafe sexual activity must be included in an assessment of health system performance."[15]

In other words, the WHO approach holds health systems responsible not just for treating lung cancer, but for preventing smoking in the first place; not just for treating heart disease, but for getting people to exercise and lay off the fatty foods.

That approach is problematic for two primary reasons. First, it does not adequately account for factors that are simply beyond the control of a health system. If the culture has a predilection for unhealthy foods, there may be little health care providers can do about it. Conversely, if the culture has a preexisting preference for healthy foods, the health care system hardly deserves the credit. (Notice the high rank of Japan, known for its healthy national diet.) And it hardly makes sense to hold the health system accountable for the homicide rate. Is it reasonable to consider the police force a branch of the health system?

Second, the WHO approach fails to consider people's willingness to trade off health against other values. Some people are happy to give up a few potential months or even years of life in exchange for the pleasures of smoking, eating, having sex, playing sports, and so on. The WHO approach, rather than taking the public's preferences as given, deems some preferences better than others (and then praises or blames the health system for them).

A superior (though still imperfect) approach would take people's health-related behavior as given, and then ask which health systems do the best job of dealing with whatever health conditions arise. We could ask, for instance, which systems do the best job of treating cancer or heart disease patients. We could then rank nations according to disease-specific mortality rates or five-year survival rates. These approaches present challenges as well, as it can be difficult to control for all confounding factors. For example, better five-year survival rates may reflect earlier detection rather than better treatment or outcomes. Still, if the goal is to assess the efficacy of countries' *health care* systems, it makes more sense to look at condition-specific success rates than indices (like the OA and OP) that fail to control for non–health-care factors like nutrition and lifestyle.

Conclusion

The analysts behind the WHO rankings express the hope that their framework "will lay the basis for a shift from ideological dis- course on health policy to a more empirical one."[16] Yet the WHO rankings themselves have a strong ideological component. They include factors that are arguably unrelated to actual health performance and some that could even improve in response to worse health performance. Even setting those concerns aside, the rankings are still highly sensitive to both measurement error and assumptions about the relative importance of the components. And finally, the WHO rankings reflect implicit value judgments and lifestyle preferences that differ among individuals and across countries. The WHO health care ranking system does not escape ideology. On the contrary, it advances ideological assumptions under the guise of objectivity. Those interested in objective measures of health system performance should look elsewhere.

Notes

1. World Health Organization, *The World Health Report 2000: Health Systems: Improving Performance* (Geneva: WHO, 2000), http://www.who.int/whr/2000/en/index.html.

2. A. Chris Gajilan, "Analysis: 'Sicko' Numbers Mostly Accurate; More Context Needed," CNN. com, June 30, 2007, http://www.cnn.com/2007/HEALTH/06/28/sicko.fact.check/index.html.

3. Christopher J. L. Murray et al., "Overall Health System Achievement for 191 Countries," Global Programme on Evidence for Health Policy Discussion Paper Series no. 28 (Geneva: WHO, undated), http://www.who.int/healthinfo/paper28.pdf.

4. Bear in mind that most nations finance the bulk of medical expenditures through health insurance, which results in a more uniform distribution of the burden of health spending.

5. To be precise, the FF measure uses the absolute value of the cubed difference, which means the value is always positive. Notice also that cubing puts an especially high weight on differences from the mean. Squaring differences is a much more common statistical approach to measuring dispersion. Cubing differences further reduces the scores of nations that rely less on government to finance medical care.

6. Rather than measuring inequality in DALE, Health Distribution measures inequality in infant mortality. Apparently, this change was made because of the better availability of data on differences in infant mortality.

7. Murray et al.

8. Though Murray et al. include a graphic showing the sensitivity intervals for different factor weights (their Figure 5, p. 8), they do not state specific bounds for those sensitivity intervals as they do for uncertainty intervals. Efforts to locate the data underlying that figure were unsuccessful. These estimates (and Figure 2 in this paper) represent the author's best attempt to reproduce the intervals in Murray et al.

9. Ajay Tandon et al., "Measuring Overall Health System Performance for 191 Countries," Global Programme on Evidence for Health Policy Discussion Paper Series no. 30 (Geneva: WHO, undated), http://www.who.int/healthinfo/paper30.pdf.

10. WHO, "World Health Organization Assesses the World's Health Systems," press release, undated, http://www.who.int/whr/2000/media_centre/press_release/en/index.html.

11. See, for example, Victoria Colliver, "We Spend Far More, but Our Health Care Is Falling Behind," *San Francisco Chronicle*, July 10, 2007, http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2007/07/10/MNGNUQTQJB1.DTL; Jan Malcom, "Spending More and Getting Less for U.S. Health Care," *MN Journal* 23, no. 2 (2007): 1, 7, http://citizensleague.org/publications/journal/archives/2006-3.pdf; IBM, "Everyone's Business: Fixing Health Care," IBM e-magazine, January 1, 2007, https://www.304.ibm.com/jct03004c/businesscenter/smb/us/en/contenttemplate/!!/gcl_xmlid=70013/.

Quoting Dan Pelino, IBM's general manager for health care and life sciences: "You would think that, given the fact that we're willing to spend four trillion . . . we would have the highest quality and we would have the best safety for health care delivery. . . . And then the World Health Organization ranks the U.S. 37th overall in health systemperformance."

12. Dean T. Jamison and Martin E. Sandbu, "WHO Ranking ofHealth SystemPerformance," *Science* 293 (August 31, 2001): 1595–96.

13. Geography may affect health because ofclimate effects. Jamison and Sandbu note that living in a tropical location appears to be associated with worse health outcomes (p. 1596).

14. Jamison and Sandbu were unable to obtain the data necessary to duplicate the WHO's analysis for all 191 countries.

15. Christopher J. L. Murray and Julio Frenk, "A Framework for Assessing the Performance ofHealth Systems," *Bulletin of the World Health Organization* 78, no. 6 (2000): 717–31, 727, http://www.who.int/docstore/bulletin/pdf/2000/issue6/bu0542.pdf.

16. Ibid., p. 728.

Chapter 10

Bending the Productivity Curve: Why America Leads the World in Medical Innovation

by Glen Whitman and Raymond Raad

Cato Institute Policy Analysis no. 654 (November 18, 2009)

Introduction

The debate over how to reform America's health care sector often involves comparisons between the United States and other countries, and with good reason. Looking at other countries can help us learn which policies, if any, to emulate, and which to avoid.

There have been many attempts at international health care system comparisons. Among the most influential are the *World Health Report 2000* published by the World Health Organization,[1] several studies published by the Commonwealth Fund,[2] and individual measures such as infant mortality and "mortality amenable to health care."[3] Generally in these studies, the United States performs poorly in comparison to Europe, Australia, and Japan. Therefore, scholars often use the studies to argue for adding even more government regulations to our already highly regulated health care system.[4]

However, these studies suffer from several problems. First, they often rely on unadjusted aggregate data—such as life expectancy, or mortality from heart disease—that can be affected by many non–health care factors, including nutrition, exercise, and even crime rates. Second, they often use process measures, such as how many patients have received a pap smear or mammogram in the past three years. Process measures tell us what doctors do, but provide only an indirect measure of doctors' productivity. Third, some of these studies inappropriately incorporate their own biases about financing in their statistics, which makes market-driven health systems appear worse even if their outcomes are similar or better.[5, 6]

An additional limitation of these studies is the omission of any measure of innovation. None of the best-known studies factor in the contribution of various countries to the advances that have come to characterize the current practice of health care in the developed world.

Every single health care test or treatment must be invented at some point. We would be living in a different world today were it not for the remarkable genius and hard work of health care inventors in the past, as well as investments from government health agencies and pharmaceutical and medical device companies. The health care issues commonly considered most important today—controlling costs and covering the uninsured— arguably should be regarded as secondary to innovation, inasmuch as a treatment must first be invented before its costs can be reduced and its use extended to everyone.

But shouldn't innovation show up in other health care measures? If the United States is making the most headway in creating cancer medications, for instance, then shouldn't cancer care be better in the

United States? Not necessarily. Most innovations are created by only a few people, but once created they can generally be used all over the world. For example, the bulk of the development of balloon angioplasty was done by a handful of physicians—most notably Andreas Greutzig in Switzerland, with some help from U.S. physicians. Once developed, however, this procedure was used well beyond these two countries to improve the care of patients with heart attacks. Similarly, the work of Michael Brown and Joseph Goldstein at the University of Texas Southwestern Medical Center was essential to the development of the cholesterol drugs called statins, which have helped to reduce deaths from strokes and heart attacks all over the world.[7]

Therefore, measuring health care costs and health outcomes across countries is not sufficient. The costs of medical innovation typically appear only in the innovating nation's health expenditures, but the health improvements that those innovations generate improve the health-outcomes statistics of many countries. Consider, for example, the frequent claim that European health systems achieve similar health outcomes to those of the United States at a much lower cost. That claim fails to consider that higher U.S. spending levels could be generating innovations that improve health outcomes in Europe and around the world. If we care about progress, we should include innovation as a separate measure, so that policymakers can adequately factor innovation into discussions of health care reform.

How to Measure Innovation

Two properties of innovations make them difficult to measure. The first is that not all advances are equal; some require more ingenuity than others. Take two similar drugs—captopril and enalapril—both of which are useful for treating high blood pressure and heart failure. Captopril was the first of its kind, developed at a time when no one—including the physicians and scientists working on it—knew whether such a drug was even possible. The development of enalapril, on the other hand, although an achievement in and of itself, was greatly assisted by the knowledge that captopril had been developed first and was effective.[8] Therefore, we cannot do justice to innovation by using simple output metrics such as the number of new drugs that are developed each year.

The second important property of innovation is that new ideas and products are often unpopular or controversial when they are first developed. A particularly well-known example is the discovery that the bacterium *Helicobacter pylori* causes stomach ulcers, a finding the medical community initially resisted. And there are other examples, such as laparoscopic surgery and CT scanning, both of which were regarded with skepticism at first. This does not necessarily reflect negatively upon health care practitioners; it is important to expose new ideas to a high standard before they are widely used. However, this property makes it very difficult to measure new innovations (e.g., a new drug or specialty hospitals), because there is controversy over which of them will turn out to be effective.

Therefore, we conclude that innovation is best measured by looking at advances that have withstood the test of time and are widely regarded as having had important positive effects on health care. This means, unfortunately, that many important innovations will have to be left out because they are not considered the cream of the crop or have been developed too recently, but we believe this method is most likely to yield a meaningful measure of innovation.

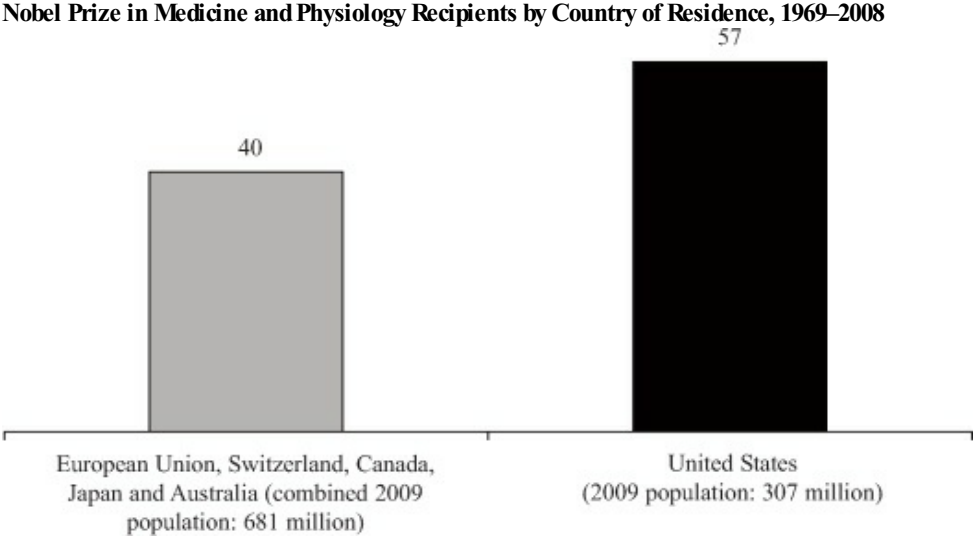
Our basic approach in this paper is to identify significant innovations in the field of health care, and then to identify who pioneered them and where. This approach is susceptible to some valid objections.

The first objection is that, like life expectancy and infant mortality, a variety of factors other than health care policy may affect innovation. The patent system, the tax code, the general business climate, the quality of universities, and other country characteristics can affect the amount and variety of innovation.

The second objection is that, even if we restrict our attention to the impact of health policies, innovation in one country can be affected by the policy choices of other countries. For instance, pharmaceutical companies in other countries might invest in new drugs with the expectation of marketing them in the United States, and U.S. pharmaceutical companies might invest in new drugs with the expectation of marketing them abroad. In this regard, it may prove difficult to isolate the effects of any given country's policies on innovation.

Nevertheless, we suspect the amount of innovation that comes out of a given country does reflect something real about its health care structure, including the amount of investment in new ideas, the willingness to accept novelty, and the talent that the country's health care sector attracts. We consider it important to acknowledge the critical role of innovation in the health care debate, and therefore also important to make an effort to isolate the contributions of various countries. We offer the statistics in this paper with the hope that they will stimulate discussion. We do not claim that cross-country differences in innovation are solely attributable to differences in health care policies, but we do think health care policy is an important part of the story.

Figure 1
Nobel Prize in Medicine and Physiology Recipients by Country of Residence, 1969–2008



Sources: Nobel Prize Internet Archive, CIA *World Factbook*. Two recipients are listed as being fromboth the United States and another country.

Types of Innovation

An innovation is any new way of doing or understanding something, and it is particularly important

when it is an improvement over previous ways. Most health care innovations fall within one of the following categories.

Basic Medical Sciences. These are advances in our understanding of the human body and of diseases—what doctors call "pathophysiolo-gy." One example is the discovery that the human immunodeficiency virus (HIV) causes the disease AIDS.

Di agnostics. These are advances that help us determine what disease an individual has or what has gone wrong with his or her body. They often take the form of either a device or a test. For example, CT scanners can help us discover whether someone has cancer, and certain blood tests help us determine whether someone has had a heart attack.

Therapeutics. These are advances that help to treat someone with a disease. They often take the form of drugs, devices, or procedures. Two recent examples are anti-depressants, such as Prozac, and laparoscopy, which makes many surgeries safer and less invasive.

Business Models. These are advances in the way that health care is organized and delivered. They can take many forms. A recent example is nurse practitioner–staffed retail clinics, which allow patients to receive care for certain common complaints at a lower cost and greater convenience than at many doctors' offices.[9, 10, 11]

Innovation in Basic Medical Sciences

Of the four classes of innovations, advances in the understanding of the body and of disease are typically the furthest removed from direct benefit to patients. It is rare that a scientific breakthrough provides a new therapy for patients without further advances. However, basic science discoveries often provide the basis for other advances in health care and can be among the greatest gifts to human life.

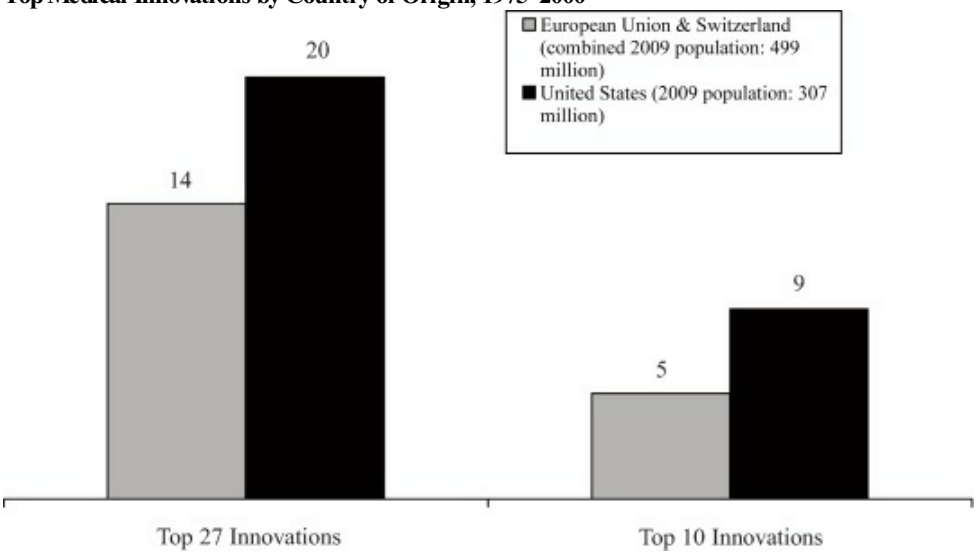
One way to measure the "cream of the crop" in contributions to basic medical science is to count the number of Nobel prizes in medicine and physiology. This award is international in scope, so it is presumably not biased for or against any particular country. A large number of Nobel prizes have been awarded to American scientists in recent history. Of the 95 recipients in the past 40 years, 57 (60 percent) were from the United States, while 40 (42 percent) were from the European Union countries, Switzerland, Canada, Japan, or Australia—countries whose combined population is more than double that of the United States.[12] (See Figure 1. Two recipients are listed as both from the United States and another country.) In 33 of those 40 years, at least one scientist from the United States received the award, while in only 25 of those years was there at least one non-American recipient.[13]

Why are Americans disproportionately represented among Nobelists in the field of medicine? Presumably the United States provides an environment that encourages basic medical research. One major contributor is the great investment in basic science research in the United States relative to other countries. Much, but not all, of that funding comes from the National Institutes of Health, which has a current annual budget of over $30 billion, as compared to its counterparts in Europe, which spend $3–$4 billion in total. Private-sector contributions also matter, and there is some indication that U.S. spending in this category is also higher, though reliable figures are not available.[14, 15]

There are likely to be other contributing factors as well. Thomas Boehm, a scientist who has worked in

Boston, Vienna, and Berlin, argues that the research environment in the United States is not only wealthier, but also more meritocratic, more supportive of risky new ideas, and more tolerant of waste, which is often a necessary component of progress. He argues that these factors explain the large number of European-born scientific researchers in the United States (about 400,000).[16]

Figure 2
Top Medical Innovations by Country of Origin, 1975–2000



Note: More than one country shares credit for some innovations.

Innovation in Diagnostics and Therapeutics

A well-known and widely cited list of top medical diagnostic and therapeutic innovations was published in a paper in 2001 by Victor Fuchs, economics professor at Stanford, and Harold Sox, professor of medicine at Dartmouth. The authors searched through the two top medical journals—the *New England Journal of Medicine* and the *Journal of the American Medical Association*—and picked out the 30 innovations that were most frequently the principal focus of a published study over the previous 25 years (i.e., since 1975). They then surveyed 225 leading primary care physicians about the effects of these innovations on patients, and used the responses to rank the 30 innovations by importance. The list, in rank order, is in Table 1.

Though this list is not necessarily and unambiguously *the* top 30 innovations since 1975, we are convinced that it cannot be too far off the mark. Each item on the list has transformed, or at least significantly contributed to, the care of at least one disease. Though surveyed physicians were invited to recommend additions, only 2 percent of respondents did so, and no specific addition was recommended

by more than one physician.[17]

We looked into the history of each of these innovations to find out where and when most of the significant work that led to its invention was done. Specifically, we looked for where the product was first developed to the point that it could be used on patients, and where the scientific advances that were crucial to its development were made. In the case of drug classes, we focused on the first drug developed in each class.

For those innovations with particularly long and complex histories, we tried our best to focus on the most significant advances in recent history (approximately 1970s to the present). For example, in studying the history of mammography, we found that it was developed through the work of many scientists, engineers, and physicians over the course of a century. However, historians divide its development into three periods, the most recent of which is the 1970s to the present; therefore, we focused on that period.[18]

Of the list of 30 innovations, at least one country is listed for all but two,[19] and all but one have been advanced significantly in the last 40 years.[20] Of the remaining 27 innovations, work performed in the United States significantly contributed to the invention or advancement of 20, including nine of the top 10. These numbers are greater than those for any other country. In comparison, the European Union plus Switzerland, whose combined population is more than 50 percent larger than that of the United States,[21] contributed significantly to 14 total innovations, including five of the top 10 (see Figure 2).[22, 23]

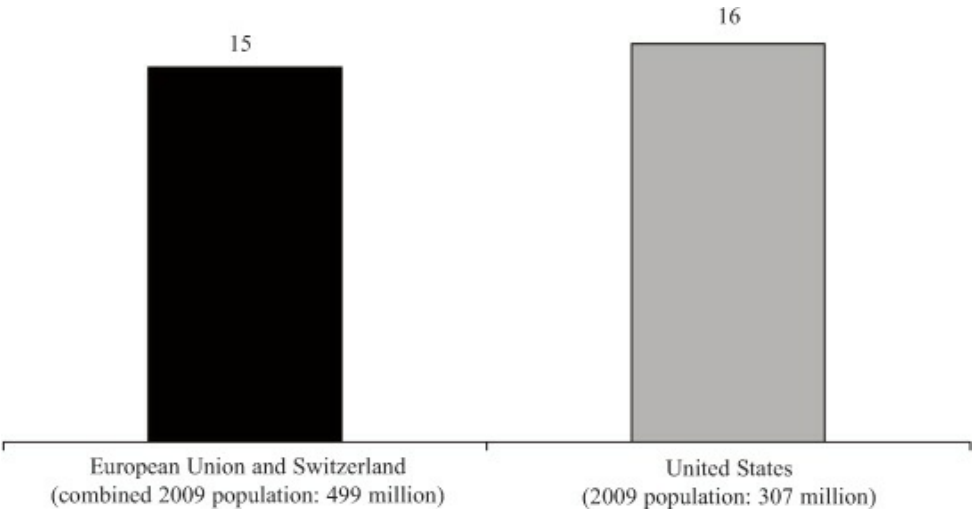
Pharmaceuticals

A second list of top innovations has also been developed—this time of drugs only. Massachusetts Institute of Technology economists Iain Cockburn and Rebecca Henderson constructed a list of 21 "impact drugs," those that had the most impact on therapeutic practice between 1965 and 1992.[24] More recently, three economists working with the Manhattan Institute—Joseph DiMasi, Christopher-Paul Milne, and Benjamin Zycher—updated this list by merging it with the 25 brand-name drugs most prescribed in the United States in 2007.[25] The result is a list of 37 drug classes. Seventeen of these classes are also included in the top 30 innovations in Table 1, while 20 are new.

For each of the 37 drug classes, we chose one or more representative drugs. In most cases, we chose the first developed or marketed version as the sole representative drug, because the first drug of each class is usually the most difficult to develop. However, for four of the classes, we chose two drugs because of one of the following reasons:

- The first to be developed differed from the one listed in the Cockburn and Hen-derson paper as having the widest impact on patient care.[26]

Figure 3
Top 29 Pharmaceutical Innovations by Country of Origin, 1968–2007



Note: More than one country shares credit for some innovations.

- There were two separate innovative drugs in the same class that were developed independently and reached the market at about the same time.[27]

Additionally, in the case of interferons, no representative was chosen because the technology to produce several of them was developed at the same time.

We then looked into the history of the development of these drugs, this time focusing on which companies or laboratories were able to synthesize them and bring them to market.

We excluded eight of the 37 drug classes because they received initial FDA approval more than 40 years ago.[28] The results for the remaining 29 classes are in Table 2. As the table makes clear, the U.S. contribution has been significant. Sixteen of the 29 representative drug classes were developed in the United States, while 15 were developed in the E.U. or Switzerland.[29] (See Figure 3. We credit two of the 29 drug classes to both the United States and a European country.) Again, all of these figures should be interpreted in light of America's notably smaller population.[30]

Although we have focused on the most significant pharmaceutical innovations, similar results seem to hold for new drugs in general. In a 2006 article, economists Henry G. Gra-bowski and Y. Richard Wang compiled a list of all drugs introduced to the world market between 1982 and 2003 and divided them by country of origin. Although European firms introduced a greater total number of new drugs to the global market than American firms did, they introduced a similar number of new drugs relative to population. With respect to first-in-class drugs (which are, in general, more innovative), American firms produced a greater number than European firms, despite Europe's larger population. The difference between American and European performance was more pronounced during the latter half of the time period.[31] Only time will tell which of these drugs will prove most beneficial to patients, but these data provide at least preliminary evidence that American firms continue to contribute significantly to the development of innovative pharmaceuticals.

Explaining America's Leading Role

Why is the United States over-represented in the development of new diagnostics and therapeutics? What factors encourage innovation in these areas? Perhaps a part of it is the quality of the innovators. But this answer is unsatisfying, for it only leads to more questions: Why does the United States attract high-quality innovators? And what environmental factors allow innovators in the United States to be so productive?

Although many factors are surely relevant, one likely contributor is differences in monetary compensation. Other things being equal, individuals and firms will tend to invest more in medical innovation when (a) they expect a larger return; (b) the returns will last for a longer period of time; and (c) the returns arrive sooner rather than later.

There is little doubt that the United States is responsible for a disproportionate share of the monetary returns to medical innovation. In recent years, the United States has accounted for 45 percent of worldwide pharmaceutical sales, as compared to Europe's 27–31 percent and Japan's 9–12 percent.[32, 33] The population of Europe is 150 percent that of the United States, and Japan 42 percent, so the greater contribution of the United States cannot be attributed to its large population. The fact is that Americans spend more per capita on pharmaceuticals. Critics often describe this as a defect of the American system —but with regard to encouraging innovation, we must consider it a feature.

The United States is also over-represented as a base of operations for top pharmaceutical firms. Of the top 15 pharmaceutical firms by pharmaceutical revenues, eight are based in the United States, six in Europe, and one in Japan.[34] The list of top pharmaceutical companies by total revenues is even more skewed: seven of the top 12 are based in the United States and five in Europe.[35] This is unlikely to be a coincidence. Although the firms might have located in the United States for historical reasons or because of a superior business climate, being near their most important market is at least a contributing factor.

Americans pay more for pharmaceuticals because of the nature of our health care system. Single-payer and other centrally organized health care systems, like those in much of Europe, are characterized by a great deal of monopsony (buyer) power that pushes down compensation. Prices for prescription drugs in Europe are 35 percent to 55 percent lower than in the United States.[36]

In addition to pushing down prices, centrally organized health care systems also limit the use of new drugs, technologies, and procedures. Those systems "control costs by upstream limits on physician supply and specialization, technology diffusion, capital expenditures, hospital budgets, and professional fees."[37] The result is that those countries use new innovations less extensively than the United States.

To take just one example, a cross-national comparison of heart attack care from 1989 to 1998 found that the United States experienced both faster adoption and more rapid diffusion of new heart treatments (including cardiac catheterization, coronary artery bypass graft, and primary angioplasty) than other developed countries. Japan displayed a similar but less pronounced tendency to adopt early and expand use quickly. A number of other countries, including Canada, Australia, Belgium, Italy, Singapore, Taiwan, and possibly France, experienced late adoption but relatively fast growth in treatment rates thereafter. Those countries with the strictest supply-based restrictions on health care, most notably the United Kingdom and the Nordic countries, experienced both late adoption and slow growth in treatment rates.[38]

The greater openness of the U.S. system to the adoption of new technologies and treatments is also evidenced by its having twice as many MRI scanners per capita as most other developed nations, and

having three times as many cardiac surgery units and catheteriza-tion labs in the 1990s.[39]

Overuse?

Is all the U.S. spending on new diagnostics and treatments worth it? Medical innovations definitely have aggregate benefits that outweigh their aggregate costs. Yet there is also good reason to believe they are overused in the United States. While the average benefits of the innovations may be quite high, the marginal benefit of extending their use to more and more patients could be quite low.[40] So in a static sense, the U.S. health care sector might be regarded as inefficient.

In a dynamic sense, however, the story is different. Americans' rapid and extensive use of new medical innovations creates a much higher expected monetary return, thereby subsidizing the development of new technologies. And the rest of the world gets an even better deal, since they can take advantage of the new technologies later and at lower cost. In effect, Americans contribute disproportionately to the production of a public good, while other nations take a relatively free ride.

Business-Model Innovations

Business-model innovations are improvements in the way medicine is organized or delivered, in an attempt to improve its quality, reduce its cost, or both. Some examples are the development of outpatient dialysis in the 1960s, the integrated system of care developed by Kaiser Permanente, and more recently, the emergence of nurse practitioner– staffed clinics. This type of innovation is not unique to for-profit enterprises, so it should be a concern for all types of health systems, from market-based systems to single-payer systems. In fact, some of the changes that the left-leaning Commonwealth Fund recommends for health care, such as increased use of electronic medical records and changes to improve coordination of care, fall into this category.

In most industries, business models change over time, especially in tandem with new technologies. Yet, unlike the innovation types discussed above, there is no list of major recent business-model innovations that have transformed health care. In fact, most medical care today in developed countries is delivered through the same two business models that were dominant a century ago: general hospitals and physician practices.[41]

If health care were a competitive market, we might conclude from the continued dominance of general hospitals and physician practices that they are highly efficient at meeting the needs of consumers. However, there are substantial barriers to competition in health care, so we cannot assume existing models are efficient.

Moreover, there is evidence that the dominant business models are not particularly efficient. Recent studies have documented a more than three-fold difference in health spending across regions within the United States, without any corresponding difference in quality, indicating that health care can be delivered more efficiently in at least some of these regions.[42, 43] The rise in health costs has led to a growing phenomenon of "medical tourism"—Americans and citizens of other developed countries traveling abroad, often to undeveloped countries, to obtain similar quality health care at a lower cost than is available at home.[44, 45]

Several scholars have recently argued that the dominant business models in health care contribute to

our high costs and poor coordination of services, and that new models are necessary to reduce costs and increase value.[46, 47, 48] Harvard Business School professor Regina Herzlinger, for example, argues for the value of specialty hospitals and other "focused factories." However, such progress has been slow. Although some consider the growth in specialty hospitals to be significant, a study by the General Accounting Office in 2003 found a total of only 78 specialty hospitals, compared with 4,908 general hospitals.[49]

Even for those who do not agree with the specifics of Herzlinger's ideas, the lack of business-model innovation in health care should be cause for concern. Some new business models that promise to deliver higher-quality care at a lower cost have emerged. Nurse practitioner– staffed clinics are an example. But these models have barely gotten off the ground. The combination of these factors make us question whether general hospitals and individual physician practices—which evolved a century ago when medicine was very different from what it is today—continue to be ideal for modern health care.

Given the lack of progress in this area across most developed nations, it would not be particularly worthwhile to compare countries. Instead, we would like to reflect on some of the many factors that have hindered the growth of new business models in health care.

Resistance to Entrepreneurship

Entrepreneurial physicians and others who develop and implement new models are often opposed by their peers and the government. For example, despite a lack of evidence that physician-owned specialty hospitals offer inferior care, and even some evidence that their care is better than general hospitals, general hospitals and other groups have lobbied for regulatory roadblocks to impede specialty hospitals. Congress has repeatedly enacted temporary moratoria on Medicare payments to specialty hospitals, which severely limits their growth.[50] The health care reforms currently under consideration in Congress may further limit the growth of specialty hospitals.[51]

Payment Systems

Business models are not sustainable if they lose money, which means that new business models can only work if some payer is willing to recognize their virtues and pay for them. Unfortunately, the dominant health care purchasers—Medicare, Medicaid, and the private insurers who follow Medicare's fee schedule (which all have interests that are not necessarily aligned with their patients' interests)—resist paying for new business models. In the words of Clayton Christensen, professor at Harvard Business School:

> Caregivers who do things the way they've always been done, or who make improvements within the present architecture of care, can get paid for what they do. Those who wish to disrupt the system by changing the very architecture of care, however, often are stymied by the specter that there literally is no money to be made from doing it.[52]

This system even discourages improvements and traps care in high-cost business models because its fees are based on the cost rather than the value of care. A good example is dialysis treatment for end-stage kidney disease. We now have the technology for patients to get this treatment at home—rather than at a dialysis center—at significantly lower cost and in a manner that better matches human physiology. Yet, despite improvements in this technology, home hemodialysis is becoming less frequent. One of the major

reasons is that we have a single-payer system for dialysis that rewards physicians for recommending high-cost dialysis centers rather than their cheaper alternative.[53, 54, 55, 56, 57]

Medical Licensing

New business models, especially those that seek to reduce cost, may need to rely on midlevel clinicians such as nurse practitioners to perform services usually performed by primary care physicians, and to rely on primary care physicians to do what is usually done by specialists. This type of pattern is one that Christensen found in a wide variety of industries: "Many of the most powerful innovations that disrupted other industries did so by enabling a larger population of less skilled people to do in a more convenient, less expensive setting things that historically could be performed only by expensive specialists in centralized, inconvenient locations."[58] Yet medical licensing is an obstacle to such progress because it allows groups of physicians and other clinicians to determine what tasks their competitors may perform. For example, despite the lack of any data showing worse outcomes when patients are treated by nurse practitioners rather than physicians, a majority of states still prohibit nurse practitioners from practicing independently.[59]

Conclusion

The health care debate should address more than just covering the uninsured and controlling costs. It should also consider whether proposed policies will promote or hinder the ability of creative individuals to innovate.

For example, proposals that increase spending on diagnostics and therapeutics could encourage such innovation. On the other hand, imposing price controls on pharmaceuticals and health insurance would tend to reduce innovation.[60] Experience with Medicare demonstrates that expanding government's role as purchaser of health care services, either by expanding existing government programs or creating new programs, would tend to reduce innovation in health care delivery.[61] Experience with the nascent reforms in Massachusetts suggests that enabling government to specify the terms of private health insurance contracts also tends to reduce innovation in health care delivery.[62]

In 2007, former Clinton administration labor secretary Robert Reich captured the potential for health care reform to influence medical innovation when he candidly told an audience that "us[ing] the bargaining leverage of the federal government in terms of Medicare, Medicaid . . . to force drug companies and insurance companies and medical suppliers to reduce their costs . . . means less innovation, and that means less new products and less new drugs on the market, which means you are probably not going to live that much longer than your parents."[63]

Unfortunately, consideration of policy factors that contribute to or hinder health care innovation has been limited, at least partly because international comparisons of health care systems generally do not include measures of innovation. We hope that this paper can be a start in reversing this trend.

In three of the four general categories of innovation examined in this paper—basic science, diagnostics, and therapeutics—the United States has contributed more than any other country, and in some cases, more than all other countries combined. In the last category, business models, we lack the data to say whether the United States has been more or less innovative than other nations; innovation in this area

appears weak across all nations.

In general, Americans tend to receive more new treatments and pay more for them—a fact that is usually regarded as a fault of the American system. That interpretation, if not entirely wrong, is at least incomplete. Rapid adoption and extensive use of new treatments and technologies create an incentive to develop those techniques in the first place. When the United States subsidizes medical innovation, the whole world benefits. That is a virtue of the American system not reflected in comparative life expectancy and mortality statistics.

Table 1
Thirty Leading Medical Innovations and Their Place of Origin

Rank	Innovation[64]	Country of Origin	Approximate Timeframe	Type
1	MRI and CT scanning[65, 66]	UK and U.S.	1970s	Diagnostic
2	ACE inhibitors[67, 68, 69]	U.S.	1970s–1980s	Therapeutic
3	Balloon angioplasty[70, 71]	Primarily Switzerland, with significant work in the U.S.	1970s	Therapeutic
4	Statins[72, 73, 74]	Japan, U.S.	1970s–1980s	Therapeutic
5	Mammography[75, 76]	Several, including U.S., Sweden, Finland, UK	1970s–1980s	Diagnostic
6	Coronary Artery Bypass Graft Surgery[77, 78, 79, 80, 81]	Russia, U.S.	1960s–1970s	Therapeutic
7	Proton pump inhibitors and H2 blockers[82, 83, 84]	Sweden, UK (U.S.-based company)	1970s–1980s	Therapeutic
8	SSRIs and recent non-SSRI antidepressants[85, 86, 87, 88, 89]	U.S.	1970s–1980s	Therapeutic
9	Cataract extraction and lens implant[90, 91, 92, 93, 94]	U.S.	1960s-1970s, and further developments recently	Therapeutic
10	Hip[95, 96, 97] and Knee replacement[98, 99, 100, 101]	Burma, UK, U.S.	1960s-1970s	Therapeutic
11	Ultrasonography[102, 103]	Indeterminate		Therapeutic
12	Gastrointestinal endoscopy[104, 105, 106]	Japan, U.S.	1957-1990s	Therapeutic
13	Inhaled steroids for asthma[107, 108, 109]	UK	1960s	Therapeutic
14	Laparoscopic surgery[110, 111, 112]	France. Germany, U.S.	1960s-1990s	Therapeutic
15	NSAIDs and Cox-2 inhibitors[113, 114]	U.S.	1980s-1990s	Therapeutic

16	Cardiac enzymes[115, 116, 117, 118]	Japan, Germany	1950s-1980s	Diagnostic
17	Fluoroquinolones[119]	Japan. Germany, U.S.	1970s-1980s	Therapeutic
I8	Recent hypoglycemic agents[120, 121, 122, 123, 124]	U.S., Japan	I940s-I990s 1970s-1990s	Therapeutic
19	HIV testing and treatment[125, 126, 127, 128, 129]	U.S., France. Switzerland, UK (U.S. facility)	1960s (synthesis); 1980s-1990s. most of the development	Both
20	Tamoxifen[130, 131]	UK	1960s-1970s	Therapeutic
21	PSA testing[132, 133]	U.S.	1979-early 2000s	Diagnostic
22	Long-acting and parenteral opioids[134]	Germany	I916[135]	Therapeutic
23	Helicobacter pylori testing and treatment[136]	Australia	1970s-1980s	Both
24	Bone densitometry[137, 138, 139]	U.S.	1960s-Present	Diagnostic
25	Third-generation cephalosporins[140, 141, 142, 143]	U.S.	I940s-1980s	Therapeutic
26	Calciumchannel blockers[144, 145]	Germany	1960s-1970s	Therapeutic
27	IV-conscious sedation	No information available		Therapeutic
28	Sildenafil (Viagra)[146, 147, 148]	UK (U.S.-based company)	1980s	Therapeutic
29	Nonsedating antihistamines[149, 150]	U.S.	1970s-1990s	Therapeutic
30	BBone marrow transplant[151, 152, 153, 154, 155]	U.S., Canada	I950s-I990s	Therapeutic

Table 2
Leading Pharmaceutical Innovations & Place of Origin (Rows in bold indicate items that do not appear in Table 1)

Drug Class	Drug	Company	Location of Company Headquarters	Location of Research Facility	Year ofFDA Approval
Angiotensin converting enzyme inhibitors[156, 157, 158]	captopril (Capoten)	Squibb	U.S.	U.S.	1981
Angiotensin II antagonists[159, 160, 161]	**losartan (Cozaar)**	**Merck**	**US.**	**U.S.**	**1995**
Calciumchannel	nifedipine (Procardia)	Bayer	Germany	Germany	1981

blockers[162, 163]					
Statins[164, 165, 166, 167]	lovastatin (Mevacor)	Merck	U.S.	U.S.	1987
Fibrates[168, 169, 170]	**clofibrate (Astromid-S)** **gemfibrozil (Lopid)**	**I.C.I.** **Parke-Davis**	**UK** **US.**	**Unclear** **UK**	**1967** **1981**
Cholesterol absorption inhibitors[171, 172]	**ezetimibe (Zetia)**	**Schering-Plough**	**U.S.**	**Unclear**	**2002**
H2 blockers[173, 174]	cimetidine (Tagamet)	Smith Kline French	U.S.	UK	1977
Proton pump inhibitors[175, 176]	omeprazole (Prilosec)	Astra	Sweden	Sweden	1989
Serotonin selective reuptake inhibitors[177, 178, 179, 180]	fluoxetine (Prozac)	Eli Lilly	U.S.	U.S.	1987
Serotonin norepinephrine reuptake inhibitors[181, 182]	venlafaxine (Effexor)	Wyeth	U.S.	Unclear	1993
Bronchodilators[183, 184, 185]	**albuterol (Ventolin)**	**Allen and Hanbury**	**UK**	**UK**	**1969* (launch)**
Inhaled corticosteroids[186, 187, 188, 189]	beclomethasone (Beclovent)	Glaxo	UK	Unclear	1980 (patent)
Leukotriene receptor antagonists[190, 191]	**montelukast (Singulair)** **zafirlukast (Accolate)**	**Merck** **Astrazeneca**	**U.S.** **Sweden**	**Unclear** **Unclear**	**1998** **1996**
Cox-2 inhibitors[192, 193]	celcoxib (Celebrex)	G. D. Searle	U.S.	Unclear	1998
Third-generation cephalosporins[194, 195, 196, 197]	cefotaxime (Claforan)	Hoechst-roussel	Germany	Unclear	1981
Imidazole and triazole antifungals[198, 199]	**fluconazole (Diflucan)** **ketoconazole (Nizoral)**	**Pfizer** **Janssen**	**U.S.** **Belgium**	**UK** **Belgium**	**1990** **1981**
Antivirals (herpes simplex/ zoster)[200, 201]	**acyclovir (Zovirax)**	**Burroughs Wellcome**	**UK**	**U.S.**	**1982**
HIV antiretro-virals[202, 203, 204, 205]	zidovudine (AZT, Retrovir)	Burroughs Wellcome	UK	U.S.	1987
Cytomegalovirus (CMV) antivirals[206]	**foscarnet (Foscavir)**	**Astra**	**Sweden**	**Sweden**	**1991**
Oral hypoglycemic agents[207, 208, 209, 210, 211]	metformin (Glucophage) pioglitazone (Actos)	Bristol-Myers Squibb Takeda	U.S. Japan	U.S. Japan	1995 1999
Selective estrogen receptor modulators[212, 213, 214]	tamoxifen (Nolvadex)	I.C.I.	UK	UK	1977
Chemotherapy agents[215, 216]	**cisplatin (Platinol)**	**Bistol-Myers**	**U.S.**	**U.S.**	**1978**

5-HT3 blockers[217, 218]	**ondansetron (Zofran)**	**Glaxo**	**UK**	**UK**	**1991**
PDE5 blockers[219, 220, 221]	sildenafil (Viagra)	Pfizer	U.S.	U.K.	1998
Nonsedating antihistamines[222, 223]	loratadine (Claritin)	Schering-Plough	U.S.	U.S.	1993
5-alpha reductase inhibitors[224, 225, 226]	**finasteride (Proscar)**	**Merck**	**U.S.**	**U.S.**	**1992**
Triptans (selective 5-HT1 agonists)[227, 228]	**sumatriptan (Imitrex)**	**Glaxo**	**UK**	**UK**	**1992**
Interferons[229, 230]	**several**	**Berlex/Chiron, Biogen, Genentech, Roche**	**Germany, Switzerland, U.S.**	**Germany, Switzerland, U.S.**	**1993**
Bisphosphonates[231, 232]	**etidronate (Didronel)**	**Proctor and Gamble**	**U.S.**	**U.S.**	**1977**

Notes

1. The World Health Organization, *The World Health Report 2000: Health Systems: Improving Performance* (Geneva: WHO, 2000), http://bit.ly/14Dee4.

2. Karen Davis et al., "Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care," *Commonwealth Fund* 59 (May 2007).

3. Ellen Nolte and Martin McKee, "Measuring the Health of Nations: Analysis of Mortality Amenable to Health Care," *British Medical Journal* 327 (November 15, 2003): 1129.

4. Paul Krugman, "The Waiting Game," *New York Times*, July 16, 2007.

5. Glen Whitman, "WHO's Fooling Who?" Cato Institute Briefing Paper no. 101, February 28, 2008, http://bit.ly/5RJL6.

6. Linda Gorman, "Commonwealth Ranking: Are We Really 19th Out of 19?" John Goodman's Health Policy Blog, July 30, 2008, http://bit.ly/b9oIh.

7. Thomas Stossel, "The Discovery of Statins," *Cell* 134 (2008): 903–05.

8. "Enalapril," Medic8.com http://bit.ly/4d6UPT.

9. Sean Parnell, "Nurse Practitioners Offer Effective, Low-Cost Care," The Heartland Institute (October 2005).

10. Harris Myers, "Focused Factories: Are You Ready for the Competition?" *Hospitals and Health Networks* 72 (1998): 24–30.

11. James Robinson, "Chapter 4: Entrepreneurial Challenges to Integrated Health Care," *Policy Challenges in Modern Health Care* (New Brunswick, NJ: Rutgers University Press, 2005), pp. 53–67.

12. Nobelprize.org, "All Nobel Laureates in Medicine," http://bit.ly/4GwSbE.

13. Nobel Prize Internet Archive, http://bit.ly/476l44.

14. Tyler Cowen, "Poor U.S. Scores in Health Care Don't Measure Nobels and Innovation," *New York Times*, October 5, 2006, http://bit.ly/3NXV6e.

15. Lennart Phillipson, "Medical Research Activities, Funding, and Creativity in Europe: Comparison with Research in the United States," *JAMA* 294 (2005): 1394–98.

16. Thomas Boehm, "How Can We Explain the American Dominance in Biomedical Research and Development?" *Journal of Medical Marketing* 5 (2005): 158–66.

17. Victor Fuchs and Harold Sox, "Physicians' Views of the Relative Importance of Thirty Medical Innovations," *Health Affairs* 20 (2001): 30–42.

18. Also included in this category are "cataract extraction and lens implantation" and "gastrointestinal endoscopy."

19. In the case of ultrasonography, the history is so complex and spread over so many countries (including the United States) that it would be difficult to determine which countries were the sites of the most significant contributions. In the case of intravenous (IV) conscious sedation, historical information could not be found.

20. In the case of long-acting opioids, most of the significant advances were in the beginning of the 20th century. In recent history, there have been new preparations and slight advances (i.e., Oxy-contin by Purdue Pharmaceuticals in the United States), but they are relatively minor compared to the initial development of the first long-acting opioids. We therefore chose not to include these examples alongside the more transformative innovations in the table.

21. Central Intelligence Agency, *The World Factbook*, http://bit.ly/4fNSF7. The population of the former Western Europe, although smaller than that of the European Union, is more than 25 percent larger than that of the United States.

22. In the case of drugs developed at pharmaceutical companies, whenever we were unable to find the specific facility where a particular drug was developed, we assumed that it was developed at a facility in the country in which the company was based at the time.

23. In the cases in which an innovation was developed at a foreign facility of a firm, the credit was given to the country in which the facility was located. If, instead, we give the credit to the country in which the firm is based, then there was a significant contribution from the United States to 22 of the 27 innovations, including all of the top 10, and a significant contribution from the E.U. or Switzerland to 13 of 27, including 5 of the top 10.

24. Iain Cockburn and Rebecca Henderson, "Public-private Interaction and the Productivity of Pharmaceutical Research," NBER Working Paper 6018 (Cambridge: National Bureau of Economic Research, 1997).

25. Joseph DiMasi, Christopher-Paul Milne, and Benjamin Zycher, *The Truth about Drug Innovation: Thirty-five Summary Case Histories on Private Sector Contributions to Pharmaceutical Science* (New York: Manhattan Institute for Policy Research, 2008).

26. This was true of the following classes: fibrates and antifungals.

27. This was true of the following classes: leuko-triene receptor antagonists and the oral hypoglycemic agents.

28. The excluded classes were beta blockers, platelet aggregation inhibitors, MAOIs, NSAIDs, long-acting opioids, immunosuppressants, fluo-roquinolones, and thyroid-stimulating hormones.

29. Three of the classes have both the United States and a European country listed. In the cases in which a drug was developed at a foreign facility of a pharmaceutical firm, the credit was given to the country in which the facility was located. If, instead, we give the credit to the country in which the pharmaceutical firm is based, then there was a significant contribution from the United States in 18 of 29 cases, and a significant contribution from the E.U. or Switzerland in 15 cases. Whenever we were unable to find the specific facility where a particular drug was developed, we assumed that it was developed at a facility in the country in which the company was based at the time.

30. Central Intelligence Agency, *The World Factbook*.

31. Henry Grabowski and Richard Wang, "The Quantity and Quality of Worldwide New Drug Introductions, 1982–2003," *Health Affairs* 25, no. 2 (March/April 2006): 452–60.

32. Jon Northrup, "The Pharmaceutical Sector," *The Business of Health Care Innovation*, ed. Lawton Robert Burns (Cambridge: Cambridge University Press, 2005), p. 29.

33. IMS Health, *Global Pharmaceutical Sales by Region—2007*, http://bit.ly/2eVeOd.

34. Contract Pharma, *Top 20 Pharmaceutical Companies Report*, 2009, http://bit.ly/NFNqc.

35. CNN Money, *Global 500*, 2009, http://bit.ly/36mIkl.

36. Colin Baker, "Would Prescription Drug Re-importation Reduce U.S. Drug Spending?" *Economic and Budget Issue Brief*, Congressional Budget Office, April 29, 2004.

37. James Robinson, *The Corporate Practice of Medicine* (London: University of California Press, 1999), p. 5.

38. We excluded eight of the 37 drug classes because they received initial FDA approval more than 40 years ago. The results for the remaining 29 classes are in Table 2. As the table makes clear, the U.S. contribution has been significant. Sixteen of the 30 representative drugs were initially developed in the United States, while 15 were developed in the E.U. or Switzerland. (We credit two of the 29 drug classes to both the United States and a European country.) Again, all of these figures should be interpreted in light of the European Union's notably larger population.

39. Thomas Bodenheimer, "High and Rising Health Care Costs. Part 2: Technologic Innovation," *Annals of Internal Medicine* 142 (June 7, 2005): 932–37.

40. Ibid.: 933.

41. Robinson, *The Corporate Practice of Medicine*, pp. 1–15.

42. Elliot Fisher et al., "Health Care Spending, Quality, and Outcomes," *The Dartmouth Atlas Project Topic Brief* (February 27, 2009).

43. It may be that high-spending regions encourage innovation, which could indirectly improve health outcomes in all regions. It is therefore possible that, to some extent, the high spending levels in both the high-cost regions within the United States and in the United States overall may be efficient in a dynamic sense.

44. Ramirez de Arellano, "Patients Without Borders: The Emergence of Medical Tourism," *International Journal of Health Services* 37 (2007): 193–98.

45. Martha Lagace, "The Rise of Medical Tourism: Q&A with Tarun Khanna," *Harvard Business School Working Knowledge* (December 17, 2007).

46. Regina Herzlinger, *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* (New York: Perseus Books, 1997).

47. Clayton M. Christensen, *The Innovator's Prescription* (New York: McGraw-Hill, 2009).

48. Regina Herzlinger, *Who Killed Health Care?* (New York: McGraw-Hill, 2007).

49. United States General Accounting Office, "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance," GAO-04-167 (October 2003).

50. John Iglehart, "The Emergence of Physician-Owned Specialty Hospitals," *New England Journal of Medicine* 352 (2005): 78–84.

51. Kate Pickert and Ken Stier, "How Health Care Reform Could Hurt Doctor-Owned Hospitals," *Time Magazine*, July 13, 2009, http://bit.ly/3yNYFI.

52. Christensen, *The Innovator's Prescription*, p. 222.

53. David McGregor et al., "Home Hemodialysis: Excellent Survival at Less Cost, but Still Underutilized," *Kidney International* 57 (2000): 2654–55.

54. Kevin McLaughlin et al., "Why Patients with ESRD Do Not Select Self-Care Dialysis as a Treatment Option," *American Journal of Kidney Disease* 41 (February 2003): 380–85.

55. Christopher Blagg, "The Renaissance of Home Hemodialysis: Where We Are, Why We Got Here, What Is Happening in the United States and Elsewhere," *Hemodialysis International* 12 (2008): s2–s5.

56. "AAKP Urges Senator John Kerry to Support a Home Hemodialysis Pilot Program," *Medical News Today*, May 6, 2008, http://bit.ly/4pt7ts.

57. Christensen, *The Innovator's Prescription*, pp. 231–33.

58. Clayton Christensen et al., "Will Disruptive Innovations Cure Health Care?" *Harvard Business Review* 78, no. 5 (September–October 2000): 102–12.

59. Sharon Christian et al., "Overview of Nurse Practitioner Scopes of Practice in the United States—Discussion," UCSF Center for the Health Professions (2007).

60. Regarding the impact of pharmaceutical price controls on innovation, see U.S. Congressional Budget Office, "Pharmaceutical R&D and the Evolving Market for Prescription Drugs," CBO Economic and Budget Issue Brief, October 26, 2009, http://bit.ly/bJJ9S. Regarding the impact of health insurance price controls on innovation, see John H. Cochrane, "Health-Status Insurance: How Markets Can Provide Health Security," Cato Institute Policy Analysis no. 633, February 18, 2009, http://bit.ly/4jcYMm

61. Medicare's fee-for-service system of reimbursement tends to preserve the fragmented nature of health care delivery in the United States. 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://bit.ly/2ZiRZ.

62. In the wake of reforms that include an "individual mandate" to purchase health insurance, Massachusetts officials are working to impose a single payment system (capitation) on the Commonwealth's entire health care market, which would greatly alter its delivery system but make it no less rigid. See Kevin Sack, "Mass. Panel Backs Radical Shift in Health Payment," *New York Times*, July 16, 2009, http://bit.ly/11hga1.

63. James Taranto, "'We're Going to Let You Die'; Who Said It? Hint: It Wasn't Sarah Palin," *Wall Street Journal*, October 14, 2009, http://bit.ly/2rppny.

64. Victor Fuchs and Harold Sox, "Physicians' Views of the Relative Importance of Thirty Medical Innovations," *Health Affairs* 20 (2001): 30–42.

65. University of Manchester, "History of MRI," http://bit.ly/375lCw, accessed March 30, 2009.

66. William R. Hendee, "Cross Sectional Medical Imaging: A History," *RadioGraphics* 9 (1989): 1155–80.

67. Charles R. Smith and John R. Vane, "The Discovery of Captopril," *The FASEB Journal* 17 (2003): 788–89.

68. DiMasi et al.

69. Janice M. Reichert and Christopher-Paul Milne, "Public and Private Sector Contributions to the Discovery and Development of 'Impact' Drugs," Tufts Center for the Study of Drug Development White Paper, May 2002, http://bit.ly/MVSBc.

70. Angioplasty.org, "History of Angioplasty," http://bit.ly/2bJo43.

71. S. B. King, "Angioplasty from Bench to Bedside to Bench." *Circulation* 93 (1996): 1621–29.

72. Jonathan A. Tobert, "Lovastatin and Beyond: The History of the HMG-CoA Reductase Inhibitors," *Nature Reviews Drug Discovery* 2 (July 2003): 517–26.

73. DiMasi et al.

74. Reichert and Milne.

75. Richard H. Gold, Lawrence W. Bassett, Bobbi E. Widoff, "Highlights from the History of Mammography," *RadioGraphics* 10 (1990): 1111–31.

76. A. Van Steen, R. Van Tiggelen, "Short History of Mammography: a Belgian Perspective," *JBR-BTR* 90 (2007): 151–53.

77. Nirav J. Mehta, MD, and Ijaz A. Khan, MD, "Cardiology's 10 Greatest Discoveries of the 20th Century," *Texas Heart Institute Journal* 29, no. 3 (2002): 164–71, http://bit.ly/4dqv5R.

78. "A Brief History of Advances in Coronary Artery Bypass Grafting," Medtronic, March 30, 2009, http://bit.ly/1xLHR6.

79. Igor E. Konstantinov, "Vasilii I. Kolesov: A Surgeon to Remember," *Texas Heart Institute Journal* 31, no. 4 (2004): 349–58, http://bit.ly/1b1X6K.

80. Andrew S. Olearchyk and Renata M. Olear-chyk, "Reminiscences of Vasilii I. Kolesov," *Annals of Thoracic Surgery* 67 (1999):

273–76, http://bit.ly/wQcZn.

81. Richard L. Mueller, Todd K. Rosengart, and O. Wayne Isom, "The History of Surgery for Ischemic Heart Disease," *Annals of Thoracic Surgery* 63 (1997): 869–878. http://bit.ly/4xKiSp.

82. Barry A. Berkowitz and George Sachs, "Life Cycle of a Block Buster Drug: Discovery and Development of Omeprazole," *Molecular Interventions* 2 (2002): 6–11, http://bit.ly/3b7Vjs.

83. Herdis Molinder, "The Development of Cimet-idine: 1964–1976: A Human Story," *Journal of Clinical Gastroenterology* 19, no. 3 (1994): 248–54, http://bit.ly/j0PPT.

84. Reichert and Milne.

85. David T. Wong, Frank P. Bymaster, and Eric A. Engleman, "Prozac (fluoxetine, Lilly 110140), The First Selective Serotonin Uptake Inhibitor and an Antidepressant Drug: Twenty Years Since its First Publication," *Life Sciences* 57, no. 5 (1995): 411–41, http://bit.ly/1RYC8o.

86. David T. Wong, Kenneth W. Perry, and Frank P. Bymaster, "The Discovery of Fluoxetine Hydrochloride (Prozac)," *Nature Reviews Drug Discovery* 4 (2005): 764–74, http://bit.ly/2Z7nBa.

87. Reichert and Milne.

88. DiMasi et al.

89. Encyclopedia of Chemistry, "Duloxetine," May 10, 2009, http://bit.ly/1v8yXk.

90. Lorne Bellan, "The Evolution of Cataract Surgery: The Most Common Eye Procedure in Older Adults," *Geriatrics and Aging* 11, no. 6 (2008): 328–32, http://bit.ly/2rqTUN.

91. "Sir Harold Ridley and His Fight for Sight," Harold Ridley, http://bit.ly/39W9K5.

92. Charles D. Kelman, "History and Development of Phacoemulsification," *International Ophthalmology Clinics* 34, no. 2 (1994): 1–12, http://bit.ly/286TNe.

93. Konrad Pesudovs and David B. Elliot, "The Evolution of Cataract Surgery," *Optometry Today*, October 19, 2001, pp. 30–32. http://bit.ly/j2J9D.

94. Marvin L. Kwitko and Charles D. Kelman *The History of Modern Cataract Surgery*, 1st ed. (The Hague: Kugler Publications, 1998) pp. 3–33, 123–30, http://bit.ly/2GPEXi.

95. "History of Total Joint Replacement," Utah Hip and Knee Center, April 1, 2009, http://bit.ly/2GJ65e.

96. Pablo F. Gomez and Jose A. Morcuende, "A Historical and Economic Perspective on Sir John Charnley, Chas. F. Thackray Limited, and the Early Arthroplasty Industry," *Iowa Orthopaedic Journal* 25 (2005): 30–37, http://bit.ly/3YrhMM.

97. "A Brief History of Hip Replacements," The Free Library, May 1, 2007, http://bit.ly/3frAr1.

98. "History of Total Joint Replacement."

99. Chitranjan Ranawat, "History of Total Knee Replacement," *Orthopaedic Care: Medical and Surgical Management of Musculoskeletal Disorders* (The Southern Orthopaedic Association, 2006), http://bit.ly/2JokZj.

100. A. A. Shetty, A Tindall, P. Ting, and F. W. Heat-ley, "The Evolution of Total Knee Arthroplasty. Part II: The Hinged Knee Replacement and the Semi-Constrained Knee Replacement," *Current Orthopaedics* 17, no. 5 (2003): 403–07, http://bit.ly/2nSjat.

101. A. A. Shetty, A. Tindall, P. Ting, and F. W. Heatley, "The Evolution of Total Knee Arthro-plasty. Part III: Surface Replacement," *Current Orthopaedics* 17, no. 6 (2003): 478–81, http://bit.ly/1Odu4l.

102. Joseph Woo, "A Short History of the Development of Ultrasound in Obstetrics and Gynecology," http://bit.ly/34JvpB.

103. "History of Medical Ultrasound," British Medical Ultrasound Society, http://bit.ly/3DjGxw.

104. James M. Edmonson, PhD, "History of the Instruments for Gastrointestinal Endoscopy," *Gastrointestinal Endoscopy* 37 (1991): s27–s56, http://bit.ly/13YvDH.

105. M V. Sivak, "Gastrointestinal Endoscopy: Past and Future," *Gut* 55 (2006): 1061–64.

106. C B. Morgenthal, W. O. Richards, B. J. Dunkin, K. A. Forde, G. Vitale, and E. Lin, "The Role of the Surgeon in the Evolution of Flexible Endoscopy," *Surgical Endoscopy* 21, no. 6 (2007): 838–53, http://bit.ly/3DilNX.

107. Graham Crompton, "A Brief History of Inhaled Asthma Therapy Over the Last Fifty Years," *Primary Care Respiratory Journal* 15 (2006): 326–31, http://bit.ly/1DScoa.

108. DiMasi et al.

109. Robert A. Maxwell and Shohreh B. Eckhardt, *Drug Discovery: A Casebook and Analysis* (Clifton, NJ: Humana Press Inc., 1990), pp. 349–59.

110. J. Périssat, D. Collet, and N. Monguillon "Advances in Laparoscopic Surgery," *Digestion* 59, no. 5 (1998): 606–18, http://bit.ly/vDwtH.

111. S. J. Spaner and G. L. Warnock, "A Brief History of Endoscopy, Laparoscopy, and Laparoscopic Surgery," *Journal of Laparoendoscopic and Advanced Surgical Techniques* 7, no. 6 (1997): 369–73.

112. "History of Minimally Invasive Surgery," *Mount Sinai*, http://bit.ly/2UZTCg.

113. Rod J. Flower, "The Development of Cox2 Inhibitors," *Nature Reviews Drug Discovery* 2, no. 3 (2003): 179–91.

114. DiMasi et al.

115. M. Hiraoka, "In Memoriam: Dr. Setsuro Ebashi (1922–2006)," *Journal of Molecular and Cellular Cardiology* 42 (2007): 459–60, http://bit.ly/2jp0WQ.

116. Makato Endo, "Calcium Ion and Troponin: Professor S. Ebashi's Epoch-Making Achievement," *Biochemical and Biophysical Research Communications* 369 (2008): 30–33, http://bit.ly/3ohXGB.

117. American Association for Clinical Chemistry, "Hugo Katus, MD," http://bit.ly/24s0k8, May 11, 2009.

118. Hugo Katus, "Development of the Cardiac Troponin T Immunoassay," *Clinical Chemistry* 54, no. 9 (2008): 1576–77, http://bit.ly/2kETfF.

119. DiMasi et al.

120. Mona Ashiya and Richard Smith, "Non-Insulin Therapies for Type-2 Diabetes," *Nature Reviews Drug Discovery* 6, no. 10 (2007): 777–78, http://bit.ly/1hoq31.

121. Walter Sneader, *Drug Discovery: A History* (West Sussex, UK: John Wiley & Sons, 2005), pp. 274–76.

122. Shari Bolen, Leonard Feldman, Jason Vassy, Lisa Wilson, Hsin-Chieh Yeh, Spyridon Marin-opoulos, and Crystal Wiley et al., "Systematic Review: Comparative Effectiveness and Safety of Oral Medications for Type 2 Diabetes Mellitus," *Annals of Internal Medicine* 147 (2007): 386–99, http://bit.ly/LAXiJ.

123. U.S. Food and Drug Administration, "Drugs@FDA," http://bit.ly/1FwfvA, accessed May 12, 2009.

124. Margie Patlak, "New Weapons to Combat an Ancient Disease: Treating Diabetes." *Federation of American Societies for Experimental Biology* 16, no. 14 (2002): 1853E, http://bit.ly/1yuKLz.

125. "An AIDS History," AIDS Education Global Information System, National Library of Medicine, NIH, http://bit.ly/1cKEgJ.

126. Sneader, *Drug Discovery*, pp. 260–64.

127. Tom Matthews, Miklos Salgo, Michael Greenberg, Jain Chung, Ralph DeMasi, and Dani Bol-ognesi, "Enfuvirtide: The First Therapy to Inhibit the Entry of HIV-1 into Host CD4 Lymphocytes," *Nature Reviews Drug Discovery* 3, no. 3 (March 2004): 215–25. http://bit.ly/41mGHV.

128. Reichert and Milne.

129. "Antiretroviral Drugs Used in the Treatment of HIV Infection," U.S. Department of Health and Human Services, Food and Drug Administration, http://bit.ly/1j0FQT.

130. V. Craig Jordan, "Tamoxifen: A Most Unlikely Pioneering Medicine," *Nature Reviews Drug Discovery* 2 (March 2003): 205–13, http://bit.ly/2kLuVb.

131. DiMasi et al.

132. Amrith Raj Rao, Hanif G. Motiwala, and Omer Karim, "The Discovery of Prostate-Specific Antigen," *British Journal of Urology International* 101, no. 1 (2008): 5–10, http://bit.ly/4m0D1V.

133. Danil V. Makarov and H. Ballentine Carter, "The Discovery of Prostate Specific Antigen as a Biomarker for the Early Detection of Adenocarci-noma of the Prostate," *Journal of Urology* 176 (2006): 2383–85, http://bit.ly/1HeLbH.

134. DiMasi et al.

135. Excluded from total numbers in the text because it is before our chosen time period (1970s–present).

136. B. J. Egan and C. A. O'Morain, "A Historical Perspective of Helicobacter gastroduodenitis and Its Complications," *Best Practice & Research Clinical Gastroenterology* 21, no. 2 (2007): 335–46, http://bit.ly/2rCZDu.

137. Larry DeWerd and James Sorenson, "Obituary: John R. Cameron," *Medical.Physics Online* 32 (2005): 1818–19. http://bit.ly/3n6sl9.

138. Ignac Fogelman and Glen M.Blake, "Different Approaches to Bone Densitometry," *Journal of Nuclear Medicine* 41 (2000): 2015–25, http://bit.ly/1opIR4.

139. "ACR Honorary Fellow Cameron Passes Away," American College of Radiology, http://bit.ly/A9B3U.

140. E. P. Abraham, "A Glimpse of the Early History of the Cephalosporins," *Review of Infectious Diseases* 1, no. 1 (1979): 99–105, http://bit.ly/wBHQa.

141. G. N. Rolinson and A. M. Geddes, "The 50th Anniversary of the Discovery of 6-Aminopenicil-lanic Acid (6-APA)," *International Journal of Anti-microbial Agents* 29 (2007): 3–8, http://bit.ly/3yidBV.

142. J. M. T. Hamilton-Miller, "Development of the Semi-Synthetic Penicillins and Cephalosporins," *International Journal of Antimicrobial Agents* 31 (2008): 189–92, http://bit.ly/2wFpoP.

143. DiMasi et al.

144. Maxwell and Eckhardt, *Drug Discovery: A Casebook and Analysis*, pp. 35–46.

145. Reichert and Milne.

146. Sneader, *Drug Discovery*.

147. DiMasi et al.

148. Nicholas K. Terrett, Andrew S. Bell, David Brown, and Peter Ellis, "Sildenafil (VIAGRA™), A Potent and Selective Inhibitor of Type 5 cGMP Phosphodiesterase with Utility for the Treatment of Male Erectile Dysfunction," *Bioorganic & Medicinal Chemistry Letters* 6, no. 15 (1996): 1819–24, http://bit.ly/3j4ewG.

149. DiMasi et al.

150. "FDA Approves Allegra-D, Manufacturer to Withdraw Seldane from Marketplace," http://bit.ly/2QsxlS.

151. Frederick R. Appelbaum, "Hematopoietic-Cell Transplantation at 50," *New England Journal of Medicine* 357, no. 15 (2007): 1472–75, http://bit.ly/3dcgWz.

152. Frédéric Baron, Rainer Storb, and Marie-Térèse Little, "Hematopoietic Cell Transplantation: Five Decades of Progress," *Archives of Medical Research* 34 (2003): 528–44, http://bit.ly/1tCbaT.

153. Thomas E. Donall, "Historical Review: A History of Haemopoietic Cell Transplantation," *British Journal of Haematology* 105 (1999): 330–39, http://bit.ly/3VYeYf.

154. Ernest A. McCulloch and James E. Till, "Perspectives on the Properties of Stem Cells," *Nature Medicine* 11 (2005): 1026–28, http://bit.ly/gwJbj.

155. Andrew G. Elefanty, "Inaugural Issue of Stem Cell Research," *Stem Cell Research* 1, no. 1 (2007): 1–2, http://bit.ly/2shcbA.

156. Charles R. Smith and John R. Vane, "The Discovery of Captopril," *FASEB Journal* 17 (2003): 788–89.

157. DiMasi et al.

158. Reichert and Milne.

159. DiMasi et al.

160. Franz H. Messerli, Michael A. Weber, and Hans R. Brunner, "Angiotensin II Receptor Inhibition: A New Therapeutic Principle," *Archives of Internal Medicine* 156 (1996): 1957–65.

161. Ruth R. Wexler, William J. Greenlee, John D. Irvin, Michael R. Goldberg, Kristine Prendergast, Ronald D. Smith, and Pieter B. M. W. M. Timmer-mans, "Nonpeptide Angiotensin II Receptor Antagonists: The Next Generation in Antihypertensive Therapy," *Journal of Medical Chemistry* 39 (1996): 625–56.

162. Maxwell and Eckhardt, *Drug Discovery: A Casebook and Analysis*, pp. 35–46.

163. Reichert and Milne.

164. Jonathan A. Tobert, "Lovastatin and Beyond: The History of the HMG-CoA Reductase Inhibitors," *Nature Reviews Drug Discovery* 2 (July 2003): 517–26.

165. DiMasi et al.

166. Reichert and Milne.

167. Thomas Stossel, "The Discovery of Statins," *Cell* 134 (2008): 903–05.

168. DiMasi et al.

169. Reichert and Milne.

170. Desmond Fitzgerald, "The Discovery of the Fibrates," *Dialogues in Cardiovascular Medicine* 8, no. 3 (2003): 155–62.

171. DiMasi et al.

172. John Earl and Peter Kirkpatrick, "Ezetimibe," *Nature Reviews Drug Discovery* 2 (February 2003): 97–98.

173. Herdis Molinder, "The Development of Cimetidine: 1964–1976: A Human Story," *Journal of Clinical Gastroenterology* 19, no. 3 (1994): 248–54, http://bit.ly/j0PPT.

174. DiMasi et al.

175. Berkowitz and Sachs, "Life Cycle of a Block Buster Drug."

176. DiMasi et al.

177. Wong, Bymaster, and Engleman, "Prozac."

178. David T. Wong, Kenneth W. Perry, and Frank P. Bymaster, "The Discovery of Fluoxetine Hydrochloride (Prozac)," *Nature Reviews Drug Discovery* 4 (2005): 764–74, http://bit.ly/2Z7nBa.

179. Reichert and Milne.

180. DiMasi et al.

181. Encyclopedia of Chemistry, "Duloxetine," May 10, 2009, http://bit.ly/1v8yXk.

182. Stacey Lee and Normal L. Keltner, "Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs): Venlafaxine and Duloxetine," *Perspectives in Psychiatric Care* 42, no. 2 (May 2006): 144–48.

183. DiMasi et al.

184. Sneader, *Drug Discovery*, pp. 191–92.

185. "Our History," GlaxoSmithKline, http://bit.ly/2fYhgo.

186. GrahamCrompton, "A BriefHistory ofInhaled Asthma Therapy Over the Last Fifty Years," *Primary Care Respiratory Journal* 15 (2006): 326–31, http://bit.ly/1DScoa.

187. DiMasi et al.

188. Maxwell and Eckhardt, *Drug Discovery: A Casebook and Analysis*, pp. 349–59.

189. "Micronised Beclomethasone Dipropionate Monohydrate Compositions and Methods ofUse," *Free Patents Online*, http://bit.ly/3SltYd.

190. "Drugs@FDA."

191. Peter R. Bernstein, "Chemistry and Structure-Activity Relationships ofLeukotriene Receptor Antagonists," *American Journal of Respiratory Critical Care Medicine* 157, no. 6 (June 1998): S220–S226.

192. Rod Flower, "The Development ofCox2 Inhibitors," *Nature Reviews Drug Discovery* 2, no. 3 (2003): 179–91.

193. DiMasi et al.

194. E. P. Abraham, "A Glimpse ofthe Early History ofthe Cephalosporins," *Review of Infectious Diseases* 1, no. 1 (1979): 99–05, http://bit.ly/wBHQa.

195. G. N. Rolinson and A. M. Geddes, "The 50th Anniversary ofthe Discovery of6 Aminopenicil-lanic Acid (6-APA)," *International Journal of Anti-microbial Agents* 29 (2007): 3–8, http://bit.ly/3yidBV.

196. Hamilton-Miller, "Development ofthe Semi-Synthetic Penicillins and Cephalosporins."

197. DiMasi et al.

198. Ibid.

199. Reichert and Milne.

200. DiMasi et al.

201. Reichert and Milne.

202. "An AIDS History," AIDS Education Global Information System, National Library ofMedicine, NIH, http://bit.ly/1cKEgJ.

203. Sneader, *Drug Discovery*, pp. 260–64.

204. Reichert and Milne.

205. "Antiretroviral Drugs Used in the Treatment ofHIV Infection."

206. Reichert and Milne.

207. Mona Ashiya and Richard Smith, "Non-Insulin Therapies for Type-2 Diabetes," *Nature Reviews Drug Discovery* 6, no. 10 (2007): 777–78

208. Sneader, *Drug Discovery*, pp. 274–76.

209. Bolen et al.

210. "Drugs@FDA."

211. Margie Patlak, "New Weapons to Combat an Ancient Disease: Treating Diabetes," *Federation of American Societies for Experimental Biology* 16, no. 14 (2002): 1853E, http://bit.ly/1yuKLz.

212. V. Craig Jordan, "Tamoxifen: A Most Unlikely Pioneering Medicine," *Nature Reviews Drug Discovery* 2 (March 2003): 205–213, http://bit.ly/2kLuVb.

213. DiMasi et al.

214. Reichert and Milne.

215. DiMasi et al.

216. Reichert and Milne.

217. DiMasi et al.

218. Reichert and Milne.

219. Sneader, Drug Discovery, pp. 135–36.

220. DiMasi et al.

221. Terrett et al.

222. DiMasi et al.

223. "FDA Approves Allegra-D"

224. DiMasi et al.

225. Reichert and Milne.

226. Sneader, *Drug Discovery*, pp. 206–07.

227. DiMasi et al.

228. Reichert and Milne.

229. DiMasi et al.

230. Reichert and Milne.

231. Marion Francis and D. J. Valent, "Historical Perspectives on the Clinical Development of Bisphosphonates in the Treatment of Bone Diseases," *Journal of Musculoskeletal Neuronal Interaction* 7, no. 1 (2007): 2–8, http://bit.ly/2ynYMX.

232. Herbert Fleisch, "Development of Bisphos-phonates," *Breast Cancer Research* 4 (2002): 30–34, http://bit.ly/3AugMv.

SECTION THREE:

ROMNEYCARE

Chapter 11

Lessons from the Fall of RomneyCare

by Michael D. Tanner

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When then-Massachusetts governor Mitt Romney signed into law the nation's most far-reaching state health care reform proposal, it was widely expected to be a centerpiece of his presidential campaign. In fact Governor Romney bragged that he would "steal" the traditionally Democratic issue of health care. "Issues which have long been the province of the Democratic Party to claim as their own will increasingly move to the Republican side of the aisle," he told Bloomberg News Ser-vice shortly after signing the bill. He told other reporters that the biggest difference between his health care plan and Hillary Clinton's was "mine got passed and hers didn't."

Outside observers on both the Right and Left praised the program. Edmund Haislmaier of the Heritage Foundation hailed it as "one of the most promising strategies out there." And Hillary Clinton adviser Stuart Altman said, "The Massachusetts plan could be-come a catalyst and a galvanizing event at the national level, and a catalyst for other states."

Today, however, Romney seldom mentions his plan on the campaign trail. If pressed he maintains that he is "proud" of what he accomplished, while criticizing how the Democratic administration that succeeded him has implemented the program. Nevertheless, he now focuses on changing federal tax law in order to empower individuals to buy health insurance outside their employer, and on incentives for states to deregulate their insurance industry. He would also use block grants for both Medicaid and federal uncompensated care funds to encourage greater state innovation. He encourages states to experiment, but does not offer his own state as a model.

A Double Failure

There's good reason for his change of position. The Massachusetts plan was supposed to accomplish two things—achieve universal health insurance coverage while controlling costs.

As Romney wrote in the Wall Street Journal, "Every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of health care will be reduced." In reality, the plan has done neither.

Perhaps the most publicized aspect of the Massachusetts reform is its mandate that every resident have health insurance, whether provided by an employer or the government or purchased individually. "I like mandates," Romney said during a debate in New Hampshire. "The mandate works." But did it?

Technically the last day to sign up for insurance in compliance with that mandate was November 15, though as a practical measure Massachusetts residents actually had until January 1, 2008. Those without insurance as of that date will lose their personal exemption for the state income tax when they file this spring. In 2009, the penalty will increase to 50 percent of the cost of a standard insurance policy.

Such a mandate was, of course, a significant infringement on individual choice and liberty. As the

Congressional Budget Office noted, the mandate was "unprecedented," and represented the first time that a state has required that an individual, simply because they live in a state and for no other reason, must purchase a specific government-designated product.

It was also a failure.

When the bill was signed, Governor Romney, the media, state lawmakers, and health care reform advocates hailed the mandate as achieving universal coverage. "All Massachusetts citizens will have health insurance. It's a goal Democrats and Re-publicans share, and it has been achieved by a bipartisan effort," Romney wrote.

Before RomneyCare was enacted, estimates of the number of uninsured in Massachusetts ranged from 372,000 to 618,000. Under the new program, about 219,000 previously uninsured residents have signed up for insurance. Of these, 133,000 are receiving subsidized coverage, proving once again that people are all too happy to accept something "for free," and let others pay the bill. That is in addition to 56,000 people who have been signed up for Medicaid. The bigger the subsidy, the faster people are signing up. Of the 133,000 people who have signed up for insurance since the plan was implemented, slightly more than half have received totally free coverage.

It's important to note that the subsidies in Massachusetts are extensive and reach well into the middle class—available on a sliding scale to those with incomes up to 300 percent of the federal poverty level. That means subsidies would be available for those with incomes ranging from $30,480 for a single individual to as much as $130,389 for a married couple with seven children. A typical married couple with two children would qualify for a subsidy if their income were below $63,000.

What we don't know is how many of those receiving subsidized insurance were truly uninsured and how many had insurance that either they or their employer was paying for. Studies indicate that substitution of taxpayer-financed for privately funded insurance is a common occurrence with other government programs such as Medicaid and the State Children's Health Insurance Program (S-CHIP). Massachusetts has attempted to limit this "crowd-out" effect by requiring that individuals be uninsured for at least six months before qualifying for subsidies. Still some substitution is likely to have occurred.

The subsidies may have increased the number of Massachusetts citizens with insurance, but as many as 400,000 Massachusetts residents by some estimates have failed to buy the required insurance. That includes the overwhelming majority of those with incomes too high to qualify for state subsidies. Fewer than 30,000 unsubsidized residents have signed up as a result of the mandate. And that is on top of the 60,000 of the state's uninsured who were exempted from the mandate because buying insurance would be too much of a financial burden.

Billion-Dollar Overrun

According to insurance industry insiders, the plans are too costly for the target market, and the potential customers—largely younger, healthy men—have resisted buying them. Those who have signed up have been disproportionately older and less healthy. This should come as no surprise since Massachusetts maintains a modified form of community rating, which forces younger and healthier individuals to pay higher premiums in order to subsidize premiums for the old and sick.

Thus, between half and two-thirds of those uninsured before the plan was implemented remain so. That's a far cry from universal coverage. In fact, whatever progress has been made toward reducing the ranks of the uninsured appears to be almost solely the result of the subsidies. The much ballyhooed mandate itself appears to have had almost no impact.

The Massachusetts plan might not have achieved universal coverage, but it has cost taxpayers a great

deal of money. Originally, the plan was projected to cost $1.8 billion this year. Now it is expected to exceed those estimates by $150 million. Over the next 10 years, projections suggest that Romney-Care will cost about $2 billion more than was budgeted. And the cost to Massachusetts taxpayers could be even higher because new federal rules could deprive the state of $100 million per year in Medicaid money that the state planned to use to help finance the program.

Given that the state is already facing a projected budget deficit this year, the pressure to raise taxes, cut reimbursements to health care providers, or cap insurance premiums will likely be intense. Romney likes to brag that he accomplished his health care plan "without raising taxes." Unless something turns around, that is not likely to be the case much longer.

Moreover, the cost of the plan is also likely to continue rising, because the Massachusetts reform has failed to hold down the cost of health care. When Romney signed his plan he claimed "a key objective is to lower the cost of health insurance for all our citizens and allow our citizens to buy the insurance plan that fits their needs." In actuality, insurance premiums in the state are expected to rise 10–12 percent next year, double the national average.

The Bureaucratic Connector

Although there are undoubtedly many factors behind the cost increase, one reason is that the new bureaucracy that the legislation created—the "Connector"—has not been allowing Massachusetts citizens to buy insurance that "fits their needs."

Although it has received less media attention than other aspects of the bill, one of the most significant features of the legislation is the creation of the Massachusetts Health Care Connector to combine the current small-group and individual markets under a single unified set of regulations. Supporters such as Robert E. Moffit and Nina Owcharenko of the Heritage Foundation consider the Connector to be the single most important change made by the legislation, calling it "the cornerstone of the new plan" and "a major innovation and a model for other states."

The Connector is not actually an insurer. Rather, it is designed to allow individuals and workers in small companies to take advantage of the economies of scale, both in terms of administration and risk pooling, which are currently enjoyed by large employers. Multiple employers are able to pay into the Connector on behalf of a single employee. And, most importantly, the Connector would allow workers to use pre-tax dollars to purchase individual insurance. That would make insurance personal and portable, rather than tied to an employer—all very desirable things.

However, many people were concerned that the Connector was being granted too much regulatory authority. It was given the power to decide what products it would offer and to designate which types of insurance offered "high quality and good value." This phrase in particular worried many observers because it is the same language frequently included in legislation mandating insurance benefits.

At the time the legislation passed, Ed Haislmaier of the Heritage Foundation reassured critics that "the Connector will neither design the insurance products being offered nor regulate the insurers offering the plans." In reality, however, the Connector's board has seen itself as a combination of the state legislature and the insurance commissioner, adding a host of new regulations and mandates.

For example, the Connector's governing board has decreed that by January 2009, no one in the state will be allowed to have insurance with more than a $2,000 deductible or total outof-pocket costs of more than $5,000. In addition, every policy in the state will be required to phase in coverage of prescription drugs, a move that could add 5–15 percent to the cost of insurance plans. A move to require dental coverage barely failed to pass the board, and the dentists—along with several other provider groups—

have not given up the effort to force their inclusion. This comes on top of the 40 mandated benefits that the state had previously required, ranging from in vitro fertilization to chiropractic services.

Thus, it appears that the Connector offers quite a bit of pain for relatively little gain. Although the ability to use pretax dollars to purchase personal and portable insurance should be appealing in theory, only about 7,500 nonsubsidized workers have purchased insurance through the Connector so far. On the other hand, rather than insurance that "fits their needs," Massachusetts residents find themselves forced to buy expensive "Cadillac" policies that offer many benefits that they may not want.

Governor Romney now says that he cannot be held responsible for the actions of the Connector board, because it's "an independent body separate from the governor's office." However, many critics of the Massachusetts plan warned him precisely against the dangers of giving regulatory authority to a bureaucracy that would last long beyond his administration.

ClintonRomneyEdwardsCare

Despite the problems being encountered in Massachusetts, the Romney plan continues to receive a surprising amount of support as a model for reform. The health care plans advocated by all three of the leading Democratic presidential candidates—Hillary Clinton, John Edwards, and Barack Obama—are all substantially the same as Romney's. They are all variations of a concept called "managed competition," which leaves insurance privately owned but forces it to operate in an artificial and highly regulated marketplace similar to a public utility. All of their plans include an individual mandate (only for children in Obama's case, and for everyone in Clinton's and Edwards's plans), in-creased regulation, a government-designed standard benefits package, and a new pooling mechanism similar to the Connector.

Romney denounces Senator Clinton's plan as "government run health care," but there really is very little difference between the Romney and Clinton plans.

In addition, several states have been seeking to use Massachusetts as a model for their own reforms. In California, Gov. Arnold Schwarzenegger added an employer mandate to a plan that otherwise looked very much like the Massachusetts plan. Other states considering similar proposals include Alaska, Kansas, Louisiana, Mary-land, Michigan, New York, Oregon, and Washington, as well as the District of Columbia. Although none of these proposals has made it into law, several remain under active consideration.

No one can deny that the U.S. health care system needs reform. Too many Americans lack health insurance and/or are unable to afford the best care. More must be done to lower health care costs and increase access to care. Both patients and providers need better and more useful information. The system is riddled with waste, and quality of care is uneven. Government health care programs like Medicare and Medicaid threaten future generations with an enormous burden of debt and taxes. Given these pressures, the temptation for a quick fix is understandable.

But, as Massachusetts has shown us, mandating insurance, restricting individual choice, expanding subsidies, and increasing government control isn't going to solve those problems. A mandate imposes a substantial cost in terms of individual choice but is almost certainly unenforceable and will not achieve its goal of universal coverage. Subsidies may increase coverage, but will almost always cost more than projected and will impose substantial costs on taxpayers. Increased regulations will drive up costs and limit consumer choice.

The answer to controlling health care costs and increasing access to care lies with giving consumers more control over their health care spending while increasing competition in the health care marketplace —not in mandates, subsidies, and regulation. That is the lesson we should be drawing from the failure of

RomneyCare.

Chapter 12

Massachusetts Miracle or Massachusetts Miserable: What the Failure of the "Massachusetts Model" Tells Us about Health Care Reform

by Michael D. Tanner

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Introduction

On April 12, 2006, Massachusetts governor Mitt Romney signed into law one of the most far-reaching experiments in health care reform since President Bill Clinton's ill-fated attempt at national health care. The legislation took full effect on July 1, 2007, meaning that we now have had sufficient time to evaluate its successes and failures.

The Massachusetts reforms were pioneering in many respects. Among the key components of the bill were

- **An Individual Mandate.** Perhaps the most widely discussed aspect of the Massachusetts reform was its unprecedented "individual mandate," a requirement that every Massachusetts resident have a minimum amount of health insurance coverage, as defined by the state. Those who do not receive insurance through their employer or a government plan such as Medicare are required to purchase it on their own.[1] Initially, a failure to comply with this mandate resulted in the loss of the individual's personal exemption from the state income tax. That penalty increased to 50 percent of the cost of a standard insurance policy, or up to $912 as of July 1, 2008.[2]
- **An Employer Mandate.** In addition to the individual mandate, the Massachusetts reform also imposed a mandate on employers with 10 or more workers. Employers who fail to provide health insurance to their workers are assessed a $295 fee per employee,[3] with additional penalties for employers whose workers repeatedly receive uncompensated care.[4] And finally, all employers are required to offer their employees a Section 125 plan.[5]
- **Middle-Class Subsidies.** The reforms established a new program called Commonwealth Care to help families with incomes up to 300 percent of the poverty level ($66,150 for a family of four) to purchase[6] The bill also expanded insurance.eligibility for Medicaid.
- **The Connector.** The Massachusetts reforms also established a new entity, called the Commonwealth Connector, to restructure the individual and small business insurance markets.[7] Intended as a way to enable individuals to purchase personal and portable health insurance on a pre-

tax basis, the Connector authority has evolved into a regulatory body with wide-ranging power over insurance in the state.

Health reform advocates on both the left and right have hailed Massachusetts as a model for reform. Numerous states have considered similar plans (although to date none have passed).[8]

More importantly, the key components of the Massachusetts plan form the core of proposals for national health care reform. In particular, both the Obama administration and congressional Democrats are leaning toward a plan that includes both an individual and employer mandate combined with middle-class subsidies.[9] In addition, while he was still a presidential candidate, Obama called for the creation of a Connector-like national "exchange."[10]

But experience so far suggests that the "Massachusetts model" actually provides an object lesson in how not to reform health care. The program has failed even by its own goal criteria of achieving universal coverage. It has failed to restrain the growth in health care costs. And it has greatly exceeded its initial budget, placing new burdens on the state's taxpayers.

At the same time, the Massachusetts Plan has increased bureaucratic control over the state's health care system, limiting consumer choice. And it has set the stage for still more state intervention in the future, including price controls and explicit rationing.

Health care reformers in other states and at the federal level should look carefully at the failures of the Massachusetts model, and learn from them.

Expanding Coverage

There is no doubt that the Massachusetts reforms have reduced the number of people without health insurance in the state, but by how much is a matter of considerable dispute. According to official state statistics, the state's uninsurance rate declined from 10.4 percent in 2006 to just 2.6 percent today, leaving just 167,300 state residents without insurance.[11] However, there are several reasons for doubting this number.

The data show that roughly 80,000 more people have been added to the Medicaid rolls. In addition, approximately 176,000 people were receiving subsidized insurance coverage through the state's Commonwealth Care program.[12] That means 256,000 previously uninsured people were being covered through government programs. The more difficult question is how many uninsured residents obtained unsubsidized coverage. Here the state relied on a telephone survey conducted by the Urban Institute in mid 2008, which estimated an increase in coverage of 187,000 people.[13] About 40,000 of these purchased individual insurance, either through the state's Connector or through the residual individual insurance market outside the Connector. The other 147,000 received coverage through their employer.

Such telephone surveys, however, are notoriously unreliable, particularly in the case of measuring health insurance coverage. For example, two groups that are much more likely to go without insurance are non-English-speaking immigrants (both legal and illegal) and young people. Yet, these groups are far less likely to be included on telephone surveys: immigrants because of the language barriers and young people because they lack traditional landline telephones.

More rigorous surveys have suggested that the number of uninsured remains far higher. For example, a

door-to-door survey by the Census Bureau, conducted at roughly the same time as the Urban Institute's phone survey, estimated that 5.4 percent of state residents were uninsured.[14] And an examination of state income tax returns (filers are required to certify their health insurance status on their returns) showed that roughly 5 percent of residents were uninsured as of January 1, 2008.[15] And, since low-income residents, who are more likely to lack insurance, are not required to file state taxes, the actual percentage of uninsured is most likely a percentage point or two higher. Those estimates suggest that more than 200,000 Massachusetts residents remain uninsured.[16]

Furthermore, if the number of uninsured in the state had indeed been reduced by 74 percent, as suggested by the state, one might expect a comparable reduction in the amount of uncompensated care provided by the state's hospitals. In reality, the number of people receiving uncompensated care has declined by just 36 percent.[17] In fact, one of the original selling points behind the Massachusetts reform was that it would shift subsidies for uncompensated care from hospitals to individuals. Uncompensated care subsidies were supposed to fade away, with the state using the savings to help low- and middle-income residents buy insurance instead. But hospitals now say that the rate of uncompensated care continues to be so high that they cannot dispense with their subsidies. The taxpayers end up paying twice.

There are also questions about the degree to which the reduction in the number of uninsured is sustainable going forward. For example, the increase in the number of people receiving employer-provided health insurance appears anomalous at a time when, nationwide, businesses are less likely to provide insurance for their employees. Also, the faltering economy and increase in unemployment will almost certainly cut into that number in the future. In addition, in the face of skyrocketing subsidy costs, the state is facing potential cutbacks to its Commonwealth Care program. It has already instituted eligibility reviews that have removed nearly 25,000 people from the program.[18]

When Massachusetts passed its reform plan, its supporters hailed it as a means to provide universal health insurance coverage. "All Massachusetts citizens will have health insurance," announced then-governor Mitt Rom-ney.[19] Thus, even by the standards of the program's supporters, it has not met its goals.[20]

It is also important to recognize that, whatever the increase in insurance coverage, most of the increase is due to subsidies, not the state's individual mandate. Fully 58 percent of the newly insured are having that insurance paid for by the government, either through Medicaid or Commonwealth Care—proving that if you give something away for free, people are inclined to take it.[21] Of the remaining 42 percent, more than three-quarters are receiving insurance through their employer.[22] It is impossible to sort out the share of those who are receiving insurance as a result of the employer mandate versus the individual mandate, or who would have received insurance even in the absence of any mandate. We do know that relatively few previously uninsured individuals who had to purchase their own insurance did so. It seems clear, therefore, that the state's generous subsidies have far more to do with the increase in insurance than does the individual mandate.

The evidence suggests a substantial degree of adverse selection taking place. Those signing up for subsidized coverage through the Commonwealth Care program were in poorer health than both the population at large and the previously uninsured population.[23] And younger residents, who composed the largest group of the uninsured before the mandate went into effect, continue to make up the largest

group of the uninsured. Slightly more than 35 percent of the state's remaining uninsured are between the ages of 18 and 25, and more than 60 percent are under the age of 35.[24] Before the mandate, those between the ages of 18 and 25 made up roughly 30 percent of the uninsured,[25] suggesting that the young (and presumably more healthy) are less likely to comply with the mandate.

One of the rationales for having the mandate was the belief that extending insurance to more young and healthy people would "strengthen and stabilize the functioning of health insurance risk pools."[26] However, the combination of subsidies and mandates may actually be making the pool older and sicker.

Thus, there seems to be little justification for an individual mandate.

Increased Insurance Regulation/Increased Cost

The proponents of the Massachusetts reforms also promised that those reforms would reduce health care costs. Governor Romney said that "the cost of health care would be reduced" and the plan would make health insurance "affordable" for every Massachusetts citizen.[27] Supporters suggested that the reforms would reduce the price of individual insurance policies by 25–40 percent.[28]

In reality, insurance premiums rose by 7.4 percent in 2007, 8–12 percent in 2008, and are expected to rise 9 percent this year.[29] By comparison, nationwide insurance costs rose by 6.1 percent in 2007, just 4.7 percent in 2008, and are projected to increase 6.4 percent this year.[30] On average, health insurance costs $16,897 for a family of four in Massachusetts, compared to $12,700 nationally.[31]

The five insurance plans available through the Massachusetts Commonwealth Care program, which subsidized care for low- and middle-income individuals, are somewhat cheaper, roughly $2,460–3,460 for an individual policy before application of the subsidy, but those costs, too, have been rising—up 11 percent since the program began for the lowest-cost plans.[32] Moreover, the initial low cost for these plans was widely attributed to low bids from two insurers who were attempting to gain customer share through the program's automatic assignment process. (Individuals participating in Commonwealth Care who do not choose an insurer are assigned to one. The lowest-bid plan receives the majority of assignees, with others receiving assignments based on how close their premiums are to the low bid.)[33] Having used their initial low bids as "loss leaders," these insurers are now pressing for substantial premium increases.

Massachusetts has always been among the states with the highest-cost insurance. In part, this is due to the type of technology-intensive medicine practiced in the state and to the domination of the state's insurance market by a few large insurers. But, it is also partly due to the state's insurance regulations, including community rating and some 40 mandated benefits.[34]

The reforms failed to deal with either of those issues. They failed to create the type of consumer incentives that would encourage consumers to become more cost conscious. Since the bill was signed, healthcare spending in the state increased by 23 percent.[35] And it generally retained the regulations and mandates that added to insurance costs.[36] In fact, the legislation established a new health care bureaucracy, the Connector, which has actually increased insurance regulation, and may have helped drive up costs.

The Massachusetts Health Care Connector was designed to combine the current small group and

individual markets under a single unified set of regulations.[37] In addition to trying to unify and rationalize two admittedly dysfunctional regulatory schemes, the Connector was also meant as way to allow workers to purchase individual insurance while receiving the same tax break as for employer-provided insurance, thereby breaking the link between employment and insurance. This would give workers portable personal insurance that they could take with them from job to job, and which they would not lose when they lost their job. Unfortunately, the Connector has not lived up to its promise in the latter regard. In fact, as of May 2008, only 18,122 people had purchased insurance through the Connector.[38]

On the other hand, as some critics feared, the Connector has become an aggressive new regulatory body. To qualify under the mandate, the Connector has decreed that insurance must now (1) include prescription drug coverage; (2) cover preventive care services; (3) have a deductible of no more than $2,000 for individuals or $4,000 for families, with drug deductibles of no more than $250 for individuals and $500 for families; (4) have an in-network out-of-pocket maximum (including deductibles, co-payments, and coinsurance) of no more than $5,000 for individuals and $10,000 for families; and (5) have no limit on annual or per sickness benefits.[39]

These rules do not apply just to the previously uninsured. Individuals who already had health insurance, but whose insurance did not meet these requirements, were required to give up their current insurance and purchase insurance that conformed to the new rules. However, the state postponed the application of the requirements for those who currently have noncomplying insurance until January 1, 2009, meaning that we do not yet have information on how many Massachusetts residents were required to switch plans.

In addition, the Connector adds its own administrative costs, estimated at 4 percent of premium costs, for plans that are sold through it.[40]

Massachusetts health reformers rejected proposals that would have reduced the rising cost of health insurance, such as eliminating regulations that drive up insurance premiums or those that limit competition in the insurance industry. Nor did they create incentives, such as increased cost-sharing, for consumers to become more value-conscious in their purchasing decisions. Instead, they increased regulatory costs and then simply threw money at the system through subsidies.

Not surprisingly, therefore, the cost of health care (and health insurance) in Massachusetts continues to rise.

Busting the Budget

When the Massachusetts reforms first became law, they were projected to cost about $1.56 billion per year in total, with the largest component, the Commonwealth Care subsidies, costing roughly $725 million per year. As it turns out, those estimates were not even close.

By mid 2008, the state was projecting that Commonwealth Care would cost $869 million for FY2009, nearly a 20 percent increase, and more than $880 million in 2010.[41] However, the state secretary of administration and finance says that she expects actual costs to be far higher—perhaps even as much as $100 million higher.[42] The entire reform plan was projected to cost more than $1.9 billion in 2009, some $300 million above projections.[43] State government spending on all health care programs has increased by 42 percent ($595 million) since 2006.[44]

Part of the spending increase can be traced to greater than anticipated participation. That is, more people qualified for subsidies than was expected. Supporters of the program focus on this aspect, and excuse the growing cost as the price of extending coverage. But, beyond increased participation, the program's growing cost can also be traced to the failure of the program to reduce health care and insurance costs.

As Massachusetts State Senator Jamie Eldridge, one of the early supporters of the plan, recently told a congressional forum:

> The assumption was that, as more people— and, in particular, more young and relatively healthy people—joined the system, premiums would go down across the board. There was also the assumption that as more people became insured, the number of people going to the emergency room would drop dramatically, saving the Commonwealth money. Neither of those things happened. . . . In fact, health reform has cost the Commonwealth much more than expected.[45]

At the same time that spending for the reforms was skyrocketing, revenues for the plan were shrinking. For example, assessments under the "play or pay" mandate on businesses were expected to bring in $45 million in its first year and $36 million in 2008. In actuality, it failed to generate any revenue in 2007 and just $7 million in 2008.[46] And as Senator Eldridge noted, expected savings from reductions in uncompensated care also failed to materialize.

With the health care program expected to contribute as much as one-third of the state's expected $1.3 billion budget deficit in 2008, Governor Deval Patrick and the legislature imposed a $1 per pack increase in the state's cigarette tax to help pay for the program. The regressive tax increase, which falls most heavily on the state's low-income residents, is projected to raise $154 million annually. The state also imposed approximately $89 million in fees and assessments on health care providers and insurers. On the cost-control side, the state imposed some modest cost-sharing increases on Commonwealth Care participants. And as mentioned, the state has begun a review of Commonwealth Care eligibility.

Despite these efforts, both cost increases and revenue shortfall are projected indefinitely into the future. Nearly all observers agree that without a concerted effort to control costs, the program is unsustainable.

Naturally there is talk of additional tax hikes. In particular, Patrick and Democratic leaders in the Massachusetts legislature are talking about an increase in the $295 assessment for businesses that do not provide health insurance.[47] But the state's ability to raise additional revenue may be constrained, especially in the face of the economic downturn and an FY2009 state budget shortfall that could top $2.4 billion.[48]

Already, the rules for compliance with the business mandate have been subtly changed in a way that will raise costs for many small businesses. The legislation originally required businesses to either cover 33 percent of the cost of premiums for their employees or have at least 25 percent of their full-time employees enrolled in their company plan. However, last year the legislature changed the "or" to "and." Small businesses are most likely to have difficulty in meeting both requirements. Many will find themselves facing either significant increases in the cost of employing workers or being required to pay the noncompliance assessment.[49]

In addition, Patrick has threatened both insurers and health care providers with price controls. Insurers participating in the Commonwealth Care program were ordered to cut reimbursements to providers by

3–5 percent.[50] There appears to have been little follow-through on that front, so Patrick has now chosen to attack the insurers directly. "Frankly, it's very hard for the average consumer, or frankly the average governor, to understand how some of these companies can have the margins they do and the annual increases in premiums that they do," Patrick mused to the media, shortly before announcing that he would explore whether the state had the power to regulate cap premiums.[51]

The state may even resort to explicit rationing. In 2008, the legislature established a special commission to investigate the health payment system in a search for ways to control costs.[52] In March 2009, the commission released a list of options that it was considering, including "exclud[ing] coverage of services of low priority/low value" under insurance plans offered through Commonwealth Care. Along the same lines, it has also suggested that Commonwealth Care plans "limit coverage to services that produce the highest value when *considering both clinical effectiveness and cost*."[53] And, while such moves would initially only impact those receiving subsidized coverage, the state is also considering "a limitation on the total amount of money available for health care services," which is a global budget—the hallmark of government-run health care systems like that in Canada.

Shortages and Waiting Lists

Experience with national health care systems around the world has long shown that insurance coverage does not necessarily equate to access to care. Massachusetts is beginning to learn that lesson.

As we saw above, the Massachusetts reforms have expanded the number of people with health insurance in the state. Not surprisingly, increased coverage has led to increased utilization. But, at the same time, Massachusetts has done nothing to increase its supply of providers. Indeed, to the degree that it ratchets down on reimbursements, it may reduce that supply. Anecdotal reports suggest that a number of physicians are limiting their practice or refusing to accept new patients.[54]

The inevitable result of an increased demand chasing a finite supply (in the absence of any form of price rationing) has always been shortages. The impact has been small so far. In 2007, 4.8 percent of state residents reported forgoing care because they could not find a doctor or get an appointment, an increase of 1.3 percentage points since the legislation was signed. For low-income residents, the problem was slightly worse: 6.9 percent couldn't find a doctor or get an appointment—a 2.7 percentage point hike since 2006.[55] Waiting times were a somewhat bigger problem, with the wait for seeing an internist, for example, increasing from 33 days to 52 days during the program's first year.[56]

However, in the future, the problems are likely to grow worse, especially if the state follows through on threats to enact cuts in reimbursements and premium caps on insurance (which will almost inevitably be reflected in reimbursement cuts, and/or global budgeting). Such policies can only further reduce the supply of providers, leading to more shortages, more difficulty in finding a doctor, and a longer waiting time if you can find one.

Conclusion

When Massachusetts passed its pioneering health care reforms, this critic warned that it would result

in "a slow but steady spiral downward toward a government-run health care system."[57] Sadly, three years later, those predictions appear to be coming true.

At a time when other states are thinking of copying Massachusetts, and, perhaps more significantly, the "Massachusetts model" is being discussed as a possible blueprint for national reform, the failures in Massachusetts provide valuable lessons for reformers.

Notably, "universal coverage" should not be the primary goal of health care reform. The key issue in health-care reform is not coverage, but freedom—and secondarily, cost. But Massachusetts reformers made universal coverage the lynchpin of their efforts at the expense of any serious effort to control health care costs. As the *New York Times* noted, "Those who led the 2006 effort said it would not have been feasible to enact universal coverage if the legislation had required heavy cost controls."[58] As a result, they pushed for universal coverage now, and put off "until another day any serious effort to control the state's runaway health costs."[59]

This was a guaranteed recipe for exploding program costs, and is likely now to lead to price controls and other restrictions that will adversely affect the availability and quality of health care.

Yet Congress and the Obama administration seem determined to head down the same exact road. The focus of their health care efforts appears likely to be a series of mandates and subsidies in an elusive search for universal coverage.[60] There is even likely to be a new government-run (and taxpayer subsidized) program similar to Medicare that will operate in "competition" with private insurance.[61] They would essentially create a new entitlement program, without taking any steps to control rising health care costs.

Already the administration's reform plans are expected to cost more $1.5 trillion over the next 10 years.[62] It will therefore be necessary either to run up more national debt—at a time when massive future budget deficits threaten to bankrupt the country—or to break President Obama's pledge not to raise taxes on the middle class.[63] And, without any other options, Congress will follow the Massachusetts model and turn to price controls and rationing. Thus, Americans will end up with the worst of all possible worlds: runaway costs and higher taxes followed by bureaucratic control over our health care choices.

Supreme Court Justice Louis Brandeis rightly called American state governments "the laboratories of democracy."[64] Under our federalist system of government, states are able to experiment with policies on a small scale before these policies are adopted by the whole nation. Of course, not all experiments are successful. And we can learn just as much from those that fail as from those that succeed.

When it comes to health care reform, Massachusetts has provided us with just such an experiment. Three years of experience shows that giving the government greater control over our health care system will have grave consequences for taxpayers, providers, and health care consumers. That is the true lesson of the Massachusetts model.

Notes

1. An Act Providing Access to Affordable, Quality, Accountable Health Care (April 12, 2006), Chapter 58 of the Acts of 2006, Section 12.

2. Ibid., Section 13.

3. Ibid., Section 47. Governor Romney vetoed this provision using his line-item veto authority, but the veto was overridden by the legislature.

4. Ibid., Section 45(b). If a company's employees incur at least $50,000 in uncompensated care, the company may be charged a "free-rider fee" of up to 100 percent of the cost of the care in excess of $50,000.

5. Ibid., Section 48. These are cafeteria plans, authorized under Section 125 of the federal Internal Revenue Code, which allow employees to set aside pre-tax dollars toward payment of insurance premiums, medical care, and dependent care expenses.

6. Ibid., Section 45.

7. Ibid., Section 101.

8. Utah has passed legislation establishing a "portal," which in many ways resembles the Connector. But the legislation has no mandates and is not nearly as comprehensive (nor as problematic) as that in Massachusetts. "2009 Utah Health Insurance Bills: What Passed?" Utah Insurance Blog, http://insuranceinutah.com/2009/04/03/2009-utah-healthcare-bills-what-passed/.

9. Robert Pear, "Democrats Agree on a Health Plan; Now Comes the Hard Part," *New York Times*, April 1, 2009.

10. See http://www.barackobama.com/issues/healthcare/.

11. Sharon K. Long, Allison Cook, and Karen Stockley, "Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey," December 18, 2008, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/hh_survey_08.ppt.

12. Massachusetts cites this number, which was as of July 2008. However, more recent data suggests that enrollment in Commonwealth Care declined to 163,000 as of January 1, 2009, http://www.mass.gov/bb/h1/fy10h1/exec10/hbudbrief20.htm

13. "Health Care in Massachusetts: Key Indicators," February 2009, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/key_indicators_02-09.pdf

14. U.S. Census Bureau, "2008 Annual Social and Economic Supplement, Table HI06: Health Insurance Coverage Status by State for All People," August 2008, http://www.census.gov/hhes/www/macro/032008/health/h06_000.htm

15. "Data on the Individual Mandate and Uninsured Tax Filers, Tax Year 2007," Massachusetts Department of Revenue, October 2008, http://www.mass.gov/Ador/docs/dor/News/PressReleases/2008/2007_Demographic_Data_Report_FINAL_(2).pdf

16. Suzanne King, "Massachusetts Health Care Reform Is Failing Us," *Boston Globe*, March 2, 2009.

17. Cedric K. Dark, "The Massachusetts Experience," Policy Prescriptions, March 15, 2009, http://www.policyprescriptions.org/?p=275.

18. "Connector Eligibility," Healthcare Financial, Inc., June 16, 2008, http://www.hfi-mass.com/news/articles/061608.shtm

19. Mitt Romney, "Health Care for Everyone? We've Found a Way," *Wall Street Journal*, April 11, 2006.

20. This is not to say that *universal* coverage should be the goal of health care reform, and certainly not the primary goal. It has been amply demonstrated by national health care systems in other countries that universal insurance coverage does not necessarily translate into better access to care. See, for example, Michael Tanner, "The Grass Isn't Always Greener: A Look at National Health Care Systems Around the World," Cato Institute Policy Analysis no. 613, March 18, 2008. And while there is evidence that those without health insurance have somewhat worse health outcomes than insured Americans, the evidence of a direct link between health insurance and health is weak. Nor is it a given that expanding insurance coverage is the best or most efficient use of resources when it comes to improving health care. Helen Levy and David Meltzer, "What Do We Really Know About Whether Health Insurance Affects Health?" Economic Research Initiative on the Uninsured, Working Paper no. 6, December 2001. Moreover, in many cases, expanding insurance coverage will exacerbate the problems of third-party payment.

21. Kevin Sack, "Massachusetts Faces Costs of Big Health Plan," *New York Times*, March 15, 2009.

22. Peter B. Smulowitz, "A Model for Expanding Health Insurance? Lessons Learned from the Massachusetts Experiment," ACEP State Legislative/ Regulatory Committee, http://acep.org/WorkArea/DownloadAsset.aspx?id=45176.

23. Sharon Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts," *Health Affairs* (July/August 2008): w270–84.

24. Ibid., Exhibit 6.

25. Allison Cook and John Holahan, "Health Insurance Coverage and the Uninsured in Massachusetts: An Update Based on the 2005 Current Population Survey Data," Blue Cross Blue Shield of Massachusetts Foundation, 2006.

26. Health Care Access and Affordability Conference Committee Report, April 3, 2006, p. 3.

27. Romney.

28. "Massachusetts Healthcare Reform" (Power-Point Presentation, Office of the Governor, April 10, 2006).

29. "Health Benefits Survey 2007," United Benefits Advisors, http://www.bio-medicine.org/medicine-news-1/survey-3a-massachusetts-employers—employees-paying-most-for-health-care-plans-10689-2/. John McDonough, "Massachusetts Health Reform Implementation: Major Progress and Future Challenges," *Health Affairs* (June 3, 2008): w285–97. "2009 CommCare Premium Contributions and Affordability Schedules," March 12, 2009,http://mahealthconnector.org/portal/binary/comepicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520U11-09%2520revised_2%2529.ppt#257,1,Slide1.

30. "Survey of Employer Health Benefits 2007," Kaiser Family Foundation, http://www.kff.org/insurance/7672/upload/7693.pdf; "Survey of Employer Health Benefits 2008," Kaiser Family Foundation, http://ehbs.kff.org/images/abstract/7814.pdf; "Hewitt Data Reveals Little Change in U.S. Health Care Cost Increases for 2009," Hewitt Associates LLC, http://www.hewittassociates.com/Intl/NA/en-US/AboutHewitt/Newsroom/PressReleaseDetail.aspx?cid=5604.

31. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey (MEPS), Insurance Component, Tables II.D.1, II.D.2, II.D.3, Medical Expenditure Panel survey (MEPS); The Henry J. Kaiser Family Foundation, Employee Health Benefits: 2008 Annual Survey, September 2008.

32. Jon Kingsdale, "About Us: Executive Director's Message," March 12, 2009, http://www.mahealth-connector.org/portal/site/connector/template.MAXIMIZE/menuitem3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_view

33. McDonough, p. w293.

34. At the time the Massachusetts reform was passed, those mandates included: treatment for alcoholism; blood lead poisoning; bone marrow transplants; breast reconstruction; cervical cancer/ HPV screening; clinical trials; contraceptives; diabetic supplies; emergency services; hair prostheses; home health care; in vitro fertilization; mammo-grams; mastectomy; maternity care and maternity stays; mental health generally (in addition there is a requirement for mental health parity); newborn hearing screening; off label drug use; phenylketon-uria (PKU) formula; prostate screening; rehabilitation services; and well child care. Services for the following providers must also be covered: chiropractors; dentists; nurse anesthetists; nurse midwives; optometrists; podiatrists; professional counselors; psychiatric nurses; psychologists; social workers; and speech or hearing therapists. Insurance policies must also provide coverage to adopted children, handicapped dependents, and newborns. Victoria Craig Bunce, J. P. Wieske, and Vlasta Prikazky, "Health Insurance Mandates in the States, 2006," Council for Affordable Health Insurance, March 2006.

35. Robert Seifert and Paul Swoboda, "Shared Responsibility," Blue Cross Blue Shield of Massachusetts Foundation, March 2009, http://www.bcbsmafoundation.org/foundationroot/en_US/documents/090406SharedResponsibilityFINAL.pdf

36. The legislation did include a provision allowing workers ages 19–26 to purchase low-cost, specially designed products offered through the Connector that avoided many of the state's mandated benefits (although some of the most expensive mandates, including mental health benefits and prescription drug coverage, would still be required). It also repealed the state's "any willing provider" rule. Chapter 58 of the Acts of 2006, Section 90.

37. Chapter 58 of the Acts of 2006, Section 101. The law defines the Connector as "a body politic and corporate and a public instrumentality." It is designed to operate independent of any other government agency and has a corporate charter, but its board consists of the Massachusetts secretary of Administration and Finance, the state Medicaid director, the state commissioner of insurance, the executive director of the group insurance commission, three members appointed by the governor, and three members appointed by the attorney general. As an entity, it falls somewhere between a government agency and a private corporation. One useful analogy would be the Federal Reserve Board.

38. Robert Steinbrook, "Health Care Reform in Massachusetts—Expanding Coverage, Escalating Costs," *New England Journal of Medicine* 358, no. 26 (2008): 2757–60.

39. McDonough, p. w289.

40. Rachel Nardin, David Himmelstein, and Steffie Woolhandler, "Massachusetts' Plan: A Failed Model for Health Care Reform," Physicians for a National Health Program, February 18, 2008, http://www.pnhp.org/mass_report/mass_report_Final.pdf.

41. Alice Dembner, "Healthcare Cost Increases Dominate Mass. Budget Debate," *Boston Globe*, March 26, 2008; "National Health Preview," *Wall Street Journal*, March 27, 2009.

42. Dembner. Other sources have suggested that the cost of Commonwealth Care could exceed $1.1 billion, but those projections were based on enrollment figures that appear higher than were actually seen in the first part of 2009. John Holahan and Linda Blumberg, "Massachusetts Health Reform: Solving the Long-Run Cost Problem," Robert Woods Johnson Foundation, January 2009.

43. Dembner.

44. Kevin Sack, "Massachusetts Faces Costs of Big Health Plan," *New York Times*, March 16, 2009.

45. Quoted in Trudy Lieberman, "Health Reform Lessons from Massachusetts, Part 1," *Columbia Journalism Review*, March 23, 2009, http://www.cjr.org/campaign_desk/health_reform_lessons_from_mas.php?page=2.

46. John Hurst, "Small Businesses Pay for Plan's Shortcomings," *Boston Globe*, August 18, 2008.

47. "State Watch: Study Examines Spending under Massachusetts Health Insurance Law," Kaiser Daily Health Policy Report, April 8, 2009, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=57923.

48. Iris J. Lav and Elizabeth McNichol, "State Budget Troubles Worsen," Center on Budget and Policy Priorities, March 13, 2009, http://www.cbpp.org/cms/?fa=view&id=711.

49. Hurst.

50. Alice Dembner, "Mass. Panel Approves Changes to Subsidized Residents Health Plan," *Boston Globe*, December 14, 2007. Notably, Massachusetts's business mandate, as well as the state's general insurance regulatory environment, is cited by the Small Business and Entrepreneurship Council as a reason for ranking Massachusetts dead last among the 50 states for business-friendly health care policies. "Best and Worst for State Health Insurance Costs," *Wall Street Journal*, February 6, 2009.

51. Quoted in Sack, "Massachusetts Faces Costs of Big Health Plan."

52. An Act to Promote Cost Containment, Transparency, and efficiency in the Delivery of Quality Health Care (September 10, 2008), Chapter 305 of the Acts of 2008.

53. Report of the Special Commission on the Health Care Payment System, March 25, 2009 (emphasis added).

54. Kevin Sack, "In Massachusetts, Universal Care Strains Coverage," *New York Times*, April 5, 2008.

55. Sharon Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts," *Health Affairs* (July/August 2008): w270–84.

56. Sack, "In Massachusetts, Universal Care Strains Coverage."

57. Michael Tanner, "No Miracle in Massachusetts: Why Governor Romney's Health Care Reform Won't Work," Cato Institute Briefing Paper no. 97, June 6, 2006.

58. Sack, "In Massachusetts, Universal Care Strains Coverage."

59. Ibid.

60. President Obama apparently does not intend to put forward a specific plan for reform. Rather, the Obama administration is offering general guidance and direction, while leaving the details up to Congress. Erica Warner, "White House Budget Director Grilled on Health Plan Details," Associated Press, March 10, 2009. However, it is possible to discern the outlines of what a health care reform proposal likely to emerge from Congress (and acceptable to the White House) will look like. See Pear.

61. Laura Litvan, "House Health Plan to Include Government-Run Option," *Bloomberg*, March 26, 2009.

62. Ricardo Alonso-Zaldivar, "Health Care Overhaul May Cost about $1.5 Trillion," Associated Press, March 17, 2009. It is worth noting that cost estimates for government programs have been wildly optimistic over the years, especially for health care programs.

For example, when Medicare was instituted in 1965, it was estimated that the cost of Medicare Part A would be $9 billion by 1990. In actuality, it was seven times higher—$67 billion. Similarly, in 1987, Medicaid's special hospitals subsidy was projected to cost $100 million annually by 1992 (just five years later); however, it actually cost $11 billion—more than 100 times as much. And in 1988, when Medicare's home care benefit was established, the projected cost for 1993 was $4 billion, but the actual cost was $10 billion. Stephen Dinan, "Entitlements Have a History of Cost Overruns," *Washington Times*, June 16, 2006.

63. Budget deficits are already projected to total more than $9.3 trillion over the next 10 years, even without consideration of the full cost of health care reform. Lori Montgomery, "U.S. Budget Deficit to Swell Beyond Earlier Estimates," *Washington Post*, March 21, 2009.

64. *New State Ice Co. v. Liebman*, 285 U.S. 262 (1932).

Chapter 13

Busting the Bay State: Hiding the Cost of Health Reform

by Michael F. Cannon

Health care's silly season is upon us. If we can be sure of anything, it is that President Barack Obama and his congressional allies will do whatever they can to hide the cost of their health plan. Lucky for them, former Massachusetts Gov. Mitt Romney, a Republican, has shown the way.

In 2006, Romney enacted a health-reform package strikingly similar to what Democrats are pushing through Congress, including individual and employer mandates, private health-insurance subsidies, broader Medicaid eligibility and a new health-insurance "exchange." Lately, Massachusetts officials have been forced to raise taxes and cancel some residents' coverage to pay for it all. Local headlines are decrying "the forbidding arithmetic of healthcare reform."

Supporters at the Massachusetts Taxpayer Foundation say the cost isn't nearly as high as many people think. A recent foundation report claims that "The cost of this achievement has been relatively modest and well within early projections of how much the state would have to spend to implement reform."

In *The Boston Globe*, foundation president Michael J. Widmer writes, "Between fiscal 2006 and 2010, the annual incremental cost from the state budget is less than $100 million, a modest sum for this historic achievement." Widmer was kind enough to walk me through his organization's estimates. As it turns out, there's more than just a little sleight of hand involved.

First, the "annual incremental cost"—$88 million—is not the total amount that the law added to the state budget each year, but the average increase from one year to the next. In other words, the total "cost from the state budget" in 2009 is not $88 million but three times that ($264 million).

Second, that average "incremental cost" assumes the state will cut payments to safety-net hospitals by $200 million next year. We'll see about that. Safety-net hospitals are already suing the state for more money. Set aside those assumed savings, and the cumulative "cost from the state budget" for 2009 is actually $408 million.

But the larger problem is that the "cost from the state budget" ignores 80 percent of the total cost of RomneyCare. As Widmer explains, state officials only have to scrape up about 20 percent of total new spending themselves. The federal government—which is to say, taxpayers in other states—kicks in another 20 percent through the Medicaid program.

The remaining 60 percent appears in no government budget. It is new "private" spending that individuals and employers must undertake according to the law's dictates. That brings the total cost of RomneyCare to at least $2.1 billion in 2009.

Both Widmer and his organization's report do mention that the law spurred employers to spend an additional $750 million on employee health coverage. But that only accounts for about two-thirds of new private spending. Moreover, they describe that mandated private spending as a benefit of the law, rather

than a cost.

Instead of a bargain, RomneyCare is therefore far costlier than conventional wisdom suggests. Beacon Hill is eliminating health coverage for 30,000 legal immigrants, and contemplating a sweeping overhaul of how medical care is purchased, organized, and delivered, just to cope with one-fifth of the law's cost.

Neither is RomneyCare terribly cost-effective. The law covered an estimated 432,000 previously uninsured residents in 2009. That means Massachusetts is covering the uninsured at a cost of about $6,700 per person, or $27,000 for a family of four. The average nationwide cost of an individual policy ($2,600 in 2007) and an employer-sponsored family policy ($12,700 in 2008) are fractions of those figures.

RomneyCare demonstrates how hard it will be for Congress to scrape up even 20 percent of the cost of the Democrats' health plans. The Massachusetts experience also counsels that when Democrats produce a health plan that costs a mere $1.5 trillion, the actual cost will be even higher.

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Chapter 14

The Massachusetts Health Plan: Much Pain, Little Gain

by Aaron Yelowitz and Michael F. Cannon

Cato Institute Policy Analysis no. 657 (January 19, 2010)

Introduction

In 2006, Massachusetts enacted a sweeping health insurance law known as Chapter 58.[1] The law created the nation's first "individual mandate" to purchase health insurance. All residents whom the Commonwealth deems able to afford health insurance must purchase it or else pay a tax penalty that rises with income. The individual mandate took effect on July 1, 2007, but penalties for noncompliance did not begin until December 31, 2007. Noncompliant residents faced the loss of their personal exemption to the state's income tax—a penalty of $219. The penalty rose the next year to a maximum of $912—more than four times the 2007 penalty. Each year after 2008, penalties increase at the rate of health insurance premium growth.[2]

Chapter 58 also established the nation's second "employer mandate" (behind Hawaii). Beginning July 1, 2007, the law required firms with 11 or more workers to offer health benefits to their workers and to "contribute" a specified amount toward the cost of that coverage or face a tax penalty of $295 per worker.[3]

The law created or expanded various government subsidies to help residents obtain health insurance. It expanded eligibility for Massachusetts' Medicaid program (Mass-Health) to children in families with incomes up to 300 percent of the federal poverty level (about $66,000 for a family of four); and to adults who are unemployed (100 percent FPL), HIV-positive (200 percent FPL), or disabled. The law created a new CommCare program to provide subsidies for private health insurance to families earning up to 300 percent of the federal poverty level.

Chapter 58 also imposed new rules for private health insurance markets, merged the individual and small-group markets, and created a new health insurance "connector" where individuals and employees of small firms (with 50 or fewer employees) may choose from a variety of health plans.

After signing Chapter 58 into law, Gov. Mitt Romney (R) wrote, "Every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of health care will be reduced."[4] Changes in Massachusetts' uninsurance rate and health care costs are therefore important measures of the law's impact. Other important indicators of the law's success include its impacts on overall health; "crowd-out" of private health insurance (that is, what percentage of insured people simply switched from private insurance to government-supported insurance); and the attractiveness of Massachusetts as a place to live.

How well Chapter 58 performs on these dimensions has particular relevance now that the federal government is considering similar legislation. When President Barack Obama told Congress in early September 2009, "there is agreement in this chamber on about 80 percent of what needs to be done,"[5] he was speaking of the provisions in federal legislation that mirror the Massachusetts law: individual and employer mandates; private health insurance subsidies; Medicaid expansions; a new health insurance "exchange"; and other private health insurance regulations.

This study uses data from the March 2006–2009 supplements to the Current Population Survey—which cover the 2005–2008 calendar years—to measure Chapter 58's impact on some of the above-mentioned factors. Our study is the first to use CPS data from 2008 to examine coverage and crowd-out. It is also the first to use CPS data to examine Chapter 58's impacts on self-reported health and in-migration, and the first to explore whether Chapter 58 introduced bias into the CPS's coverage estimates in Massachusetts. We consider this study to be a first approximation of the effects of Chapter 58 through 2008, and hope that further studies will refine and augment our results.

Methods

To evaluate the impact of the Massachusetts health law on coverage levels, crowd-out, health status, and in-migration patterns, we rely on CPS data from 2005 through 2008. The March supplement to the Census Bureau's CPS has been described as "the survey of record" and "the most viable estimate" of the uninsured.[6] The Bureau of the Census administers the CPS for the Bureau of Labor Statistics, which scientifically selects the sample to represent the civilian noninstitutional population. The CPS is the official source for national health insurance estimates like the widely cited estimate of 46 million uninsured U.S. residents. The CPS has asked about health insurance since the 1980s, and those questions have been largely unchanged since 1994.[7] The response rate for the March supplement is exceptionally high compared to other voluntary household-based surveys. The nonre-sponse rate for the health insurance questions in Massachusetts in 2008 was 16 percent. Nonresponse rates for other surveys measuring the effects of Chapter 58 have been as high as 55 percent[8] and 68 percent.[9] Unlike those surveys, the Census Bureau includes residences without telephones by virtue of conducting interviews both by telephone and in person. The CPS data are publicly available from the Census Bureau.[10] To our knowledge, ours is the first study to employ data from the March 2009 supplement to the CPS, which covers all of calendar year 2008, and the first to examine Massachusetts two years prior to the mandate (2005–2006) and two years after the mandate (2007–2008).

Considerable difficulties arise when we try to measure the impact of a complex piece of legislation such as Chapter 58. For example, the outcomes of interest may be influenced by other changes occurring at the same time. The fact that the various elements of Chapter 58 took effect at different times may further complicate the picture.

Similar to Long et. al.,[11] we employ a difference-in-differences model to control for many factors that might also influence the outcomes of interest. We compare outcomes in Massachusetts to those of other New England states: Maine, New Hampshire, Vermont, Rhode Island, and Connecticut. We include controls for poverty thresholds, marital status, sex, education, race/ethnicity, and fixed effects for state and year. Our "Chapter 58 effect" is therefore identified from the interaction of state and year. We

weight all regressions with the CPS weights, stratify by age group, and estimate models without imputed values. We attribute any differences between Massachusetts and the remaining New England states to the Massachusetts law. Our overall results on gains in insurance coverage are very similar to those of Long et al.

We are unaware of any published estimate of the full cost of Chapter 58, including costs that do not appear in government budgets—which is significant in itself. For data on the cost to the Commonwealth of Massachusetts and the federal government, we rely on estimates published by the Massachusetts Taxpayers Foundation.[12] For estimates of the costs imposed on the private sector, we rely on personal communications with staff from the Massachusetts Taxpayers Foundation.[13]

Coverage Effects

A primary objective of Chapter 58 is to expand health insurance coverage in Massachusetts, with the goal of universal coverage. In this section, we examine how many Massachusetts residents remain uninsured, and how much of the increase in coverage since 2006 can be attributed to Chapter 58.

How Many Residents Remain Uninsured?

For 2003 through 2006, the CPS reported that the uninsured rate in Massachusetts hovered around 10 percent. Massachusetts' uninsured rate was low compared to the national average of 15 to 16 percent during that period. It was especially low relative to southwestern states, where the uninsured rate often exceeds 20 percent.

Various estimates exist of how many Massachusetts residents currently lack health insurance. The Commonwealth relies on one survey that provides an estimate of 2.6 percent uninsured in 2008.[14] The Census Bureau's American Community Survey provides an estimate of 4.1 percent.[15]

There is controversy over whether the CPS accurately estimates Massachusetts' uninsured rate, which results from the CPS's method for dealing with households that do not answer the survey's questions about insurance status. When a respondent fails to answer a question on the CPS, the Census Bureau imputes a response for that person based on the answers of similar individuals.[16] For 2008, the CPS imputes the insurance status of 1 million out of a total of 6.4 million Massachusetts residents to arrive at an uninsured estimate of 5.5 percent.[17] The CPS imputes the insurance status of nearly 670,000 non-elderly adults (hereafter: "adults"), or one-sixth of the 4.1 million adult residents.

Davern et al. find that the CPS's imputation procedure tends to overstate the uninsured rate in states like Massachusetts that have relatively low uninsured rates, and that that bias may be greatest in Massachusetts.[18] Working with the 1998–2000 March supplements, they estimate that the CPS's imputation procedure overstated the Massachusetts uninsured rate by 1.8 percentage points, or 13.9 percent—the largest error in any state.[19] The authors suggest a rudimentary way to adjust for that bias would be to reduce Massachusetts' official uninsured rate by 13.9 percent,[20] which yields an estimate of 4.7 percent.

Excluding imputed answers from the 2008 sample produces an estimate of 3.8 percent, or 205,472 uninsured residents, which is very close to the ACS estimate.

"Are You Breaking the Law?"

Research has not yet explored another potential source of bias related to the CPS's imputation procedure. Chapter 58 creates incentives for uninsured Massachusetts residents to conceal their true insurance status. Since December 31, 2007, not having health insurance coverage has had legal consequences for Massachusetts residents. Uninsured residents who accurately report their insurance status would be admitting to unlawful activity and subject to penalties.[21] In addition, Chapter 58's individual mandate may have created a social norm that uninsured residents might be reluctant to admit they are violating. If Chapter 58 induces uninsured residents to conceal their insurance status from the CPS, then that would bias the uninsured estimate downward.

Uninsured Massachusetts residents can conceal their lack of coverage from government surveys like the CPS in three ways. First, they may refuse to participate in the survey. Second, they may participate in the survey but misrepresent their coverage status. Third, they may participate in the survey but not answer the survey's health-insurance questions, whether by skipping those questions, refusing to answer them, or terminating the interview early. Nonresponse is more likely for sensitive questions like income.[22] Since 2006, insurance coverage may have become a more sensitive question in Massachusetts.

Each concealment strategy would bias the CPS estimate of Massachusetts' uninsured rate in the direction of overstating the law's impact on the uninsured. If uninsured residents refuse to take the survey, they would be underrepresented in the sample. If they misrepresent their coverage status, that would cause uninsured residents to be counted as insured. If they decline to answer the insurance questions, and the CPS imputes their response, that would further increase the number of households that are counted as insured but that are actually uninsured.

We cannot observe the first or second strategies, but we can observe how often respondents do not answer the CPS's health insurance questions across states and over time. And we can compare that to nonre-sponse rates for other questions in the March supplements. If uninsured Massachusetts residents respond to the incentives to conceal their true insurance status, we would expect to see an increase in the rate of nonresponse to the insurance questions relative to other states and to other questions on the CPS.

We find evidence that nonresponse to the CPS's health-insurance questions increased after Massachusetts enacted its mandate. In one estimation, we compare the nonresponse rates for Massachusetts residents with those of other New England states. We find no overall effect of Chapter 58 on imputations among children, but imputations among adults rose by a statistically significant 2.1 percentage points (standard error: 0.9)—a 9-percent increase. The effect appears particularly strong between 150–300 percent FPL, where initial insurance coverage was relatively low and where compliance requires residents to pay some portion of their premiums. Imputations increased by 5.3 percentage points among children (standard error: 2.2) and 4.7 percentage points among adults (standard error: 2.0) in this income stratum. There was no statistically significant change in imputations among those below 150 percent FPL.[23]

Table 1 Changes in Response Rates to CPS Health Insurance and Income Questions in Massachusetts after Chapter 58

	Any Imputed Health Insurance Item	Any Imputed Income Item

Under 18 N=24,489	0.003 (0.015)	-0.016 (0.003)
Below 150% FPL N=5,089	0.005 (0.014)	
150–300% FPL N=6,004	0.053 (0.022)	
Above 300% FPL N=13,396	-0.016 (0.023)	
Age 18 to 64 N=51,582	0.021 (0.009)	-0.068 (0.007)
Below 150% FPL N=7,367	0.021 (0.016)	
150–300% FPL N=10,807	0.047 (0.020)	
Above 300% FPL **N=33,408**	0.015 (0.011)	

Notes: Each estimate is a difference-in-differences estimate from a separate ordinary least squares regression. The number of observations is shown for models including all of the 2005–2008 years. All specifications include fixed effects for an individual's age, state, and year. Robust standard errors are in parentheses, corrected for clustering state-year cell.
All results are weighted.

In short, if the entire 2.1 percentage point increase in imputations among adults was the result of them concealing their uninsured status, then the (unadjusted) insurance rate would be 5.1 percent, instead of the 3.8 percent reported by the CPS.

These results are consistent with Chapter 58 inducing uninsured Massachusetts residents to conceal their true insurance status. Imputations rise among those between 150–300 percent FPL, who were more likely to be uninsured prior to the law's enactment, and whom the law forces to purchase health insurance with their own money. Rather than comply with the mandate, some of these "insured" individuals may instead be concealing their lack of coverage by refusing to answer the CPS's insurance-status questions. In contrast, there was no discernable change in response rates by individuals below 150 percent FPL, who receive "free" coverage and who face no penalties for not obtaining coverage.

Next, we compare nonresponse to insurance-status questions to nonresponse to the CPS's questions about income. While the response rate for the insurance-status questions fell after the enactment of Chapter 58, the response rate for income-related questions increased. Income imputations fell by 1.6 percentage points for children (standard error: 0.3), and among adults by 6.8 percentage points (standard error: 0.7). This suggests that Massachusetts residents who participated in the survey were not less

forthcoming overall, just less forthcoming about health insurance coverage.

We draw a number of conclusions. First, the Commonwealth's estimate that only 2.6 percent of residents remain uninsured—the lowest estimate available—is most likely too low. More rigorous surveys all yield higher estimates. As noted above, even ignoring imputations, the CPS yields an uninsured rate of 3.8 percent. Second, we conclude that Chapter 58 has introduced a new source of bias into the CPS's estimate of Massachusetts' uninsured rate. The 3.8-percent figure is not biased upward by the CPS imputation procedure, but it may be biased downward by the incentives that Chapter 58 creates for uninsured residents to conceal their true coverage status. Whether this is a significant source of bias is unclear. As noted previously, if the entire 2.1-percentage-point rise in imputations among adults were the result of them concealing their uninsured status, then the (unadjusted) uninsured rate would be 5.1 percent.[24] To the extent that uninsured residents employed either of the other concealment strategies, the true uninsured rate would be even higher and the number of newly insured residents even lower. We therefore regard 3.8 percent to be a lower-bound estimate of Massachusetts' uninsured rate. (In the same vein, we consider the below estimates of Chapter 58's impact on coverage to be an upper-bound estimate.) Third, this source of bias may also affect other surveys, including non-government surveys.

How Many Newly Insured?

The direction of Chapter 58's effect on insurance coverage is not in dispute. The law appears to have had a significant impact on the number of insured residents. Using two-year averages, the Census Bureau estimates that Massachusetts' uninsured rate dropped from 9.8 percent in 2005–2006 to 5.4 percent in 2007–2008—a 4.4 percentage point reduction.[25] But is the new law solely responsible for this increase, or did other factors contribute to it?

To isolate how many additional residents obtained coverage as a result of Chapter 58, we control for other factors that might influence coverage levels by performing a difference-indifferences estimation using only non-imputed observations, as did Long et al. Unlike Long et al., we use other New England states as controls, and we examine 2005–2008, rather than 2004–2007.

Our results, presented in Table 2, suggest that Chapter 58 reduced the uninsured rate for children by 2 percentage points, and for adults by 6.7 percentage points. These results are similar to those of Long et al., who found an increase of 6.6 percentage points in coverage among adults.[26] The effects were greatest among children between 150 percent and 300 percent of the federal poverty level (7.6 percentage points), and among adults at both below 150 percent (11 percentage points) and between 150 percent and 300 percent of the federal poverty level (14.2 percentage points). These results are unsurprising, since those groups were both the main targets of the new subsidies and subject to penalties under the individual mandate. Our difference-in-differences estimations produce a point estimate of 297,000 Massachusetts residents newly insured as of 2008 as a result of Chapter 58.

Table 2
Effect of Chapter 58 on Insurance Coverage, Self-Reported Health, and In-migration

	Insurance Coverage	Private Coverage	Self-Reported Health: Excellent	Self-Reported Health: Very Good or Better	Self-Reported Health: Good or Better	In-migration
			Under 18			
All Income Levels N=19,454	0.020 (0.005)	-0.044 (0.016)	-0.068 (0.013)	-0.024 (0.012)	0.011 (0.002)	
Under 150% FPL N=4,153	0.027 (0.016)	-0.146 (0.035)	-0.025 (0.031)	0.092 (0.045)	0.019 (0.009)	
Between 150–300% FPL N=4,715	0.076 (0.012)	0.001 (0.048)	-0.161 (0.033)	-0.133 (0.030)	0.027 (0.005)	
Over 300% N=10,586	-0.002 (0.005)	-0.013 (0.005)	-0.050 (0.018)	-0.031 (0.010)	0.002 (0.002)	
Non-movers N=18,272	0.019 (0.005)	-0.045 (0.017)	-0.068 (0.014)	-0.031 (0.012)	0.009 (0.003)	
			Age 18 to 64			
All Income Levels N=41,873	0.067 (0.003)	0.022 (0.007)	-0.042 (0.005)	-0.013 (0.006)	0.008 (0.004)	-0.009 (0.003)
Under 150% N= 5,784	0.11 (0.014)	-0.062 (0.024)	-0.057 (0.027)	-0.004 (0.010)	0.007 (0.019)	-0.016 (0.012)
Between 150–300% N= 8,664	0.142 (0.009)	0.067 (0.019)	-0.045 (0.014)	0.040 (0.020)	0.007 (0.014)	-0.007 (0.005)
Over 300% N=27,425	0.042 (0.003)	0.031 (0.003)	-0.034 (0.089)	-0.028 (0.007)	0.001 (0.003)	-0.007 (0.004)
Non-movers N=40,938	0.065 (0.003)	0.021 (0.006)	-0.045 (0.005)	-0.016 (0.006)	0.010 (0.003)	

Notes: Each estimate is a difference-in-differences estimate from a separate ordinary least squares regression. Observations with imputed values for health insurance or health status were excluded. The number of observations is shown for models including all of the 2005–2008 years. All specifications include fixed effects for an individual's age, state, and year. Health results exclude the 2007 calendar year. Robust standard errors are in parentheses, corrected for clustering state-year cell. All results are weighted.

One potential implication of these findings is that Chapter 58's subsidies did more to expand coverage than the individual mandate. Since Massachusetts introduced both to roughly the same populations at roughly the same time, it is difficult to discern which intervention had the greater impact on coverage levels. Given that we examined 2005–2008, yet obtained similar results to Long et al., one possible interpretation is that the subsidies that became available in 2007 had a greater impact on insurance

coverage than the individual mandate, which only became binding as of December 31, 2007, and whose penalties dramatically increased in 2008. At a minimum, our results suggest that the subsidies had a strong impact on coverage, since the groups targeted with new subsidies saw the greatest coverage gains.

We consider 297,000 to be an optimistic estimate of Chapter 58's effect on insurance coverage, for it assumes that no uninsured Massachusetts residents concealed their insurance status. To the extent that the legal penalties or a new social norm did induce uninsured residents to conceal their coverage status, our results overstate Chapter 58's impact on coverage. A "back of the envelope" calculation suggests that if the entire 2.1-percentage-point increase in imputations among adults is the result of concealment, for example, then Chapter 58 extended coverage to only 204,000 residents.

We thus conclude that the Commonwealth's estimate of 432,000 newly insured residents[27] is too high, as it lies above the upper bound of the 95-percent confidence interval (327,000) for our point estimate. The number of insured residents may have risen by 432,000 as of 2008, but the portion that can be attributed to Chapter 58 is almost certainly smaller. The Commonwealth's official estimate appears to overstate the actual impact of the law by 45 percent.

Self-Reported Health

A primary reason to expand health insurance coverage is to improve health. An important measure of Chapter 58's impact, therefore, is whether it improved the health of Massachusetts residents. The CPS enables researchers to gauge changes in health by observing self-reported health status.

The March 2009 supplement is more useful for examining the effects of Chapter 58 on health than the March 2008 supplement, which would count individuals as "insured" if they obtained coverage on Dec. 31, 2007. (We would expect little effect on health from one day's worth of insurance coverage.) By observing self-reported health one year after both the subsidies and penalties took effect, the March 2009 supplement is more likely to capture any effects that Chapter 58 would have on health status. Of course, we would not expect data covering 1.5 years of the experience with Chapter 58 to capture the full effect of the expanded health insurance coverage on health outcomes, but it is reasonable to assume that some improvement should be visible. Researchers such as Janet Currie and Jonathan Gruber find that Medicaid expansions affect health outcomes of infants and children in a short period of time.[28]

We again perform a difference-in-differences estimation using other New England states as controls. Since the law had been only partially implemented in 2007, we exclude data from 2007 and compare self-reported health in 2005–2006 to 2008.[29] We find mixed effects on self-reported health after 2006. Table 2 shows improvements in good (or better) health, but declines in excellent and very good (or better) health. For example, among children, excellent health fell by 6.8 percentage points but good (or better) health increased by 1.1 percentage points. Where the coefficients are statistically significant, those countervailing effects are similar for adults and for most income subgroups. One exception is children under 150 percent FPL: the reduction in excellent health is not statistically significant, but the improvements in both good (or better) and very good (or better) health are statistically significant. Another exception is that adults between 150–300 percent FPL saw a statistically significant increase in very good (or better) health. Yet the same group also saw a drop in excellent health and no discernable change in good (or better) health.

Overall, it appears that the distribution of health status compressed, but did not necessarily improve,

in response to Chapter 58. To date, the law appears to have achieved more success in giving residents health insurance than shifting the population toward better health.

Evidence of Crowd-Out

One concern that arises when expanding government assistance is the tendency for government subsidies to substitute for, or "crowd-out," private effort. Crowd-out can occur because those newly eligible for government health insurance subsidies drop their private coverage or because employers cease offering coverage to eligible groups.[30] Previous studies of Chapter 58 have found no evidence of crowd-out, in that both public and private coverage expanded since 2006.[31]

Using a difference-in-differences estimation, we find that while coverage generally expanded for children and adults, private insurance coverage fell among certain income groups in Massachusetts relative to other New England states. Table 2 shows that private coverage fell by 4.4 percentage points among children, perhaps driven by a 14.6-percentage-point drop among children below 150 percent of the federal poverty level. Private coverage rose for adults overall, but fell by 6.2 percentage points among adults below 150 percent of poverty level. Again, this result is unsurprising, as Massachusetts targeted government programs principally at those groups.

We consider this to be evidence of substantial crowd-out among the poor, as well as a conservative measure of overall crowd-out, given that we cannot observe the extent to which public subsidies offered to those who purchase private insurance merely substituted for private dollars.

In-migration

Another potential effect of Chapter 58 is that its taxes and subsidies may affect Massachusetts' attractiveness as a place to live. The law affects different individuals differently; individuals likely to receive net subsidies may find the Commonwealth a more attractive place to relocate, while those likely to face net taxes would find it less attractive. The March supplement to the CPS measures in-migration for each state, which offers one tool to evaluate any effects that Chapter 58 may have on people's decisions to relocate to Massachusetts.

From 2005 to 2008, in-migration into other New England states fell from 2.4 percent to 2.2 percent. Migration into Massachusetts fell from 1.6 percent to 1.2 percent (data not shown.) A "back of the envelope" difference-in-differences estimate thus suggests that Massachusetts became a less attractive place to relocate after the enactment of Chapter 58.

The statistically significant regression-adjusted estimates are broadly consistent with the unadjusted data. Relative to other New England states, Massachusetts saw a 0.61 percentage point decline in in-migration post-Chapter 58 for the sample as a whole. For adults, the decline was 0.87 percentage points. For adults aged 18 to 29, in-migration fell by a sizable 2.8 percentage points—more than four times the magnitude for the entire sample, and a 62-percent drop from baseline in-migration among young adults (data not shown). Since the young tend to have much higher uninsurance rates, and the combination of the individual mandate and Massachusetts' strict community-rating price controls imposes greater

implicit taxes on young adults than others,[32] a reasonable interpretation of these results is that those whom Chapter 58 would most adversely affect voted with their feet and avoided Massachusetts.

Is It Worth the Cost?

Chapter 58's benefits must be weighed against the costs it imposes.[33] Premiums appear to have declined in the non-group market,[34] which accounts for 4 percent of private health insurance in Massachusetts.[35] It is unclear, however, whether and to what extent that was the result of greater efficiency or cost-shifting to the (larger) small-employer market when Chapter 58 merged the two. Whatever the case, premiums in the other 96 percent of the market moved in the opposite direction. One study found that public and private spending on health insurance have accelerated.[36] Another found that premiums for employer-sponsored insurance in Massachusetts grew 21–46 percent faster than the national average over roughly the period studied here.[37]

The full cost of Chapter 58 includes not only new state and federal government spending, but also any new private-sector spending undertaken to comply with the law's unfund-ed mandates. The law uses the Commonwealth's sovereign power to require employers and individuals to purchase health insurance for previously uninsured residents. It even requires some residents who already were insured to purchase additional coverage to comply with the individual mandate's standard for "minimum creditable coverage."

We are unaware of any effort to tally all of the costs imposed by Chapter 58. The Massachusetts Taxpayers Foundation has formally estimated the cost to the state and federal governments and declared the cost of Chapter 58 to be "modest," based on the costs to the state government. Working with informal estimates provided by the Massachusetts Taxpayers Foundation, we reach a "back of the envelope" estimate that new state and federal spending amounts to just two-thirds of all new spending under Chapter 58, the remaining third being additional private-sector spending to comply with the individual and employer mandates. We estimate the total new spending to be more than $1 billion in 2008, or 57 percent more than the Massachusetts Taxpayers Foundation formal estimates suggest.

We consider this to be a conservative estimate of Chapter 58's cost for a number of reasons. This estimate includes only new federal spending, state spending, and new spending by previously uninsured residents. It does not include any new spending that previously insured Massachusetts residents must undertake to comply with the individual mandate, which required many residents to purchase coverage with less cost-sharing and more covered services than they had. In addition, there is a strong argument that the true cost of the individual and employer mandates includes not just the *new* spending mandated by the law, but *all* mandated spending, including the health insurance premiums that residents had been paying voluntarily. In its official cost estimate of the Clinton administration's health plan, the Congressional Budget Office included all mandatory premiums in the federal budget.[38] Viewed from that perspective, our estimate dramatically understates the cost of Chapter 58.

Is It Cost-Effective?

Even less attention has been paid to whether Chapter 58 was the lowest-cost means of achieving

whatever outcomes the law has produced. We are aware of no effort to ascertain whether the benefits of Chapter 58—in terms of better health, better access to care, financial security, etc.—could have been obtained at a lower cost.

This appears to be a hole in both the economic literature and the priorities of policymakers. In 2004, Helen Levy and David Meltzer wrote, "There is no evidence at this time that money aimed at improving health would be better spent on expanding insurance coverage than on . . . other possibilities."[39] Levy and Meltzer reaffirmed that conclusion in 2008:

> The central question of how health insurance affects health, for whom it matters, and how much, remains largely unanswered at the level of detail needed to inform policy decisions. . . . Understanding the magnitude of health benefits associated with insurance is not just an academic exercise . . ., it is crucial to ensuring that the benefits of a given amount of public spending on health are maximized.[40]

Judicious policymaking is unlikely in the absence of that information.

Conclusion

Our analysis of CPS data for 2008 shows that Massachusetts' health law has had a smaller impact on insurance coverage levels and a much higher cost than supporters claim. Gains in coverage have been overstated by nearly 50 percent, while costs have been understated by at least one-third, and likely more. The law has done little to improve overall self-reported health, though it does appear to have crowded out private health insurance and made Massachusetts a less attractive place to relocate, particularly for young people.

These findings hold lessons for the legislation moving through Congress, which largely resembles the Massachusetts law. As in Massachusetts, there has been no effort to estimate the full cost of the legislation—that is, including the mandates it would impose on individuals and employers. The costs of that legislation are therefore far greater than members of Congress and voters believe, while the benefits may be smaller than the conventional wisdom about Massachusetts suggests.

Notes

1. This description of Chapter 58 draws from Sharon K. Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," *Health Affairs* Web Exclusive (June 3, 2008), p. w271, http://bit.ly/7kTVcG.

2. See Commonwealth of Massachusetts Department of Revenue, "DOR Issues Updated Report on Insurance Mandate Compliance in 2007 and Draft Penalty Guidelines for the Uninsured in 2009," December 22, 2008, http://bit.ly/67kEha.

3. Economists broadly agree that "employer contributions" to employee health benefits are not employer contributions at all, but are deducted from workers' wages. See 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.

4. Romney emphasized, "All Massachusetts citizens will have health insurance." Mitt Romney, "Health Care for Everyone? We've Found a Way," *Wall Street Journal*, April 11, 2006, http://bit.ly/5dfgBI.

5. White House Office of the Press Secretary, "Remarks by the President to a Joint Session of Congress on Health Care," September 9, 2009, http://bit.ly/5OZNAs.

6. M. Davern et al., "Are the CPS Uninsurance Estimates Too High? An Examination of Imputation," *HSR: Health Services Research* 42, no. 5 (October 2007): 2038–2055.

7. The Census Bureau did add a health insurance verification question in the March 2000 supplement.

8. Long, "On the Road to Universal Coverage."

9. Sharon K. Long, Allison Cook, and Karen Stock-ley, "Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey," Division of Health Care Finance and Policy, Commonwealth of Massachusetts Office of Health and Human Services, December 19, 2008, p. 2, http://bit.ly/7ll8wk.

10. See U.S. Bureau of the Census, Current Population Survey, http://www.bls.census.gov/cps_ftp.html.

11. Sharon K. Long et al., "Another Look at the Impacts of Health in Massachusetts: Evidence Using New Data and a Stronger Model," *American Economic Review: Papers and Proceedings* 99, no. 2 (May 2009): 508–11, http://bit.ly/5VOWKa.

12. Alan G. Raymond, "Massachusetts Health: The Myth of Uncontrolled Costs," Massachusetts Taxpayers Foundation, May 2009, http://bit.ly/4WUnIb.

13. Personal correspondence with Massachusetts Taxpayers Foundation president Michael J. Widmer, July 20, 2009, available on request.

14. Commonwealth of Massachusetts Health Connector, "Health Facts and Figures," August 2009, p. 4, http://bit.ly/4Tza1G.

15. Joanna Turner et al., "A Preliminary Evaluation of Health Insurance Coverage in the 2008 American Community Survey," U.S. Bureau of the Census, September 22, 2009, p. 9, http://bit.ly/4GxDQ1.

16. Davern et al., "Are the CPS Uninsurance Estimates Too High?"

17. U.S. Bureau of the Census, "Historical Health Insurance Tables: Table HIA-4. Health Insurance Coverage Status and Type of Coverage by State—All Persons: 1999 to 2008," September 22, 2009, http://bit.ly/7jG4ND. There is a scholarly consensus that although the March supplement to the CPS attempts to capture the number of respondents who were uninsured for the whole of the previous year, it actually captures the number of respondents who were uninsured on the day they took the survey, which tends to be larger than the number actually uninsured for all of the previous year. See, for example, U.S. Congressional Budget Office, "How Many People Lack Health Insurance and For How Long?" May 2003, http://bit.ly/6uWfUh. The CPS can nevertheless capture trends in health insurance coverage.

18. "Th[e] combination of having a relatively low uninsurance rate and having a relatively high number of imputations makes Massachusetts more susceptible to the bias." M. Davern et al., ''Missing the Mark? Possible Imputation Bias in the Current Populations Survey's State Income and Health Insurance Coverage Estimates,'' *Journal of Official Statistics* 20, no. 3 (2004): 544.

19. M. Davern et al., ''Missing the Mark?"

20. Ibid., p. 546.

21. A small number of Massachusetts residents are exempt from the individual mandate.

22. Davern et al., ''Missing the Mark?," pp. 519–49.

23. Our data reveal that imputed values for health insurance were unusually high in 2005 relative to the 2006–2008 period. More than 30 percent of individuals had at least one CPS health insurance item imputed in 2005, compared with 13.4–17.6 percent in the subsequent years. On the other hand, imputed values for income vary between 29.6 and 31.1 percent over the full time period. Due to the concern about the high relative rate of imputations in 2005, we re-ran our regressions excluding the 2005 calendar year. Our assessment of the impact of the Massachusetts law on the incentive to not report, if anything, is strengthened by excluding 2005.

24. This figure ignores any increase in imputations among children, which is statistically significant in the 150–300 percent FPL stratum, and therefore underestimates the potential bias from induced nonresponse.

25. This is statistically significant at a 90-percent confidence interval. U.S. Bureau of the Census, "Number and Percentage of People without Health Insurance Coverage by State Using 2- and 3-Year Averages: 2005–2006 and 2007–2008," http://bit.ly/7gcazN.

26. See Sharon K. Long et al., "Another Look at the Impacts of Health in Massachusetts: Evidence Using New Data and a Stronger Model," *American Economic Review: Papers and Proceedings* 99, no. 2 (May 2009): 511, Table 1, http://bit.ly/5VOWKa.

27. Raymond.

28. See Jonathan Gruber and Janet Currie, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health," *Quarterly Journal of Economics* 111, no. 2 (May 1996): 431–66, http://bit.ly/6M6iI8; and Jonathan Gruber and Janet Currie, "Saving Babies: The Efficacy and Cost of Recent Expansions of Medicaid Eligibility for Pregnant Women," *Journal of Political Economy* 104, no. 6 (January 1997): 1263–96, http://bit.ly/8LRWQ9. Presumably, the response of an objective health measure like infant mortality to policy changes should be more inelastic than the response of self-reported health. The main shortcoming of using self-reported health as a health outcome is how self-reported health maps onto more objective measures of health.

29. Including 2007 data reduces the improvements in good (or better) health, yet still shows self-reported health compressing (data not shown).

30. For an overview of the literature on crowd-out, see 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, http://bit.ly/74UzPy.

31. See Sharon K. Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year Long," *Health Affairs* Web Exclusive (June 3, 2008): w271, http://bit.ly/7kTVcG; and Sharon K. Long et al., "Another Look at the Impacts of Health in Massachusetts: Evidence Using New Data and a Stronger Model," *American Economic Review: Papers and Proceedings* 99, no. 2 (May 2009): 508–11, http://bit.ly/5VOWKa.

32. See Aaron Yelowitz, "ObamaCare: A Bad Deal for Young Adults," Cato Institute Briefing Paper no. 115, November 5, 2009, http://bit.ly/7qUTXm

33. Some observers maintain that cost control was not an objective of Chapter 58, in spite of Governor Romney's promises of lower health care costs. See, for example, Michelle Andrews, "Health Care: Stop Focusing on the Cost," *CBS Moneywatch*, August 6, 2009, http://bit.ly/4EfSN0.

34. U.S. Census Bureau, "Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2008," Current Population Survey, 2009 Annual Social and Economic Supplement, Page Last Modified: September 11, 2009, http://bit.ly/8Qh1LW.

35. Ibid.

36. Robert Seifert and Paul Swoboda, "Shared Responsibility: Government, Business, and Individuals: Who Pays What for Health?" Blue Cross Blue Shield of Massachusetts Foundation, March 2009, http://bit.ly/4X3NaI.

37. Cathy Schoen, Jennifer L. Nicholson, and Sheila D. Rustgi, "Paying the Price: How Health Insurance Premiums Are Eating up Middle-Class Incomes," The Commonwealth Fund, August 2009, p. 8, http://bit.ly/91cTbe.

38. See U.S. Congressional Budget Office, "An Analysis of the Administration's Health Proposal," February 1994, http://bit.ly/5VxkUP.

39. Helen Levy and David Meltzer, "What Do We Really Know about Whether Health Insurance Affects Health?" in *Health Policy and the Uninsured*, ed. Catherine G. McLaughlin (Washington: Urban Institute Press, 2004), p. 201.

40. Helen Levy and David Meltzer, "The Impact of Health Insurance on Health," *Annual Review of Public Health* 29 (April 2008): 399–409, http://bit.ly/4ytnhz.

Chapter 15

Romney's Chronic Health Care Problem

by Michael D. Tanner

They haven't even finished counting 2010 midterm ballots (New York's 1st congressional district is still undecided), but already potential Republican candidates are testing the presidential waters for 2012. Among the early frontrunners will be former Massachusetts governor Mitt Romney.

Romney will have several powerful advantages: name recognition, plenty of money, a strong organization left over from 2008, and a reputation for business competence during an election in which economic issues and job creation are likely to dominate. But he will also have one enormous albatross hanging around his neck: the Massachusetts health-care program.

One of the clearest lessons of the 2010 elections was that voters remain strongly opposed to President Obama's health-care reform. And if voters in general dislike Obamacare, Republican voters positively loathe it. According to the most recent Rasmussen survey, voters overall support repealing Obamacare by a margin of 58–37. Among Republicans, 84 percent favor repeal.

Romney's problem is that, despite his demurrals, the parallels between Obamacare and his 2006 Massachusetts reform plan are striking. Both plans are built around an individual mandate requiring citizens to purchase a government-designed insurance plan. Both plans dramatically increase government subsidies and Medicaid eligibility. Both plans use an exchange to redesign the individual and small-group insurance markets, creating a "managed competition" model for insurance. And both Massachusetts and Obamacare prohibit insurers from managing risk, shifting costs from older and sicker individuals to the young and healthy. Neither Obamacare nor

Romneycare includes any substantial cost-containment mechanism.

Romneycare has proven to be a disaster in Massachusetts, providing a clear vision of the future under Obamacare. The number of uninsured has been reduced—at great cost—but the program has failed to achieve the promise of universal coverage. The subsidies and other costs have proven an enormous burden for the state budget. Insurance premiums have continued to rise, leading Massachusetts to attempt to impose premium caps and even a global budget. Insurers are losing money and threatening to pull out of the state.

It isn't very hard to imagine his primary opponents preparing their 30-second attack ads.

Already, Tea Party activists are raising alarms. Romneycare is "something he's going to have to explain," warns Christen Varley, president of the Greater Boston Tea Party, "and it might just be a disaster for him." Plymouth Rock Tea Party founder Lisa Martin says her distaste for Romneycare has forced her to consider other potential candidates, such as Sarah Palin. And presaging national discontent, Tea Party Express president Amy Kremer told the Christian Broadcasting Network that Romney's Massachusetts health-care reform will "absolutely not pass muster with members."

Romney has taken to making three arguments in his defense. First, he criticizes Obamacare for its $669

billion in tax increases, claiming that the Massachusetts plan did not increase taxes. That is technically true—if you consider only the legislation as Romney signed it. However, it is also true that the legislation relied heavily on federal subsidies—more than $300 million—and was still underfunded. Romney's successor was forced both to cut back on some benefits that the plan originally offered and to raise the state's cigarette tax by $1 per pack ($154 million annually) to help pay for the program. The state also imposed approximately $89 million in fees and assessments on health-care providers and insurers.

Second, Romney correctly points out that he used his line-item veto to challenge several objectionable provisions of the bill, including its employer mandate, but had his vetoes overridden by the Democratic-controlled legislature. To some degree those vetoes were an exercise in political theater, since the override was always a given. In the end, Romney signed the bill itself, even knowing that the objectionable provisions would be put back in. And he continues to support some of the plan's worst aspects, notably the individual mandate.

Finally, Romney criticizes Obamacare as a "one size fits all" federal plan, whereas his plan was implemented in only one state. That's true. Governor Romney only messed up the health-care system in Massachusetts, while President Obama has messed up health care for the entire country. Of course, as governor, Romney didn't have the power to impose his model outside of his state. He now says that he opposes any national plan, calling for states to experiment with different approaches as the "laboratories of democracy." That would certainly be an improvement over Obamacare. On the other hand, he has repeatedly said that he sees the Massachusetts plan as a model for the nation and has urged other states to copy his approach.

Other than the defenses above, Romney has so far been surprisingly stubborn, refusing to back down from his backing of the Massachusetts plan, calling it "a conservative plan." In March, he told Fox News, "I think our plan is working well. And perhaps the best thing I can say about it is that it is saving lives. It is the ultimate pro-life effort, if you will, because people who otherwise could have lost their lives are now able to get the kind of care that they deserve."

As a candidate who has been accused in the past of switching positions in order to curry political favor, Romney may have no choice but to stick with this one. But it is not going to make his road to the White House any easier.

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Chapter 16

RomneyCare:
Making a Fool of Every Republican It Touches Since 2006

by Michael F. Cannon

New Jersey Gov. Chris Christie's (R) hearts former Massachusetts Gov. Mitt Romney (R), so much that Christie says it is "completely intellectually dishonest" to compare RomneyCare to ObamaCare. Why? Because Romney didn't raise taxes, and President Obama did. Oh.

Avik (pronounced O-vik) Roy explains how Christie gets RomneyCare so very, very wrong:

> There isn't a single person, left or right, who follows health policy seriously who disagrees with the assertion that Romneycare was the model for Obamacare. And Massachusetts *has* had to raise taxes, after Romney left office, to pay for the law's significant cost overruns.

Here are some examples, left and right. But Roy omits a few important points.

1. **Mitt Romney increased taxes the moment he signed RomneyCare.** RomneyCare increased *net government spending.* That in itself is an increase in the tax burden. All that remains to be determined is who will pay for that added spending and when they will pay it. The fact that the incidence of that added tax burden fell after Romney left office does not mean that's when the added tax burden was created.
2. **Mitt Romney has raised taxes on as many people as Barack Obama has.** Half of RomneyCare's new spending was financed by the federal government through the Medicaid program, which is financed through federal taxes, which fall on taxpayers in all 50 states. That means that when Romney financed half of RomneyCare's new spending by pulling down more federal Medicaid dollars, he increased taxes on residents of all 50 states.
3. **RomneyCare was born of, and expanded, a corrupt scheme by Massachusetts politicians to tax residents of all 50 states.** What motivated Romney to enact RomneyCare, as former Romney/Obama adviser Jonathan Gruber explains here, was the widespread desire (within Massachusetts) to hang on to $385 million of federal Medicaid money that Massachusetts had secured using one of Medicaid's notorious and fraudulent "provider tax" scams. In other words, the whole purpose of RomneyCare was to enable Massachusetts to hold on to $385 million that it received by defrauding and taxing residents of other states. And of course, Romney/RomneyCare caused the tax burden that Massachusetts effectively imposes on non-Massachusetts residents to grow.

Christie is so laughably wrong about RomneyCare that one cannot help but smile that his remarks

came during the same news cycle as this:

> Newly obtained White House records . . . show that senior White House officials had a dozen meetings in 2009 with three health-care advisers and experts who helped shape the health care reform law signed by Romney in 2006. . . . One of those meetings, on July 20, 2009, was in the Oval Office and presided over by President Barack Obama, the records show.
>
> "The White House wanted to lean a lot on what we'd done in Massachusetts," said Jon Gruber, an MIT economist who advised the Romney administration on health care and who attended five meetings at the Obama White House in 2009, including the meeting with the president. "They really wanted to know how we can take that same approach we used in Massachusetts and turn that into a national model" . . .
>
> Romney said the people involved in the White House meetings were "consultants," not "aides" . . .
>
> [Gruber said,] "If Mitt Romney had not stood up for this reform in Massachusetts . . . I don't think it would have happened nationally. So I think he really is the guy with whom it all starts."

All of which is pretty much what my colleague/boss David Boaz and I have been saying since April 2010 in this well-worn Cato video.

This article was posted on October 12, 2011 on Cato@Liberty.org.

Chapter 17

RomneyCare Just Got $150 Million More Expensive

by Michael F. Cannon

One of the ways Massachusetts officials have tried to temper RomneyCare's cost overruns was by denying participation to legal immigrants. Last week, the Commonwealth's highest court ruled that restriction violates the Massachusetts Constitution:

> Massachusetts cannot bar legal immigrants from a state health care program, according to a ruling issued Thursday by the state's highest court . . .
>
> The ruling said that a 2009 state budget that dropped about 29,000 legal immigrants who had lived in the United States for less than five years from Commonwealth Care, a subsidized health insurance program central to this state's 2006 health care overhaul, violated the State Constitution.
>
> "This appropriation discriminated on the basis of alienage and national origin," wrote Justice Robert J. Cordy of the Supreme Judicial Court, ruling that the action "violates their rights to equal protection under the Massachusetts Constitution." . . .
>
> State officials say they will abide by the decision, although they are not yet sure how to pay for the change.
>
> "This decision has significant fiscal impacts for the commonwealth, adding somewhere in the range of $150 million in annual costs to what is already a very challenging budget," said Jay Gonzalez, secretary of administration and finance.

No doubt their "pay for" will involve another unpopular minority.

Former Romney/Obama advisor Jonathan Gruber has written that RomneyCare was already costing the state $50 billion more than projected by 2009. Of course, supporters have been hiding RomneyCare's costs (and exaggerating its benefits) all along.

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SECTION FOUR:

OBAMACARE

Chapter 18

Does Barack Obama Support Socialized Medicine?

by Michael F. Cannon

Cato Institute Briefing Paper no. 108 (October 7, 2008)

Introduction

Democratic presidential nominee Sen. Barack Obama (IL) has proposed an ambitious plan to reform America's health care sector. According to his campaign website, "Obama will sign a universal health care plan into law by the end of his first term in office. His plan will provide affordable, quality health care coverage for every American."[1]

Obama proposes to accomplish those goals with a number of reforms. He would create a "National Health Insurance Exchange," where Americans could choose among a number of private insurance plans, or opt for a new health plan run by the federal government and modeled on the Medicare program. Through the Exchange, Obama would have the federal government regulate the content and price of all health insurance plans offered in the United States. Obama would require employers to contribute to the cost of their employees' health insurance or pay a tax. He would require all parents to obtain health insurance for their children. And he would expand existing government health insurance programs such as Medicaid and the State Children's Health Insurance Program.[2]

Rather than engage in a detailed critique of Obama's health-care plan,[3] many critics prefer to label it "socialized medicine."[4] Is that a fair description of the Obama plan and similar plans?

Over the past year, prominent media outlets and respectable think tanks have investigated that question and come to a unanimous answer: no. Those investigations leave much to be desired.

The Bogeyman That Just Won't Die

The phrase "socialized medicine" has been used to defame Harry Truman's proposed national health insurance program (1945), Medicare (1965), Bill Clinton's Health Security Act (1993), and proposals to expand the State Children's Health Insurance Program (2007). In the 2008 presidential campaign, it has been deployed against every Democratic candidate's health care plan—as well as the Massachusetts reforms then–governor Mitt Romney (R) signed into law in 2006.[5]

To say that this epithet gets under the Left's skin would be putting it mildly. For the past year, supporters of universal coverage have been hard at work trying to neutralize, in the words of Rutgers

professor David Greenberg, the "talismanic power" of this "old slayer of reform proposals past," and recast the phrase as a piece of "atavistic Cold War–era alarmism."[6]

"'Socialized medicine' is the bogeyman that just won't die," wrote Yale political scientist Jacob Hacker in the *Washington Post*.[7] In a study for the left-leaning Urban Institute, researchers Stan Dorn and John Holahan conclude, "It is a significant exaggeration to claim that proposals like [the] plans advanced by the leading Democratic presidential candidates represent steps toward socialized medicine."[8]

In April 2008, the Urban Institute held a public forum titled "What Is Socialized Medicine and Is It Relevant to Health Care Reform?" where scholars dismissed claims that Obama's and similar plans would move America toward socialized medicine.[9] The *New York Times*, the Associated Press, and National Public Radio have all run ostensibly objective stories with the same purpose.[10] Of those organizations, only the Associated Press bothered to solicit input from anyone who thinks such claims are valid.

Perhaps the only fair hearing the charge has received came during a presidential debate in 2007, when a journalist likened Sen. Hillary Clinton's (D-NY) health care reform plan to socialized medicine.

"I have never advocated socialized medicine," Clinton responded testily. When her interlocutor objected, "But that's what universal medicine is," Clinton turned the question back on him. "Do you think Medicare is socialized medicine?" she asked. "To a degree, it is," he replied. "Well, then, you are in a small minority in America," Clinton responded.[11]

Actually, he's not. A recent poll by Harris Interactive and the Harvard School of Public Health found that a majority of responders—and fully 60 percent of those who claim to know what the phrase means—consider Medicare to be socialized medicine. Even larger majorities took the journalist's side on whether Clinton supports socialized medicine (69 percent of those who claim to know the term's meaning) and whether universal coverage equals socialized medicine (79 percent).[12]

That's not necessarily bad news for supporters of socialized—er, universal coverage. Seventy percent of Democrats think socialized medicine would improve American health care, whereas 70 percent of Republicans say the opposite. Independents are evenly split. Nevertheless, supporters of universal coverage are scrambling to inoculate themselves against the charge that they are pushing "socialized medicine," principally by attempting to narrow the term's definition.

Defining Socialism Down

At the above-mentioned forum, Urban Institute president and former Congressional Budget Office director Robert Reischauer claimed, "Classic socialism involves government or collective ownership of the means and distribution of production. . . . Truly socialized medicine doesn't exist anywhere in the world."[13] He's right. But were we to define everything so narrowly, we would find that capitalism doesn't exist anywhere in the world, either. Neither does democracy.

Others, such as Dorn and Holahan, suggest that medicine can't be considered socialized if a country retains a large role for the private sector. They write, "Strictly speaking, socialized medicine involves government financing and direct provision of health care services, as with the traditional British system." The Obama plan and other major Democratic plans cannot be considered socialized medicine because

"none would overturn the dominant role of private insurance and private providers in America's health care system."[14]

But that's not quite right, either. There is little functional difference between health care system A, a public program through which the government taxes and spends your money on its health care priorities, and health care system B, a completely "private" system in which the government forces *you* to spend your money on identical priorities. In a paper for the left-wing Center for American Progress, University of Texas public affairs professor Jeanne Lam-brew and colleagues write that the concept of socialized medicine "has been embraced, demonized, and misunderstood since the early 20th century in the United States." Nevertheless, they acknowledge that a (nominally) private sector is no barrier to socialized medicine: "the government role in socialized medicine systems [can include] public financing of private insurance and providers."[15]

Clinton, Dorn, and Holahan suggest that health care systems cannot be fairly described as socialized if they provide adequate access to care. In her exchange with the journalist, Clinton responded, "Medicare is a system that we fund through our paychecks. And yes, the government pays the bills. But no government bureaucrat tells you what doctor you have to go to or what hospital you have to go to."[16] Dorn and Holahan write that "strict limits on consumer choice, rationing, delays, and poor quality [are] all concerns traditionally associated with socialized medicine. These concerns, however, do not apply to the . . . plans advanced by leading Democratic candidates. . . . "[17]

Again, this notion does not sit well. Barriers to access occur when the government limits spending below what is required to meet patients' demand for medical care. To say that socialized medicine only exists when there are access problems (e.g., waiting lists) is to make the rather curious argument that socialized medicine would disappear if the government wrote bigger checks.

The boldest attempt to narrow the definition of socialized medicine comes from University of North Carolina–Chapel Hill health policy professor Jonathan Oberlander. In a 2007 interview with National Public Radio, Oberlander wryly noted that the American Medical Association has used the term to describe most anything they do not like, including free-market innovations like health maintenance organizations. Oberlander therefore concludes that the term "socialized medicine" has no meaning at all.[18]

We've seen this sort of tactic before. In a 1993 journal article titled "Defining Deviancy Down," the late senator Daniel Patrick Moyn-ihan (D-NY) argued that when deviant behavior grows beyond the amount that society can "afford to recognize," society will cope by narrowing its definition of deviancy.[19] Similarly, supporters of universal coverage are trying to convince the public that policies generally considered socialist really aren't.

What Is Socialized Medicine?

Contrary to Oberlander's claim—and the physician lobby's naked opportunism—a reasonable definition is possible. *Socialized medicine exists to the extent that government controls medical resources and socializes the costs*. We might even award countries an extra red rose—the official symbol of the Socialist International[20] —if they socialize the costs according to the Marxist principle of "from each according to his ability."

Notice that under this definition, it is irrelevant whether we describe medical resources (e.g., hospitals,

employees) as "public" or "private." What matters—what determines real as opposed to nominal ownership—is who controls the resources. The particular decisions that government makes about those resources are likewise irrelevant. It matters not whether the government is stingy about medical spending (as in Canada's Medicare system, the British National Health Service, or the U.S. Medicaid program) or obscenely lavish (as in the U.S. Medicare program). What matters is who decides.

By that definition, America's health sector is already well more than half socialized. Government purchases 46 percent of all medical care.[21] In a tip of the hat to Karl Marx, government finances that spending largely with tax rates that rise with one's earnings. Oberlander and others posit that government ultimately controls about 60 percent of U.S.

health spending.[22] According to Holahan, "all but 5 percent of the U.S. population that is insured receive government assistance" of one form or another.[23] In the Harris/Harvard poll, the public acknowledged the importance of who controls the money: 73 percent said that socialized medicine exists when "the government pays most of the cost of health care."[24]

Yet controlling the money that purchases medical services is only one among many ways that government controls America's medical resources:

- **Medical personnel.** Federal and state governments rarely employ physicians. But state-level clinician licensing laws do control the number of physicians, who can hire them, where medical professionals can practice, and what tasks they may perform.[25] Those laws and the Medicare and Medicaid programs largely determine how and how much physicians and other clinicians will be paid.
- **Medical products.** Government doesn't manufacture medical products, but it sets prices for most of them through the Medicare and Medicaid programs. The federal Food and Drug Administration controls whether, how, and to whom medical products may be marketed and sold.
- **Physical capital.** Most U.S. hospitals are privately owned. Through "certificate-of-need" laws, however, state governments frequently control who can open a hospital or invest in new equipment. Federal tax policy greatly influences hospitals' corporate form (profit vs. nonprofit).
- **Health insurance.** Most Americans have private health insurance. Yet state and federal governments control what kind of health insurance we may purchase, how much we will purchase, where we may purchase it, and often the premiums we will pay.

The list goes on. Oberlander himself argues that few Americans understand the extent to which government already controls their health care.[26] To paraphrase Keyser Soze, the greatest trick that supporters of socialized medicine ever played was to convince the American people we don't already have it.[27]

The reasonable definition suggested here (socialized medicine exists to the extent that government controls medical resources and socializes the costs) allows for gradations of socialism and makes sense of the public's belief that Medicare and universal coverage constitute socialized medicine. Medicare gives government enormous control over the medical resources consumed by beneficiaries and nonbeneficiaries alike.[28] Universal coverage likewise requires extensive government controls, as markets will not provide health insurance to everyone. Harvard health economist David Cutler writes, "Universal coverage necessarily means a larger role for government than is the case now."[29]

Conclusion

This definition also suggests that Obama's health care plan, and indeed all attempts at universal coverage, would socialize medicine even further. Though no rigorous projections have been done on the Obama plan, the Lewin Group estimates that a similar plan would enroll 40 million people in a new government insurance program, which would be akin to doubling the Medicare rolls. The Lewin Group projects that plan would increase federal spending by more than $140 billion per year,[30] which some observers consider a vast underestimate.[31] Further, Obama's proposed National Health Insurance Exchange would let government dictate who must purchase coverage, how much coverage they must purchase, and the premiums for every insurance policy in the nation.

Reasonable people can disagree over whether Obama's health plan would be good or bad. But to suggest that it is not a step toward socialized medicine is absurd.

Public opinion belies that absurdity. The Harvard/Harris poll reports that, of those who claim to know what socialized medicine is, 57 percent believe Obama supports it.[32]

Obama's supporters belie that absurdity. Some, including *New York Times* columnist Paul Krugman, support the Obama plan *because* it would lead to socialized medicine. Krugman writes hopefully that the Obama plan (and other major Democratic plans) "could evolve into single-payer over time."[33] "Single-payer" is shorthand for a health care system, like Canada's, where the government pays all the bills. Even health policy analysts consider single-payer a form of socialized medicine.[34]

Finally, Obama himself belies that absurdity. He has repeatedly signaled his support for a single-payer health care system. In 2003, Obama stated, "I happen to be a proponent of a single-payer, universal health care plan."[35] At a town hall meeting in August 2008, Obama responded to a question about the single-payer concept, "If I were designing a system from scratch, I would probably go ahead with a single-payer system." He then hinted that, once implemented, his reform plan could take Krug-man and like-minded supporters where they ultimately want to go: "my attitude is let's build up the system we got . . . [and] we may . . . over time . . . decide that there are other ways for us to provide care more effectively."[36]

Unfortunately, such absurdities often pass for impartial journalism and informed commentary at major media outlets and policy organizations, while one-sided events staged to arrive at foregone conclusions often pass for debate.

At the Urban Institute forum, Susan Dentzer, editor-in-chief of the journal *Health Affairs*, remarked, "The people who like socialized medicine don't call it that."[37] Indeed they don't, but they really can't blame others for doing so. There's more substance than smear to the charge.

Notes

1. Obama '08, "The Blueprint for Change: Barack Obama's Plan for America," http://www.barackobama.com/pdf/ObamaBlueprintForChange.pdf

2. See Obama '08, "Barack Obama's Plan for a Healthy America: Lowering Health Care Costs and Ensuring Affordable, High-Quality Health Care for All," http://www.barackobama.com/pdf/HealthPlanFull.pdf

3. For a detailed critique of Obama's health care plan, see Michael D. Tanner, "A Fork in the Road: Obama, McCain, and Health

Care," Cato Institute Briefing Paper no. 104, July 29, 2008, http://www.cato.org/pubs/bp/bp104.pdf.

4. Paul Steinhauser, "Giuliani Attacks Democratic Health Plans as 'Socialist'," CNN.com, July 31, 2007, http://www.cnn.com/2007/POLITICS/07/31/giuliani.democrats/index.html.

5. Ibid., and Vin Suprynowicz, "Seizing Guns and Socializing Medicine—Romney's a Republican?" *Las Vegas Review-Journal*, August 26, 2007, http://www.lvrj.com/opinion/9380526.html.

6. David Greenberg, "Who's Afraid of Socialized Medicine? Two Dangerous Words that Kill Health-Care Reform," Slate.com, October 8, 2007, http://www.slate.com/id/2175477/.

7. Jacob S. Hacker, "Let's Try a Dose. We're Bound to Feel Better," *Washington Post*, March 23, 2008. p. B01, http://www.washingtonpost.com/wp-dyn/content/article/2008/03/21/AR2008032102743.html.

8. Stan Dorn and John Holahan, "Are We Heading toward Socialized Medicine?" Urban Institute, April 2008, p. 10, http://www.urban.org/UploadedPDF/411648_socialized_medicine.pdf.

9. "What Is Socialized Medicine and Is It Relevant to Health Care Reform?" Urban Institute forum, April 16, 2008, http://www.urban.org/Pressroom/otherevents/socmed.cfm For a transcript, see "What Is Socialized Medicine and Is It Relevant to Health Care Reform," kaisernetwork.org, April 16, 2008, http://kaisernetwork.org/health_cast/uploaded_files/041608_urban_socializedmed_transcript.pdf.

10. Michael Cooper and Julie Bosman, "Parsing Mc-Cain on the Democrats' Health Plans," *New York Times*, May 3, 2008, http://www.nytimes.com/2008/05/03/us/politics/03check.html; Kevin Freking, "Insurance Model Follows American Tradition," *Boston Globe*, May 12, 2008, http://www.boston.com/news/education/higher/articles/2008/05/12/insurance_model_follows_american_tradition/; Julie Rovner, "Socialized Medicine Belittled on Campaign Trail," NPR Morning Edition, December 6, 2007, http://www.npr.org/templates/story/story.php?storyId=16962482.

11. "Clinton Confronts Critic," CNN Video, August 9, 2007, http://www.cnn.com/video/#/video/politics/2007/08/09/sot.clinton.medicare.cnn; Patrick Healy, "A Testy Exchange on Health Care," The Caucus (NewYorkTimes.com), August 9, 2007, http://thecaucus.blogs.nytimes.com/2007/08/09/a-testy-exchange-on-health-care/.

12. Harvard School of Public Health and Harris Interactive, "Debating Health: Election 2008—Americans' Views on Socialized Medicine," http://www.hsph.harvard.edu/news/press-releases/files/Topline__Socialized_Med_Havard_Harris.pdf. These and all subsequent percentages are of those who claimed to know what socialized medicine means.

13. "What Is Socialized Medicine and Is It Relevant to Health Care Reform?"

14. Dorn and Holahan, p. 1.

15. Marla Bizzle, Denise Fraga, Laurie Seremetis, and Jeanne Lambrew, "The Specter of Socialized Medicine: What Is It and Is It Invading Our Country?" Center for American Progress, May 14, 2008, http://www.americanprogress.org/issues/2008/05/socialized_medicine.html.

16. "Clinton Confronts Critic."

17. Dorn and Holahan, p. 1.

18. Rovner.

19. Daniel Patrick Moynihan, "Defining Deviancy Down," *American Scholar* (Winter 1993), http://www2.sunysuffolk.edu/formans/DefiningDeviancy.htm.

20. See Socialist International website, http://socialistinternational.org/; or "Socialist International," Wikipedia.org, http://en.wikipedia.org/wiki/Socialist_International.

21. U.S. Centers for Medicare and Medicaid Services, "National Health Expenditure Projections 2007–2017," Table 3, p. 5, http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf.

22. Steffie Woolhandler and David U. Himmelstein, "Paying for National Health Insurance—And Not Getting It," *Health Affairs* 21, no. 4 (July/August 2002): 88–98, http://content.healthaffairs.org/cgi/content/abstract/21/4/88; Jonathan Oberlander, "Are

Americans Closer than We Think to National Health Insurance?" *Health Affairs* 21, no. 4 (July/ August 2002): 103–104, http://content.healthaffairs.org/cgi/content/extract/21/4/103.

23. "What Is Socialized Medicine and Is It Relevant to Health Care Reform?" p. 14.

24. Harvard School of Public Health and Harris Interactive.

25. See, for example, Shirley Svorny, "Medical Licensing: An Obstacle to Affordable, Quality Care," Cato Institute Policy Analysis no. 621, September 17, 2008..

26. Oberlander.

27. *The Usual Suspects*, Gramercy Pictures, 1995. ("The greatest trick the devil ever pulled was convincing the world he did not exist.") See also Charles Baudelaire "Le Joueur généreux," *Le Spleen de Paris; Petits Poèmes en Prose*, 1862. ("Mes chers frères, n'oubliez jamais . . . que la plus belle des ruses du diable est de vous persuader qu'il n'existe pas!")

28. See, for example, David A. Hyman, *Medicare Meets Mephistopheles* (Washington: Cato Institute, 2006).

29. David M. Cutler, *Your Money or Your Life: Strong Medicine for America's Healthcare System* (Oxford, UK: Oxford University Press, 2004), p. 116.

30. Cathy Schoen, Karen Davis, and Sara R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs* 27, no. 3 (May/June 2008): http://content.healthaffairs.org/cgi/content/abstract/27/3/646.

31. At a forum on that Obama-like plan, former Medicare administrator Gail Wilensky remarked, "I do not believe Lewin estimates for a moment." Alliance for Health Reform and Commonwealth Fund transcript, "Medicare as a Building Block for Health Reform: Should Americans Buy In?" June 6, 2008, p. 45, http://www.allhealth.org/briefingmaterials/Transcript-1255.pdf.

32. Harvard School of Public Health and Harris Interactive.

33. Paul Krugman, "Why Not Single-Payer?" *New York Times* blog, October 7, 2007, http://krugman.blogs.nytimes.com/2007/10/07/why-not-single-payer/.

34. See Harvard School of Public Health and Harris Interactive. Notwithstanding their highly tailored definition of socialized medicine, Dorn and Holahan admit that "single-payer plans can involve such a major expansion of the government's role that they would become the functional equivalent of socialized medicine." Dorn and Holahan, p. 10.

35. Physicians for a National Health Program, "Barack Obama on Single Payer in 2003," June 4, 2008, http://www.pnhp.org/news/2008/june/barack_obama_on_sing.php.

36. Amy Chozick, "Obama Touts Single-Payer System for Health Care," Washington Wire, *Wall Street Journal*, August 19, 2008, http://blogs.wsj.com/washwire/2008/08/19/obama-touts-single-payer-system/.

37. "What Is Socialized Medicine and Is It Relevant to Health Care Reform?" p. 6.

Chapter 19

Health Care Reform: Questions for the President

by Michael F. Cannon

"Health care reform is on life support," says Rep. Jim Cooper of Tennessee. And he's a Democrat.

President Obama has spent months building momentum for health care reform. But when the Congressional Budget Office put the price tag near $2 trillion, it stopped reform dead in its tracks.

What Senate Finance Committee chairman Max Baucus, D-Mont., once called "nearly inevitable" now seems much less so—and that's before supporters have confronted the really tough questions.

Before this debate is over, Obama should answer a few questions about his plans for reform, including:

- Mr. President, in your inaugural address and elsewhere, you said you are not interested in ideology, only what works. Economists Helen Levy of the University of Michigan and David Meltzer of the University of Chicago, where you used to teach, have researched what works. They conclude there is "no evidence" that universal health insurance coverage is the best way to improve public health. Before enacting universal coverage, shouldn't you spend at least some of the $1 billion you dedicated to comparative-effectiveness research to determine whether universal coverage is comparatively effective? Absent such evidence, isn't pursuing universal coverage by definition an ideological crusade?
- A draft congressional report said that comparative-effectiveness research would "yield significant payoffs" because some treatments "will no longer be prescribed." Who will decide which treatments will get the axe? Since government pays for half of all treatments, is it plausible to suggest that government will not insert itself into medical decisions? Or is it reasonable for patients to fear that government will deny them care?
- You recently said the United States spends "almost 50 percent more per person than the next most costly nation. And yet . . . the quality of our care is often lower, and we aren't any healthier." Achieving universal coverage could require us to spend an additional $2 trillion over the next 10 years. If America already spends too much on health care, why are you asking Americans to spend even more?
- You have said, "Making health care affordable for all Americans will cost somewhere on the order of $1 trillion." Precise dollar figures aside, isn't that a contradiction in terms?
- Last year, you told a competitiveness summit that rising health care costs are "a major anchor on the ability of American business to compete." In May, you wrote, "Getting spiraling health care costs under control is essential to . . . making our businesses more competitive." The head of your Council of Economic Advisors says such claims are "schlocky." Who is right: you or your top economist?
- You recently told an audience, "No matter how we reform health care, we will keep this promise to the American people. . . . If you like your health care plan, you'll be able to keep your health care

plan, period. No one will take it away, no matter what." The Associated Press subsequently reported, "White House officials suggest the president's rhetoric shouldn't be taken literally." You then clarified, "What I'm saying is the government is not going to make you change plans under health reform." Would your reforms encourage employers to drop their health plans?

- You found $600 billion worth of inefficiencies that you want to cut from Medicare and Medicaid. If government health programs generate that much waste, why do you want to create another?
- You and your advisors argue that Medicare creates misaligned financial incentives that discourage preventive care, comparative-effectiveness research, electronic medical records, and efforts to reduce medical errors. Medicare's payment system is the product of the political process. What gives you faith that the political process can devise less-perverse financial incentives this time?
- You claim a new government program would create "a better range of choices, make the health care market more competitive, and keep insurance companies honest." Since when is having the government enter a market the remedy for insufficient competition? Should the government have launched its own software company to compete with Microsoft? Are there better ways to create more choices and more competition?
- When government entered the markets for workers compensation insurance, crop and flood insurance, and disaster insurance, it often completely crowded out private options. Do you expect a new government health insurance program would do the same?
- You have said there are "legitimate concerns" that the government might give its new health plan an unfair advantage through taxpayer subsidies or by "printing money." How do you propose to prevent this Congress and future Congresses from creating any unfair advantages?

President Obama needs to address questions these directly. The health of millions depends on his answers.

*This article appeared on **ABC News.com** on June 24, 2009.*

Chapter 20

U.S. Healthcare: What Hath Obama Wrought?

by Michael F. Cannon

The healthcare law that President Barack Obama signed on 23 March stands among the most sweeping pieces of social legislation in the United States' history. By 2014, it will have conscripted nearly the entire U.S. population into a compulsory health insurance scheme. Whether the law deserves to be seen as a *reform*, however, depends on one's perspective. To the Left, the law is milquetoast. It fails to establish a 'single-payer' health care system, as adopted by Canada or the UK, or even a robust 'public option' to compete with private insurers. 'ObamaCare' likewise infuriates the Right, which considers the law to be a great leap toward socialism—conservatives thought it only fitting when Comrade Fidel hailed the new law as a 'miracle'. The law's supporters, meanwhile, probably felt French President Nicolas Sarkozy's backhanded compliment to be more appropriate: 'Welcome to the club of countries that does not dump its sick people.'

On the surface, America appears to deserve both *entendres*. The U.S. had been the last of the economically developed nations not to provide a government guarantee of health insurance coverage to all its citizens. To its European friends, that was the most baffling aspect of a healthcare system already rife with illogic. But President Obama has now issued such a guarantee. Nearly all legal U.S. residents must purchase health insurance by 2014, under threats of fines and imprisonment. Private insurers may vary premiums based on age and smoking status, and for individuals versus families; but they may neither deny coverage to the sick nor charge them higher premiums than anyone else. Those whom the government deems unable to afford coverage will either receive it directly from the government or via subsidized private insurance. Thus it finally appears—on paper, anyway—as though the U.S. will no longer deny medical care to sick people.

There is, of course, many a slip twixt the cup and the lip. Governments everywhere do a better job of issuing guarantees than delivering on them. For decades, the U.S. government has guaranteed medical care to low-income children through the Medicaid program. That guarantee, however, did not prevent the death of a 12-year-old Maryland boy named Deamonte Driver. In 2007, Driver succumbed to an overwhelming infection that began in an abscessed tooth. His senseless death could have been prevented with a simple tooth extraction, yet his mother could not find a dentist willing to accept Medicaid's meager payments. Of the estimated 32 million uninsured that the new law will cover, about half can expect the same insurance that Driver was given.

Indeed, every member of Sarkozy's 'club' has its stories of sick people who have been 'dumped' in one manner or another, despite laws that officially preclude such things from ever happening. In 2005, Canada's Supreme Court wrote of its country's Medicare system: 'Access to a waiting list is not access to healthcare. As we noted above, there is unchallenged evidence that in some serious cases, patients die as a result of waiting lists for public health care.' The British, meanwhile, often seem more content to let the National Health Service shortchange its patients than to let an American lecture them about how

often it happens.

The checkered history of government guarantees is why so many Americans—a majority, in fact—oppose President Obama's new law, which they believe will move the U.S. even further from Sarkozy's ideal world than it is now.

Consider the requirement that insurers charge everyone of a given age the same premium, regardless of their health status. Despite its compassionate overtones, this requirement will effectively deny care to sick Americans who are content with their existing coverage. If healthy people cost $5,000 to insure and sick people cost $25,000, forcing insurers to charge the same $10,000 premium turns every sick person into a $15,000 dollar liability. Consequently, insurance plans that provide quality care to those sick patients will quickly go out of business, as research by one of President Obama's economic advisors confirms. If private insurers are to survive, then they will do whatever they can to avoid the sick, including denying their claims, because that is what the government's price controls reward.

Or consider how those same price controls could cause private markets to collapse. My colleague Victoria Payne and I calculate that under Obama's law, healthy individuals could save $3,000 annually—and families of four as much as $8,000—by dropping their coverage, paying the fines, and waiting until they are sick to buy coverage again. Since insurers would be required to cover them at standard premiums, healthy people would have little to lose. Perhaps Americans' sense of social solidarity will nevertheless oblige them to shell out thousands of dollars each year to private insurance companies for nothing in return. Or perhaps healthy people will drop their coverage, premiums will rise, and even more healthy people will drop their coverage in an ever more vicious cycle.

Technically, in any event sick Americans will still have a legal right to coverage, but they may find this 'guarantee' to be of cold comfort when that 'right' may only be realized through a private insurer that doesn't want them or a government program that doesn't think their health is worth much. Of greater comfort would be innovations that genuinely made healthcare more effective, affordable and secure. Fortunately, whatever the faults of the healthcare sector (and there are many) the U.S. has long proven itself to be conducive to medical innovation, both technical and administrative.

A recent Cato Institute study found that the U.S. has been home to most of the important medical advances made over the past 40 years. In some fields, America contributes more important innovations than all other nations combined. These innovations are preventing sick people from being 'dumped' throughout the world.

Furthermore, when the U.S. government *has* given market forces room to breathe, entrepreneurs have devised innovative ways of delivering healthcare. Integrated health plans such as Kaiser Permanente, which has fared well in comparison with the NHS, reduce the cost of care and deploy electronic medical records that make medicine better, safer and more convenient.

American innovation has also made health insurance more secure. Decades ago private markets catered to the $5,000 patient's fear of becoming a $25,000 patient by guaranteeing that her premiums would rise no faster than the rest of the pool, no matter how sick she got. Private markets are now just one step away from offering the 'holy grail' of health insurance guarantees: coverage that both protects against higher premiums and makes insurers *compete* to cover the sick, instead of avoiding them.

The price controls that Obama's law imposes on pharmaceuticals and health insurance will prevent the market from expressing a demand for further innovations. Massachusetts enacted a nearly identical law in 2006, which is already threatening to extinguish innovation in payment systems and healthcare delivery.

President Obama could have come up with a law making healthcare better, more affordable and more

secure through the bottom-up process of innovation. Instead, he extended the world's most expensive health care system to 32 million more people. And he did so in a way that could 'dump' more sick Americans than ever before.

That ObamaCare an attractive target for repeal.

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Chapter 21

Bad Medicine:
A Guide to the Real Costs and Consequences of the New Health Care Law

by Michael D. Tanner

Cato Institute White Paper (February 14, 2011)

Introduction

On March 21, 2010, in an extraordinary Sunday night session, the House of Representatives gave final approval to President Obama's long-sought health insurance plan in a partisan 219–212 vote.[1] The bill had earlier passed the Senate on Christmas Eve 2009. Not a single Republican in either chamber voted for the bill. Four days later, the Senate, using a parliamentary tactic known as reconciliation to avoid a Republican filibuster, gave final approval to a package of changes designed to "fix" the bill.[2]

More than 2,500 pages and 500,000 words long,[3] the Patient Protection and Affordable Care Act represents the most significant transformation of the American health care system since Medicare and Medicaid. It will fundamentally change nearly every aspect of health care from insurance to the final delivery of care.

The final legislation was in some ways, an improvement over earlier versions. It was not the single-payer system sought by many liberals. Nor did it include the interim step of a so-called "public option" that would likely have led to a single-payer system in the long run.[4] The employer mandate is far less onerous than the 8 percent payroll tax once championed by the House.[5] And a proposed income tax surtax on the wealthy was dropped.[6] But that does not mean that this is, as the president has claimed, a "moderate" bill.

It mandates that every American purchase a government-designed insurance package, while fundamentally reordering the insurance market and turning insurers into something resembling public utilities, privately owned while their operations are substantially regulated and circumscribed by Washington. Insurance coverage will be extended to millions more Americans as government subsidies are expanded deep into the middle class. Costs will be shifted between groups, though ultimately not reduced. And a new entitlement will be created, with the threat of higher taxes and new debt for future generations. In many ways, it has rewritten the relationship between the government and the people, moving this country closer to European-style social democracy.

The legislation remains deeply unpopular. Recent polls show substantial majorities support repealing it. For example, a Rasmussen poll in late January of this year showed 58 percent of likely voters supported repeal, with just 38 percent opposed. Similarly, a mid-January Fox News poll showed registered voters favoring repeal by 17 percent. In fact, with the exception of a *New York Times*/CBS News poll of "all Americans," recent polling has consistently shown that most voters support repeal

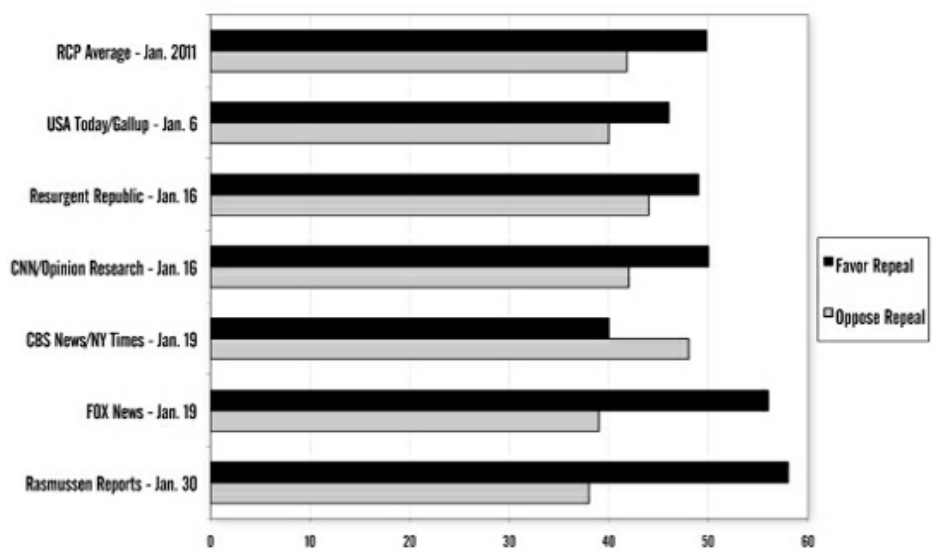
(Figure 1).

Republicans ran on a platform of "repeal" or "repeal and replace" during the 2010 midterm elections, and surveys suggest that opposition to the health care law was an important reason that they recaptured the House and gained six Senate seats. On health care, exit polls showed that at least half of voters wanted to repeal Obamacare. This represented an almost unprecedented level of opposition for a major entitlement expansion. Given that exit polls have a history of over-sampling Democratic voters, an even better measure might be an election-night Rasmussen telephone poll that found 59 percent of voters in favor of repeal.[7] A Kaiser Foundation survey of voters found similar results: 56 percent of midterm voters said they wanted to see some or all of the law repealed.[8] Another post-election survey found that 45 percent saw their vote as a specific message of opposition to the health care bill.[9]

The new Republican majority in the House has already begun efforts to undo the health care law. On January 18, 2011, the House voted 245 to 189 to repeal it.[10] While repeal is all but impossible in the short term, given Democratic control of the Senate and a presidential veto, Republicans plan a continued assault on the law, ranging from attempts to repeal some of the most unpopular provisions to plans for de-funding implementation.[11]

Meanwhile, outside of Washington, opposition remains active. Seven states—Arizona, Idaho, Louisiana, Missouri, Oklahoma, Utah, and Virginia—have passed variations of the

Figure 1
Repeal of Health Care Law



Source: Real Clear Politics.

Health Care Freedom Act prohibiting mandatory health insurance.[12] Similar legislation has been introduced in nearly all remaining states. State governments have also been slow to cooperate with federal

efforts to implement the law. For example 23 states refused to set up a high-risk pool in response to the law, and several states are considering a refusal to establish exchanges.

Numerous court challenges have also been filed, raising questions about the constitutionality of various aspects of the legislation, especially its individual mandate.[13] Plaintiffs include 28 states, as well as individuals, business groups, and others.[14] To date, the outcome of those suits has been mixed. In two minor lawsuits in Michigan and Virginia, courts have upheld the mandate.[15] However, in the two most closely watched—and extensively argued—cases, federal judges struck down the mandate, and while the judge in the Virginia case allowed other portions of the law to go forward, the judge in Florida ruled that the lack of a severability clause made the entire law unconstitutional.[16] All the cases will be appealed and the final decision will be made by the U.S. Supreme Court.

It seems almost certain, therefore, that the debate over health care reform will be with us for some time to come.

In the meantime, the legislation has spawned enormous confusion. Insurance companies report people calling and asking, "Where do we get the free Obamacare, and how do I sign up for that?"[17] But for good or ill, those expecting immediate change are likely to be disappointed. Most of the major provisions of the legislation are phased in quite slowly. The most heavily debated aspects, mandates, subsidies, and even most of the insurance reforms don't begin until 2014 or later.

Former House Speaker Nancy Pelosi once famously told us: "We have to pass the bill so you can find out what's in it."[18] A year after passage, we are indeed discovering what is in it. And what we are finding increasingly looks like it will leave Americans less healthy, less prosperous, and less free.

Part I:
The Patient Protection and Affordable Care Act

Individual and Employer Mandates

Perhaps the single most important aspect of the law is its individual mandate, a legal requirement that every American obtain health insurance coverage that meets the government's definition of "minimum essential coverage." Those who don't receive such coverage through government programs, their employer, or some other group would be required to purchase individual coverage on their own.[19]

This individual mandate is unprecedented in U.S. governance. Back in 1993, when the Clinton health care plan was under consideration, the Congressional Budget Office noted: "A mandate requiring all individuals to purchase health insurance would be an unprecedented federal action. The government has never required people to buy any good or service as a condition of lawful residence in the United States."[20] Moreover, the individual mandate raises serious constitutional questions.[21] Even the Congressional Research Service was not able to conclude it was constitutional![22]

Under the law, beginning in 2014, those who failed to obtain insurance would be subject to a tax penalty. That penalty would be quite mild at first, either $95 or one percent of annual income in 2014, whichever is greater.[23] But it ramps up quickly after that, the greater of $325 or 2 percent of annual income in 2015, and the greater of $695 or 2.5 percent of annual income after that. In calculating the total penalty for an uninsured family, children count as half an adult, which means that in 2016 an uninsured family of four would face a minimum penalty of $2,085 ($695+$695+$347.50+$347.50), pro-rated on the basis of the number of months that the person was uninsured over the course of the year.[24] Individuals will be exempt from the penalties if they earn less than an income threshold to be determined by the secretary of Health and Human Services (but presumed to be roughly the poverty level), or if they are unable to obtain insurance that costs less than 8 percent of their gross incomes.[25]

According to the CBO, roughly four million Americans will be hit by penalties in 2016, with the penalties averaging slightly more than $1,000.[26] In fact, the federal government expects to raise $17 billion from penalties by 2019.[27]

Simply having insurance, however, is not necessarily enough to satisfy the mandate. To qualify, insurance would have to meet certain government-defined standards for "minimum essential coverage." For example, in order to qualify, plans would be required to cover ambulatory patient services, emergency services, hospitalization; maternity and newborn care, mental health and substance abuse treatment; prescription drugs; rehabilitative and habitative services; laboratory services; preventative services; wellness services; chronic disease management; pediatric services; and dental and vision care for children.[28] The secretary of HHS is given the authority to define the meaning of those terms and ultimately to set the minimum benefits package.[29] That process is ongoing, as an Institute of Medicine committee considers whether to mandate the inclusion of benefits such as autism treatment or *in vitro* fertilization.[30]

In addition, plans must meet the new insurance regulatory requirements below.

Unlike previous versions of the bill, however, individuals who currently have insurance are grandfathered in, meaning they will not have to change their current insurance to meet the new minimum benefit.[31] They will even be able add a spouse or children to the plan without changing. While clearly an improvement over earlier versions, this does not necessarily mean that people will be able to keep their current plan. In particular, making changes to their current plan will end the plan's grandfathered status,

and would require that individuals bring their plan into compliance with the full range of federal mandates and requirements, even if those additional mandates make the new plan more expensive or include benefits that the individual does not want. What changes meet the threshold to end grandfathered status will be determined by the secretary of HHS.[32]

Regardless of what federal regulators eventually decide, the grandfathering of current plans may be short-lived. That is because, aside from spouses and children, insurers will not be able to continue enrolling new customers in the noncomplying plans. As a result, insurers may stop offering these plans. Over time, the vast majority of noncomplying plans will simply fade away.

There has been some dispute over the government's ability to enforce the mandate. While the law imposes penalties for failure to comply and authorizes the IRS to collect those penalties (indeed, the IRS is expected to hire as many as 11,800 additional agents, auditors, and examiners for enforcement)[33] it does not contain any criminal penalties for failing to comply, and it forbids the use of liens or levies to collect the penalties. However, the IRS is nothing if not resourceful. Already, IRS deputy commissioner Steven Miller has said that the IRS may withhold tax refunds to individuals who fail to comply with the mandate.[34] And, because money is fungible, the IRS could simply apply part of your regular tax payments toward the mandate penalty, and then penalize you for failing to pay those regular taxes in full.

Interestingly, the law may have created the worst of both worlds, a mandate that is costly and violates individual liberty, but one that is still weak enough that it may be cheaper for many individuals to pay the penalty than to purchase insurance. As a result it may fall far short of its proponents' goal of bringing young and healthy individuals, who today frequently forego insurance, into the insurance pool. The Congressional Budget Office, in fact, estimates that the penalties from individuals failing to comply with the mandate will generate $17 billion between 2014 and 2019.[35] And according to a RAND Corporation study, those remaining uninsured after implementation are likely to be younger and healthier as a group than today's uninsured.[36] Massachusetts's experience with an individual mandate yielded just such a result. Slightly more than 35 percent of that state's remaining uninsured are between the ages of 18 and 25, and more than 60 percent are under the age of 35.[37] Before the mandate, those between the ages of 18 and 25 made up roughly 30 percent of the uninsured, suggesting that the young (and presumably healthier) are less likely to comply with the mandate.[38]

Indeed, evidence suggests that Massachusetts residents are increasingly "gaming" the system: purchasing insurance when they know they are going to use health care services, then dropping it when they no longer need it. In 2009 alone, 936 people signed up for coverage with Blue Cross and Blue Shield of Massachusetts for three months or less and ran up claims of more than $1,000 per month while in the plan. Their medical spending while insured was more than four times the average for consumers who buy coverage on their own and retain it in a normal fashion.[39] Given that the penalties under the Massachusetts mandate are actually stronger than those under the Patient Protection and Affordable Care Act, this does not bode well for the national plan.[40]

The law also contains an employer mandate. Beginning in 2014, if a company with 50 or more full-time employees (or the equivalent[41]) does not provide health insurance to its workers, and as a result even a single worker qualifies for a subsidy to help purchase insurance through the exchange (see below), the company must pay a tax penalty of $2,000 for every person they employ full time (minus 30

workers). Thus a company employing 100 workers would be assessed a penalty of $2,000 x 70 workers.[42] CBO estimates that those penalties will cost businesses $52 billion from 2014 to 2019.[43]

Even more than the individual mandate, the employer mandate may affect people who already have health insurance coverage. In part, this would be because far more people receive their insurance through work. But, in addition, HHS has released rules suggesting that if companies make any significant changes to their current coverage they will no longer be "grandfathered" under the employer mandate, meaning that they will have to bring their plan into full compliance with all the new federal requirements. Among the changes that would end "grandfathered" protection would be a change in insurance carrier, changes in or the elimination of any currently covered benefit, decreases in the employer's contribution rate, increases in annual payment limits, and increases in employee cost-sharing, including any increase in deductibles or copayments.[44] An internal study by HHS estimates that more than two-thirds of companies could be forced to change their current coverage. For small businesses, the total could reach 80 percent.[45]

Even offering the correct benefits will not necessarily exempt companies from penalties. Companies that offer coverage, but which have employees who still qualify for a subsidy because the employee's contribution is deemed unaffordable (that is, it exceeds 8 percent of an employee's income), will still have to pay a penalty of the lesser of $3,000 per employee receiving a subsidy or $2,000 per worker whether they are receiving subsidy or not. A survey by the employer benefits firm, Mercer, suggests that as many as one-third of employers could face penalties for failing to meet the affordable insurance requirement.[46]

Such a mandate is simply a disguised tax on employment. As Princeton University professor Uwe Reinhardt, the dean of health care economists, points out, "[Just because] the fiscal flows triggered by the mandate would not flow directly through the public budgets does not detract from the measure's status of a *bona fide* tax."[47]

And while it might be politically appealing to claim that business will bear the new tax burden, nearly all economists see it quite differently. The amount of compensation a worker receives is a function of his or her productivity. The employer is generally indifferent to the composition of that compensation. It can be in the form of wages, benefits, or taxes. What really matters is the total cost of hiring that worker. Mandating an increase in the cost of hiring a worker by adding a new payroll tax does nothing to increase that worker's productivity. Employers will therefore seek ways to offset the added cost by raising prices (the least likely solution in a competitive market), lowering wages, reducing future wage increases, reducing other benefits (such as pensions), cutting back on hiring, laying off current workers, shifting workers from full-time to part-time, or outsourcing.[48] In fact, a survey by Towers Watson shows that employers are preparing to take exactly those steps.[49]

And, as with the individual mandate, the penalty may be low enough that many businesses may find it less costly to "pay" than to "play."[50] As an internal document prepared for Verizon explains "Even though the proposed assessments [on companies that do not provide health care] are material, they are modest when compared to the average cost of health care."[51] In fact, CBO estimates that at least 10 to 12 million workers could lose their current employer-provided health insurance.[52] Approximately 8 to 9 million could end up on Medicaid, with the rest purchasing subsidized coverage through the exchanges (see below).[53] But this may vastly underestimate the actual number of workers who could be dumped

from their current coverage, as several large U.S. corporations have indicated that they may drop their current coverage.[54]

Insurance Regulations

Since the advent of the McCarran-Fergusson Act in 1945, health insurance has been primarily regulated at the state level.[55] The Patient Protection and Affordable Care Act imposes a host of new federal insurance regulations that will significantly change the way the health insurance industry does business. Some of these regulatory changes are likely to be among the law's most initially popular provisions. But many are likely to have unintended consequences.

Perhaps the most frequently discussed regulatory measure is the ban on insurers denying coverage because of preexisting conditions. Throughout the health care debate, proponents of reform highlighted stories of people with terrible illnesses who were unable to get insurance coverage.[56]

Under the Patient Protection and Affordable Care Act insurers would be prohibited from making any underwriting decisions based on health status, mental or physical medical conditions, claims experience, medical history, genetic information, disability, other evidence of insurability, or other factors to be determined later by the secretary of HHS.[57]

Specifically, the law would require insurers to "accept every employer and individual . . . that applies for such coverage."[58] Insurers are also forbidden to cancel insurance if a policyholder becomes sick.[59] Finally, there will be limits on the ability of insurers to vary premiums on the basis of an individual's health. That is, insurers must charge the same premium for someone who is sick as for someone who is in perfect health.[60] Insurers may consider age in setting premiums, but those premiums cannot be more than three times higher for their oldest than their youngest customers.[61] Smokers may also be charged up to 50 percent more than nonsmokers.[62] The only other factors that insurers may consider in setting premiums are geographic location and whether the policy is for an individual or a family.[63]

It is also worth noting that, while a ban on preexisting conditions for children started last year, the rules will not apply to adults until 2014.[64] Until then, adults with preexisting conditions will be eligible to participate in federally sponsored high-risk pools.[65] The high-risk pools will contract with private, nonprofit insurers for plans that must cover at least 65 percent of the costs of participants' care. Out-of-pocket costs would be capped at $5,950 a year for an individual or $11,900 for a family. The risk pools were supposed to be in place no later than the end of June 2010, but there have been numerous delays.[66] As many as 23 states have declined to establish the pools, forcing the federal government to set them up in those states.

So far, very few people have enrolled in the risk polls. In fact, by the end of 2010, only 8,011 people had signed up nationwide.[67] One reason may be that premiums within the pools are relatively high. For example, the premium for a non-smoking 45–54 year old ranges from $330 per month in Hawaii to $729 per month in North Carolina.[68] However, a bigger problem may be the structure of the program, which is incompatible with existing state high-risk pools.[69] Individuals currently insured through their state risk pool must drop out of that pool, remain uninsured for six months, then join the federal pool. It's not surprising that that has not been a popular option.

While the ban on medical underwriting may make health insurance more available and affordable for those with preexisting conditions and reduce premiums for older and sicker individuals, it will increase premiums for younger and healthier individuals. The RAND Corporation recently conducted a study for

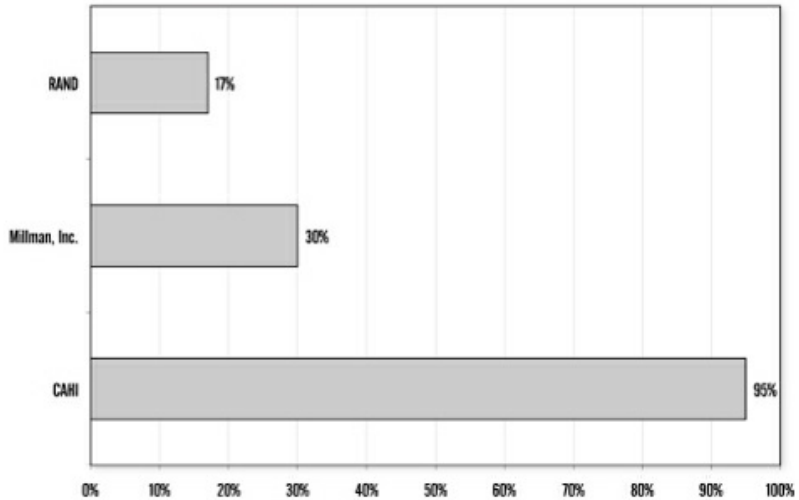
the Associated Press concluding that premiums for the young would rise about 17 percent, roughly $500 per year, as a result of the new law.[70] Other studies suggest that the increase could be much higher. For example, a study by the independent actuarial firm Millman, Inc., concluded that premiums for young men could increase by 10 to as much as 30 percent.[71] The Council for Affordable Health Insurance suggests that premiums for some individuals could increase by 75 to 95 percent in states that do not now have guaranteed issue or community rating requirements (see Figure 2).[72]

Moreover, the ban may not be as effective as proponents hope in making insurance available to those with preexisting conditions. Insurance companies have a variety of mechanisms for evading such restrictions. A simple example is for insurers to focus their advertising on young healthy people, or they can locate their offices on the top floor of a building with no elevator or provide free health club memberships while failing to include any oncologists in their network.

Even the ban on excluding preexisting conditions for children has already had unintended consequences. Several large insurers have stopped offering "child only" insurance plans, thereby depriving thousands of parents of a low-cost insurance option.[73]

In a similar vein, the law also bans "rescissions," or the practice of insurers dropping coverage for individuals who become sick.[74] Under existing practices, insurers sometimes retroactively review an individual's initial insurance application and cancel the policy if the application is found to be inaccurate.[75] Because insurers would undertake such a review only when individuals submitted large claims (and were therefore sick) and the grounds for rescission often appeared to be very minor discrepancies, the practice was widely condemned by the bill's proponents. Under the legislation, insurers could cancel coverage only in cases of fraud or intentional misrepresentation of material fact. While likely to be very popular, this provision may have little practical impact. According to a congressional report, there are actually fewer than 5,000 rescissions per year, and at least some of those were cases of actual fraud where cancellations would still be allowed under this legislation.[76]

Figure 2
Possible Premium Increases for Young Workers Under PPACA



Source: RAND and Millman studies cited in Carla Johnson, "Health Premiums Could Rise 17 Percent for Young Adults," Associated Press, March 29, 2010; and Brian McManus, "Universal Coverage + Guaranteed Issue + Modified Community Rating = 95% Rate Increase," Council for Affordable Health Insurance, August 2009.

A second new insurance regulation would prohibit insurers from imposing lifetime limits on benefit payouts.[77] Although popular, this provision is also likely to have less impact than most people believe. Roughly 40 percent of insured Americans already had policies with no lifetime caps. For those policies that did have a cap on lifetime benefits, that cap was usually somewhere between $2.5 and 5 million, with many running as high as $8 million, amounts that very few people ever reached.[78] Still, some individuals with chronic or catastrophic conditions will undoubtedly benefit from this provision, although there are no solid estimates on how many. Removing lifetime caps will most likely increase the cost of reinsuring policies, leading ultimately to higher premiums, but most insurers predict the increase will be modest.[79]

This regulation, however, may have a much bigger impact on more than one million part-time, seasonal, and low-wage workers who currently take advantage of low-cost, limited benefit plans. Those plans, known in the industry as "mini-med" plans, have inexpensive premiums because they can, among other things, restrict the number of covered doctor visits or impose a maximum on insurance payouts in a year. They are particularly popular with low-wage workers in the restaurant and retail industries. The prohibition on lifetime caps could all but eliminate these plans, meaning that as many as a million workers could lose the coverage they have now. Some could be forced into Medicaid, while others would be forced to purchase much more expensive insurance than they have today.[80]

In fact, the administration has already been forced to issue more than 728 waivers as of February 2011, allowing some employers to continue offering mini-med plans.[81] These include large employers

such as McDonald's, which had threatened to drop coverage for most of its workforce in the absence of an exemption.[82] Several unions, including at least three locals of the Service Employees International union, 17 Teamsters chapters, 28 affiliates of the United Food and Commercial Workers Union, several locals of the Communications Workers of America, and chapters of the American Federation of Teachers have received waivers as well.[83] However, at least 50 companies have had their requests for waivers denied. (The administration will not divulge the names of those companies.)[84]

The law also places limits on deductibles. Employer plans may not have an annual deductible higher than $2,000. Family policies are limited to deductibles of $4,000 or less.[85] There is an exception, however, for individuals under the age of 30, who will be allowed to purchase a catastrophic policy with a deductible of $4,000 for an individual, $8,000 for a family.[86]

In addition, the law requires insurers to maintain a medical loss-ration (that is the ratio of benefits paid to premiums collected) of at least 85 percent for large groups and 80 percent for small groups and individuals.[87] Insurance companies that pay out benefits less than the required proportion of the premium, must rebate the difference to policy holders on an annual basis beginning in 2011.[88] This requirement is intended to force insurers to become more efficient by reducing the amount of premiums that can be used for administrative expenses (and insurer profits).[89] However, while there is undoubtedly waste in insurance overhead, such a rigid cap may create a number of unintended consequences. Insurance overhead includes many useful services and programs. These include efforts to monitor patient care to ensure that those with chronic medical conditions are getting appropriate care, exactly the type of program that President Obama says he wants to encourage, and efforts to combat fraud and abuse. Those programs can actually reduce overall costs and result in lower insurance premiums. Forcing insurers to abandon those efforts could have the perverse effect of increasing costs to consumers.[90]

Finally, the legislation would also allow parents to keep their dependent children on their policies until the child reaches age 27. This too is generally considered a popular aspect of the new law, but it does come with a price tag. HHS estimates that every dependent added to a policy will increase premiums by $3,380 per year.[91] And employers have indicated that they are reluctant to add dependent children to the coverage they provide, even if insurers offer it, meaning parents will have to pay most or all of the additional cost.[92]

The new insurance regulations may result in many insurers withdrawing from their less profitable markets, leaving many consumers with few insurance choices. Already, Principal Financial has stopped selling health insurance, which has resulted in coverage being dropped for some 840,000 people.[93] And Aetna has announced that it is pulling out of the individual market in Colorado.[94] Perversely, the Patient Protection and Affordable Care Act could reduce competition in the insurance market.

Overall, most of the law's insurance reforms have been among the more politically popular aspects of the new law, but they are likely to have only a minor impact and may, indeed, have a number of unintended consequences.

Subsidies

The number one reason that people give for not purchasing insurance is that they cannot afford it.[95] Therefore, the legislation's principal mechanism for expanding coverage (aside from the individual and employer mandates) is to pay for it, either through government-run programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) or through subsidizing the purchase of private health insurance.

Starting this year, states are required to expand their Medicaid programs to cover all U.S. citizens with incomes below 133 percent of the poverty level ($14,404 for an individual; $29,327 for a family of four; higher in Alaska, Hawaii, and the District of Columbia).[96] Previously, only pregnant women and children under age six were covered to 133 percent of the poverty level. Children 6–18 were required to be covered up to 100 percent of the poverty level, though 18 states covered children from families with higher incomes. In fact a few states covered pregnant women and children under age 1 up to 185 percent of the poverty level.[97] Most other low-income children were covered through SCHIP (up to 250 percent of poverty).

Thus, the primary result of the law's Medicaid expansion would be to extend coverage to the parents in low-income families and to childless adults. In particular, single, childless men will now be eligible for Medicaid. This raises potentially serious concerns. Low-income, childless, adult men in particular are a high-risk, high-cost health care population. That means costs may run higher than expected, a problem that may be exacerbated by adverse selection within that population.

Tennessee's experience with TennCare provides a cautionary tale. In 1994, Tennessee expanded Medicaid eligibility to uninsured citizens who weren't able to get health insurance through their employers or existing government programs and to citizens who were uninsurable because of pre-existing conditions. Over the next 10 years, Medicaid costs in the other 49 states rose by 71 percent. In Tennessee they increased by an overwhelming 149 percent.[98] Despite this massive increase in spending, health outcomes did not improve. Even the state's Democratic governor Phil Bredesen called the program "a disaster."[99] Similar problems with the Patient Protection and Affordable Care Act's Medicaid expansion could dramatically drive up costs for both the federal and state governments.

Initially, the federal government will pay 100 percent of the cost for new enrollees. However, beginning in 2017, states will be required to pick up a portion of the cost. The impact on state budgets would very dramatically. Those states like California, whose eligibility standards already are close to the new federal requirements and are therefore unlikely to see large enrollment increases, will see only modest cost increases. In the case of California, Medicaid costs would go up only about 4.5 percentage points higher than they would have risen in the absence of PPACA's requirements, or about $11.7 billion between 2014 and 2023. But other states would see far bigger increases. Texas, for example, would receive the largest percentage hit, being forced to absorb an increase 20 percentage points higher than it otherwise would have, a cost of $30.5 billion from 2014 to 2023. New York would see the largest cost increase in dollars, $65.5 billion over those 10 years, largely because of its already high cost per enrollee.[100] It is important to remember that these are costs over and above already rising Medicaid costs.

Arizona has already requested a waiver exempting the state's Medicaid program from the law's "maintenance of effort" requirement. That provision prohibits states from changing their current

eligibility levels, but Arizona is seeking to drop 280,000 people from the program in order to help close the state's budget deficit. Several other states may follow suit.[101]

SCHIP would be continued until September 30, 2019. Between 2014 and 2019, the federal government will increase its contribution to the program, raising the federal match rate by 23 percentage points (subject to a 100 percent cap).[102] States must maintain their current income eligibility levels for the program.[103]

Individuals with incomes too high to qualify for Medicaid but below 400 percent of the poverty level ($88,000 per year) will be eligible for subsidies to assist their purchase of private health insurance. These subsidies, which will be provided in the form of refundable tax credits, are expected to total more than $457 billion between 2014, when individuals are first eligible for the payments, and 2020.[104]

There are actually two separate credits designed to work more or less in conjunction with one another. The first is a "premium tax credit."[105] The credit is calculated on a sliding scale according to income in such a way as to limit the total proportion of income that an individual would have to pay for insurance.[106] Thus, individuals with incomes between 133 and 200 percent of the poverty level will receive a credit covering the cost of premiums up to four percent of their income, while those earning 300–400 percent of the poverty level will receive a credit for costs in excess of 9.5 percent of their income.

The second credit, a "cost-sharing credit" provides a subsidy for a proportion of out-of-pocket costs, such as deductibles and co-payments. Those subsidies are also provided on a sliding income-based scale, so that those with incomes below 150 percent of the poverty level receive a credit that effectively reduces their maximum out-of-pocket costs to 6 percent of a plan's actuarial value, while those with incomes between 250 and 400 percent of the poverty level would, after receiving the credit, have maximum out-of-pocket costs of no more than 30 percent of a plan's actuarial value.

As with many tax credits, the phase-out of these benefits creates a high marginal tax penalty as wages increase. In some cases, workers who increase their wages could actually see their after-tax income decline as the subsidies are reduced. This creates a perverse set of incentives that can act as a "poverty trap" for low-wage workers.[107]

In addition to the individual subsidies, there will also be new government subsidies for some small businesses. Beginning this year, businesses with fewer than 25 employees and average wages below $50,000 are eligible for a tax credit to help offset the cost of providing insurance to their workers.[108] To be eligible, employers must provide insurance to all full-time workers and pay at least 50 percent of the cost of that coverage. The actual amount of the credit depends on the size of the employer and the average worker salary. Between 2011 and 2014, when the exchanges begin operation (see below), employers with 10 or fewer workers and an average wage below $25,000 per year would be eligible for a credit equal to 35 percent of the employer's contribution. For a typical family policy, the credit would be around $2,000. The credit gradually phases out as the size of the company and average wages increase.

Once the exchanges are operational after 2014, businesses with 10 or fewer employees and average wages below $25,000 that purchase their insurance through the exchange will be eligible for a credit of up to 50 percent of the employer's contribution toward a worker's insurance. Again, the credit is phased out as the size of the company and average wages increase. The credit can only be claimed for two years.

In addition, the legislation establishes a $5 billion temporary reinsurance program for employers who

provide health insurance coverage for retirees over age 55 who are not yet eligible for Medicare.[109] The program will reimburse insurers for 80 percent of retiree claims between $15,000 and $90,000.[110] Insurers are required to pass those savings on to employers through lower premiums, though how that will be enforced remains a question.[111]

The law also increases funding for community health centers by $11 billion.[112] Approximately $1.5 billion would be used for the construction of new health centers in inner-city or rural low-income communities, with the remainder designed to subsidize operations for existing centers. Community health centers are expected to treat nearly 40 million patients by 2015, nearly double today's utilization.[113]

All together, this law represents a massive increase in the welfare state, adding millions of Americans to the roll of those dependent, at least to some extent, on government largess. Yet for all the new spending, the Patient Protection and Affordable Care Act falls short of its goal of achieving universal coverage (see below).

The Exchanges

Perhaps the most fundamental reordering of the current insurance market is the creation of "exchanges" in each state. Ezra Klein, one of the bill's most prominent liberal supporters, maintains that that the exchanges are "the most important element in the plan."[114] The exchanges would function as a clearinghouse, a sort of wholesaler or middleman, matching customers with providers and products.

Exchanges would also allow individuals and workers in small companies to take advantage of the economies of scale, both in terms of administration and risk pooling, which are currently enjoyed by large employers. The larger risk pools should theoretically reduce premiums, as would the exchanges' ability to "use market share to bargain down the prices of services."[115]

However, one should be skeptical of claims that the exchange will reduce premiums. In Massachusetts, supporters of the "Connector" claimed that it would reduce premiums for individual insurance policies by 25 to 40 percent.[116] Instead, premiums for policies sold through the Connector have been rising, up 11 percent for the lowest cost plans since the program began.[117]

Beginning in 2014, one or more exchanges would be set up by each state and largely operated according to rules developed by that state. States would also have the option of joining with other states and creating regional exchanges. If a state refuses to create an exchange, the federal government is empowered to set one up within that state.[118] States are given considerable discretion over how the exchanges would operate, but some of the federal requirements are significant.

Exchanges may be either a governmental agency or a private nonprofit entity.[119] And states would have the option of either maintaining separate insurance pools for the individual and small-group markets or of combining them into a single pool.[120] The pools would also include individual or small-group policies sold outside the exchange.[121] Existing plans could not be included in those pools, however.[122]

Initially, only businesses with fewer than 50 employees, uninsured individuals, or the self-employed may purchase insurance through the exchange. Members of Congress and senior congressional staff are also required to purchase their insurance through the exchange.[123] However, beginning in 2017, states have the option of opening the exchange to large employers.[124]

Insurance plans offered for sale within the exchanges would be grouped into four categories based on actuarial value: bronze, the lowest cost plans, providing 60 percent of the actuarial value of a standard plan as defined by the secretary of HHS; silver, providing 70 percent of the actuarial value; gold, providing 80 percent of the actuarial value; and platinum, providing 90 percent of the actuarial value.[125] In addition, exchanges may offer a special catastrophic plan to individuals who are under age 30 or who have incomes low enough to exempt them from the individual mandate.[126]

For all categories of plans, out-of-pocket expenses would be limited according to the income of the purchaser. For individuals and families with incomes above 400 percent of the poverty level, out-of-pocket expenses would be limited to $5,950 for individuals and $11,900 for families, approximately the current limits for a health savings account (HSA). Those limits would also apply to those who purchase the catastrophic plan. Individuals with incomes between 300 and 400 percent of the poverty level would have out-of-pocket expenses limited to two-thirds of the HSA limits ($3,987/individual and $7,973/family); 200 to 300 percent of poverty would have out-of-pocket expenses limited to one-half of the HSA limits ($2,975/individual and $5,950/family); and those with incomes below 200 percent of

poverty would have out-of-pocket expenses limited to one-third of the HSA limits ($1,983 per individual and $3,967 per family).[127] The reductions in out-of-pocket expenses would occur within the plan in such a way as to not change their overall actuarial value.

CBO estimates that premiums for bronze plans would probably average between $4,500 and $5,000 for an individual and between $12,000 and $12,500 for family policies.[128] The more inclusive policies would have correspondingly higher premiums.

Plans offered through the exchange must meet the federal requirements for minimum benefits. State mandated benefits are not preempted, meaning that states may continue to impose additional mandates (though states must pay for the cost of the additional mandates in subsidized policies.)[129]

In addition to the state insurance plans, the legislation authorizes the federal Office of Personnel Management to contract with private insurers to ensure that each state exchange offers at least two multi-state insurance plans. These multi-state plans are supposed to resemble the Federal Employee Health Benefit Plan, but will operate separately from the FEHBP and will have a separate risk pool.[130] The multi-state plans must meet the licensing and regulatory requirements of each state in which they are offered.[131] At least one plan must not include abortion coverage, and one must be offered by a nonprofit insurer. The legislation also provides start-up funds for states to establish health insurance cooperatives, which may participate in the state's exchange.[132]

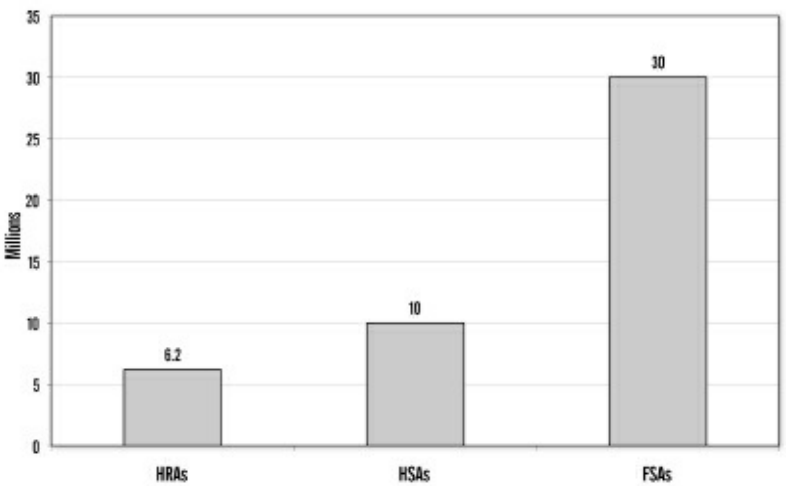
Exactly how significant the exchanges will prove to be remains to be seen. At the very least exchanges will change the way individuals and small businesses purchase health insurance. However, if expanded to include large businesses or their employees, exchanges represent a potential framework for a far more extensive government intervention in the insurance market.

Impact on Consumer Directed Health Plans

The health care bill reverses much of the progress in recent years toward more consumer-directed health care.

Consumer-directed health care is a broad term used to describe a variety of insurance arrangements, including health savings accounts, flexible spending accounts (FSAs), and health reimbursement accounts (HRAs), based on the concept that patients ("consumers") should have more control over the utilization of their health care dollars.[133] The goal is to simultaneously control costs and improve quality by creating incentives for consumers to make judgments based on price and value; in short to purchase health care the way we buy other goods and services.[134] More than 46 million workers currently participate in consumer-directed health plans (see Figure 3).

Figure 3
Workers with Consumer-Directed Health Plans



Source: Source for HRAs: Employer Benefit Research Institute, "What Do We Know About Enrollment in Consumer-Driven Health Plans?" vol. 30, no. 12, December 2009.

President Obama has always been hostile to consumer-directed health care. In his book, *The Audacity of Hope,* for example, he dismisses health savings accounts as being based on the idea that people have "an irrational desire to purchase more than they need."[135] That hostility is reflected in the final legislative language. Notably, the legislation puts substantial new restrictions on such consumer-oriented innovations as HSAs and FSAs.

Roughly 10 million Americans currently have health savings accounts.[136] Nothing in the legislation directly prohibits them. However, the law does add several new restrictions. For example, the tax penalty for HSA withdrawals that are not used for qualified medical expenses will be doubled from the current 10 percent to 20 percent, starting this year.[137] In addition, the definition of "qualified medical

expense" has been made more restrictive. Among other things, over-the-counter medications are no longer considered a "qualified medical expense."[138]

Of greater concern is the potential impact of the law on high-deductible insurance plans. Current law requires that an HSA be accompanied by such a policy. However, many of the insurance regulations discussed above raise questions about whether or not high-deductible plans will remain viable.

For example, the lowest permissible actuarial value for an insurance plan (the bronze plan) would be 60 percent.[139] It is unclear whether a plan's actuarial value would include employer or individual contributions made to the individual's HSA. That decision is left to the discretion of the Secretary of HHS.[140] Whether or not HSA contributions are included can make as much as a 10–20 percent difference in a plan's actuarial value. As a result, if the contributions are not included, many, if not most, high-deductible plans will not qualify. The fate of HSAs is therefore dependent on a regulatory ruling by the secretary of HHS in an administration avowedly hostile to HSAs.

The 80 percent minimum medical loss ratio required of insurance plans could also prove problematic for HSAs. Again, how this provision will work in practice will depend on rules to be developed by the secretary of HHS. But, the legislation makes no distinction between traditional and high-deductible insurance plans. Few if any current high-deductible policies meet this requirement.

In addition, there is reason to wonder whether high-deductible insurance plans will likely be able to meet the law's requirement that insurance plans provide first-dollar coverage for all "preventive services."[141] Currently, most high-deductible plans *do* cover preventive services as defined by the IRS. However, as discussed above, under the Patient Protection and Affordable Care Act, preventive services will be defined by the U.S. Preventative Services Task Force and, once again, the secretary of HHS.[142] If the new definition of preventive services is more expansive than the IRS definition, as seems likely, most current high-deductible plans will once again be out of compliance.

Finally, insurers must make certain that their high-deductible plans are designed so as to comply with the law's limits on out-of-pocket expenses.

In theory, a high-deductible plan designed to work with health savings accounts could meet all the new requirements. But industry sources warn that a plan designed to those specifications would offer few if any advantages over traditional insurance and would not be competitive in today's markets. As a result, insurers may stop offering highdeductible policies.[143] And since the rules for HSAs require that they be accompanied by a high-deductible plan, the result would be to end HSAs.

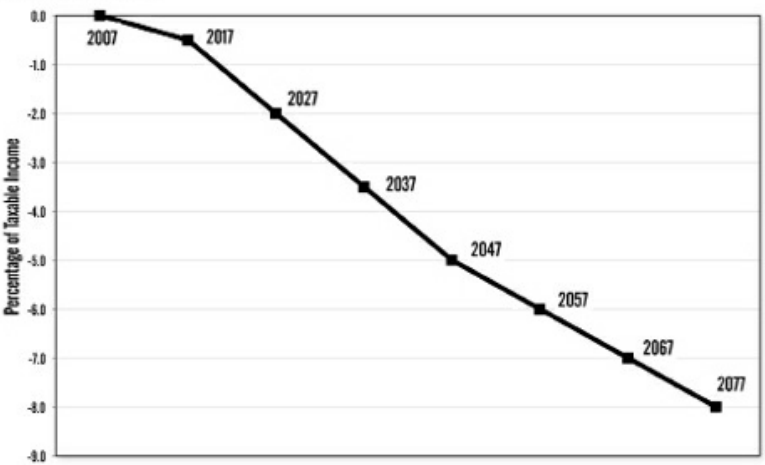
The law also includes new limits on FSAs, which are currently used by as many as 30 million Americans.[144] Starting this year, the maximum tax-exempt contribution to an FSA was cut in half, from $5,000 annually to just $2,500.[145] The new definition of "qualified medical expense" will also be applied to FSAs, meaning that as with HSAs, FSAs can no longer be used to pay for over-the-counter medications.[146]

The impact of these provisions extends well beyond their impact on workers who currently take advantage of such innovative products as HSAs and FSAs. More significantly, the assault on these products represents a fundamental philosophical shift in the health care debate. Through this legislation, the president and democrats in Congress reject consumer-oriented health care reform in clear favor of government control.

Medicare Cuts

Despite denials from the Obama administration and Democrats in Congress, the legislation *does* cut Medicare—and it should. Medicare is facing unfunded liabilities of $50 to $100 trillion depending on the accounting measure used, making future benefit cuts both inevitable and desirable.[147] Of course it would have been better if the savings from any cuts had been used to reduce the program's future obligations rather than to fund a brand new entitlement program. And, clearly, not all Medicare cuts are created equal.[148] Still, that should not obscure the necessity for dealing with Medicare's looming financial crisis (see Figure 4).

Figure 4
Medicare Cash Flow



Source: 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Figure II.E2.

The legislation anticipates a *net* reduction in Medicare spending of $416.5 billion over 10 years.[149] Total cuts would actually amount to slightly more than $459 billion, but since the bill would also increase spending under the Medicare Part D prescription drug program by $42.6 billion, the actual savings would be somewhat less.[150]

The key word here is "anticipates," because several of those cuts are speculative at best. For example, the bill anticipates a 23 percent reduction in Medicare fee-for-service reimbursement payments to providers.[151] But Medicare has been slated to make reductions to those payments since 2003, yet each year Congress has voted to defer the cuts. There is no reason to believe that Congress is now more likely to follow through on such cuts. In fact, in a perfect exercise in cynicism, the House has already passed separate legislation to repeal them.

More likely, but still problematic, are $136 billion in cuts to the Medicare Advantage program. Currently, some 10.2 million seniors, 22 percent of all Medicare recipients, are enrolled in the Medicare Advantage program, which allows Medicare recipients to receive their coverage through private insurance

plans.[152] The bill would change the way payments are calculated for Medicare Advantage. Currently Medicare Advantage programs receive payments that average 14 percent more than traditional fee-for-service Medicare,[153] something that Democrats have derided as wasteful.[154] However, the program also offers benefits not included in traditional Medicare, including preventive-care services, coordinated care for chronic conditions, routine physical examinations, additional hospitalization, skilled nursing facility stays, routine eye and hearing examinations, glasses and hearing aids, and more extensive prescription drug coverage than offered under Medicare Part D.[155]

The law imposes a new competitive bidding model on the Medicare Advantage program that will effectively end the 14 percent overpayment.[156] The change will be phased in over three years beginning in 2012. In response, many insurers are expected to stop participating in the program, while others will increase the premiums they charge seniors. Medicare's chief actuary estimates more than 7 million seniors could be forced out of their current insurance plan and back into traditional Medicare.[157] The Congressional Budget Office predicts these cuts "could lead many plans to limit the benefits they offer, raise their premiums, or withdraw from the program." Already, Harvard Pilgrim Health Care has dropped its Medicare Advantage program, forcing 22,000 seniors in Massachusetts, New Hampshire, and Maine to seek other coverage.[158]

Particularly hard hit would be minorities and seniors living in underserved areas. For example, nearly 40 percent of African-American and 54 percent of Latino seniors participate in Medicare Advantage, in part because lower-income seniors see it as a low-cost alternative to Medigap insurance for benefits not included under traditional Medicare.[159] Interestingly, the law exempts three counties in south Florida from the Medicare Advantage cuts.

In addition, a new "productivity adjustment" would be applied to reimbursements to hospitals, ambulatory service centers, skilled nursing facilities, hospice centers, clinical laboratories, and other providers, resulting in an estimated savings of $196 billion over 10 years.[160] There would also be $3 billion in cutbacks in reimbursement for services that the government believes are over-used, such as diagnostic screening and imaging services. And, beginning next year, the "utilization assumption" used to determine Medicare reimbursement rates for high-cost imaging equipment will be increased from 50 to 75 percent, effectively reducing reimbursement for many services.[161] This change is expected to reduce total imaging expenditures by as much as $2.3 billion over 10 years.[162] Other Medicare cuts include freezing reimbursement rates for home health care and inpatient rehabilitative services and $1 billion in cuts to physician-owned hospitals.[163]

And, for the first time, the secretary of HHS would be permitted to use comparative effectiveness research in making reimbursement decisions. The use of comparative effectiveness research has been extremely controversial throughout this debate. On the one hand, many health care experts believe that much of U.S. health care spending is wasteful or unnecessary.[164] Medicare spending varies wildly from region to region, without any evidence that the variation is reflected in the health of patients or procedural outcomes.[165] A case could certainly be made that taxpayers should not have to subsidize health care that has not proven effective, nor can Medicare and Medicaid pay for *every* possible treatment regardless of cost-effectiveness.

On the other hand, the use of such research in determining what procedures are reimbursed could fundamentally alter the way medicine is practiced and could interpose government bureaucracies in

determining how patients should be treated. Moreover, there are significant questions about whether comparative effectiveness can provide a truly effective basis for determining reimbursement policy.[166] In fact, it could be argued that Medicare is particularly unsuited for such a policy.[167]

Many others worry that the use of comparative effectiveness research for government programs such as Medicare sets the stage for its extension to private medical practice. There is no doubt that national health care systems in other countries use comparative effectiveness research as the basis for rationing.[168] Some of President Obama's health care advisers, such as former senator Tom Daschle have recommended that it be extended to private insurance plans.[169] And the president has named as the new director of the Center for Medicare and Medicaid Services Dr. Donald Berwick, who is an outspoken admirer of the British National Health Service, and particularly its National Institute for Clinical Effectiveness, which makes such cost-effectiveness decisions.[170]

Although some of the cuts described above are problematic, many other proposed cuts in this bill are actually steps in the right direction. For example, the law reduces Medicare Part D subsidies by $10.7 billion for high-income recipients. This means that individuals with incomes over $85,000 and couples with incomes over $170,000 will no longer have their prescription drug purchases subsidized by taxpayers.

In addition, the law will eliminate part of a Bush-era subsidy for businesses that includes prescription drug coverage in retiree health plans.[171] Since 2006, as part of the Medicare prescription drug program, companies have received a federal subsidy for 28 percent (up to a cap of $1,330 per retiree) of the cost of providing prescription drugs to retired workers.[172] Proponents justified the subsidy on the grounds that companies would otherwise dump workers into Medicare, raising the cost of the Part D, prescription drug plan. However, not only do businesses receive the subsidy, they were also allowed to deduct the subsidy from their taxes, receiving what was in effect a second subsidy. In fact, UC Berkeley Economist Brad DeLong estimates that by making the original subsidy tax free, the federal government actually ends up subsidizing 63 percent of the cost of retiree drug benefits for some companies.[173] The health care legislation retains the subsidy but eliminates the tax break beginning in 2013.[174]

This change received a great deal of press attention when it forced several companies, such as Caterpillar, Lockheed Martin, and AT&T, to take charges against earnings on their Securities and Exchange Commission (SEC) filings. Altogether those charges could total more than $4.5 billion, reflecting future tax costs to those companies.[175]

Democrats reacted to the accounting changes with outrage and threatened hearings on the issue. However, the charges appear to be required under SEC rules, and Democrats later backed down.[176] On the other side, Republicans attempted to score points by warning that the change could reduce economic growth and reduce employment. They have a point in that the money that the companies will now have to pay in taxes is money that cannot be used to expand operations or pay workers. However, not all tax breaks are created equal. This one, in particular, appears to be a highly questionable form of corporate welfare.

Finally, the new law establishes a new Independent Payment Advisory Board, which would have the power to recommend changes to the procedures that Medicare will cover, and the criteria to determine when those services would be covered, provided its recommendations "improve the quality of care" or "improve the efficiency of the Medicare program's operation."[177] Starting in 2013, if Medicare spending

is projected to grow faster than the combined average rate of general inflation and medical inflation (averaged over five years), IPAB must submit recommendations bringing spending back in line with that target. Beginning in 2018, the annual spending target becomes the rate of GDP growth plus 1 percent. Once IPAB makes its recommendations, Congress would have 30 days to vote to overrule them. If Congress does not act, the secretary of HHS would have the authority to implement those recommendations unilaterally.

Given Congress's proven inability to restrain the growth in Medicare spending, an independent commission, and a requirement that Congress vote on the issue, could prove beneficial. Unfortunately, IPAB is prohibited from making any recommendation that would "ration care," increase revenues, or change benefits, eligibility, or Medicare beneficiary cost-sharing (including Medicare premiums).[178] That leaves IPAB with few options beyond reductions in provider payments. Hospitals and hospices would be exempt from any cuts until 2020.[179] Thus, most of the cuts would initially fall on physicians. With Medicare already underreimbursing providers, further such cuts would have severe consequences, including driving physicians from the program and increased cost-shifting to private insurance. Eventually hospitals will also see significant reimbursement cuts. The Centers for Medicare and Medicaid Services estimates that this could cause about 15 percent of hospitals, nursing homes, and home health agencies to close.[180]

Given the opposition such service cutbacks are likely to engender, it is quite possible that IPAB will end up as neutered as previous attempts to impose fiscal discipline on government health care programs.[181]

On the other side of the ledger, the legislation *increases* subsidies under the Medicare Part D prescription drug program. A Medicare recipient enrolled in the standard version of the prescription drug plan currently pays a deductible of $310. Thereafter, Medicare pays 75 percent of costs between $310 and $2,800 in drug spending. The patient will pay the remaining 25 percent of these costs. The patient then encounters the notorious "doughnut hole." For drug costs above $2,800 but below $4,450 in out-of-pocket spending, the patient must pay 100 percent of the costs. After that, the prescription drug plan kicks in again and pays 95 percent of costs above $4,450.[182]

The Patient Protection and Affordable Care Act ever so slowly closes this donut hole. In June, seniors enrolled in the program who have drug costs in excess of $2,700 began receiving a $250 check as a partial rebate of their drug costs.[183] Starting in 2011, a slow reduction in the amount that seniors have to pay out-of-pocket within the donut hole begins, eventually reducing that amount from the current 100 percent to 25 percent by 2020. Part of the cost of filling the donut hole will be borne by pharmaceutical companies, which will be required to provide a 50 percent discount on the price of brand-name drugs. This provision's cost to drug companies has been estimated at approximately $42.6 billion.[184] The remaining 25 percent reduction in out-of-pocket costs will come from federal subsidies. For generic drugs, the entire out-of-pocket cost reduction is through subsidies.

In considering any of the cuts discussed above, there are three things to keep in mind. First, cuts in Medicare are both necessary and inevitable. However, there will almost certainly be an impact on the quality and availability of care. Second, savings from the cuts will not be used to deal with Medicare's looming budget shortfalls, but rather to finance the new entitlements under the legislation. Democrats have pointed out that changes under the legislation, combined with new Medicare tax revenue, would extend the life of the Medicare Trust Fund by as much as 12 years. While technically true, this

represents a very misleading double counting of the savings and revenue.

And third, there is ample reason to be skeptical about whether the cuts will ever actually occur. Medicare's actuary warns that the proposed cuts "may be unrealistic."[185] The CBO itself cautions that "it is unclear whether such a reduction in the growth rate of spending could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or through reductions in access to care or the quality of care."[186]

Congress's record in this regard is decidedly mixed. As the bill's proponents point out, it is untrue to say that Congress has *never* cut Medicare spending. At least 11 times since 1980, Congress has passed Medicare cuts that actually did take place.[187] Most were modest reductions in payments to certain types of providers, reductions in "disproportionate share" (DSH) payments to hospitals, or small increases in cost-sharing by seniors, or in Medicare premiums. At least in limited circumstances, Congress *has* been able to trim Medicare.[188]

However, Medicare is still facing a $50–100 trillion funding gap, and Congress has proven itself unable to take the steps necessary to deal with this long-term gap. Some of the most significant cuts that have been proposed have later been reduced or repealed. For instance, in 1997, as part of the Balanced Budget Act, Congress established the "sustainable growth rate" (SGR), designed to hold annual increases in Medicare reimbursements to a manageable growth rate. But in 2003, 2005, 2007, 2008, and this year (reaching back to 2009), Congress has overturned provider payment cuts that would have been required by the SGR. A bill before Congress—the infamous "doc fix" (see below)—would permanently eliminate future SGR mandated cuts.[189]

In some ways the legislation is a victim of Medicare itself. Because the legislation does nothing to reform the program's unsustainable structure, Congress is caught between two unpalatable choices. If it makes the cuts called for under the legislation, it risks, according to the CBO "reductions in access to care or the quality of care."[190] But if it fails to make those cuts, then the legislation will add a huge new cost to an already exploding debt.

That is a recipe for legislative paralysis.

Taxes

The Patient Protection and Affordable Care Act imposes more than $569 billion in new or increased taxes over the first 10 years.[191] These include

- **Tax on "Cadillac" Insurance Plans**. One of the most heavily debated new taxes in the health care bill was the tax on high-cost insurance plans. Beginning in 2018, a 40 percent excise tax will be imposed on employer-provided insurance plans with an actuarial value in excess of $10,200 for an individual or $27,500 for families. (The threshold is increased to $11,850 for individuals and $30,950 for families whose head of household is over the age of 55 or engaged in high-risk professions such as police, firefighters, or miners.) The tax falls on the value of the plan over the threshold and is paid by the insurer, or the employer if self-insured.[192] The benefit value of employer-sponsored coverage would include the value of contributions to employees' FSAs, HRAs, and HSAs. It is estimated that 12 percent of workers will initially have policies that are subject to the tax.[193] However, the tax is indexed to inflation rather than the faster-rising medical inflation, which drives insurance premiums. As a result, more and more workers will eventually find their insurance plans falling subject to the tax. In fact, a study for the benefits consulting firm Towers Watson concludes, "Assuming even reasonable annual plan cost increases to project 2018 costs, many of today's average plans will easily exceed the cost ceilings directed at today's 'gold-plated' plans."[194]
- **Payroll tax hike**. The Medicare payroll tax will be increased from 2.9 percent today to 3.8 percent for individuals with incomes over $200,000 for a single individual or $250,000 for a couple.[195] The payroll tax hike would mean that in eight states, workers would face marginal tax rates in excess of 50 percent (see Figure 5).[196]
- **Tax on Investment Income**. Starting in 2013, the 3.8 percent Medicare tax will be applied to capital gains and interest and dividend income if an individual's total gross income exceeds $200,000 or a couple's income exceeds $250,000.[197] The tax would only apply to the amount of income in excess of those limits, but would be based on total income. Thus, if a couple had $200,000 in wage income and $100,000 in capital gains, $50,000 would be taxed. Moreover, the definition of capital gains includes capital gains from the sale of real estate, meaning that an individual who sold his or her home for a profit of $200,000 or more would be subject to the tax. Given the current weakness in the housing market, this would seem to create a particularly pernicious outcome. Numerous studies have shown that high capital gains taxes discourage investment, resulting in lower economic growth, fewer jobs, and reduced wages.
- **Limit on Itemized Deductions.** Beginning in 2013, the threshold at which taxpayers can deduct medical expenses will be raised from the current 7.5 percent of adjusted gross income to a new floor of 10 percent.[198] The increased threshold would be postponed until 2016 for taxpayers age 65 or older.[199]
- **Tax on Prescription Drugs**. Starting this year, the legislation imposes a new tax on brand-name prescription drugs designed to raise a specific amount of money annually. Rather than imposing a specific tax amount, the legislation identifies a specific amount of revenue to be raised, ranging from $2.5 billion in 2011 to $4.2 billion in 2018, before leveling off at $2.8 billion thereafter, and

assigns a proportion of that amount to pharmaceutical manufacturers according to a formula based on the company's aggregate revenue from branded prescription drugs.[200] The structure of this tax almost guarantees that it will be passed along to consumers through higher prices.

- **Tax on Medical Devices**. A 2.3 percent federal sales tax is imposed on medical devices, which includes everything from CT scanners to surgical scissors.[201] The secretary of HHS has the authority to waive this tax for items that are "sold at retail for use by the general public."[202] However, almost everything used by doctors, hospitals, or clinics would be taxed. The tax would also fall on laboratory tests. The government's chief actuary has concluded that this tax, as those on pharmaceutical manufacturers and insurers "would generally be passed through to health consumers."[203] In fact, a study by the Republican staff of the Joint Economic Committee estimates that the pass-through could cost the typical family of four with job-based coverage an additional $1,000 a year in higher premiums.[204]
- **Additional Taxes on Insurers**. Similar to the tax on pharmaceutical companies, the legislation imposes a tax on health insurers based on their market share.[205] The total assessment will begin at $8 billion and rise to $14.3 billion by 2018. Thereafter the total assessment will increase by the same percentage as premium growth for the previous year.[206] The tax will be allocated according to a formula based on both the total premiums collected by an insurer and the insurer's administrative costs.[207] However, some insurers in Michigan and Nebraska received a special exemption.[208] This tax is also expected to be passed through to consumers through higher premiums. (Interestingly, AARP is exempt from this tax on sales of its highly profitable Medigap policies.)[209]
- **Tax on Tanning Beds**. The legislation imposes a 5 percent tax on tanning salons.[210] While tanning may be seen as a luxury or frivolous expenditure, it is actually a recommended treatment for psoriasis and certain other medical conditions. The law makes no distinction between tanning for medical or cosmetic reasons. This tax went into effect July 1, 2010.

The combination of taxes and subsidies in this law results in a substantial redistribution of income. The new law will cost families earning more than $348,000 per year, (top 1 percent of incomes) an additional $52,000 per year on average in new taxes and reduced benefits.[211] In contrast, those earning $18,000–$55,000 per year will see a net income increase of roughly $2,000 per family.[212]

Figure 5
States with Marginal Tax Rates over 50 percent after PPACA

Source: Tax Foundation, Private Report.

The new law contains other tax-related provisions that will add significantly to business costs. For example, the legislation requires that businesses provide a 1099 form to every vendor with whom they do more than $600 worth of business over the course of a year.[213] This provision has proven so unpopular that there is strong bipartisan support for repeal. In fact, on February 2, 2011, the Senate voted 81 to 17 to repeal this provision. The House will likely follow suit.[214]

For both individual Americans and businesses large and small, the Patient Protection and Affordable Care Act is a tax and regulatory nightmare.

The CLASS Act

The health care legislation establishes a new national long-term care program, called the Community Living Assistance and Support Act (CLASS Act), designed to help seniors and the disabled pay for such services as an in-home caretaker or adult day services.[215]

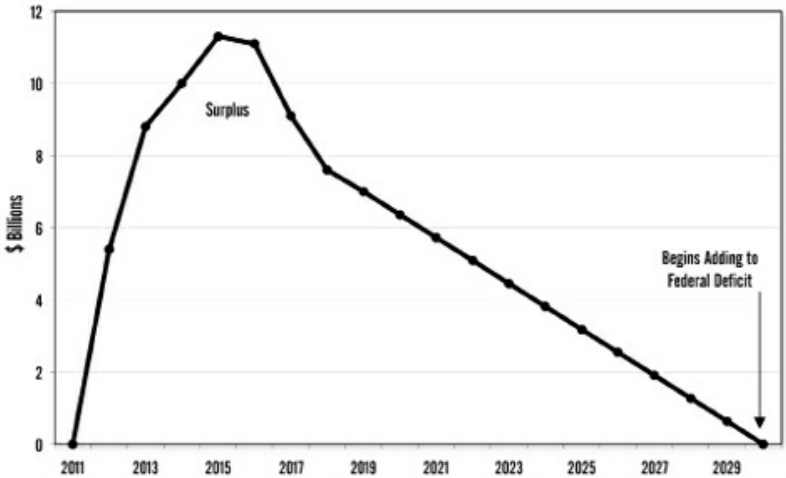
The CLASS Act is theoretically designed to be self-financed. Workers would be automatically enrolled in the program, but would have the right to opt out. Those who participate will pay a monthly premium that has not yet been determined.[216] However, the CBO estimates that will be roughly $123 per month for the average worker.[217] Other estimates suggest that the premiums could be much higher, perhaps $180–$240 per month.[218] Workers must contribute to the program for at least five years before they become eligible for benefits.[219] (Individuals age 55 or over at the time the program is fully implemented must not only contribute for five years, but must be employed for at least three years following the program's implementation date.)[220] There is no health underwriting of participation or premiums.

The actual benefits to be provided under the program are among the many details that remain to be determined but will not be "less than an average of $50 daily adjusted for inflation."[221] Some estimates suggest that benefits will average roughly $75 per day, or slightly more than $27,000 per year.[222] Benefits will be paid directly to the individual, not to the service provider, based on the degree of an individual's impairment, and can be used to purchase home care and other community-based long-term care assistance, as well as certain nonmedical services.[223] Benefits may be paid daily, weekly, monthly, or deferred and rolled over from month to month at the beneficiary's discretion.[224] There is no lifetime limit to benefits.

Eligibility for benefits will be based on the same criteria currently used to qualify for federal-tax-qualified long-term-care insurance benefits. That is, a person must be unable to perform at least two "activities of daily living" from a list of six such activities, or need substantial supervision due to cognitive impairment.[225] The secretary of HHS may also develop different or additional eligibility requirements.[226]

During the law's first five years it will collect premiums, but not pay benefits. As a result, over the first 10 years, the period conveniently included in the budget scoring window, the CLASS Act will run a surplus, collecting more in premiums than it pays out in benefits (see Figure 6).

Figure 6
Effect of CLASS Act on Federal Budget



Source: Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010, and Letter from Douglas Elmendorf, director, Congressional Budget Office, to Sen. Tom Harkin, November 25, 2009.

Those premiums will accrue in a CLASS Act Trust Fund, similar to the Social Security and Medicare trust funds. Using trust fund accounting measures, the premium payments will reduce the federal deficit over that period by roughly $70.2 billion.[227] However, thereafter, the CLASS Act will begin to pay out benefits faster than it brings in revenue. Although this time period falls outside the formal 10-year scoring window, CBO warns, "In the decade following 2029, the CLASS program would begin to increase budget deficits . . . by amounts on the order of tens of billions of dollars for each 10-year period."[228] CBO goes on to warn, "We have grave concerns that the real effect of [the CLASS Act] would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues."

Trust fund accounting, of course, is little more than budgetary sleight of hand. Because the government is structurally incapable of saving such surpluses, they become simply a source of current revenue for the government to use for whatever purpose seems most pressing at the time. It does not provide resources with which to pay the future obligations that have been created.[229] Even Senate Budget Committee chairman Kent Conrad (D-ND), who eventually voted for the bill, called it "a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of."[230] And the bipartisan Commission on Fiscal Responsibility and Reform (the Bowles-Simpson Commission) recognized that the CLASS Act program will "require large general revenue transfers or collapse of its own weight."[231] The commission recommended that the CLASS Act be reformed in some unspecified way so as to make it credibly sustainable over the long term; otherwise it should be repealed.

In addition, the structure of the program creates a huge "adverse selection" risk that could add to the program's financial instability. As the actuarial firm Milliman Associates points out, "The voluntary

aspect of the program allows low-risk individuals to never sign up for the program while the guaranteed issue enables some of the highest-risk individuals to join the program. This is a formula that is virtually certain to create financial instability in any insurance program unless there are other important provisions to control risk."[232]

The law tries to ameliorate the adverse selection problem by requiring individuals who opt out of the program to pay a higher premium—up to 250 percent higher—if they later decide to opt back in.[233] But experts suggest that these provisions will be insufficient to prevent gaming the system. And other provisions actually make adverse selection *more* likely. For example, the law limits marketing costs to no more than 3 percent of premiums. The resulting lack of marketing will likely result in a low participation rate by the public at large, while those with health problems are most likely to seek out the benefits. The American Academy of Actuaries estimates that only about 6 percent of the U.S. population will participate in the program.[234] And, Richard Foster suggests that just 2 percent of workers will participate after three years.[235] Given such low participation levels, the covered population will almost certainly be far sicker than general insurance pool. Foster warns that "there is a very serious risk that the problem of adverse selection will make the CLASS program unsustainable."[236]

Making matters worse, the legislation caps premiums for low-income workers and undergraduate students and prohibits future premium hikes for some groups of retirees.[237] Therefore, if the program is to remain self-sustaining, other workers will have to bear a disproportionate share of future premium hikes. That in turn increases the risk that program premiums will exceed those for products available in the private market. Healthier individuals, in particular, would have an incentive to flee the program for less expensive private alternatives, leaving only the sickest and most expensive participants in the government plan. The adverse selection death spiral would be in full force, which could tempt the government to solve the problem by making participation mandatory, forcing Americans into a program they may not want and to which there are superior private alternatives.[238] The only other alternative will be a taxpayer bailout.

The CLASS Act, therefore, while little debated, may represent one of the health care legislation's biggest fiscal time bombs.

Growing the Nanny State

A little-discussed provision of the health care legislation requires restaurant chains with at least 20 locations or franchises to post calorie counts next to prices on menus, menu boards, and drive-through menus. In addition, restaurateurs would be required to post a brief statement regarding daily caloric intake and advise guests that additional nutrition information is available. Other nutrition data, which must be available on request, would include calories from fat, total fat, saturated fat, cholesterol, sodium, carbohydrates, sugars, dietary fiber and protein.[239] More than 200,000 establishments will be affected by the change.[240] The law also requires nutrition information to be posted on food and beverage vending machines.[241]

There is no doubt that the United States has a serious obesity problem.[242] However, posting calories is unlikely to have a significant impact. Studies show that only about 56 percent of chain restaurant customers said they even notice posted calorie information, while even fewer, just 15 percent, take the calorie information into account when making their choices.[243]

But, while they are unlikely to significantly reduce obesity, the new regulations will impose a cost on restaurants and consumers. Estimates suggest that the cost of analyzing calories runs as high as $1,000 per meal.[244] In addition there will be the cost of changing all those menus and signs. And, the cost of posting the information on vending machines has been estimated to be at least $56.4 million for the first year.[245]

While the financial cost of this provision is not substantial, especially in the context of other taxes and regulatory costs imposed by this law, it does represent yet another blow against individual responsibility.

Other Provisions

The legislation includes a number of pilot programs designed to increase quality of health care or control costs. Most are well intentioned but unlikely to have significant impact, especially in the short term. These would include programs such as bundled payments, global payments, accountable-care organizations and medical homes through multiple payers and settings.[246] It would also create a new Center for Innovation within the Centers for Medicare and Medicaid Services (CMS) to evaluate innovative models of care, and would require CMS to develop a National Quality Strategy to "improve care delivery, health outcomes and population health.[247]

The federal government would also provide grants to states for incentives for Medicaid beneficiaries to participate in healthy-lifestyle programs. A state option would enroll Medicaid beneficiaries with chronic illnesses into health homes that offer comprehensive, team-based care, and a new optional Medicaid benefit would allow people with disabilities to receive community-based services and supports.[248] Other grants would provide incentives for states to shift Medicaid beneficiaries away from nursing homes and toward care in the home or community.[249]

The law would also reward hospitals for providing value-based care, and penalize hospitals that perform poorly on quality measures such as preventable hospital readmissions.[250]

Of greater concern is a provision to establish a private, nonprofit institute to conduct comparative effectiveness research.[251] Many health care reform advocates believe that much of U.S. health care spending is wasteful or unnecessary. Certainly it is impossible to draw any sort of direct correlation between the amount of health care spending and outcomes.[252] In fact, by some estimates as much as 30 percent of all U.S. health spending produces no discernable value.[253] Medicare spending, for instance, varies wildly from region to region, without any evidence that the variation is reflected in the health of patients or procedural outcomes.[254] The Congressional Budget Office suggests that we could save as much as $700 billion annually if we could avoid treatments that do not result in the best outcomes.[255] It makes sense, therefore, to test and develop information on the effectiveness of various treatments and technology.

Critics fear, however, that comparative effectiveness research will not simply be used to provide information, but to impose a government-dictated method of practicing medicine. The legislation prohibits use of the research to create health care practice guidelines or for insurance coverage decisions.[256] The research would initially be informative only. Still, there is no doubt that many reformers hope to ultimately use the information to restrict the provision of "unnecessary" care.[257]

The Patient Protection and Affordable Care Act also includes several provisions aimed at increasing the health care workforce. This is particularly important given the law's emphasis on increasing coverage and therefore the demand for services. The United States already faces a potential shortage of physicians, especially primary-care physicians and certain specialties such as geriatric care. Some estimates suggest we will face a shortage of more than 150,000 physicians in the next 15 years.[258] The legislation itself could exacerbate this trend if physicians find their reimbursement rates reduced under Medicare and Medicaid, or find more bureaucratic interference with their medical decisionmaking. Indeed, one survey found that 45 percent of physicians would at least consider the possibility of quitting as a result of this health care legislation.[259]

The law attempts to combat this by increasing funding for physician and nursing educational loan programs, and would expand loan forgiveness under the National Health Service Corps.[260] It would also fund new educational centers in geriatric care, chronic-care management, and long-term care.[261] It also takes more controversial steps toward increasing the supply of primary-care physicians by shifting reimbursement rates for government programs, such as Medicare and Medicaid, to reduce payments to specialists while increasing reimbursement for primary care.[262] Yet, what possible reason is there to believe that the federal government can (a) know the proper mix of primary-care physicians and specialists, and (b) fine-tune reimbursements in a way that will produce those results? Nothing in the government's previous activities suggests that such central planning would be effective.

Finally, there is a host of special interest provisions. The so-called "cornhusker kickback" (a provision that committed the federal government to picking up the cost of Nebraska's Medicaid expansion forever) was removed by the reconciliation bill.[263] However, much other pork remains. For example, the legislation included $100 million in special funding for a hospital in Connecticut;[264] and money for asbestos abatement in a Montana town.[265] There was also a provision that gives drug makers 12 years of protection, or exclusivity, to sell biologic medicines before facing the threat of cheaper, off-brand alternatives.[266]

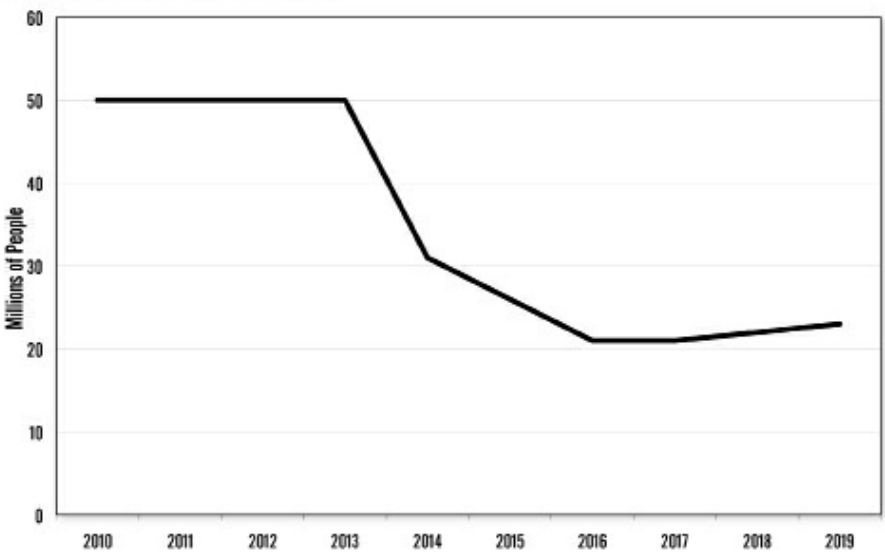
Part II:
Costs and Consequences

Expanded, Not Universal, Coverage

Passage of health care reform was heralded by some in the media as providing "near universal coverage."[267] Indeed, President Obama made it clear that one of the primary reasons he was pushing for health care reform was "it should mean that all Americans could get coverage."[268] But by this standard, the Patient Protection and Affordable Care Act falls far short of its goals.

According the Congressional Budget Office, the legislation would reduce the number of uninsured Americans by about 32 million people by 2019.[269] Most of those gains in the number of insured will not occur until after 2014 when the mandates and subsidies kick in. And even by 2019, CBO expects there to be more than 23 million uninsured (see Figure 7).[270] About one-third of the uninsured would be illegal immigrants. But that would still leave 15–16 million legal, non-elderly U.S. residents without health insurance.

Figure 7
Number of Uninsured under PPACA



Source: Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010.

Supporters of the legislation point out that that would decrease the number of uninsured Americans to roughly 6–8 percent of non-elderly Americans, a far cry from universal coverage, but undoubtedly better than today's 15 percent.[271]

Independent analysis suggests a modestly more pessimistic result. The RAND Corporation, for example, estimates that roughly 28 million more Americans would be insured under the legislation than would have been under the status quo, leaving roughly 25 million uninsured.[272] RAND also estimates

that increases in coverage would occur somewhat more slowly than does the CBO.[273]

Not surprisingly, most of those remaining uninsured will be young and healthy. In fact, the uninsured after implementation are likely to be somewhat younger, healthier, and wealthier as a group than today's uninsured.[274] If so, it may prove a blow to projections of reduced insurance costs through bringing the young and healthy into the insurance pool. In addition, as many as 38 percent of the remaining uninsured will be eligible for Medicaid, SCHIP, or government programs, but will not have enrolled.[275] That is a similar percentage to the status quo. And, nearly a third will be illegal immigrants, roughly double the proportion of uninsured today who are undocumented residents.[276] This suggests that we should not anticipate significant future reductions in the number of uninsured beyond 2019.

It is also important to realize that roughly 47 percent of the newly insured will not be receiving traditional health insurance, but will instead be put into the Medicaid or SCHIP programs.[277] Given that roughly a third of physicians no longer accept Medicaid patients,[278] these individuals may still find significant barriers to access, despite their newly insured status.

The Massachusetts health reform plan enacted in 2006 provides a useful warning on this score. Like the new federal legislation, Massachusetts expanded its coverage in large part by enrolling more people in Medicaid. However, after the reform was enacted, 6.9 percent of low-income residents reported that they could not find a doctor or get an appointment, a nearly 50 percent increase since the plan went into effect.[279] Waiting times were an even bigger problem, with the wait for seeing an internist, for example, increasing from 33 days to 52 days during the program's first year.[280]

Increased Spending, Increased Debt

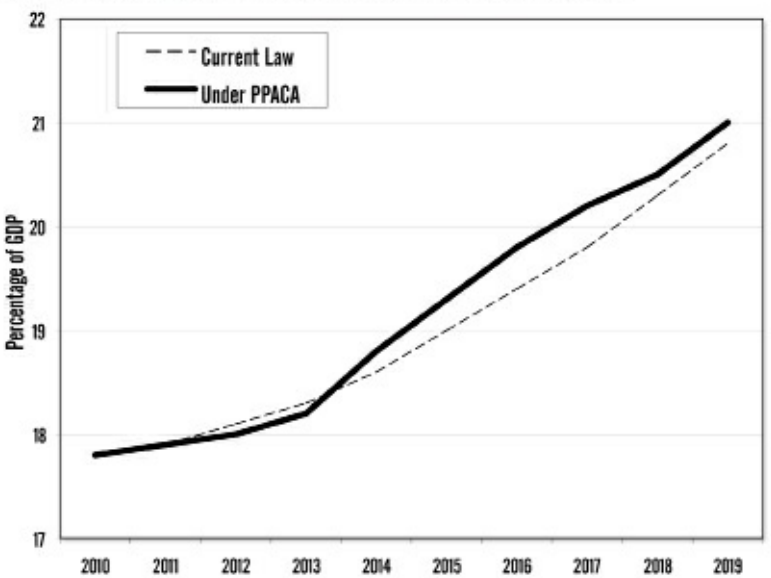
Throughout the health care debate, President Obama emphasized the need to control the rise in health care spending. As the president put it:

> We've got to control costs, both for families and businesses, but also for our government. Everybody out there who talks about deficits has to acknowledge that the single biggest driver of our deficits is health care spending. We cannot deal with our deficits and debt long term unless we get a handle on that. So that has to be part of a package.[281]

Proponents of reform correctly pointed out that the U.S. spends far more on health care than any other country, whether measured as a percentage of GDP or by expenditure per capita.[282] Health care costs are rising faster than GDP growth and now total more than $2.5 trillion—more than Americans spend on housing, food, national defense, or automobiles.[283]

However, the Patient Protection and Affordable Care Act fails to do anything to reduce or even restrain the growth in those costs. According to Richard Foster, the government's chief health care actuary, the legislation will actually increase U.S. health care spending by $311 billion over 10 years (see Figure 8).[284]

Figure 8
Estimated Increases in National Health Expenditures under PPACA



Source: Richard S. Foster, chief actuary, Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,'" as amended, April 22, 2010.

This should not come as a big surprise. The primary focus of the legislation was to expand insurance

coverage. Giving more people access to more insurance, not to mention mandating that current insurance cover more services, will undoubtedly result in more spending. In fact, we should not be surprised if the increased coverage results in even more spending than the government predicts. MIT economist Amy Finkelstein, for example, estimates that roughly 40 percent of the real increase in per capita health spending from 1950 to 1990 reflected the spread of comprehensive health insurance.[285] If utilization increases substantially as result of the coverage expansions in this legislation, spending could likewise skyrocket.

The failure to restrain costs will have serious consequences for government spending under the legislation. As CBO director Douglas Elmendorf noted in his official blog:

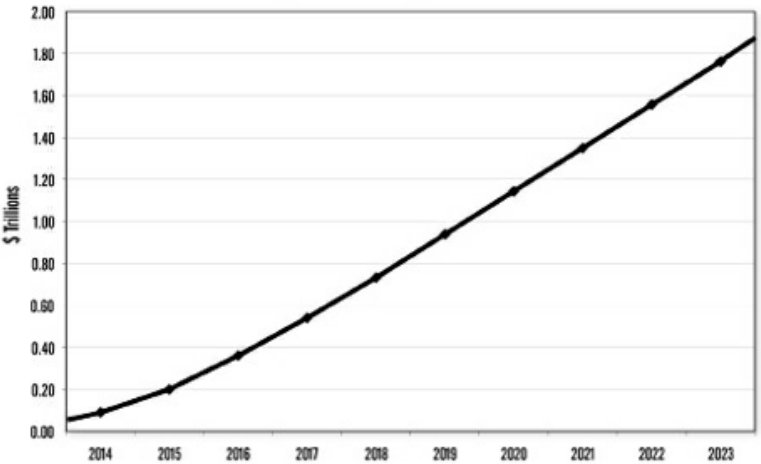
> The rising costs of health care will put tremendous pressure on the federal budget during the next few decades and beyond. . . . In CBO's judgment, the health legislation enacted earlier this year does not substantially diminish that pressure. In fact, CBO estimated that the health legislation will increase the federal budgetary commitment to health care.[286]

The Congressional Budget Office scored the Senate-passed Patient Protection and Affordable Care Act as costing $875 billion over 10 years.[287] The changes passed under reconciliation increased that cost to $938 billion.[288] However, those numbers do not tell the whole story, nor do they reveal the law's true cost.

The CBO does not provide formal budget analysis beyond the 10-year window, pointing out that any calculation made beyond 2020, "reflects the even greater degree of uncertainty" regarding those years.[289] However, since program costs will be on an upward trajectory through 2019 (see Figure 9), it expects the cost of the program to continue to grow rapidly after 2019.

Moreover, as Figure 9 makes clear, most of the spending under this legislation doesn't take effect until 2014. So the "10-year" cost projection includes only 6 years of the bill. However, as Figure 9 shows, if we look at the legislation more honestly over the first 10 years that the programs are actually in existence, say from 2014 to 2024, it would actually cost nearly $2 trillion.

Figure 9
Total Spending under PPACA through 10 Years of Implementation



Source: Author's calculations based on Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

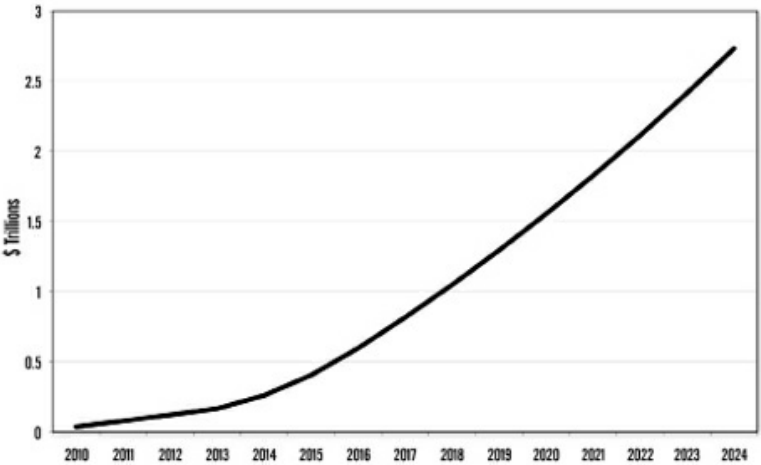
CBO officially scored the bill as reducing the budget deficit by $138 billion over 10 years. Putting that in perspective, if true, it would amount to roughly 62 percent of the total deficit that the federal government incurred *in February of 2010 alone.*[290] In reality, however, that scoring is achieved through the use of yet another budget gimmick.

As mentioned above, the legislation anticipates a 23 percent reduction in Medicare fee-for-service reimbursement payments to providers, yielding $196 billion in savings.[291]

Those cuts were part of a Medicare reimbursement reduction first called for in 2003, as part of changes to the sustainable growth rate required by the Balanced Budget Act of 1997.[292] However, as discussed earlier, the cuts have never actually been implemented, with Congress regularly postponing their effective date. Current law would reduce payment rates for providers by 21 percent beginning in January 2011, and by an average of 2 percent each year thereafter through the end of the decade. This is the baseline that the CBO used to project the bill's future costs. However no one in Washington seriously believes that those cuts will actually occur. In fact, congressional Democrats have introduced a separate bill, the Medicare Physicians' Payment Reform Act of 2009 (HR 3961), effectively repealing the cuts. According to the Congressional Budget Office, the 10-year cost of repealing those cuts would be $259 billion.[293] However, other sources, including the Obama administration have suggested the cost could go as high as $371 billion.[294]

In a letter to Congressman Paul Ryan (R-WI), the Congressional Budget Office confirms that if the costs of repealing the payment reductions, known as the "doc-fix," as reflected in HR 3961, were to be included in the cost of health care reform, the legislation would actually increase budget deficits by $59 billion over 10 years. [295]

Figure 10
Total Cost of PPACA through 10 Years of Implementation, including "Doc Fix" and Administrative/Implementation Costs



Source: Author's calculations based on Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

Moreover, the initially projected cost failed to include discretionary costs associated with the program's implementation. The legislation does not provide specific expenditures for these items, but simply authorizes "such sums as may be necessary." Therefore, because the costs are subject to annual appropriation and the actions of future congresses are difficult to predict, it may be impossible to put a precise figure to the amount. However, CBO suggests that they could add as much as $115 billion to the 10-year cost of the bill.[296]

As Figure 10 shows, adding the cost of the doc-fix, discretionary costs, and other costs that were not originally included in CBO's score to the legislation brings the total cost over 10 years of actual operation to over $2.7 trillion.[297]

In addition, estimates of the PPACA's impact on the budget deficit double count both Social Security taxes and revenue and savings from Medicare. As mentioned above, scoring for the health care bill anticipates a net reduction in Medicare spending of $416.5 billion over 10 years. The law would also bring in additional payroll tax revenue through the 0.9 percent increase in the Medicare payroll tax, and the imposition of the tax to capital gains and interest and dividend income. This money is funneled through the Medicare Trust Fund, reducing the unfunded liabilities under Medicare Part B from $37 trillion to just $12.9 trillion.[298] As mentioned, this will extend the life of the Trust Fund by as much as 12 years.

The new funds would indeed be routed through the Medicare Trust Fund, where government trust fund accounting methodology would count them as extending the trust fund's solvency. However, as has been pointed out with regard to the Social Security Trust Fund, the government is structurally incapable of actually saving the money. In fact, the funds would be used to purchase special-issue Treasury bonds. When the bonds are purchased, the funds used to purchase them become general revenue, and are spent on the government's annual general operating expenses. What remains behind in the trust fund are the

bonds, plus an interest payment attributed to the bonds (also paid in bonds, rather than cash). Government bonds are, in essence, a form of IOU. They are a promise against future tax revenue. When the bonds become due, the government will have to repay them out of general revenue.[299] In the meantime, however, the government counts on that new general revenue to pay for the cost of the new health legislation. Thus, the government spends the money now, while pretending it is available in the future to pay for future Medicare benefits. This results in a double counting of roughly $398 billion.

As Medicare's chief actuary points out, "In practice, the improved [Medicare] financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."[300]

The same is true regarding $53 billion in additional Social Security taxes generated under the PPAC. CBO assumes that, as discussed above, many employers may ultimately decide that it is cheaper to "pay than play," and will stop offering health insurance to their workers. CBO assumes that in those cases workers will receive higher wages to offset at least some of the loss in non-wage (insurance) compensation. The workers will, however, have to pay taxes, including Social Security payroll taxes, on those additional wages. The additional revenue from those taxes is counted in CBO's scoring of the Patient Protection and Affordable Care Act. However, because they are paying additional taxes, those workers are also accruing additional Social Security benefits. Yet, because those benefits will paid outside the 10-year budget window, the cost of the additional benefits is not included in the scoring. Only one side of the revenue-benefit equation is included.

And, as noted above, revenue from the CLASS Act is similarly double counted. Eliminating all of this double counting, and including the full cost of the bill as discussed above, means that the PPACA will actually add at least $823 billion to the budget deficit over the program's first 10 years. Some estimates suggest that over the program's second 10 years, it could add as much as an additional $1.5 trillion to the deficit.[301]

Finally, it is important to point out that much of the bill's cost is shifted off the federal books onto businesses, individuals, and state governments through mandates and other regulatory requirements. These business and individual mandates are the equivalent of tax increases, but those costs aren't included in the law's cost estimates. And, as mentioned above, state governments will have to pick up at least $34 billion of the cost to expand Medicaid.

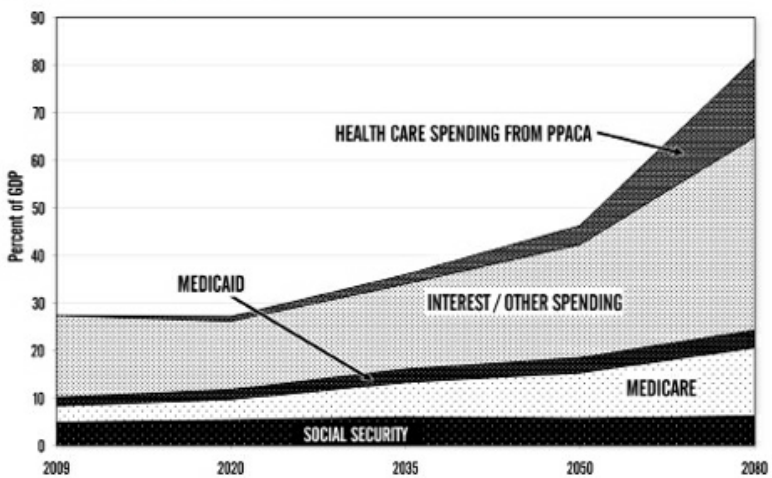
When the CBO scored the Clinton health care plan back in 1994, those costs were included, and accounted for as much as 60 percent of the law's total cost.[302] Despite repeated requests, CBO did not produce a similar analysis for this bill. But if a similar ratio were to hold for the Patient Protection and Affordable Care Act, the real cost of the legislation would be somewhere in the vicinity of $7 trillion.[303]

It is also worth noting that cost estimates for government programs have been wildly optimistic over the years, especially for health care programs. For example, when Medicare was instituted in 1965, government actuaries estimated that the cost of Medicare Part A would be $9 billion by 1990. In actuality, it was seven times higher—$67 billion.[304] Similarly, in 1987, Medicaid's special hospitals subsidy was projected to cost $100 million annually by 1992, just five years later; it actually cost $11 billion, more than 100 times as much.[305] And, in 1988, when Medicare's home-care benefit was established, the projected cost for 1993 was $4 billion, but the actual cost in 1993 was $10 billion.[306] If the current estimates for the cost of Obamacare are off by similar orders of magnitude, costs and future deficits would be even larger.

There is certainly reason to believe that the costs of this law will exceed projections. For example, as discussed above, increased insurance coverage could lead to increased utilization and higher subsidy costs. At the same time, if companies choose to drop their current insurance and dump employees into subsidized coverage or Medicaid, it could substantially increase the program's costs. One estimate, cited by *Fortune* magazine, notes that "if 50 percent of people covered by company plans get dumped, federal health care costs will rise by $160 billion in 2016, in addition to the $93 billion in subsidies already forecast by the CBO."[307] Another study, by former CBO director Douglas Holtz-Eakin and Cameron Smith warns that shifting employees to government-subsidized coverage could increase the legislation's cost by as much as $1.4 trillion over 10 years.[308] And, adverse selection could increase Medicaid costs. Thus, the multi- trillion-dollar estimated cost of this legislation should be seen as a *best case* scenario.

This is all taking place at a time when the government is facing an unprecedented budgetary crisis. The U.S. budget deficit hit $1.5 trillion in 2011, and we are expected to add as much as $9 trillion to the national debt over the next 10 years, a debt that is already in excess of $14.3 trillion and rising at a rate of nearly $4 billion per day.[309] Under current projections, government spending will rise from its traditional 20–21 percent of our gross domestic product to 43 percent by 2050.[310] That would require more than a doubling of the tax burden just to keep up.

Figure 11
Spending Projections under PPACA



Source: Author's calculations based on Congressional Budget Office, "Long-Term Outlook for Medicare, Medicaid, and Total Health Care Spending."

Figure 11 shows how the new health care law will add to the burden of future government spending. By 2050, the new law will push total government spending toward 50 percent of GDP. By the end of the century, federal government spending would become almost unfathomable, surpassing 80 percent of GDP.

By any realistic measure, therefore, the Patient Protection and Affordable Care Act dramatically increases government spending, the national debt, and the burden of government on the economy as a

whole.

Higher Insurance Premiums

During the 2008 presidential campaign, candidate Obama promised that his health care reform plan would reduce premiums by up to $2,500 per year.[311] That promise has long since been abandoned. However, without putting a dollar amount to it, the president continues to promise that health care reform will reduce insurance costs.[312] While that may be true for those Americans receiving subsidies or those who are currently in poor health, millions of others will likely end up paying higher premiums.

Today, the average nongroup-insurance plan costs $2,985 annually for an individual and $6,328 for a family.[313] In the non-group—that is employer-based—market, premiums average $4,825 for an individual, and $13,375 for a family.[314] CBO estimates that if reform had not passed, premiums in the individual market would have risen to $5,200 for an individual and $13,100 for a family by 2016. And, the cost of employer-provided insurance would rise to $7,800 for an individual, $20,300 for a family.[315] That increase would place a significant burden on both individuals and businesses.

However, the health care law does little or nothing to change this. The biggest businesses, those with more than 100 employees, would see the biggest benefit, but even here the benefit would be minimal. CBO estimates that large companies would see a premium increase between zero and three percent less than would otherwise occur.[316] That means that under the best case scenario, their premiums for a family plan would only increase to $20,100, compared with $13,375 today, and $20,300 if the bill hadn't passed.[317] That represents a savings of $200 over what would have happened if the bill had not passed, but still represents a $6,350 increase over what the company is paying today.

Small businesses would see a premium increase between zero and just 1 percent less than would otherwise occur.[318] Thus, again under the best-case scenario, small business premiums for a family plan would only increase to $19,200, compared to $19,300 if the bill hadn't passed, a savings of just $100.[319]

But the millions of Americans who purchase insurance on their own through the nongroup market will actually be worse off as a result of this law. According to CBO, their premiums will increase 10–13 percent faster than if the bill had not passed. That is, an individual premium would increase from $2,985 today to $5,800, compared to $5,500 if the bill had never passed. A family policy will increase from today's $6,328 to $15,200. If the bill hadn't passed, it would only have increased to $13,100.[320] Thus, this bill will cost a family buying their own health insurance an additional $2,100 per year in higher premiums (see Table 1).

Table 1
Premiums under PPACA

Type of Plan	Current	2016	
		With bill	Without bill
Large Business	$13,375	$20,100	$20,300
Small Business	$13,375	$19,200	$19,300
Individual Policy	$6,328	$15,200	$13,100

Source: Current cost of health insurance policy based on America's Health Insurance Plans' (AHIP) data; future estimates based on Letter from Douglas Elmendorf, director, Congressional Budget Office, to Sen. Evan Bayh, November 30, 2009.

Indeed,

premiums for 2011 have risen rapidly due to factors both related and unrelated to the PPACA.[321] Early estimates suggest that the bill itself has been responsible for a premium hike of roughly 9 to 12 percent.[322]

Of course, for low- and some middle-income Americans, any increase in premiums may ultimately be offset by government subsidies. But individuals whose income falls in the range where subsidies begin to phase out and those not receiving subsidies will likely see significant increases in what they have to pay.

The bill's proponents also point out that most of the increased cost is due to increased benefits mandated by the new law, and the new insurance reforms. It is not that the per unit cost of insurance will have risen faster than the baseline, but that individuals will be purchasing more insurance. That, however, does not change the bottom line. Individuals will be paying more, and not because they choose to do so. If everyone was mandated to trade their current car for a new BMW, people would have a better car—but they would still be poorer.

That is not at all what the president promised.

Conclusion

Health care reform was designed to accomplish three goals: (1) provide health insurance coverage for all Americans, (2) reduce insurance costs for individuals, businesses, and government, and (3) increase the quality of health care and the value received for each dollar of health care spending. Judged by these goals, the new law should be considered a colossal failure. The president and the law's supporters in Congress also promised that the legislation would not increase the federal budget deficit or unduly burden the economy. And, of course, we were repeatedly promised that "If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what."[323] But Richard Foster, the government's own chief actuary, has testified that that statement is "not true."[324] Individual and employer mandates will ultimately force individuals and businesses to change plans in order to comply with the government's new standards for insurance, even if the new plans are more expensive or contain benefits that people don't want. Flexible spending accounts have already been reduced, and health savings accounts could be eliminated. More than 7 million seniors with Medicare Advantage plans will likely be forced out of those plans and back into traditional Medicare. On these grounds too, the Patient Protection and Affordable Care Act doesn't come close to living up to its promises.

The legislation comes closest to success on the issue of expanding the number of Americans with insurance. Clearly, as a result of this law, millions more Americans will receive coverage. This results mainly from an expansion of government subsidies and other programs, with nearly half of the newly insured coming through the troubled Medicaid program. Thus, the degree to which expanded coverage will lead to expanded access is still an open question. And, despite the passage of this legislation, at least 23 million Americans will still be uninsured by 2019. On this dimension, therefore, the new law is an improvement over the status quo, but a surprisingly modest one.

The law also makes some modest insurance reforms that will prohibit some of the industry's more unpopular practices. However, those changes come at the price of increased insurance costs, especially for younger and healthier individuals, and reduced consumer choice.

At the same time, the legislation is a major failure when it comes to controlling costs. While we were once promised that health care reform would "bend the cost curve down,"[325] this law will actually *increase* U.S. health care spending. This failure to control costs means that the law will add significantly to the already crushing burden of government spending, taxes, and debt. Accurately measured, the Patient Protection and Affordable Care Act will cost more than $2.7 trillion over its first 10 years of full operation, and add more than $823 billion to the national debt. And this does not even include more than $4.3 trillion in costs shifted to businesses, individuals, and state governments.

It is not just government that will face higher costs under this law. In fact, most American workers and businesses will see little or no change in their skyrocketing insurance costs—while millions of others, including younger and healthier workers and those who buy insurance on their own through the nongroup market, will actually see their premiums go up faster as a result of this legislation.

Clearly the trajectory of U.S. health care spending under this law is unsustainable. Therefore, it raises the inevitable question of whether it will lead to rationing down the road.

We should be clear, however. With a few minor exceptions governing Medicare reimbursements, the law would not directly ration care or allow the government to dictate how doctors practice medicine.

There is no "death board" as Sarah Palin once wrote about in a Facebook posting.[326] Even so, by setting in place a structure of increased utilization and rising costs, the new law makes government rationing far more likely in the future.[327]

Indeed, this trend is already playing out in Massachusetts. With the cost of the state's reform becoming unsustainable, the legislature established a special commission to investigate the health payment system in a search of ways to control costs.[328] In March of 2009, the commission released a list of options that it was considering, including "exclud[ing] coverage of services of low priority/low value" under insurance plans offered through Commonwealth Care. Along the same lines, it has also suggested that Commonwealth Care plans "limit coverage to services that produce the highest value when *considering both clinical effectiveness and cost.*"[329]

The Patient Protection and Affordable Care Act will also significantly burden businesses, thereby posing a substantial threat to economic growth and job creation. While some businesses may respond to the law's employer mandate by choosing to pay the penalty and dumping their workers into public programs, many others will be forced to offset increased costs by reducing wages, benefits, or employment.

The legislation also imposes more than $569 billion in new or increased taxes, the vast majority of which will fall on businesses. Many of those taxes, especially those on hospitals, insurers, and medical-device manufacturers, will ultimately be passed along through higher health care costs. But other taxes, in particular new taxes on investment income, are likely to reduce economic and job growth. Businesses will also face new administrative and record-keeping requirements under this legislation that will also increase their costs, reducing their ability to hire, expand, or increase compensation.

It is becoming increasingly clear that millions of Americans will not be able to keep their current coverage. Seniors with Medicare Advantage and those workers with health savings accounts are the most likely to be forced out of their current plans. Millions of others are at risk as well. As mentioned above, many businesses may choose to "pay" rather than "play," dropping their current coverage and forcing workers either into Medicaid or to purchase their insurance through the government-run exchanges. CBO's estimate of 10–12 million workers being dropped from their current employer coverage is probably conservative. With other, and much larger, businesses now reportedly considering such an approach, the number of workers forced out of their current plans could increase significantly.

Finally, the law's individual mandate continues to pose a threat to people being able to keep their current coverage. While the final bill grandfathered current plans—a significant improvement over previous versions—individuals will still be forced to change coverage to a plan that meets government requirements if they make any changes to their current coverage. And, by forbidding noncompliant plans from enrolling any new customers, the law makes those plans nonviable over the long term. As a result, Americans whose current insurance does not meet government requirements may ultimately not have the choice to keep that plan.

All of this represents an enormous price to pay in exchange for the law's small increases in insurance coverage. There is very little "bang for the buck."

Even more significantly, this law represents a fundamental shift in the debate over how to reform health care. It rejects consumer-oriented reforms in favor of a top-down, "command and control," government-imposed solution. As such, it sets the stage for potentially increased government involvement, and raises the specter, ultimately, of a government-run single-payer system down the road.

The debate over health care reform now moves to other forums. Numerous lawsuits have been filed

challenging provisions of the law, especially the individual mandate, with two federal judges striking down all or part of the law.[330] Republicans, having won an enormous victory in the mid-term elections, have vowed to make repealing the PPACA a central part of their legislative agenda. And while institutional barriers such as the filibuster and presidential veto make an actual repeal unlikely, there will almost certainly be efforts by Congress to delay, de-fund, or alter many aspects of the law.

One thing is certain—the debate over health care reform is far from over.

Appendix I: A Timeline

Anyone expecting to see major changes to the health care system in the next few months or years is liable to be disappointed. Although some insurers and businesses have begun raising rates and taking other preemptive actions in anticipation of changes to come, most of the major provisions of the legislation are phased in quite slowly. As Table 2 shows, the most heavily debated aspects, mandates, subsidies, and even most of the insurance reforms don't begin until 2014 or later.

A handful of small changes began last year, notably a provision allowing parents to keep their children on the parent's policy until the child reaches age 26 and a ban on preexisting-condition exclusions for children. There was also a $250 rebate to seniors whose prescription drug costs fell within the Medicare Part D "donut hole." A few other provisions, notably the small business tax credits, kick in this year. From here on, however, there will be few benefits from the law until 2014 or later. At the same time, with the exception of the tax on tanning beds, most of the new taxes in the new law do not start until 2012 or later. The individual and employer mandates do not come into effect until 2014. In fact, some aspects of the new law, such as the tax on "Cadillac" insurance plans do not take place until 2018. The Medicare prescription drug "donut hole" is not scheduled to be fully eliminated until after 2020.

This means there remains time to repeal or at least make significant changes to the legislation before most of it takes effect. If not, this legislation will be very bad news for American taxpayers, businesses, health care providers, and patients.

Table 2
Patient Protection and Affordable Care Act Timeline for Implementation

2010 (already in place)	Five percent tax imposed on tanning salons.
	Seniors with prescription drug costs of at least $2,700 receive a check for $250. If seniors reach the $2,700 ceiling later in the year, they will receive the check at the end of the quarter in which they reach the ceiling.
	$5 billion for temporary reinsurance program for employers who provide health insurance coverage for retirees over age 55 who are not yet eligible for Medicare. The program ends in 2014.
	Insurers required to provide coverage for children regardless of preexisting conditions. The prohibition on excluding preexisting conditions does not apply to adults until 2014.
	High-risk pools established to cover adults with preexisting conditions. Pools will be eliminated after the ban on excluding preexisting conditions goes into effect in 2014.
	Parents may keep children on their insurance plan until the child reaches age 26.
	Lifetime caps on insurance benefits prohibited.

2011

Medicare payroll tax increases from 1.45 percent to 2.35 percent for individuals earning more than $200,000 and married filing jointly above $250,000.

A three-year phase-out of subsidies to Medicare Advantage begins. Some seniors may be forced back into traditional Medicare.

States must expand Medicaid eligibility to all individuals with incomes below 133 percent of the poverty line. The federal government will cover the cost of this expansion until 2017.

Businesses with fewer than 25 employees and average wages below $50,000 become eligible for a tax credit to help offset the cost of providing insurance to their workers. The credit applies to 2010 taxes filed in 2011.

Maximum contributions to flexible spending accounts (FSAs) reduced from $5,000 to $2,500. FSAs and health savings accounts (HSAs) cannot be used to purchase over-the-counter medications.

Workers begin contributing to the CLASS Act long-term care program, or may opt out of the program.

$2.5 billion in new taxes are imposed on the pharmaceutical industry. The tax, or assessment, rises to $4.2 billion by 2018, and is imposed on manufacturers according to a formula based on the company's aggregate revenue from branded prescription drugs.

2012

Businesses required to complete 1099 forms for every business-to-business transaction of $600 or more.

2013

2.3 percent excise tax imposed on sale of medical devices.

Floor for deducting medical expenses from income taxes rises from 7.5 percent of income to 10 percent.

The Employer Medicare Part D subsidy deduction for employers eliminated. Employers will lose the tax deduction for subsidizing prescription drug plans for Medicare Part D–eligible retirees.

The 3.8 percent Medicare tax is applied to capital gains and interest and dividend income if an individual's total gross income exceeded $200,000 or a couple's income exceeds $250,000.

An $8 billion tax is imposed on insurers, based on market share. The tax rises to $14.3 billion by 2018.

2014	Individual mandate imposed. With few exceptions, every American is required to have a government-designed minimum insurance package. Failure to comply will result in a fine equal to 1 percent of income. The penalty increases to 2 percent in 2015, and finally to 2.5 percent in 2016.
	Employer mandate imposed. Companies with 50 or more employees must offer coverage to employees or pay a $2,000 penalty per employee after their first 30 if at least one of their employees receives a tax credit. Employers who offer coverage but whose employees receive tax credits will pay $3,000 for each worker receiving a tax credit.
	All insurance must meet federal minimum benefit requirements.
	Prohibition on preexisting condition exclusions applies to adults.
	Health plans prohibited from imposing annual limits on coverage.
	Subsidies begin for individuals and families with incomes up to 400 percent of the poverty line. Refundable tax credits limit the percent of income that must be paid for either insurance premiums or out-of-pocket expenses.
	Insurance exchanges become operational.
2015	Independent Medical Advisory Commission (IMAC) established.
2016	Individuals may begin collecting benefits from CLASS Act long-term care program.
2017	States have option to allow large employers to participate in exchanges.
	States must begin covering part of the cost of Medicaid expansion.
2018	"Cadillac" insurance tax imposed on high-cost, employer-provided health plans with an actuarial value exceeding $27,500 for family coverage and $10,200 for individual coverage.

Notes

The author thanks Jacob Shmukler and Carey Anne Lafferty for their contributions.

1. David Espo, "Landmark Health Bill Passes," Associated Press, March 22, 2010. See also, "Final Vote Results for Roll Call 165," March 21, 2010, http://clerk.house.gov/evs/2010/roll165.xml.

2. The Senate did make minor amendments to the bill, requiring it to go back to the House for final approval, which it received the next day. Alan Fram, "Senate OK's Health Care Fix-It Bill; House is Next," Associated Press, March 25, 2010; Erica Werner, "At Last: Final Health Care Measure Heads to Obama," Associated Press, March 25, 2010.

3. There are 2,562 pages and 511,520 words when both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act are combined.

4. HR 3200, sec. 221. Regardless of how it was structured or administered, such a government-run plan would have an inherent advantage in the marketplace because it ultimately could be subsidized by American taxpayers. The government plan could keep its premiums artificially low or offer extra benefits since it could turn to the U.S. Treasury to cover any shortfalls. Consumers naturally would be attracted to the lower-cost, higher-benefit government program, thus undercutting the private market. The actuarial firm Lewin Associates estimated that, depending on how premiums, benefits, reimbursement rates, and subsidies were structured, as many as 118.5 million people, roughly two-thirds of those with insurance today, would have shifted from private to public coverage—or be pushed. Businesses would have had every incentive to dump their workers into the public plan. The result would have been a death spiral for private insurance, and eventually a single government-run system. John Sheils and Randy Haught, "Analysis of the July 15 Draft of the American Affordable Health Choices Act of 2009," Lewin Associates, July 23, 2009.

5. HR 3200, sec. 313.

6. Ibid., sec. 441.

7. Rasmussen Reports, "Election Night 2010: Exit Poll Results," November 2, 2010, http://www.rasmussenreports.com/public_content/politics/elections/election_2010/election_night/election_night_2010_exit_pol

8. http://www.kff.org/kaiserpolls/8120.cfm

9. Chris Cillizza, "A Referendum, Sure, but Was It on Health Care?" *Washington Post*, November 8, 2010.

10. Russell Berman, "House Repeals Healthcare Law, *The Hill*, January 19, 2011. Three Democrats—Dan Boren (OK), Mike McIntyre (NC), and Mike Ross (AR)—joined all 242 Republicans in voting for repeal.

11. A Republican effort to force a Senate vote on repeal failed on a party-line procedural vote, 47–53. David Herszenhorn, "Senate Rejects Repeal of Health Care Law," *New York Times*, February 2, 2011.

12. Equivalent legislation is being considered in current sessions in state legislatures in Arkansas, Florida, Kentucky, Indiana, Maryland, Michigan, Montana, Nebraska, South Carolina, South Dakota, Texas, and Wyoming. "State Legislation and Actions Challenging Certain Health Reforms, 2010–11," National Conference of State Legislatures, January 21, 2011, http://ncsl.org/default.aspx?tabid=18906.

13. These lawsuits can be tracked at http://healthcarelawsuits.org/.

14. Twenty-six states joined *Florida v. U.S. Dept. of Health and Human Services*. Virginia and Oklahoma filed their own cases.

15. *Thomas Moore Law Center v. Barack Hussein Obama et al.*, October 7, 2010; *Liberty University v. Geitner*, November 30, 2010.

16. *Commonwealth of Virginia ex. rel. Cuccinelli v. Sebelius*, no. 3:10CV188-HEH (E.D. Va. 2010); *Florida v. U.S. Dept. of Health and Human Services*.

17. Margaret Talev, "Health Care Overhaul Spawns Mass Confusion in Public," McClatchy Newspapers, April 6, 2010.

18. Nancy Pelosi, "Remarks to the 2010 Legislative Conference for National Association of Counties," March 9, 2010, http://www.speaker.gov/newsroom/pressreleases?id=1576.

19. In what appears to be an unintentional error, the military's TRICARE program, which covers nearly 10 million service people,

retirees, and dependents, does not appear to meet the legislation's definition of "minimumessential coverage," meaning individuals in this programwould face penalties for failing to satisfy the mandate. Sen. JimWebb (D-Va) has introduced legislation to correct the error. Michael Posner, "Veterans Push for Fixes to New Law," *Congress Daily*, April 6, 2010.

20. Robert Hartman and Paul van de Water, "The Budgetary Treatment ofan Individual Mandate to Buy Health Insurance," Congressional Budget Office Memorandum, August 1994.

21. This paper is not the place to do justice to the serious constitutional issues involved. However, those who oppose the mandate on constitutional grounds make generally make two arguments. First, that the federal government lacks the authority to impose such a mandate, especially regarding a matter that is neither interstate nor commerce. Although the Patient Protection and Affordable Care Act contains language justifying itselfon the grounds that "the individual responsibility requirement provided for in this sec. . . . is commercial and economic in nature, and substantially affects interstate commerce," Patient Protection and Affordable Care Act–Title I, sec. 1501(a)(1). This bill would expand the commerce clause far beyond any current interpretation, and would give the federal government virtually unlimited authority to regulate any activity it chose. As Judge Vinson wrote in his decision in *Florida v. U.S. Dept. of Health and Human Services*, "The problemwith this legal rationale, however, is it would essentially have unlimited application. *There is quite literally no decision that, in the natural course of events, does not have an economic impact of some sort.* The decisions ofwhether and when (or not) to buy a house, a car, a television, a dinner, or even a morning cup ofcoffee also have a financial impact that—when aggregated with similar economic decisions—affect the price ofthat particular product or service and have a substantial effect on interstate commerce. To be sure, it is not difficult to identify an economic decision that has a cumulatively substantial effect on interstate commerce; rather, the difficult task is to find a decision that does not." (Emphasis added). Proponents, ofcourse, note that the Supreme Court has interpreted the Commerce Clause broadly enough to reach wholly intrastate economic "activity" that substantially affects interstate commerce. *Wickard v. Filburn* 317 US 111 (1942). But the individual mandate goes beyond regulating even intrastate activity to regulate non-activity. Under proponents' interpretation ofthe Commerce Clause, therefore, Congress would be free to order you to take or not take a job, to sell or not sell your house, to buy or not buy a car. There would have been no need for a "cash for clunkers" program Congress could simply have ordered every American to purchase a new car. Judge Vinson put it this way, *"Congress could require that people buy and consume broccoli at regular intervals, not only because the required purchases will positively impact interstate commerce, but also because people who eat healthier tend to be healthier, and are thus more productive and put less of a strain on the health care system.* Similarly, because virtually no one can be divorced fromthe transportation market, Congress could require that everyone above a certain income threshold buy a General Motors automobile—now partially government-owned—because those who do not buy GMcars (or those who buy foreign cars) are adversely impacting commerce and a taxpayer-subsidized business." *Florida v. U.S. Dept. of Health and Human Services* (42). Second, proponents argue that the penalty is simply a tax and therefore is authorized under Congress's power "to lay and collect Taxes." U.S. Constitution, art. I, § 8, cl. 1. The penalty would seemto much more closely fit the definition ofa fine than a tax. As Jeff Rowes and Robert McNamara ofthe Institute for Justice point out, "For an exaction to be a true tax, it has to be a genuine revenue-raising measure," whereas the penalty for failing to comply with the mandate "exists solely to coerce people into acquiring healthcare coverage. Ifthe mandate were to work perfectly, it would raise literally no revenue." Jeff Rowes and Robert McNamara, unpublished memorandum, Institute for Justice, May 2010, quoted in Robert Levy, "The Taxing Power ofObamacare, National Review Online, April 20, 2010. And, as Judge Vinson and others have noted, prior to passage ofthe bill, supporters ofthe mandate, including President Obama, insisted that the penalty was not a tax. The change frompenalty to tax occurred only after the measure reached the courts. Jennifer Hakerborn, "Judge Disses Dems 'Alice in Wonderland' Defense," *Politico*, October 14, 2011. But even ifone accepts the argument that the penalty is a tax, it does not meet the constitutional requirements for income, excise, or direct taxes. It does not fit the definition ofeither an income or excise tax, and ifit is a direct tax, it does not meet the constitutional requirement that it be "apportioned among the several States," U.S. Constitution. art. I, § 2, cl. 3. Furthermore, the courts have ruled that Congress cannot use the taxing power as a backdoor means ofregulating an activity, unless the regulation is authorized elsewhere in the Constitution. *Bailey v. Drexel Furniture Co.* 259 US 20 (1922). For further discussion, see Randy Barnett, "The Insurance Mandate in Peril," *Wall Street Journal*, April 29, 2010 or Levy. The same reasoning holds true regarding supporters' reliance on the Constitution's "Necessary and Proper Clause," which gives the government the power to enact laws that are necessary and proper to the conduct ofits duties. U.S. Constitution, art. I, § 8, cl. 18. Those "necessary and proper" actions must be linked to otherwise constitutional actions by the government. Judge Vinson made this clear in his decision in *Florida v. U.S. Dept. of Health and Human Services*: "The Necessary and Proper Clause cannot be utilized to pass laws for the accomplishment ofobjects" that are not within Congress's enumerated powers." Ofcourse final determination ofthe constitutionality ofthe mandate (and the Patient Protection and Affordable Care act more generally) awaits a decision by the U.S. Supreme Court.

22. Jennifer Staman and Cynthia Brougher, "Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis," Congressional Research Service, July 24, 2009.

23. "The Patient Protection and Affordable Care Act (Public Law 111-148), Subtitle F, Part I, sec. 1501, as amended by the Health Care and Education Affordability Reconciliation Act," sec. 1002. Note this amends Subtitle D ofChapter 48 ofthe Internal Revenue Code of1986.

24. Ibid.

25. Patient Protection and Affordable Care Act, Title I, Subtitle F, sec. 1501, as amended by the Health Care and Education Affordability Reconciliation Act, Title I, Subtitle A, sec. 1002(b)(2). Also exempt are American Indians, those with qualifying religious objections, illegal immigrants, and, ironically, people in jail. The Patient Protection and Affordable Care Act, Subtitle F, Part I, sec. 1501(d)(2-4). The 8 percent exemption is far less clear cut than it appears at first glance. For example, a single adult earning 245 percent of the Federal poverty line ($27,500) would be forced to pay the tax, because he could buy subsidized health insurance for a little less than 8 percent of his income. A single adult earning 250 percent of the Federal poverty line (~$28,000) would not have to pay the tax, because subsidized health insurance would cost him a bit more than 8 percent of his income. A 34-year-old single adult earning $50,000 could be in a ratings band where the cheapest health insurance he can purchase is $4,000. If he doesn't comply with the mandate, he'd have to pay the fine. If after he turns 35, the cheapest health insurance he could purchase is now $4,100, he would no longer have to pay the fine. Alternatively, if at 34 he started smoking (not even buying cigarettes necessarily) and the cheapest insurance he could now purchase was $4,500, he would no longer have to pay the fine. Or if he moved a few zip codes over to a slightly more expensive community rating area and the cheapest health insurance he can purchase is now $4,200, he's then again exempt from a fine. Thus, whether a person has to pay the tax (and how much) depends not just on income, but also on age, family size, smoking status, and location.

26. Congressional Budget Office and the staff of the Joint Committee on Taxation, "Payments of Penalties for Being Uninsured under PPACA," April 22, 2010.

27. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

28. The Patient Protection and Affordable Care Act, Subtitle D, sec. 1302(b)(1).

29. The Patient Protection and Affordable Care Act, sec. 1302(b)(2)(A).

30. N. C. Aizenman, "'Basic' Gets Tricky in the Health-Care Law," *Washington Post*, January 15, 2011.

31. The Patient Protection and Affordable Care Act, sec. 1251.

32. While specific rules have not yet been issued for grandfathering individual policies, those rules are likely to be similar to the rules for the small-group market, which have been issued and are discussed below, meaning changes to carriers, benefits, and/or cost-sharing would remove the plan from grandfathered status.

33. House Republicans on the Ways and Means Committee, "The Wrong Prescription: Democrats' Health Overhaul Dangerously Expands IRS Authority," March 18, 2010. Politifact suggests that the number of new agents could be as few as 5,000. Carol Fader, "Fact Check, 16,500 New IRS Agents Probably Not on the Way," *Jacksonville Times-Union*, April 11, 2010. Regardless of quibbles over the numbers, the point remains that the health care bill will result in a significant expansion of the IRS and its powers. In fact, the IRS has informed Congress that it may need to change its mission statement to acknowledge its new responsibilities and duties. Internal Revenue Service, National Taxpayer Advocate, "2010 Annual Report to Congress, vol. 1," p. 17.

34. Martin Vaughn, "IRS May Withhold Tax Refunds to Enforce Health-Care Law," *Wall Street Journal*, April 16, 2010.

35. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

36. Jeanne S. Ringel et al., "Analysis of the Patient Protection and Affordable Care Act, HR 3590," Rand Corporation, March 2010.

37. Sharon Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts," *Health Affairs* (July/August 2008): w270–w284, Exhibit 6.

38. Allison Cook and John Holahan, "Health Insurance Coverage and the Uninsured in Massachusetts: An Update Based on the 2005 Current Population Survey Data," Blue Cross Blue Shield of Massachusetts Foundation, 2006.

39. Kay Lazar, "Short-Term Customers Boosting Health Care Costs," *Boston Globe*, April 4, 2010.

40. The penalty in Massachusetts is up to half the cost of a standard insurance policy. Chapter 58 of the Acts of 2006, sec. 13.

41. For instance two half-time workers are considered the equivalent of one full-time employee for the purpose of determining a company's size. A full-time worker is considered to work 30 hours per week. There is also some confusion in the legislation over how companies with exactly 50 workers will be treated. In a testimony to the rushed and sloppy way in which the bill was passed, sec. 1513(A) of the Patient Protection and Affordable Care Act refers to "*at least* 50 full time workers," (emphasis added), while sec. 1513(B) refers to "*more than* 50 full times workers" (emphasis added).

42. The Patient Protection and Affordable Care Act, sec. 4908H(a), as amended by the Health Care and Education Affordability Reconciliation Act," sec. 1003.

43. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

44. http://www.healthcare.gov/news/factsheets/keeping_the_health_plan_you_have_grandfathered.html.

45. Ibid.

46. Robert Pear, "Study Points to Health Law Penalties," *New York Times*, May 23, 2010.

47. Quoted in Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review* 79, no. 2 (May 1989): 177–83.

48. Economists are divided about the most likely way that the cost of an employer mandate would be passed along to employees. Some suggest that most of the mandate's cost would be offset through lower wages. A study by Jonathan Gruber, for example, looking at the impact of a requirement that health insurance cover comprehensive childbirth benefits found strong evidence that employers reduced wages to pay for the benefits. Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* 84, no. 3 (June 1994): 662–41. And Alan Krueger and Uwe Reinhardt suggest that in the long run, the cost of the employer mandate would be shifted to the employee not through immediate wage cuts but through smaller future wage increases than would otherwise occur. Alan Krueger and Uwe Reinhardt, "The Economics of Employer versus Individual Mandates," *Health Affairs* 13, no. 2 (Spring II, 1994): 34–53. However, a large group of economists believe that most of the offset costs would come in the form of job loss. They argue that workers are likely to resist current wage reductions, particularly if they value wage compensation over heath insurance, which seems likely for many of the currently uninsured. Aaron Yelowitz, "Pay-or-Play Health Insurance Mandates: Lessons from California," Public Policy Institute of California, http://www.ppic.org/content/pubs/cep/EP_1006AYEP.pdf In addition, minimum wage laws provide a floor for how far employers could reduce wages. As Larry Summers, now head of the White House's National Economic Council, once wrote, the minimum wage means that "wages cannot fall to offset employers' cost of providing a mandated benefit, so it is likely to create unemployment." Summers, pp. 177–83.

49. "The Impact of Health Reform on Employers," Towers Watson, May 2010, http://www.towerswatson.com/united-states/research/1935.

50. Roughly 70 percent of Americans under age 65 get their health insurance through work. Carmen DeNavas-Walt, et al., "Income, Poverty and Health Insurance Coverage in the United States: 2006," Current Population Reports, U.S. Census Bureau, August 2007. Today there is no requirement that businesses provide insurance. And, while most businesses continue to do so (because, in a competitive labor market, it is an effective recruitment and retention tool), there has been a slow but steady decline in the number who do. Elise Gould, "Employer-Sponsored Health Insurance Erosion Continues," Employment Policy Institute, October 27, 2009. However, through the exchanges (see below) and expanded Medicaid eligibility, the bill creates a way for businesses to divest themselves of the expense and other headaches of offering health insurance without cutting the worker off completely. This may accelerate the tendency of employers to dump their workers from their current coverage.

51. Jennifer Haberkorn, "Four Companies Mulled Dropping Health Insurance Plans," *Politico*, May 7, 2010.

52. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010.

53. Ibid.

54. Haberkorn, "Four Companies Mulled Dropping Health Insurance Plans." The calculation is fairly simple. AT&T, for example, paid $2.4 billion last year in medical costs for its 283,000 workers. If the firm dropped its health insurance plan and instead paid an annual penalty of $2,000 for each uninsured employee, the fines would total less than $600 million, meaning AT&T would save about $1.8 billion a year. John Goodman, "Goodbye, Employer-Provided Insurance," *Wall Street Journal*, May 21, 2010.

55. 15 U.S.C. secs. 1011-1015.

56. Interestingly though, for all the hype about insurance reform, the most commonly cited insurance provisions take up roughly 20 pages, or less than one percent of the 2,409-page bill.

57. Public Health Service Act, Title XXVII, Part A, sec. 2705(a)(1-9), as amended by the Patient Protection and Affordable Care Act, Title I, Subtitle C, sec. 1201.

58. Public Health Service Act, Title XXVII, Part A, sec. 2702(a), as amended by Patient Protection and Affordable Care Act, Title I,

Subtitle C, sec. 1201.

59. Ibid.

60. Public Health Service Act, Title XXVII, Part A, sec. 2701, as amended by Patient Protection and Affordable Care Act, Title I, Subtitle C, sec. 1201.

61. Public Health Service Act, Title XXVII, Part A, sec. 2701(a)(1)(A)(iii), as amended by the Patient Protection and Affordable Care Act, Title I, Subtitle C, sec. 1201.

62. The Public Health Service Act, Title XXVII, Part A, sec. 2701(a)(1)(A)(iv), as amended by the Patient Protection and Affordable Care Act, Title I, Subtitle C, sec. 1201,

63. Public Health Service Act, Title XXVII, Part A, sec. 2701(a)(1)(B), as amended by the Patient Protection and Affordable Care Act, Title I, Subtitle C, sec. 1201.

64. The legislation appears to include a loophole that would allow insurers to continue excluding many children with preexisting conditions. Sec. 1201 of the bill prohibits insurers from excluding coverage of preexisting conditions for children who are currently covered. Thus, it would require insurers who currently provide coverage for children but exclude payments for certain ongoing medical situations, for example a congenital heart condition, to drop that exclusion. But for children who are not insured today, insurers would not be required to insure them until the full ban on preexisting conditions kicks in, in 2014. Robert Pear, "Coverage now for Sick Children? Check the Fine Print," *New York Times*, March 28, 2010. However, despite the wording of the law, most major insurers have said that they will nevertheless cover children with such conditions. Robert Pear, "Insurers to Comply with Rules on Children," *New York Times*, March 30, 2010. At the very least this shows the dangers of rushed legislation.

65. The Patient Protection and Affordable Care Act, Title I, Subtitle B, sec. 1101. Interestingly, high-risk pools were actually an important component of Republican alternatives to the Democratic health bill.

66. The creation of a federal high-risk pool may have created some unintended consequences in the 35 states that already operated high-risk pools. The insurance available through the federal risk pool is frequently more generous and sometimes less expensive than that available through the state pools. However, eligibility rules for the federal pool require applicants to be uninsured for at least six months. That would mean that current participants in the state pools cannot transfer to the federal pool, even if it's a better deal. Thus people in states that have attempted to deal with the problem of preexisting conditions are, in effect, penalized. Ricardo Alonso-Zaldivar, "Low-Cost Coverage in Obama Health Plan Not for All," Associated Press, April 16, 2010.

67. "State-by-State Enrollment in Pre-Existing Condition Insurance Plan, as of November 1, 2010," healthcare.gov.

68. Phil Galewitz, "HHS Cuts Premiums for Some High-Risk Pools," *Kaiser Health News*, November 5, 2010; Kevin Sack, "High-Risk Insurance Pools Are Attracting Few," *New York Times*, November 4, 2010.

69. See, for instance, Letter from M. Jodi Rell, Governor of the State of Connecticut, to Kathleen Sebelius, Secretary of U.S. Department of Health and Human Services, September 30, 2010.

70. Carla Johnson, "Health Premiums Could Rise 17 Percent for Young Adults," Associated Press, March 29, 2010.

71. Ibid.

72. Brian McManus, "Universal Coverage + Guaranteed Issue + Modified Community Rating = 95% Rate Increase," Council for Affordable Health Insurance, August 2009.

73. N. C. Aizenmanm, "Major Insurers to Stop Offering New Child-Only Policies," *Washington Post*, September 20, 2010.

74. Public Health Service Act, Title XXVII, Part A, sec. 2712, as amended by the Patient Protection and Affordable Care Act, Title I, Subtitle A, sec. 1001.

75. Henry Waxman and Joe Barton, " Memorandum to Members and Staff of the Subcommittee on Oversight and Investigations: Supplemental Information Regarding the Individual Health Insurance Market," June 16, 2009, http://energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf

76. Ibid.

77. Public Health Service Act, sec. 2711, as amended by the Patient Protection and Affordable Care Act, Title X, Subtitle A, sec. 10101.

78. Brie Zeltner, "How Will Removing Lifetime Caps on Health Coverage Affect You? Health Care Fact Check," *Cleveland-Plain Dealer*, March 24, 2010.

79. Emily Bregel, "Lifting the Cap on Coverage," McClatchy Newspapers, April 12, 2010.

80. Jennifer Haberkorn, "Health Bill Could Ban Low-Cost Plans," *Politico*, June 8, 2010. Many of these plans also ran afoul of the law's minimum loss ratio (MLR) requirement (see below).

81. The waivers affect plans covering more than 1.5 million workers. To see which companies have received waivers, check http://www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html.

82. Janet Adamy, "McDonald's Says It May Drop Health Plan," *Wall Street Journal*, September 30, 2010.

83. http://www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html.

84. Jason Millman, "Some Healthcare Waiver Requests Denied Even as HHS Approves 500 Others," *The Hill*, January 27, 2011.

85. The Patient Protection and Affordable Care Act, sec. 1302(c)(2)(A).

86. The Patient Protection and Affordable Care Act, sec. 1302(c)(1)(b)(ii).

87. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9016(a).

88. Companies operating in Massachusetts, New Jersey, Ohio, and Tennessee may receive a temporary exemption from this requirement at the request of their states' insurance commissioners. Michelle Malkin, "Big Labor's Obamacare Escape Hatch," *New York Post*, January 29, 2011.

89. Although insurance companies are undoubtedly one of the nation's most unpopular industries, it should be noted that their profits are not particularly high as industries go. The health insurance industry today actually has a profit margin of just 5.5 percent for traditional insurers and only 3.8 percent for Health Maintenance Organizations. Joseph Paduda, "Insurance Industry Profit Margins," *Managed Care Matters*, December 9, 2004, citing data from Weiss Ratings.

90. J. P. Wieske, "High Loss Ratios Undermine the Affordability of Health Insurance, *Health Care News*, July 1, 2007. There have been a few state-level experiments with minimum pay-out requirements, notably in Kentucky and North Dakota, and the results are cause for concern. Insurers abandoned the market in those states and left consumers with fewer choices and higher premiums.

91. Ricardo Alonso-Zaldivar, "New Coverage for Young Adults Will Raise Premiums," Associated Press, May 10, 2010.

92. Michelle Andrews, "Graduates May See Coverage Gap After All," *New York Times*, May 31, 2010.

93. Reed Ableson, "Insurer Cuts Health Plan as New Law Takes Hold," *New York Times*, September 30, 2010.

94. "Aetna Withdrawing from Colorado Individual Market," Colorado Insurance Insider, January 31, 2011.

95. "The Uninsured: A Primer, Key Facts about Americans without Health Insurance," Kaiser Family Foundation, December 2003.

96. The Patient Protection and Affordable Care Act, Title II, Subtitle A, sec. 2001(a).

97. Andy Schneider, Risa Elias, and Rachel Garfield, "Chapter 1: Medicaid Eligibility," Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14259.

98. Patient Protection and Affordable Care Act, sec. 2001(b)(2)(gg)(2).

99. Quoted in Marsha Blackburn and Phil Roe, "TennCare Lessons for Healthcare Reform," RealClear Politics.com, July 22, 2009, http://www.realclearpolitics.com/articles/2009/07/22/tenncare_lessons_for_modern_health_care_reform_97570.html.

100. Jagadeesh Gokhale, "Estimating ObamaCare's Effect on State Medicaid Expenditure Growth: A Study of Five Most Populous U.S. States," Cato Institute Working Paper, January 2011.

101. Ginger Rough and Mary Reinhart, "Brewer Signs Law Seeking Medicaid Waiver," *Arizona Republic*, January 21, 2011.

102. Patient Protection and Affordable Care Act, sec. 2101, as amended by the Health Care and Education Affordability Reconciliation Act," sec. 10201.

103. Patient Protection and Affordable Care Act, Title II, Subtitle B, sec. 2101(b).

104. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010. A refundable tax credit is paid regardless of an individual's actual tax liability. Thus, even an individual who pays no federal income tax would still receive the payment. In such cases, despite President Obama's insistence that such credits represent a "tax cut" it is appropriate to think of the payments as a form of welfare.

105. The Patient Protection and Affordable Care Act, Title I, Subtitle E, Part I, Subpart A, sec. 1401.

106. Based on the lowest cost Silver Plan available.

107. For a detailed discussion of the marginal tax problem in this legislation, see Michael Cannon, "Obama's Prescription for Low-Wage Workers: High Implicit Taxes, Higher Premiums," Cato Institute Policy Analysis no. 656, January 13, 2010.

108. The Patient Protection and Affordable Care Act, Title I, Subtitle E, Part II, sec. 1421.

109. The Patient Protection and Affordable Care Act, Title I, Subtitle B, sec. 1102.

110. The Patient Protection and Affordable Care Act, Title I, Subtitle B, sec. 1102 (c)(3).

111. The Patient Protection and Affordable Care Act, Title I, Subtitle B, sec. 1102 (c)(4).

112. The Patient Protection and Affordable Care Act, Title X, Subtitle E, sec. 10503.

113. Doug Trapp, "Health Reform May Mean 40 Million Health Center Patients in 5 Years," *American Medical News*, April 13, 2010.

114. Ezra Klein, "The Most Important, Undernoticed Part of Health Reform," http://voices.washingtonpost.com/ezra-klein/2009/06/health_insurance_exchanges_the.html.

115. Ezra Klein, "Health Care Reform for Beginners: The Many Flavors of the Public Option," *Washington Post*, June 8, 2009.

116. Office of the Governor, "Massachusetts Healthcare Reform," PowerPoint Presentation, April 10, 2006.

117. Jon Kingsdale, "About Us: Executive Director's Message," March 12, 2009, http://www.mahealthconnector.org/portal/site/connector/template.MAXIMIZE/menuitem3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_view

118. The Patient Protection and Affordable Care Act, sec. 1321(c).

119. The Patient Protection and Affordable Care Act, sec. 1311(d)(1)

120. The Patient Protection and Affordable Care Act, sec. 1312(c)(3)

121. The Patient Protection and Affordable Care Act, sec. 1312(d)(1).

122. The Patient Protection and Affordable Care Act, sec. 1312(c)(1).

123. The Patient Protection and Affordable Care Act, sec. 1312(d)(3)(D).

124. The Patient Protection and Affordable Care Act, sec. 1312(f)(2)(B). If they do so, many companies may choose to drop their current insurance coverage and push their employees into the exchange. Jennifer Haberkorn, "Four Companies Mulled Dropping Health Insurance Plans." That would, of course, mean that millions more American workers would not be able to keep their current coverage. And, since many of those employees would become eligible for subsidies, it would substantially increase the program's costs.

125. The Patient Protection and Affordable Care Act, sec. 1302(d)(1)(A-D).

126. The Patient Protection and Affordable Care Act, sec. 1302(e)(2).

127. The Patient Protection and Affordable Care Act, sec. 1402(c).

128. Estimates are for 2016. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Sen. Olympia Snowe, January 11, 2010.

129. Patient Protection and Affordable Care Act, sec. 1311(d)(3)(ii).

130. Patient Protection and Affordable Care Act, Title I, Subtitle D, Part IV, sec. 1334(g)(2), as amended by sec. 10104(q).

131. Patient Protection and Affordable Care Act, Title I, Subtitle D, Part IV, sec. 1334(b)(2), as amended by sec. 10104(q). The legislation also prohibits federal funds frombeing used for abortion services and requires separate accounts for payments for such services. Patient Protection and Affordable Care Act, Title I, Subtitle D, sec. 1303(b)(2)(B)(i), as amended by PPACA, Title X, Subtitle A, sec. 10104(c).

132. A cooperative, or co-op, is simply a member-owned business, operated on a not-for-profit basis, with the officers and directors elected by the members, in this case presumably the people whomit insures. States already have the power to charter co-ops, including health insurance co-ops. In fact, several co-operative insurance companies already exist. Health Partners, Inc. in Minneapolis has 660,000 members and provides health care, health insurance, and HMO coverage. The Group Health Cooperative in Seattle provides health coverage for 10 percent of Washington State residents. PacAdvantage, a California co-op, covers 147,000 people. There is no evidence that they are significantly less expensive or more efficient than other insurers. Several previous attempts by governments to set up co-ops have, in fact, failed. Perhaps the largest such failure was the Florida Community Health Purchasing Alliance, which was set up by the State of Florida in 1993, and at one time covered 98,000 people. It was unable to attract small business customers and ultimately went out of business in 2000.

133. See, for example, John Goodman, "What Is Consumer-Directed Health Care?" *Health Affairs* 25 (November–December 2006): 540–43. See also, Michael Tanner and Michael Cannon, *Healthy Competition: What's Holding Back Health Care and How to Free It* (Washington, Cato Institute, 2008, 2nd ed.); John Goodman and Gerald Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington: Cato Institute, 1993).

134. Essentially, we all want to live forever. This makes health care a very desirable good. At the same time, the normal restraints imposed by price are frequently lacking. Today, of every dollar spent on health care in this country, just 13 cents is paid for by the person actually consuming the goods or services. Roughly half is paid for by government, and the remainder is covered by private insurance. As long as someone else is paying, consumers have every reason to consume as much health care as is available. By contrast, when consumers share in the cost of their health-care purchasing decisions, they are more likely to make those decisions on the basis of price and value. Take just one example. If everyone were to receive a CT brain scan every year as part of their annual physical, we would undoubtedly discover a small number of brain cancers much earlier than we otherwise would, perhaps early enough to save a few patients' lives. But given the cost of such a scan, adding it to everyone's annual physical would quickly bankrupt the nation. But, if they are spending their own money, consumers will make their own rationing decisions based on price and value. That CT scan that looked so desirable when someone else was paying may not be so desirable if you have to pay for it yourself. The consumer himself becomes the one who says no. The RAND Health Insurance Experiment, the largest study ever done of consumer health purchasing behavior, provides ample evidence that consumers can make informed cost-value decisions about their health care. Under the experiment, insurance deductibles were varied from zero to $1,000. Those with no out-of-pocket costs consumed substantially more health care than those who had to share in the cost of care. Yet, with a few exceptions, the effect on outcomes was minimal. Emmett B. Keeler, "Effects of Cost Sharing on Use of Medical Services and Health," RAND Corporation, Health Policy Program, 1992; See also, Joseph P. Newhouse, "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine* 305 (December 17, 1981): 1501–07. And, in the real world, we have seen far smaller increases in the cost of those services, like Lasik eye surgery or dental care, that are not generally covered by insurance, than for those procedures that are insured. Barbara Kiviat, "Can Price Shopping Improve Health Care?" *Time*, April 19, 2010.

135. Barack Obama, *The Audacity of Hope: Thoughts on Reclaiming the American Dream* (New York: Three Rivers Press, 2006), p. 179.

136. "2010 Census Shows 10 Million People Covered by HAS/High-Deductible Health Insurance Plans," America's Health Insurance Plans (AHIP), press release, May 2010. A health savings account (HSA) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan. The funds contributed to the account are not subject to federal income or payroll taxes at the time of deposit. Unspent funds in an HSA may be rolled over from year to year, and may be withdrawn for nonmedical purposes beginning at age 65.

137. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9004. The Joint Committee on Taxation estimates this tax will cost families an additional $1.4 billion over the bill's first 10 years. Joint Committee on Taxation, "Estimated Revenue Effects of the Manager's Amendment to the Revenue Provisions Contained in the 'Patient Protection and Affordable Care Act,'" December 19, 2009.

138. The Patient Protection and Affordable Care Act, sec. 9003.

139. "Actuarial value" is a method of measuring an insurance plan's benefit generosity. It is expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. For a more detailed explanation, see Chris Peterson, "Setting and Valuing Health Insurance Benefits," Congressional Research Service, April 6, 2009.

140. The Patient Protection and Affordable Care Act, sec. 1302(d)(2)(B).

141. Ibid., sec. 10406.

142. Ibid., sec. 4003.

143. John Fund, "Health Reform's Hidden Victims," *Wall Street Journal*, July 24, 2009. Indeed, at least one Virginia-based insurer that specialized in HSAs has already gone out of business, citing the "considerable uncertainties" created by the new health care law. Michael Schwartz, "Start Up Health Insurer Shutting," RichmondBizSense.com, June 4, 2010, http://www.richmondbizsense.com/2010/06/04/startup-health-insurer-shutting/.

144. Bureau of Labor Statistics, "Pretax Benefits: Access, Private Industry Workers," National Compensation Survey, March 2007, Table 24. Flexible spending accounts (FSAs) allow an employee to set aside a portion of his or her salary on a tax-advantaged basis to pay for qualified expenses, most commonly medical expenses, as part of an employer's "cafeteria plan," of benefits under sec. 125 of the Internal Revenue Code. Money deposited in an employee's FSA is not subject to income or payroll taxes. Unlike health savings accounts, funds deposited in an FSA may not be rolled over from year to year. Unused funds revert back to the plan administrator under what is commonly known as the "use-it-or-lose-it" rule.

145. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9005.

146. The rules on over-the-counter medications would also apply to health reimbursement accounts (HRAs). The Patient Protection and Affordable Care Act, sec. 9003(c).

147. Social Security and Medicare Board of Trustees, "A Summary of the 2009 Annual Reports."

148. For a discussion of how Cato scholars believe Medicare should be reformed, see Michael Cannon, "Medicare," in *Cato Handbook for Policy Makers*, ed. Ed Crane and David Boaz (Washington: Cato Institute, 2009), pp. 125–31, http://www.cato.org/pubs/handbook/hb111/hb111-12.pdf.

149. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

150. Ibid.

151. Ibid.

152. Kaiser Family Foundation, "Medicare Advantage Fact Sheet," April 2009.

153. "The Medicare Advantage Program," Testimony of Peter R. Orzag, director, Congressional Budget Office, before the Committee on the Budget, U.S. House of Representatives, June 28, 2007.

154. For example, President Obama told ABC News, "We've got to eliminate programs that don't work, and I'll give you an example in the health care area. We are spending a lot of money subsidizing the insurance companies around something called Medicare Advantage, a program that gives them subsidies to accept Medicare recipients but doesn't necessarily make people on Medicare healthier. And if we eliminate that and other programs, we can potentially save $200 billion out of the health care system" ABC *World News Tonight*, January 11, 2009.

155. Supporting Information, Official U.S. Government Site for People with Medicare, http://www.medicare.gov/MPPF/Static/TabHelp.asp?language=English&version=default&activeTab=3&planType=MA.

156. The Patient Protection and Affordable Care Act, Title III, Subtitle C, sec. 3201, as amended by the Health Care and Education Affordability Reconciliation Act, sec. 1102.

157. Testimony of Richard Foster, chief actuary, Center for Medicare and Medicaid Services, before the House Committee on the Budget, January 26, 2011, cited in Ricardo Alonso-Zaldivar, "Medicare Official Doubts Health Savings," Associated Press, January 27, 2011.

158. Robert Weisman, "Harvard Pilgrim Cancels Medicare Advantage Plan," *Boston Globe*, September 28, 2010.

159. Ibid.

160. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

161. "ACR Strongly Opposes Imaging Cuts in Health Care and Education Affordability Reconciliation Act," March 19, 2010, http://www.dotmed.com/news/story/12058/.

162. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010.

163. Patient Protection and Affordable Care Act, Title III, Subtitle B, Part III, sec. 3131.

164. Certainly it is impossible to draw any sort of direct correlation between the amount of health care spending and outcomes. Gerard Anderson and Kalipso Chalkidou, "Spending on Medical Care: More Is Better?" *Journal of the American Medical Association* 299, no. 20 (May 28, 2008): 2444–45. In fact, by some estimates as much as 30 percent of all U.S. health spending produces no discernable value. Elliott Fisher, "Expert Voices: More Care Is Not Better Care," National Institute for Health Care Management, January 2005.

165. See, for example, Elliott Fisher, Julie Bynum, and Jonathan Skinner, "Slowing the Growth of Health Care Costs—Lessons from Regional Variation," *New England Journal of Medicine* 360, no. 9 (2009): 849–52.

166. First, "quality" and "value" are not unidimensional terms. In fact, such concepts are highly idiosyncratic, with every individual having different ideas of what "quality" and "value" means to them, based on such things as a person's pain tolerance, lifestyle, feeling about hospitalization, desire to return to work, and so forth. For example, a surgeon may tell you that the only way to ensure a cure for prostate cancer is a radical prostatectomy. But that procedure's side-effects can severely impact quality of life—so some people prefer a procedure with a lower survival rate, but fewer side effects. Second, comparative effectiveness research too often has a tendency to gear its results toward the "average" patient. But many patients are outliers, whose response to any particular treatment, for either good or ill, can vary significantly from the average. This matters little when the research is simply informative. However, if the research becomes the basis for more prescriptive requirements, for example prohibiting reimbursements for some types of treatment, the impact on patient outliers could be severe. In the end, the answer to Medicare and Medicaid's open-ended subsidies is to change the structure of those programs, shifting the subsidy (to the degree there is one) directly to the consumer through some form of capped premium support. The consumer would then be required to make comparative cost-value decisions.

167. Michael Cannon, "A Better Way to Generate and Use Comparative-Effectiveness Research," Cato Institute Policy Analysis no. 632, February 6, 2009.

168. For example, in Great Britain, the National Institute on Clinical Effectiveness makes such decisions, including a controversial determination that certain cancer drugs are "too expensive." Jacob Goldstein, "U.K. Says Glaxo's Breast Cancer Drug Isn't Worth the Money," *Wall Street Journal*, July 7, 2008.

169. Tom Daschle, Scott Greenberger, and Jeanne Lambrew, *Critical: What We Can Do about the Health-Care Crisis* (New York: Thomas Dunne Books, 2008), p. 179.

170. Jennifer Haberkorn, "GOP: Medicare Pick Favors 'Rationing'," *Politico*, May 12, 2010.

171. Patient Protection and Affordable Care Act, Title IX, sec. 9012.

172. See http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:h1enr.txt.pdf.

173. Cited in Jon Healey, "The Healthcare Reform Exposes an Extraordinary Tax Subsidy," *Los Angeles Times*, March 21, 2010.

174. Patient Protection and Affordable Care Act, Title IX, sec. 9012, as amended by the Health Care and Education Affordability Reconciliation Act of 2010, sec. 1407.

175. Kris Maher, Ellen Schultz, and Bon Tita, "Companies Take Health Care Charges," *Wall Street Journal*, March 26, 2010.

176. "Dems Cancel Hearing on Business Health Gripes," Associated Press, April 14, 2010.

177. The Patient Protection and Affordable Care Act, Title III, Subtitle E, sec. 3403.

178. The Patient Protection and Affordable Care Act, Title III, Subtitle E, sec. 3403(c)(2)(a)(ii).

179. Social Security Act, sec. 1899A(c)(2)(A)(iii), as amended by the Patient Protection and Affordable Care Act, sec. 3403.

180. Testimony of Richard Foster, chief factuary, Center for Medicare and Medicaid Services, before the House Committee on the Budget, January 26, 2011, cited in Ricardo Alonso-Zaldivar "Medicare Official Doubts Health Savings."

181. See Cannon, "A Better Way to Generate and Use Comparative Effectiveness Research."

182. U.S. Department of Health and Human Services, "What Is the Donut Hole?" August 9, 2010, http://www.healthcare.gov/news/blog/donuthole.html.

183. Perry Bacon, Jr., and Michael Shear, "Obama Will Tout $250 Health-Care Rebate in Town-Hall Meeting with Seniors," *Washington Post*, June 8, 2010. Seniors become eligible for the rebate at the end of the quarter in which they reach the $2,700 ceiling. Therefore, the checks will initially be sent to those seniors that had $2,700 in prescription drug expenses by May 31, 2010. Other seniors may receive rebate checks later in the year.

184. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010. However, drug companies expect to more than make up this cost from other provisions in the bill, such as expanded insurance coverage and an inclusion of prescription drugs, in the minimal acceptable coverage mandate. As a result, the pharmaceutical industry strongly supported the bill's passage.

185. Ibid.

186. Ibid.

187. The Omnibus Budget Reconciliation Act of 1981, the Tax Equity and Fiscal Responsibility Act of 1982, the Deficit Reduction Act of 1984, the Consolidated Omnibus Budget Reconciliation Act of 1985, the Omnibus Budget Reconciliation Acts of 1986, 1987, 1989, 1990, and 1993, the Balanced Budget Act of 1997, and the Deficit Reduction Act of 2005.

188. See, James Horney and Paul van de Water, "House-Passed and Senate Health Bills Reduce Deficit, Slow Health Costs, and Include Realistic Medicare Savings," Center on Budget and Policy Priorities, December 4, 2009.

189. HR 3961.

190. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010.

191. Ibid.

192. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9001, as amended by the Health Care and Education Affordability Reconciliation Act, sec. 1401.

193. Richard Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services, April 22, 2010.

194. "Cadillac Health Plan Tax to Penalize Majority of Employers by 2018," Towers Watson, press release, May 19, 2010.

195. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9015.

196. California, Hawaii, Maryland, New Jersey, New York, Oregon, Rhode Island, and Vermont. Data provided by Tax Foundation.

197. Health Care and Education Affordability Reconciliation Act, Title I, Subtitle E, sec. 1411.

198. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9013.

199. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9013(b).

200. The Patient Protection and Affordable Care Act, Title IX, Subtitle E, sec. 9008, as amended by the Health Care and Education Affordability Reconciliation Act, sec. 1404.

201. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9009, as amended by the Health Care and Education Affordability Reconciliation Act, sec. 1405.

202. The Patient Protection and Affordable Care Act, Title IX, Subtitle E, sec. 9009, as amended by the Health Care and Education Affordability Reconciliation Act, sec. 1405(b)(2)(E).

203. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended."

204. "New Tax Could Boost Small Business Premiums by $1,000 per Year," Joint Economic Committee, Republican staff, April 22, 2010.

205. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9010, as amended by the Health Care and Education Affordability Reconciliation Act, sec. 1406(a)(4).

206. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9010, as amended by the Health Care and Education Affordability Reconciliation Act, sec. 1406.

207. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9010(b)(1)(A).

208. Patient Protection and Affordable Care Act, Title IX, sec. 9010(c)(2)(C), as amended by Title X, Subtitle H, sec. 10905(c), and sec. 9010(c)(2)(E), as amended by Title X, Subtitle H, sec. 10905(c).

209. Patient Protection and Affordable Care Act, Title IX, sec. 9010 (c)(2)(C), as amended by Title X, Subtitle H, sec. 10905(d). AARP insurance plans are also exempt fromseveral other provisions ofthe law, including the prohibition on excluding preexisting conditions, sec. 1201(2)(A); medical loss-ratio requirements, sec. 1103; and limits on compensation for insurance executives, sec. 9014.

210. The Patient Protection and Affordable Care Act, Title IX, Subtitle E, sec. 9009, as amended by the Health Care and Education Affordability Reconciliation Act, sec. 4191.

211. Patrick Fleenor and Gerald Prante, "Health Care Reform: How Much Does It Redistribute Income?" Tax Foundation Fiscal Fact no. 22, April 15, 2010. That is on top ofwhat was already expected to accrue to families in the top 1 percent ofincomes.

212. Ibid. Those with incomes below $18,000 per year gain relatively little because they already receive government assistance under Medicaid and other programs.

213. Internal Revenue Code of1986, chap. 32, as amended by the Health Care and Education Affordability Act, Title I, Subtitle E, sec. 9006.

214. Vicki Needham, "Senate Approves 1099 Repeal as Amendment to FAA Measure," *Roll Call*, February 2, 2011.

215. The Patient Protection and Affordable Care Act, sec. 8002(a)(1).

216. They will eventually be set by the secretary ofHHS.

217. Letter fromDouglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010.

218. Foster, "Estimated Financial Effects ofthe 'Patient Protection and Affordable Care Act,' as Amended."

219. Public Health Service Act, sec. 3202(6)(i), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).

220. Public Health Service Act, sec. 3202(6)(ii), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).

221. Public Health Service Act, sec. 3203(a)(1)(D)(i), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).

222. Letter fromDouglas Elmendorf, director, Congressional Budget Office, to Sen. Kay Hagan, July 6, 2009.

223. Benefits will actually be paid into an individual's "life independence fund," which will be managed by private institutions, but must have electronic capability and a debit card function. Public Health Service Act, sec. 3205(c)(1), as amended by the Patient Protection and Affordable Care Act, sec. 8002(a).

224. Public Health Service Act, sec. 3203(a)(1)(D)(iii), as amended by Patient Protection and Affordable Care Act, sec. 8002(a). However, benefits cannot be rolled over year to year.

225. Public Health Service Act, sec. 3203(a)(1)(C)(i), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).

226. Public Health Service Act, sec. 3203(a)(1)(C)(iii), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).

227. Letter fromDouglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

228. Ibid. In short, the CLASS Act will create a situation analogous to Social Security. For Social Security, this means that once the cash-flow turns negative, beginning in 2016, the government will be faced with the choice to increase taxes, reduce benefits, or run additional debt.

229. June O'Neill, "The Trust Fund, the Surplus, and the Real Social Security Problem," Cato Institute Social Security Choice Paper

no. 26, April 9, 2002.

230. Lori Montgomery, "Proposed Long-Term Insurance Program Raises Questions," *Washington Post*, October 27, 2009.

231. "The Moment of Truth," National Commission on Fiscal Responsibility and Reform, December 2010.

232. Allen Schmitz, "Adverse Selection and the CLASS Act," Milliman Health Reform Briefing Paper, December 2009.

233. Public Health Service Act, sec. 3203(b)(1)(E), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).

234. American Academy of Actuaries, "Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program," July 22, 2009. http://www.actuary.org/pdf/health/class_july09.pdf

235. Richard Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services, April 22, 2010.

236. Ibid.

237. Public Health Service Act, sec. 3203(a)(1)(A)(ii), as amended by the Patient Protection and Affordable Care Act, Title XIII, sec. 8002(a).

238. Mandatory participation seems entirely in line with arguments that the bill's individual mandate for health insurance was necessary to prevent adverse selection.

239. Patient Protection and Affordable Care Act, sec. 4205.

240. Ed Ou, "Health Care Bill Requires Calories on Menus at Chain Restaurants," Associated Press, March 23, 2010.

241. Patient Protection and Affordable Care Act, sec. 4205.

242. About a third of the US population is considered obese. Nanci Helmich, "U.S. Obesity Rate Levels Off, at about One-Third of Adults," *USA Today*, January 13, 2010. Obesity-related illnesses are estimated to cost the U.S. health care system as much as $147 billion per year, according to the Centers for Disease Control. "Obesity Costs U.S. Health System $147 Billion: Study," Reuters, July 28, 2009.

243. Roni Caryn Rabin, "How Posted Calories Affect Food Orders," *New York Times*, November 2, 2009.

244. Bryan Bollinger, Phillip Leslie, and Alan Sorenson, "Calorie Posting in Chain Restaurants," Stanford University and National Bureau of Economic Research, January 2010.

245. National Automatic Merchandise Association Legislative Alert, October 30, 2009. http://www.vending.org/pdf/NAMA_October_30_2009_Leg_Alert.pdf

246. Patient Protection and Affordable Care Act, Title II, Subtitle I, sec. 3023, sec. 2705, sec. 2706.

247. Patient Protection and Affordable Care Act, Title III, Part III, sec. 3021.

248. Patient Protection and Affordable Care Act, Title II, Subtitle E, sec. 2401.

249. Patient Protection and Affordable Care Act, Title II, Subtitle E, sec. 2402.

250. Patient Protection and Affordable Care Act, Title III, Part III, sec. 3025.

251. Public Health Service Act, Title III, sec. 399HH, as amended by the Patient Protection and Affordable Care Act, sec. 3011.

252. Anderson and Chalkidou, pp. 2444–45.

253. Fisher.

254. See, for example, Fisher, Bynum, and Skinner, pp. 849–52.

255. "Opportunities to Increase Efficiency in Health Care," Statement of Peter Orszag, director, Congressional Budget Office, at the Health Reform Summit of the Committee on Finance, United States Senate, June 16, 2008.

256. Social Security Act, Title IX, sec. 1181(d)(8)(A)(iv), as amended by the Patient Protection and Affordable Care Act, Title VI,

Subtitle D, sec. 6301.

257. As the CBO notes, "To affect medical treatment and reduce health care spending in a meaningful way, the results of comparative effectiveness analyses would not only have to be persuasive but also would have to be used in ways that changed the behavior of doctors, other health professionals and patients." Congressional Budget Office, "Research on the Comparative Effectiveness of Medical Treatments," December 2007.

258. Susan Sataline and Shirley Wang, "Medical Schools Can't Keep Up," *Wall Street Journal*, April 12, 2010.

259. Terry Jones, "45% of Doctors Would Consider Quitting If Congress Passes Health Care Overhaul," *Investors Business Daily*, September 15, 2009.

260. Patient Protection and Affordable Care Act, Title X, Subtitle E, sec. 10503, Title V, Subtitle C, sec. 5202; sec. 5203; 5204; and sec. 5205.

261. Patient Protection and Affordable Care Act, Title V, Subtitle D, sec. 5305.

262. Social Security Act, Title XVIII, sec. 1833, as amended by the Patient Protection and Affordable Care Act, Title V, Subtitle F, sec. 5501.

263. Patient Protection and Affordable Care Act, Title X, Subtitle B, Part I, sec. 10201(z)(B)(3), as amended by the Health Care and Education Affordability Reconciliation Act of 2010, Title I, Subtitle C, sec. 1201.

264. Patient Protection and Affordable Care Act, Title X, Subtitle E, sec. 10502.

265. Patient Protection and Affordable Care Act, Title X, Subtitle C, sec. 10323.

266. Public Health Service Act, sec. 351(k)(7)(A), as amended by the Patient Protection and Affordable Care Act, Title XII, sec. 7002(a)(2).

267. See for example, "Health Bill to Bring Near Universal Coverage," Associated Press, March 22, 2010.

268. "Obama Makes Case for Universal Coverage, End of Medical Red Tape," CNNPolitics.com, June 15, 2009, http://www.cnn.com/2009/POLITICS/06/15/obama.ama/index.html.

269. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010.

270. Ibid.

271. Ibid., Table 4.

272. Ringel et al.

273. Ibid.

274. Ibid.

275. Ibid.

276. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

277. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 18, 2010.

278. The Physicians' Foundation, "The Physicians' Perspective: Medical Practice in 2008," Survey Key Findings, November 18, 2008.

279. Long, pp. w270–w284.

280. Kevin Sack, "In Massachusetts, Universal Care Strains Coverage," *New York Times*, April 5, 2008.

281. Jesse Lee, "Reaching Across the Aisle on Jobs and Health Reform," White House Blog, February 9, 2010, http://www.whitehouse.gov/blog/2010/02/09/reaching-across-aisle-jobs-and-health-reform

282. "OECD Health Data 2007: Statistics and Indicators for 30 Countries," Organization for Economic Cooperation and

Development, July 2007.

283. Center for Medicare and Medicaid Services, "National Health Expenditures 2009 Highlights," January 20, 2011, http://www.cms.gov/NationalHealthExpendData/downloads/highlights.pdf High health care spending is not necessarily bad. To a large degree, America spends money on health care because it is a wealthy nation and chooses to do so. Economists consider health care a "normal good," meaning that spending is positively correlated with income. As incomes rise, people want more of that good. Because we are a wealthy nation, we can and do demand more health care. Uwe Reinhardt of Princeton University, for example, estimates that nearly half of the difference in spending between the United States and other industrial nations is due to America's higher GDP. Uwe Reinhardt, Peter Hussey, and Gerald Anderson, "U.S. Health Care Spending in an International Context," *Health Affairs* 23 (May/June 2004): 11–12. Still, most experts on all sides of the debate recognized that the current trend in health care spending is unsustainable, and favored efforts to restrain the growth in spending.

284. Richard Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services, April 22, 2010.

285. Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," *Quarterly Journal of Economics* 122, no. 3 (2007): 1–37.

286. Douglas Elmendorf, "Health Costs and the Federal Budget," CBO Director's Blog, May 28, 2010, http://cboblog.cbo.gov/?utm_source=Newsletter&utm_medium=Email&utm_creampaign=Fix%2BHealth%20Care&p=1034.

287. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Senate Majority Leader Harry Reid, March 11, 2010.

288. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 18, 2010. Note that CBO calls this "a preliminary estimate" and it may be revised in the future.

289. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 18, 2010.

290. The February 2010 deficit was $220.0 billion, the highest monthly deficit in U.S. history. "Another Record Month of Red Ink: Government Racked Up Record Monthly Deficit of $220 Billion in February," ABCNews.com, March 10, 2010, http://blogs.abcnews.com/politicalpunch/2010/03/another-record-month-of-red-ink-government-racked-up-record-monthly-deficit-of-220-billion-in-februa.html.

291. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

292. Balanced Budget Act of 1997, sec. 4502.

293. Congressional Budget Office, "Summary of Medicare Physician Payment Reform Act of 2009," November 4, 2009.

294. Cited in Shawn Tully, "Health Care: Going from Broken to Broke," Cnnmoney.com, March 12, 2010.

295. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Rep. Paul Ryan, March 19, 2010. Note that the change is not a matter of simply adding the cost of the doc-fix to the cost of the health bill, because of the interaction of the doc-fix with changes in the Medicare Advantage program. Some proponents of the bill argue that it is unfair to assign the cost of the doc-fix to the health care bill since it almost certainly would have occurred anyway. See, for example, Ezra Klein, "One More Time with the Medicare Doc-Fix," Washington Post Online, April 28, 2010, http://voices.washingtonpost.com/ezra-klein/2010/04/one_more_time_with_the_medicar.html. But the question isn't one of assigning cost, but whether projections of the bill's cost and impact on future deficits uses an unrealistically low baseline.

296. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Rep. Jerry Lewis, May 11, 2010.

297. Authors calculations, assuming a 6 percent growth rate in both revenues and expenditures after 2019.

298. "2010 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds," Table III.C15.

299. Perhaps the clearest explanation appeared in the Clinton Administration's FY2000 budget, in reference to the Social Security Trust Fund: "These Trust Fund balances are available to finance future benefit payments . . . but only in a bookkeeping sense. . . . They do not consist of real economic assets that can be drawn down in the future to fund benefits. Instead, they are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing benefits or other expenditures. The existence of Trust Fund balances, therefore, does not by itself have any impact on the government's ability to pay benefits." Executive Office of the President of the United States, *Budget of the United States Government, Fiscal Year 2000,*

Analytic Perspectives, p 337.

300. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended."

301. Letter from Douglas Holtz-Eakin and 200 economists to House and Senate leadership, January 18, 2001.

302. Robert Reischauer "An Analysis of the Administration's Health Proposal," Congressional Budget Office, February 1994.

303. Michael Cannon, "ObamaCare's Cost Could Top $6 Trillion," Cato @ Liberty Blog, November 27, 2009, http://www.cato-at-liberty.org/2009/11/27/obamacares-cost-could-top-6-trillion/.

304. Stephen Dinan, "Entitlements Have a History of Cost Overruns," *Washington Times*, June 16, 2006.

305. Ibid.

306. Ibid. In fairness, it should be pointed out that, so far, Medicare Part D is costing less than estimated.

307. Shawn Tully, "Documents Reveal AT&T, Verizon, Others Thought about Dropping Health Care Plans," *Fortune*, May 6, 2010.

308. Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform: New Results," American Action Forum, May 2010.

309. Congressional Budget Office, "Budget and Economic Outlook: Fiscal Years 2011 to 2021," January 2011.

310. See http://www.whitehouse.gov/omb/assets/omb/financial/reports/citizens_guide.pdf.

311. "Obama Health Care Plan," Memorandum from David Blumenthal, David Cutler, and Jeffrey Liebman, 2007.

312. "Will Health Care Bill Lower Premiums?" Associated Press, March 17, 2010, http://www.cbsnews.com/stories/2010/03/17/politics/main6306991.shtml.

313. "A Comprehensive Survey of Premiums, Availability, and Benefits," American Health Insurance Plans, October 2009. It should be noted that premiums differ significantly from state to state. For example, the premium for a family health plan in Iowa is just $5,609, while in New York a similar plan is $13,296. Premiums also vary significantly on the basis of age, ranging from $1,350 for persons under age 18 to $5,755 for persons aged 60–64, and according to such factors as co-payments and deductibles.

314. John Fritze, "Average Family Health Insurance Policy $13,375, Up 5%," *USA Today*, September 16, 2009, citing survey data from the Kaiser Family Foundation.

315. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Sen. Evan Bayh, November 30, 2009. Although this was a November estimate, and CBO and has not updated it to reflect the final bill language, CBO noted in May 2010 that "the effects of the enacted legislation are expected to be quite similar," http://www.cbo.gov/publications/collections/health.cfm Premiums for employer policies usually have lower deductibles and more comprehensive benefits, accounting for the higher employer-based premiums. Premiums for identical policies are generally higher in the nongroup market.

316. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Sen. Evan Bayh.

317. Ibid.

318. Ibid.

319. Ibid.

320. Ibid.

321. "U.S. Health Care Cost Rate Increases Reach Highest Levels in Five Years, According to New Data from Hewitt Associates," press release, September 27, 2010.

322. Janet Adamy, "Health Insurers Plan Hikes," *Wall Street Journal*, September 7, 2010.

323. White House, "Remarks by the President at the Annual Conference of the American Medical Association," press release, June 15, 2009, http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-the-Annual-Conference-of-the-American-Medical-Association/.

324. Testimony of Richard Foster, chief actuary, Center for Medicare and Medicaid Services, before the House Committee on the Budget, January 26, 2011, cited in Ricardo Alonso-Zaldivar, "Medicare Official Doubts Health Savings."

325. The White House, "Remarks by the President in Town Hall Meeting on Health Care," Office of the Press Secretary, 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/.

326. Mark Thiessen, "Palin Says Obama's Health Care Plan is 'Evil'," Associated Press, August 8, 2009.

327. In the long run, the only way to spend less on health care is to consume less health care. The real health care debate, therefore, is not about whether we should ration care, but about *who* should ration it. Thus, while free-market health care reformers want to shift more of the decisions (and therefore the financial responsibility) back to the individual, this legislation rejects that approach (see the discussion on consumer-directed health care above) and therefore would ultimately put the government in charge of those decisions.

328. Chapter 305 of the Acts of 2008: An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care, September 10, 2008.

329. Report of the Special Commission on the Health Care Payment System, March 25, 2009 (emphasis added).

330. http://healthcarelawsuits.org/.

Chapter 22

The New Health Care Law: What a Difference a Year Makes

Cato Policy Forum

When President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010, few would have predicted what happened in the following year. Opposition to the law has led to Republican gains in Congress, a House vote to repeal it, and two federal courts striking down part or all of the law as unconstitutional. At a half-day Cato Institute conference, held one year after the House of Representatives passed the law, Kavita Patel, M.D., managing director of delivery-system reform at the Engelberg Center for Health Care Reform at the Brookings Institution; Michael F. Cannon, director of health policy studies at the Cato Institute; Ron Pollack, executive director of Families USA; and Douglas Holtz-Eakin, former director of the Congressional Budget Office, debated how the law has already affected America's health care sector, labor markets, and the federal budget, and what impact it will have in the future.

KAVITA PATEL: My background is in primary care as an internal medicine physician, and that's where we often talk about quality, delivery-system reforms, and some of the actual transformations in the Affordable Care Act. We're seeing some of those changes right now—in medical homes, patient care coordination, transitions in care—by virtue of the fact that one of the things we tried to do in the ACA was show that those are the promising areas for the next decades. A lot of us working on the health care law knew that there were mechanisms—bureaucratic, statutory, and otherwise—preventing the Centers for Medicare and Medicaid Services from rewarding places doing "innovative" things. Out of that was born the Centers for Medicare and Medicaid Innovation, with $10 billion for projects, research, and evaluation. One of the first things out the gate from that $10 billion—over 10 years—was the promotion of primary care and medical homes at the state level. This is a population for which innovation is desperately needed.

In terms of quality, we've known now for the last seven or eight years that the quality of care in our country has been, at most—on average—"good" about half the time. If you're in Las Vegas, that may be decent odds. If you're dealing with health care, that's unacceptable.

So, in an effort to make sure that we understand the gap—but also so that we can do something about it—we really need to understand what works. That means not just putting money into data on websites, but actually investing in effectiveness, in comparing research that looks at treatments and processes of care—as well as establishing guidelines on how our evidence is used by clinicians. Streamlining and coordinating what the government does was something that all of us thought were broken and dysfunctional.

One year later we've already seen agencies coordinating and making their data accessible— agencies that had not spoken to each other before and historically had not necessarily even traded data or had their data accessible to the public.

Looking forward, the key changes are not spelled out in much minutiae in the law, offering an opportunity for not only interpretation, but also for action and decision making on behalf of health care providers.

Those changes impact accountable-care organizations, medical homes, value-based purchasing, a lot of the insurance design benefits that we're hoping that we will see in Medicare, as well as some of the state-based Medicaid contracts. That's exactly where the promise of not only cost containment and bending the cost curve will come from, but also the true promise of delivering the right care, at the right time, in the right place.

MICHAEL CANNON: ObamaCare is no more going to improve the quality of health care than its consumer protections are going to protect patients. Most of the provisions that are supposed to improve the way we deliver health care were not specified in the law. Basically what happened, we created a Center for Medicare and Medicaid Innovation to run pilot programs and experiment with different ways of setting prices and different financial incentives—different terms of exchange—to see if providers will deliver care that is more coordinated.

The problem with these pilot programs—and this approach for reforming health care—is that we have tried it and it has never worked. Medicare has been trying pilot programs for its entire existence, and either those pilot programs fail or, if they succeed in either improving the quality of care or reducing the cost of care, are blocked by the corners of the health care industry whose income streams those innovations threaten: the low-quality providers or high-cost providers who will see Medicare revenues delivered someplace else. Under lobbying pressure, these pilot programs are eliminated.

There's an article in the most recent issue in the journal *Health Affairs* that polled physicians in Switzerland and asked them, "What would it take for you to provide more coordinated care than what you're providing right now?"—to join into the sort of accountable- care organizations that are discussed in this law? The Swiss doctors said they would want a 40 percent raise before they took these steps to improve the quality of care. That's the sort of resistance that you're going to see to these pilot programs.

This law will not improve the cost of medical care or health insurance, either. The individual mandate, portions of which began taking effect on September 23, 2010, is already increasing the cost of health insurance for millions of Americans. One insurance company reported those provisions were forcing it to increase premiums on some customers by up to 30 percent.

Another reason for the backlash is that many believe the law is overkill. If you look at the preexisting-condition insurance plans that the law has set up in each state, they've attracted just 12,000 enrollees at last count, or three percent of the 375,000 projected to enroll. Since the primary motivation of the law was to protect people with preexisting conditions, that suggests that it wasn't necessary to conscript 200 million Americans into a compulsory health insurance scheme to solve that problem. The projections that ObamaCare will permanently eliminate 800,000 jobs—not to mention any temporary job losses—is striking fear in those battered by the recession.

Finally, many Americans are taking this law personally. The president promised to put an end to the game playing, but then made backroom deals with the drug lobby and Walmart, while Senate Democrats who drafted this law used tax dollars to buy votes in support for it. Americans watched Kathleen Sebelius repeatedly censor insurers who disagreed with her. They saw their tax dollars buy ads where Andy Griffith used "weasel words"—those aren't my words, those are from FactCheck.org—to mislead seniors about how this law will affect their coverage. They hear the president continue to say things that they know are untrue, that his own advisers in some cases—and nonpartisan observers in others—have

discredited: for instance, ObamaCare will allow Americans to keep their coverage, reduce costs, and reduce the deficit. We heard that the individual mandate was a tax. Then the president told us that it was not a tax. Then his Justice Department went into court to argue that, in fact, it is a tax. At a certain point, people start to feel insulted.

Newt Gingrich predicted that this law would be repealed by April 2013. I don't know if anyone can know if that's true, but I'm struck by two things. The first is that if Congress doesn't repeal this law, we'll be back here on the second anniversary of ObamaCare, the fifth anniversary of ObamaCare, the 10th anniversary of ObamaCare—having conferences like this one, in rooms like this one, in Washington, D.C., and elsewhere in the country. We'll be asking why health care spending is still rising out of control, why we still don't have coordinated care, accountable-care organizations, comparative-effectiveness research that helps us to improve the quality of care, and health information technologies; and we'll be questioning why insurers are being rewarded by ObamaCare's price controls for avoiding or mistreating the sick. The second thing that I'm struck by is just how plausible Gingrich's prediction is. It's certainly far more plausible than anyone thought one year ago today.

RON POLLACK: We have already seen significant and helpful changes due to the Affordable Care Act. So far, much of the conversation about the Act has focused on matters that go into effect in 2014. But there are a number of things that have already gone into effect, and they are very significant and helpful. Let me pick out the more salient ones. In no particular order they include: Young adults—who turn out to be the age most likely to be uninsured—now can continue to stay on their parents' policy until their 26th birthday. I don't know how many young adults have already availed themselves of such coverage, but they can now get coverage through their parents.

(There's a moral here: Be good to your parents.) Second, with respect to seniors, some have already seen the benefit of this legislation in two different respects. One of them is helpful to those who currently fall into the huge prescription drug gap in coverage, the so-called "doughnut hole,"— where, after seniors and people with disabilities in Medicare have spent a certain amount of money, they fall into a no-coverage zone. In today's dollars, once a senior has spent $2,840 in drugs during the year, the gap in coverage begins, and it doesn't end until they've spent $6,484—a gap of $3,644 dollars. With each passing year that gap is supposed to get larger. Last year, people who fell in the doughnut hole received a modest $250 check. This year, anyone falling into the doughnut hole can purchase brand name drugs with a 50 percent discount. In other words, somebody who falls into the doughnut hole can receive a $1,822 benefit to help them afford their drugs. Seniors also receive the benefit of free preventive care, so that Medicare becomes more of a preventive and primary care system, not just a sickness care system.

A third group aided is small business owners. They can receive a tax credit of up to 35 percent of the costs of covering their workers if they have fewer than 25 workers. I don't yet know how many have availed themselves of this tax-credit benefit, but there are over 4 million who qualify for it. Children are another group already helped. They are the first to receive the benefit of insurance-related protections such that they cannot be denied coverage due to a preexisting condition. An insurance company can't deny coverage just because a child has asthma or diabetes. This important protection is extended to adults in 2014.

The Affordable Care Act is also providing reinsurance for early retirees between the ages of 55 and 64, and this enables more and more companies to continue providing coverage for their early retirees.

Already in effect is a prohibition on lifetime limits on insurance benefits. As a result, somebody with a catastrophic illness (such as cancer) or who gets into a bad accident will no longer be bankrupted because

he or she has to spend money totally out of pocket once reaching a lifetime cap.

Under the Affordable Care Act, insurance companies can no longer take away your coverage once you get sick if you have paid your premiums all along. In the past, there have been a number of insurance companies that rescinded policies when people got sick. That no longer is lawful, and that is providing new, important protections.

In the longer run, the Affordable Care Act makes huge progress in expanding health coverage for people who are uninsured. It does so by providing direct help to people with incomes below 400 percent of the poverty level (which will help a family of three with approximately $75,000 in income or less). Additionally, the Act expands the safety-net Medicaid program to cover people and families with incomes below 133 percent of the federal poverty level. As a result largely of these two improvements, the Congressional Budget Office tells us about 34 million people who don't have coverage today will receive it. It is possible that even more than 34 million people will gain coverage, depending on how well enrollment and retention systems are established through regulations and state implementation. This coverage expansion is worthy of strong support.

DOUGLAS HOLTZ-EAKIN: One of the things that has been forgotten, in the course of the debate and the enactment, and now the anniversary, is that there was a time several years ago, beginning in 2009, when there was a bipartisan consensus that America needed sensible health care reforms that would control the growth of spending, improve the delivery system, and expand coverage. What actually happened was a highly partisan activity that has given me just one more piece of evidence that all partisan laws end up being bad policy. It is unwise in a democracy to push through large legislation on one party's votes. Those laws are never infused with the best ideas of both sides, and as a result they are not as good, and they immediately become objects for overturning. It doesn't serve our country—which needs a durable and functional health care system—to undertake this kind of activity, and so I expect us to be back again in the future, discussing either the demise of the Affordable Care Act or alternatives that build upon its shaky foundation.

What are the problems with that foundation? Michael Cannon asked me to talk about the ACA from the perspective of budget, labor market, and economic policy, and there I think it is indeed a dramatically dangerous piece of legislation at the wrong point in our history. I hope it is now well understood that the federal government's budget is on the road to hell. There is no polite way to describe why the world's largest economy has placed itself on a trajectory that looks like a third-world debt crisis. It is for that reason mystifying to me when the very prosperity and freedom that has built our economy is put at a risk by taking a decisive step in the wrong direction, at a time when we already have deep problems.

There is no way you can pretend that the Affordable Care Act will improve the government's fiscal or budgetary condition. It sets up two new entitlement spending programs: insurance subsidies for those in the exchanges, and the so-called "Class Act," a long-term care insurance program—both of which the CBO estimates will grow at an average of eight percent per year annually as far as the eye can see. Tax revenues will not grow at eight percent a year annually as far as the eye can see; the economy will not grow at a rate eight percent a year annually as far as the eye can see; there will be no way either of those things will be able to keep up with those spending demands, and the budget will deteriorate, not improve. You can paper that over with a variety of budgetary gimmicks, as has been done with this legislation. You can count on savings that will never appear in the Medicare program, because we haven't reformed the Medicare program. Its business law remains the same, its costs will be the same, its providers will need the same money, or we just won't cover the beneficiaries. And I think when Congress is faced with

that choice, it will cover the beneficiaries. You can't just simply pretend that the Class Act will collect money inside the budget window and not pay out benefits past the budget window.

You cannot leave out the annual appropriations that are necessary to set up and run the program. You cannot do all the things that they did, and somehow trick people into believing this is a good step from a budgetary point of view. Another big risk is that we'll end up with more people in the exchanges—because employers can do arithmetic. They understand that there is so much taxpayer money on the table in those exchanges that it is entirely possible for them to drop their coverage, particularly for anyone under 300 percent of the federal poverty line. It is a no-brainer to drop the coverage, pay the penalty, give the worker a raise, and allow the worker to take the post-tax wage plus the subsidies and buy insurance at the exchanges that is just as good or better. If you take the population that's eligible for that kind of bargain, and assume that not even all of them do it, you can double the $1 trillion cost easily over the first 10 years, or triple it.

I would have loved to have stood here on the first anniversary of a bipartisan health care bill that took care of the costs problems and enhanced the prospect for coverage in the United States. Instead, we're celebrating the anniversary of something which represents another missed opportunity in health care reform in the United States, a dangerous step from an economic and budgetary policy point of view, and something that really cannot survive. And regardless of what we call it—repeal, replace, or simply throw up our hands and pray—it will not be this way in the future.

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Chapter 23

ObamaCare—The Way of the Dodo

by Michael F. Cannon

If you are reading this, chances are good you have traded the luxury of newspapers for medical texts, 24-hour shifts, and chronicling every nanosecond of your day. So let's recap what's going on in the world.

The U.S. government is borrowing roughly 40 cents of every dollar it spends, creating a budget deficit of $1.3 trillion.[1] Uncle Sam has been at this for some time; he is now $10 trillion in the hole. That equals roughly two-thirds of everything the United States produces in a year.[2] If we extend current federal tax and spending policies into the future, the size of the federal debt becomes cataclysmic. Think "Greece." Few recognize the extent of the danger, because Congress has cleverly cooked the books to make future debt levels appear merely horrifying.

Let's pick one of Congress's accounting frauds at random: the "sustainable growth rate" (SGR) formula.

This little gremlin cuts Medicare payments to physicians every year on January 1. Or it would, except every year these cuts have come due, Congress has postponed them. But so long as hundreds of billions of dollars of *future* cuts remain on the books, future deficits and debt appear that much smaller.

Everyone knows Congress is going to postpone those cuts when docs and seniors start complaining. But by pretending that it won't, Congress makes the federal government's finances look better. (The real genius of the SGR is that the cumulative effect of pushing all postponed cuts into future years both preserves the SGR's debt-concealing power and ensures that physicians will grow increasingly desperate to make campaign contributions with each passing year.)

Returning to current events, the unemployment rate has been stuck above 8 percent since January 2009,[3] despite numerous government stimulus packages. Since World War II, American voters have ousted every president who presided over an election-day unemployment rate above 7.2 percent.[4] It is now 9.1 percent.[5] The current White House occupant recommends another government stimulus package.

Stimulating both the federal debt and the unemployment rate is the Patient Protection and Affordable Care Act of 2010, better known as "ObamaCare," a moniker even its namesake now embraces.

During the initial debate over ObamaCare, House Speaker Nancy Pelosi (D-CA) famously said, "We have to pass [it] so you can find out what's in it."[6] One irreverent heir to Hippocrates quipped, "That's what I tell my patients when I ask them for a stool sample."[7] The similarities scarcely end there.

Shortly after the signing ceremony, the *New York Times* noticed that ObamaCare actually bars members of Congress from participating in the Federal Employees Health Benefits Program, throwing

them out of their health plans and leaving them with no coverage.[8] Oops. The Obama administration quietly ignored this inconvenient part of the law, thereby holding the political class harmless and allowing President Obama to keep his promise that every American would be able to keep his or her current health plan.

Or at least, every member of Congress. Things ended differently when the law pushed carrier Principal Financial Group (PFG) to exit the market, curing nearly one million ordinary Americans of the preexisting condition known as being able to keep your health plan.[9] Quite unlike how it responded when the law threatened members of Congress, in this case the Obama administration did not suspend, or even bother to discern, the responsible provisions of the law. Evidently, health care "reform" is only for the little people.

The most likely culprit behind PFG's exit was ObamaCare's minimum "medical loss ratio" rule, which requires health insurance carriers to spend at least 80 percent of premium revenue on medical care and quality-improvement activities (as opposed to "administrative costs") or issue rebates to their customers. A study sponsored by the Robert Wood Johnson Foundation and published in the *American Journal of Managed Care* estimates this one requirement will impel so many carriers to leave the market that hundreds of thousands more Americans will lose their current health insurance. That includes 155,000 or so seriously ill Americans, who were protected against premium spikes by their current health plans, but may not be able to afford coverage through any other carrier. Since that study looked only at Americans who buy their own insurance (just 10 percent of the private market) and excluded California (home to America's largest "individual" market), the actual number of seriously ill Americans who lose their coverage may be higher.[10]

This 2,000-page congressional emanation also creates two new entitlement programs. The Obama administration confessed that one of them, a new long-term care entitlement known as the "Class Act," is "totally unsustainable."[11] The Department of Health and Human Services (HHS) shut down the office responsible for implementing the Class Act, reassigned its staff elsewhere, and asked Congress not to fund it. When reports emerged that HHS was scuttling the Class Act, the agency naturally denied the charge.[12] Shortly thereafter, HHS announced it was scuttling the Class Act.[13] ObamaCare supporters were quick to cite the Class Act's spectacular failure as evidence that he law *works*.[14] Naturally, the White House opposes repeal.[15]

ObamaCare's other new entitlement program offers considerable subsidies to low-income workers who migrate into ObamaCare's health insurance "exchanges." It creates even larger incentives for employers to lend a hand, whether by dropping their health benefits or by firing these workers and rehiring them as contractors. Those (perverse) incentives, plus the threat of ObamaCare's employer mandate, plus the added labor costs stemming from the law's coverage mandates, have left employers wary of hiring until either the Obama administration reduces the uncertainty by assigning values to these variables, or Congress or the Supreme Court reduces the uncertainty by eliminating them. This entitlement will also prove unsustainable when its cost turns out to be higher than projected, yet still fails to make ObamaCare's mandatory health insurance affordable (see below).

Even if the official spending projections are correct, ObamaCare will add another $1 trillion of new government spending during its first 10 years (actually during the first 6;[16] another accounting gimmick). One thing it doesn't spend money on: eliminating the SGR cuts. Congressional Democrats promised the American Medical Association *et alia* a permanent SGR fix in return for supporting ObamaCare.[17] That

was 2 years ago. Reports that the deal included a bridge in Brooklyn have not been confirmed.

ObamaCare finances half of that $1 trillion of new spending with tax hikes on everything from tanning beds to health insurance to pharmaceuticals. It increases the Medicare payroll tax—in the sense that it applies this tax to non-payroll income, and uses the revenue for things other than Medicare.[18] ,[19] It finances the other half-trillion dollars of new government spending with promised Medicare cuts that are as bogus as the SGR—but sure do make future deficits look smaller.

When ObamaCare's first batch of mandates took effect in September 2010, carriers notified their customers how much premiums would be raised as a result of these mandates. One Connecticut insurer put the hidden ObamaCare tax in the range of 20–30 percent of premiums.[20] Naturally, HHS Secretary Kathleen Sebelius threatened carriers with bankruptcy if they continued furnishing cost estimates.[21] The notifications stopped.

Earlier this year, the chief Medicare actuary exposed another unknown and (one hopes) unintended feature of the law when he discovered it opens Medicaid to millions of middle-class early retirees.[22]

More recently, observers found cracks in the new health insurance exchanges, which under the law may be established either by states or, should they decline, the federal government. With many states balking, *Politico* revealed that the law doesn't actually provide any funding for HHS to create exchanges.[23] And there is exactly zero chance of any such funding emerging from the GOP House.

Legal scholars discovered an even bigger glitch that could scuttle both the entitlement to premium assistance and the employer mandate. It turns out the law only authorizes premium assistance in *state-run* exchanges. It does not authorize such assistance to those purchasing coverage in a federally created exchange.[24, 25]

There is more to this glitch than meets the eye. With the subsidies, six in ten people in Wisconsin's individual market will still see their premiums go up by an average 31 percent, according to MIT economist Jonathan Gruber, one of the law's biggest cheerleaders. (So much for those subsidies making coverage affordable.) But suppose a state refuses to create an exchange and HHS (somehow) creates one. Remember, the IRS has no legal authority to offer premium assistance in a federally run exchange. Gruber estimates that without the law's subsidies, *nine* in ten will see their premiums jump by an average of *41 percent*.[26]

In what has become a recurring theme, the IRS says it will ignore what the law says and disburse those unauthorized subsidies anyway.[27] (Given the Obama administration's proclivity for doing whatever it pleases, regardless of what the law says, one wonders why it even waited for Congress to pass a health care law in the first place.) But even this power play may not be enough to save this second entitlement program.

Or the law's "employer mandate." If the Obama administration provides unauthorized premium assistance through federally created exchanges, then some of those subsidies will, under the law's employer mandate, trigger penalties against employers. Employers would then have standing to challenge the unauthorized subsidies in court.[28] In states that decline to create exchanges, those lawsuits could scuttle not only the unauthorized premium assistance but also the employer mandate.

In an ideal world, doctors would be looking over their shoulders at competitors who are innovating to drive down costs. That's how markets make health care affordable today for people who couldn't afford it yesterday. Instead, doctors are looking over their shoulders at federal bureaucrats, who may whack physicians-cum-employers with an employer mandate, and in particular at politicians, to whom doctors

must pay tribute lest the politicians cut physicians' pay.

ObamaCare supporters are ignoring the federal government's dire fiscal situation; ignoring the law's impact on premiums, jobs, and access to health insurance; ignoring that a strikingly similar law has sent health care costs higher in Massachusetts;[29] ignoring public opinion, which has been solidly against the law for more than 2 years; ignoring the law's failures (when they're not declaring them successes); and ignoring that the law was so incompetently drafted that it cannot be implemented without shredding the separation of powers, the rule of law, and the U.S. Constitution itself. Rather than confront their own errors of judgment, they self-soothe: *The public just doesn't understand the law. The more they learn about it, the more they'll like it.*

Such behavior can only be explained by the fact that ObamaCare supporters are part of a political movement that has fought for more than a century to secure a government guarantee of access to medical care for everyone. They have suffered a century of disappointments, and have never been so close to achieving their goal—which, to be clear, is not so much *access to care* as it is *the guarantee*. They will cling to this achievement, such as it is, to the bitter end. To modify an old joke: What's the difference between an ObamaCare supporter and a Rottweiler? The Rottweiler eventually lets go.

This denial takes its most sophisticated form in the periodic surveys that purport to show how those silly voters still don't understand the law. (In the mind of the ObamaCare zombie, no one really understands the law until they support it.) A prominent health care journalist had just filed her umpteenth story on such surveys when I asked her, "At what point do you start to question whether ObamaCare supporters are just kidding themselves?"

Her response? "Soon . . . "

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REFERENCES

1. Congressional Budget Office. The budget and economic outlook: an update (2011). http://www.cbo.gov/ftpdocs/123xx/doc12316/08-24-BudgetEconUpdate.pdf. Accessed October 20, 2011.
2. Congressional Budget Office. CBO's 2011 long-term budget outlook. http://cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf. Accessed October 20, 2011.
3. U.S. Department of Labor Bureau of Labor Statistics. Databases, tables, and calculators by subject: labor force statistics from the current population survey. http://data.bls.gov/timeseries/LNS14000000. Accessed October 20, 2011.
4. Benen S. Presidents, unemployment rates, and context. *Washington Monthly*. June 2, 2011. http://www.washingtonmonthly.com/political-animal/2011_06/presidents_unemployment_rates029975.php. Accessed October 20, 2011.
5. U.S. Department of Labor Bureau of Labor Statistics. Labor force statistics from the current population survey. http://www.bls.gov/cps/. Accessed October 20, 2011. ObamaCare will give the unemployment rate a permanent little boost. The CBO projects the law eliminate an estimated 800,000 jobs. (Anderson JH. CBO director says Obamacare would reduce employment by 800,000 workers. http://www.weeklystandard.com/blogs/cbo-director-says-obamacare-would-reduce-employment-800000-workers_547288.html. *Weekly Standard*. February 10, 2011. Accessed October 27, 2011.) The fashionable retort is to note that this effect "primarily comes from workers

who choose not to work because they no longer have to work at jobs just for the health insurance." (Holan AD. Michele Bachmann says Obamacare will kill 800,000 jobs. http://www.politifact.com/truth-o-meter/statements/2011/jun/14/michele-bachmann/michele-bachmann-says-obamacare-will-kill-800000-j/. *PolitiFact*. June 13th, 2011. Accessed October 27, 2011.) That defense fails for two reasons. First, a "job" is when Smith and Jones exchange labor for money. It doesn't matter whether Jones withdraws the money or Smith withdraws the labor. Either act eliminates a job. Second, it's an odd defense of a law to say it encourages people to consume without producing.

6. Texas GOP says Speaker Nancy Pelosi said people will know content of terrible health-care plan after it passes. *PolitiFact*. March 15, 2011. http://www.politifact.com/texas/statements/2010/mar/15/republican-party-texas/texas-gop-says-speaker-nancy-pelosi-said-people-wi/. Accessed October 20, 2011.
7. This quip came to me second-hand, through a reporter. I cannot guarantee it originated with a physician, but the gallows humor is strongly suggestive.
8. Pear R. Baffled by health plan? So are some lawmakers. *New York Times*. April 12, 2010. http://www.nytimes.com/2010/04/13/us/politics/13health.html. Accessed October 20, 2011.
9. Johnson A. Principal Financial quits writing health-care policies. October 1, 2010. http://online.wsj.com/article/SB10001424052748704789404575524281126700388.html. Accessed October 20, 2011.
10. Abraham JM, Karaca-Mandic P. Regulating the medical loss ratio: implications for the individual market. *Am J Managed Care*. 2011:17(3):211-218. http://www.ahipcoverage.com/wp-content/uploads/2011/03/AJMC-MLR-Paper.pdf. Accessed October 20, 2011.
11. Roy A. Sebelius: CLASS Act is "totally unsustainable," mandate possible. http://www.forbes.com/sites/aroy/2011/02/23/sebelius-class-act-is-totally-unsustainable-mandate-possible/. *Forbes*. February 23, 2011. Accessed October 20, 2011.
12. The definition of insanity: why no one wants to repeal a program that everyone knows is a fraud. *Wall Street Journal*. October 4, 2011. http://online.wsj.com/article/SB10001424052970204422404576594571813960198.html. Accessed October 20, 2011.
13. Pear R. Health law to be revised by ending a program. *New York Times*. October 14, 2011. http://www.nytimes.com/2011/10/15/health/policy/15health.html. Accessed October 20, 2011.
14. Klein E. What the CLASS Act says about health-care reform. *Washington Post*. October 17, 2011. http://www.washingtonpost.com/blogs/ezra-klein/post/what-the-class-act-says-about-health-care-reform/2011/08/25/gIQA8cL0rL_blog.html. Accessed October 20, 2011.
15. Pecquet K. Obama opposed repeal of healthcare program suspended last week. *The Hill*. October 17, 2011. http://thehill.com/blogs/healthwatch/health-reform-implementation/187949-white-house-opposes-formal-class-act-repeal. Accessed October 20, 2011.
16. Congressional Budget Office. Testimony: statement of Douglas W. Elmendorf, director: CBO's analysis of the major health care legislation enacted in March 2010 (March 30, 2011). http://cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf. Accessed October 20, 2011.
17. Laugesen MJ. Civilized medicine: physicians and health care reform. *J Health Polit Policy Law*. 2011;36(3): 507-512.

18. Sahadi J. Medicare tax hikes: what the rich will pay. *CNN Money*. March 25, 2010. http://money.cnn.com/2010/03/22/news/economy/medicare_tax_increase/index.htm. Accessed October 20, 2011.
19. Dorey A. HHS Secretary Sebelius admits to double-counting in Obama budget. *Daily Caller*. March 4, 2011. http://dailycaller.com/2011/03/04/hhs-secretary-sebelius-admits-to-double-counting-in-obamacare-budget/. Accessed October 20, 2011.
20. Sturdevant M. Health insurers seeking rate hikes of more than 20 percent in Connecticut. *Hartford Courant*. September 15, 2010. http://articles.courant.com/2010-09-15/health/hc-health-insurance-rate-hike-0914-20100914_1_health-insurers-small-group-plans-individual-market. Accessed October 20, 2011.
21. Cannon MF. Secretary Sebelius slips on the brass knuckles. *Cato @ Liberty*. September 10, 2010. http://www.cato-at-liberty.org/secretary-sebelius-slips-on-the-brass-knuckles/. Accessed October 20, 2011.
22. Alonso-Zaldivar R. Obama health care law glitch opens Medicaid to millions of middle-class Americans. *Huffington Post*. June 21, 2011. http://www.huffingtonpost.com/2011/06/21/obama-health-care-law-medicaid-middle-class_n_881412.html. Accessed October 20, 2011.
23. Feder JL. HHS may have to get "creative" on exchange. *Politico*. August 16, 2011. http://www.politico.com/news/stories/0811/61513.html. Accessed October 20, 2011.
24. Hogberg D. Oops! No ObamaCare tax credit via federal exchanges? *Investors.com*. September 7, 2011. http://www.investors.com/NewsAndAnalysis/Article/584085/201109071840/ObamaCare-Subsidy-Error-Found.aspx. Accessed October 20, 2011.
25. Hogberg D. Companies could challenge ObamaCare employer fines. *Investors.com*. September 16, 2011. http://www.investors.com/NewsAndAnalysis/Article/585053/201109161746/ObamaCare-Goof-On-Firm-Fines-.aspx. Accessed October 20, 2011.
26. Gorman Actuarial, LLC. The impact of the ACA on Wisconsin's health insurance market: prepared for the Wisconsin Department of Health Services; July 18, 2011. http://www.freemarkethealthcare.wi.gov/docview.asp?docid=22035&locid=173. Accessed October 20, 2011.
27. Hogberg D. Oops! No ObamaCare tax credit via federal exchanges? *Investors.com*. September 7, 2011. http://www.investors.com/NewsAndAnalysis/Article/584085/201109071840/ObamaCare-Subsidy-Error-Found.aspx. Accessed October 20, 2011.
28. Hogberg D. Companies could challenge ObamaCare employer fines. *Investors.com*. September 16, 2011. http://www.investors.com/NewsAndAnalysis/Article/585053/201109161746/ObamaCare-Goof-On-Firm-Fines-.aspx. Accessed October 20, 2011
29. Cogan JF, Hubbard RG, Kessler D. The effect of Massachusetts' health reform on employer-sponsored premiums. *Forum Health Econ Policy*. 2010:13(2): article 5. http://www.bepress.com/fhep/13/2/5/. Accessed October 20, 2011.

Chapter 24

How Sebelius Plans to Save Obamacare: Creating Dependence

by Michael F. Cannon

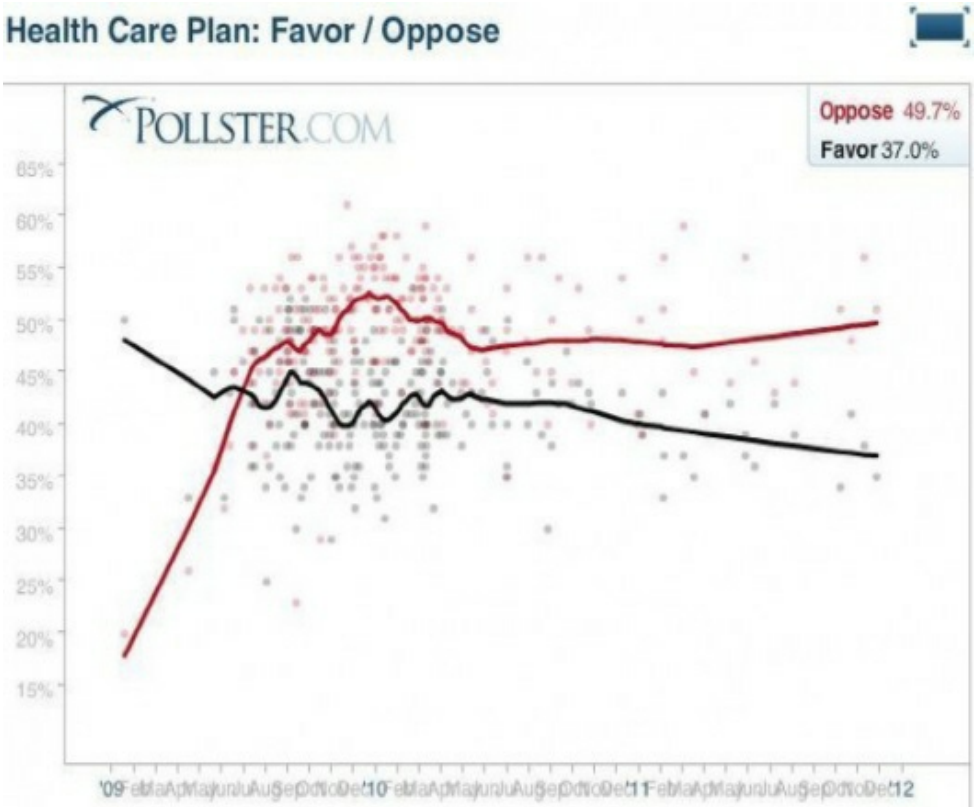
By now, probably everyone has heard these old Obamacare saws:

March 9, 2010–"We have to pass the bill so that you can find out what is in it." (House Speaker Nancy Pelosi)

March 28, 2010–"As more and more people get to understand what's in this bill, people are going to like it." (Pennsylvania Gov. Ed Rendell)

August 4, 2010–"It's very obvious that people have a lack of understanding of our health care reform bill . . . The more people learn about this bill, the more they like it . . . The trend is turning all over America today . . . Once you explain what's in the bill, the American people of course like it." (Senate Majority Leader Harry Reid)

Here's how those predictions have borne out:



Thus supporters have now gone from claiming that *of course* the public will love Obamacare to declaring, *We need to make people dependent on government for their health care* pronto, *or Obamacare is sunk*:

> **January 19, 2012**–"The more we educate people about the law, the more they'll be able to take advantage of the benefits. The more they take advantage of the benefits, the harder it will be for opponents to take those benefits away. Once you have something and you like it and you're using it, you will fight with your own member of Congress to keep it." (HHS Secretary Kathleen Sebelius)

Obamacare will not benefit people by lowering the cost of medical care, as even Sebelius must know by now. The only way Obamacare will "benefit" anybody is by making him or her the recipient of an explicit or implicit government transfer. That is, Obamacare is going to rob Peter to subsidize Paul. Obamacare's survival depends on making Paul dependent on that government transfer. I'm just surprised Sebelius is being so up front about it.

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Chapter 25

Bill 'Reforms' Constitution

by Robert A. Levy and Michael F. Cannon

The Democrats' health-care overhaul asserts for Congress a power that the framers of the Constitution never envisioned: the power to force Americans to purchase unwanted goods or services.

With all the hype, one might think the "public option" is the linchpin of the Democratic health plan. Yet Congress has created entitlements in the past, and enrollment in a public option would not be mandatory (at least not initially).

The legislation's centerpiece is really the "individual mandate"—an unprecedented legal requirement that Americans purchase health insurance under penalty of law. The mandate is nearly universal, and without it, as President Obama admitted to a joint session of Congress, the legislation would fall apart.

But is it constitutional? The Constitution grants Congress the power to regulate interstate commerce. Does that power extend to behaviors, such as not purchasing health insurance, that are neither interstate nor commerce?

If you think the answer is a self-evident "no," then you haven't been following the Supreme Court over the past seven decades. Instead of serving as a shield against states that attempt to interfere with interstate commerce, the commerce power today has become a sword that the federal government wields in pursuit of a boundless array of socio-economic programs.

The Supreme Court has held that the power to regulate interstate commerce extends to trade within a single state if it has a substantial effect on interstate markets. Even noncommercial activities within a state can be restricted if they threaten to undercut federal regulation of interstate markets.

That's the framework into which Senate Majority Leader Harry Reid (D., Nev.) shoehorned his health bill. What he came up with is a paper-thin pretense for asserting extra-constitutional powers.

First, Reid tried obfuscation. Tucked away in that 2,074-page bill is a citation of a 1944 Supreme Court ruling that deemed insurance to be interstate commerce. Reid conveniently omitted any reference to the McCarran-Ferguson Act passed the very next year, which gave states absolute authority to regulate health insurance.

That law's effect has been to bar individuals from purchasing health insurance across state lines. Accordingly, there is no interstate market to be affected, much less undercut.

Reid's second ploy was to pretend that forcing Americans to purchase a product that many of them do not want is integral to the regulation of our national health-care system. Perhaps so, but only if the Constitution's commerce clause, which was intended to eliminate state barriers to interstate trade, becomes the vehicle by which the federal government can compel people to engage in intrastate trade. Not even the Supreme Court's tortured commerce-clause jurisprudence goes that far.

If Congress were interested in using the commerce clause for its intended purpose, we would be debating the Health Care Choice Act, which would permit the interstate purchase of individual health policies. The Democrats, however, bottled up that bill in committee.

They would rather exploit the cartelization of health insurance in selected states to argue for a government-run insurance company. Never mind that a major reason for those cartels is the prohibition against purchasing insurance across state lines.

Finally, Reid would enforce this unconstitutional mandate with an unconstitutional tax. The Senate bill attaches a penalty for not complying with the mandate to the Internal Revenue Code. But the penalty is not based on income, so it's not an income tax. And it's not based on the value of the policy not purchased, so it's not an excise tax. Instead, the tax is a fixed amount based on family size. That means it's levied per person and therefore a "direct tax" under the Constitution, which requires that such taxes be apportioned among the states according to their population, as determined by the census.

The individual mandate would extend the dominion of the federal government to virtually all manner of human conduct—including the non-conduct of not buying health insurance—by establishing a federal police power that is authorized nowhere in the Constitution. Democrats will have legislated a new quasi-crime, and perhaps the sole offense in our history that can be committed only by people of a certain income, since those below the poverty line would be exempt from the mandate.

Congress' attempt to punish a non-act that harms no one is an intolerable affront to the Constitution, liberty, and personal autonomy. That shameful fact cannot be altered by calling it health-care reform.

This article appeared in the **Philadelphia Inquirer** *on December 11, 2009.*

Chapter 26

The Case against President Obama's Health Care Reform: A Primer for Nonlawyers

by Robert A. Levy

Cato Institute White Paper (April 25, 2011)

Introduction

The Supreme Court will soon get a crack at President Obama's most important piece of domestic legislation. Three lower courts—in Virginia, Michigan, and Washington, D.C.[1] —have ruled that the Patient Protection and Affordable Care Act (PPACA)[2] is constitutional. Two other courts—in Florida and a second district in Virginia[3] —disagreed. Appeals are pending. Oral argument in the Virginia cases is scheduled for May 10 before the U.S. Court of Appeals for the Fourth Circuit. The Michigan case will be heard on June 1 before the Sixth Circuit, and the Florida case will be heard on June 8 before the Eleventh Circuit. A momentous Supreme Court decision on the limits of congressional power is likely during the 2012–13 term, or earlier if the Court unexpectedly grants Virginia's motion for expedited review, which would skip the intermediate appeals process.

The central issue is whether there is constitutional authorization for Congress to have enacted PPACA —more specifically, the mandate in PPACA that individuals must acquire prescribed health insurance or pay a penalty for not doing so. Proponents of PPACA have cited the Taxing Power, the Commerce Clause, and the Necessary and Proper Clause as their constitutional pedigrees. Opponents dispute each of those arguments. For a better understanding of the constitutional complexities, here is a primer on the case against President Obama's health care reform.

The Individual Mandate

The health insurance mandate is the centerpiece of PPACA. It's an unprecedented legal requirement that Americans purchase an approved policy, under penalty of law. Without the mandate, said President Obama to a joint session of Congress, the rest of the legislation falls apart. That's because PPACA bars insurers from denying coverage for preexisting conditions—a step meant principally to address loss of coverage when a sick employee changes jobs. Predictably, there are unintended consequences. Consumers are not ignorant. If they know an insurer cannot deny coverage for preexisting conditions, rational consumers will wait until they are sick or injured before buying a policy. The waiting game means insurers won't collect premiums from healthy people to cover the claims of unhealthy people. PPACA's solution: Don't let consumers wait until they're sick; require everyone to buy insurance now, and

impose a penalty on anyone who declines.

Prior to 2010, a federal mandate to purchase a product from a private company had never been tested in the courts. When one was last proposed in the context of Hillary-care in 1994, the Congressional Budget Office wrote: "A mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action. The government has never required people to buy any good or service as a condition of lawful residence in the United States."[4] Yet that is precisely what PPACA will do—unless and until the Supreme Court says otherwise.

The Taxing Power

Art. I, sec. 8, cl. 1: "The Congress shall have Power To lay and collect Taxes . . . [to] provide for the . . . general Welfare of the United States."

The federal government's first line of argument is that the mandate is authorized under Congress's Taxing Power. Contrary to modern readings, that clause does not grant Congress an independent power to tax for the general welfare. If it did, there would be no need to enumerate any other powers. Rather, the clause authorizes Congress to raise revenue in support of the specifically enumerated powers that follow it. And the general welfare restriction precludes Congress from taxing to provide for special interests.

All the same, the Supreme Court in Helvering v. Davis (1937)[5] established that taxes can be levied for just about any purpose that allegedly serves the general welfare. According to the Obama administration, that would include subsidizing insurers so they can afford to cover preexisting conditions. To their credit, none of the five federal courts that have ruled on PPACA has embraced the Taxing Power logic.

Backdoor Regulation

Challengers offered three responses to the administration's Taxing-Power justification. First, Congress cannot use the Taxing Power as a backdoor means of regulating, unless the regulation is authorized elsewhere in the Constitution (see Bailey v. Drexel Furniture [1922])[6]. The purpose of a tax is to generate revenue. By contrast, the insurance mandate exists solely to coerce people into obtaining healthcare coverage. If the mandate worked perfectly, it would raise no revenue.

But U.S. district judge Roger Vinson rejected that claim of "backdoor regulation."[7] Although he denied the federal government's motion to dismiss a lawsuit by Florida—joined by 25 other states, the National Federation of Independent Businesses, and two individual plaintiffs—Vinson noted that courts no longer draw a sharp distinction between regulatory and revenue-raising purposes. In some sense, he declared, every tax has a regulatory component; the mandate is not unconstitutional merely because it regulates.

A Penalty, Not a Tax

The challengers fared considerably better in their second response to the government's invocation of the Taxing Power. The assessment is not a tax, they asserted, but a penalty. Judge Vinson agreed. He pointed out that Congress had written "tax" in an earlier version of PPACA, but changed the word to "penalty" in the final version. Moreover, the word "tax" is used elsewhere in the bill to describe other sources of revenue; so the drafters of the legislation knew how to specify a tax when that's what they meant. In addition, PPACA cited not the Taxing Power but the Commerce Clause as its constitutional

authority. The bill even barred the IRS from using its ordinary enforcement methods to collect the penalty, and the dollars supposedly to be collected were not counted in revenue estimates from the Congressional Budget Office. Apparently, Congress did not want the scrutiny that attaches to multibillion-dollar tax increases—especially after President Obama had repeatedly called the assessment a penalty and reminded voters of his promise not to impose any new taxes on the middle class.

On the basis of that record, Judge Vinson was justifiably reluctant to override clear congressional intent. He concluded that "penalty" was not just a label, but was indicative of a nontax legislative purpose. In December, a month before the Vinson opinion, a second federal judge, Henry Hudson, reached the same conclusion, upholding Virginia's challenge to PPACA. He characterized revenue generation as "a transparent afterthought" and "extraneous to any tax need."[8] Plainly, the mandate imposes a penalty, not a tax.

Income, Excise, and Direct Taxes

Assume, however, the Supreme Court ultimately disagrees and finds that the penalty for not purchasing health insurance is indeed a tax. Nevertheless, say opponents of PPACA, the tax would be unconstitutional. They underscore that taxes are of three types—income, excise, or direct. Each type must meet specified constitutional constraints. Because the mandate penalty under PPACA does not satisfy any of the constraints, it is not a valid tax.

Income taxes, authorized by the Sixteenth Amendment, must (by definition) be triggered by income. Yet the mandate penalty is triggered by the nonpurchase of insurance. Except for an exemption available to low-income families, the amount of the penalty depends on age, family size, geographic location, and smoking status. So the penalty is not an income tax.

Excise taxes are assessed on selected transactions. Because the penalty arises from a nontransaction, perhaps it qualifies as a reverse excise tax. If so, it has to be uniform across the country (U.S. Const., Art. I, sec. 8). But the penalty varies by location, so it cannot be a constitutional excise tax.

Direct taxes are assessed on persons or their property. Because the penalty is imposed on nonownership of property, perhaps it could be classified as a reverse direct tax. But direct taxes must be apportioned among the states by population (U.S. Const., Art. I, sec. 2). The mandate penalty is assessed on individuals without regard to any state's population. Hence, it is not a lawful direct tax.

Of Credits and Debits

Despite that, the administration notes that PPACA would have raised no eyebrows if the mandate had been structured as a tax credit for those who purchase health insurance rather than a debit for those who do not. After all, the Internal Revenue Code is replete with credits that incentivize various behaviors. Why not a credit for buying health insurance? Any person obtaining a policy would pay less tax than a person who did not—precisely the effect of PPACA's penalty.

The reality, however, is that Congress decided on a debit, not a credit. If Congress had enacted a credit, it would have lessened the impact of a preexisting, (presumably) legitimate tax —thus implicating the Constitution only to ensure that favored parties would not have to relinquish key rights as quid pro quo, and disfavored parties would not be subject to invidious or otherwise unreasonable discrimination. Furthermore, because tax credits reduce government revenue, some budget analysts characterize them as "tax expenditures." If one subscribes to the notion that credits are equivalent to expenditures, then they would be authorized under Congress's power to spend money.

Conversely, instead of reducing revenue, tax debits raise money and must therefore be authorized

under the Taxing Power. As noted, the Taxing Power is subject to constraints not applicable to spending —that is, taxes must be income, excise, or direct; and each tax, depending on its type, must respectively be triggered by income, be geographically uniform, or be apportioned by population. The penalty for non-purchase of health insurance does not qualify as any of the three types of tax.

Plainly put, the mandate cannot be justified under Congress's "Power To lay and collect Taxes . . . [to] provide for the . . . general Welfare of the United States." And that leads to the president's second asserted source of constitutional authority: the power "To regulate Commerce . . . among the several States."

The Commerce Clause

Art. I, sec. 8, cl. 3: "Congress shall have Power . . . To regulate Commerce . . . among the several States."

The Commerce Power was not designed to provide Congress open-ended authority to regulate anything and everything that affects commerce. Instead, the Framers aimed at creating a national "free-trade zone," putting an end to the interstate protectionism allowed under the Articles of Confederation. To ensure free trade among the states, Congress was given the power to regulate, or "make regular," such commerce. If the clause had been understood to grant Congress the limitless regulatory power it now exercises, the Constitution would never have been ratified. Yet, in recent decades, the courts have allowed Congress to drift far from the original meaning of the Commerce Clause, regulating behaviors that are neither interstate nor commerce. That regrettable development was rooted in the New Deal.

Wickard v. Filburn

The infamous 1942 case of Wickard v. Filburn laid the groundwork for a vastly expanded regulatory state.[9] Filburn grew wheat primarily for consumption by his family and farm animals. During the 1930s, to boost depressed prices of agricultural products, the Roosevelt administration decided to cut wheat production. Accordingly, the federal government ordered Filburn to grow fewer bushels. When Filburn asked officials for their constitutional authority, the government cited the power to regulate interstate commerce.

Filburn responded that his farm was entirely within a single state and he neither bought nor sold crops across state lines. No matter, held the Supreme Court. By growing his own wheat, Filburn avoided buying. And, if he had not eaten what he grew, he would have been able to sell what was left over. Thus, by not buying and not selling, Filburn had an effect on the supply and demand for wheat—which, when considered in the aggregate, along with the crops of other farmers who did the same, undoubtedly impacted interstate commerce. That opened the floodgates through which the regulatory state was ready to pour—regulating anything and everything under the Commerce Clause.

The Modern Framework

Still, could the power to regulate commerce—properly defined as the exchange of goods—conceivably cover a non-economic event; that is, an event that does not involve growing, mining, manufacturing, buying, selling, distributing, or consuming? It took the Supreme Court more than a half-century to clarify the answer to that question. In United States v. Lopez (1995), the Court held that the Commerce Clause does not empower the federal government to criminalize possession of a gun near a school.[10] Five years

later, in United States v. Morrison, the Court overturned a statute that invoked the Commerce Clause to grant victims of gender-motivated violence a right to sue in federal court.[11]

Those two cases, together with Wickard, yielded this modern framework for interpreting the Commerce Clause: Congress may regulate the exchange of products—that is, commerce—across state lines, and transportation linked to such exchanges. Congress can also regulate noncommercial, economic acts having a substantial aggregate effect on interstate commerce, such as growing and consuming wheat in Wickard. But Congress may not regulate non-economic acts, such as the mere possession of a gun in Lopez or a gender-based crime in Morrison.

Constitutional originalists insist that the rules derived from Wickard and Lopez are far more expansive than the Framers intended. Today, instead of serving as a shield against state interference with free trade, the Commerce Power has become a sword wielded by the federal government in pursuit of a boundless array of regulations. Indeed, if the Framers intended the Commerce Clause to cover any economic act that had a substantial effect on interstate commerce, why did they separately enumerate powers for Congress to coin money, establish post offices, and issue patents? Surely, those powers would be redundant and add nothing to the text. Yet, as Chief Justice John Marshall admonished in Marbury v. Madison (1803), "It cannot be presumed that any clause in the constitution is intended to be without effect."[12]

Compelled Activity

Nonetheless, that's where we now stand. The federal Commerce Power is indeed expansive. But the individual mandate in PPACA stretches still further—beyond dictating how, when, and under what conditions a product may be produced, distributed, exchanged, or consumed. The mandate actually compels that a transaction occur. Rather than merely regulating an economic act that affects interstate commerce, PPACA commands the purchase of a product—health insurance—that cannot legally be purchased across state lines. Under PPACA, neither an act nor an interstate market exists to be regulated.

Essentially, the insurance mandate is regulatory bootstrapping of the worst sort. Congress forces someone to engage in commerce, then proclaims that the activity may be regulated under the Commerce Clause. If Congress can do that, it can prescribe all manner of human conduct.

We know, however, that liberty and pervasive government cannot coexist. Even if Congress can regulate Filburn's wheat production, that does not mean Congress can require consumers to purchase bread from their local grocer in order to subsidize wheat growers. At least for now, the Supreme Court's tortured Commerce Clause jurisprudence does not reach that far. In Judge Hudson's words: Courts have "never extended Commerce Clause powers to compel an individual to involuntarily enter the stream of commerce by purchasing a commodity in the private market."[13]

The litmus test is economic activity. A mental decision not to buy insurance is not a physical economic act. In that respect, it is no different than a decision not to work. Neither decision can be regulated simply because the non-act, if converted into an act, might have an effect on interstate commerce. As Judge Hudson put it, "the subject matter must be economic in nature and affect interstate commerce, and . . . must involve activity."[14] (Emphasis added.) Thought processes are not subject to regulation.

Other Mandates

Defenders of PPACA respond that courts have upheld other federal mandates such as jury duty, the military draft, and obtaining guns

for militia service. Perhaps so; but those mandates are encompassed within specific constitutional provisions. The Sixth and Seventh Amendments guarantee jury trials, which imply a power to select jurors. Article I, section 8 expressly empowers Congress "To raise and support Armies" and "provide for . . . arming . . . the Militia." When necessary, the Framers knew how to provide an express power, independent of the Commerce Clause.

What about state mandates such as involuntary community service, compulsory schooling, and car insurance? First, states exercise police power and are not subject to constraints on federal authority in the U.S. Constitution. Second, community service does not require purchasing a good or service, and is not imposed by all schools—especially private and home schools. Third, compulsory schooling and mandatory car insurance are designed to protect the rights of innocent third parties—children, other drivers, and pedestrians. No car owner is compelled to buy casualty or comprehensive insurance that reimburses for injury to himself or his property. By contrast, PPACA directs individuals to acquire insurance on their own health. Fourth, cars are driven on public roads, so the government has some authority to dictate conditions for use of those roads. Fifth, nondrivers are not required to purchase car insurance. Driving is a voluntary activity, which has associated responsibilities. The insurance mandate is not voluntary and is imposed on everyone.

Timing Decisions

Finally, even if the mandate, considered in isolation, doesn't regulate economic activity, PPACA supporters contend that requiring health insurance is no different than requiring advance purchase of health care. Nearly everyone ultimately consumes health care; and consumption is clearly an economic act. Why then, so the argument goes, wouldn't the Commerce Clause allow the federal government to direct that health care be purchased now, by obtaining insurance, rather than later when the medical bill comes due? In other words, buying health insurance is just a timing decision about when, not whether, to incur medical costs. And if failure to purchase insurance were to trigger a penalty, it too would be mere timing—no different than assessing a penalty later, on someone who obtains future services from a hospital or doctor and does not pay the bill.

Judge Vinson was not convinced. Nor should he have been. Virtually all forms of insurance represent timing decisions—paying up front for burial costs, loss of life, disability, supplemental income, credit default, business interruption, and more. Only a federal government of unbounded powers could mandate that every American insure against such risks. And while it might be permissible to penalize an uninsured person who shows up at a hospital or doctor's office demanding that his expenses be borne by the taxpayers, that is not what PPACA does. Instead, PPACA penalizes all uninsured persons, not just those who seek to be reimbursed by government for costs they should have borne themselves. And PPACA does more than mandate coverage; it also prescribes certain provisions that each policy must include. Many Americans who prefer to insure using, for example, Health Savings Accounts with high deductible coverage, will be told by their federal overseers that such coverage isn't adequate.

Never has the Commerce Clause been stretched to such lengths. Never could the Framers have envisioned such overweening federal power. That's why proponents of PPACA had to fashion a fallback position.

The Necessary and Proper Clause

Art. I, sec. 8, cl. 18: "Congress shall have Power . . . To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers."

The Necessary and Proper Clause grants Congress the means to execute its enumerated powers or ends. It adds no new ends. And the chosen means must be both "necessary and proper": They must respect the Constitution's structure and spirit of limited government, the dual sovereignty of state and federal governments, and the rights retained by the people.

The Obama administration attempts, unsuccessfully, to shoehorn the insurance mandate into that framework. Suppose the mandate to buy health insurance does not qualify as a direct regulation of interstate commerce. Even so, the administration argues, the Constitution authorizes implicit powers under the Necessary and Proper Clause. If government can show that (a) it has Commerce Clause authority to regulate interstate health care, (b) the insurance mandate is necessary for Congress to regulate interstate health care, and (c) the mandate is a proper means of doing so, then the courts are unlikely to intervene.

Note that the government's argument is still premised on its underlying Commerce Clause authority—but over health care, not health insurance. Forcing Americans to purchase an insurance product they do not want is ostensibly permissible, but only because the mandate is a necessary and proper means of regulating the national health care system. That assertion is the corollary of two underlying contentions, both of which are flawed.

Cost Shifting and the Uninsured

First, the mandate is said to be necessary because its elimination would perpetuate the problem of the uninsured—that is, taxpayers would continue to bear the burden of uncompensated emergency care. Without the mandate, responsible, insured consumers would have to pay the health costs of irresponsible, uninsured consumers.

To put that in perspective, the Census Bureau reports that roughly 46 million Americans did not have health insurance at some point during 2007. But 10 million were noncitizens, mostly illegal; 14 million either did not report their Medicaid enrollment to the Census, or qualified but did not enroll; 10 million earned more than $75,000 annually and might have preferred to self-insure.[15] Even allowing for overlap, there were far fewer than 46 million uninsured citizens with income below $75,000 who were not receiving or eligible to receive Medicaid. And many of the uninsured were temporarily without coverage because they were starting or switching jobs. Yes, there's a residual problem, but it's much less severe than trumpeted by backers of PPACA.

Furthermore, as Judge Vinson observed, cost shifting by the uninsured is not inevitable. It arises only if a person gets sick, seeks medical care, cannot pay, and has no access to funds from family, friends, or private charities.[16] That cost can be more efficiently addressed if and when it arises.

Uncompensated care in the United States accounts for $56 billion yearly—about 2.2 percent of our annual $2.5 trillion in national health expenditures.[17] That's meaningful, but scarcely a crisis. Besides, many of the uninsured—those who are financially able and choose to self-insure—pay their bills without imposing costs on anyone. And because they self-insure, they typically pay higher prices for medical care—significantly more than is ordinarily reimbursed by public or private insurance. Those higher prices subsidize unhealthy insured individuals and offset the tax burden of uncompensated care.

Moreover, an insurance mandate does not eliminate the cost of uncompensated care. It simply transfers the cost to insurance companies, which recoup their outlays by selling PPACA-mandated

policies to individuals who prefer not to own them. In fact, total healthcare costs will increase as more persons become insured. That's the moral hazard predicament. Insured persons demand more medical services than persons who pay their own way. Higher demand means higher prices. It's no accident that the costs of lasik and cosmetic surgery, which are not covered by insurance, have declined while the cost of MRIs, which is covered by insurance, has skyrocketed. PPACA's insurance mandate will make matters worse. It is not only unnecessary; it is undesirable.

Admittedly, nonpurchasers of health insurance sometimes impose costs on others; but so do nonpurchasers of many other products that could potentially reduce health costs—such as nutritional foods, exercise gear, and preventive medicine. Does the government also claim authority under the Necessary and Proper Clause to coerce purchase of those products? If so, why stop with health care? Defaults on credit cards and mortgages surely impose substantial costs on nondefaulters. Can government compel credit card and mortgage insurance?

Preexisting Conditions

The administration's second rationale for invoking the Necessary and Proper Clause is no more convincing: Namely, it is essential that everyone be covered for preexisting conditions, and the insurance mandate is key to accomplishing that goal.

Interestingly, PPACA

allotted $5 billion for the Department of Health and Human Services to provide stopgap insurance to persons with preexisting conditions until the mandate is effective in 2014. Taxpayers subsidize 65 percent of the costs; coverage is extended to anyone turned down by a single insurance company; and premiums vary only by age, not health status. From the program's inception in July 2010 through January 2011, combined federal and state enrollees numbered just over 12,000. Compare that to HHS estimates of 375,000 enrollees in the first four months and 400,000 more each year. That prompted the Wall Street Journal to editorialize that claims about a nation of sick indigents who are denied insurance may well be bogus. The country likely does not need a multitrillion-dollar entitlement to help 12,000 people.[18]

The Meaning of "Necessary"

Ironically, HHS has defended both sides of this argument. On one hand, the mandate is presumably necessary for purposes of the Necessary and Proper Clause. On the other hand, in its legal briefs, HHS advised the courts that the mandate is "severable"—meaning that PPACA need not be overturned in its entirety even if the mandate is declared unconstitutional. Put somewhat differently, HHS maintains that the mandate can be stripped from the legislation without affecting the bulk of its other provisions.

To explain that apparent contradiction, the administration relies on an 1819 Supreme Court opinion, McCulloch v. Maryland.[19] There, Chief Justice John Marshall rejected the commonplace meaning of "necessary"—that is, required, needed, essential—and broadened it to include all means that are "plainly adapted" to achieving a designated objective. Applying that expansive standard, Congress decided that compulsory health insurance is a reasonable measure to facilitate coverage of preexisting conditions. Thus, pronounces HHS, the mandate may not be indispensible, but it is "plainly adapted."

Once again, Judge Vinson saw through the sophistry: The mandate is artificially necessary—required only because Congress went down a particular path that left few if any alternatives. Vinson wrote: "[T]he individual mandate is actually being used as the means to avoid the adverse consequences of the

Act itself [i.e., compulsory coverage of preexisting conditions]. . . . [T]he more dysfunctional the results of the statute are, the more essential or 'necessary' the statutory fix would be. Under such a rationale, the more harm the statute does, the more power Congress could assume for itself under the Necessary and Proper Clause."[20]

The Supreme Court is unlikely to endorse that rationale. But there is one other, more technical legal argument that the Court should also consider when it interprets "necessary" as it relates to the Commerce Clause. Prior cases established two bounds in deciding what means could be employed in regulating interstate commerce. First, if an activity is not commerce and not interstate, its regulation qualifies as "necessary" only if the activity has a "substantial effect" on interstate commerce. Second, if an activity is "non-economic," its regulation falls outside the limits of "necessary." PPACA's challengers now ask the Court to establish a third restraint: The regulation of inactivity is never necessary in executing Congress's Commerce Clause authority. That principle is easily administered by the courts, vital to constrain all-embracing federal power, and crucial to the Framers' original design for limited government.

The Meaning of "Proper"

Lastly, consider the remaining term in the Necessary and Proper Clause: the requirement that a regulation be "proper." Here too, Chief Justice Marshall set the standard in McCulloch. A regulation is "proper" if it does not violate established rights and is consistent "with the letter and spirit of the constitution."[21] Only a handful of scholarly articles have addressed the legal meaning of "proper"; but Judge Vinson had no trouble applying Marshall's guidepost: "The individual mandate . . . cannot be reconciled with a limited government of enumerated powers. By definition, it cannot be 'proper.'"[22]

Joseph Story, the renowned constitutional expert, expressed the same sentiment in his 1833 Commentaries: "The constitution of the United States is to receive a reasonable interpretation of its language, and its powers, keeping in view the objects and purposes, for which those powers were conferred. . . . [I]n case the words are susceptible of two different senses, the one strict, the other more enlarged, that should be adopted, which is most consonant with the apparent objects and intent of the Constitution."[23] Extending that test to PPACA, no one could plausibly argue that the Commerce Power is so elastic as to compel the purchase by every American of an unwanted, government-designed product from a private company.

For a slightly different perspective on the meaning of "proper," recall the Tenth Amendment, which provides that all powers not enumerated and delegated to the national government "are reserved to the States . . . or to the people." That provision protects both state sovereignty and personal sovereignty against federal encroachment. One aspect of such protection is to bar the federal government from commandeering state legislatures (see New York v. United States [1992])[24] and state enforcement authorities (see Printz v. United States [1997])[25] to carry out federal programs. Because the Tenth Amendment is neutral as between reserving powers to the states or to the people, it follows that neither individuals nor states may be commandeered. Accordingly, a mandate that coerces individual acts is no more "proper" than a mandate that coerces state acts.

What Should Congress Have Done?

What then should Congress

have done about uninsured consumers and coverage of preexisting conditions, without running afoul of the Commerce Clause and the Necessary and Proper Clause? A number of options were suggested to Congress, but rejected. First, expedite competition by allowing interstate sales of health insurance. Second, encourage the states to reform their medical malpractice laws. Third, eliminate restrictions on Health Savings Accounts with high-deductible coverage. Fourth, and most important, change the income tax treatment of health insurance premiums that discriminates against individual polices in favor of corporate policies.

Medical insurance premiums are mainly paid by employers, not patients. Because patients do not bargain directly with providers of corporate health insurance, guaranteed renewable coverage, which would largely alleviate the problem of preexisting conditions, is not available in the corporate market. By comparison, individual consumers of term life insurance have no problem obtaining guaranteed renewable policies.

Our tax code is the culprit. Employees do not have to include the cost of employer-provided medical insurance as part of their taxable income, and businesses can deduct that cost as an ordinary expense. No equivalent deduction is available to individuals who buy their own health insurance. So it's more economical for each person to obtain standardized coverage through his employer, rather than tailored coverage from an insurer. In that manner, federal tax policy drives another wedge between the patient and his care provider. Not only is there an insurance company that pays the doctor or hospital, but also an employer that pays the insurance company. The net result is that patients seldom monitor the cost of their medical care or their insurance. One solution: Allow patients to deduct the cost of medical insurance against their personal income taxes. That would eliminate the incentive for employers to pay for health insurance and remove the employer from the doctor-patient relationship. It would encourage consumers to do what they do in other markets—shop around for adequate and fairly priced service.

Those market-based solutions, grounded on individual responsibility, would raise no constitutional concerns. In contrast, PPACA is grounded on subsidies, dependency, and compulsion. Most significant, PPACA's key provision—the individual insurance mandate—is unconstitutional. It is not a tax; it is not interstate commerce; and it is neither necessary nor proper to fix our ailing healthcare system.

"At its core," wrote Judge Hudson in the Virginia case, "this dispute is . . . about an individual's right to choose to participate."[26] In Florida, Judge Vinson put it this way: "If Congress can penalize a passive individual for failing to engage in commerce, the enumeration of powers in the Constitution would have been in vain."[27] That sums it up.

Notes

1. Liberty Univ., Inc. v. Geithner, 2010 U.S. Dist. LEXIS 125922 (W.D. Va. 2010); Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882 (D. Mich. 2010); Mead v. Holder, 2011 U.S. Dist. LEXIS 18592 (D.D.C. 2011).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

3. Florida v. United States HHS, 2011 U.S. Dist. LEXIS 8822 (D. Fla. 2011); Commonwealth ex rel. Cuccinell v. Sebelius, 728 F. Supp. 2d 768 (D. Va. 2010).

4. Congressional Budget Office, "The Budgetary Treatment of an Individual Mandate to Buy Health Insurance," August 1994, p. 1,

http://www.cbo.gov/ftpdocs/48xx/doc4816/doc38.pdf

5. Helvering v. Davis, 301 U.S. 619 (1937).

6. Bailey v. Drexel Furniture Co., 259 U.S. 20 (1922).

7. Florida v. United States HHS, 716 F. Supp. 2d 1120, 1132 (D. Fla. 2010).

8. Commonwealth ex rel. Cuccinell v. Sebelius, 728 F. Supp. 2d 768, 786 (D. Va. 2010).

9. Wickard v. Filburn, 317 U.S. 111 (1942).

10. United States v. Lopez, 514 U.S. 549 (1995).

11. United States v. Morrison, 529 U.S. 598 (2000).

12. Marbury v. Madison, 5 U.S. (1 Cranch) 137, 174 (1803).

13. Commonwealth ex rel. Cuccinell v. Sebelius, 728 F. Supp. 2d 768, 782 (D. Va. 2010).

14. Commonwealth ex rel. Cuccinell v. Sebelius, 728 F. Supp. 2d 768, 781 (D. Va. 2010).

15. Sally C. Pipes, "The Top Ten Myths of American Health Care," Pacific Research Institute, October 2008, pp. 31–40, http://www.pacificresearch.org/docLib/20081020_Top_Ten_Myths.pdf.

16. Florida v. United States HHS, 2011 U.S. Dist. LEXIS 8822, *93 (D. Fla. 2011).

17. Jack Hadley, et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs 27, no. 5 (2008): w399-w415, http://content.healthaffairs.org/content/27/5/w399.abstract.

18. Editorial, "The 8,011-Person Crisis: Obamacare's Pre-existing Condition Program Is a Bust," Wall Street Journal, November 12, 2010. Note: Through October 31, 2010, 8,011 persons had enrolled for the preexisting condition program. Three months later, as noted in the text above, the number of enrollees had risen to 12,000—a trivial increase of 1,330 per month.

19. McCulloch v. Maryland, 17 U.S. 316 (1819).

20. Florida v. United States HHS, 2011 U.S. Dist. LEXIS 8822, *110–11 (D. Fla. 2011).

21. McCulloch v. Maryland, 17 U.S. 316, 421 (1819).

22. Florida v. United States HHS, 2011 U.S. Dist. LEXIS 8822, *116 (D. Fla. 2011).

23. Joseph Story, 1 Commentaries on the Constitution of the United States 404 (Boston, Hilliard, Gray, & Co. 1833).

24. New York v. United States, 505 U.S. 144 (1992).

25. Printz v. United States, 521 U.S. 898 (1997).

26. Commonwealth ex rel. Cuccinell v. Sebelius, 728 F. Supp. 2d 768, 788 (D. Va. 2010).

27. Florida v. United States HHS, 2011 U.S. Dist. LEXIS 8822, *79 (D. Fla. 2011).

Chapter 27

Elena's Nanny State

by Michael D. Tanner

Suppose that the federal government, in its infinite wisdom, decided that it would deal with the obesity crisis and improve the health and welfare of the American people—by mandating that every American eat three helpings of vegetables and three helpings of fruit every day. Anyone caught failing to eat the required food would be subject to a fine or tax. Would such a law be constitutional?

Sen. Tom Coburn (R-Okla.) put that question to Supreme Court nominee Elena Kagan this week. Kagan, the U.S. solicitor general, couldn't answer. In fact, she implied that under the court's "expansive" view of the Constitution's Commerce Clause, a fruit and vegetable mandate *might* be just fine.

Now, some may think that such a hypothetical question is silly, other than giving us a glimpse of Kagan's virtually unlimited view of government power. Congress would never pass such a "dumb" law, to use Kagan's term—would it?

But Congress has just taken a very similar step, mandating that every American purchase a government-designed package of health-insurance benefits. The issue is now before the courts—there's a hearing today.

And supporters of the mandate justify it under exactly the broad interpretation of the Commerce Clause that Kagan cited. In fact, the health-care bill itself says that the mandate is constitutional because "the individual responsibility requirement . . . is commercial and economic in nature, and substantially affects interstate commerce."

The Founders must be spinning in their graves.

The Commerce Clause grants Congress the power to "regulate Commerce . . . among the several States." It was intended to prevent states from erecting trade barriers among themselves, as was common practice under the Articles of Confederation (our governing national document before ratification of the Constitution), and to allow the federal government to deal with such issues as river navigation.

However, in the 1942 case of *Wickard v. Filburn* , the high court interpreted the clause so as to give Congress the authority to reach wholly intrastate-economic activity that "substantially affects" interstate commerce.

In that case, the federal government, in order to help farmers by keeping wheat prices high, had imposed limits on how much wheat farmers could grow.

One farmer, Roscoe Filburn, was growing wheat not for sale but to feed to his own chickens. He argued that since he wasn't selling wheat—let alone selling it across state lines—he wasn't subject to the restrictions.

The court, setting the foundation for the modern regulatory state, held that because Filburn's farming reduced the amount of wheat he would buy for chicken feed from others, and because wheat was traded nationally, growing his own wheat *was* affecting interstate commerce, and therefore could be regulated.

But the individual mandate contained in the health-care reform bill goes beyond regulating even

intrastate activity to regulate *non*activity. That is: Everything you do or don't do could be seen as affecting interstate commerce—so, in this interpretation, everything you do or don't do could be regulated by Congress.

Thus, Congress would be free to order you to take or not take a job, to sell or not sell your house, to buy or not buy a car—or to eat more fruits and vegetables.

This individual-insurance mandate is unprecedented in U.S. governance. As the Congressional Budget Office noted, "a mandate requiring all individuals to purchase health insurance would be an unprecedented federal action. The government has never required people to buy any good or service as a condition of lawful residence in the United States."

However, as Sen. Coburn's question and Kagan's response make clear, if the courts uphold the mandate's constitutionality, the last limits on federal-government power will be gone.

It was easy to see the debate over health-care reform as being about the best way to deliver and pay for health care. But it was always about much more than that. If nothing else, we owe a debt of gratitude to Solicitor General Kagan for making absolutely clear what is really at stake: freedom.

This article appeared in the New York Post *on July 1, 2010.*

Chapter 28

Obamacare Is Unconstitutional

by Roger Vinson

On March 23, 2010, President Obama signed The Patient Protection and Affordable Care Act. This case was filed minutes after the President signed it. This case is not about whether the Act is wise or unwise legislation, or whether it will solve or exacerbate the myriad problems in our health care system. In fact, it is not really about our health care system at all. It is principally about our federalist system, and it raises very important issues regarding the Constitutional role of the federal government.

James Madison, the chief architect of our federalist system, observed in Federalist No. 51:

> In framing a government which is to be administered by men over men, the great difficulty lies in this: you must first enable the government to control the governed; and in the next place oblige it to control itself.

The Founders endeavored to resolve Madison's identified "great difficulty" by creating a system of dual sovereignty. The Tenth Amendment reaffirmed that relationship: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." The Framers believed that limiting federal power, and allowing the "residual" power to remain in the hands of the states (and of the people), would help "ensure protection of our fundamental liberties" and "reduce the risk of tyranny and abuse." The great Chief Justice John Marshall noted "that those limits may not be mistaken, or forgotten, the Constitution is written."

THE SCOPE OF THE COMMERCE CLAUSE

To say that the federal government has limited and enumerated power does not get one far, however, for that statement is a long-recognized and well-settled truism. The ongoing challenge is deciding whether a particular federal law falls within or outside those powers.

For this claim, the plaintiffs contend that the individual mandate exceeds Congress' power under the Commerce Clause. At issue here is the assertion that the Commerce Clause can only reach individuals and entities engaged in an "activity"; and because the plaintiffs maintain that an individual's failure to purchase health insurance is, almost by definition, "inactivity," the individual mandate goes beyond the Commerce Clause and is unconstitutional. The defendants contend that activity is not required before Congress can exercise its Commerce Clause power, but that, even if it is required, not having insurance constitutes activity.

The Commerce Clause is a mere sixteen words long, and it provides that Congress shall have the power:

to regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.

For purposes of this case, only seven words are relevant: "To regulate Commerce . . . among the several States." There is considerable historical evidence that in the early years of the Union, the word "commerce" was understood to encompass trade, and the intercourse, traffic, or exchange of goods. In a frequently cited law review article, constitutional scholar Randy E. Barnett has painstakingly tallied each appearance of the word "commerce" in Madison's notes on the Constitutional Convention and in *The Federalist*, and discovered that in none of the 97 appearances of that term is it ever used to refer unambiguously to activity beyond trade or exchange.

The Supreme Court's first description of commerce (and still the most widely accepted) is from *Gibbons v. Ogden*. Chief Justice Marshall explained that "Commerce, undoubtedly, is traffic, but it is something more: it is intercourse. It describes the commercial intercourse between nations, and parts of nations, in all its branches, and is regulated by prescribing rules for carrying on that intercourse."

To acknowledge the foregoing historical facts is not necessarily to say that the power under the Commerce Clause was intended to (and must) remain limited to the trade or exchange of goods, and be confined to the task of eliminating trade barriers erected by and between the states. The drafters of the Constitution were aware that they were preparing an instrument for the ages, not one suited only for the exigencies of that particular time.

NOVEL AND UNPRECEDENTED

The plaintiffs rely heavily on *Lopez* and *Morrison* in framing their arguments, while the defendants look principally to *Wickard* and *Raich*. These cases all have something to add to the discussion. However, while they frame the analysis, and are important from a historical perspective, they do not by themselves resolve this case. That is because, as Congress's attorneys in the Congressional Research Service and Congressional Budget Office advised long before the Act was passed into law, the notion of Congress having the power under the Commerce Clause to directly impose an individual mandate to purchase health care insurance is "novel" and "unprecedented." Never before has Congress required that everyone buy a product from a private company (essentially for life) just for being alive and residing in the United States. However, unprecedented or not, I will assume that the individual mandate can be Constitutional under the Commerce Clause and will analyze it accordingly.

IS INACTIVITY ACTIVITY?

The threshold question that must be addressed is whether activity is required before Congress can exercise its power under the Commerce Clause. Commerce Clause jurisprudence has contracted and expanded (and contracted and expanded again) during our nation's development. But, in every one of those instances—in both the contractive and expansive—there has always been clear and inarguable activity, from exerting control over and using navigable waters (*Gibbons*) to growing or consuming marijuana (*Raich*). The Supreme Court has never been called upon to consider if "activity" is required.

The defendants contend, however, that despite the inarguable presence of activity in every Supreme Court case to date, activity is not required under the Commerce Clause. In fact, they go so far as to suggest that to impose such a requirement would be bold and radical. According to the defendants,

because the Supreme Court has never identified a distinction between activity and inactivity as a limitation on Congress's commerce power, to hold otherwise would "break new legal ground" and be "novel" and "unprecedented." First, it is interesting that the defendants—apparently believing the best defense is a good offense—would use the words "novel" and "unprecedented," since those are the exact same words that the CRS and CBO used to describe the individual mandate before it became law.

Furthermore, there is a simple and rather obvious reason why the Supreme Court has never distinguished between activity and inactivity before: it has not been called upon to consider the issue because, until now, Congress had never attempted to exercise its Commerce Clause power in such a way before. In every Supreme Court case decided thus far, Congress was not seeking to regulate, under its commerce power, something that could even arguably be said to be "passive inactivity."

It would be a radical departure from existing case law to hold that Congress can regulate inactivity under the Commerce Clause. If it has the power to compel an otherwise passive individual into a commercial transaction with a third party merely by asserting—as was done in the Act—that compelling the actual transaction is itself "commercial and economic in nature, and substantially affects interstate commerce," it is not hyperbolizing to suggest that Congress could do almost anything it wanted. It is difficult to imagine that a nation which began, at least in part, as the result of opposition to a British mandate giving the East India Company a monopoly and imposing a nominal tax on all tea sold in America would have set out to create a government with the power to force people to buy tea in the first place. If Congress can penalize a passive individual for failing to engage in commerce, the enumeration of powers in the Constitution would have been in vain, for it would be "difficult to perceive any limitation on federal power" (*Lopez*), and we would have a Constitution in name only. Surely this is not what the Founding Fathers could have intended.

Having found that "activity" is an indispensable part [of] the Commerce Clause analysis, the constitutionality of the individual mandate will turn on whether the failure to buy health insurance is "activity." Preliminarily, based solely on a plain reading of the Act itself (and a commonsense interpretation of the word "activity" and its absence), I must agree with the plaintiffs' contention that the individual mandate regulates inactivity. Section 1501 states in relevant part: "If an applicable individual fails to [buy health insurance], there is hereby imposed a penalty." By its very own terms, therefore, the statute applies to a person who does not buy the government-approved insurance; that is, a person who "fails" to act pursuant to the congressional dictate.

The defendants insist that the uninsured are active. In fact, they even go so far as to make the claim—which the plaintiffs call "absurd"—that going without health insurance constitutes "economic activity to an even greater extent than the plaintiffs in *Wickard* or *Raich*."

The defendants contend that there are three unique elements of the health care market which, when viewed cumulatively and in combination, belie the claim that the uninsured are inactive. First, as living and breathing human beings who are always susceptible to sudden and unpredictable illness and injury, no one can "opt out" of the health care market. Second, if and when health services are sought, hospitals are required by law to provide care, regardless of inability to pay. And third, if the costs incurred cannot be paid (which they frequently cannot, given the high cost of medical care), they are passed along (cost-shifted) to third parties, which has economic implications for everyone. Congress found that the uninsured received approximately $43 billion in "uncompensated care" in 2008 alone. These three things, according to the defendants and various health care industry experts and scholars on whom they rely, are "replicated in no other market" and defeat the argument that uninsured individuals are inactive.

First, it is not at all clear whether or why the three allegedly unique factors of the health care market are constitutionally significant. What if only one of the three factors identified by the defendants is present? After all, there are lots of markets—especially if defined broadly enough—that people cannot "opt out" of. For example, everyone must participate in the food market. Instead of attempting to control wheat supply by regulating the acreage and amount of wheat a farmer could grow as in *Wickard*, under this logic Congress could more directly raise too-low wheat prices merely by increasing demand through mandating that every adult purchase and consume wheat bread daily, rationalized on the grounds that because everyone must participate in the market for food, non-consumers of wheat bread adversely affect prices in the wheat market.

Or, as was discussed during oral argument, Congress could require that people buy and consume broccoli at regular intervals, not only because the required purchases will positively impact interstate commerce, but also because people who eat healthier tend to be healthier, and are thus more productive and put less of a strain on the health care system. Similarly, because virtually no one can be divorced from the transportation market, Congress could require that everyone above a certain income threshold buy a General Motors automobile—now partially government owned—because those who do not buy GM cars (or those who buy foreign cars) are adversely impacting commerce and a taxpayer- subsidized business.

That the defendants' argument is "unsupported by Commerce Clause jurisprudence" can perhaps best be seen by looking to Lopez. Although that case is distinct from this one in some notable ways, in the context of the defendants' "health care is unique" argument, it is quite similar.

THE LOPEZ CASE

In *Lopez*, the majority was concerned that using the Commerce Clause to regulate things such as possession of guns in school zones would "obliterate" the distinction between what is national and what is local and effectively create a centralized government that could potentially permit Congress to begin regulating "any and all aspects" of our lives, including marriage, divorce, child custody, and education. The dissent insisted that this concern was unfounded because the statute at issue was "aimed at curbing a particularly acute threat" of violence in schools that had "singularly disruptive potential." This was "the rare case, then, that a statute strikes at conduct that (when considered in the abstract) seems so removed from commerce, but which (practically speaking) has so significant an impact upon commerce."

Two things become apparent after reading these arguments attempting to justify extending Commerce Clause power to the legislation in that case, and the majority opinion (which is the controlling precedent) rejecting those same arguments. First, the contention that Commerce Clause power should be upheld merely because the government and its experts or scholars claim that it is being exercised to address a "particularly acute" problem that is "singular [ ]," "special," and "rare"— that is to say "unique"—will not by itself win the day. Uniqueness is not an adequate limiting principle, as every market problem is, at some level and in some respects, unique. If Congress asserts power that exceeds its enumerated powers, then it is unconstitutional, regardless of the purported uniqueness of the context in which it is being asserted.

Second, and perhaps more significantly, under *Lopez* the causal link between what is being regulated and its effect on interstate commerce cannot be attenuated and require a court "to pile inference upon inference," which is, in my view, exactly what would be required to uphold the individual mandate. For example, in contrast to individuals who grow and consume marijuana or wheat (even in extremely small

amounts), the mere status of being without health insurance, in and of itself, has absolutely no impact whatsoever on interstate commerce—not "slight," "trivial," or "indirect," but no impact whatsoever—at least not any more so than the status of being without any particular good or service. If impact on interstate commerce were to be expressed and calculated mathematically, the status of being uninsured would necessarily be represented by zero.

Of course, any other figure multiplied by zero is also zero. Consequently, the impact must be zero, and of no effect on interstate commerce. The uninsured can only be said to have a substantial effect on interstate commerce in the manner as described by the defendants: (i) if they get sick or injured; (ii) if they are still uninsured at that specific point in time; (iii) if they seek medical care for that sickness or injury; (iv) if they are unable to pay for the medical care received; and (v) if they are unable or unwilling to make payment arrangements directly with the health care provider, or with assistance of family, friends, and charitable groups, and the costs are thereafter shifted to others. In my view, this is the sort of piling "inference upon inference" rejected in *Lopez* and subsequently described in *Morrison* as "unworkable if we are to maintain the Constitution's enumeration of powers."

While $43 billion in uncompensated care from 2008 was only 2% of national health care expenditures for that year, it is clearly a large amount of money, and it demonstrates that a number of the uninsured are taking the five sequential steps. And when they do, Congress plainly has the power to regulate them at that time (or even at the time that they initially seek medical care), a fact with which the plaintiffs agree. But, to cast the net wide enough to reach everyone in the present, with the expectation that they will (or could) take those steps in the future, goes beyond the existing "outer limits" of the Commerce Clause and would, I believe, require inferential leaps of the sort rejected in *Lopez*. The defendants' argument that people without health insurance are actively engaged in interstate commerce based on the purported "unique" features of the much broader health care market is neither factually convincing nor legally supportable.

The defendants next contend that the uninsured have made the calculated decision to engage in market timing and try to finance their future medical needs out-of-pocket rather than through insurance, and that this "economic decision" is tantamount to activity.

The problem with this legal rationale, however, is it would essentially have unlimited application. There is quite literally no decision that, in the natural course of events, does not have an economic impact of some sort. It is not difficult to identify an economic decision that has a cumulatively substantial effect on interstate commerce; rather, the difficult task is to find a decision that does not.

CONCLUSION

Because I find both the "uniqueness" and "economic decision" arguments unpersuasive, I conclude that the individual mandate seeks to regulate economic inactivity, which is the very opposite of economic activity. And because activity is required under the Commerce Clause, the individual mandate exceeds Congress' commerce power, as it is understood, defined, and applied in the existing Supreme Court case law.

Congress must operate within the bounds established by the Constitution. For the reasons stated, I must reluctantly conclude that Congress exceeded the bounds of its authority in passing the Act with the individual mandate. Because the individual mandate is unconstitutional and not severable, the entire Act must be declared void. This has been a difficult decision to reach, and I am aware that it will have indeterminable implications. At a time when there is virtually unanimous agreement that health care

reform is needed in this country, it is hard to invalidate and strike down a statute titled "The Patient Protection and Affordable Care Act."

My conclusion in this case is based on an application of the Commerce Clause law as it exists pursuant to the Supreme Court's current interpretation and definition. Only the Supreme Court (or a Constitutional amendment) can expand that.

The Patient Protection and Affordable Care Act is unconstitutional.

This article appears in Cato Policy Report, March/April 2011.

Chapter 29

U.S. Department of Health & Human Services v. Florida

by Ilya Shapiro, Trevor Burrus, Robert A. Levy, Roger Pilon, Timothy Sandefur and Anastasia Killian

Cato Legal Brief (February 13, 2012)

With the scheduled three days of oral argument six weeks away, Cato filed its fourth and final Supreme Court *amicus* brief in the Obamacare saga, this time on the most critical issue: the constitutionality of the individual mandate. Cato, alongside Pacific Legal Foundation, Competitive Enterprise Institute, 14 other organizations, and a bipartisan group of 333 state legislators, urges the Court to affirm the Eleventh Circuit's ruling that the mandate exceeds Congress's power to regulate interstate commerce. Under modern doctrine, regulating intrastate *economic* activity can be a "necessary" means of carrying out Congress's regulatory authority (as that term is understood under the Necessary and Proper Clause) if, in the aggregate, it has a substantial effect on interstate commerce. But the obvious corollary is that regulating non-economic activity cannot be "necessary," regardless of its economic effects. And a power to regulate inactivity—to compel activity—is even more remote from Congress's commerce power. The government characterizes not being insured as the activity of making an "economic decision" of how to finance health care services, but the notion that probable future participation in the marketplace constitutes economic activity now pushes far beyond existing precedent. Further, that definition of "activity" leaves people with no way of avoiding federal regulation; at any moment, we are all not engaged in an infinite set of activities. Retaining the categorical distinction between economic and non-economic activity limits Congress to regulating intrastate activities closely connected to interstate commerce—thus preserving the proper role of states and preventing Congress from using the Commerce Clause as a federal police power. The categorical distinction also provides a judicially administrable standard that obviates fact-based inquiries into the purported economic effects and the relative necessity of any one regulation, an exercise for which courts are ill-suited. Finally, the mandate violates the "proper" prong of the Necessary and Proper Clause in that it unconstitutionally commandeers the people—and in doing so, circumvents the Constitution's preference for political accountability. The Constitution permits Congress to intrude on state and popular sovereignty only in certain limited circumstances: when doing so is textually based or when it relates to the duties of citizenship. For example, Congress may require people to respond to the census or serve on juries. In forcing people to engage in transactions with private companies, the individual mandate allows Congress and the president to evade being held accountable for what would otherwise be a tax increase. In improperly commandeering citizens to engage in economic activity, the mandate obscures Obamacare's true costs and thus avoids the political accountability and transparent budgeting that the Constitution demands. Thus, the mandate is neither a necessary nor proper means for carrying into execution Congress's power to

regulate interstate commerce. Upholding it would fundamentally alter the relationship of the federal government to the states and the people; nobody would ever again be able to claim plausibly that the Constitution limits federal power.

Download the complete brief.

Chapter 30

Baking Some Humble Pie for Congress

by Trevor Burrus

The challenge to the Affordable Care Act, a.k.a. Obamacare, has come a long way since then-Speaker of the House Nancy Pelosi incredulously asked "are you serious?" in response to a reporter's question on its constitutionality. As oral arguments before the Supreme Court near, the Court should show Pelosi just how "serious" a transgression this law is. Not only is the individual mandate, which requires nearly every American purchase a qualifying health insurance plan, a forced wealth transfer that is not authorized by any of Congress's limited powers, it is a forced transfer that was deliberately and deceptively passed in order to avoid the political liability of imposing a tax. For both reasons it is unconstitutional. For the second reason we should be angry.

By forcing relatively healthy people to purchase insurance, Congress hoped to subsidize the health care costs of less healthy people. Under current constitutional law, the same result could have been accomplished by increasing taxes and directly subsidizing insurance companies. Instead, Congress chose to command everyone to give their money to a private business. The ultimate effect is essentially the same: an expensive, dysfunctional, and ineffective health care system mostly controlled by the federal government. By choosing to use the individual mandate Congress has not only harmed our health care system, it has seriously imperiled our Constitution.

Imagine a world in which Congress is allowed to avoid the political accountability of huge tax increases and budgetary explosions by commanding people to purchase a product. Members of Congress would be able to claim accurately, if not totally honestly, that they did not raise taxes or increase the budget during their term. The Framers of the Constitution understood politicians' self-interested motives and thus added safeguards that limit the powers of Congress and ensure the accountability of our representatives to the people. By ignoring these safeguards, the Act violates "the letter and spirit of the constitution," in the words of Chief Justice John Marshall.

The Framers were aware that the power to tax was among the most dangerous powers of government. During the Constitutional Convention they devoted considerable time to debating the Origination Clause, a relatively unknown clause requiring that all "Bills for raising Revenue shall originate in the House of Representatives." Many delegates saw the clause as so essential to good government that they were willing to quit the convention if it were not included. In the words of George Mason, to not include the clause would "unhinge the compromise" that had created popular representation in the House and equal representation in the Senate.

The clause was crucial because, in the words of Ben Franklin, "It was always of importance that the people should know who had disposed of their money, and how it had been disposed of." Only the House, being closest to the people in terms of number of constituents and length of term, could be trusted with taking money from the people in a responsible fashion.

Additionally, in order to provide the people information on how much money is being taken and spent, the Framers also included the Statement and Account Clause, which requires a "regular Statement and Account of Receipts and Expenditures of all public Money shall be published from time to time."

Though both the Origination Clause and the Statement and Account Clause are largely unenforceable through the courts, they form part of the "spirit of the constitution," and that spirit is clear: forced wealth transfers must be above-the-board and transparent. The individual mandate is not only off-the-books, it is a duplicitous attempt on the part of Congress to avoid the political liability for the costs of an entitlement program but to still receive the political gains from the beneficiaries.

President Clinton's health care proposal mostly failed because of an astronomical budgetary estimate that included the personal costs of an individual mandate. After that episode, Congress learned to be sneaky when it comes to budget estimates. By using special accounting tricks in Obamacare, the costs to individuals forced to purchase insurance are not included in the budgetary estimate of the law. In other words, the individual mandate allows Congress to achieve the ultimate politicians' coup: clandestinely taking money and doling out benefits.

If this law stands, they will do it again. How could they resist?

The challenge to the Affordable Care Act not only asks the Supreme Court to enforce the limits on congressional power explicitly listed in our Constitution, it asks for the return of some measure of humility to a Congress that self-interestedly ignored constitutional limits. The Court should unambiguously chide Congress and restore some dignity to the men who sat through a hot Philadelphia summer to ensure an honest and accountable government.

This article appeared in Huffington Post *on March 27, 2012.*

Chapter 31

The Supreme Obamacare Question

by Michael D. Tanner

Next week, the Supreme Court will devote six hours over three days to hearing challenges to the Patient Protection and Affordable Care Act, a k a ObamaCare.

The last time the court spent this much time hearing arguments in a case was in 1966, when it devoted six hours to the case establishing a defendant's Miranda rights and seven hours to the case that upheld the Voting Rights Act. This decision is likely to be just as momentous.

That's because this case isn't really about health-care reform. Rather, it's about government power and the fundamental relationship between government and the people.

The court will hear four separate but related arguments, but all the issues boil down to a simple but important question: Do we have a government of limited, enumerated powers or a government of unbridled power, with the authority to control and direct every aspect of our lives?

In defending the health-care law, the Obama administration relies on two constitutional provisions to justify its claim of federal power. The first is the Commerce Clause, which grants Congress the power to "to regulate commerce . . . among the several states." This is supposed to justify ObamaCare's mandating that each of us buy insurance (the "individual mandate").

How does a decision *not* to buy something constitute commerce?

Well, since the New Deal era, the courts have expanded the definition of commerce to include any "activity" that has a "substantial economic effect on interstate commerce." Thus the high court has held that such things as growing wheat to feed to your cattle (*Wickard v. Philburn*) or distributing medical marijuana (*Gonzalez v. Raich*) can be regulated as interstate commerce.

But both growing wheat and giving away pot involve *doing something*. The Obama administration is seeking to extend Congress's power to *inactivity*. Congress would not only have the power to regulate how you do something or to prohibit you from doing it, Congress now could *require* you to do something.

In a bit of Orwellian logic, the administration argues that by *not doing* something, you actually are *doing* something.

As a lower-court judge wrote in upholding the mandate, choosing not to do something is "mental activity," and is therefore subject to regulation. Thus, government essentially is asserting its authority over every thought in your head.

The crucial concern here is what lawyers call a "limiting principle." If the court upholds the government's power to force you to buy health insurance, is there *any* limit to this power? Is there anything the government *can't* require you to do?

So far, the administration hasn't found anything that lies outside their reach.

Deputy Assistant Attorney General Beth Brinkmann, arguing this case before a lower court, was asked whether a federal law requiring Americans to eat broccoli would be constitutional.

"It depends," she replied, but said she could envision cases in which it would be. Likewise, she thought that a law requiring people to buy cars from General Motors to keep it in business might well be constitutional.

If the court buys into the administration's reasoning, we probably still wouldn't have to worry about the broccoli police anytime soon—but there would be little constitutional protection from Washington's regulation of anything you do . . . or don't do.

The administration also cites the Constitution's Necessary and Proper Clause, which grants Congress authority "To make all Laws which shall be necessary and proper for carrying into Execution [its constitutional powers]."

The argument here is that health care is an important problem facing this country, and the administration's preferred remedy for that problem can't be carried out without the individual mandate. The mandate, therefore, is a "necessary and proper" way to accomplish its larger goals.

Again, this would open the door to unlimited government power. If the government has the authority to enact any law it deems necessary to doing whatever it wants to do, the Constitution essentially becomes meaningless.

As the 11th Circuit Court wrote when it ruled that the mandate was unconstitutional, "We have not found any generally applicable, judicially enforceable limiting principle that would permit us to uphold the mandate without obliterating the boundaries inherent in the system of enumerated congressional powers."

That, and not a costly boondoggle of a health-care plan, is what's really at stake next week.

This article appeared in the **New York Post** *on March 22, 2012.*

Chapter 32

That's Not a Limiting Principle, Noah Feldman Edition

by Michael F. Cannon

Harvard law professor Noah Feldman opines that U.S. Solicitor General Don Verrilli "faltered" yesterday when Supreme Court justices asked whether the Obama administration's claim that the Constitution empowers Congress to force people to purchase health insurance contains any limiting principle. Put differently, if the power "To regulate commerce . . . among the several States" allows the government to force you to buy health insurance, can the government also force you to buy broccoli?

Feldman laments that Verrilli's "failure to offer a sharp distinction could be disastrous for the government's case," but assures us, "There is a good, sharp answer to this wholly reasonable question." Here is the preface to Feldman's answer:

> [W]hen it comes to the strange and unusual case of health insurance, inaction causes the whole market to break down. By not buying health insurance, the healthiest person is depriving everyone of a public good. By sitting on their hands—and acting rationally— people who do not purchase insurance are unintentionally causing the market to fail.

One problem here is that if Congress can compel you to buy something whenever not buying it would deprive someone else of a public good, then Congress can also force you to purchase—not just tax and provide to you, but force *you* to purchase—tanks, fighter jets, and military bases; lighthouses; software; fireworks displays; e-books; comparative-effectiveness research (or really any type of research); a subscription to *Consumer Reports*; landscaping services; parks; rare and endangered species; street lights; *et cetera ad nauseam*. That isn't much of a limiting principle.

Another problem is that economists use the term "market failure" to describe a situation where one or more features of a free market cause that market to fall short of the efficiency-maximizing outcome. Feldman misuses it to mean, "This market isn't doing what I want." That is *not* market failure. Nor is it much of a limiting principle. If the Commerce Clause empowered Congress to force people to buy things to correct every perceived shortcoming in every market, Congress' powers would be without limit. Even worse, Feldman doesn't even bother identify whether the outcome he deplores is caused by some feature of a free market or government intervention (see below).

But that was just preface to Feldman's supposed limiting principle. Here's the meat of it:

> The government can penalize inaction only when that inaction deprives everyone else of a public good . . . There must be an asymmetry of information about the relevant facts governing insurance—like the difference between my knowledge of how healthy I am and the insurance company's ability to suss it out. And the market must be one in which that information asymmetry leads to adverse selection.

Though Feldman begins by stating government can force you to purchase any public good— another economic concept he seems to misunderstand—by the end of the paragraph he narrows his limiting principle to situations where asymmetric information causes market failures in insurance. Sorry, but that's still not much of a limiting principle. For one thing, it would enable Congress to force Americans to purchase basically any type of insurance.

Asymmetries of information, in the absence of regulation, lead to adverse selection in all insurance markets. Insurers typically remedy this problem by adjusting premiums to reflect the risk posed by the purchaser, but there will always be situations where some purchasers know they pose a greater risk of filing claims than carriers realize. Fortunately, the risk-aversion of other purchasers acts as a counterweight and prevents those markets from collapsing. But since all adverse selection causes at least *some* mutually beneficial insurance purchases not to occur—the sort of welfare loss that constitutes an actual market failure—Feldman's so-called limiting principle would allow Congress to force you to buy any type of insurance it wants, so long as Congress finds even a sliver of adverse selection. That opens to door for Congress to mandate that everyone purchase life, auto, disability, flood, mortgage, renter's, terrorism, earthquake, deposit, pet, earthquake, divorce, and long-term care insurance. Congress could even require you to purchase reinsurance—i.e., insurance against the that risk that your other insurance policies won't pay. No doubt adverse selection prevents some unfortunate professional athletes and performers from insuring against the failure of their hair, legs, hands, teeth, vocal chords, fingers, ankles, tongues, and entire bodies. Ditto the threat of a paternity suit. If so, then Feldman's "limiting principle" would let Congress mandate that everyone purchase those insurance policies, too.

Feldman's limiting principle would even allow Congress to force Americans to purchase types of insurance that currently don't exist. What if adverse selection so bedevils the markets for BAC-level insurance, positive-drug-test insurance, short-term-suicide insurance, overgrown-grass insurance, and oversleeping insurance that no carriers even offer such policies? Under Feldman's rule, Congress could fix that by forcing carriers to offer such insurance and forcing you to buy it.

And that's only what Congress could do in the presence of whatever scant adverse selection exists in unregulated insurance markets. But regulation typically *encourages* adverse selection–a point that Feldman elides, as if the catastrophic adverse selection that ObamaCare's "community rating" price controls will cause were the market's fault rather than Congress'. So what Feldman is actually saying is that Congress can force you to purchase insurance even if Congress itself caused the adverse selection. Which brings us back to broccoli.

Remember broccoli? Feldman writes, "If I choose not to buy broccoli, others can still buy it at a market price." Perhaps that is true today. But let's assume Feldman subscribes to the Obama administration's argument that the Commerce Power enables Congress to regulate the timing and method of payment for a good that moves in interstate commerce. That would mean that Feldman believes Congress could pass a law stating that all broccoli purchasers must henceforth purchase it through a new method of payment called "broccoli insurance," where all purchasers pay broccoli insurers a flat fee based on average broccoli consumption within the insurer's pool of customers, regardless of how much broccoli an individual customer may consume. What would happen if Congress did that?

Well, those who consume the most broccoli would be thrilled. They could eat as much broccoli as they want—they could even stucco or decorate their houses with it—while paying much less than they did before. Those who rarely buy broccoli, on the other hand, would see their broccoli bills skyrocket. They may decide not to buy broccoli at all. When they leave the broccoli market, average consumption by

those in the market will rise, as will broccoli premiums. That will cause more low-end broccoli consumers to leave the market, and the cycle will repeat itself.

Feldman will recognize this process as—you guessed it—adverse selection caused by asymmetric information. Which, under his limiting principle, means that Congress can swoop down and mandate that Americans purchase broccoli insurance. After all, those people choosing not to buy broccoli are "depriving everyone of [what Feldman calls] a public good." In sum, Feldman's limiting principle would allow Congress to force all Americans to buy broccoli. Which is to say, it's not a limiting principle at all.

Like every other so-called limiting principle offered by ObamaCare's defenders, Feldman's has no basis in the Constitution or any other law. It is a *post hoc* rationalization, made by people who are shocked to find themselves before the Supreme Court, defending the constitutionality of their desire to bully others into submission.

Lord only knows where these guys get all their self-assuredness. Maybe it's part of Harvard's employee benefits package.

Update: Prof. Feldman commits another error that I did not initially catch, and therefore perpetuated. It is not asymmetric information that leads to adverse selection in the markets for health/broccoli insurance and causes those markets to collapse. It is the fact that the government's "community rating" price controls prevent insurance carriers from using information they possess to set premiums in a way that prevents adverse selection. HT: Me.

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Chapter 33

In Opposing Obamacare, We Were Serious the Whole Time

by Ilya Shapiro

"Can you create commerce in order to regulate it?" With those words, Justice Anthony Kennedy sent the legal establishment reeling.

Was the Supreme Court really taking seriously the preposterous claims of the Tea Party-inspired hacks who were suing the federal government? Was there really a chance that five justices, acting as would-be partisan hacks themselves, would throw out President Obama's signature achievement? Could Obamacare, which name everyone is now allowed to use because the administration itself has adopted it, really fall on some technicality about mandating economic activity rather than regulating it when it occurs?

In a word, yes.

Those of us who have been challenging the constitutionality of the individual health insurance mandate have been serious the whole time. We thought we had put to rest the slurs about our cases being frivolous or political sour grapes when multiple federal judges denied the government's motions to dismiss them. Or when those same judges struck down the individual mandate. Or when an appellate court, including a judge appointed by President Clinton, affirmed one of those rulings.

When 26 states (and two more in separate lawsuits) argue that the constitutional power to regulate interstate commerce—which the Court has interpreted to include the regulation of local economic activity that has a substantial effect on interstate commerce—does not give the federal government the power to force people to buy stuff, maybe there's a legitimate point of debate.

Is it not valid to ask where federal power ends, as it must under the Constitution's grant of enumerated and therefore limited powers? What legal principle can courts apply to sanction economic mandates with respect to healthcare but not in other areas?

At the very least, when the Supreme Court granted an historic six hours of oral argument over three days—akin to *Brown v. Board of Education* or *Roe v. Wade*—surely the government's supporters in the media and academy recognized that there was something to what we were saying.

Yet on the eve of the arguments, nationally renowned commentators like Linda Greenhouse and Dahlia Lithwick breezily predicted an easy victory for the government. And 85% of academics and journalists polled by the American Bar Association said the law would be upheld. (Never mind the question of why we need proof that elite liberals overwhelmingly support the elite liberal view.)

After all, holding otherwise would take us back to the dark times when children could work in stores and the government couldn't tell farmers how to go about their business. We all know that only Justice Clarence Thomas would endorse those kinds of hunger games.

And so, despite the plaintiffs' methodical progress and impressive lawyering—led by Paul Clement, possibly the nation's best advocate—the punditocracy still managed to be caught off-guard when four

justices expressed skepticism about the government's position. (Thomas was characteristically silent but can indeed be expected to support the structural limits on federal power.)

CNN's own Jeffrey Toobin called it a "train wreck" for the administration, a reaction emblematic of the apoplexy with which the chattering classes reacted to last week's hearings. There had to be some explanation—beyond the obviously implausible idea that the challengers' claims had any merit— and indeed two narratives emerged: (1) the government's lawyer, Solicitor General Donald Verrilli, turned in a horrible performance, and (2) the justices were playing politics.

Neither of these excuses is convincing. While it's true that Verrilli wasn't at his best—the experienced super-lawyer seemed to strain under a decidedly non-frivolous weight—he ably conveyed the carefully crafted legal positions that the government has advanced all along.

And while it's also true that all the anti-Obamacare votes will come from justices appointed by Republican presidents, that doesn't mean those justices are acting from partisan motives (any more than the pro-Obamacare justices are). Indeed, unlike any previous "controversial" case, here 72% of the American people—including 56% of Democrats and 54% of those who think the law is a good thing—think the individual mandate is unconstitutional.

No, the reason that the government had a bad week is that its position is weak. It has become abundantly clear that the reason that the solicitor general failed to articulate a principled limit to his theory of federal power—despite knowing that this would be the primary question he would face—is that there isn't one.

No matter how much Yale's Akhil Amar and Northwestern's Andrew Koppelman protest, we must recognize the validity of an interpretive theory that gives judges the power to enforce the Constitution's structure. Features such as federalism and the separation of powers are there not as some abstract exercise in applied political theory but to protect individual liberty. Before we even get to the Bill of Rights, which was a hotly debated afterthought, or the political checks on power, we have a constitutional design that denies the federal government the sort of plenary "police" power that states enjoy.

That's why the infamous "broccoli hypothetical" is so telling. Economists say that diet and exercise have a greater effect on taxpayer spending on healthcare than rates of ownership of insurance, so if anything healthy-food and gym-membership mandates have *greater* constitutional warrant than what we're dealing with now.

By the same token, Congress's ability to concoct lots of well-intentioned national reform schemes doesn't give it unfettered means to pursue those noble ends. It is a theory that would allow such unchecked federal power every time Congress acts under a self-declared "national problem" that cannot survive serious constitutional scrutiny.

Returning to Justice Kennedy, "here the government is saying that the Federal Government has a duty to tell the individual citizen that it must act, and that is different from what we have in previous cases, and that changes the relationship of the Federal Government to the individual in a very fundamental way."

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OBAMACARE'S COST

Chapter 34

Is Universal Coverage Comparatively Effective?

by Michael F. Cannon

As congressional Democrats prepare to deliver on President Barack Obama's goal of "expanding coverage to all Americans,"(.pdf) an important question remains unanswered: is universal coverage worth the money?

Extending health insurance coverage to the estimated 46 million (.pdf) Americans without it could easily cost $2 trillion over the next 10 years. If the underlying goal is to make people healthier, are there other ways to spend that $2 trillion that would help Americans, including the uninsured, live even longer, healthier lives? There may well be, and one can hardly imagine a more fit topic for comparative-effectiveness research.

Health reformers love a good we-all-know statement, like, "We all know that health insurance is a good investment," or, "We all know that investing in preventive care saves money."

Health economists, on the other hand, enjoy embarrassing the we-all-know-it-alls. For example, a recent *New England Journal of Medicine* article concluded, "Although some preventive measures do save money, the vast majority reviewed in the health economics literature do not."

Likewise, economists Helen Levy of the University of Michigan and David Meltzer of the University of Chicago have thrown cold water on the conventional wisdom that expanding health insurance is a good investment.

In 2004, Levy and Meltzer reviewed the literature for the Urban Institute and concluded: "There is no evidence at this time that money aimed at improving health would be better spent on expanding insurance coverage than on . . . other possibilities," such as programs that fund inner-city clinics, screen for discrete diseases such as hypertension, or promote better nutrition.

Writing in the *Annual Review of Public Health* in 2008, Levy and Meltzer reaffirmed that conclusion: "The central question of how health insurance affects health, for whom it matters, and how much, remains largely unanswered at the level of detail needed to inform policy decisions."

"Understanding the magnitude of health benefits associated with insurance is not just an academic exercise," they explain, "it is crucial to ensuring that the benefits of a given amount of public spending on health are maximized."

Not only is there "no evidence" that universal coverage is the most cost-effective use of our $2 trillion, the benefits may not exceed the costs at all.

In a 2008 article for the *Journal of Public Economics*, Amy Finkelstein of the Massachusetts Institute of Technology and Robin McKnight of Wellesley College reported that even though Medicare achieved universal coverage for the elderly, it had no impact on elderly mortality rates in its first 10 years.

Medicare may (or may not) have improved enrollees' health in other ways. Yet Finkelstein's and McKnight's results leave open the question of whether those and any additional benefits were worth Medicare's substantial cost.

For decades, health reformers have been beating the drums for "evidence-based medicine," all the while ignoring the lack of evidence behind the push for universal coverage. "Science for thee," we lecture physicians, "but not for me."

It's time to start practicing evidence-based health policy. Here's how.

Before Congress spends $2 trillion on reforms of unknown value, it should direct the $1.1 billion it has allocated for "comparative effectiveness" research toward experiments that will tell us whether universal coverage or some other strategy would deliver the most health for the money.

The idea has precedent. In the 1970s, at a time when many reformers were demanding to make health care "free" for all, Congress funded a massive social experiment to test the idea. The RAND Health Insurance Experiment startled reformers by showing that "free" care cost far more than mere catastrophic health insurance, yet offered little or no additional improvements in health.

Levy and Meltzer note that "definitive answers" will come only by "investing in social experiments designed to answer specific questions about the value of improved health insurance coverage or other policies to improve health." George Mason University economist Robin Hanson has even started a petition to demand a new RAND-like experiment, which he estimates would cost a mere $500 million over 10 years.

I oppose spending taxpayer dollars on such research, for reasons both principled and practical. But if Congress is going to spend the money anyway, the least it could do is let us know whether universal coverage is a comparatively effective use of our $2 trillion.

*This article appeared on **KaiserHealthNews.org** on May 31, 2009.*

Chapter 35

The $1.5 Trillion Fraud

by Michael F. Cannon

If House Democrats hold a vote on their health-care overhaul this weekend, they might as well vote on abolishing the Congressional Budget Office too. It would be no more audacious—and much more honest—than their current strategy for hiding the true cost of their legislation.

Never mind the everyday budget gimmicks House Democrats have used, such as removing $250 billion of deficit spending to be voted on separately. Or claiming their bill would cost just $894 billion—around $400 billion less than the CBO actually projected. We've seen this kind of trickery plenty in recent years; to suppress an inconvenient cost estimate of its proposed Medicare drug entitlement, the Bush administration threatened to fire Medicare's chief actuary.

Deceptions on this scale are child's play, at least when compared to what has to be the biggest fiscal obfuscation in the history of American politics: The current leadership has rigged the legislation so that 60 percent of its total cost will not be made public by the CBO in advance of the House vote. Here's how they did it.

The centerpiece of the bills currently under consideration is not the "public option," but the "individual mandate"—a legal requirement that all U.S. residents purchase health insurance, on penalty of fines and/or imprisonment.

The CBO describes an individual mandate as "an unprecedented form of federal action" whose closest analogue in federal law is the draft. But as President Obama told a joint session of Congress, the rest of the legislation won't work unless the federal government forces Americans to purchase health insurance.

President Clinton's ill-fated health plan had an individual mandate, too. Back in 1994, the CBO decided that since "the mandatory premiums . . . would constitute an exercise of sovereign power," the agency would treat all premiums as federal revenues, including them in the federal budget.

That revealed to the public the full cost of Clinton's health plan. Clinton's secretary of health and human services, Donna Shalala, called the CBO's decision "devastating." Journalist Ezra Klein writes that it "helped kill the bill."

Rather than admit the individual mandate's unpopularity and move on, congressional Democrats simply ensured that its costs would not appear in the federal budget this time around by gaming the CBO's rule for what constitutes "federal revenues."

The CBO explains it will not count mandatory premiums as federal revenues if the individual mandate leaves consumers with what the CBO considers a "sufficient" or "meaningful" or "substantial" degree of choice among health plans. That rule is both amorphous and arbitrary. (For example, it presumes that the freedom not to purchase health insurance—which an individual mandate would eliminate—is not "meaningful." Millions of Americans would disagree.) More important, evading that rule doesn't make an individual mandate any less compulsory, or any less costly. It just hides those costs by pushing them

off-budget.

Obama budget director Peter Orszag laid the groundwork for this feat. While director of the CBO in 2007 and 2008, he fostered a more collaborative relationship between the CBO and members of Congress, which enabled the agency to provide behind-the-scenes guidance to Democrats crafting their mandate. That's why the cost of the Democrats' individual mandates appears nowhere in the half-dozen or more "preliminary cost estimates" the CBO has completed on various Democratic health-care bills.

In Massachusetts, which has enacted what is essentially the Democrats' health plan, mandatory premiums account for about 60 percent of overall costs, according to the Massachusetts Taxpayers Foundation. On-budget government spending is just 40 percent. By my count, mandatory premiums accounted for a similar share of the Clinton health plan's projected cost.

So while the CBO estimates that the coverage expansions in the House Democrats' legislation would trigger about $1 trillion of new federal spending over ten years, the actual cost of those coverage expansions is more like $2.5 trillion.

The CBO exists to bring honest accounting to the federal government. House Democrats are gaming the CBO, subverting this purpose. Anyone who cares about honest accounting or transparency in government should put the brakes on this vote until the American people have all the facts.

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Chapter 36

Bland CBO Memo, or Smoking Gun?

by Michael F. Cannon

This weekend, the Congressional Budget Office released "a very strange memo" titled, "Budgetary Treatment of Proposals to Regulate Medical Loss Ratios." You wouldn't know it from the title, but that little memo is the smoking gun that shows how congressional Democrats have very carefully hidden more than half the cost of their health care bills.

First, a little history. Like both the House and Senate bills, the Clinton health plan would have mandated that individuals and employers purchase private insurance. In its 1994 score of the Clinton plan, Bob Reischauer's CBO included those mandated "private" payments in the federal budget—i.e., as federal revenues and federal expenditures.

And yet, none of the CBO scores of this year's bills include the costs of similar individual/employer mandates as federal revenues or federal spending.

My read of the CBO's score of the Clinton health plan is that the private-sector mandates accounted for around 60 percent of the Clinton health plan's total cost, the remainder being (traditional) government spending. So how is it that the CBO made the full cost of the Clinton health plan apparent to the public in 1994, but may now be revealing only 40 percent of the cost of the Obama health plan?

For some time, I've suspected the answer is that congressional Democrats have very carefully tailored their individual and employer mandates to avoid CBO's definition of what shall be counted in the federal budget. Democrats are still smarting over the CBO's decision in 1994. By revealing the full cost of the Clinton plan, the CBO helped to kill the bill.

Since then, keeping the cost of their private-sector mandates out of the federal budget has been Job One for Democratic health wonks. While head of the CBO, Obama's budget director Peter Orszag altered the CBO's orientation to make it more open and collaborative. One of the things about which the CBO has been more open is the criteria it uses to determine whether to include mandated private-sector spending in the federal budget. The CBO even published a paper on the topic. Read this profile of Orszag by Ezra Klein, and you'll see that those criteria were also a likely area of collaboration with lawmakers.

The Medical Loss Ratios memo is the smoking gun. It shows that indeed, Democrats have been submitting proposals to the CBO behind closed doors and tailoring their private-sector mandates to avoid having those costs appear in the federal budget. Proposals that would result in a complete cost estimate—such as the proposal by Sen. Rockefeller discussed in the Medical Loss Ratios memo—are dropped. Because we can't let the public see how much this thing really costs.

Crafting the private-sector mandates such that they fall just a hair short of CBO's criteria for inclusion in the federal budget does not reduce their cost, nor does it make those mandates any less binding. But it dramatically reduces the *apparent* cost of the legislation. It is the reason we're all talking about an $848

billion Reid bill, rather than a $2.1 trillion Reid bill.

If someone sold you a house, or a car, or a mutual fund this way, we would put them in jail.

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Chapter 37

Oops, Maybe ObamaCare's Cost Controls Won't Work after All

by Michael F. Cannon

One of ObamaCare's big selling points was that it would launch lots of pilot programs so that Medicare bureaucrats could learn how to reduce health care costs and improve the quality of care. Yesterday, the Congressional Budget Office threw cold water on the idea.

In 2010, Peter Orszag and Ezekiel Emanuel explained the promise of ObamaCare's pilot programs:

> [The law's] pilot programs involving bundled payments will provide physicians and hospitals with incentives to coordinate care for patients with chronic illnesses: keeping these patients healthy and preventing hospitalizations will be financially advantageous . . . And the secretary of health and human services (HHS) is empowered to expand successful pilot programs without the need for additional legislation.

Atul Gawande wrote even more glowingly:

> The bill tests, for instance, a number of ways that federal insurers could pay for care. Medicare and Medicaid currently pay clinicians the same amount regardless of results. But there is a pilot program to increase payments for doctors who deliver high-quality care at lower cost, while reducing payments for those who deliver low-quality care at higher cost. There's a program that would pay bonuses to hospitals that improve patient results after heart failure, pneumonia, and surgery. There's a program that would impose financial penalties on institutions with high rates of infections transmitted by…

You get the idea.

The thing is, pilot programs in Medicare are not new. And in a review of dozens of Medicare pilot programs released yesterday, the Congressional Budget Office revealed they aren't very successful, either:

> The disease management and care coordination demonstrations comprised 34 programs . . .
>
> In nearly every program, *spending was either unchanged or increased* relative to the spending that would have occurred in the absence of the program, when the fees paid to the participating organizations were considered . . .
>
> *Only one of the four demonstrations of value-based payment has yielded significant savings* for the Medicare program.

No big deal, you say. Startups fail all the time. What's important is not that 37 startups failed, but that

one succeeded.

That's how things are supposed to work. But as Alain Enthoven explained to Gawande, the really perverse thing about Medicare pilot programs is that even the successful ones die:

> Gawande got it wrong about pilots . . . The Medical Industrial Complex does not want such pilots and often strangles them in the crib. For example, nothing lasting and significant came of the pilot to reward people for getting their heart bypass surgery at regional centers of excellence. I don't remember the details of how it died, but I believe it was tried and went nowhere. No doubt every hospital thought it was a center of excellence and wanted to be so rewarded.
>
> Another more recent example is durable medical equipment. David Leonhardt had an excellent article in the *New York Times* on June 25, 2008 called "High Medicare Costs Courtesy of Congress." Someone had sold the good idea that prices of durable medical equipment should be determined by competition, and there was a provision in law for pilots to test competition. The industry lobbied hard to stop it and promulgated scare stories. "Grandma won't get her oxygen." Leonhardt recounts how Democratic and Republican leaders got together and postponed the pilot—and, I suspect, postponed it forever. There were proposals to test health plan competition, fought off by the industry of course. So this is not a fertile political environment for pilots. In fact, one of the most important lessons that has come out of the current "reform" process is the enormous power of the medical industrial complex and their large financial contributions and armies of lobbyists to block any significant cost containment.

Rather than a reason for more government interference in health care, the death of these pilots is a *consequence* of government interference. If the federal Medicare program weren't such an enormous player in the U.S. health care sector, industry lobbyists (and their servants in Congress) wouldn't have so many ways to protect themselves from competition by more efficient providers.

Enthoven summed up ObamaCare's approach to cost control best:

> The American people are being deceived. We are being told that health expenditure must be curbed, therefore "reform is necessary." But the bills in Congress, as Gawande acknowledges, do little or nothing to curb the expenditures. When the American people come to understand that "reform" was not followed by improvement, they are likely to be disappointed. Our anguish is only intensified by the fact that the Republicans are no better at fiscal responsibility, probably worse as they demagogue reasonable attempts to limit expenditures.
>
> Congress is sending the world an unmistakable signal that it is unable or unwilling to control health expenditures and the fiscal deficit. That is not going to make it easier to sell Treasury bonds on international markets. I fear this will lead to higher interest rates.

FYI, Enthoven wrote those words in 2009.

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Chapter 38

A Closer Look at Those Industry Deals

by Michael F. Cannon

On May, President Barack Obama announced that industry lobbyists had agreed to reduce the growth of health care spending by 1.5 percentage points each year, which would yield just enough savings to cover the uninsured. The lobbyists quickly denied that was the agreement, prompting an administration official to backtrack ("the president misspoke"), before un-backtracking ("I don't think the president misspoke").

Since then, the administration has announced similar deals with industry groups who have supposedly put self-interest aside to make a contribution to health care reform.

If only that were true. Far from being "game-changers," those agreements are the same old Washington game of bribes, backroom deals, profiteering and protectionism—and a harbinger of what health care will look like if the president's reforms succeed.

In June, the pharmaceutical lobby PhRMA agreed to give 50 percent discounts to seniors in Medicare's "doughnut hole," where enrollees now pay 100 percent of their drug costs. President Obama hailed the agreement as a "significant breakthrough," while PhRMA spun it as their $80 billion contribution toward health care reform.

Yet the PhRMA agreement would not save taxpayers $80 billion. It would cost them $80 billion, and then some.

Under the agreement, the full price of each drug would continue to count toward seniors' catastrophic deductible. As a result, even more seniors would exceed that deductible, after which taxpayers would pay 95 percent of their drug costs. Obama also agreed to oppose stricter price controls for government purchases. PhRMA members agreed to cut their prices for seniors only because Obama agreed that taxpayers would buy more drugs at higher prices.

Think about it: Would drug companies enter this agreement unless they knew they would be net winners? Lobbyists never advocate less revenue for their members.

An agreement reached with Wal-Mart was also deceptively self-serving. Two weeks ago, the nation's largest private employer pledged to support a key Obama priority: a mandate requiring all employers to offer health benefits. An administration official called Wal-Mart's support for an employer mandate "significant."

Yet Wal-Mart's announcement was less Nixon going to China than, say, Stalin going to China. As one Wal-Mart lobbyist candidly explained to me, the company supports an employer mandate because it would primarily harm Wal-Mart's competitors. (The 315,000 jobs an employer mandate would destroy? Collateral damage.) Wal-Mart's competitors are not amused.

President Obama has been working the same protection racket on other employers. According to the *New York Times*, "Rahm Emanuel, the White House chief of staff, [said] chief executives of other

companies—he did not specify which—had also expressed interest in embracing an employer mandate."

Finally, last week Vice President Joe Biden announced that three hospital groups agreed to support $155 billion in cuts in federal payments to hospitals. "I want to know what the 'ask' is," fellow Democrat and acting Senate Health, Education, Labor and Pensions Committee Chairman Chris Dodd, Conn., responded skeptically. "The 'ask' sometimes can exceed the value of your cost savings."

Dodd was right to be skeptical. The Obama administration essentially issued those groups an insurance policy. To guarantee that the groups would get at least $155 billion back from the government in the form of newly insured customers, the administration agreed that the new subsidies would start flowing immediately, while the pay cuts would take effect over time. That means the pay cuts may never take effect at all: physicians have been blocking their own scheduled pay cuts for nearly a decade.

The administration further bribed the hospital groups with unspecified protections from competing physician-owned hospitals as well as protections for the same inefficient hospitals Obama has criticized.

Last month, President Obama compared the Mayo Clinic to McAllen, Texas, "where costs are actually a third higher than they are at Mayo, but the outcomes are worse." Yet Obama agreed that any cuts in Medicare's hospital payments would be across-the-board, rather than targeted at high-cost hospitals. Across-the-board cuts would actually penalize Mayo for its efficiency, while still paying McAllen hospitals more. Low-cost hospitals, including an association that represents Mayo, have formed a coalition to fight across-the-board cuts.

Each agreement was negotiated behind closed doors, away from public scrutiny. All are contingent on the favored groups getting something they want, and all "savings" could be undone by future lobbying. To paraphrase George Bailey, the industry isn't selling—the industry is buying.

President Obama's idea of health care reform is to give the federal government sweeping new powers to dictate what Americans will purchase and how much they will pay. If you want to know who will benefit from that approach, who will pay and who will be pulling the strings, the president is doing his best to show you.

*This article appeared on **KaiserHealthNews.org** on July 16, 2009.*

Chapter 39

Fannie Med?
Why a "Public Option" Is Hazardous to Your Health

by Michael F. Cannon

Cato Institute Policy Analysis no. 642 (July 27, 2009)

Introduction

President Obama,[1] Senate Finance Committee chairman Max Baucus (D-MT),[2] and other leading Democrats have proposed creating a new government health insurance program as an "option" for Americans under the age of 65. This program would operate within the context of a new, federally regulated market—typically described as a "National Health Insurance Exchange." House Speaker Nancy Pelosi (D-CA)[3] and four House caucuses representing more than 100 Democrats[4] have stated that a new government health insurance program modeled on Medicare is the sine qua non of health care reform. Sixteen Democratic senators have signed a letter signaling their support.[5] Senate Health, Education, Labor, and Pensions Committee chairman Edward M. Kennedy (D-MA) has proposed legislation that would create such a program,[6] as have three key House committees.[7]

Others have suggested that Congress should adopt a different model. Senate Budget Committee chairman Kent Conrad (D-ND) and Sen. Charles Schumer (D-NY) have proposed that Congress create one or more health-insurance "cooperatives," although each endorses different structures and different levels of government support. Cooperatives are member-run health plans that already exist in many areas of the country; for instance, Group Health Cooperative already covers 580,000 Americans in the states of Washington and Idaho.[8] Schumer proposes that Congress spend $10 billion to create a single nationwide cooperative, which would be governed by a federal board and endowed with the power to use Medicare-like price controls.[9] Conrad proposes multiple cooperatives[10] with start-up subsidies in the neighborhood of $4 billion.[11]

Advocates of a new government health insurance program claim that government provides coverage more efficiently than the private sector. University of California–Berkeley political scientist Jacob Hacker writes:

> The public Medicare plan's administrative overhead costs (in the range of 3 percent) are well below the overhead costs of large companies that are self-insured (5 to 10 percent of premiums), companies in the small group market (25 to 27 percent of premiums), and individual insurance (40 percent of premiums).[12]

Supporters claim they are willing to put government to the test by having it compete against private plans in the context of a new government-run "exchange." President Obama claims that a new government program "gives consumers more choices, and it helps keep the private sector honest, because there's some competition out there."[13] The House Democrats' legislation would create a "public health insurance option" that would be "self-sustaining and compet[e] on [a] 'level field' with private insurers."[14] Columnist E. J. Dionne writes, "The public-option idea . . . would allow the United States to move gradually toward a government-run system if—*and only if*—a substantial number of consumers freely chose to join such a plan. The market would test the idea's strength."[15]

A full accounting, however, shows that government programs are less efficient than private insurance. Administrative costs are higher in government programs such as Medicare, because they avoid administrative activities that increase efficiency and incur other administrative costs that are purely wasteful. Government programs also suppress innovation, and thereby reduce the quality of care for all patients, whether publicly or privately insured.

The central problem with proposals to create a new government program is not that government is less efficient than private insurers, however, but that government can hide its inefficiencies and draw consumers away from private insurance, despite offering an inferior product. If the government plan's premiums reflected its full costs—and private insurance premiums reflected only their actual costs—there would be no reason not to let the government enter the market. As Dionne suggests, the market would test the idea's strength. Yet government possesses both the power to hide its true costs (which keeps its premiums artificially low) and to impose costs on its competitors (which unnecessarily pushes private insurance premiums higher). It makes no difference whether a new program adopts a "co-operative" model or any other. The government possesses so many tools for subsidizing its own program and increasing costs for private insurers—and has such a long history of subsidizing and protecting favored enterprises—that unfair advantages are inevitable. This is in no small part because supporters of a new government program *want* it to have unfair advantages.

Literally Ousting Patients from Their Health Plans

In a speech to the American Medical Association, President Obama reiterated a promise that he has made repeatedly since the 2008 presidential campaign:

> No matter how we reform health care, we will keep this promise to the American people. If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what.[16]

After the Congressional Budget Office estimated that as many as 15 million Americans could lose their existing coverage under Senator Kennedy's legislation,[17] the Associated Press reported, "White House officials suggest the president's rhetoric shouldn't be taken literally."[18]

Indeed, a new government program would literally oust millions of Americans from their current health plans and threaten their relationships with their doctors, as employers choose to drop their current employee health plans and as private health plans close down. A Lewin Group analysis estimated that Obama's campaign proposal would move 32 million Americans into a new government-run plan.[19] Lewin subsequently estimated that if Congress used Medicare's price controls and opened the new program to everyone, it could pull 120 million Americans out of private insurance—more than half of the

private market.[20] The share of Americans who depend on government for their health care would rise from just over one-quarter to two-thirds.[21] Many of those millions would be involuntarily ousted from their current health plans—much like President Obama suggested ousting 10 million seniors[22] from their private Medicare Advantage plans and forcing them into the traditional Medicare program.[23] Yet even those who voluntarily chose a new government program over their existing coverage would do so not because the government program provides better value for the money, but because the government program would hide some of its cost.

A health insurance "exchange," where consumers choose between private health plans with artificially high premiums and a government program with artificially low premiums, would not increase competition. Instead, it would reduce competition by driving lower-cost private health plans out of business. President Obama's vision of a health insurance exchange is not a market, but a prelude to a government takeover of the health care sector. In the process, millions of Americans would be ousted from their existing health plans, and all would suffer the consequences of government-run health care.

Is Government More Efficient?

Supporters of a new government program note that private insurers spend resources on a wide range of administrative costs that government programs do not. These include marketing, underwriting, reviewing claims for legitimacy, and profits. The fact that government avoids these expenditures, however, does not necessarily make it more efficient. Many of the administrative activities that private insurers undertake serve to *increase* the insurers' efficiency. Avoiding those activities would therefore make a health plan less efficient. Existing government health programs also incur administrative costs that are purely wasteful. In the final analysis, private insurance is more efficient than government insurance.

Administrative Costs

Time magazine's Joe Klein argues that "the profits made by insurance companies are a good part of what makes health care so expensive in the U.S. and that a public option is needed to keep the insurers honest."[24] All else being equal, the fact that a government program would not need to turn a profit suggests that it might enjoy a price advantage over for-profit insurers. If so, that price advantage would be slight. According to the Congressional Budget Office, profits account for less than 3 percent of private health insurance premiums.[25] Furthermore, government's lack of a profit motive may not be an advantage at all. Profits are an important market signal that increase efficiency by encouraging producers to find lower-cost ways of meeting consumers' needs.[26] The lack of a profit motive could lead a government program to be less efficient than private insurance, not more.

Moreover, all else is not equal. Government programs typically keep administrative expenditures low by avoiding activities like utilization or claims review. Yet avoiding those activities increases overall costs. The CBO writes, "The traditional fee-for-service Medicare program does relatively little to manage benefits, which tends to reduce its administrative costs *but may raise its overall spending* relative to a more tightly managed approach."[27] Similarly, the Medicare Payment Advisory Commission writes:

> [The Centers for Medicare & Medicaid Services] estimates that about $9.8 billion in erroneous

> payments were made in the fee-for-service program in 2007, a figure more than double what CMS spent for claims processing and review activities. In Medicare Advantage, CMS estimates that erroneous payments equaled $6.8 billion in 2006, or approximately 10.6 percent of payments. . . . The significant size of Medicare's erroneous payments suggests that the program's low administrative costs may come at a price.[28]

CMS further estimates that it made $10.4 billion in improper payments in the fee-for-service Medicare program in 2008.[29]

Medicare keeps its measured administrative-cost ratio relatively low by avoiding important administrative activities (which shrinks the numerator) and tolerating vast amounts of wasteful and fraudulent claims (which inflates the denominator).[30] That is a vice, yet advocates of a new government program praise it as a virtue.[31] Medicare also keeps its administrative expenditures down by conducting almost no quality-improvement activities. Journalist Shannon Brownlee and Obama adviser Ezekiel Emanuel write:

> [S]ome administrative costs are not only necessary but beneficial. Following heart-attack or cancer patients to see which interventions work best is an administrative cost, but it's also invaluable if you want to improve care. Tracking the rate of heart attacks from drugs such as Avandia is key to ensuring safe pharmaceuticals.[32]

According to the CBO, private insurers spend nearly 1 percent of premiums on "medical management."[33] The fact that Medicare keeps administrative expenditures low by avoiding such quality-improvement activities may likewise result in higher overall costs—in this case by suppressing the quality of care.

Supporters who praise Medicare's apparently low administrative costs often fail to note that some of those costs are hidden costs that are borne by other federal agencies, and thus fail to appear in the standard 3-percent estimate.[34] These include "parts of salaries for legislators, staff and others working on Medicare, building costs, marketing costs, collection of premiums and taxes, accounting including auditing and fraud issues, etc."[35]

Also, Medicare's administrative costs should be understood to include the deadweight loss from the taxes that fund the program. Economists estimate that it can easily cost society $1.30 to raise just $1 in tax revenue, and it may sometimes cost as much as $2.[36] That "excess burden" of taxation is a very real cost of administering (i.e., collecting the taxes for) compulsory health insurance programs like Medicare, even though it appears in no government budgets.

Comparing administrative expenditures in the traditional "fee-for-service" Medicare program to private Medicare Advantage plans can somewhat control for these factors. Hacker cites a CBO estimate that administrative costs are 2 percent of expenditures in traditional Medicare versus 11 percent for Medicare Advantage plans. He writes further: "A recent General Accounting Office report found that in 2006, Medicare Advantage plans spent 83.3 percent of their revenue on medical expenses, with 10.1 percent going to nonmedical expenses and 6.6 percent to profits—a 16.7 percent administrative share."[37]

Yet such comparisons still do not establish that government programs are more efficient than private insurers. The CBO writes of its own estimate: "The higher administrative costs of private plans do not

imply that those plans are less efficient than the traditional FFS program. Some of the plans' administrative expenses are for functions such as utilization management and quality improvement that are designed to increase the efficiency of care delivery."[38] Moreover, a portion of the Medicare Advantage plans' administrative costs could reflect factors inherent to government programs rather than private insurance. For example, Congress uses price controls to determine how much to pay Medicare Advantage plans. If Congress sets those prices at supracompetitive levels, as many experts believe is the case,[39] then that may boost Medicare Advantage plans' profitability beyond what they would earn in a competitive market. Those supracompetitive profits would be a product of the forces that would guide a new government program—that is, Congress, the political system, and price controls—rather than any inherent feature of private insurance.

Economists who have tallied the full administrative burden of government health insurance programs conclude that administrative costs are far higher in government programs than in private insurance. In 1992, University of Pennsylvania economist Patricia Danzon estimated that total administrative costs were more than 45 percent of claims in Canada's Medicare system, compared to less than 8 percent of claims for private insurance in the United States.[40] Pacific Research Institute economist Ben Zycher writes that a "realistic assumption" about the size of the deadweight burden puts "the true cost of delivering Medicare benefits [at] about 52 percent of Medicare outlays, or between four and five times the net cost of private health insurance."[41]

Administrative costs can appear quite low if you only count some of them. Medicare hides its higher administrative costs from enrollees and taxpayers, and public-plan supporters rely on the hidden nature of those costs when they argue in favor of a new government program.

Cost Containment vs. Spending Containment

Advocates of a new government health care program also claim that government contains overall costs better than private insurance. Jacob Hacker writes, "public insurance has a better track record than private insurance when it comes to reining in costs while preserving access. By way of illustration, *between 1997 and 2006, health spending per enrollee (for comparable benefits) grew at 4.6 percent a year under Medicare, compared with 7.3 percent a year under private health insurance.*"[42] In fact, looking at a broader period, from 1970 to 2006, shows that per-enrollee spending by private insurance grew just 1 percentage point faster per year than Medicare spending, rather than 2.7 percentage points.[43] That still omits the 1966–1969 period, which saw rapid growth in Medicare spending.

More importantly, Hacker's comparison commits the fallacy of conflating *spending* and *costs*. Even if government contains health care spending better than private insurance (which is not at all clear), it could still impose greater overall costs on enrollees and society than private insurance. For example, if a government program refused to pay for lifesaving medical procedures, it would incur considerable nonmonetary costs (i.e., needless suffering and death). Yet it would look better in Hacker's comparison than a private health plan that saved lives by spending money on those services. Medicare's inflexibility also imposes costs on enrollees. Medicare took 30 years longer than private insurance to incorporate prescription drug coverage into its basic benefits package. The taxes that finance Medicare impose costs on society in the range of 30 percent of Medicare spending.[44] In contrast, there is no deadweight loss associated with the voluntary purchase of private health insurance.

Hacker nods in the direction of nonspend-ing costs when he writes, "Medicare has maintained high

levels of . . . patient access to care."[45] Yet there are many dimensions of quality other than access to care. It is in those areas that government programs impose their greatest hidden costs, on both publicly and privately insured patients.

Government Programs Suppress Quality, Cost Lives

Supporters also claim that government programs outperform private health insurance on quality. On the surface, the quality of medical care in government programs tends to be similar to, or worse than, the quality of care under private insurance. This may be largely due to the fact that government programs uniformly lag private insurance in adopting quality innovations. Beneath the surface, however, government programs suppress the quality of care for all patients, whether publicly or privately insured.

Researchers estimate that patients receive high-quality, evidence-based care only about half of the time, regardless of whether they are enrolled in Medicare, Medicaid, or private insurance.[46] A recent Minnesota study found, however, "On eight of the nine statewide measures, performance in achieving high-quality care was significantly lower at both the statewide and medical group levels for [Medicaid and other government programs] compared with [private insurance]."[47] Patients with Medicaid coverage experience more unmet medical needs than similar patients with private insurance.[48] Studies have found that Medicaid patients suffer worse outcomes than similar privately insured patients when it comes to cancer,[49] unstable angina,[50] and coronary artery bypass graft surgery.[51] The Veterans' Health Administration appears to outperform private insurance on some dimensions of quality,[52] but exhibits serious deficiencies in others.[53] President Obama's secretary of Health and Human Services, Kathleen Sebelius, has called the government-run Indian Health Service a "historic failure."[54]

Nevertheless, supporters make the demonstrably false claim that government programs are more innovative than private insurance. Hacker writes, "Medicare has been slow to adopt quality innovations —though generally quicker than private health plans."[55] Peter Harbage and Karen Davenport of the Center for American Progress cite Medicare's policy on "never events"—severe medical errors that should "never" happen—as proof of government's superior ability to promote quality: "Witness steps such as Medicare's refusal to pay medical care providers for 'never events,' where a patient suffers a knowable and catastrophic mistake, such as having the wrong limb removed. This is something other major insurers are now adopting."[56]

In reality, Medicare and other government programs uniformly lag private insurers when it comes to quality innovations. For example, private insurers began experimenting with "pay-for-performance" financial incentives almost an entire decade before Medicare.[57]

"Never events" provide an even clearer illustration. In 2003, an estimated 181,000 severe medical errors occurred in hospitals alone.[58] Throughout its 43-year history, Medicare has actually *encouraged* such errors by financially rewarding health care providers when an error leads to more services, and financially penalizing providers who reduce error rates.[59] In October 2008, Medicare eliminated those perverse incentives for a short list of medical errors called "never events." That policy will likely discourage *some* medical errors by forcing providers to pay for *some* of the associated costs. Yet the first private health plan to force providers to bear the *full* financial cost of *all* medical errors was offered by the Ross-Loos Clinic in 1929.[60] Kaiser Permanente has done so since the 1940s. Medicare didn't even play a leading role on "never events" among fee-for-service plans, as Harbage and Davenport claim.

HealthPartners of Minnesota stopped paying for "never events" in January 2005.[61] Medicare merely followed suit.

Stagnation Costs Lives

Government programs are not merely slow to innovate, they are outright hostile to quality innovations. Government programs inject rigidity into health care markets that suppresses the quality of care for publicly and privately insured patients alike. The result is greater morbidity and mortality.

This can be seen most clearly in the way government suppresses competition between different methods of paying doctors, hospitals, and other health care providers. As noted above, Medicare financially rewards medical errors and penalizes error-reduction efforts because it pays providers on a fee-for-service basis. Fee-for-service payment, as the name suggests, means that providers collect an additional fee for each additional service they provide. Conversely, if providers deliver fewer services, they collect less revenue. Fee-for-service payment thus creates a perverse incentive: if low-quality care (e.g., a medical error, poor coordination between providers, insufficient attention to medical evidence) results in a patient requiring more services, then low-quality providers will receive more revenue than providers who adopt quality innovations. According to the *New York Times,* for example:

> Park Nicollet Health Services, a hospital and clinic system based in St. Louis Park, Minn[esota] . . . started . . . spending as much as $750,000 annually on more nurses and on sophisticated software to track heart failure patients after they left the hospital. It reduced readmissions for such patients to only 1 in 25, down from nearly 1 in 6. But the reduction has been a losing proposition. Although the effort saved Medicare roughly $5 million a year, Park Nicollet is not paid to provide the follow-up care. Meanwhile, fewer returning hospital patients mean lower revenue for Park Nicollet. "We've kept it up out of a sense of moral obligation to these patients, but we're getting killed," said David K. Wessner, chief executive of Park Nicollet. "We will totally run out of gas."[62]

Medicare suppresses countless quality innovations by making them "a losing proposition."

A free market would use competition from different methods of paying providers to keep those perverse incentives in check. Under "prepayment" or "capitation," for example, providers receive a flat fee to provide medical care for a given patient or group of patients. Group Health Cooperative is an example of an integrated, prepaid health plan. Prepayment *rewards* providers for avoiding unnecessary and harmful services: whatever money providers save by avoiding medical errors, for example, the providers get to keep. It is no coincidence that prepaid health plans, like Kaiser Permanente, lead the market in innovations such as coordinated care and electronic medical records, which help avoid unnecessary services. Prepayment also creates its own perverse incentive: providers get to keep whatever money they save by denying access to needed care as well. In a free market, however, competition from fee-for-service providers would force them not to stint on necessary care. By the same token, competition from prepaid plans would force fee-for-service providers to coordinate care, offer electronic medical records, and avoid medical errors.

Government health insurance programs—principally Medicare—block competition between different payment systems, and therefore dramatically reduce the quality of care. As the largest purchaser of medical services in the United States, Medicare accounts for two- thirds to four-fifths of revenues for many hospitals and specialties.[63] Medicare's influence is so vast that hospitals and other providers organize the delivery of medical care around the financial incentives it creates. Providers like Park

Nicollet Health Services cannot stay in business by providing high-quality coordinated care, because that means less revenue from Medicare. Because privately insured patients use the same doctors and hospitals, that means Medicare suppresses the quality of care even for privately insured patients.[64]

The main reason that the U.S. health care sector lacks coordinated care, electronic medical records, and comparative-effectiveness research is that government rewards providers who avoid these quality innovations and penalizes providers who adopt them. The main reason that as many as 100,000 Americans die from medical errors each year is that the nation's largest health care purchaser rewards providers who tolerate medical errors and punishes providers who reduce them.

Congress cannot solve this problem by reforming Medicare's payment system, creating a new program that uses a different payment system, or attempting to incorporate such competition into a government program. All methods of paying health care providers create perverse incentives. If Medicare or a new program adopts the payment system used at Group Health Cooperative, Congress will merely trade the perverse incentives of fee-for-service payment (uncoordinated care, medical errors) for those of prepayment (less provider choice, greater rationing). Only competition between different payment systems can hold those perverse incentives in check. Yet government programs like Medicare and Medicaid stifle such competition. Medicare Advantage attempts to allow such competition, yet different health plans with different payment systems constantly lobby Congress for special advantages. Meanwhile, politicians, such as President Obama, propose eliminating such competition entirely.

Harbage and Davenport write that a new government program "will create incentives for effective performance just as today's Medicare program promotes quality care alongside cost containment."[65] That is precisely the problem. A new government program would suppress quality, just as Medicare has, by further stifling competition between payment systems. Sebelius says that making Medicare "a strong and sustainable program depends on our ability to fix what's broken in the rest of the system."[66] Sebelius has it exactly backward: Medicare *is* what's broken in the rest of the system.

We need not look to Canada to find horror stories about government-run health care. Estimates of 100,000 deaths each year in the United States from medical errors should be frightening enough.[67] A new government program, whether modeled on Medicare or not, would further suppress health care quality and cause additional morbidity and mortality.

The Fair-Competition Fantasy

President Obama admits, "I think there can be some legitimate concerns on the part of private insurers that if any public plan is simply being subsidized by taxpayers endlessly, that over time they can't compete with the government just printing money."[68] Nevertheless, supporters claim that Congress can create a new government program that competes with private insurers on a level playing field. The "Blue Dog Coalition" of moderate House Democrats has offered several criteria that a new program would have to satisfy in order to do so.[69] The Blue Dogs insist, for example, that the program would have to be completely self-sustaining (i.e., premium revenue would cover all costs), that the government not leverage its market power to favor the new program, and that government not enact any regulations that favor a new government program over private insurers. Supporters such as Len Nichols and John Bertko

of the New America Foundation claim that a new program can satisfy those conditions.[70]

Yet the government need neither subsidize its own program with taxpayer money, nor newly printed money, nor must it do so "endlessly," to supplant private insurance with an inferior option. Indeed, government has countless other ways to prevent the true cost of a new program from appearing in its premiums, and to increase the premiums of its competitors. Moreover, government's long history of subsidizing, protecting, and bailing out favored enterprises shows that such special advantages would be inevitable. For example, Amtrak requires repeated taxpayer subsidies to stay afloat.[71] And Congress famously bailed out Fannie Mae and Freddie Mac.

Congress has made Medicare increasingly less self-sustaining over time. When Congress created Medicare in 1965, enrollee premiums covered 50 percent of the cost of physician services. Under pressure from Medicare enrollees, subsequent Congresses gradually reduced that share to 25 percent. The U.S. Postal Service is similarly unable to sustain itself. According to one critic:

> Make no mistake . . . the Postal Service is not self-sufficient. It is kept afloat by a number of hidden taxpayer subsidies. For starters, it has a monopoly on First Class and Standard mail. No private company can deliver a letter for less than $3 or twice what USPS charges, whichever is greater. . . . Meanwhile, USPS is immune from antitrust lawsuits and exempt from taxes on its massive real-estate holdings. . . . It enjoys power of eminent domain. And it doesn't even pay parking tickets.[72]
>
> It calculates the amount of corporate income tax it would owe if it were a private company—and then pays that amount to itself.[73]

Likewise, state governments have repeatedly crowded out private insurance in markets for workers' compensation insurance, crop and flood insurance, and reinsurance for medical malpractice and natural disasters, according to University of Pennsylvania economist Scott Harrington, because "the public sector is supported by various types of subsidies or special rules that allow it to compete with the private sector."[74]

Direct Subsidies

Among the many ways that Congress could favor a new government program is through direct subsidies—that is, real resources provided to the government program, yet withheld from private insurers:

- The federal and state governments finance Medicaid and the State Children's Health Insurance Program almost entirely through tax revenue. As a result, those programs crowd out private insurance among individuals who could otherwise obtain coverage on their own.[75] Likewise, taxpayer subsidies fund nearly 90 percent of Medicare spending, which helps that program almost completely crowd out private health insurance for the elderly.[76]
- Creating a new program around Medicare's existing infrastructure, as some supporters propose, would bestow start-up subsidies not available to new private health plans.[77] Senator Schumer has insisted that a government-sponsored "co-operative" receive $10 billion in start-up subsidies.
- The leading Democratic proposals would create a "risk-adjustment" mechanism that would essentially tax all health plans to compensate those that attract a disproportionate share of high-cost patients and/or that do little to reduce wasteful expenditures.[78] Whether a new government program

proves to be more attractive to high-cost patients or does a poorer job of controlling unnecessary expenditures, the risk-adjustment program could easily become a tool for taxing private insurers to subsidize the government plan.

- When estimating Medicare's administrative costs, the federal government does not count the cost of activities undertaken by other federal agencies to support Medicare.[79] If the government fails to include such costs when calculating the premiums for a new program, that would constitute an implicit subsidy and enable the new program to set its premiums below its true costs.

To the extent that a new government program receives direct subsidies that are not available to private insurers, its relative cost would also be higher due to the deadweight loss of taxation, yet that added cost likewise would not appear in the government program's premiums.

Indirect Subsidies

To subsidize a new government program, Congress need not hand it bags of cash or use creative accounting when setting premiums. Congress can instead subsidize its program indirectly, whether by granting it special status or increasing its competitors' costs:

- The taxpayer subsidies and other advantages granted to Medicare give the federal government a degree of market power that private insurers cannot match. That market power in turn creates opportunities for Congress to grant other special advantages to a new government program. Many supporters propose that a new program should adopt price controls identical or similar to Medicare's, or that the federal government should require providers to participate in the new program as a condition of Medicare participation.[80] Sen. Jay Rockefeller (D-WV) proposes to let a new program use Medicare's price controls for two years, and to require doctors who participate in Medicare to participate in the new program for three years;[81] yet those time frames could easily be extended to four years, six years, or beyond. Leveraging the special advantages granted to Medicare would enable a new government program to achieve a level of provider participation at a lower cost than private insurers.
- Adopting Medicare-like price controls would also increase the prices that providers charge private insurers. Experts disagree about the exact mechanism that drives prices higher for private insurers.[82] Whatever the case, such price controls would increase the cost of private insurance relative to a new government program.
- Tightening the price controls that Medicaid uses to purchase prescription drugs, or expanding those price controls into either Medicare or a new government program, would likewise increase costs for the new program's private competitors. The price controls that Congress imposes on drug purchases through the Medicaid program have the effect of increasing prices for private insurers by an estimated 15 percent.[83] The Senate Finance Committee has suggested tightening this price control,[84] while House Energy and Commerce Committee chairman Henry Waxman (D-CA) has proposed importing those price controls into Medicare.[85] Either move would further increase costs for private insurers.
- Any new program would come with an implicit guarantee that Congress would bail it out if premiums proved insufficient to cover its costs. Hacker argues for an *explicit* bailout guarantee when he writes that reserve requirements "would not make sense for the public health insurance plan,

which has the full faith and credit of the federal government behind it."[86] Even if the bailout guarantee were only implicit, that would enable the new program to set its premiums below costs. According to a 1996 Treasury Department report signed by Larry Summers, who is now President Obama's National Economic Council chairman, a similar implicit guarantee saved Fannie Mae and Freddie Mac an estimated $6 billion per year.[87] Meanwhile, private insurers would effectively face higher reserve requirements than the government program.

- Unlike many private insurers, government programs pay no taxes. The presence of corporate income taxes, investment taxes, etc., increases the price of private insurance relative to a government program. The CBO estimates that taxes account for 1.2 percent of private health insurance premiums, on average.[88] Government could further advantage its program by raising taxes on private insurers, such as through the special tax on insurance-company profits proposed by Senator Schumer.[89]
- Government can increase the effective cost of private insurance by imposing penalties on consumers who choose it instead of the government plan. Federal regulations penalize seniors who opt out of Medicare to obtain private health insurance by taking away their Social Security benefits, past and future.[90] That penalty exists in spite of a provision in the Medicare statute called, "Option to Individuals to Obtain Other Health Insurance Protection," which reads: "Nothing contained in this title shall be construed to preclude . . . any individual from purchasing or otherwise securing, protection against the cost of any health services."[91]

Even if Congress could create a new government program with no special advantages, a truly level playing field would require a credible guarantee that no future Congress and no future regulator would ever confer any special advantages on that program. Given the bailout craze of 2008–2009, it is not credible to suggest the government would not bail *itself* out if premiums were insufficient to support the new program's outlays. That public perception would itself create an implicit bailout guarantee, and redound to the exclusive benefit of a new government program. Moreover, today's Congress cannot bind future Congresses. Supporters of a new program know this, and they are already contemplating future efforts to secure special advantages for any new program that Congress creates.[92]

Medicare Advantage

Medicare Advantage demonstrates that the playing field between a government program and private insurers could never be level. The Medicare Advantage program allows private insurers to compete with the traditional, government-run Medicare program. The playing field shifts depending on whether the party in power prefers government or private insurance. In 2003, President George W. Bush and a Republican Congress adopted fairly high price controls for the Medicare Advantage plans. More recently, a Democratic Congress has sought stricter price controls. President Obama even proposed to throw private plans out of Medicare entirely, which is not so much a level playing field as it is a cliff.

Nichols and Bertko admit that the playing field isn't level in Medicare Advantage due to congressional interference, and they claim that such interference is "not inherent in public-private competition."[93] Yet when Congress creates a federal health insurance program and a federal bureaucracy to craft and enforce the rules of competition between that program and private plans, nothing is more inherent to such a scheme than Congress and its whims.

If wise philosopher-kings could somehow create a new government health insurance program and (permanently) deny it of any special advantages, *it would cease to be a government program*. It would be just another private insurer. If that is what supporters of a new government program want, there is no need for Congress to act. Supporters can gather investors and launch their own private health plan right now. The only rationale for having Congress construct a new health plan is to create socially harmful competition whose objective is a government takeover of the U.S. health care sector.

Conclusion

A new government program would supplant private insurance, despite offering inferior care at a higher cost. The program would attract consumers not by virtue of its superior performance, but by government's ability to prevent the full cost of its program from appearing in enrollee premiums and its ability to increase the cost of private options. As the new program's artificially low premiums crowd out private insurance, the government would exert even greater downward pressure on quality. Any new government health insurance program would shortly lead to a government takeover of health insurance markets—and the entire health care sector.

No one should be surprised. President Obama has repeatedly affirmed his preference for a single-payer, government-run health care system, such as exists in Canada.[94] Many people, including *New York Times* columnist Paul Krugman, support a new government program precisely because they believe it will lead to a single-payer system.[95] Hacker has quipped, "Someone once said to me, 'This is a Trojan Horse for single-payer,' and I said, 'Well, it's not a Trojan Horse—it's right there! I'm telling you: we're going to get there, over time, slowly.'"[96]

If Congress wants to make health care more efficient and increase competition in health insurance markets, there are far better options. Congress should let consumers—rather than employers or the government—control their health care dollars and choose their health plan. It should convert Medicare into a program that gives seniors a voucher and frees them to purchase any health plan on the market.[97] Reforming the tax treatment of employer-sponsored insurance with "large" health savings accounts would give workers the thousands of dollars of their earnings that employers currently control, and likewise free workers to purchase any health plan on the market.[98] Finally, Congress should expand competition by prohibiting states from denying market entry to health plans and providers licensed by other states—that is, by making clinician and health-insurance licenses portable across state lines.[99] Those reforms would reduce costs, increase innovation, and reduce the number of uninsured—without higher taxes or additional government spending.

Congress should reject proposals to create a new government health insurance program—not for the sake of private insurers, who would be subject to unfair competition, but for the sake of American patients, who would be subject to unnecessary morbidity and mortality.

Notes

1. See Obama '08, "Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All," http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf.

2. Max Baucus, "Call to Action: Health Reform 2009" (white paper, Senate Finance Committee, November 12, 2008), http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf.

3. Ryan Grim, "Pelosi: Health Care Reform Can't Pass Without Public Option," *Huffington Post*, June 11, 2009, http://www.huffingtonpost.com/2009/06/11/pelosi-health-care-reform_n_214303.html.

4. "Caucuses Unite behind Public Health Insurance Plan Option" (press release, The Congressional Black Caucus, April 28, 2009), http://www.house.gov/apps/list/speech/mi13_kilpatrick/mprenews/04_28_09_Public_Plan_Option.html.

5. Sherrod Brown, "Letter to Senator Kennedy and Senator Baucus," April 29, 2009, http://brown.senate.gov/imo/media/doc/Letter.pdf.

6. Ceci Connolly, "Kennedy Readies Health-Care Bill," *Washington Post*, June 6, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/06/05/AR2009060504036.html; and Senate Committee on Health, Education, Labor, and Pensions, "Affordable Health Choices Act," http://help.senate.gov/BAI09A84_xml.pdf.

7. House of Representatives Committee on Ways and Means, "Key Features of the Tri-Committee Health Reform Draft Proposal in the U.S. House of Representatives," June 9, 2009, http://waysandmeans.house.gov/media/pdf/111/tri.pdf.

8. Group Health, "Group Health Overview," http://www.ghc.org/about_gh/co-op_overview/index.jhtml.

9. Dana Bash and Ted Barrett, "Negotiations over Health Insurance Co-Ops at Impasse," CNN.com, June 23, 2009, http://www.cnn.com/2009/POLITICS/06/23/health.care/.

10. Kent Conrad, "Bridging the Divide with a Cooperative Health Care Proposal" (press release, June 30, 2009), http://conrad.senate.gov/pressroom/record.cfm?id=315210&.

11. Kevin Sack, "Health Co-op Offers Model for Overhaul," *New York Times,* July 6, 2009, http://www.nytimes.com/2009/07/07/healthpolicy/07coop.html.

12. Jacob S. Hacker, "The Case for Public Plan Choice in National Health Reform: Key to Cost Control and Quality Coverage," Center for Health, Economic and Family Security, University of California–Berkeley School of Law, and the Institute for America's Future, December 16, 2008, p. 5, http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf.

13. Reed Abelson, "A Health Plan for All and the Concerns It Raises," *New York Times*, March 24, 2009, http://www.nytimes.com/2009/03/25/health/policy/25medicare.html.

14. House of Representatives Committee on Ways and Means, "Key Features of the Tri-Committee Health Reform Draft Proposal in the U.S. House of Representatives," June 9, 2009, p. 3, http://waysandmeans.house.gov/media/pdf/111/tri.pdf.

15. E. J. Dionne Jr., "Not Yesterday's Health Fight," *Washington Post*, April 23, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/04/22/AR2009042203091.html. Emphasis in original.

16. "Remarks by the President at the Annual Conference of the American Medical Association" (White House press release, June 15, 2009), http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-the-Annual-Conference-of-the-American-Medical-Association/.

17. Congressional Budget Office (letter to the Honorable Edward M. Kennedy, June 15, 2009, p. 1), http://www.cbo.gov/ftpdocs/103xx/doc10310/06-15-HealthChoicesAct.pdf.

18. Ricardo Alonso-Zaldivar, "Promises, Promises: Obama's Health Plan Guarantee," Associated Press, June 19, 2009, http://www.google.com/hostednews/ap/article/ALeqM5gK8UACQa5gEv1cZ-SRxXDc3XDwRwD98TPSP80.

19. The Lewin Group, "McCain and Obama Health Care Policies: Cost and Coverage Compared," October 15, 2008, p. ES-3, http://www.lewin.com/content/Files/The_Lewin_Group_McCain-Obama_Health_Reform_Report_and_Appendix.pdf.

20. John Sheils and Randy Haught, "The Cost and Coverage Impacts of a Public Plan: Alternative and Design Options," The Lewin Group Staff Working Paper no. 4, April 8, 2009, http://www.lewin.com/content/publications/LewinCostandCoverageImpactsofPublicPlan-Alternative%20DesignOptions.pdf.

21. Author's calculations based on Carmen DeNavas-Walt, Bernadette Proctor, and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," U.S. Bureau of the Census, August 2008, p. 61, http://www.census.gov/prod/2008pubs/p60-235.pdf.

22. Kaiser Family Foundation, "Medicare Fact Sheet: Medicare Advantage," April 2009, http://www.kff.org/medicare/upload/2052-12.pdf.

23. President-elect Obama opined, "We've got to eliminate programs that don't work, and I'll give you an example in the health care area. We are spending a lot of money subsidizing the insurance companies around something called Medicare Advantage, a program that gives them subsidies to accept Medicare recipients but doesn't necessarily make people on Medicare healthier. And if we eliminate that and other programs, we can potentially save $200 billion out of the health care system that we're currently spending, and take that money and use it in ways that are actually going to make people healthier and improve quality. So what our challenge is going to be is identifying what works and putting more money into that, eliminating things that don't work, and making things that we have more efficient." ABC News, *This Week with George Stephanopolous,* January 12, 2009, http://media.bulletinnews.com/playclip.aspx?clipid=8cb4275f6a44ad3.

24. Joe Klein, "The Fire This Time: Is This Health Care's Moment?" *Time Magazine*, May 7, 2009, http://www.time.com/time/politics/article/0,8599,1896574,00.html.

25. Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," December 2008, p. 69, http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

26. If profits fail to serve that purpose in private health insurance markets, the reason may be that government gives employers control over 70 percent of all spending on private health insurance, which forces insurers to respond to the needs of employers more than consumers. U.S. Centers for Medicare & Medicaid Services, "Sponsors of Health Care Costs: Businesses, Households, and Governments, 1987–2007," http://www.cms.hhs.gov/NationalHealthExpendData/downloads/bhg07.pdf, and author's calculations.

27. Congressional Budget Office, "Key Issues," p. 93, http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf. Emphasis added.

28. Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2009, p. 12, http://medpac.gov/documents/Mar09_EntireReport.pdf.

29. Lewis Morris (testimony before Senate Finance Committee, U.S. Department of Health and Human Services, Office of the Inspector General, April 21, 2009, p. 2), http://finance.senate.gov/hearings/testimony/2009test/042109lmtest.pdf.

30. The Department of Health and Human Services' Office of the Inspector General estimates that every $1 it spends on Medicare audits saves taxpayers $17. Morris, p. 1, http://finance.senate.gov/hearings/testimony/2009test/042109lmtest.pdf. A rational health care purchaser would keep increasing such audits until $1 of oversight yielded exactly $1 of savings—in economic jargon, the marginal return would be $1. Unfortunately, the OIG does not calculate the marginal return on investment for Medicare audits. Donald B. White, Department of Health and Human Services' Office of the Inspector General, Public Affairs, e-mail message to author, July 9, 2009. However, the average return on investment is not only high, but has been steadily rising in recent years. U.S. Department of Health and Human Services, Office of the Inspector General, "FY 2010 Online Performance Appendix," http://www.oig.hhs.gov/publications/docs/budget/FY2010_online_performance_appendix.pdf. At a minimum, that raises the question of whether Medicare underinvests in claims auditing.

31. On the vices of government health insurance programs, see generally, David A. Hyman, *Medicare Meets Mephistopheles* (Washington: Cato Institute, 2006).

32. Shannon Brownlee and Ezekiel Emanuel, "5 Myths about Our Ailing Health Care System," *Washington Post*, November 23, 2008, http://www.washingtonpost.com/wp-dyn/content/article/2008/11/20/AR2008112002420.html.

33. Congressional Budget Office, "Key Issues," pp. 69–70, http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

34. Hacker is a notable exception. See Hacker, "The Case for Public Plan Choice," p. 6, http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf.

35. Mark E. Litow, "Medicare versus Private Health Insurance: The Cost of Administration," Milliman, January 6, 2006, p. 4, http://www.cahi.org/cahi_contents/resources/pdf/CAHIMedicareTechnicalPaper.pdf.

36. Martin Feldstein, "How Big Should Government Be?" *National Tax Journal* 50, no. 2 (June 1997): 197, http://ntj.tax.org/wwtax%5Cntjrec.nsf/36CFE3E5BCCB188C85256863004A5939/$FILE/v50n2197.pdf.

37. Hacker, "The Case for Public Plan Choice," p. 6, http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf.

38. Congressional Budget Office, "Designing a Premium Support System for Medicare," December 2006, p. 12, http://www.cbo.gov/ftpdocs/76xx/doc7697/12-08-Medicare.pdf.

39. Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2009, p. 252, http://medpac.gov/documents/Mar09_EntireReport.pdf.

40. Patricia M. Danzon, "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" Health Affairs 11, no. 1 (Spring 1992): 40, http://content.healthaffairs.org/cgi/reprint/11/1/21.pdf.

41. Benjamin Zycher, "Comparing Public and Private Health Insurance: Would A Single-Payer System Save Enough to Cover the Uninsured?" Manhattan Institute Medical Progress Report no. 5, October 2007, http://www.manhattan-institute.org/html/mpr_05.htm Private health insurance in the United States is no doubt less efficient than it could be. Danzon writes, "Although there may well be waste in U.S. private insurance markets, it is attributable primarily to tax and regulatory factors and is not intrinsic to private health insurance." Danzon, p. 40. Yet Medicare's administrative costs are still higher.

42. Hacker, "The Case for Public Plan Choice," p. i, http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf. Emphasis in original.

43. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2009, p. 10, http://medpac.gov/documents/Mar09_EntireReport.pdf.

44. See, for example, Amy Finkelstein and Robin McKnight, "What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out-of-Pocket Medical Spending," *Journal of Public Economics* 92, no. 7 (2008): 1660, http://econpapers.repec.org/article/eeepubeco/v_3a92_3ay_3a2008_3ai_3a7_3ap_3a1644-1668.htm.

45. Hacker, "The Case for Public Plan Choice," p. i, http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf.

46. Asch et al., "Who is at Greatest Risk for Receiving Poor-Quality Health Care?" *New England Journal of Medicine* 354 (March 16, 2006): 1147–56, http://content.nejmorg/cgi/reprint/354/11/1147.pdf.

47. Anne M. Snowden et al., "2008 Health Care Disparities Report for Minnesota Health Care Programs," Minnesota Community Measurement, Minnesota Department of Human Services, 2009, p. 2, http://www.mncmorg/site/assets/reports/2008_Health%20Care%20Disparities%20Report_Final.pdf.

48. Amy J. Davidoff, Bowen Garrett, and Alshadye Yemane, "Medicaid-Eligible Adults Who Are Not Enrolled: Who Are They and Do They Get the Care They Need?" Urban Institute Policy Brief, series A, no. A-48, October 1, 2001, p. 1, http://www.urban.org/UploadedPDF/310378_anf_a48.pdf.

49. Cathy J. Bradley et al., "Cancer, Medicaid Enrollment, and Survival Disparities," *Cancer* 103 (2005): 1712–18.

50. Salpy V. Pamboukin et al., "Disparities by Insurance Status in Quality of Care for Elderly Patients with Unstable Angina," *Ethnicity and Disease* 16 (Autumn 2006): 799–807.

51. Anoar Zacharias et al., "Operative and Late Coronary Artery Bypass Grafting Outcomes in Matched African-American versus Caucasian Patients: Evidence of a Late Survival-Medicaid Association," *Journal of the American College of Cardiology* 46 (2005): 1526–35.

52. See, for example, Eve A. Kerr et al., "Diabetes Care Quality in the Veterans Affairs Health Care System and Commercial Managed Care: the Triad Study," *Annals of Internal Medicine* 141, no. 4 (April 17, 2004): 272–81, http://www.annals.org/cgi/content/abstract/141/4/272; and Steven M. Asch et al., "Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample," *Annals of Internal Medicine* 141, no. 12 (December 21, 2004): 938–45, http://www.annals.org/cgi/content/abstract/141/12/938.

53. See Jim Powell, "U.S.-Run Health Care? Ask a Veteran," Orange County Register, April 12, 2009, http://www.cato.org/pub_display.php?pub_id=10125; and Marie McCullough, "Specter Plans Hearing on VA Prostate Cancer Treatment," *Philadelphia Inquirer*, June 23, 2009, http://www.philly.com/inquirer/front_page/20090623_Specter_plans_hearing_on_VA_prostate_cancer_treatment.html. Notably, the leading Democratic reform plans do not propose to model a new government program on the Veterans Health Administration.

54. Mary Clare Jalonick, "AP Interview: Sebelius to Boost Indian Health Care," Associated Press, June 16, 2009, http://abcnews.go.com/Politics/wireStory?id=7851097.

55. Jacob S. Hacker, "Healthy Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement," Berkeley Center on Health, Economic and Family Security, University of California–Berkeley School of Law, and the Institute for America's Future, April 2009, p. 4, www.ourfuture.org/files/Hacker_Healthy_Competition_FINAL.pdf.

56. Peter Harbage and Karen Davenport, "Competitive Health Care: A Public Health Insurance Plan that Delivers Market Discipline," Center for American Progress Action Fund, March 2009, p. 2, http://www.americanprogressaction.org/issues/2009/03/pdf/competitive_health.pdf.

57. Michael F. Cannon, "Pay-for-Performance: Is Medicare a Good Candidate?" *Yale Journal of Health Policy, Law & Ethics* 7, no. 1 (Winter 2007): 3, http://www.cato.org/pubs/papers/cannon_p4p.pdf.

58. Congressional Budget Office, "Key Issues," p. 151, http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

59. See generally, Medicare Payment Advisory Commission, *Report to the Congress: Variation and Innovation in Medicare* (2003), p. 108, http://www.medpac.gov/publications/congressional_reports/June03_Entire_Report.pdf; and Michael F. Cannon and Alain Enthoven, "Life Saving Insurers," *American Spectator* (online), May 13, 2008, http://spectator.org/archives/2008/05/13/life-saving-insurers.

60. Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982 [actually published in January 1983]), p. 301.

61. "HealthPartners Hospital Payment Policy," HealthPartners, http://www.healthpartners.com/portal/866.html.

62. Reed Abelson, "Hospitals Pay for Cutting Costly Readmissions," *New York Times*, May 8, 2009, http://www.nytimes.com/2009/05/09/business/09relapse.html.

63. See, for example, Uwe E. Reinhardt, "The Medicare World from Both Sides: A Conversation with Tom Scully," *Health Affairs* 22, no. 6 (2003): 167–74, http://content.healthaffairs.org/cgi/content/abstract/22/6/167.

64. Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition,* July 2004, p. 28, http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

65. Peter Harbage and Karen Davenport, "Competitive Health Care: A Public Health Insurance Plan that Delivers Market Discipline," Center for American Progress Action Fund, March 2009, p. 2, http://www.americanprogressaction.org/issues/2009/03/pdf/competitive_health.pdf.

66. Kathleen Sebelius, "Statement on New Medicare Trustees Report" (press release, U.S. Department of Health and Human Services, May 12, 2009), http://www.hhs.gov/news/press/2009pres/05/20090512a.html.

67. Institute of Medicine, *To Err Is Human: Building a Safer Health System* (Washington: National Academy Press, 2000).

68. "Press Conference by the President" (White House transcript, June 23, 2009), http://www.whitehouse.gov/the_press_office/Press-Conference-by-the-President-6-23-09/.

69. Blue Dog Coalition, "Health Care Reform: Ensuring Choice in the Marketplace," June 4, 2009, http://www.house.gov/melancon/BlueDogs/Press%20Releases/Health%20Care%20Reform%20%20Ensuring%20Choice%20in%20

70. Len M. Nichols and John M. Bertko, "A Modest Proposal for a Competing Public Health Plan," New America Foundation, March 2009, http://www.newamerica.net/files/CompetingPublicHealthPlan.pdf.

71. "With a history of operating losses, Amtrak is highly dependent on federal government subsidies to sustain its operations." Government Accountability Office, "Activities of the Amtrak Inspector General" (letter to the Honorable John F. Tierney, U.S. House of Representatives, March 4, 2005), http://www.gao.gov/new.items/d05306r.pdf. See also Michael W. Lynch, "Amtrak Accounting," *Reason*, May 2000, http://www.reason.com/news/show/27688.html.

72. Robert R. Schrum, "Don't Bail out the Mail," *Forbes*, January 19, 2009, http://www.forbes.com/2009/01/19/usps-privatize-postal-oped-cx_rs_0119schrum.html.

73. Robert R. Schrum, "Postal Service Fails to Deliver for Consumers," *The Virginian-Pilot*, March 30, 2009, http://lexingtoninstitute.org/1390.shtml.

74. Scott Harrington, "Public Plan Option: Competitor or Predator?" (presentation at an American Enterprise Institute event, "The

Five (Not So) Easy Pieces of Health Reform," June 4, 2009), http://www.aei.org/audio/100486; see also http://www.aei.org/docLib/Harrington%20Presentation.pdf.

75. 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; and 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.

76. See generally, Sue Blevins, *Medicare's Midlife Crisis* (Washington: Cato Institute, 2001).

77. Hacker, "Healthy Competition," p. 7, http://www.ourfuture.org/files/Hacker_Healthy_Competition_FINAL.pdf; and http://www.washingtonpost.com/wp-dyn/content/article/2009/06/05/AR2009060504036.html.

78. See, for example, Senate Committee on Health, Education, Labor, and Pensions, "Affordable Health Choices Act," p. 46–47, http://help.senate.gov/BAI09A84_xml.pdf.

79. Benjamin Zycher, "Comparing Public and Private Health Insurance: Would A Single-Payer System Save Enough to Cover the Uninsured?" Manhattan Institute Medical Progress Report no. 5, October 2007, http://www.manhattan-institute.org/html/mpr_05.htm

80. See, for example, Commission on a High Performance Health System, "The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way," The Commonwealth Fund, February 19, 2009, http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Feb/The%20Path%20to%20a%20High%20P also see Connolly, "Kennedy Readies Health-Care Bill," http://www.washingtonpost.com/wp-dyn/content/article/2009/06/05/AR2009060504036.html.

81. Jay Rockefeller, "Rockefeller Introduces Bill Detailing Public Plan Option" (press release, June 17, 2009); and draft legislation, p. 7–8, http://rockefeller.senate.gov/press/Rockefeller%20Consumers%20Health%20Care%20Act%20Bill%20Text.pdf.

82. See, for example, Congressional Budget Office, "Key Issues," p. 114–16, http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf; Paul Ginsburg, "Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?" *Health Affairs* web exclusive (October 3, 2008): W3-472–79, http://healthaffhighwire.org/cgi/reprint/hlthaff.w3.472v1.pdf; Michael A. Morrissey, "Cost-Shifting: New Myths, Old Confusion, and Enduring Reality," *Health Affairs* web exclusive (October 3, 2008): W3-472–79, http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.489v1.pdf; and Michael A. Morrissey, *Cost-Shifting in Health Care: Separating Rhetoric from Evidence* (Washington: AEI Press, 1994), p. 41–45.

83. "[T]he average price of a non-Medicaid prescription would have been 13.3 percent lower in 2002 in the absence of Medicaid's pricing rule." Mark Duggan and Fiona M. Scott Morton, "The Distor-tionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing," *Quarterly Journal of Economics* 121, no. 1 (February 2006): 4, http://www.mitpressjournals.org/doi/pdf/10.1162/qjec.2006.121.1.1?cookieSet=1.

84. Senate Committee on Finance, "Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options" (white paper, p. 11), http://finance.senate.gov/sitepages/leg/LEG%202009/051809%20Health%20Care%20Description%20of%20Policy%20Options.p

85. David Rogers, "Drug Deal May Be Bad Trip for Dems," *Politico*, July 6, 2009, http://www.politico.com/news/stories/0709/24546.html.

86. Hacker, "Healthy Competition," p. 7, http://www.ourfuture.org/files/Hacker_Healthy_Competition_FINAL.pdf.

87. U.S. Department of the Treasury, "Government Sponsorship of the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation," July 11, 1996, p 10, http://www.archive.org/stream/governmentsponso00uni#page/10/mode/1up.

88. Congressional Budget Office, "Key Issues," p. 69–70, http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

89. Laura Litvan and Kristin Jensen, "Insurers May Face Fees to Help Fund Health Overhaul," Bloomberg.com, July 16, 2009, http://www.bloomberg.com/apps/news?pid=20601103&sid=aIoDa2C7wCKo.

90. See, for example, *Brian Hall et al. v. Michael Leavitt et al.*, "Plaintiffs' Memorandum of Points and Authorities in Opposition to Defendants' Motion to Dismiss and in Support of Plaintiffs' Motion for Summary Judgment," filed March 18, 2009,

http://www.medicarelawsuit.org/pdf/MemorandumInOppositiontoMotiontoDismiss.pdf.

91. 42 U.S.C. 1395b, http://www.socialsecurity.gov/OP_Home/ssact/title18/1803.htm

92. "Congress could always step in and fix the program later. . . . Political bargains struck today . . . cannot . . . bind a fiscally desperate future Congress . . ." Harold Pollack, "Should We Finesse One of Reform's Thorniest Issues?" *New Republic*, March 23, 2009, http://blogs.tnr.com/tnr/blogs/the_treatment/archive/2009/03/23/the-pros-and-cons-of-compromising-on-a-public-plan.aspx.

93. "Imbalances in the competition [in Medicare Advantage] that have arisen from time to time were (and are) the result of payment formulae being imposed (against professional judgment) by Congress, but are not inherent in public-private competition with appropriately structured governance and accountability mechanisms." Nichols and Bertko, http://www.newamerica.net/files/CompetingPublicHealthPlan.pdf.

94. See Physicians for a National Health Program, "Barack Obama on Single Payer in 2003" (video, June 4, 2008), http://www.pnhp.org/news/2008/june/barack_obama_on_sing.php; Amy Chozick, "Obama Touts Single-Payer System for Health Care," *Wall Street Journal*, August 19, 2008, http://blogs.wsj.com/washwire/2008/08/19/obama-touts-single-payer-system/; and "Remarks by the President in Rio Rancho Town Hall on Credit Card Reform" (White House transcript, May 14, 2009), http://www.koat.com/money/19463436/detail.html.

95. Paul Krugman, "Why Not Single-Payer?" *New York Times*, October 7, 2007, http://krugman.blogs.nytimes.com/2007/10/07/why-not-singlepayer/.

96. Patients United Now, "The Public Plan Deception—It's Not About Choice" (video), http://www.youtube.com/watch?v=zZ-6ebku3_E.

97. See Michael F. Cannon, "Medicare," *Cato Handbook for Policymakers*, 7th ed. (Washington: Cato Institute, 2009), p. 125, http://www.cato.org/pubs/handbook/hb111/hb111-12.pdf.

98. Ibid., "The Tax Treatment of Health Care," *Cato Handbook for Policymakers*, 7th ed. (Washington: Cato Institute, 2009), p. 141, http://www.cato.org/pubs/handbook/hb111/hb111-14.pdf.

99. Ibid., "Health Care Regulation," *Cato Handbook for Policymakers*, 7th ed. (Washington: Cato Institute, 2009), pp. 151, 167, http://www.cato.org/pubs/handbook/hb111/hb111-15.pdf; http://www.cato.org/pubs/handbook/hb111/hb111-16.pdf.

Chapter 40

ACO Debacle Exposes Obamacare's Fatal Conceit

by Michael F. Cannon

Obamacare's number-one idea for improving health care quality and reducing costs is to promote something called "accountable care organizations" in Medicare. That effort is sinking like a stone, because it—like the rest of this sweeping law—is premised on the fatal conceit that government experts can direct the market better than millions of consumers making their own decisions.

"Accountable care organizations" is jargon for the radical concept that when doctors and nurses actually *talk* to each other about shared patients, there will be fewer mix-ups, less duplication and patients will receive better, more convenient care at a lower cost. Markets created the first ACOs, including Kaiser Permanente, more than six decades ago.

The federal government, in contrast, has long tried to ensure that nothing so sensible ever happens. For nearly five decades, Medicare regulations have financially penalized doctors who coordinate care. The Medicare Payment Advisory Commission reports that Medicare regulations are "largely neutral or negative towards quality" and sometimes pay providers "even more when quality is worse," like when poor coordination injures Medicare patients.

Obamacare supporters say the solution to this failure of centralized economic planning is . . . more centralized economic planning. The law therefore authorizes Medicare to encourage care-coordinating ACOs.

Medicare's idea of encouragement is this: If doctors and hospitals invest substantial resources to form an ACO, and better care coordination reduces the amount they bill Medicare, then the ACO will get to keep *part* of the savings.

"Here's a flash for the policy wonks pushing ACOs," writes industry expert Robert Laszewski. "They only work if the provider gets paid less for the same patient population. Why would they be dumb enough to voluntarily accept that outcome?"

The Mayo Clinic, the Cleveland Clinic and 93 percent of multi-specialty physician groups are not that dumb. In what the Associated Press called an "unusual rebuke," they and other providers that President Obama has hailed as models for his ACO program have refused to participate in it.

Many of the recalcitrant providers gladly participated in a similar program launched by the Bush administration, and this week we learned why: that program failed to produce any significant savings for taxpayers. They now want Obama's ACO program to cough up more money before they will participate.

How much more? A survey of Swiss doctors is not encouraging. It found "general practitioners will require a pay increase of up to 40 percent before they are willing to accept coordinated care." Hospitals claim their start-up costs would be ten times higher than Medicare bureaucrats estimate.

A frantic Obama administration took less than a week to capitulate. It told providers like the Mayo Clinic, in effect, "Name your price." It is also "considering" whether other ACOs "could receive an

advance on the shared savings they are expected to earn." The administration promises to recoup those up-front subsidies, you know, later.

When purchasing health care, the government should do what it can to improve quality while reducing costs. But this latest debacle once again demonstrates that for all its immense purchasing power, Medicare is paradoxically powerless to do so. Why? Because greater efficiency necessarily means that low-quality/high-cost providers will get less money, and those providers all hire lobbyists to protect their Medicare subsidies.

Inefficient providers have effectively killed nearly every pilot program that previous administrations promised would make Medicare more efficient. Suppliers of wheelchairs and other medical equipment have blocked efforts to reduce the inflated prices Medicare pays them. The industry has killed or sabotaged at least four federal agencies dedicated to researching which medical treatments don't work.

Obamacare's new comparative-effectiveness agency, countless pilot programs and even its "Independent Payment Advisory Board"—a rationing board supposedly insulated from the influence of industry lobbyists—will suffer the same fate.

The only way to improve quality while reducing costs is to give patients the incentive and the power to say "no" to inefficient providers. The Medicare reforms that passed the House don't go as far as they should, but they are a good start.

For one thing, they would do a better job of promoting ACOs. The House reforms build on Medicare Advantage, which already gives one fifth of Medicare enrollees the freedom to choose their own health plan. Kaiser Permanente CEO George Halvorson says the new law's ACO program "is not as good as" Medicare Advantage when it comes to promoting accountable care.

And he should know something about that.

*This article appeared on **KaiserHealthNews.org** on June 3, 2011.*

Chapter 41

Oregon's Verdict on Medicaid

by Michael F. Cannon

Americans may be surprised to learn that little solid evidence exists to support the claim that expanding health insurance will improve the health and financial security of the uninsured; that some research calls into question whether broad coverage expansions improve health at all; and that some research even suggests that the overall benefits of such expansions may not be worth the cost. We lack definitive evidence because no developed nation has ever conducted a study that randomly assigns people to receive health insurance in order to control for other factors that might affect these outcomes. Until now.

In 2008, Oregon decided to enroll an additional 10,000 people in its Medicaid program via lottery. The nation's top health economists pounced on the opportunity to compare medical consumption, health outcomes, and financial stress among "able-bodied uninsured adults below 100 percent of [the] poverty [line]," some of whom were randomly assigned to Medicaid and some of whom were not. The Oregon Health Insurance Experiment is particularly relevant because, starting in 2014, President Obama's new health-care law will enroll another 16 to 20 million such people in Medicaid.

Today, the OHIE researchers released their results after year one of the experiment.

As one might expect, Medicaid coverage led to higher medical consumption. The likelihood of having a hospital admission rose from roughly 7 percent to 9 percent. Average outpatient visits rose from 1.9 to 3. Mammograms for women over age 40 increased from 30 percent to 49 percent, and diabetes screening increased from 60 percent to 69 percent. Average spending was about 25 percent (or $778) higher for Medicaid enrollees in the first year.

Other findings were less intuitive. For example, medical consumption was no higher in the first half of the year, suggesting there was no "pent-up demand" for medical care. Though President Obama has claimed that broader health-insurance coverage and consumption of preventive care would lead to a reduction in emergency-room visits, the OHIE found no discernible difference in ER use between Medicaid enrollees and the control group.

What benefits did all this medical care purchase? As one might have expected, Medicaid reduced financial strain. The likelihood of having out-of-pocket medical expenses fell from 56 percent to 36 percent, while the likelihood of having to borrow money or skip paying other bills to pay for medical care fell from 36 percent to 21 percent. Enrollees' likelihood of having any type of unpaid bill sent to collection fell from 50 percent to 45 percent.

What about health? Though the president has claimed his health-care law will "save lives," the OHIE detected no evidence that extending Medicaid to 10,000 adults did so in the first year. On one hand, we might not expect to see any effect just one year into the experiment, since mortality rates among adults aged 19 to 64 are relatively low. On the other hand, this finding is consistent with a previous study, coauthored by one of the OHIE researchers, that found no evidence that Medicare (which covers a much

older and sicker population) saved any lives even ten years after its introduction. (In future years, OHIE researchers will be able to report on other objective measures of health such as blood pressure and cholesterol levels.)

On subjective measures of health, the likelihood of screening positive for depression fell from 33 percent to 25 percent, and the share reporting their health to be good or better rose from 55 percent to 68 percent. However, two-thirds of the improvement in self-reported health occurred almost immediately after enrollment, *before* any increases in medical consumption. The authors posit that much of this improvement could reflect "an improved overall sense of well-being" rather than "changes in objective physical health."

Supporters of President Obama's health-care law may tout these benefits, but the OHIE does not provide the vindication they seek. First, despite being eligible for Medicaid, 13 percent of the control group had private health insurance—suggesting that on some dimension, Medicaid's eligibility rules are already too broad.

Second, the OHIE extended coverage to the most vulnerable population of uninsured Americans, yet the improvements in health and financial security are so far apparently modest. At higher income levels, where individuals have greater baseline access to health insurance and medical care, the benefits of expanding coverage are likely to be smaller and the costs (to the extent that crowd-out is higher at higher income levels) will be greater.

Third, supporters must show not only that expanding coverage improves health but also that it does so at a lower cost to taxpayers than alternative policies. Health economists generally agree that discrete programs promoting highly effective treatments (for hypertension, diabetes, etc.) could produce health gains as large as expanding health insurance would, but at far less expense. Reducing taxes could plausibly reduce financial strain to a similar degree by expanding job creation.

Finally, the OHIE illuminates an unflattering feature of the push for Obamacare. For a century, the Left has advocated universal health insurance despite not knowing what benefits it might bring. In 2010, Congress and President Obama vastly expanded Medicaid without waiting for the results of the one study that might tell them what taxpayers would get in return for their half a trillion dollars. As the law's supporters seek to cajole doctors into practicing evidence-based medicine, it is no small irony that they themselves dove head-first into evidence-free policymaking.

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Chapter 42

The CLASS Act: This is Confidence-Inspiring?

by Michael F. Cannon

The Obama administration has officially scrapped one of the two entitlement programs Congress created under Obamacare. The failure of the "CLASS Act" shows how the rest of that law threatens every American's private health insurance.

The idea behind CLASS was that the government would run a voluntary and self-sustaining insurance plan to help the disabled pay for long-term care, including nursing home care. It was doomed to fail, thanks to a special kind of government price control Congress imposed on the premiums.

Congress required CLASS to set each applicant's premiums according to the *average* applicant's risk of needing such long-term care, rather than her individual risk. But averaged premiums are only attractive to people with above-average risks. Since few people with below-average risks would enroll, the average premium would rise. That would encourage more people with below-average risks not to enroll, and the vicious cycle would continue until the program collapsed.

As it turns out, CLASS collapsed even before its 2012 start date. The same thing happened when Obamacare imposed the same sort of price controls on health insurance for children in September 2010: the markets for child-only coverage collapsed in a total of 17 states, and are slowly collapsing in even more.

Everyone with a rudimentary understanding of insurance saw this coming. The government's non-partisan actuaries warned of "a very serious risk" that CLASS would be "unsustainable." One wrote, "Thirty-six years of actuarial experience lead me to believe that this program would collapse in short order and require significant federal subsidies to continue."

The Democratic chairman of the Senate Budget Committee called CLASS "a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of." An Obama administration official wrote, "Seems like a disaster to me." One of President Obama's own cabinet secretaries called the program "totally unsustainable" and echoed a presidential commission on fiscal responsibility by recommending it be "reformed or repealed."

In the face of this setback, Obamacare supporters are naturally declaring victory. Jonathan Cohn of The New Republic sees "vindication." Kevin Drum of Mother Jones proudly announces, "What happened here is that government worked exactly the way it ought to." The Washington Post's Ezra Klein instructs, "The CLASS experience should, if anything, make us more confident in the underlying law." It's hard to argue with such logic, but let's try.

Cohn agrees with government actuaries that voluntary, self-sustaining insurance plans "face a significant risk of failure" when government imposes these price controls. Yet he claims the CLASS Act's failure "strengthens the case" for the rest of the law because when Obamacare imposes those price controls on everyone's health insurance in 2014, it will also force low-risk people to buy that overpriced health insurance. It is a *virtue*, he argues, that Obamacare forces people to take what they consider a bad

deal.

The law also tries to prevent the market from unraveling by using roughly half a trillion dollars of new tax revenue to subsidize people's premiums. It is a *virtue*, say supporters, that Obamacare raises taxes (amid high unemployment, no less) to encourage people to buy something they would not voluntarily purchase with their own money.

Obamacare inspires confidence in its supporters, then, because one part of the law throws a Hail Mary pass to prevent another part of the law from stripping Americans of the insurance that currently protects them from illness and impoverishment. Feel safer?

One of the law's biggest supporters offers reason to think the Hail Mary strategy won't work. MIT economist Jonathan Gruber projects the law will increase net premiums for six out of 10 people in Wisconsin's individual market by an average of 31 percent. (A study of Obamacare's impact on Ohio projected much larger premium increases for many individuals and businesses.) That is, low-risk people will still have plenty of reason to walk away. And insofar as the Hail Mary succeeds in delaying collapse, the growth in health insurance premiums will accelerate.

Klein writes, "One way of looking at the administration's [CLASS] decision is that it shows a commitment to fiscal responsibility." If so, then let's handle the rest of Obamacare exactly the same way. Congress should require Obamacare's health insurance provisions to be voluntary and self-sustaining, just like CLASS: no individual mandate, no taxpayer subsidies.

Or is fiscal irresponsibility part of the plan?

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Chapter 43

The Independent Payment Advisory Board: PPACA's Anti-Constitutional and Authoritarian Super-Legislature

by Diane Cohen and Michael F. Cannon

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Introduction

Decades of centralized economic planning, through the federal Medicare program and other government interventions, have led to excessive health care spending in the United States and suppressed the quality of medical care.[1] For example, Congress has proven incapable of containing wasteful Medicare spending. Medicare purchases medical care on behalf of 46 million elderly and disabled U.S. residents[2] and is placing enormous strain on the federal budget.[3] Annual Medicare spending is currently $555 billion,[4] and the best evidence suggests that one-third of Medicare spending is pure waste.[5] Yet Medicare spending per enrollee typically grows at an unsustainable 2.5 percentage points faster than U.S. gross domestic product (GDP), to say nothing of growth in enrollment.[6]

Even Medicare's defenders acknowledge it penalizes high-quality care and encourages low-quality care. Peter Orszag, former director of the federal Office of Management and Budget under President Barack Obama, notes that Medicare literally encourages unnecessary hospital readmissions by penalizing hospitals if they deliver high-quality care that reduces readmissions:

> Reimbursement from Medicare is still primarily based on how many services hospitals perform rather than on how well they care for patients, so hospitals are often financially penalized for improving value and quality. The Mount Sinai [Medical Center] program to reduce readmissions, for example, is costly for the hospital both because of the extra expense of running it and because fewer readmissions means less revenue. Ken Davis, the president and chief executive officer of Mount Sinai, says the hospital won't be able to afford continuing the successful program if [Medicare's] financial incentives remain so skewed against it.[7]

As the largest purchaser of medical care in the nation, Medicare's perverse incentives shape the delivery of care to all Americans, even those with private health insurance.

These and other government failures seem impervious to reform. Medicare spending grows uncontrollably because, as one journalist puts it, "Congress has a record of ignoring or voting down many proposals to save money in Medicare."[8] According to Orszag and many other defenders of government-run health care, the fault is not in government itself, but in the fact that government is too accountable to the people.[9] The problem is not government, but *democratic* government.

"Enter the Platonic Guardians"[10]

In March 2010, Congress and President Obama enacted the Patient Protection and Affordable Care Act (PPACA, or "the Act"), which attempts to sidestep the obstacles the U.S. Constitution puts in the way of government officials seeking to direct the economy's health care sector. The Act authorizes approximately $1 trillion of new federal entitlement spending. Congress financed roughly half of this new spending through provisions designed to reduce the projected growth in Medicare spending, including cuts in payments to health care providers that serve Medicare enrollees.

Since Congress frequently rescinds such cuts under political pressure from providers and Medicare enrollees, Obama, Orszag, and others prevailed on Congress to create a new government agency called the Independent Payment Advisory Board, or IPAB. The Act authorizes IPAB to cut Medicare payments even further than PPACA itself does. More importantly, Congress designed IPAB so that its decisions would automatically take effect, even in the face of popular resistance that would prevent Congress itself from enacting the same measures. Orszag describes IPAB as an attempt "to take some of the politics out" of government direction of the health care sector.[11]

Instead, IPAB is an admission that government has badly mismanaged health care. It's also an effort to solve that problem by giving unfettered power to unelected government officials. The Act literally bypasses the constitutionally prescribed manner by which proposed legislation becomes law, the separation of powers between the executive and legislative branches, and the related checks and balances between those branches. The Act empowers IPAB's unelected government officials to propose legislation that can become law without congressional action, meaningful congressional oversight, and without being subject to a presidential veto, administrative review, or judicial review. The Act even attempts to prevent future Congresses from repealing IPAB.

The Independent Payment Advisory Board is worse than unconstitutional—it is *anti*-constitutional. Congress's legislative powers do not include the power to alter the constitutional procedure required for the passage of laws. Nor does it include the power to entrench legislation by preventing it from being altered by future Congresses.

IPAB's Structure

When fully empanelled, IPAB will consist of 15 voting members appointed by the president and confirmed by the Senate.[12] Board members may nominally serve up to two consecutive six-year terms. If a board member reaches the end of his term and the president declines to appoint (or the Senate fails to confirm) a successor, however, he may serve indefinitely.[13] Board members will be executive-branch employees, with each earning upward of $165,000 per year.[14] PPACA automatically funds IPAB in perpetuity, with an initial budget of $15 million.[15]

PPACA does not require the board to be bipartisan, as is required for most other independent agencies.[16] The president could therefore use his power to make recess appointments to stack the board entirely with members of his own party.[17] If recent history is any guide, the president could even make "recess" appointments while the Senate is not in recess.[18]

An Economic Dictator

In some circumstances, PPACA vests IPAB's vast powers in the hands of just a few unelected government officials. Though the Act allows as many as 15 voting board members, the board may conduct business whenever half of its appointed members are present, and may act upon a majority vote by all members present.[19] When there are no vacancies, therefore, the board will reach a quorum whenever as few as eight members gather, and any five members could wield IPAB's considerable powers. When vacancies do exist—before the president and the Senate put the initial 15 members in place, or when board members resign or die in office—an even smaller cadre of unelected officials could wield the full range of the board's powers.

In some cases, PPACA vests IPAB's powers in just one individual. If there are 14 vacancies on the board, the Act allows the sole appointed member to constitute a quorum, conduct official business, and issue "proposals." The greater danger, then, is not that a president might pack the board with multiple party loyalists, but that he might appoint only one. Or none: if the president fails to appoint any board members (or the Senate fails to confirm the president's appointments, or a majority of the board cannot agree a proposal) the Act authorizes the Secretary of Health and Human Services to exercise the board's powers unilaterally. These powers include the ability to appropriate funds to her own department to administer her own directives (see Box 1).

IPAB's Mission

IPAB's stated mission is to prevent per-enrollee Medicare spending from growing faster than a specified target rate. Through 2017, that rate will be the average of medical inflation and overall inflation. Beginning in 2018, it will be the rate of growth of the economy per capita plus one percentage point.

1. IPAB Gives HHS the Power of the Purse

In certain circumstances, PPACA grants the Secretary of Health and Human Services the power to appropriate funds to that department, and empowers either the president or a minority of the Senate to trigger that grant of power. The Act requires that every IPAB proposal "shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal," and "shall include . . . a legislative proposal that implements the recommendations."[20] Absent congressional action, that "legislative proposal" becomes law. The act then transfers that appropriations power to the Secretary under certain circumstances:

> If . . . the Board is required, but fails, to submit a proposal to Congress and the President by the deadline . . . the Secretary shall develop a detailed and specific proposal that satisfies the requirements of subparagraphs (A) [i.e., the power to appropriate funds to the Secretary] . . . and contains the information required paragraph (3)(B) [including the "legislative proposal that implements" those appropriations]).[21]

As noted nearby, the president could give the Secretary that power simply by refusing to appoint any

IPAB members. A minority of the U.S. Senate could also do so by refusing to end debate on the confirmation of IPAB nominees.

Whenever the federal government projects that per-enrollee spending in traditional Medicare (Parts A, B, and D) will grow faster than that target growth rate, IPAB must make, by January 15 of the preceding year, a "detailed and specific" "legislative proposal" that is "related to the Medicare program."[22] The Act requires the board to issue a "proposal" every year with only two exceptions: (1) when projected Medicare spending is less than its target growth rate, or (2) when medical inflation is less than overall inflation.[23] The Act requires that those proposals "shall . . . result in a net reduction in total Medicare program spending . . . that is *at least equal* to the applicable savings target."[24] The savings target is generally 1.5 percent of total Medicare spending, but this is a minimum. The Board may "propose" even greater reductions in projected Medicare expenditures.[25]

If historical trends persist, IPAB will likely issue a proposal every year. Per-enrollee Medicare spending has historically grown an average of 2.6 percentage points faster than per capita GDP.[26] The Obama administration claims IPAB might not issue any proposals at all, because the Congressional Budget Office projects that "the rate of growth in Medicare spending per beneficiary [will] remain below the levels at which the IPAB will be required to intervene to reduce Medicare spending" through 2021.[27] Nevertheless, Congress appropriated $15 million per year for IPAB in perpetuity, reflecting Congress' presumption that IPAB will act; the relevant projections will change from year to year; and those projections rest on the dishonest accounting required by the Act.[28] Moreover, the Congressional Budget Office projects that IPAB will begin issuing proposals after 2021.[29] Supporters further claim that IPAB may not issue a single proposal, because the mere threat of IPAB acting could motivate Congress to restrain Medicare spending. However, as we explain below, the Constitution does not grant Congress either the authority to endow an agency with IPAB's vast lawmaking powers, or the authority to bind future Congresses. Both components of this strategy—creating IPAB, and using it to force future Congresses to act—are therefore unconstitutional. The Constitution is not a hostage that one Congress can threaten to shoot in order to control the behavior of future Congresses.

IPAB's Powers

The Independent Payment Advisory Board faces almost no limitations on its power to limit Medicare spending, reallocate Medicare spending, or regulate health care broadly. Beginning in 2015, PPACA gives IPAB the power to impose price controls and other regulations, to impose taxes (see Box 2), and—despite disclaimers to the contrary—to ration care for all Americans, whether the government pays their medical bills or not.

PPACA explicitly authorizes IPAB to cut Medicare payments to health care providers and private insurers participating in Medicare (including private drug plans), and to restructure the terms of Medicare payments from "fee for service" payment (where providers profit from providing more services) to "capitated" payments (where providers profit by providing fewer services) or some hybrid.[30] Yet IPAB's powers go further.

IPAB's defenders note that PPACA explicitly prohibits IPAB's proposals from directly rationing

health care, raising certain Medicare revenues, increasing Medicare beneficiary cost sharing, restricting Medicare benefits, or modifying Medicare eligibility criteria.[31] These restrictions, however, are not what they seem.

First, by carving out a discrete list of limitations on the board's delegated powers, the Act implicitly gives IPAB otherwise unlimited power to exercise any enumerated congressional power with respect to any governmental body, industry, property, product, person, service, or activity. Aside from these limitations, nothing in the Act prevents IPAB from proposing any kind or magnitude of regulation or tax that is within the power of Congress to enact (see Box 2). Nor does PPACA preclude IPAB from proposing the appropriation of federal funds or the imposition of conditions on the receipt of such funds. The Board could propose, for instance, to require states to implement federal laws or to enact new state laws in order to receive federal funding. The Board need only demonstrate that its proposals and recommendations relate to Medicare in some undefined way.[32]

Second, the explicit restrictions that PPACA imposes on IPAB's proposals are illusory. For example, while the Act prohibits IPAB from rationing care, the Act does not define rationing. It instead leaves that task to IPAB and the Secretary of Health and Human Services and shields their definition from any meaningful review (see below). If IPAB and the Secretary adopt a narrow definition of rationing—say, that rationing only occurs when Medicare flatly refuses to pay for a given service—then IPAB could deny access to care as it sees fit simply by setting Medicare's prices for certain treatments and procedures so low that no providers will offer them. This is hardly an abstraction. Under current law, by the end of the century Medicare's prices for hospital and physician services will fall from roughly 66 percent and 80 percent of what private insurers pay (respectively) to roughly one-third of what private insurers pay.[33] These current-law price controls could result in "a serious decline in the availability and/or quality of health services for Medicare beneficiaries," according to Medicare's actuaries.[34] As many as 15 percent of hospitals "might end their participation in the program" before the end of the decade.[35] (For further discussion, see Box 2.) As discussed below, IPAB can impose such rationing measures even when Congress would not approve them and would otherwise rescind them.

IPAB's Scope

The Independent Payment Advisory Board's defenders typically speak of the Board as if it will only affect the Medicare program.[39] On the contrary, IPAB will have the power to ration or reorganize care even for those who are not enrolled in government programs. The Act grants IPAB the power to regulate non-federal health care programs and private health care and health insurance markets, so long as such action is "related to the Medicare program," "improv[es] health care outcomes," and serves IPAB's other stated goals.[40] IPAB's ability to regulate private health care markets comes from the sweeping powers discussed above. Numerous provisions of the Act show this was also the clear intent of IPAB's architects.

2. Can IPAB Tax?

IPAB's poorly constrained legislative powers raise a troubling question: could IPAB increase taxes?

The answer is yes.

PPACA states that IPAB's proposals "shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria."[36] Rather than a flat prohibition on raising revenue, this restriction appears only to prevent IPAB from proposing to increase revenues under those specific sections of the Social Security Act, which cover premium revenue under Medicare Parts A and B. Even if IPAB were subject to judicial review, federal courts likely would defer to IPAB's and the Secretary's permissive interpretation of that language.[37] But PPACA specifically states that the Secretary's implementation of IPAB's proposals is not judicially reviewable.

Yet assume, for the sake of argument, that this language does prohibit IPAB from proposing higher Medicare premiums, or an increase in the Medicare payroll tax, or a tax on Medicare-participating providers (on the theory that it would reduce Medicare spending), or any other tax. What if IPAB proposed one of these revenue enhancements anyway? What would stop it from becoming law? Put differently, is there an enforcement mechanism behind PPACA's prohibition on such proposals?

There is not. The Act exempts the Secretary's implementation of IPAB proposals from administrative and judicial review, so no one could sue to block it. The president could not shelve it, because IPAB submits its proposals directly to Congress. If the Secretary submits a proposal in IPAB's stead, PPACA requires the president to submit the proposal directly to Congress. The Act allows Congress and the president to block that tax increase by offering a substitute or by mustering a three-fifths majority in the Senate— but that merely shows that IPAB's tax increases and spending cuts are on an equal footing.[38] If Congress and the president fail to reject IPAB's tax increase or to enact on a substitute, the Act requires the Secretary to implement it, with the help of funds that IPAB may itself appropriate.

Indeed, to enforce PPACA's prohibition on IPAB increasing taxes, the president or Congress would have to violate PPACA. If the president refused to submit IPAB's tax increase to Congress, or Congress and the president enacted a law with less than a three-fifths majority in the Senate that simply blocked the tax increase, or if a federal court chose to review the tax increase and struck it down, or if the Secretary chose (possibly at the president's direction) not to implement it, then those government officials would be violating the law by ignoring the various statutory rules protecting IPAB's proposals.

Consider another implication of the potential claim that federal officials can ignore the rules protecting IPAB proposals whenever they determine, in their judgment, that IPAB has violated limitations on its own powers. If that were true, then those officials could also block *each and every* IPAB proposal merely by declaring that, in their judgment, the proposal achieves savings by limiting Medicare enrollees' access to care, and therefore violates the prohibition on IPAB rationing care. If Congress and the courts can block an IPAB tax, in other words, then they can block any IPAB proposal. That is inconsistent with the clear meaning and intent of IPAB's authorizing statute.

IPAB can raise taxes as surely as it can alter Medicare payments. The Act creates an unaccountable lawmaking body, and leaves elected officials with little to stop it.

First, IPAB has a statutory obligation to "coordinate" its proposals and recommendations with

studies of private markets and non-federal delivery systems.[41] For example, the Act requires IPAB to produce a "public report" containing "standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title."[42] The Act requires IPAB to include in its reports "[a]ny other areas that the Board determines affect overall spending and quality of care in the private sector."[43] The Act then requires IPAB to rely on these reports when formulating its proposals.[44]

Second, PPACA requires IPAB to submit to Congress and the president recommendations to "slow the growth in national health expenditures" and "Non-Federal Health Care Programs."[45] These include recommendations that may "require legislation to be enacted by Congress in order to be implemented" or that may "require legislation to be enacted by State or local governments in order to be implemented."[46]

Third, PPACA presumes that IPAB's proposals will include areas of the health care sector that lie beyond the Senate Finance Committee's jurisdiction, which encompasses Medicare, Medicaid, the State Children's Health Insurance Program, and even the tax treatment of private health insurance and medical expenses. The Act alters Senate rules so that, when considering an IPAB legislative proposal, the Senate Finance Committee may approve legislative matters outside the committee's jurisdiction "if that matter is relevant" to an IPAB proposal.[47] If the requirement that IPAB proposals be related to the Medicare program meant that they would be confined to the Medicare program or even confined to the Finance Committee's jurisdiction, then it would be unnecessary to alter this Senate rule. This language instead indicates IPAB's proposals will affect matters outside of Medicare, and even outside the Finance Committee's expansive jurisdiction.

Fourth and most importantly, the Act provides that if the Medicare actuaries project that the growth rate of national health expenditures will exceed that of per-enrollee Medicare spending, IPAB's "proposal shall be designed to help reduce the growth rate [of national health expenditures] while maintaining or enhancing beneficiary access to quality care under [Medicare]."[48] This is a clear mandate to reduce both government and private-sector health care spending. Indeed, the simplest way to reduce overall health care spending while maintaining access to care for Medicare enrollees is to limit spending on patients outside of Medicare.

PPACA's authors had originally named IPAB the Independent *Medicare* Advisory Board. The reconciliation bill that amended PPACA changed the name to the Independent *Payment* Advisory Board, suggesting the law's authors made a deliberate choice to grant IPAB the power to regulate beyond Medicare.[49] Timothy Jost, a leading expert on and defender of PPACA, has written that it may not be possible to curb Medicare expenditures without addressing private expenditures, and that the board is likely to end up setting prices for all medical services.[50]

A New Legislative Process

IPAB's proposals are not mere proposals. Orszag, who is perhaps the foremost advocate of IPAB, explains that the Act vests IPAB with "an enormous amount of potential power"[51] —in effect, the unilateral power to make law:

> President Obama fought hard for IPAB, over strong opposition from Congress, which saw the board as *usurping its power*. When IPAB starts up in 2014, it will comprise an independent panel of medical experts charged with devising changes to Medicare's payment system. In each year that Medicare's per capita costs exceed a certain threshold, IPAB will be responsible for making proposals to reduce this projected cost growth to the specified threshold. The policies will then take effect automatically unless Congress specifically passes legislation blocking them and the president signs that legislation. In other words, the default is that [IPAB's] policies . . . will take effect.[52]

Orszag notes that thanks to IPAB, "the default is now switched in a very important way."[53] The default has indeed shifted so significantly that it is misleading to call IPAB's edicts "proposals."

IPAB's proposals will have force of law. The reasons for this are twofold. First, PPACA requires the Secretary of Health and Human Services to implement them. Second, it severely restricts Congress' ability to block their implementation by rejecting them or offering a substitute proposal. These provisions will effectively make IPAB's proposals law without the approval of Congress or the signature of the president.[54]

Lack of Checks and Balances

Anticipating that voters would resist having 15 unelected officials ration care to 300 million Americans, PPACA's authors included several provisions designed to prevent future Congresses, presidents, and courts from blocking IPAB's proposals. These provisions have the effect of insulating IPAB from any meaningful accountability to the people whose lives its decisions will affect.

First, PPACA exempts the development of the board's proposals from the administrative rulemaking requirements that Congress imposes on other executive-branch agencies.[55] Such requirements are essential to representative government because they are the only way the public can provide input, data, and analysis on whether an agency should reject, approve, or modify a proposed regulation. Congress passed the Administrative Procedures Act for this very purpose.[56] However, PPACA does not require IPAB to hold hearings, take testimony, or receive evidence from the public.[57]

Second, PPACA authorizes IPAB to submit its proposals directly to Congress in a "legislative proposal." When the Secretary develops a proposal in IPAB's stead, PPACA states the president "shall within 2 days submit such proposal to Congress."[58] This requirement restricts the president's authority under the Constitution's Recommendations Clause, which states the president may "recommend to [Congress's] Consideration such Measures as he shall judge necessary and expedient."[59] For example, in 2009, President Obama invoked the Recommendations Clause with regard to provisions of the Omnibus Appropriations Act:

> Several provisions of the Act . . . effectively purport to require me and other executive officers to submit budget requests to Congress in particular forms. Because the Constitution gives the President the discretion to recommend only 'such Measures as he shall judge necessary and expedient' . . . I shall treat these directions as precatory.[60]

PPACA unconstitutionally attempts to deny the president his constitutional prerogative to use his own

discretion as to what measures he submits to Congress.

Third, once a legislative proposal arrives in Congress, the Act protects it by codifying changes to the Senate's parliamentary rules that limit the ability of the Senate—and thereby the House of Representatives, which must reach agreement with the Senate—to modify or reject the proposal before it automatically becomes law. These statutorily entrenched parliamentary rules include, but are not limited to, the following:

- The Act imposes parliamentary rules that limit each chamber's ability to make any changes to a legislative proposal that would result in greater Medicare spending.[61] To prevent an IPAB proposal from becoming law, then, Congress must offer a substitute piece of legislation that achieves the same budgetary result.
- The Act requires a three-fifths vote of all of the members of the Senate to waive the foregoing Senate rules.[62]

If Congress and the president do not enact a substitute that reaches the same budgetary result, or waive the foregoing rules with a three-fifths majority in the Senate, then IPAB's legislative proposal automatically becomes law, and the Act requires the Secretary of Health and Human Services to implement it.[66]

3. In 2020, Congress Loses All Power to Control IPAB

PPACA requires the Secretary of Health and Human Services to enact all IPAB proposals with only three exceptions. The first exception is that the Secretary shall not implement proposals issued before the year 2020 if Congress supersedes them, which requires Congress either to enact an equivalent substitute or to muster a three-fifths majority in the Senate to block a proposal.[63]

The second is that the Secretary shall not implement any IPAB proposal after the year 2019 if Congress repeals IPAB in 2017 through the highly restrictive process described below. If, however, Congress fails to repeal IPAB through that process, this exception prevents Congress from rejecting or altering any IPAB proposal after 2019. The Act clearly states that the Secretary must implement IPAB proposals issued after 2019, unless Congress both repealed IPAB in 2017 and supersedes the proposal at hand.[64] That structure may appear odd, in that it seems to imply that after 2020, a board that Congress has already repealed might nevertheless issue a proposal for Congress to supersede. The structure of this exception makes more sense, however, in the light of IPAB's overarching purpose. If Congress fails to repeal IPAB through the prescribed process, then Congress loses its ability to alter or reject IPAB proposals, and the Secretary must implement all such proposals. This plain-meaning interpretation of the statute is consistent with PPACA's goal of limiting Congress' ability to interfere with IPAB's lawmaking powers.

The combined effect of these first two exceptions is that Congress may amend or reject IPAB proposals, subject to stringent limitations, but only from 2015 through 2019. If Congress fails to repeal IPAB in 2017, then after 2019, IPAB may legislate without any congressional interference. The Secretary must implement all IPAB proposals as written, subject to the third exception, below.

The third exception applies in 2019 and thereafter. The Act directs the Secretary not to implement an IPAB proposal if the chief Medicare actuary projects the growth rate of per capita national health expenditures will exceed the growth rate of per-enrollee Medicare expenditures. This exception may not apply in two consecutive years.[65] In all other cases, the Act requires the Secretary to implement all IPAB proposals.

Worse, if Congress fails to repeal IPAB through the restrictive procedure laid out in the Act, then after 2020, Congress loses the ability even to offer substitutes for IPAB proposals. As explained in Box 3, in that case the Act requires the Secretary to implement IPAB's proposals even if Congress does enact a substitute. To constrain IPAB at all after 2020, Congress must repeal it between January and August in 2017.

Finally, PPACA gives IPAB and the Secretary the sole authority to judge their own actions by prohibiting administrative or judicial review of the Secretary's implementation of an IPAB proposal.[67]

Shielding IPAB from the People

Consistent with their attempts to protect individual IPAB proposals, Congress and President Obama went to extraordinary, unconstitutional, and even absurd lengths to try to protect IPAB from itself being repealed by future Congresses. The Act states that Congress may only repeal IPAB if it follows these precise steps:

1. Wait until the year 2017.
2. Introduce a specifically worded "Joint Resolution" in the House and Senate between January 1 and February 1.
3. Pass that resolution with a three-fifths vote of all members of each chamber by August 15.[68]

The president must then sign that joint resolution.

Whereas Congress can repeal any other federal statute at any time with just a majority vote in each chamber and the president's signature, under PPACA Congress has only about 15 business days in the year 2017 to propose this joint resolution of repeal. Otherwise, the Act forever precludes repeal. Congress must then pass that resolution with a three-fifths supermajority by August 15, 2017, or the Act forever precludes repeal. Even if a repeal resolution should clear these hurdles, IPAB would retain its power to legislate through January 15, 2018.[69] If Congress fails to follow these precise steps, then PPACA states the American people's elected representatives may never repeal IPAB, ever.

An Implausible Reinterpretation

The Obama administration has argued in federal court that the language concerning a repeal resolution merely "establishes *one* way for Congress to repeal the Board *if* Congress wishes the repeal effort to qualify for the expedited procedures established by that provision."[70] That interpretation does not square with the plain meaning or the structure of the statute.

First, the administration ignores the clear language of the Act, which states a "Joint Resolution [Is]

Required To Discontinue the Board."[71] Not optional, but required. Only in Washington, D.C., could a statute stating that a "Joint Resolution [Is] Required To Discontinue the Board," mean that a joint resolution is *not* required to discontinue that board.

Second, the anti-repeal provisions cannot plausibly be described as creating an "expedited procedure." While PPACA does exempt a repeal resolution from some of Congress's procedural hurdles, it also sets a higher bar for approval: a three-fifths majority in both chambers. Moreover, those exemptions cannot be invoked until 2017 and would have no force until 2020. (Box 4 explains the differences between "fast track" congressional rules, and the rules protecting IPAB.) Only in Washington could a provision that prevents Congress from introducing a resolution for seven years, and then prevents that resolution from taking effect for an additional three years, be described as an "expedited" procedure.

Third, the structure of PPACA clearly shows it attempts to deny Congress the power to repeal IPAB outside of the "joint resolution" procedure. As explained in Box 3, the Act requires the secretary to implement IPAB proposals with only three exceptions: (1) if, in years prior to 2020, Congress supersedes an IPAB proposal; (2) if, in 2020 and thereafter, Congress has already approved the specifically worded and time-limited joint resolution of repeal *and* supersedes IPAB's proposal; and (3) if, in 2019 and thereafter, Medicare's actuaries project that national health expenditures will grow more rapidly than per-enrollee Medicare spending.[79] If the Act merely "establishes *one* way for Congress to repeal the Board," then there would have been no need to list the second exception, because *any* method of repeal would relieve the Secretary of her duty to implement IPAB proposals. Alternatively, the Act would have to include a fourth exception explaining that any method of repeal *other than* the specifically worded joint resolution would also relieve the Secretary of this duty. Yet the Act clearly requires the Secretary to implement IPAB proposals unless Congress enacts the specifically worded repeal resolution within the statutory time limits.

4. Far Beyond "Fast-Track" Authority

PPACA's defenders claim that the Act's limitations on Congress's ability to alter and reject IPAB proposals, or to repeal IPAB, are no different from "fast-track authority," where Congress provides for expedited procedures for committee and floor action on specifically defined types of bills or resolutions.[72] The administration defends IPAB by likening it to the Defense Base Closure and Realignment Commission (BRAC)[73] and the Congressional Review Act (CRA),[74] both of which established fast-track procedures for Congress's disapproval of agency regulations.

In reality, neither BRAC nor CRA has anything in common with IPAB in terms of purpose, policy, procedure, or the creation of a lawmaking entity independent from Congress and the courts. Moreover, both the BRAC and CRA statutes included provisions for congressional oversight and constraint, which IPAB lacks.

The Defense Base Closure and Realignment Commission

Congress established BRAC and charged it with issuing recommendations regarding the closure and realignment of military installations, through what the Supreme Court has described as an "elaborate process."[75] BRAC's task did not even begin until after the Secretary of Defense prepared closure and

realignment recommendations, based on statutorily set selection criteria, which he established after notice and an opportunity for public comment. Congress required BRAC to hold public hearings and prepare a report on those recommendations before issuing its own recommendations.[76] The president retained the authority to decide whether to submit BRAC's recommendations to Congress. Congress then had the opportunity to enact a resolution to disapprove the recommendations and bar the closures, under normal congressional rules and without any further action.[77] PPACA contains no similar requirements for public input or presidential review of IPAB's proposals before they become law, and it does not permit a simple congressional disapproval. Peter Orszag approvingly notes that Congress and the president will have less power to stop IPAB's proposals than they had to stop BRAC's proposals.[78]

The Congressional Review Act

The CRA is also entirely different from IPAB's enabling legislation. The CRA establishes expedited procedures allowing Congress to disapprove agency regulations. While it establishes a fast-track procedure for review of regulations, it does nothing to alter the administrative rulemaking process or judicial review of regulations; nor does it entrench regulations from repeal or amendment; nor does it condition Congress's power to strike down a regulation on Congress enacting a statute that achieves an equivalent result.

The difference in the substance of the two statutes is no less stark. While the CRA protects Congress's lawmaking power from encroachment by the executive branch, IPAB encroaches on that very power.

The Obama administration's reinterpretation of IPAB's anti-repeal provisions is absurd on its face. Those provisions can have no other meaning than to prohibit Congress from repealing IPAB through any other process. If PPACA's authors had their way, IPAB would be the most unrepealable provision in federal law. After 2017, Congress could repeal Medicare, but not the board it created to run Medicare. Congress (and the states) could repeal the Bill of Rights. But not IPAB.

IPAB versus the Constitution

As the foregoing analysis suggests, IPAB's constitutional infirmities are numerous.

An Unconstitutional Delegation of Legislative Power

Congress's attempt to delegate its legislative powers to IPAB lies beyond the legislative power that the people delegated to Congress through the U.S. Constitution. Article I, Section 1, of the Constitution states, "All legislative Powers herein granted shall be vested in a Congress of the United States . . . "[80] The Supreme Court has explained that Congress may not "abdicate, or . . . transfer to others, the essential legislative functions with which it is vested."[81]

The Court has held that, while Congress may create administrative agencies and commissions, it may not yield to another authority the ultimate power to make law. The Supreme Court has indicated that the "true distinction" between legitimate and illegitimate delegations of authority is that an agency may not

exercise the power to make law, but may be given the "authority or discretion as to its execution, to be exercised under and in pursuance of the law."[82] This is a distinction "of degree,"[83] and "varies according to the scope of the power congressionally conferred."[84] In other words, the broader the authority conferred on an agency, the more tightly it must be bound by legislative, judicial, or executive oversight, and the more precise and narrow its instructions from Congress must be.

Accordingly, the Supreme Court has held that the legislative power of Congress does not include the power to delegate legislative authority to an executive agency unless Congress provides an "intelligible principle" that constrains the exercise of such authority.[85] This intelligible-principle test is one that examines the totality of the circumstances, "standards, definitions, context, and reference to past administrative practice" in the statute empowering the agency in order to determine whether the agency's decisionmaking is properly guided and confined.[86]

Congress's unprecedented delegation of legislative power to IPAB fails this test. The Act provides almost no limit on IPAB's legislative powers, and no intelligible standard constraining the exercise of those powers. While the absence of judicial review and rulemaking requirements do not in themselves make IPAB unconstitutional under the intelligible principles test, they are factors the Supreme Court has used to analyze the constitutionality of congressional delegation. In *J. W. Hampton v. United States*, the Court upheld a delegation to the Tariff Commission in part because the agency issued recommendations only after giving notice and an opportunity to be heard.[87] Likewise, in *Mistretta v. United States*, the Court emphasized that the Sentencing Commission engaged in Administrative Procedures Act notice-and-comment rulemaking and was fully accountable to Congress, "which can revoke or amend any or all of the [Commission's] Guidelines as it sees fit either within the 180-day waiting period . . . or at any time."[88] The Independent Payment Advisory Board need not engage in notice-and-comment rulemaking, and PPACA constrains Congress's ability to revoke or amend IPAB's edicts.

Not long ago, Supreme Court Justice Antonin Scalia predicted that, unless courts rigorously enforce the constitutional prohibition on delegations of legislative power, Congress could create:

> "expert" bodies, insulated from the political process, to which Congress will delegate various portions of its lawmaking responsibility. How tempting to create an expert Medical Commission (mostly M.D.s, with perhaps a few Ph.D.s in moral philosophy) to dispose of such thorny, "no-win" political issues as the withholding of life-support systems in federally funded hospitals. The only governmental power the Commission possesses is the power to make law; and it is not the Congress.[89]

What Justice Scalia foresaw now exists in IPAB.

Separation of Powers Doctrine Protects Liberty

The Separation of Powers doctrine also denies Congress the authority to establish IPAB. The Constitution's system of checks and balances among the legislature, the executive, and the judiciary exists to protect freedom.[90] As the Supreme Court recently wrote, "Separation-of-powers principles are intended, in part, to protect each branch of government from incursion by others. Yet the dynamic between and among the branches is not the only object of the Constitution's concern. The structural principles secured by the separation of powers protect the individual as well."[91]

The following factors exhibit an unprecedented violation of that doctrine. The Independent Payment Advisory Board is an executive agency that possesses legislative powers. The Act delegates these legislative powers to IPAB, and potentially to a single individual, without an intelligible standard. The Board's legislative powers are subject neither to the Administrative Procedures Act's rulemaking requirements, nor to administrative or judicial review, nor to any meaningful congressional review. Congressional review is not meaningful because PPACA severely limits Congress' ability to alter or amend IPAB's proposals. The Act curtails the president's constitutional authority to recommend only such measures as he considers expedient. The Act requires the Secretary of Health and Human Services to implement these legislative proposals without regard for congressional or presidential approval. Congress may only stop IPAB from issuing self-executing legislative proposals if three-fifths of all sworn members of Congress pass a joint resolution to dissolve IPAB during a short window in 2017. Even then, IPAB's enabling statute dictates the terms of its own repeal, and it continues to grant IPAB the power to legislate for six months after Congress repeals it. If Congress fails to repeal IPAB through this process, then Congress can never again alter or reject IPAB's proposals.

These factors in their totality reveal an unprecedented delegation of legislative, executive, and judicial authority in violation of the Separation of Powers doctrine.

Amending the Constitution by Statute

The Independent Payment Advisory Board's anti-repeal provisions are so unconstitutional as to be absurd. They would deny future Congresses their basic legislative powers, and thereby diminish Congress's constitutional authority by statute.

It is a maxim of representative government that Congress does not have the power to bind the hands of a subsequent Congress by statute. Thomas Jefferson noted that if a present legislature were to "pass any act, and declare it shall be irrevocable by subsequent assemblies, the declaration is merely void, and the act repealable, as other acts are."[92] The Supreme Court has long held that "a general law . . . may be repealed, amended or disregarded by the legislature which enacted it," and "is not binding upon any subsequent legislature."[93]

There is one lawful way for one Congress to bind future Congresses: the amendment process of Article V.[94] Anyone who wishes to deny future Congresses the legislative powers granted by the Constitution, or to limit the discretion of future presidents to recommend to Congress only those measures they consider necessary and expedient, must employ Article V's amendment process, which requires the consent of two-thirds of the members of each chamber of Congress, and three-fourths of state legislatures. That Congress may not supersede the Constitution by statute was recognized by Justice John Marshall as being "one of the fundamental principles of our society."[95] Charles Black writes that this "most familiar and fundamental principle" has long been perceived as "so obvious as rarely to be stated."[96] Yet PPACA attempts to sidestep the inconveniences of Article V by amending the Constitution through simple congressional majorities and the president's signature.

As the Obama administration now concedes, "Nothing prevents Congress from repealing the Board via ordinary legislation."[97] This welcome admission that IPAB's anti-repeal provisions cannot do what their authors hoped does not change the clear language and intent of those provisions, nor can it absolve Congress and President Obama from attempting to amend the Constitution via statute.

A Milestone on the Road to Serfdom

The federal government's attempts to direct America's health care sector, up to and including IPAB, closely track the predictions Nobel laureate economist Friedrich Hayek made in his 1944 book *The Road to Serfdom*. Hayek explained how government planning of the economy leads to frustration with democracy and support for authoritarian forms of government such as IPAB:

> It may be the unanimously expressed will of the people that its parliament should prepare a comprehensive economic plan, yet neither the people nor its representatives need therefore be able to agree on any particular plan. The inability of democratic assemblies to carry out what seems to be a clear mandate of the people will inevitably cause dissatisfaction with democratic institutions. Parliaments come to be regarded as ineffective "talking shops," unable or incompetent to carry out the tasks for which they have been chosen. The conviction grows that if efficient planning is to be done, the direction must be "taken out of politics" and placed in the hands of experts—permanent officials or independent autonomous bodies . . .
>
> The delegation of particular technical tasks to separate bodies, while a regular feature, is yet only the first step in the process whereby a democracy which embarks on planning progressively relinquishes its powers.[98]

Nearly eight decades before Peter Orszag argued that IPAB would "take some of the politics out" of government-run health care, Hayek presaged Orszag's argument almost verbatim.[99]

Hayek then explained why authoritarian lawmaking bodies will do no better a job of directing the economy than democratic ones:

> The expedient of delegation cannot really remove the causes which make all the advocates of comprehensive planning so impatient with the impotence of democracy . . . [A]greement that planning is necessary, together with the inability of democratic assemblies to produce a plan, will evoke stronger and stronger demands that the government or some single individual should be given powers to act on their own responsibility. The belief is becoming more and more widespread that, if things are to get done, the responsible authorities must be freed from the fetters of democratic procedure.

The cry for an economic dictator is a characteristic stage in the move toward planning.[100] Those cries, Hayek wrote, will sometimes carry the day.[101] Advocates of government direction of the economy turn against democracy precisely because democracy "is an obstacle to the suppression of freedom which the direction of economic activity requires."[102]

Modern Authoritarianism

Compare Hayek's predictions to current proposals offered by advocates of government direction of the economy. In 2008, former Senate Majority Leader Tom Daschle (D-SD) proposed an unelected "Federal Health Board" similar to IPAB, whose "recommendations would have teeth."[103] Such a board is necessary because:

> [While] there is a general agreement on basic reform principles . . . the traditional legislative

> process has failed to deliver . . . Professional expertise and trustworthiness—these are qualities that Congress lacks when it comes to health care . . . In Congress, every decision is political . . . There is a strong argument to be made that appointed experts, proceeding in a deliberate, sometimes plodding way, would make better health-care decisions than politicians . . . [H]ealth-care policy shouldn't be subject to the whims of subcommittee chairmen and special interests . . . After nearly a century of failure, it's time to try another way."[104]

Under Daschle's proposal, Congress could overturn Federal Health Board decisions or abolish the board at any time. In other words, IPAB is more authoritarian—has more "teeth"—than even Daschle recommended.

University of Chicago public health professor Harold Pollack sees IPAB as progress because "we must reduce congressional micromanagement of Medicare policy" in favor of "a more centralized approach." Pollack concludes, "Despite many reasons for caution . . . I'm becoming more of a believer in an imperial presidency in domestic policy. Congress seems too screwed up and fragmented to address our most pressing problems."[105] Note that it would be easier to remove an "imperial president" that IPAB's members.

In an article titled, "Why We Need Less Democracy," Peter Orszag writes, "What we need . . . are ways around our politicians."[106] Like Daschle and Pollack, Orszag does not mean that we, the people should have more freedom to make our own decisions. Orszag's *we* refers to government "experts," who should have more power to impose their decisions on the people without the people's desires getting in the way. The problem with representative government, in Orszag's estimation, is the *representative* part:

> In other words, radical as it sounds, we need to counter the gridlock of our political institutions by making them a bit less democratic . . . I believe that we need to jettison the Civics 101 fairy tale about pure representative democracy and instead begin to build a new set of rules and institutions that would make legislative inertia less detrimental to our nation's long-term health.[107]

These new rules include "creating more independent institutions" that can impose taxes and other laws without representation. Orszag writes, "Proposals abound for expanding this type of process. In the late '90s, economist Alan Blinder proposed shifting responsibility for tax policy to a Fed-like institution of experts." He continues, "Perhaps the most dramatic example of this idea is the Independent Payment Advisory Board." Orszag "wish[es] it were not necessary" to vest so much power in unelected and unaccountable government officials. Alas, "certain aspects of representative government can end up posing serious problems. And so, we might be a healthier democracy if we were a slightly less democratic one."[108]

Governor Bev Perdue (D-NC) made an equally radical proposal during a discussion of how Congress might better manage the economy:

> You have to have more ability from Congress, I think, to work together and to get over the partisan bickering and focus on fixing things. *I think we ought to suspend, perhaps, elections for Congress for two years* and just tell them we won't hold it against them, whatever decisions they make, to just let them help this country recover. I really hope that someone can agree with me on

that.[109]

Thankfully, this proposal did not catch fire.[110] Nevertheless, Purdue's comments illustrate the danger Hayek identified.

The federal government's attempts to plan the health care sector of the economy have been a failure. The creation of IPAB is proof of that failure and demonstrates that government direction of the economy is a threat to democracy. This is in no small measure because, as Hayek's analysis suggests, IPAB's inevitable failures will generate support for even more authoritarian measures. Not that we will need to wait for IPAB to fail: President Obama proposed expanding IPAB's powers before he even appointed a single member to the board.[111]

Conclusion

The Patient Protection and Affordable Care Act and the Independent Payment Advisory Board are not merely unconstitutional—they are *anti*-constitutional. The Board is an unelected and unaccountable lawmaking body. It possesses unprecedented power to make laws free of any meaningful oversight. It is "independent" in the worst sense of the word: independent of Congress, independent of the president, independent of the judiciary, and independent of the will of the people. Through this Act, Congress and President Obama attempted to rewrite multiple provisions of the Constitution, to deny future Congresses their powers under the Constitution, to deny current and future voters their right to alter and abolish unjust laws, and to deny the judiciary its role as a check against unjust laws. If IPAB survives—if Congress and President Obama succeed in amending various provisions of the U.S. Constitution by statute—then the United States will have a Constitution in name only. The United States will have become a *de facto* majoritarian democracy or worse, in which the majority always has the option of surrendering even more power to unelected bureaucrats, but not necessarily the option of reclaiming it. Congress, not the Constitution, will define the limits of its own power. Congress will vest whatever powers its majorities choose in whatever individuals they deem fit. The Independent Payment Advisory Board poses a threat to the U.S. Constitution and representative government that transcends party and ideology, and that has earned IPAB opponents of all political stripes.

Among the many legal challenges to PPACA is *Coons v. Geithner*, a lawsuit challenging IPAB as an unconstitutional delegation of Congress's lawmaking authority.[112] But Congress need not wait for the courts to strike down IPAB. It can assert the powers that PPACA purports to deny it by repealing IPAB. Legislation to repeal the board has garnered 235 cosponsors in the House of Representatives—a majority of the House, including 20 Democrats.[113] A modified version of that bill passed the House with 223 votes (including seven Democrats), and the House has voted to repeal PPACA in its entirety.[114]

It is tempting to dismiss IPAB as an absurdity that the body politic will soon reject. Unless and until that occurs, IPAB will empower as few as one unelected government official to ration health care to all Americans; to impose any tax or regulation; to appropriate funds; and to wield many other lawmaking powers.

Notes

We would like to thank Nick Dranias, director of the Center for Constitutional Government, and Christina Sandefur, attorney, both with the Goldwater Institute.

1. See generally, Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It* (Washington: Cato Institute, 2007).

2. U.S. Congressional Budget Office, *The Long-Term Budget Outlook*, August 2010, p. 29, http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-ltbo.pdf.

3. Ibid., p. iii.

4. U.S. Congressional Budget Office, *The Budget and Economic Outlook: An Update*, August 24, 2011, http://cbo.gov/ftpdocs/123xx/doc12316/08-24-BudgetEconUpdate.pdf.

5. Elliott S. Fisher, "Expert Voices: More Care Is Not Better Care," National Institute for Health Care Management 7, January 2005, http://nihcmorg/pdf/ExpertV7.pdf.

6. U.S. Congressional Budget Office, *The Long-Term Budget Outlook*, August 2010, p. 33.

7. Peter R. Orszag, "Medicare Spending Slows as Hospitals Improve Care," Bloomberg, August 23, 2011, http://www.bloomberg.com/news/2011-08-24/medicare-spending-slows-as-hospitals-improve-care-peter-orszag.html. Orszag serves on the board of the Mount Sinai Medical Center in New York.

8. Jennifer Haberkorn, "The Independent Payment Advisory Board," Health Affairs/Robert Wood Johnson Foundation Health Policy Brief no. 59, December 15, 2011, p. 3, www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_59.pdf.

9. See Peter R. Orszag, "Too Much of a Good Thing: Why We Need Less Democracy," *New Republic*, September 14, 2011, http://www.tnr.com/article/politics/magazine/94940/peter-orszag-democracy, discussed further below in notes 74, 99, and 106–108.

10. Timothy S. Jost, "The Independent Medicare Advisory Board," *Yale Journal of Health Policy, Law and Ethics* 11, no. 1 (2011): 21–31.

11. Orszag, "Medicare Spending Slows as Hospitals Improve Care."

12. The Secretary of Health and Human Services, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration will "serve ex officio as nonvoting members of the Board." H.R. 3590 (as modified by H.R. 4872) §3403 (42 U.S.C. § 1395kkk(g)(1)(A)(i) and (ii) (2010)).

13. 42 U.S.C. § 1395kkk(g)(2).

14. Jennifer Haberkorn, "The Independent Payment Advisory Board," Health Affairs/Robert Wood Johnson Foundation Health Policy Brief no. 59, December 15, 2011, p. 2, www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_59.pdf.

15. 42 U.S.C. § 1395kkk(m).

16. Such agencies include the Sentencing Commission, the Federal Communications Commission, the Equal Employment Opportunity Commission, the Federal Elections Commission, the Federal Trade Commission, the Securities and Exchange Commission, the Commodities Futures Trading Commission, the International Trade Commission, and the National Transportation Safety Board.

17. Christopher M. Davis and Henry B. Hogue, "Independent Payment Advisory Board Membership: The President's Recess Appointment and Removal Authorities," Congressional Research Service Memorandum, March 18, 2011, http://coburn.senate.gov/public//index.cfm?a=Files. Serve&File_id=3fc9e198-fe6c-4fb2-9777-88c69ff72356.

18. See, for example, Jonathan Turley, "Is the Cordray Recess Appointment Constitutional?" *JonathanTurley.org* (blog), January 6, 2012, http://jonathanturley.org/2012/01/06/is-the-cordray-recess-appointment-constitutional/. ("I like [Richard] Cordray, but circumventing the Constitution is no solution to a political stalemate.")

19. 42 U.S.C. § 1395kkk(h).

20. 42 U.S.C. § 1395kkk(c)(2)(A)(v) and 42 U.S.C. § 1395kkk(c)(3)(B)(iv).

21. 42 U.S.C. § 1395kkk(c)(5).

22. 42 U.S.C. § 1395kkk(b)(1)(3); (c)(1)(A) and (c) (2)(A)(vi); (d)(1)(A), (B), (C), (D); and (e)(1) and (3).

23. 42 U.S.C. § 1395kkk (c)(3)(A)(ii).

24. H.R. 3590 (as modified by H.R. 4872) § 3403 (42 U.S.C. § 1395kkk(c)(2)(A)(i) (2010)). Emphasis added.

25. Others have erroneously reported that the savings target is a ceiling rather than a floor. See, for example, Jennifer Haberkorn, "The Independent Payment Advisory Board," Health Affairs/ Robert Wood Johnson Foundation Health Policy Brief no. 59, December 15, 2011, p. 3, www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_59.pdf.

26. Chapin White and Paul B. Ginsburg, "Slower Growth in Medicare Spending—Is This the New Normal?" *New England Journal of Medicine* 366 12 (2012): 1073–75, http://www.nejmorg/doi/full/10.1056/NEJMp1201853.

27. Nancy-Ann DeParle, "The Facts about the Independent Payment Advisory Board," White House Blog, April 20, 2011, http://www.whitehouse.gov/blog/2011/04/20/facts-about-independent-payment-advisory-board; and Douglas W. Elmendorf, Director, Congressional Budget Office, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*, testimony before the Subcommittee on Health, House Committee on Energy and Commerce, 112th Cong., 1st Sess., March 30, 2011, p. 26, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf.

28. As required by PPACA, this CBO projection makes unreasonable assumptions about future Medicare spending on physician services. The Act provides that if the current-law formula for calculating Medicare's physician payments (the so-called "sustainable growth rate" or SGR formula) would yield a cut in those payments, then for purposes of determining whether IPAB must issue a proposal the chief Medicare actuary should assume no change in Medicare payments to physicians. See 42 U.S.C. § 1395kkk(c)(6)(B)(ii)(I). As it has for the past decade, the SGR formula currently mandates sizeable cuts to physician payments. Yet Congress typically replaces such cuts with increases in physician payments. See Centers for Medicare and Medicaid Services, Office of the Actuary, "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2012," November 2011, Table 6, p. 8, https://www.cms.gov/SustainableGRatesConFact/Downloads/sgr2012fpdf. The required assumption of zero increases is thus unrealistic.

More importantly, the IPAB "trigger" also requires the chief Medicare actuary to incorporate unreasonable assumptions about Medicare payments to hospitals and other facilities. The Act reduces the rate of growth in Medicare payments to such providers to a degree that the CBO diplomatically says "might be difficult to sustain." Congressional Budget Office, *Selected CBO Publications Related to Health Care Legislation, 2009–2010* (Washington, DC: Government Printing Office, December 2010), p. 24, http://cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12033/12-23-selectedhealthcarepublications.pdf. Medicare's chief actuary likewise says those payment levels "may be unrealistic" because pressure from Medicare patients and providers will likely force Congress to increase them in the future. Centers for Medicare and Medicaid Services, Office of the Actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, p. 9, https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf. Yet the Act requires the Medicare actuary to use those unrealistically low spending levels when making its determination of whether IPAB must issue a "proposal."

29. Congressional Budget Office, *CBO's 2011 Long-term Budget Outlook*, June 2011, p. 38, http://cbo.gov/sites/default/files/cbofiles/attachments/06-21-Long-Term_Budget_Outlook.pdf.

30. 42 U.S.C. § 1395kkk(c)(2)(A) and (c)(2)(B).

31. See H.R. 3590 (as modified by H.R. 4872) § 3403 (42 U.S.C. § 1395kkk(c)(2)(A) (2010)).

32. H.R. 3590 (as modified by H.R. 4872) § 3403 (42 U.S.C. § 1395kkk(c) (1)(A) and (2)(C) (2010)).

33. Centers for Medicare and Medicaid Services, Office of the Actuary, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," May 13, 2011, pp. 6–8, https://www.cms.gov/ReportsTrustFunds/downloads/2011TRAlternativeScenario.pdf.

34. Ibid., p. 9.

35. Centers for Medicare and Medicaid Services, Office of the Actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended."

36. 42 U.S.C. § 1395kkk(c)(2)(A).

37. See, for example, Robert A. Levy and William Mellor, *The Dirty Dozen: How Twelve Supreme Court Cases Radically Expanded Government and Eroded Freedom* (New York: Sentinel, 2008). "*Chevron U.S.A., Inc. v. Natural Resources Defense Council* [is] a 1984 case in which the Court established a two-part test for reviewing agency interpretation of statutes. First, the court determines whether Congress has spoken directly to the question at issue. If so, the court adopts the express provisions of the statute. But if the statute is 'silent or ambiguous,' as is frequently the case, then the court examines whether the agency's regulations are 'based on a

permissible construction of the statute.' In practice, the *Chevron* test has been highly deferential; the vast majority of agency interpretations have been deemed 'permissible.'" (Internal citations omitted.)

38. If anything, Congress's ability to enact a substitute proposal would *encourage* IPAB to propose tax increases. The Independent Payment Advisory Board members would know that they could force Congress to enact alternative tax increases or other measures that would achieve the same budgetary result.

39. DeParle, "The Facts about the Independent Payment Advisory Board."

40. See, generally, 42 U.S.C. §1395kkk(c)(2)(B) (i-vii) and (n).

41. H.R. 3590 (as modified by H.R. 4872) § 3403 (42 U.S.C. § 1395kkk (c)(2)(B), (n), (o)(1), and (2) (2010)).

42. 42 U.S.C. § 1395kkk(n)(1).

43. 42 U.S.C. § 1395kkk(n)(1)(E).

44. 42 U.S.C. § 1395kkk(c)(2)(B)(vii).

45. 42 U.S.C. § 1395kkk(o)(1).

46. 42 U.S.C. § 1395 (o)(A)-(E).

47. 42 U.S.C. § 1395kkk(d)(2)(C).

48. 42 U.S.C. § 1395kkk(c)(2)(A)(vii). Section 1395kkk(e)(3) states that starting in 2019, the secretary shall not implement an IPAB proposal if the projected growth in national health expenditures exceeds the projected growth in per-enrollee Medicare spending. However, that exception cannot apply in two consecutive years.

49. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 952 (2010).

50. Timothy S. Jost, "The Independent Medicare Advisory Board," *Yale Journal of Health Policy, Law and Ethics* 11, no. 1 (2011): 21–31.

51. Peter R. Orszag, "Obama's Budget Director: Powerful Rationing Panel (Not Doctors) Will Control Health Care Levels," Video of Remarks at the Economic Club of Washington, D.C., 1:53, Breitbart.tv, April 26, 2010, http://www.breitbart.tv/obamas-budget-director-powerful-rationing-panel-not-doctors-will-control-health-care-levels/.

52. Peter R. Orszag, "How Health Care Can Save or Sink America," *Foreign Affairs*, July/August 2011, http://www.foreignaffairs.com/articles/67918/peter-r-orszag/how-health-care-can-save-or-sink-america. Emphasis added.

53. Orszag, "Obama's Budget Director: Powerful Rationing Panel (Not Doctors) Will Control Health Care Levels."

54. 42 U.S.C. §1395kkk(e)(1).

55. Administrative rulemaking requirements apply, for example, to all agencies listed in note 11. The Act permits but does not require IPAB follow rulemaking procedures. "The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable . . ." 42 U.S.C. § 1395kkk(h)(i)(1).

56. 5 U.S.C. § 552.

57. 42 U.S.C. §1395 (h)(i)(1). Likewise, the Act permits, but does not require, the Secretary to engage in "interim final rulemaking" when implementing IPAB recommendations. See 42 U.S.C. § 1395kkk(e)(2)(B).

58. 42 U.S.C. § 1395kkk(c)(4).

59. U.S. Const. art. I (article 2), § 3.

60. See Barack Obama, "Statement on Signing the Omnibus Appropriations Act, 2009," March 11, 2009, http://www.gpo.gov/fdsys/pkg/PPP-2009-book1/pdf/PPP-2009-book1-Doc-pg216.pdf; see also, William J. Clinton, "Statement on Signing the Oceans Act of 2000," August 7, 2000, http://www.gpo.gov/fdsys/pkg/WCPD-2000-08-14/pdf/WCPD-2000-08-14-Pg1805.pdf ("The Recommendations Clause . . . protects the President's authority to formulate and present his own recommendations [to Congress]."). President Clinton construed the statute so as not to extend to proposals or responses that he did not wish to present.

61. H.R. 3590 (as modified by H.R. 4872) § 3403 (42 U.S.C. § 1395kkk(d)(3) (2010)).

62. H.R. 3590 (as modified by H.R. 4872) § 3403 (42 U.S.C. § 1395kkk(d)(3)(C), (D), (E) (2010)).

63. 42 U.S.C. § 1395kkk (e)(3)(A)(i).

64. The relevant language is:

> "(3) EXCEPTIONS.
>
> "(A) IN GENERAL.—The Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or the President to Congress pursuant to this section if—
>
> "(i) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: 'This Act supercedes [sic] the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act.'; and
>
> "(ii) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

42 U.S.C. § 1395kkk (e)(3)(A). The first exception derives from clause (i) and applies only through the year 2020. The second exception emerges from the interaction of clauses (i) and (ii). The key term is the "and" that joins the two clauses. Both conditions must hold for the second exception to relieve the Secretary of her duty to implement an IPAB proposal issued in 2020 or thereafter.

65. 42 U.S.C. § 1395kkk (e)(3)(B).

66. H.R. 3590 (as modified by H.R. 4872) § 3403 (42 U.S.C. § 1395kkk(e)(1) (2010)).

67. 42 U.S.C. §1395kkk(e)(5).

68. H.R. 3590 (as modified by H.R. 4872) § 3403 (42 U.S.C. § 1395kkk(f) (2010)); but see, due to an apparent scrivener's error, § 1395kkk(f)(1) should cross-reference subsection (e)(3)(A), not (e)(3)(B).

69. 42 U.S.C. § 1395kkk(e)(3)(A).

70. *Nick Coons et al. v. Timothy Geithner et al.*, Motion to dismiss, CV-10-1714-PHX-GMS, at 45, (D. Ariz. May 31, 2011), http://aca-litigation.wikispaces.com/file/view/U.S.+motion+to+dismiss+%2805.31.11%29.pdf Emphasis in original.

71. 42 U.S.C. § 1395kkk (f).

72. Several IPAB provisions are designated "fast track." See 42 U.S.C. § 1395kkk (d)(3)(A)-(E) and (d)(4)(A)-(F).

73. 10 U.S.C. § 2687.

74. 5 U.S.C. §§ 801–808.

75. See *Dalton v. Specter*, 511 U.S. 462, 464–465 (1994).

76. Ibid.

77. Ibid.

78. Peter R. Orszag, "Too Much of a Good Thing."

79. 42 U.S.C. § 1395kkk (e)(3).

80. U.S. Const. art. I, § 1.

81. *Currin v. Wallace*, 306 U.S. 1, 15 (1939).

82. *Loving*, 517 U.S. 748, 758–59 (1996).

83. *Mistretta v. United States*, 488 U.S. 361, 415 (1989) (Scalia, J. dissenting).

84. *Whitman v. Am. Trucking Ass'ns, Inc.*, 531 U.S. 457, 475 (2001).

85. *J. W. Hampton v. United States*, 276 U.S. 394, 409 (1928).

86. See *Bowsher v. Synar*, 478 U.S. 714, 720 (1986).

87. *Hampton*, 276 U.S. at 405.

88. *Mistretta*, 488 U.S. at 393–94. See also *United States v. Lopez*, 938 F.2d 1293, 1297 (D.C. Cir. 1991) (the lack of judicial review in the Sentencing Reform Act was offset by "ample provision for review of the guidelines by the Congress and the public" and, thus, "no additional review of the guidelines as a whole is either necessary or desirable"); Sentencing Act, 28 U.S.C. § 994(p).

89. *Mistretta*, 488 U.S. at 422.

90. *Loving v. United States*, 517 U.S. at 756.

91. *Bond v. United States*, 2011 WL 2369334 *8 (June 16, 2011).

92. Thomas Jefferson, *Notes on the State of Virginia* (Boston, MA: Wells and Lilly, 1829), p. 126, http://books.google.com/books?id=Nbw9AAAAYAAJ&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false.

93. *Manigault v. Springs*, 199 U.S. 473, 487 (1905); see also *Street v. United States*, 133 U.S. 299, 300 (1890) (holding that an act of Congress "could not have . . . any effect on the power of a subsequent Congress"); and *Reichelderfer v. Quinn*, 287 U.S. 315, 318 (1932) (stating that "the will of a particular Congress . . . does not impose itself upon those to follow in succeeding years").

94. "The Congress, whenever two thirds of both Houses shall deem it necessary, shall propose Amendments to this Constitution, or, on the Application of the Legislatures of two thirds of the several States, shall call a Convention for proposing Amendments, which, in either Case, shall be valid to all Intents and Purposes, as Part of this Constitution, when ratified by the Legislatures of three fourths of the several States, or by Conventions in three fourths thereof, as the one or the other Mode of Ratification may be proposed by the Congress; Provided that no Amendment which may be made prior to the Year One thousand eight hundred and eight shall in any Manner affect the first and fourth Clauses in the Ninth Section of the first Article; and that no State, without its Consent, shall be deprived of its equal Suffrage in the Senate." U.S. Const. art. V.

95. *Marbury v. Madison*, 5 U.S. 137, 177 (1803).

96. Charles L. Black, Jr., "Amending the Constitution: A Letter to a Congressman," *Faculty Scholarship Series*, Paper 2597, December 1972, http://digitalcommons.law.yale.edu/fss_papers/2597.

97. *Nick Coons et al. v. Timothy Geithner et al*., Motion to dismiss.

98. F. A. Hayek, *The Road to Serfdom*, 50th Anniversary Edition (Chicago: University of Chicago Press, 1994), pp. 69–70. This dynamic obviously holds whether government attempts to direct the entire economy or just one-sixth of it.

99. Peter R. Orszag, "Medicare Spending Slows as Hospitals Improve Care." Compare with Hayek's "taken out of politics" quote, above.

100. Hayek, *The Road to Serfdom*, pp. 74, 75.

101. Ibid., p. 75. It is a myth that Hayek claimed government planning of the economy inevitably leads to dictatorship (see pp. 3, 6): "Nor am I arguing that these developments are inevitable. If they were, there would be no point in writing this."

102. Ibid., pp. 69–79. Hayek clarified that the government intervention in the economy is dangerous not because it threatens democracy *per se*, but the freedoms that democracy exists to protect: "The fashionable concentration on democracy as the main value threatened is not without danger. It is largely responsible for the misleading and unfounded belief that, so long as the ultimate source of power is the will of the majority, the power cannot be arbitrary . . . Democratic control *may* prevent power from becoming arbitrary, but it does not do so by its mere existence. If democracy resolves on a task which necessarily involves the use of power which cannot be guided by fixed rules, it must become arbitrary power." Hayek, p. 79.

103. 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. 179.

104. Ibid., pp. 107, 108, 115, 134–36.

105. Harold Pollack, "The Real Problem with the Independent Payment Advisory Board," *Tapped* (The American Prospect blog), April 23, 2011, http://prospect.org/csnc/blogs/tapped_archive?month=04&year=2011&base_name=the_real_problem_with_the_inde.

106. Orszag, "Too Much of a Good Thing: Why We Need Less Democracy."

107. Ibid.

108. Ibid.

109. J. B. Frank, "Perdue Jokes about Suspending Congressional Elections for Two Years," *Charlotte News-Observer* (blog), September 27, 2011, http://projects.newsobserver.com/under_the_dome/perdue_suggests_suspending_congressional_elections_for_two_years_was_sh "The comment—which came during a discussion of the economy—perked more than a few ears. It's unclear whether Perdue, a Democrat, is serious—but her tone was level and she asked others to support her on the idea." A Perdue spokesman said the

governor was using "hyperbole." Emphasis added.

110. Even a prominent left-wing blog took issue with this "breathtaking" and "blatantly unconstitutional" proposal: "it's a dangerous precedent to set to suggest we simply suspend democracy every time unemployment goes above 9 percent." Marie Diamond, "North Carolina Governor Proposes Ignoring Constitution And Suspending Congressional Elections For Two Years," *Think Progress Justice* (blog), September 27, 2011, http://thinkprogress.org/justice/2011/09/27/330060/north-carolina-governor-proposes-ignoring-constitution-and-suspending-congressional-elections-for-two-years/.

111. U.S. Office of Management and Budget, "Living within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction," September 2011, pp. 39–40, http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommittereport.pdf.

112. See Goldwater Institute, "*Coons v. Geithner* (Federal Health Care Lawsuit)," goldwaterinsti tute.org, August 12, 2010, http://goldwaterinstitute.org/article/coons-v-geithner-federal-healthcare-lawsuit.

113. See, for example, Jennifer Haberkorn, "Democrats Split on Independent Payment Advisory Board," *Politico*, July 10, 2011, http://www.politico.com/news/stories/0711/58655.html. And see the *U.S Library of Congress: Thomas*, "Bill Summary & Status, 112th Congress (2011–2012), H.R.452, Cosponsors," 2012, http://thomas.loc.gov/cgi-bin/bdquery/z?d112:HR00452:@@@P.

114. United States House of Representatives, Office of the Clerk, "Final Vote Results for Roll Call 126," March 22, 2012, http://clerk.house.gov/evs/2012/roll126.xml. United States House of Representatives, Office of the Clerk, "Final Vote Results For Roll Call 14," January 19, 2011, http://clerk.house.gov/evs/2011/roll014.xml; *U.S. Library of Congress: Thomas*, "Bill Summary and Status, 112th Congress.

Chapter 44

Can We Stop Calling Them "Consumer Protections" Now?

by Michael F. Cannon

Supporters of the health law are lamenting how the nickname "ObamaCare" has achieved wider purchase than the law's official title. More egregious, though, is how supporters have successfully misbranded ObamaCare's health insurance regulations as "consumer protections."

In anticipation of the (now-postponed) House vote to repeal ObamaCare, for example, three Obama cabinet officials last week warned House Speaker John Boehner, R-Ohio, about the consequences of eliminating the law's "consumer protections."

Major media outlets routinely play along. The *New York Times* reports, "Many of the law's consumer protections take effect [January 1]. Health plans generally must allow adult children up to age 26 to stay on their parents' policies and cannot charge co-payments for preventive services or impose a lifetime limit on benefits.

Other "consumer protections" already in place limit the percentage of revenues insurers can spend on administrative expenses and prohibit them from turning away children with pre-existing conditions.

Who could object to such rules? As it happens, an awful lot of people.

These supposed consumer protections are hurting millions of Americans by increasing the cost of insurance, increasing the cost of hiring and driving insurers out of business.

At the same time Secretary of Health and Human Services Kathleen Sebelius was threatening to bankrupt insurers who claim ObamaCare is increasing premiums by more than 1 percent, her own employees estimated that one of the law's regulations—the requirement to purchase unlimited annual coverage—will increase some people's premiums by 7 percent or more when fully implemented. A Connecticut insurer estimated that just the provisions taking effect last year would increase some premiums by 20–30 percent.

Such mandates force consumers to divert income from food, housing, and education to pay for the additional coverage. That can leave consumers worse off, even threaten their health. They can also force employers to reduce hiring, leaving some Americans with neither a job nor health insurance. This reality led McDonald's to seek a waiver from the unlimited annual coverage mandate, among other rules.

The ban on discriminating against children with pre-existing conditions has caused insurers to stop selling child-only policies in dozens of states. The dependent-coverage mandate was cited as one of the reasons spurring a Service Employees International Union local in New York City to eliminate coverage for 6,000 dependent children.

In 2008, Congress passed a similar mandate that supporters said would expand coverage for mental-health and substance-abuse services. Instead, that mandate spurred the Screen Actors Guild to eliminate mental-health coverage for 12,000 of its lower-paid members. It had the same effect on 3,500 members of the Chicago's Plumbers Welfare Fund, and 2,200 employees of Woodman's Food Market in Wisconsin.

Other employers are curtailing access to mental-health services thanks to this mandate, and some insurers have stopped selling such coverage altogether.

The list goes on. ObamaCare now forces insurers to spend no more than 20 percent of revenues—15 percent for large employers—on administrative expenses. Similar state laws have done nothing to slow the growth of premiums.

ObamaCare's rule spurred Principal Financial Group to stop selling health insurance before it even took effect, leaving nearly 1 million consumers to find new coverage and threatening their continuity of care. Experts expect more consumers to suffer the same fate. This supposed consumer protection also punishes efforts to reduce fraud and improve quality by reviewing claims. Thus, in addition to increasing premiums, it may expose patients to unnecessary and even harmful services.

Consumers, insurers, employers, unions and state officials are begging for protection from these so-called protections. Sebelius has so far issued 222 waivers, which raises the question: if these were really consumer protections, why waive them?

These rules may end up helping somebody, and that should count in the law's favor.

Yet rules that were supposed to protect children have stripped sick kids of their health insurance and made it harder for parents to find coverage for kids who may soon fall ill. Other rules have reduced wages and discouraged hiring amid high unemployment. Just as the mental-health mandate is ousting vulnerable patients from their rehab or therapy and cutting off their meds, ObamaCare's voluminous mandates are threatening even more Americans' access to care.

Calling these rules "consumer protections" implies that the people harmed don't matter, or one has clairvoyance to know that the benefits outweigh the costs.

ObamaCare supporters should call these supposed consumer protections what they are: regulations that can hurt even more than they help.

*This article appeared on **Kaiser Health News.org** on January 10, 2011.*

Chapter 45

BCBSNC's Premium Refunds Show the Perils of ObamaCare

by Michael F. Cannon

Some of the worst news for President Barack Obama's beleaguered health care law comes from North Carolina. Yet the law's supporters are treating it like good news.

When President Obama signed his health care overhaul into law in March, he said it would "lower costs for families and for businesses" and that "children who have a pre-existing condition will finally be able to purchase the coverage they need." Much has already been made of the fact that ObamaCare is instead triggering premiums hikes as high as 30 percent and causing insurers to flee the market for child-only coverage.

But BlueCross BlueShield of North Carolina's announcement that it will refund $156 million to policyholders shows that ObamaCare is replacing badly needed consumer protections with price controls that imperil access to care for the seriously ill.

Market competition long ago generated a consumer protection called a renewal guarantee: if you get sick, your premiums rise at the same rate as the healthy people in your pool. To deliver that protection, insurers collect extra money from healthy policyholders up front to cover the future medical bills of those who become seriously ill. That $156 million is the money BCBSNC collected to pay the future medical bills of its policyholders.

In 2014, however, ObamaCare will eliminate BCBSNC's "guaranteed renewable" plans. The law will also require insurers to charge everyone in a given age group the same premium, regardless of risk.

Since BCBSNC now only needs enough to cover their sick policyholders for three more years, they refunded policyholders an average of $725. Secretary of Health and Human Services Kathleen Sebelius praised the refunds as evidence of ObamaCare's benevolence.

Sebelius has it entirely backward. Guaranteed renewability protects consumers by enabling insurers to profit from covering the sick. ObamaCare is replacing that protection with government price controls that will reduce access to care for the seriously ill by turning the sick into a losing proposition for insurers.

Here's how. Suppose that, within a given age group, healthy people cost $5,000 to insure, while the seriously ill cost $25,000. When ObamaCare's price controls force insurers to charge everyone the same premium (say, $10,000), insurers will compete to enroll healthy people (profit: $5,000) and avoid the sick (loss: $15,000).

If they don't flee the market entirely—which is already happening in the market for child-only coverage—insurers will keep seriously ill patients away by providing lousy access to care.

BCBSNC's refunds show that ObamaCare is leaving seriously ill patients with less protection, not more. Health insurance was hardly perfect before ObamaCare, but BCBSNC's policyholders had insurance that had pre-funded many of their future medical bills.

Now, ObamaCare has effectively transferred those reserves from the sick to the healthy.

Seriously ill policyholders now have less protection against BCBSNC reneging on its commitments to them. Competition used to discourage skimping; ObamaCare rewards it.

This article appeared in **The Charlotte Observer** *on October 6, 2010.*

Chapter 46

Why ObamaCare Won't Help the Sick

by Michael F. Cannon

The *Financial Times* published my letter to the editor [$]:

Sir, "Imminent 'ObamaCare' ruling poses challenge for Republicans" [$] (May 25) doesn't quite capture my views when it reports that I believe "resurrecting protections for patients with pre-existing conditions would be wrong." ObamaCare is wrong precisely because those provisions will *not* protect patients with pre-existing conditions.

Those "protections" are nothing more than government price controls that force carriers to sell insurance to the sick at a premium far below the cost of the claims they incur. As a result, whichever carrier attracts the most sick patients goes out of business. The ensuing race to the bottom will even harm sick Americans who currently have secure coverage.

The debate over ObamaCare is not between people who care and people who don't care. It is between people who know how to help the sick, and those who don't.

This article appeared on June 4, 2012 on Cato@Liberty.org.

OBAMACARE'S THREAT TO FREEDOM OF SPEECH, CONSCIENCE, RELIGION . . .

Chapter 47

A 'Soviet-Style Power-Grab,' to Squelch Bad Press for ObamaCare

by Michael F. Cannon

The Department of Health and Human Services has released new guidelines on communications between department employees and the media. The guidelines evidently require all communications to be approved by the Assistant Secretary for Public Affairs. Also: no off-the-record communications.

The media are not happy. The editor of FDA Webview & FDA Review writes (via Poynter; more here):

> The new formal HHS Guidelines on the Provision of Information to the News Media represent, to this 36-year veteran of reporting FDA news, a Soviet-style power-grab. By requiring all HHS employees to arrange their information-sharing with news media through their agency press office, HHS has formalized a creeping information-control mechanism that informally began during the Clinton Administration and was accelerated by the Bush and Obama administrations. The U.S. now takes a large step toward joining other information-controlling countries like my native Australia, where government employees who talk with the news media without permission commit a federal crime. I came to the U.S. in 1974 to escape this oppression.

The HHS guidelines once again show that the purpose of a public information office is not to disseminate information to the public but to withhold information from the public.

Since this came on the heels of an HHS official announcing that the agency is scuttling ObamaCare's long-term care entitlement, a.k.a. the "CLASS Act," one wonders if there is a connection. Or maybe HHS is just motivated by a general fear that the more the public learns about ObamaCare, the less we will like it.

(**Update:** Turns out, HHS released their new guidelines the same day that agency official voiced his opinion about the future of the CLASS Act. HT: Chris Jacobs.)

This article appeared on September 27, 2011 on Cato@Liberty.org.

Chapter 48

ObamaCare Is Not Pro-Choice—for Anyone

by Michael F. Cannon

This is a health care bill, not an abortion bill," says President Obama. *Au contraire, mon frère.*

Whatever your views on abortion, the fight over abortion in the Obama health plan illustrates perfectly why government should stay out of health care.

When the government subsidizes health care, anything you do with that money becomes the voters' business. And rather than allow for choice between different ways of doing things, the government typically imposes the preferences of the majority—or sometimes, a vocal minority—on everybody.

On Saturday, the House of Representatives passed their version of President Obama's health care overhaul. Among other things, the legislation would subsidize private health insurance for millions of Americans.

To appease pro-life Democrats, Speaker Nancy Pelosi (D-Calif.) allowed them to insert an amendment to prohibit taxpayer dollars from touching any health insurance plan that covers abortion. House Majority Whip Jim Clyburn (D-S.C.) says the bill would have come up 10 votes short without it.

The amendment incensed pro-choice Democrats. The bill's subsidies would be so pervasive that prohibiting the use of taxpayer dollars for abortion coverage would restrict access to such coverage even for women who don't use the subsidies. Rep. Diana DeGette (Colo.) says she and 40 other pro-choice Democrats "are not going to let this into law."

Democratic leaders are searching for a compromise, but there is no way to split the baby here. Either the government will force taxpayers to fund abortions, or the restrictions necessary to prevent taxpayer funding will reduce access to abortion coverage. There is no middle ground. Somebody has to lose. Welcome to government-run health care.

The same thing happens, in all areas of health care, whenever government foots the bill. Do you think chiropractic is nonsense? Too bad, the government forces you to pay for it through Medicare.

Faith healing seem like quackery too you? Sorry, Charlie. Medicare and Medicaid force you to pay for faith healers at prices "comparable with those of real health care providers," according to law professors David Hyman and Charles Silver.

The problem extends far beyond those trivial examples. The government uses price and exchange controls to pay health care providers. We call those controls Medicare's "fee-for-service payment system" in polite company. Yet the effects are anything but genteel.

Researchers believe Medicare's exchange controls encourage unnecessary services, which account for at least one third of its $430 billion budget, according to the Dartmouth Atlas. Those controls actually penalize doctors and hospitals that coordinate care, use electronic medical records, or try to reduce the estimated 100,000 annual deaths due to medical errors. Congress has "reformed" Medicare's exchange controls approximately once in the program's 43-year history, with a "payment system" that encourages an estimated $12 billion of avoidable hospitalizations per year.

President Obama's economic advisor Larry Summers sums it up: "Price and exchange controls inevitably create harmful economic distortions. Both the distortions and the economic damage get worse with time."

Should grandma want to escape Medicare's price and exchange controls—if she would rather see a doctor that operates under less-perverse financial incentives—too bad. If she would prefer a smaller network of doctors that provides safer, more convenient, coordinated care, she's out of luck. The choice of what kind of medicine she receives belongs to the majority, or a vocal minority.

To be fair, the Medicare Advantage program allows some seniors to escape the traditional Medicare program's price and exchange controls. But Medicare Advantage has its own perversities, thanks to a separate price-and-exchange-control scheme the government uses to pay participating insurers. And in keeping with the overall hypothesis, Democrats are trying to eliminate Medicare Advantage, anyway.

Pro-choice Democrats want to preserve access to private abortion coverage. Pro-life Democrats want to preserve the right to choose whether to fund abortions. Fair enough. But any vote for government subsidies is a vote against choice.

Get government out of health care, and you'll be able to make choices for yourself. Not before.

*This article appeared on **TownHall.com** on November 13, 2009.*

Chapter 49

The Illiberality of ObamaCare

by Michael F. Cannon

On Friday, President Obama tried to quell the uproar over his ongoing effort to force Catholics (and everyone else) to pay for contraceptives, sterilization, and pharmaceutical abortions. Unfortunately, the non-compromise he floated does not reduce by one penny the amount of money he would force Catholics to spend on those items. Worse, this mandate is just one manifestation of how the president's health care law will grind up the freedom of every American.

Even though the contraceptives mandate exempts parish priests and the Church hierarchy, it still violates Catholics' religious liberty in at least four ways.

First, the mandate fines Catholic institutions like Notre Dame and the Eternal World Television Network that adhere to the Church's teaching that contraception "is an offense against the law of God and of nature, and those who indulge in such are branded with the guilt of a grave sin." In order not to sin against their God, these employers must now pay tribute to Caesar.

Second, it takes away the freedom of Catholics to donate to institutions that uphold their religious views. There is a reason my parents donate to Catholic institutions rather than Planned Parenthood: they don't want to fund contraception. The mandate takes away that choice.

Third, it violates the freedom of Catholic business owners. How is it that the First Amendment protects the religious liberty of the employers who sit on the altar, but not the equally devout employers who sit in the pews?

Fourth, it violates the freedom of Catholic workers by forcing nearly every individual American to purchase contraceptive coverage. How is it that the First Amendment protects a devout Catholic if she works as a secretary for her local parish, but not if she works as a scientist at an environmental consulting firm?

The administration's defense of the mandate—that a majority of self-identified Catholics use contraception and that some Catholic institutions already cover it—likewise has at least four flaws.

First, thank God we don't live in a theocracy that forces those folks to adhere to Church dogma. But why should the government commit the opposite sin of forcing doctrinaire Catholics to violate a religious principle that imposes no harm on others? Second, Catholics are not the only ones who consider contraception sinful. Third, it is nonsense to argue that the percentage of Americans who believe contraception is forbidden by God is small enough that the First Amendment doesn't apply to them; the whole point of the First Amendment is to protect minorities. Devout Catholics are a minority, but they are quite sincere.

Finally, it's not just people who consider contraception sinful that oppose this mandate. That's because the mandate also violates the freedom of those who have non-religious reasons for not wanting to purchase contraceptives, who would rather pay for contraceptives out of pocket, or who want such coverage now but might change their minds in the future.

Rather than respect each individual's freedom to make their own choice, President Obama demands that even those who will never need contraception—gays, lesbians, the post-menopausal, the celibate, the infertile—must underwrite other people's sex lives.

In his most recent address to Congress, President Obama asked Americans to emulate the military, encouraging us not to "obsess over [our] differences," but to "focus on the mission at hand." The president seeks to achieve universal health insurance coverage by forcing everyone to purchase it. With a populace sharply divided over what health insurance should include, however, that mission becomes an altar for sacrificing individual rights.

President Obama is not the first world leader to call on his people to subordinate their essential diversity and freedom to a military ethos. Even left-wing Catholics like E.J. Dionne and Sen. Bob Casey (D-Pa.) protested the health care law's impact on this one type of liberty. That suggests how illiberal an enterprise universal coverage really is.

This article appeared on **The Huffington Post** *on February 14, 2012.*

Chapter 50

Contraceptives Mandate Brings ObamaCare's Coercive Power into Sharper Focus

by Michael F. Cannon

President Obama is catching some well-earned blowback for his decision to force religious institutions "to pay for health insurance that covers sterilization, contraceptives and abortifacients." You see, ObamaCare penalizes individuals (employers) who don't purchase (offer) a certain minimum package of health insurance coverage. The Obama administration is demanding that coverage must include the aforementioned reproductive care services. The exception for religious institutions that object to such coverage is so narrow that, as one wag put it, not even Jesus would qualify. HHS Secretary Kathleen Sebelius reassures us, "I believe this proposal strikes the appropriate balance between respecting religious freedom and increasing access to important preventive services." Ummm, Madam Secretary . . . the Constitution only mentions one of those things. The Catholic church is hopping mad. Even the reliably left-wing E.J. Dionne is angry, writing that the President "utterly botched" the issue "not once but twice" and "threw his progressive Catholic allies under the bus."

As I wrote over and over as Congress debated ObamaCare, anger and division are inevitable consequences of this law. I recently debated the merits of ObamaCare's individual mandate on the pages of the *Wall Street Journal*. Here's a paragraph that got cut from my essay:

> We can be certain . . . that the mandate will divide the nation. An individual mandate guarantees that the government—not you—will decide what medical services you will purchase, including contraceptives, fertility services that result in the destruction of human embryos, or elective abortions. The same apparatus that can force Americans to subsidize elective abortions can also be used to ban private abortion coverage once the other team wins. The rancor will only grow.

Or as I put it in 2009,

> Either the government will force taxpayers to fund abortions, or the restrictions necessary to prevent taxpayer funding will reduce access to abortion coverage. There is no middle ground. Somebody has to lose. Welcome to government-run health care.

The same is true for contraception. The rancor will grow until we repeal this law.

ObamaCare highlights a choice that religious organizations—such as the United States Conference of Catholic Bishops, where my grandfather served as counsel—have to make. Either they stop casting their lots with Caesar and join the fight to repeal government health care mandates and subsidies, or they forfeit any right to complain when Caesar turns on them. Matthew 26:52.

This article appeared on February 1, 2012 on Cato@Liberty.org.

Chapter 51

Republicans Must Stop Fighting against Birth Control and Battle Government Control Instead

by Michael D. Tanner

With his mandate that all employers, including religiously affiliated institutions such as Catholic hospitals and charities, provide workers with health insurance that covers contraceptives, President Obama handed Republicans a terrific opportunity to talk about the growing intrusiveness of government.

This is, after all, an administration that wants to dictate what foods we eat, what lightbulbs we use, what cars we drive, even how our toilets flush.

Yet Republicans are in the process of fumbling this opportunity away by turning what should be a discussion of government power into an argument about contraception.

For a long time, it was said that Democrats are terrified that somewhere someone is making money, and Republicans are terrified that someone somewhere is having fun. And with this issue—as so often seems the case when the subject turns to sex—Republicans seem determined to prove this stereotype true.

The most obvious case was the suggestion by Foster Friess, the biggest funder of Republican presidential candidate Rick Santorum's super PAC, that the best contraception was for women to put an aspirin between their knees. Friess now suggests that he was joking. Yet Rush Limbaugh and Sean Hannity, among others, have joined in with this line of argument, suggesting that contraception was unnecessary if women just exercised "self-restraint." Running through the Republican outrage over this issue has been a subcurrent that contraceptives are, in Santorum's words, "a license to do things in the sexual realm that is counter to how things are supposed to be."

Setting aside the fact that even married women use contraceptives, why are Republicans using this issue to lecture us on morality?

The problem with the contraceptive mandate is not the contraceptive part—it's the *mandate*. The new health-care law requires every employer with 50 or more employees to provide their workers with health insurance. It also requires every American who doesn't receive health insurance through work or a government program to buy insurance themselves or face a fine.

But simply providing or buying insurance is not enough to fulfill the mandate. The insurance must satisfy the government's definition of what qualifies as proper insurance, including a long list of benefits that the government thinks you should have.

In this case, the benefit we are talking about is contraceptives, and it has sparked particular outrage because it will force religious institutions to pay, even indirectly, for a benefit that they find morally repugnant. But it is hardly the only benefit that the new health-care law mandates. Among other benefits, your policy must now include mental health benefits, drug and alcohol rehabilitation, prescription drugs, dental and vision care for children and a host of other services. You may not want those benefits, and they may make your insurance more expensive, but it is no longer your choice. The government will now

decide for you. Your choice of deductibles and co-payments will also be restricted.

This debate has nothing to do with access to birth control. Contraceptives are legal. There is nothing that prevents any woman who wants contraceptives from purchasing them. Most insurance plans already do so, and when they don't, women can purchase a rider that provides the additional coverage.

This is a debate about forcing all employers to pay for a benefit, rather than having such decisions based on the choices of employers and employees. It doesn't matter whether we are talking about contraceptives, dental care or spa treatments.

This should provide Republicans with an opening to discuss the arrogance of a government that presumes to know better than we do how to run our lives. Yet too many Republicans seem to see this as an opportunity to tell us how they would run our lives instead. Both sides in this debate are contemptuous of our ability to make our own decisions.

Most Americans would prefer that the government simply leave us alone. They do not want the president to be our national employee benefits administrator, nor do they want him to be our preacher-in-chief.

Republicans need to learn the difference.

This article appeared in the **New York Post** *on February 18, 2012.*

Chapter 52

Yes, the IRS Can Use Liens and Incarceration to Enforce ObamaCare's Individual Mandate

by Michael F. Cannon

Here's a poor, unsuccessful letter I sent to the editor of the *Washington Post*:

A recent article ["Could the health-care law work without the individual mandate?", Mar. 28, A8] claims the IRS "will be barred from using . . . collection tools such as placing liens or threatening incarceration" to enforce compliance with the requirement that Americans obtain health insurance. Not so.

Suppose the IRS assesses me a $1,000 penalty for failing to obtain health insurance. It is true that the law prohibits the IRS from using liens or incarceration to collect *that* $1,000. But, money being fungible, the IRS may simply deem my first $1,000 of income-tax withholding to be payment of that penalty. As a result, I would owe an additional $1,000 in *income tax* at the end of the year, and the IRS could come after me with every tool at its disposal, including liens and incarceration.

This article appeared on May 18, 2012 on Cato@Liberty.org.

Chapter 53

Obamacare Can't Be Fixed, and Now Is the Time to Dismantle It

by Michael F. Cannon

At the 2011 Conservative Political Action Conference, Indiana governor Mitch Daniels observed that to turn the United States into a European-style social democracy, the Left "need only play good defense. The federal spending commitments now in place will bring about the leviathan state they have always sought. The healthcare travesty now on the books will engulf private markets and produce a single-payer system or its equivalent, and it won't take long to happen." We even know the drop-dead date: Jan. 1, 2014. That's when Obamacare takes full effect, and it's less than three years away.

On that date, the feds will compel you to purchase health coverage, dictate the content of that health insurance, slap government price controls on it, and begin handing out hundreds of billions of dollars in new entitlement spending. The relatively minor provisions of the law that have taken effect to date are already killing jobs, increasing premiums and taxes, reducing take-home pay, causing private-insurance markets to collapse, and throwing Americans out of their health plans. Yet today's cost increases and other dislocations will look like the good old days compared with what Americans will suffer when—if—they allow Obamacare to take full effect. The nonpartisan Congressional Budget Office projects, for example, that Obamacare will permanently eliminate 800,000 jobs by 2021. That's not to mention any temporary job losses.

Even more ominous: Obamacare is already creating constituencies dedicated to its preservation. For months, the Obama administration has been writing checks to states, seniors, and employers, and trumpeting the implicit subsidies that flow from the law's price controls, all with the goal of protecting Obamacare by making more and more people dependent on it.

Such efforts have so far failed to make the law popular. Polls still show that a majority or plurality of the public opposes the law, as has been the case since the first draft of Obamacare was introduced in Congress in June 2009. The latest Rasmussen poll finds that 84 percent of Republicans and 59 percent of independents favor repeal. Not even the $250 checks that the legislation is sending seniors have won them over: The latest Kaiser Family Foundation poll shows that their opposition is now higher than at any point since enactment (59 percent).

That will change if Obamacare is still on the books in 2014. Tens of millions of Americans will begin to receive thousands of dollars each in government subsidies, whether through an expanded Medicaid program or Obamacare's new health insurance "exchanges." Medicare's chief actuary predicts that these state-based exchanges will slowly crowd out other private coverage (such as through employers) until "essentially all" Americans get their health insurance through them. Just as important, whatever private insurance companies are still standing in 2014 will begin enrolling tens of millions of customers through the same channels. With boots on the ground and deep pockets, these two constituencies will quash any effort to eliminate their new subsidies. Public opinion may even turn in favor of the law—not because

Obamacare works, but because tens of millions of people will be dependent on it for their health insurance.

What this means is that opponents may never have more power to chart Obamacare's course than they do right now. In particular, the decisions that federal and state officials make today could determine whether the 2012 elections produce a Congress and president who are willing to repeal the law. In other words, the iron is hot.

Congressional Republicans appear to grasp the weight of this moment. They are doing everything they can to ensure that Obamacare never sees the year 2014: forcing votes on repealing and de-funding the law, and undertaking a two-year campaign to expose its harmful effects. Unfortunately, their efforts are being undercut by their friends back home.

Rather than beat their plowshares into swords, Obamacare opponents in most state capitols are laying the bureaucratic foundations for the law's new entitlement spending and lending it legitimacy by accepting its debt-financed federal grants. Secretary of Health and Human Services Kathleen Sebelius boasts that 48 states have already accepted at least $1 million each from the federal government to help them plan their exchanges.

It's not just Democrats who have taken the money. Wisconsin governor Scott Walker has won plaudits for staring down government-worker unions and returning a $637,000 Obamacare grant. Yet Walker accepted a $38 million Obamacare grant to help get Wisconsin's exchange up and running. Kansas governor Sam Brownback voted against Obamacare when he was in the U.S. Senate. Yet he has accepted a $32 million Obamacare grant and is allowing his Republican insurance commissioner, Sandy Praeger, to forge ahead with creating a Kansas exchange.

Wisconsin and Kansas are two of the 26 plaintiff states in *Florida v. HHS*, the case in which a federal court ruled that Obamacare is unconstitutional and void. In response to that ruling, Walker's attorney general, J. B. Van Hollen, declared the law "dead" in Wisconsin, a reality no less true in the other plaintiff states. Yet Brownback and Walker accepted their $30 million—plus Obamacare grants *after* the ruling. Some governors, including Idaho Republican Butch Otter, have said that the fact that they are accepting Obamacare grants and holding exchange-planning meetings does not mean they have decided to create an exchange. But taking the money lends legitimacy to a law that Otter himself is suing to overturn as unconstitutional. To date, only two governors—Florida's Rick Scott and Alaska's Sean Parnell, both Republicans—have refused to accept any Obamacare money or create any Obamacare bureaucracies.

While Obamacare takes a beating in Congress, the federal courts, and the court of public opinion, why are so many opponents acting as its agents? Some state officials say they are hedging their bets. "Some legislators think the state version of the exchange is their only option, even if they don't want it," explains Twila Brase, president of the Minnesota based Citizens' Council for Health Freedom. "They think the federal exchange is an absolute certainty and that they'll have more power over it if it's a state-built exchange." But that rationale rests on the false premise that Obamacare can be fixed, or its damage mitigated, if it is implemented the right way.

Obamacare confronts states with a veiled Hobson's choice. The law provides that in 2014, each state will have its own health-insurance exchange where individuals who don't have job-based coverage may purchase a federally regulated and subsidized (but "private") health plan. States that develop and obtain federal approval of an exchange blueprint by 2013 may administer their own exchanges in 2014. In states that choose not to create an exchange, HHS will step in to create and administer one.

The veil is the assurance that states will be able to tailor their exchanges. Sebelius audaciously claims

that Obamacare "is built on the belief that states understand their health-insurance markets better than anyone else. As such, it puts the states in the driver's seat to lead the process." Other supporters have sought to frighten Republican governors into implementing the law by holding out the nightmare scenario of the federal government's administering the exchanges. Who administers the exchanges, however, is unimportant. What counts is who writes the rules that govern them. Those rules will be written entirely in Washington.

Unfortunately, many Republican governors have taken the bait. "We cannot let the insurance exchange default to federal control," says a spokesman for Ohio governor John Kasich, "so we are moving forward with the planning that is required to make the exchange work best for Ohio." A spokesman for Georgia governor Nathan Deal put it more forcefully: "The state cannot halt midstream, because that would be irresponsible. It would put us too far behind if our litigation is not successful in the end." But federal control is not just the exchanges' default setting—it's the only setting.

In a February 24 letter to the nation's governors, Sebelius extolled the four types of flexibility that Obamacare allows states in shaping their exchanges: 1) States can restrict insurers from participating; 2) states can add even more benefit mandates than Obamacare requires; 3) come 2017, states can opt out of Obamacare by creating a single-payer health-care system; and 4) states can adopt their own "governance structure" and "operational philosophy." In sum, states can impose harsher regulations than Obamacare requires and can choose who sits on their exchange's board. That's it. The only additional latitude the Obama administration has offered came when President Obama told the National Governors Association that he is open to letting them launch single-payer systems in 2014 rather than 2017. (Vermont governor Peter Shumlin is champing at the bit.) States already had all these powers, of course, and would continue to possess them if Obamacare were repealed tomorrow. What states need, and Obamacare denies them, is the power to remove the law's harmful regulations, which will block market competition and cost-saving innovations.

Running their own exchanges won't empower states to prevent both the most economical and the most comprehensive health plans from disappearing from their markets. Affordable plans will disappear because Obamacare requires all purchasers to buy whatever coverage Sebelius mandates as "essential," a definition that will grow ever broader, as such definitions always do. The law's price controls will require insurers to charge everyone of a given age the same premium, regardless of whether an actuarially fair premium might be $5,000 or $50,000. Even state-run exchanges would see comprehensive health plans crumble under the weight of too many patients who cost $50,000 but pay far less. Nor can state-run exchanges prevent other dimensions of quality from eroding. Even in state-run exchanges, the sickest patients would struggle to get their claims paid by insurers who are trying to avoid, mistreat, and dump them, because that is what Obamacare's price controls reward.

States that run their own exchanges will likewise be powerless to prevent HHS from loading health-savings-account (HSA) plans down with mandated benefits. They will have no power to save HSAs from Obamacare's "medical-loss ratio" and "minimum actuarial value" requirements, both of which threaten to destroy health savings accounts.

Twenty-one Republican governors recently told Sebelius that she should prepare to administer their states' exchanges unless HHS 1) provides them "complete flexibility" in running their exchanges; 2) waives all of Obamacare's benefit mandates; 3) waives the provisions that threaten HSAs; and 4) gives states "blanket discretion" to move non-disabled Medicaid enrollees into the exchanges. There is zero chance that Sebelius will accede, because she cannot. Granting the first three demands would mean

repealing most of Obamacare's central requirements: the price controls on health insurance, the individual mandate, and the medical-loss-ratio requirements, for starters. That would require an act of Congress. Obamacare vests vast discretionary power in the HHS secretary, but not this much.

And even that act of Congress would not fix Obamacare. The new entitlement spending, in Medicaid and the exchanges, would begin flowing in 2014 as scheduled. The law would still impose an enormous unfunded Medicaid mandate on states. My colleague Jagadeesh Gokhale estimates that new York State would get hit the hardest, being forced to shell out an additional $66 billion over the first ten years. Indeed, the "blanket discretion" these governors seek to move Medicaid enrollees into the exchanges, aside from being a fairly shameless ploy to shift the cost of their Medicaid programs to taxpayers in other states, would entrench Obamacare by making millions of current Medicaid enrollees dependent on the exchange subsidies.

Sebelius's official response to the governors was, effectively, "drop dead." Having received this answer, the 21 governors should stick to their guns and join Scott and Parnell by refusing any additional Obamacare funds, returning the funds they have heretofore received, and declaring that they will not create any Obamacare exchanges. Brase argues that such a move might doom the exchanges because HHS likely cannot create that many without the help of state officials. "The future is uncertain about a federal exchange," she explains. "Why should we do the feds' work when they might never achieve the exchange without our help?"

There is simply no rationale for implementing an exchange that stands up to scrutiny. Some governors have indulged the fantasy that they can create a *better* exchange, one that does not comply with Obamacare. It's an audacious stratagem. But ask yourself: What insurance company will participate in an exchange that flouts federal law? Before you answer, remember that the federal government is some insurance companies' largest customer.

And remember that every new bureaucracy is itself a constituency for more government.

It would be better that states not create exchanges at all. "Anytime you can keep a government from setting up any bureaucracy of any sort," writes Charlie Arlinghaus of New Hampshire's free-market Josiah Bartlett Center for Public Policy, "it is a victory."

There is no good way, or even a less-bad way, for states or the feds to implement Obamacare's exchanges or other central elements. Permitted to stand, Obamacare will reduce Americans' incomes, harm their health, and decrease their freedom. The only way to fix it is to demolish it. "Collaboration in setting up exchanges only encourages the corporate interests who will profit from them and sends a signal that 'repeal and replace' is not serious," writes the Pacific Research Institute's John R. Graham. Rather than spend any time, money, or energy creating constituencies for Obamacare, Graham writes, "we have to discourage implementation, totally and immediately."

In *The Bridge on the River Kwai*, the British POW Colonel Nicholson recognizes that his collaboration with his Japanese captors was madness, and gives his life to undo it. State lawmakers need to have a similar epiphany about Obamacare, before things reach the point where correcting their mistakes will cost them their political lives. Unlike soldiers, politicians aren't into self-sacrifice.

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Chapter 54

Should New Hampshire Create a Health Insurance Exchange?

by Michael F. Cannon

Committee on Commerce and Consumer Affairs New Hampshire House of Representatives

Good morning, Chairman Hunt and members of the committee. I am very pleased to be with you today. My name is Michael F. Cannon. I am the director of health policy studies at the Cato Institute, a non-partisan, non-profit educational foundation in Washington, D.C.. The mission of the Cato Institute is to promote the principles of individual liberty, limited government, free markets, and peace.

Background

The most important health policy issue facing New Hampshire is the fate of the health care law that President Barack Obama signed in March of 2010, whose official title is the "Patient Protection and Affordable Care Act." That law is already increasing the cost of health insurance by as much as 30 percent in some cases, and will cause even greater premium increases in the years to come.

When that law takes full effect in 2014, it will set in motion several important changes. Though states are already struggling to pay for their current Medicaid programs, beginning in 2014, this law will add to those burdens with enormous unfunded mandates. The law imposes government price controls on health insurance that will dramatically increase premiums for healthy purchasers. The law's so-called "individual mandate" will increase premiums further and compel nearly all Americans to purchase a nominally private but government-designed health insurance policy. Those who fail to comply will face penalties including fines and/or imprisonment.

Neutral observers and even supporters of the law estimate that due to the law's government price controls and individual mandate alone, premiums for some Americans would more than double. A study performed by Milliman Inc. for the state of Ohio, projects: "In the individual market, a healthy young male (with benefit coverage at the market average actuarial value pre- and post-[PPACA]) may experience a rate increase of between 90 percent and 130 percent . . . In the ESI-small group market, rating changes may result in a premium increase of 150 percent . . . " A study of the law's impact on Wisconsin by MIT economist Jonathan Gruber, a leading defender of the law, projects that premiums for some individuals will rise by 139 percent or more.

Finally, the law envisions health insurance "Exchanges" that would become operational in 2014. These new government bureaucracies would enforce these costly new regulations and distribute hundreds of billions of taxpayer dollars to private health insurance companies, thereby driving up the national debt. The law allows but does not require states to create an Exchange.

To be clear: contrary to what some state officials have claimed, New Hampshire is under no obligation to create a health insurance Exchange. The authors of the health care law knew that such a requirement would be unconstitutional. Instead, the law asks states to do the heavy lifting of creating these bureaucracies, and as a fallback allows the federal government to create an Exchange if a state declines to

do so.

The Health Care Law's Future Is in Doubt

Supporters introduced the first draft of President Obama's health care law in Congress in June 2009, and a bipartisan majority or plurality of the American people have consistently opposed it ever since. A mere 37 percent of the public supports the law. Opposition is highest among likely voters. More than 80 percent of Americans oppose the law's individual mandate; Officials representing 28 states and both political parties have filed suit to overturn the entire law. Multiple federal courts have struck down all or part of the law as unconstitutional. The U.S. Supreme Court will hear oral arguments on the constitutional challenges to the individual mandate and Medicaid mandate in March 2012. Legal experts predict the Court will rule on these challenges the following summer. One of the two major political parties has committed itself to wholesale repeal.

Should New Hampshire Create a Health Insurance Exchange?

Against this backdrop, the most immediate question facing state officials is whether to create a health insurance Exchange. In the remainder of my remarks, I will explain why, whether one opposes or supports this law, the responsible course is not to create an Exchange.

The question of whether or not to create an Exchange is simplest for state officials who have taken the position that the federal health care law is unconstitutional. New Hampshire officials, like state officials nationwide, take an oath to protect not just their own state's Constitution, but also the U.S. Constitution. They are therefore oath-bound to use all lawful means to block laws that they believe violate the U.S. Constitution. The same duty that obliges officials to sue to overturn the health care law also obliges them not to implement it. To implement this health care law, to create an Exchange, is to violate their oath of office.

Whether you support or oppose the law, there are several reasons for New Hampshire legislators not to create an Exchange.

First, you don't have the time. There is not just one Exchange; there are two of them. If you opt to create an Exchange, then among your many responsibilities will be such diverse tasks as the following. You would be responsible for ensuring that carriers do not follow the law's enormous financial incentives to avoid, mistreat, and dump the sick. You would have to run a reinsurance program and a risk-adjustment program. You would have to define and monitor "network adequacy" as well as each insurance carrier's service area. You would have to monitor each carrier's marketing materials. You would have to monitor and enforce carriers' compliance with the law's other anti-discrimination provisions. You would have to fund and monitor the "navigators" the law envisions. You would have to fund the Exchange in 2015 and beyond, perhaps with a premium tax. (Oregon has opted for a premium tax of up to 5 percent.) Then there's all the reporting you would have to do to Washington, the approvals you would have to obtain, and the months and months of waiting for an answer on everything.

Unless New Hampshire's economy and unemployment situation are somehow bucking the national trend, New Hampshire's elected officials have more pressing matters to attend. If you do somehow find that you are not busy enough, at the end of my testimony I suggest some real health care reforms you might advance.

Second, you don't have the money. That's because there is no money. Unless New Hampshire's state budget is likewise bucking the national trend, neither New Hampshire nor the federal government has money to spend on new government bureaucracies. Every dollar that New Hampshire spends on an

Exchange is a dollar it cannot spend on roads, education, or police—or more important, a missed opportunity to spur economic recovery by reducing the tax burden. Any federal grants that New Hampshire has already received, and any additional federal funds it may receive, are adding to the nation's debt burden and bringing the United States closer to a Greek-style debt crisis. The fiscally responsible option, which many states have exercised, is to send that money back to Washington and to refuse any additional funds.

Third, it makes little sense to create a new government bureaucracy today to implement a law that may be repealed or overturned tomorrow.

Fourth, creating an Exchange will leave New Hampshire officials to take the blame when this law begins hurting the state's sickest patients. When the Exchanges open for business, they will be inundated with high-cost patients. The government price controls that the law imposes on health insurance premiums will create massive incentives for insurers to avoid, dump, and mistreat the sick—as carriers have done in every market where governments have imposed these price controls. The law creates several programs whose sole purpose is to protect sick people from the perverse incentives inherent in these price controls. I mention many of these programs above: programs that tax some health plans in order to subsidize others, "network adequacy" rules, requirements that carriers serve a large enough "service area," restrictions on marketing, and other anti-discrimination provisions.

States that create their own Exchanges will be responsible for running these programs and protecting the perverse and harmful incentives the law creates. Let's be clear about what is happening here: the federal government wants you to stop insurers from mistreating the sick, even while the federal government is offering insurers huge financial incentives to do just that. In other words, the federal government is setting you up to take the fall. The programs intended to prevent such misbehavior will inevitably fail, and many of New Hampshire's sickest patients will be hurt and angry. Those patients will not blame the well-meaning price controls that create those perverse incentives. They will blame whoever is running the programs that were supposed to stop the insurers from responding to those incentives. If New Hampshire creates an Exchange, those patients will blame you for not standing up to the insurance companies like you should have. One can already imagine the attack ads, where very sick patients tell your constituents how you don't care about them. If you create an Exchange, you are volunteering to take a bullet for the federal government, and shield federal officials from responsibility for their actions.

The Mirage of State Control

Some Exchange proponents argue that creating an Exchange will give New Hampshire officials more control over New Hampshire's health insurance market. The promise of local control is a mirage.

The law allows the federal government to commandeer any state-run Exchange that falls short of full compliance with federal dictates. An Obama administration missive explains that the new law "authorizes [the federal government] to ensure that States with Exchanges are substantially enforcing the Federal standards . . . and to set up Exchanges in States that elect not to do so *or are not substantially enforcing related provisions* ." (Emphasis added.) Paradoxically, if New Hampshire officials create an Exchange, you will be surrendering control over your health insurance markets because you would be cementing in place a federal takeover.

The fact that an Exchange is state-run does not diminish federal control by one iota. To be clear: there is nothing that a federal Exchange can do that the federal government cannot also force a state-run Exchange to do through regulation. The federal government will heap regulations upon state-run

Exchanges; indeed, it is already imposing greater requirements on them than the law itself does. Creating a state-run Exchange would not prevent a federal takeover of New Hampshire's health insurance markets, it would lend manpower to that effort.

The conservative Heritage Foundation once took the position that states should set up a "defensive" Exchange to preserve a modicum of control over their Medicaid programs. After reading the administration's Exchange regulations and concluding that the federal government will allow state-run Exchanges no such autonomy, Heritage scholars now counsel states to refuse to establish one of the law's Exchanges and to send all related grants back to Washington.

Creating an Exchange Undermines Repeal

Some opponents of the law nevertheless argue for creating an Exchange so that states can be prepared in case the law is not overturned or repealed. Yet creating an Exchange would entrench the law and make it less likely to be repealed or overturned.

- First, creating an Exchange lends a veneer of legitimacy to the law. The Obama administration heralds the creation of each new Exchange as proof that the law is gaining acceptance, and heralds states accepting the federal grants available under the law in the same manner. The administration even cited New Hampshire as one of the states that is making steady progress toward establishing an Exchange.
- Second, declaring the law unconstitutional but then accepting the funding it offers and setting up an Exchange undermines the credibility of state officials seeking to overturn the law and also undermines the lawsuits themselves. One federal judge who overturned the law wrote that the fact that some of the plaintiff states are themselves implementing the law "undercut" their own argument that he should order the federal government to halt implementation.
- Third, to create an Exchange is to create a taxpayer-funded lobbying group dedicated to fighting repeal. An Exchange's employees would owe their power and their paychecks to this law. Naturally, they would aid the fight to preserve the law.
- Fourth, both Congress and the courts are less likely to eliminate actual government bureaucracies that have assembled dedicated constituencies than they are to eliminate theoretical ones. The more disruptive repeal would be, the less likely it becomes.
- Fifth, many knowledgeable observers believe few Exchanges, state or federal, will be operational by 2014. If states like New Hampshire create their own Exchanges, they will begin handing out billions of taxpayer dollars sooner than if the federal government creates them. Creating a state-run Exchange will hasten the day when the private insurance companies who receive those subsidies plow much of the money back into fighting repeal.
- Sixth, and perhaps most important, due to a recently discovered glitch in the statute, the law only authorizes premium subsidies in *state*-run Exchanges. It does not authorize these subsidies in federal Exchanges. Viewed from one perspective, this gives state governments the ability to protect themselves from penalties under the law's "employer mandate." The law imposes fines on large employers if any of their workers obtain subsidized coverage through an Exchange. If a state creates its own Exchange, it will be subject to those penalties. But if the state refuses to establish an Exchange and the federal government does instead, then the federal government will have no authority to penalize states because it will have no authority to distribute those subsidies. Viewed from another perspective, this glitch gives states the collective power to deny the federal government the legal authority to dispense more than a half-trillion dollars in new deficit spending and to expose the

full cost of the law's mandates and government price controls. All that states need do is not set up a health insurance Exchange. If New Hampshire joins other states in refusing to create an Exchange, it can essentially force Congress to reconsider the law. If New Hampshire instead creates an Exchange, it will increase the federal deficit and debt, hide the full cost of the health care law, expose New Hampshire employers to penalties and reduce the likelihood of repeal. (See the attached article for more information.)

The Obama administration is offering financial inducements to states to create Exchanges because the administration knows that every new Exchange helps it shield the law from the American people. For opponents of the law, creating an Exchange is not a hedging-your-bets strategy but a sabotaging-your bets strategy.

A Free-Market Government Bureaucracy?

Some conservatives have recommended that states create "market-friendly" (i.e., non-compliant) Exchanges that offer an "alternative vision" to the law.

There is no conservative rationale for doing so. Former Utah Gov. Jon Huntsman (R) created a health insurance Exchange in 2008. A Utah official overseeing that Exchange says, "Nearly every Exchange function already exists in the private sector." For instance, eHealthInsurance.com already enables one-stop shopping for health insurance. One conservative group advocates government-created Exchanges as a vehicle for enabling workers to purchase their own health plan using tax-free dollars from their employers. Yet workers can already do that under a provision of the federal tax code known as "health reimbursement arrangements," or HRAs. Companies like Minneapolis' Bloom Health are helping employers take advantage of HRAs and giving workers that freedom, without any new government bureaucracies or regulations.

More fundamentally, there is no such thing as a market-friendly government bureaucracy. As Thomas Jefferson explained more than 200 years ago: "The natural progress of things is for liberty to yield, and government to gain ground." Government bureaucracies will always seek more power because that is their nature. Former Massachusetts Gov. Mitt Romney (R) proposed a "market-friendly" health insurance Exchange in 2006. By the time he signed it into law, it had become the very market-unfriendly plan on which Congress modeled the federal law. When Utah politicians saw that health insurance was more expensive inside their Exchange than on the open market, they imposed a series of taxes on consumers outside of the Exchange to prop up the health plans inside it. In the process, Utah unwittingly put in place the infrastructure for a federal Exchange: if Utah's Exchange fails to comply with the health care law in 2014, the federal government will commandeer it or brush it aside.

Whatever is plaguing America's health care sector, a lack of government bureaucracies is not it. There is simply no reason for New Hampshire to create any kind of Exchange.

Conflicts of Interest

Finally, I encourage you to bear in mind that the interests of those asking the legislature to create an Exchange may not line up with the interests of patients. For instance, private insurers' pro-Exchange lobbying efforts may be related to the fact that Exchanges are necessary for them to tap hundreds of billions of dollars in taxpayer subsidies. The consultants who have been criss-crossing the country encouraging states to set up Exchanges are often bidding on the contracts that result. Insurance regulators and state health care officials across the country have urged their governors and legislatures to create an

Exchange, otherwise they would have to watch the federal takeover from the sidelines rather than be an active participant. Unfortunately, a state-run Exchange cannot preserve their influence. Only repeal can do that.

Conclusion

The most responsible course for New Hampshire is to refuse to create an Exchange. Many governors, including Florida's Rick Scott (R), Louisiana's Bobby Jindal (R), Kansas' Sam Brownback (R), Oklahoma's Mary Fallin (R), and Wisconsin's Scott Walker (R) have already done so. New Hampshire should also send back to Washington whatever funds it has received under this law, as these and other states have done. New Hampshire can send that money back with a message that if Congress is looking to cut federal spending, a good place to start would be laws that federal courts have declared unconstitutional.

In the meantime, there are other steps New Hampshire can take to make health insurance and medical care more affordable to consumers.

First, the General Court can permit New Hampshire employers and consumers to purchase health insurance licensed by other states. Wyoming, Maine, and Georgia have already given their residents this freedom. Enabling New Hampshire residents to purchase health insurance across state lines would expand choice and competition, and would reduce premiums by letting consumers avoid unwanted regulatory costs. As important, granting New Hampshire residents this freedom would not require any new government spending or the creation of any new government bureaucracies. Domestic carriers typically object to giving consumers this freedom because they would prefer what they call a "level playing field"—i.e., where government protects them from competition, and leaves New Hampshire residents with fewer choices.

Second, the General Court can make basic medical care more affordable for the poor by broadening the scopes of practice of mid-level clinicians such as nurse practitioners and physician assistants. One promising approach, similar to letting New Hampshire residents purchase health insurance across state lines, is to let clinicians licensed by other states practice in New Hampshire under the terms of their license but subject to New Hampshire's malpractice laws. Reforms such as these would spur the growth of retail clinics and other innovations that bring quality medical care within reach for more low-income New Hampshire residents. At a minimum, New Hampshire should emulate Tennessee and Illinois by allowing clinicians licensed by other states to provide free charitable care to New Hampshire residents under the terms of their license.

Third, the General Court can reduce unnecessary medical malpractice costs by giving patients and doctors the freedom to choose caps on non-economic damages, "loser pays" rules, mandatory binding arbitration, or other liability rules. The obstacle to patients and providers (and insurers) exercising this freedom is that courts will not enforce such contracts. Thus we have a perverse situation where judges can by fiat force patients to "purchase" an unlimited right to sue, or the legislature can by fiat drastically reduce their right to recover, but the patient has no power to voice her preferences. The General Court should instruct New Hampshire judges to enforce contracts that adopt damage caps and other medical malpractice reforms. This approach would make damage caps available to those who want them (read: those who cannot afford medical care otherwise), while respecting the preferences of those who prefer other malpractice liability protections.

Fourth, New Hampshire should apply for a waiver from the health care law's Medicaid expansion that would allow the state to replicate the Oregon Health Insurance Experiment. Instead of expanding

Medicaid to all residents below 138 percent of the federal poverty level as the new law requires, and which one study projects would add 56,000 new recipients to New Hampshire's Medicaid rolls by 2019, the state could randomly assign half of this group to receive Medicaid coverage and the other half not to receive it, and then measure the outcomes of both groups. Such a study could help fill the tremendous gaps in our knowledge about the actual benefits of expanding Medicaid, and whether there are more cost-effective ways of improving the health of low-income households. Along the way, such a waiver would reduce both state and federal spending.

Again, I am very pleased to be with you today, and I look forward to any questions you may have.

This testimony was delivered on February 2, 2012. Video available at Cato@Liberty.

Chapter 55

Will States Lose Medicaid Funds If They Fail to Create an ObamaCare 'Exchange'?

by Michael F. Cannon

In recent weeks, officials from two states have claimed that if they do not set up an ObamaCare health insurance "Exchange," the state will lose federal Medicaid or State Children's Health Insurance Program funds. Idaho Gov. Butch Otter (R), has since walked back that claim. New Hampshire Commissioner of Health and Human Services Nicholas Toumpas has not.

In a January 19 letter to the New Hampshire House of Representatives, Toumpas writes:

> The Patient Protection and Affordable Care Act ("ACA") mandates that states create a virtual health coverage marketplace called an Exchange. To ensure compliance with this federal mandate the law provides that having an Exchange in place by January 1, 2014, is a *condition precedent* to receipt of Medicaid funding commencing in 2014.

I have not heard the Obama administration or any other ObamaCare supporter claim that the law contains such a mandate. I have made inquiries in a handful of states. None of them report that the Obama administration has said that failing to create an Exchange will result in the loss of Medicaid or SCHIP funds. If what Toumpas says is true, it will certainly come as a shock to the 35 states that have not enacted legislation to create an Exchange, including many states that have flat-out refused.

But is it true? Parts of ObamaCare might seem to support Toumpas' claim.

- Section 1311 declares that each state "shall" set up an Exchange.
- The law also imposes conditions on the receipt of federal Medicaid and SCHIP funds, and those provisions do make reference to Exchanges. Section 2101 provides that, with regard to certain children who are not eligible for SCHIP, states receiving federal SCHIP funds "shall establish procedures to ensure that the children are enrolled in a qualified health plan that . . . is offered through an Exchange established by the State under section 1311."
- Section 2201 provides that as a condition of receiving federal Medicaid funds, states "shall establish procedures for" several things, including "ensuring that individuals who apply for but are determined to be ineligible for [Medicaid and SCHIP] are screened for eligibility for enrollment in qualified health plans offered through such an Exchange." The words "such an Exchange" refer to the words "an Exchange established by the State under section 1311," which appear a few lines before.

Thus, sections 2101 and 2201 might seem to require states to establish an Exchange so that the required "procedures" can interface with it. But there are serious problems with that interpretation.

First, the directive that states "shall" create Exchanges does not amend that part of the U.S. code where Congress imposes conditions on Medicaid and SCHIP funds—i.e., the Social Security Act, or

chapter 7 of title 42. It instead appears in chapter 157, which is also where Congress explains that the consequence for failing to create an Exchange is that the federal government will create one.

Second, sections 2101 and 2201 provide, respectively, that states "shall establish procedures to" enroll certain children through a state-run Exchange, and that states "shall establish procedures for" enabling the state's Medicaid-eligibility system to coordinate with a state-run Exchange. One need not diagram those sentences to see that the object of "shall establish" is "procedures," not "Exchange."

Third, ObamaCare does create these "coordination" conditions within the Social Security Act. That fact demonstrates that ObamaCare's authors knew how to make the directive to create an Exchange an explicit condition of receiving Medicaid and SCHIP funds, if that's what they wanted to do.

Fourth, if ObamaCare's authors had intended to condition Medicaid and SCHIP funds on the creation of Exchanges, or if that were a defensible interpretation of the law as written, then one might expect to have heard members of Congress discussing it. One might expect the Obama administration to have informed states of this condition as part of their effort to encourage states to implement the law. I have been paying fairly close attention to this issue. I have seen no evidence of either.

Fifth, the Supreme Court has held that "if Congress desires to condition the States' receipt of federal funds, it must do so unambiguously, enabling the States to exercise their choice knowingly, cognizant of the consequences of their participation." It is simply not credible to argue that ObamaCare unambiguously conditions Medicaid and SCHIP funds on the creation of an Exchange. The law never does so explicitly, and the language and structure of the law militate against the claim that it does so implicitly.

A more reasonable interpretation of these conditions is that states will be in compliance so long as they have the required procedures at the ready—regardless of whether those procedures are coordinating with a state-created Exchange, a federal Exchange, or no Exchange (in the event that neither level of government creates one).

I have no doubt that, had ObamaCare's authors had any inkling that two thirds of states might balk at setting up an Exchange, they would have made it a condition of Medicaid and SCHIP participation. But they didn't foresee the widespread resistance ObamaCare would encounter. When drafting ObamaCare and for some time afterward, they honestly thought, "The more people learn about this bill, the more they [will] like it." Thus they didn't create that requirement.

If Toumpas is the only state or federal official who sees this mandate in the law, that's probably because it isn't there. Just as important, there is no evidence that the Obama administration sees or is enforcing such a requirement. If Toumpas has such evidence, he should furnish it.

Until then, New Hampshire and the other 49 states can be confident that refusing to create an Exchange will not cost them Medicaid or SCHIP funds.

This article was posted on February 6, 2012 on Cato@Liberty.org.

Chapter 56

No Obamacare Exchanges

by Michael F. Cannon

Obamacare had a bad couple of days before the Supreme Court—so bad that President Obama made some ill-considered comments about the Court from which he still hasn't totally backpedaled. Though the oral arguments over the individual mandate and severability were encouraging, we cannot count on the Supremes to kill Obamacare. Opponents must keep fighting it on all fronts.

The most important front right now is to ensure that states do not create the health-insurance exchanges Obamacare needs in order to operate. Refusing to create exchanges is the most powerful thing states can do to take Obamacare down. Think of it as an insurance policy in case the Supreme Court whiffs.

Exchanges are the new government bureaucracies through which millions of Americans will be compelled to purchase Obamacare's overpriced and overregulated health insurance. Through these bureaucracies, insurance companies will receive hundreds of billions of dollars in taxpayer subsidies. Without these bureaucracies, Obamacare cannot work.

Here are just a few reasons why states should refuse to create them.

Jobs. Refusing to create an exchange will block Obamacare from imposing a tax on employers whose health benefits do not meet the federal government's definition of "essential" coverage. That tax can run as high as $3,000 per employee. A state that refuses to create an exchange will spare its employers from that tax, and will therefore enable them to create more jobs.

Religious freedom. In blocking that employer tax, state officials would likewise block Obamacare's effort to force religious employers to provide coverage for services they find immoral— like contraception, pharmaceutical abortions, and sterilization.

The federal debt. Refusing to create exchanges would also reduce the federal debt, because it would prevent the Obama administration from doling out billions of dollars in subsidies to private insurance companies.

The U.S. Constitution. The Obama administration has indicated that it might try to tax employers and hand out those subsidies anyway—even in states that don't create an exchange, and even though neither Obamacare nor any other federal law gives it the power to do so. If that happens, the fact that a state has refused to create an exchange would give every large employer in the state—including the state government itself—the ability to go to court to block the administration's attempt to usurp Congress's legislative powers.

A lower state tax burden. States that opt to create an exchange can expect to pay anywhere from $10 million to $100 million per year to run it. But if states refuse, Obamacare says the federal government must pay to create one. Why should states pay for something that the federal government is giving away?

Bye-bye, Obamacare. That is, if the feds can create an exchange at all. The Obama administration has

admitted it doesn't have the money—and good luck getting any such funding through the GOP-controlled House. Moreover, without state-run exchanges, the feds can't subsidize private insurance companies. That by itself could cause Obamacare to collapse.

Unfortunately, ever since Obamacare became law, lobbyists for the insurance companies and others who would financially benefit from it have been wooing state officials with the false promise that a state-run exchange would preserve state control over health care. If the Supreme Court fails to strike down the entire law, they'll say, "Aw, shucks. Now you have to create an exchange."

Nonsense. Obamacare does not and cannot mandate that states create exchanges. Moreover, state-run exchanges do not preserve local control. They will do Washington's bidding, or else they will be commandeered or swept aside.

Even if we assume the Obama administration figures out a way to impose a federal exchange on states, are there any atrocities a federal exchange might inflict that federal regulations could not require state-run exchanges to inflict? Of course not.

That's why every conservative and free-market group, including the Heritage Foundation and the American Legislative Exchange Council, has advised states to refuse to create an exchange and to send all related grants back to Washington. Florida, Louisiana, Oklahoma, Kansas, and Wisconsin have already done so.

If the Court strikes Obamacare down, state officials who refused to create an exchange will look prescient. If not, they will be positioned to drive a stake through its heart.

This article appeared on **National Review (Online)** *on April 12, 2012.*

Chapter 57

One Executive Order That Could Stop ObamaCare

by Michael F. Cannon

A new memo from the Congressional Research Service explains that the next president cannot simply stop ObamaCare ("PPACA") by executive order:

> [A] president would not appear to be able to issue an executive order halting statutorily required programs or mandatory appropriations for a new grant or other program in PPACA, and there are a variety of different types of these programs. Such an executive order would likely conflict with an explicit congressional mandate and be viewed "incompatible with the express . . . will of Congress" . . . However, there may be instances where PPACA leaves discretion to the Secretary to take actions to implement a mandatory program, and . . . an executive order directing the Secretary to take particular actions may be analyzed as within or beyond the President's powers to provide for the direction of the executive branch.

In other words, the worst elements of ObamaCare—the government price controls it imposes on health insurance, the individual mandate, and the new spending on health-insurance entitlements— are "statutorily required programs" that, say, President Romney cannot repeal or even halt by executive order.

However, there is one executive order that could effectively block ObamaCare, and that lies well within the president's powers.

The Obama administration has issued a proposed IRS rule that would offer "premium assistance" (a hybrid of tax credits and outlays) in health insurance "exchanges" created by the federal government. The only problem is, ObamaCare only authorizes these tax credits and outlays in "an Exchange established by the State." The administration did so because without premium assistance, ObamaCare will collapse, at least in states that do not create their own Exchanges. Yet the executive branch does not have the power to create new tax credits and outlays. Only Congress does. So if the final version of this IRS rule offers premium assistance in federal Exchanges, it will clearly exceed the authority that Congress and the Constitution have delegated to the executive branch.

In that case, the next president could issue an executive order directing the IRS either not to offer premium assistance in federal Exchanges or to rescind this rule and draft a new one that does not. The U.S. Constitution demands that the president "take Care that the Laws be faithfully executed." Such an executive order therefore lies clearly within the president's constitutional powers: it would ensure the faithful execution of the laws by preventing the executive from usurping Congress' legislative powers.

While such an executive order would not repeal ObamaCare, as Jonathan Adler and I explain in this *Wall Street Journal* op-ed, it would "block much of ObamaCare's spending and practically force Congress to reopen the law."

This was posted on November 30, 2011 on Cato@Liberty.org.

SECTION FIVE:

REFORMING HEALTH CARE

Chapter 58

Obama Doesn't Have the Only Prescription for Healthcare Reform

by Michael D. Tanner

Sometime this month, the Supreme Court will issue its ruling on the constitutionality of the Patient Protection and Affordable Care Act (aka ObamaCare). The justices, of course, have many options. They could strike down the law in its entirety or uphold all of it. They could strike down just parts of it, most likely the individual insurance mandate and/or the requirement that states expand their Medicaid programs, while upholding the rest. They could even decide not to decide, ruling that the law is not "ripe" for a challenge until the mandate goes into effect in 2014.

But one thing is certain, no matter how the Court decides: The battle over health care reform is far from over.

If the Court upholds the law or at least major parts of it, Republicans will still seek its repeal legislatively. And, if the Court strikes down large parts of President Obama's signature legislative accomplishment, the administration is unlikely to shrug its shoulders and forget about it.

Most importantly, regardless of the Court's decision, the problems with our health-care system are not going away.

The U.S. health-care system has much to recommend it. We produce most of the research, innovation and technology that improves health care throughout the world. Americans have more choice of physicians and treatments than patients in other countries. And if you are sick, your chances of survival are far better in this country than elsewhere.

But one only has to open their latest insurance bill to see that the cost of health care is still going up. On average, health insurance in New York now costs nearly $6,000 for an individual and $16,000 for a family, more in New York City. Premiums are expected to rise by 8.2% this year, increasing faster than wages.

At the same time, too many Americans remain uninsured. Although the number of uninsured is often exaggerated by critics of the system, approximately 50 million Americans could be without health insurance at any given time, 2.7 million of them in New York.

Even if ObamaCare is fully implemented, as many as 23 million Americans would still lack health insurance by 2020.

What then should we do to reform health care? Here are five ideas:

1. Make health insurance personal and portable

Nothing would do more to fix our health-care system than moving away from a system dominated by employer-provided health insurance and instead making health insurance personal and portable, controlled by the individual rather than government or an employer. There is, after all, no logical reason for an individual to receive health insurance through their job. We don't receive most other types of insurance—auto, homeowners, life—in that way.

Employer-based health insurance is an anomaly that grew out of unique historical circumstances during World War II. Despite the widespread entry of women into the labor force during the war, the shift of men from private employment to the military created a labor shortage. At the same time, wage controls prevented employers from competing for available workers by raising salaries. In an effort to circumvent the regulations and compete for available workers, employers began to offer non-wage benefits, including health insurance.

In 1953, the IRS ruled that employer-provided health insurance was not part of wage compensation for tax purposes. This means that if a worker is paid $40,000, but their employer also provides an insurance policy worth $16,000, the worker pays taxes on just the $40,000 in wages. If, however, instead of providing insurance, the employer gave the worker a $16,000 raise—allowing the worker to purchase his or her own insurance—the worker would have to pay taxes on $66,000, a tax hike of as much as $2,400. This puts workers who buy their own insurance at a significant disadvantage compared to those who receive insurance through work.

Employment-based insurance distorts our health-care system in several ways. Most significantly, it hides much of the true cost of health care to consumers, thereby encouraging over consumption. If workers believe someone else is paying for their health care, they have less incentive to be frugal consumers. People naturally eat more at the all-you-can-eat buffet, than if they have to pay a la carte.

Basing insurance on employment also means that if you lose your job, you are likely to end up uninsured. Worse, once you've lost insurance, it can be hard to get new coverage, especially if you have a pre-existing condition.

Changing from employer to individual insurance requires changing the tax treatment of health insurance. Employer-provided insurance should be treated the same as other compensation for tax purposes: that is, as taxable income. To offset the increased tax, workers should receive a standard deduction, a tax credit, or expanded Health Savings Accounts (HSAs), regardless of whether they receive insurance through their job or purchase it on their own.

As a result of this shift in tax policy, employers would gradually substitute higher wages for insurance, allowing the worker to shop for the insurance policy that most closely matched his or her needs. That insurance would be more likely to be true insurance, protecting the worker against catastrophic risk, while requiring out-of-pocket payment for routine, low-dollar costs, and it would belong to the worker, not the employer, meaning that workers would be able to take it from job to job and would not lose it if they became unemployed.

And, since workers could maintain continuous coverage, the issue of preexisting conditions becomes far less of a problem.

Putting workers in charge of their own insurance would significantly reduce the cost of insurance. A study by Stephen Parente of the University of Minnesota suggests that making this change would increase the number of people with health insurance by 21-27 million, nearly as many as projected under ObamaCare.

2. Increase competition and break up insurance cartels

Putting purchasing power in the hands of consumers is only half of market-based reform. We also need to increase competition in the insurance market. Today, for example, people can't purchase health insurance across state lines. This effectively creates near monopolies in many states with only a handful of insurance companies controlling the vast majority of a state's market. For example, in New York, just two insurers, GHI and Empire Blue Cross, represent 47% of the market. In New Jersey, a single insurer,

Horizon Blue Cross and Blue Shield, controls 43% of the market. And in Connecticut, Wellpoint holds an astounding 55%.

Nationwide, there are more than 1,300 insurance companies, including some 500 nonprofit, cooperative and mutual insurers. Consumers should be able to buy insurance from any of them, forcing insurers to compete on price and service.

And because different states have very different regulations and mandates, costs can vary widely depending on where you live. These regulations are a major reason why New York and New Jersey have some of the nation's highest insurance premiums. But with consumers able to escape those costly regulations by purchasing insurance elsewhere, states would be forced to evaluate whether their regulations offered true value or simply reflected the influence of special interests.

3. Empower non-physician medical professionals

It's not just the insurance industry that needs more competition. Consumers should also have more choice of health-care provider. Nurse practitioners, physician assistants, midwives, naturopaths, chiropractors, and other non-physician medical professionals should have far greater ability to treat patients. This means rethinking medical licensure and "scope of practice" laws, which too often reflect the power of special-interest lobbies intent on preventing competition, rather than protecting public health and safety.

New York, for example, has some of the nation's tightest restrictions on non-physician medical professionals. But there is no evidence that these rules make New Yorkers safer or healthier. On the other hand, it does make health care more expensive. It is time to ease those regulations to permit more competition and choice.

4. Have seniors make their own Medicare decisions

While much of the debate over health-care reform focuses on private health insurance, it is important to remember that half of all health-care spending is done by the federal government. And the 800-pound gorilla of the American health-care system is Medicare.

Medicare was essentially modeled after a 1965 Blue Cross insurance plan, and has not been substantially updated since. It pays doctors on the basis of how much treatment they provide, not on whether that treatment is effective. In fact, if the treatment makes you sicker, and you have to receive additional treatment, the doctor gets paid more. At the same time, physicians are reimbursed at such low rates per procedure that some costs are shifted onto privately insured workers, while physicians are beginning to drop out of the system.

Worse, because of changing demographics, and because most seniors receive far more in Medicare benefits than they pay in Medicare taxes and premiums, the program is threatening to bankrupt the country. Even if one accepts the most optimistic estimates for Medicare's finances, the program faces future shortfalls of more than $56 trillion. Other estimates suggest that the program's unfunded liabilities could actually reach as much as $125 trillion.

The Obama administration's answer is to empower an unelected board, the Independent Payment Advisory Board (IPAB), to further reduce physician payments. This could lead to more physicians refusing to see Medicare patients, and possibly even some hospitals closing. The president would also rely on comparative effectiveness research to weed out ineffective or overly expensive treatments. We've seen some of this recently in recommendations for men to skip prostate screenings, or for women to delay mammograms.

A better answer would be to have the government set a fixed amount per recipient that it is willing to spend on Medicare. Then instead of directly paying hospitals and physicians, the government should turn that money over to the recipients themselves, as a voucher to help them purchase private health insurance. Lower-income seniors and those with higher health-care costs because of illness could receive a bigger subsidy.

Seniors could use these vouchers, combined with whatever they wish to spend of their own money, to choose an insurance plan that has a cost and mix of benefits that best meets their needs. Rather than the government imposing cuts from above or rationing care, seniors could decide for themselves if they wanted to pay for services over and above a minimum set of benefits.

5. Let states experiment with Medicaid

The government's other big health care program is Medicaid. Like Medicare, its costs are exploding, posing serious threats to both the national and state budgets. Medicaid costs New York taxpayers more than $15.9 billion annually. At the same time, the program is notorious for providing poor care. Because reimbursements are so low, nearly a third of primary-care physicians will not accept Medicaid patients, driving recipients to hospital emergency rooms for treatment. In fact, Medicaid patients are more likely to end up in emergency rooms than are those with no insurance at all.

Congress should follow the lead of the successful Clinton-era welfare reform and return funding and responsibility for the program to state governments in the form of a block grant. This would allow states to treat Medicaid like other welfare programs, imposing work requirements, time limits, and tougher eligibility requirements. States could experiment with new delivery and reimbursement models, including subsidizing private insurance for the poor. Finally, a block grant would cap Medicaid spending and end the practice of states leveraging federal funding to expand their programs beyond what they can afford.

The Supreme Court's decision will clearly not be the last word on ObamaCare or health-care reform. As the debate goes forward, it's important to remember that there are alternatives— alternatives based on free-markets and consumer choice.

This article appeared in the New York Post *on June 9, 2012.*

Chapter 59

Innovation Best Alternative to Obamacare

by Michael F. Cannon

There is an alternative to the Obama health plan. It's called innovation.

Economist Glen Whitman and physician Raymond Raad found that, when it comes to basic medical sciences, diagnostics (e.g., MRIs and CT scanners), and therapeutics (e.g., ACE inhibitors and statins), the United States often produces more medical innovations than all other nations combined.

America's health insurance markets are not following suit, despite the ready availability of innovations that can improve the delivery of care, insure the "young invincibles," and provide secure coverage for the sick. Bringing those innovations to consumers requires tearing down regulatory barriers to competition—the very barriers that the Obama plan would stack higher.

Health researchers have long complained of the need for comparative-effectiveness research, health information technologies, coordinated care, and payment systems that better reward quality care.

Innovations that meet those needs are already at hand. Health plans like Kaiser Permanente and Group Health Cooperative are leaders in effectiveness research and health information technologies. Both emphasize cost-effective preventive care, and compete based on the convenience offered by their electronic medical records.

Those successes are the offspring of earlier innovations. Kaiser and Group Health use a payment system called "prepayment," combined with an integrated delivery system, which both enable and reward comparative-effectiveness research, electronic medical records, coordinated care, and prevention.

Yet these innovations lie beyond the reach of most consumers, Stanford health economist Alain Enthoven explains, because our employment-based health insurance system—a creature of the federal tax code—blocks entry by integrated, prepaid health plans.

Reformers also seek to cover millions of "young invincibles"—twentysomethings who decline health insurance because, reformers believe, they think they will never get sick.

While the Obama plan would force young invincibles to purchase health insurance, markets have developed insurance policies that can achieve the same result without coercion. Such policies pay a deferred dividend to customers who end up not filing any claims. The same miscalculation that causes young invincibles to underestimate their need for insurance also causes them to overestimate the probability that they will receive a dividend. Therefore, they insure.

Law professors Tom Baker of the University of Pennsylvania and Peter Siegelman of the University of Connecticut report these innovations are currently available in China, and were quite popular in life-insurance markets in the United States until they were demonized as a form of gambling. Lower barriers to market entry, including clear regulatory guidance about these products' legality, would cover many young invincibles without the need for more government.

Providing secure coverage to patients with high-cost illnesses may be our toughest challenge. The Obama plan tries to address this problem with price controls—i.e., by forcing insurers to charge all

applicants of a given age the same premium, regardless of health status.

Markets long ago responded to consumer demand for protection against premium spikes, explains University of Pennsylvania health economist Mark Pauly, with an innovation that guarantees that those who develop a costly illness can renew their policy at the same premium as the rest of the group.

Many believe such renewal guarantees still leave insurers with incentives to mistreat their sick customers. Competition would solve that problem, too, University of Chicago finance economist John Cochrane explains, by pushing insurers to offer a total-satisfaction guarantee: "If at any time you are dissatisfied with your coverage, we will pay for you to switch to another insurance company at no additional cost to you." (Think about it: wouldn't you buy a health plan that offered that guarantee?)

Guaranteed renewability is a large step toward a total-satisfaction guarantee, and the market is busy making additional strides. Last year, UnitedHealth launched a new product that guarantees customers the option to buy coverage in the future at standard rates, no matter how sick they get in the meantime.

Expanding that guarantee so that customers could choose policies sold by another other insurance company, Cochrane explains, requires reducing barriers to competition—in particular, the very price controls that Democrats hope to expand.

Congress could jump-start these innovations with two reforms: letting individual consumers—elderly and nonelderly—control their health care dollars; and letting them purchase a health insurance plan regulated by the state of their choice.

Piling the regulations higher is a sure-fire way to block these innovations, and even more dramatic innovations that we cannot foresee.

This article appeared on **Orange County Register** *on March 19, 2010.*

Chapter 60

Yes, Mr. President: A Free Market Can Fix Health Care

by Michael F. Cannon

Cato Institute Policy Analysis no. 650 (October 21, 2009)

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 En-thoven 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 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]

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 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-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 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.

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/hlthaff27.3.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.nihcm.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-mgazine.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 d7e64593-297Maternity 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 Health Marts," 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 employer-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&

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 pay-outs, 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 normand 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.

The Tax Treatment of Health Care

by Michael F. Cannon

Cato Handbook for Policymakers, 7th Edition, Chapter 14

14. The Tax Treatment of Health Care

State legislators should

- avoid creating special tax breaks for health insurance and medical care, and
- eliminate existing tax breaks for health insurance and medical care while reducing the overall tax burden.

Congress should

- avoid refundable tax credits and other tax reforms that would create new categories of government spending;
- replace all existing health-related tax breaks with a tax break for "large" health savings accounts; and
- subsequently eliminate all tax breaks and reduce tax rates, by moving to a tax system that is neutral toward medical care and other forms of consumption.

Many presume the U.S. health care sector to be a free market because the private sector plays a greater role in it than in other advanced countries. It is an error, however, to assume that a market is free because it is private. Government can exert as much control over the private sector as the public sector, simply by ordering private individuals and firms to apply their resources toward the government's goals rather than their own. The fact that the U.S. health care sector is more "private" and less "public" than other nations' therefore tells us little

about whether that market is free or unfree. What matters—what determines real as opposed to nominal ownership—is who controls the nation's medical resources.

With Tax Cuts Like This, Who Needs Tax Increases?

One of the most far-reaching and damaging ways that government controls private-sector health care is through tax laws. The federal government exempts certain health-related uses of income from income and payroll taxes. The largest of these tax breaks is the exclusion of employer-sponsored health insurance from income and payroll taxes.

Workers who obtain health insurance through an employer pay no taxes on the "employer contribution" to the premium, and (thanks to Section 125 plans) many workers pay no taxes on the "employee contribution" either. The tax exclusion for employer-sponsored health insurance is the largest tax break in the federal tax code. In 2007, the revenue loss to the federal government was $147 billion, nearly twice the size of the projected loss from the second-largest revenue loser, the mortgage-interest deduction.

On an individual level, a worker's health insurance premiums and marginal tax rate determine the value of the tax break. Both factors vary across workers. In 2007, the average family premium for job-based coverage was roughly $12,000, to which employers "contributed" an average of roughly $9,000. A worker's overall marginal tax rate is determined by summing her marginal payroll tax rate for Social Security and Medicare (which can be as high as 15.3 percentage points), her marginal federal income tax rate (which may climb to 35 percentage points), and her marginal state income tax rate (which may climb as high as 10 percentage points).

Workers who do not obtain health insurance in an employment setting face a concomitant tax *penalty* when purchasing coverage. They must purchase insurance with income that has already been taxed at marginal rates as high as 50 percent. As a result of the tax break for employer-sponsored insurance, consumers who seek to choose their own health insurance plan must often pay twice as much for less coverage. That hefty tax penalty discourages many workers from seeking insurance on the "individual" market.

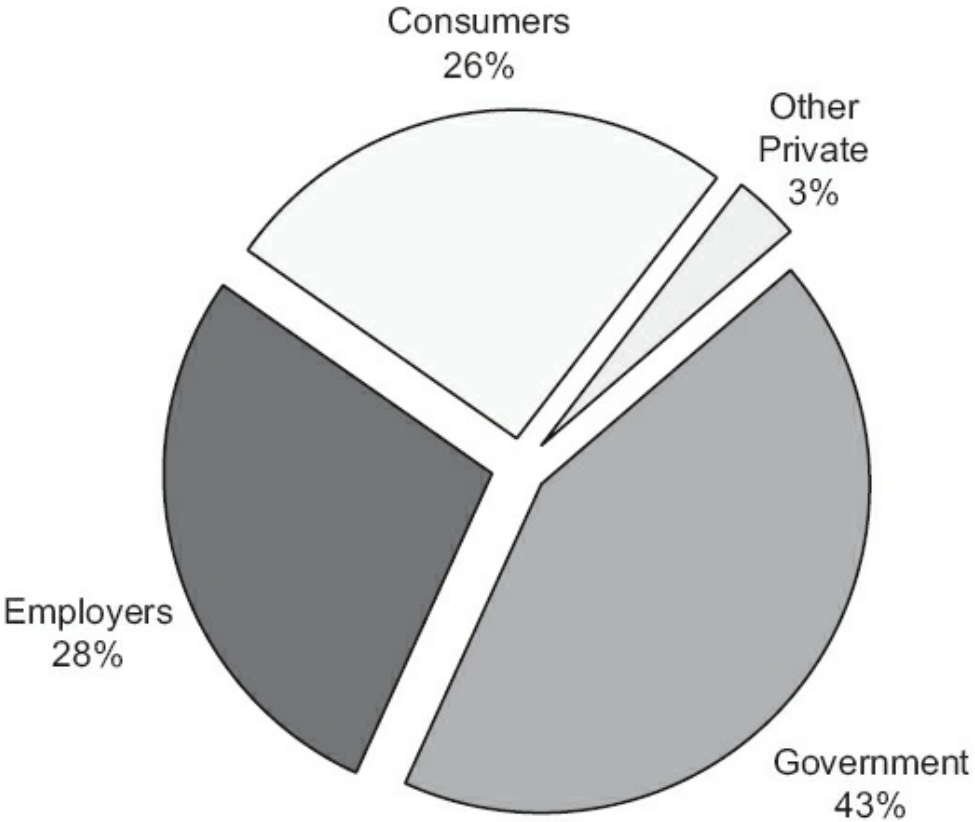
Even for workers with employer-sponsored health insurance, this tax break operates more like a tax increase. A survey by economists Michael Morrisey and John Cawley found that 91 percent of health economists agree that *the money that employers use to purchase health insurance comes out of workers' wages*. In other words, if employers were not providing health benefits to workers, they would have to return that $9,000 to workers in the form of higher cash wages. That implies that, rather than encourage employers or shareholders to spend their own money on workers' health benefits, this tax break instead gives employers control over a significant portion of their workers' earnings. As a result, employers effectively control 28 percent of the $2.5 trillion sloshing around America's health care sector. (See Figure 14.1.) Workers who wish to reclaim that money would probably have to find a different job that offers higher cash wages but no health benefits. (Employers seldom "cash out" workers who decline health benefits.) The workers would then have to pay taxes on that money, handing as much as $4,500 of it over to the government.

If government took $9,000 from workers and used it to provide workers with health

insurance, we would call that a tax increase. Yet when government drives a wedge between workers and $9,000 of their earnings, we rather curiously call it a tax "cut."

The tax exclusion for employer-sponsored health insurance has made a fine mess of private-sector health care. Even though workers pay for their job-based coverage through lower wages, that cost is not salient to them. Workers feel like they are spending someone else's money. They therefore demand more health insurance than they would if they owned and controlled those dollars. The additional coverage they demand in turn insulates workers from the cost of medical care, which encourages workers to consume many low-value services. Duke University professor Christopher Conover estimates that the exclusion thus imposed a deadweight economic loss on U.S. consumers equal to $106 billion in 2002. It no doubt contributes to Dartmouth Medical School professor Elliot Fisher's conclusion that as much as 30 percent of U.S. medical spending may do nothing to improve health.

Figure 14.1
America's $2.5 Trillion Health Care Sector: Who Controls the Money?



SOURCE: Centers for Medicare & Medicaid Services.

The exclusion affects workers negatively. Health insurance premiums persistently rise faster than wages, in part because the exclusion strips workers of any incentive to curb their medical consumption. Rapidly rising health insurance premiums eat into wage increases, but workers have little incentive or ability to do anything about it. When employers try to contain premiums with health plan features that discourage low-value care (such as cost sharing or managed care rules), workers revolt. And why wouldn't they? Stanford 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." The lack of choice hurts, too. Economists Mark Pauly, Allison Percy, and Bradley Herring estimate that reduced choice itself

imposes on workers a welfare loss equal to somewhere between 5 and 10 percent of premiums. Tying health insurance to employment means that losing a job means losing health insurance. That leads to "job lock," a phenomenon where workers would prefer to leave their jobs but feel compelled to stay lest they lose their health coverage. According to Mark Pauly and Robert Lieberthal, tying health insurance to employment also doubles the risk that many workers with high-cost medical conditions will end up uninsured.

The exclusion also inhibits competition from potentially higher-value forms of health insurance and health care delivery. As Pauly and Lieberthal note, coverage purchased on the individual market doesn't automatically disappear when a worker changes or loses a job—a feature that offers considerable security. Yet the tax exclusion penalizes that type of insurance. Enthoven argues that the exclusion holds back prepaid group practices like Kaiser Permanente, which have shown great promise in providing high-value care at a reasonable cost. Though many workers prefer such plans, others do not. Employers that offer just one insurance option therefore tend not to offer a prepaid group plan. At the same time, employers often avoid offering more than one plan due to the higher administrative costs. (See also Chapter 15, "Health Care Regulation.")

Reforming of Health Care via the Tax Code

Ideally, government would offer *no* special tax breaks for health care expenses. The purpose of taxes should be solely to raise revenue for the government. If the government must impose a tax, it should distort individuals' economic decisions as little as possible. Creating special tax breaks for certain types of behavior—thereby imposing concomitant tax penalties on other behaviors—is just one more illegitimate tool for controlling the citizenry. If politicians want to subsidize an item like medical care, they should raise general taxes and spend the resulting revenue on that item.

The ultimate goal of tax-based health care reforms should be to eliminate all tax breaks for health-related uses of income, and to tax medical consumption like any other type of consumption. Consumers should make choices about whether, where, and how much health insurance and medical care to purchase based on their values—not on the values that special-interest groups have wormed into the tax code.

Eliminating tax breaks is problematic both in principle and for political reasons. All else being equal, eliminating a tax break brings more revenue into government coffers. That increases government revenues and undoubtedly encourages mischief. In addition, to remove a tax break is to impose a tax on previously untaxed activity. Eliminating the tax break for employer-sponsored insurance would raise taxes on most U.S. workers by requiring them to pay payroll and income taxes on the value of their health insurance premiums. Workers are therefore likely to resist reforms that merely eliminate health-related tax breaks.

A more sensible approach would eliminate those tax breaks and also reduce payroll and income tax rates to a point where the overall amount of revenue raised remains constant or even falls. That would prevent government budgets from growing. Yet even if government revenues remained constant, some individuals would pay lower taxes, while others would face higher tax burdens. The latter group—typically those with the most expensive employer-sponsored

health benefits—would still resist reform. In the short term, therefore, it appears politically infeasible to eliminate health-related tax breaks completely.

As a preliminary step, Congress should enact tax reforms that (1) reduce tax-based distortions within the health care sector and (2) prepare consumers and the health care sector for a new tax system with no health-related tax breaks.

Congress took a small step in that direction by creating tax-free health savings accounts (HSAs). HSAs are owned by the individual consumer and follow the account holder from job to job. A worker or her employer can make tax-free contributions to the worker's HSA. If the worker uses those funds to purchase medical care, they remain untaxed. Interest earned on the account is likewise tax-free.

HSAs enable workers to own and control a portion of their health care dollars, because HSA contributions receive the same tax status as employer-sponsored insurance premiums. Workers do not have to surrender those earnings to their employer to obtain the tax break. However, HSAs are only available to consumers who obtain a qualified high-deductible health plan that is rigidly defined by Congress. In addition, HSAs enable workers to control only a small portion of their earnings that their employer otherwise would control. The reason is that HSAs only create tax parity for HSA *contributions*. If workers want to purchase their own health insurance, generally they must still pay the premiums with aftertax dollars. HSAs offer small comfort to a worker whose employer doesn't offer them, or who dislikes the one narrow type of health plan that Congress permits HSA holders to obtain.

HSAs do, however, present an opportunity to reform the tax treatment of health care consistent with the two goals mentioned earlier. Congress should take three steps to expand HSAs:

- Increase HSA contribution limits dramatically, say, from $2,850 to $8,000 for individuals and from $5,500 to $16,000 for families;
- Remove the requirement that HSA holders be covered by a qualified high-deductible health plan, or any type of health plan; and
- Allow HSA holders to purchase health insurance, of any type and from any source, tax-free with HSA funds.

Congress should replace all existing health-related tax breaks with one tax break for these new, "large" HSAs. Large HSAs would reduce distortions within the health care sector and allow workers to purchase the health plan of their choice. Moreover, they would give workers more immediate ownership over that $9,000 that their employer currently controls, and would engender less political opposition than other reforms.

How would Large HSAs work? Suppose a worker currently receives family coverage through her employer. The total premium is $12,000 per year, of which the employer pays $9,000 and the worker pays $3,000. Rather than set aside $9,000 for the worker's health benefits, the employer would add that amount to the worker's salary. The worker would decide how much to contribute to her Large HSA. As with employer-paid health premiums today, those contributions would be exempt from both income and payroll taxes. She could then use those Large HSA funds to purchase health insurance, of any type, from her employer or another source, tax-free. She could stay on the company plan, or choose a policy that would

stay with her family when she changes jobs. Her decisions about whether to purchase coverage, where to purchase coverage, what type of coverage to purchase, and whether to pay for medical care out-of-pocket or through insurance would be completely undistorted by the tax code. Unlike today, the worker would *own* every dime she spends on coverage and care, and therefore would seek out health plans and providers who deliver value for the money.

Large HSAs versus Other Proposals

Large HSAs have distinct advantages over other options for reforming the tax treatment of health care, including capping of the exclusion, tax credits (including refundable credits), a standard deduction for health insurance, and full deductibility for all medical spending.

Any reform that achieves tax parity between employer-sponsored health insurance and other forms of insurance (e.g., tax credits, a standard deduction) will cause a certain amount of uncertainty and anxiety. Will healthy workers stay in their employer's health plan? If they leave, will the premiums for the older, sicker workers who remain become unaffordable? Economists agree that if employer plans unravel, employers will return to their workers the money they were spending on health benefits. That will help any workers who are left in the lurch. However, there is also uncertainty about *when* employers will return those funds to workers.

Large HSAs create a very visible moment when employers will be *expected* to add that $9,000 to workers' cash wages—most likely, January 1 of the year that Large HSAs take effect. By ensuring that the shift occurs immediately, and by focusing attention on employers' actions, Large HSAs would do more than other reforms to reduce uncertainty for workers, particularly high-risk workers. Thus, Large HSAs would reduce political opposition to parity in a way that other reforms cannot.

Large HSAs would further mitigate political opposition because fewer workers would face tax increases than would occur under other reforms. Had Congress enacted Large HSAs in 2006, fewer than 3 percent of workers with employment-based coverage would have seen any reduction in the amount of health benefits exempt from income and payroll taxes. And even those workers would have received a tax cut, because they would have gained *ownership* and *control* over the first $8,000 or $16,000 of their health benefits.

Various estimates have shown that tax reform would reduce the number of Americans who lack health insurance. For example, the Congressional Budget Office projects that a standard tax deduction for health insurance would reduce the number of uninsured by nearly 7 million. Although no estimates have yet been made for Large HSAs, they likely would lead to a comparable reduction in the number of the uninsured.

By comparison, other reforms leave much to be desired. Capping the exclusion has for decades been a political nonstarter, and would neither give workers ownership of their health care dollars nor achieve parity between job-based and other forms of insurance. Uniform tax credits would increase taxes on many workers, yet do nothing to encourage employers to cash out their workers quickly. "Refundable tax credit" is merely code for new government spending and would require even greater (i.e., less politically feasible) tax increases. Full deductibility for all medical spending, as advocated by economists John Cogan, Glenn Hubbard, and Daniel

Kessler, would neither give workers ownership nor level the playing field, nor contain the economic distortions due to health-related tax breaks. A standard deduction for health insurance would dramatically reduce the tax code's influence over consumer decisionmaking. Yet even that reform does little to alleviate the uncertainty about what will become of workers' $9,000 when Congress levels the playing field between employment-based and other forms of insurance.

Endgame

Indeed, that uncertainty may be the most significant (if unacknowledged) obstacle to fundamental tax reform. If Congress attempts fundamental tax reform without first giving workers ownership of that $9,000, and giving consumers time to learn how to navigate health insurance markets, opponents will be able to demagogue tax reform to death. To succeed, the demagogues need only frighten a small share of the 180 million Americans with employment-based health insurance.

Large HSAs, however, would allow tax reform to proceed in two steps. First, Large HSAs would give consumers control of the money that employers now spend on their behalf, and would acclimate consumers to making their own health insurance decisions. Consumers are likely to appreciate the option of purchasing health insurance that doesn't disappear when they get sick and lose their jobs. Second, Congress could make the (much smaller) leap to a flat, fair, or national sales tax without having to answer consumers' anxieties about whether they will be able to keep their health insurance, or whether employers will return to workers what's rightly theirs.

Suggested Readings

Cannon, Michael F. "Health Savings Accounts: Do the Critics Have a Point?" Cato Institute Policy Analysis no. 569, May 30, 2006.

_____. "Large Health Savings Accounts: A Step toward Tax Neutrality for Health Care." *Forum for Health Economics & Policy* 11, no. 2 (2008).

Cannon, Michael F., and Michael D. Tanner. *Healthy Competition: What's Holding Back Health Care and How to Free It*. Washington: Cato Institute, 2007.

Cochrane, John. "Time-Consistent Health Insurance." *Journal of Political Economy* 103, no. 3 (1995).

Hyman, David A. "Getting the Haves to Come Out Behind." *Journal of Law & Contemporary Problems* 69, no. 4 (2006).

Kling, Arnold. *Crisis of Abundance: Rethinking How We Pay for Health Care*. Washington: Cato Institute, 2006.

Pauly, Mark V., and Robert D. Lieberthal. "How Risky Is Individual Health Insurance?" *Health Affairs* 27, no. 3 (2008).

Pauly, Mark, Allison Percy, and Bradley Herring. "Individual versus Job-Based Insurance: Weighing the Pros and Cons." *Health Affairs* 18, no. 6 (1999)

—Prepared by Michael F. Cannon

Chapter 62

Health Insurance Regulation

by Michael F. Cannon

Cato Handbook for Policymakers, 7th Edition, Chapter 16

16. Health Insurance Regulation

State legislators should

- eliminate licensing of health insurance or, as a preliminary step, recognize insurance products licensed by other states.

Congress should

- eliminate states' ability to use licensing laws as a barrier to trade with out-of-state insurers, and
- relinquish any role as an insurance regulator.

Every year in the United States, thousands upon thousands of Americans walk or are carried into hospitals. Some are in extreme pain. Some are close to death. Using the tools of modern medicine, doctors routinely heal their pain and save their lives. No less marvelous, however, is the fact that the bill is often paid, voluntarily, *by complete strangers*. These benefactors do not know the patient. They do not know her illness. They may not practice the same religion or speak the same language. Were they to meet the patient, they might not even like her. And yet, without anyone pressuring or forcing them to do so, these people repeatedly purchase lifesaving medical care for complete strangers. Indeed, they play a role every bit as important as the doctors and hospitals. By some marvel, this wonderful phenomenon occurs every day in the United States.

That marvel is health insurance. When individuals choose to purchase health insurance, they make an agreement to pay for the medical expenses of those in the insurance pool who become sick or injured. They uphold that agreement by paying a periodic premium to an insurance

company. To be sure, it is not compassion for others but self-interest that motivates most insurance purchasers: each wants to have her own medical bills paid in the event of a catastrophe. Yet that only makes health insurance all the more marvelous. Health insurance harnesses the self-interest of millions of strangers to produce an unquestionably compassionate result.

As discussed in Chapter 13 ("Medicaid and the State Children's Health Insurance Program"), that sort of generosity invites opportunistic behavior. If the insurance pool is paying for all their medical care, some patients will consume more medical care than they need. (And why not? Those other people in the pool are just strangers.) Likewise, health care providers will try to sell those patients more medical care than they need. If individuals can tap that generosity whenever they choose, many will not contribute to the pool until they become sick. By the time they join the pool, their medical expenses would well exceed their contributions. Before long, the premiums would spiral out of control, and no one would want to participate. For these reasons, members of the insurance pool hire someone to protect the members' generosity from opportunistic behavior.

Health insurance companies are essentially intermediaries between members of the pool. They charge higher premiums to enrollees who purchase more extensive coverage, because those members will draw more money from the pool. They require members to pay part of the cost of their own medical care (through deductibles, coinsurance, and copayments) to ensure that members aren't careless with other members' money. They look over physicians' shoulders (with managed-care tools like capitation payment, preauthorization, and utilization review) to ensure physicians are being careful with their members' money. They also calibrate each new member's premium to her expected claims. If an individual waits until she is sick to join the pool, her premiums will therefore be much higher than if she joined while healthy. Risk-based premiums thus *promote* compassionate behavior, because they encourage individuals to contribute to the pool while they are still healthy—so their premiums can help save the lives of strangers. Once in the pool, however, insurers don't increase members' premiums when they become ill.

Insurers compete to see who can best manage these features, and provide members the protection they desire at the lowest possible premium. That competition is the market's way of navigating the Samaritan's dilemma, discussed in Chapter 13 ("Medicaid and the State Children's Health Insurance Program").

Do Health Insurance Markets Fail?

Critics claim that unregulated insurance markets do not provide secure access to medical care; that risk-based premiums are unfair; that insurance companies drop people when they get sick; that markets will not provide health insurance to everyone; and that government must create pooling arrangements that correct these alleged market failures.

Evaluating the performance of unregulated health insurance markets is complicated by the fact that most Americans obtain health insurance in markets heavily regulated or distorted by government. For example:

- Nearly all seniors obtain health insurance from government through the federal Medicare program (see Chapter 12).
- Due to large tax preferences for employer-sponsored insurance (see Chapter 14, "The Tax Treatment of Health Care"), about 90 percent of nonelderly Americans with health insurance obtain it through an employer.
- Only 10 percent of the nonelderly insured (about 18 million people) obtain insurance directly from an insurance company, i.e., through the "individual" market.

In addition, many states impose significant regulations on their individual health insurance markets. Even if a state does not, administrative costs and premiums in that market will be higher than necessary because government diverts most consumers into the employment-based market.

Researchers examining America's badly hampered individual health insurance markets nevertheless have found considerable evidence that unregulated markets provide consumers with reliable long-term protection from the cost of illness. For example, University of Pennsylvania economist Mark Pauly and colleagues find as follows:

- "Actual premiums paid for individual insurance are much less than proportional to risk, and risk levels have a small effect on obtaining coverage."
- "Premiums do rise with risk, but the increase in premiums is only about 15 percent of the increase in risk. Premiums for individual insurance vary widely, but that variation is not very strongly related to the level of risk."
- "Guaranteed renewable" policies, which are intended to protect against premium increases if the enrollee becomes sick, "appear to be effective in providing protection against reclassification risks in individual health insurance markets."
- The vast majority of insurance products (75 percent) provided guaranteed renewability *before* they were required to do so by government.
- High-cost individuals who are covered by small employers are nearly twice as likely to end up uninsured as high-cost individuals covered in the individual market.
- "On average, guaranteed renewability works in practice as it should in theory and provides a substantial amount of protection against high premiums to those high-risk individuals who bought insurance before their risk levels changed. The implication is that, although there are some anecdotes about individual insurers trying to avoid covering people who become high risk (for example, by canceling coverage for a whole class of purchasers), the data on actual premium-risk relationships strongly suggest that such attempts to limit risk pooling are the exception rather than the rule."

Similarly, RAND economist Susan Marquis and colleagues find that the individual market protects enrollees with expensive conditions and that risk-based premiums are not as harsh as critics imply:

- "Purchasers derive value from having the range of choices that the individual market offers."
- In the individual market, "a large number of people with health problems do obtain

coverage."

- "We also find that there is substantial pooling in the individual market and that it increases over time because people who become sick can continue coverage without new underwriting."
- Regarding enrollees who purchase insurance and later become sick, "in practice they are not placed in a new underwriting class."
- "Our analysis confirms earlier studies' findings that there is considerable risk pooling in the individual market and that high risks are not charged premiums that fully reflect their higher risk."

Recent experience in California shows that insurance companies will sometimes rescind coverage when enrollees provide inaccurate information about preexisting conditions—and perhaps even when enrollees have not done so. California insurers have since reinstated coverage for many enrollees. That episode demonstrates that media scrutiny is an important market mechanism; that government enforcement of insurance contracts can prevent individuals from defrauding strangers and prevent insurers from breaching their contracts; and that both types of consumer protection can spur insurers to change their behavior. All told, free markets provide considerably better health coverage than critics suggest.

Should Markets Provide Universal Coverage?

Critics are correct that markets will not provide health insurance to everyone. Voluntary insurance pools often will not cover medical conditions that are known to exist at the time an individual enrolls.

Health insurance markets are completely justified in not covering preexisting conditions. If they did, few would purchase insurance until they had an expensive medical condition, and the pool would unravel. Thus, there is a very good reason why markets will not deliver universal coverage.

That still leaves a problem. Risk-based premiums will encourage most people to purchase insurance before they become ill. Yet there will always be some people who either did not join a pool while they were still healthy or never had the opportunity because their high-cost condition has been with them since birth.

Assuming they cannot afford medical care, individuals with expensive preexisting conditions require *subsidies*, which is not to say they need *insurance*. Insurance is merely one way—and a very expensive way—of subsidizing preexisting conditions. More than other types of subsidies, insurance resembles a blank check. In general, strangers do not voluntarily give blank checks to other strangers, again with good reason: strangers are difficult to monitor, and the beneficiaries (encouraged by their health care providers) may take more than they need. Other ways of subsidizing the needy include limited amounts of cash, vouchers, or in-kind subsidies from providers, private charities, or government. Compared with the alternatives, the added costs of subsidizing preexisting conditions with insurance outweigh the added benefits.

Exclusions for preexisting conditions do not indicate a lack of compassion by insurance companies or consumers. They are the insurance market's way of telling us that consumers do

not want to subsidize people with preexisting conditions *through insurance*. They do not preclude other options for subsidizing the needy, a topic discussed in Chapter 13 ("Medicaid and the State Children's Health Insurance Program").

State Regulation of "Individual" Health Insurance Markets

As a result of the damage it has sustained from federal and state governments, however, the individual market performs well below its potential. As noted earlier, the federal government diverts the vast majority of insurance purchasers into job-based insurance. Moreover, state governments impose countless regulations on their insurance markets. Those regulations include restrictions on insurance pools' ability to limit or refuse coverage, to vary premiums according to risk, and to negotiate price discounts from providers. States also limit enrollees' freedom to purchase only the coverage they wish. Finally, states prohibit their residents from purchasing insurance from states with more consumer-friendly regulation.

The most disastrous state health insurance regulations are known as "guaranteed issue" and "community rating." Guaranteed issue requires insurers to offer coverage to all comers. Supporters claim that requiring insurers to offer coverage to all individuals will increase access to coverage for those with preexisting conditions. States with guaranteed-issue requirements include Idaho, Maine, Massachusetts, New Jersey, New York, Ohio, Rhode Island, and Vermont. Similarly, 31 states and the federal government restrict, to a lesser extent, insurance pools' ability to deny coverage for preexisting conditions.

Guaranteed issue allows individuals to avoid contributing to an insurance pool until they have a high-cost condition, which is akin to letting drivers who cause an accident purchase retroactive auto insurance. Such laws allow people to take advantage of strangers by removing the insurance pool's ability to protect itself from opportunistic behavior. They leave insurance pools smaller and sicker, which puts upward pressure on premiums.

Despite guaranteed-issue requirements, insurance pools can protect themselves somewhat by charging higher premiums to individuals who wait until they are sick to join the pool. As one might expect, many people with preexisting conditions cannot afford those risk-based premiums. Since the very purpose of guaranteed-issue laws is to give those individuals access to health insurance, many states also limit the extent to which insurance pools can price coverage according to risk. In its purest form, "community rating" requires insurance pools to charge the same premium to all members. States with the strictest community-rating laws include Maine, Massachusetts, New Jersey, New York, North Dakota, Oregon, Vermont, and Washington. Some 10 additional states impose lesser limits on insurance pools' ability to adjust premiums according to new enrollees' age and health status.

Community-rating laws try to force insurance pools to provide greater subsidies to people with preexisting conditions. In effect, community rating forces healthy people to pay higher premiums so that irresponsible people can wait until they are sick to purchase insurance. Put differently, community rating prevents insurers from responsibly managing the relationships between members of the pool. When community rating requires insurers to charge healthy 18-year-olds the same premium as 50-year-olds with multiple chronic conditions, it encourages all parties to behave in ways that are harmful to the pool and to society:

- Individuals with preexisting conditions see their premiums fall, and therefore purchase more coverage. That increases claims made against the pool, which increases the community-rated premium.
- Healthy individuals are essentially asked to subsidize sicker members of the pool, who are generally older and (ironically) have higher incomes. As the healthy members see their premiums rise, many will drop out of the pool, safe in the knowledge that they can always return and pay a community-rated (i.e., average) premium. Their departure makes the pool sicker on average, which further increases the community-rated premium. As that premium rises, additional healthy members drop out of the pool, and the cycle repeats itself. Economists and actuaries call that process an "adverse selection death spiral."
- All individuals find that they can no longer reduce their health insurance premiums by engaging in healthy behaviors or avoiding unhealthy behaviors. Thus, fewer individuals will do so, which reduces health and increases claims and premiums.
- Insurers compete to enroll healthy individuals and avoid the sick. Since all enrollees must pay the same premium regardless of their expected claims, healthy members become a gold mine and sick enrollees become a liability. Insurers therefore market their products with benefits (e.g., gym memberships) and advertising (e.g., featuring healthy-looking families) designed to appeal only to healthy people. They may also make enrollment difficult for sicker people, or curtail services that sick people value, hoping that sicker members will choose another insurer.

Community rating contributes to the large number of uninsured. It is one reason why residents of New York and New Jersey face some of the most expensive health insurance premiums in the nation.

For all the damage they cause, community-rating laws appear to offer little benefit. On the basis of his studies of unregulated markets and markets with community rating, Pauly concludes:

> We find that regulation modestly tempers the (already-small) relationship of premium to risk, and leads to a slight increase in the *relative* probability that high-risk people will obtain individual coverage. However, we also find that the increase in overall premiums from community rating slightly reduces the total number of people buying insurance. All of the effects of regulation are quite small, though. We conjecture that the reason for the minimal impact is that guaranteed renewability already accomplishes a large part of effective risk averaging (without the regulatory burden), so additional regulation has little left to change.

Some 21 states also increase the cost of health insurance with "any-willing-provider" laws. Health insurers frequently negotiate discounts from providers. In exchange, those "preferred" providers receive a greater volume of business as insurers steer enrollees toward them. Any-willing-provider laws, however, require insurers to offer the same payment levels and contract terms to any provider who agrees to those terms. "Any-willing-provider legislation removes the incentive to compete aggressively on a price basis," writes health economist Michael

Morrisey. "No one has an incentive to offer much of a discount since discounts will result only in lower prices with little or no expanded volume," he adds. The result is that enrollees pay more for medical care and health insurance.

All states increase the cost of health insurance by requiring consumers to purchase certain types of coverage, whether or not they want the particular coverage. As a result of these "mandated coverage" laws:

- Teetotalers must purchase coverage for alcoholism treatment (45 states).
- Nonsmokers must purchase coverage for smoking-cessation programs (2 states).
- Nondrug users must purchase coverage for drug-abuse treatment (34 states).
- Many consumers must purchase coverage for services they consider quackery, such as acupuncture (11 states), chiropractic (44 states), and naturopathy (4 states).
- Consumers are required to purchase coverage for services that may be more economical to purchase directly, such as various screening exams (mammograms, 50 states; cervical cancer and/or human papillomavirus, 29 states; colorectal cancer, 28 states; newborn hearing, 17 states; ovarian cancer, 3 states; and prostate cancer, 33 states), as well as uncomplicated deliveries (21 states) and well-child care (31 states).
- Ten states require residents to purchase coverage for hairpieces.
- Many consumers must purchase insurance that covers services or people in relationships that they find morally offensive, such as coverage for contraceptives (31 states), human papillomavirus vaccine (16 states), in vitro fertilization (13 states), and domestic partners (13 states).
- States have also required consumers to purchase coverage for medical treatments that later proved *harmful* to health, such as hormone replacement therapy (2 states) and high-dose chemotherapy with autologous bone marrow transplant for breast cancer (at least 1 state, Minnesota).

Eleven states require consumers to purchase 50 or more types of mandated coverage: California (50), Connecticut (51), Maine (53), Maryland (63), Minnesota (64), Nevada (52), New Mexico (51), New York (55), Texas (54), Virginia (55), and Washington (53). Another dozen states require at least 40 types of mandated coverage. State legislatures have enacted a total of 1,961 mandated coverage laws.

Mandated coverage laws are not sought by broad coalitions of consumers. Legislatures impose these requirements on consumers in response to pressure from special-interest groups, such as chiropractors, acupuncturists, massage therapists (four states), and other providers who want to expand the market for their services. Mandated coverage laws are special-interest legislation that harms consumers by reducing choice and increasing both the cost of health insurance and the number of Americans who cannot afford coverage.

States impose many additional regulations on insurance pools, from premium taxes to rules limiting insurers' ability to manage utilization. The Congressional Budget Office estimates that, on average, state regulations increase the cost of health insurance by 15 percent. Moreover, states prohibit individuals (and employers) from avoiding those laws by purchasing health insurance from states with more consumer-friendly regulations.

The Cure: Force Regulators to Compete

The original sin of health insurance regulation is not guaranteed issue, community rating, any-willing-provider laws, or mandated coverage laws. The original sin of health insurance regulation is insurance-licensing laws. Each state uses insurance-licensing laws to require every insurance policy sold to their residents to comply with all other insurance regulations. Insurance-licensing laws prohibit individual insurance purchasers from joining insurance pools with residents of other states. Put differently, they prohibit residents from purchasing out-of-state insurance products that come with a different set of regulatory protections. As a result, insurance-licensing laws erect barriers to trade between the states and prevent individuals from shopping for regulatory protections the same way they shop for other insurance features. In effect, insurance-licensing laws give each state's insurance regulators a monopoly over providing regulatory protections. Those regulators then behave the way all monopolists do: they provide a low-quality product at an excessively high cost.

The best solution would be for states to repeal insurance-licensing laws. Doing so would eliminate government's ability to use regulation to redistribute income, or to shower rents on favored special interests. Government enforcement of contracts would continue to provide the financial solvency protections and other safeguards that insurance purchasers demand. If that is infeasible politically, preliminary steps could provide nearly as much benefit to consumers.

With an approach known as "regulatory federalism" the federal or state governments would leave most health insurance regulations intact but would allow individuals and employers to purchase health insurance from other states, regulated by that second state. If a purchaser is content with her own state's regulations, she could continue to purchase a policy regulated at home. But if her state imposes too many mandates, or prevents the insurance pool from protecting itself from irresponsible and opportunistic behavior, then the purchaser could choose an insurance plan with more consumer-friendly regulations. A recent study by economist Stephen Parente and colleagues estimated the following:

- Letting individuals and employers purchase health insurance from out of state could reduce the number of uninsured Americans by as many as 17 million, or one-third of the most-cited estimate of the number of uninsured.
- When combined with tax reforms (see Chapter 14), this approach could cover as many as 24 million uninsured Americans.

Regulatory federalism would increase competition in health insurance markets. Insurers would face lower barriers to introducing products into new states. As a result, consumers would have much greater choice among cost-saving features (e.g., cost sharing and care management), provider financial incentives (fee-for-service, prepayment, and combinations thereof), and delivery systems (integrated, nonintegrated, and everything in between). Insurance pools would be more stable, and consumers would have much more freedom to obtain coverage that fits their needs.

Perhaps most important, regulatory federalism would force *insurance regulators* to compete against one another to provide the optimal level of regulation. States that impose unwanted regulatory costs on insurance purchasers would see their residents' business—and their

premium tax revenue—go elsewhere. The desire to retain premium tax revenue would drive states to eliminate unwanted, costly regulations and retain only those regulations that consumers value. It is likely that one or a handful of states would emerge as the dominant regulators in a national marketplace. Regulatory federalism already exists for corporate chartering, where Delaware has created a niche for itself by offering a hospitable regulatory environment.

Many people, of course, will not want greater competition. Insurance regulators enjoy being monopoly providers. They will oppose threats to their monopoly position, even at the cost of harming consumers. The insurance industry will oppose regulatory federalism, which would subject them to greater competition as well. What insurance company wants to have to look over its shoulder to see if someone else might be doing a better job of managing insurance pools? Those are the very competitive pressures that benefit consumers, yet regulators and insurers will paint competition as a *threat* to consumers.

For example, opponents will claim that regulatory federalism will lead to a "race to the bottom," with some states so eager to attract premium tax revenue that they will eliminate all regulatory protections or skimp on enforcement. In reality, both market and political forces would prevent a race to the bottom. As producers of regulatory protections, states are unlikely to attract or retain customers—insurers, employers, or individual purchasers—by offering an inferior product. Purchasers will avoid states whose regulations prove inadequate, and ultimately, so will insurers. Moreover, the first people to be harmed by inadequate regulatory protections will likely be residents of that state, who will demand that their legislators remedy the problem. The resulting level of regulation would *not* be zero regulation. Rather than a race to the bottom, regulatory federalism would spur a race to equilibrium—or multiple equilibria—between too much and too little regulation. That balance would be struck by consumers' revealing their preferences.

Opponents of regulatory federalism will also claim that consumers would have to travel to another state to have those protections enforced. On the contrary, those protections can be enforced in the consumer's state of residence. Not only will state courts enforce other states' laws, when appropriate, but another state's regulations can be incorporated into an insurance contract and enforced in the purchaser's home state. Such "choice-of-law" decisions are complicated and often disputed, but are ultimately controlled by extensively developed legal doctrine and case precedents. Insurance regulators can even play a role in policing and enforcing other states' regulatory protections. There is no reason not to allow consumers to choose where they purchase their health insurance.

There are several options for implementing regulatory federalism. Ideally, each state would unilaterally give its residents the right to purchase insurance from out of state. All a legislature need do is deem as licensed in its state any health insurance policy licensed by any of the other 49 states or the District of Columbia.

States could also give their residents a more limited right to purchase coverage out of state. For example, they could allow residents to purchase insurance from select states, or they could enter into reciprocal compacts with other states. These approaches, however, would be less desirable. They would unnecessarily limit competition among insurers and regulators, as well as limit consumer choice. The latter option would condition each consumer's access to

affordable health insurance on whether the legislature *of another state* is willing to do the right thing. Lowering this trade barrier unilaterally and completely is the more consumer-friendly option.

The best way to eliminate those trade barriers might be for Congress to do so. The Framers intended the United States to be one large free-trade zone. Article I, section 8, of the Constitution grants Congress the power to regulate commerce among the states, largely so that Congress could prevent states from erecting trade barriers that keep out products from other states. Insurance-licensing laws are a clear example of such trade barriers and a perfect target for congressional elimination. As with state-level reform, Congress need not alter any state's health insurance regulations. All that is necessary is for Congress to require each state to recognize the insurance licenses issued by the other states.

The Constitution, however, does not grant Congress the power to regulate health insurance. Thus, in the same legislation, Congress should relinquish any role as an insurance regulator. Were Congress to do otherwise, the federal government itself would soon emerge as a monopoly provider of regulatory protections, and consumers would be even worse off than they are today. Over time, rent-seeking special interests would storm Capitol Hill with demands for additional regulation. Once those federal regulations were enacted, they would be even further removed from the people than state regulations, and much more difficult to dislodge. It is crucial, therefore, that any federal law aimed at regulatory federalism do nothing more than allow consumers to purchase health insurance regulated by another state and ensure that those are the only regulations that govern. If Congress uses the opportunity to regulate health insurance itself, reform will not have been worth the effort.

Suggested Readings

Cannon, Michael F., and Michael D. Tanner. *Healthy Competition: What's Holding Back Health Care and How to Free It.* Washington: Cato Institute, 2007.

Hyman, David A. "The Massachusetts Health Plan: The Good, the Bad, and the Ugly." Cato Institute Policy Analysis no. 595, June 28, 2007.

Cochrane, John. "Time-Consistent Health Insurance." *Journal of Political Economy* 103, no. 3 (1995).

Conover, Christopher J. "Health Care Regulation: A $169 Billion Hidden Tax." Cato Institute Policy Analysis no. 527, October 4, 2004.

Herring, Bradley, and Mark V. Pauly. "Incentive-Compatible Guaranteed Renewable Health Insurance Premiums." *Journal of Health Economics* 25, no. 3 (May 2006).

Epstein, Richard A. "Antidiscrimination Principle in Health Care: Community Rating and Preexisting Conditions." In *American Health Care: Government, Market Processes, and the Public Interest,* edited by Roger Feldman. New Brunswick, NJ: Transaction Publishers, 2000.

Miller, Tom. "A Regulatory Bypass Operation." *Cato Journal* 22, no. 1 (Spring–Summer 2002).

Morrisey, Michael. "State Health Insurance Reform: Protecting the Provider." In *American Health Care: Government, Market Processes, and the Public Interest,* edited by Roger Feldman. New Brunswick, NJ: Transaction Publishers, 2000.

Parente, Stephen T., and others. "Consumer Response to a National Marketplace for

Individual Insurance." Final report, University of Minnesota Carlton School of Management, June 28, 2008.

Pauly, Mark V., and Bradley Herring. *Pooling Health Insurance Risks.* Washington: AEI, 1999.

_____. "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market." *Health Affairs* 26, no. 3 (May–June 2007).

Pauly, Mark V., Allison Percy, and Bradley Herring. "Individual versus Job-Based Health Insurance: Weighing the Pros and Cons." *Health Affairs* 18, no. 6 (November–December 1999).

—Prepared by Michael F. Cannon

Chapter 63

Providing Secure Health Insurance to American Consumers

by Michael F. Cannon

Subcommittee on Domestic Policy Committee on Oversight and Government Reform
United States House of Representatives

Mr. Chairman, members of the subcommittee, thank you for this opportunity to present my perspective on providing secure health insurance to American consumers.

The Marvel of Voluntary Health Insurance Markets

Every year in the United States, thousands upon thousands of Americans walk or are carried into hospitals. Some are in extreme pain. Some are close to death. Using the tools of modern medicine, doctors routinely heal their pain and save their lives.

No less marvelous, however, is the fact that the bill is often paid, voluntarily, by complete strangers. These benefactors do not know the patient. They do not know her illness. They may not practice the same religion or speak the same language. Were they to meet the patient, they might not even like her. And yet, without anyone pressuring or forcing them to do so, these people repeatedly purchase lifesaving medical care for complete strangers. Indeed, they play a role every bit as important as the doctors and hospitals. By some marvel, this wonderful phenomenon occurs every day in the United States.

That marvel is health insurance. When individuals choose to purchase health insurance, they make an agreement to pay for the medical expenses of those in the insurance pool who become sick or injured. They uphold that agreement by paying a periodic premium to an insurance company. To be sure, it is not compassion for others but self-interest that motivates most insurance purchasers: each wants to have her own medical bills paid in the event of a catastrophe. Yet that only makes health insurance all the more marvelous. Health insurance harnesses the self-interest of millions of strangers to produce an unquestionably compassionate result.

Of course, such generosity inevitably invites opportunistic behavior. If the insurance pool paid for all their medical care, some patients would consume more medical care than they need. And why not—those other people in the pool are just strangers. Health care providers could try to sell those patients more medical care than they need. If individuals can tap the pool members' generosity whenever they chose, many would not contribute to the pool until they became sick. By the time they join the pool, their medical expenses would well exceed their contributions. Before long, premiums would spiral out of control, and no one would want to participate. For these reasons, members of the insurance pool hire someone to protect them from opportunistic behavior.

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Insurers compete and innovate to see who can best manage these features, and provide members the protection they desire at the lowest possible premium. That competition is the market's way of navigating what economists call "the Samaritan's dilemma," or the human tendency to take advantage of other people's compassion.[2]

Do Health Insurance Markets Fail?

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- Only 10 percent of the nonelderly insured (about 16 million people) obtain insurance directly from an insurance company, i.e., through the "individual" market.

In addition, many states impose significant regulations on their individual health insurance markets. Even if a state does not, administrative costs and premiums in that market will be higher than necessary because government diverts most consumers into the employment-based market.

Researchers examining America's badly hampered individual health insurance markets nevertheless have found considerable evidence that unregulated markets provide consumers with reliable long-term protection from the cost of illness. For example, University of Pennsylvania economist Mark Pauly and colleagues find:

- "Actual premiums paid for individual insurance are much less than proportional to risk, and risk levels have a small effect on obtaining coverage."[5]
- "Premiums do rise with risk, but the increase in premiums is only about 15 percent of the increase in risk. Premiums for individual insurance vary widely, but that variation is not very strongly related to the level of risk."[6]
- "Guaranteed renewable" policies, which are intended to protect against premium increases if the enrollee becomes sick, "appear to be effective in providing protection against reclassification risks in

individual health insurance markets."[7] The vast majority of insurance products (75 percent) provided guaranteed renewability before they were required to do so by government.[8]

- High-cost individuals who are covered by small employers are nearly twice as likely to end up uninsured as high-cost individuals covered in the individual market.[9]
- "On average, guaranteed renewability works in practice as it should in theory and provides a substantial amount of protection against high premiums to those high-risk individuals who bought insurance before their risk levels changed. The implication is that, although there are some anecdotes about individual insurers trying to avoid covering people who become high risk (for example, by canceling coverage for a whole class of purchasers), the data on actual premium-risk relationships strongly suggest that such attempts to limit risk pooling are the exception rather than the rule."[10]

Similarly, RAND economist Susan Marquis and colleagues find that the individual market protects enrollees with expensive conditions and that risk-based premiums are not as harsh as critics imply:

- "Purchasers derive value from having the range of choices that the individual market offers."[11]
- In the individual market, "a large number of people with health problems do obtain coverage."[12]
- "We also find that there is substantial pooling in the individual market and that it increases over time because people who become sick can continue coverage without new underwriting."[13]
- Regarding enrollees who purchase insurance and later become sick, "in practice they are not placed in a new underwriting class."[14]
- "Our analysis confirms earlier studies' findings that there is considerable risk pooling in the individual market and that high risks are not charged premiums that fully reflect their higher risk."[15]

Recent experience in California shows that insurance companies will sometimes rescind coverage when enrollees provide inaccurate information about pre-existing conditions—and perhaps even when enrollees have not done so. California insurers have since reinstated coverage for many enrollees, often under the threat of breach-of-contract suits. As one California attorney told *The Washington Post*, "These cases are very, very good in front of a jury . . . I wish I could tell you the amount of money they throw at us just to make it go away and keep quiet."[16]

That episode demonstrates that government enforcement of insurance contracts can prevent individuals from defrauding strangers and prevent insurers from breaching their commitments to care for the sick; that media scrutiny is an important market mechanism; and that both types of consumer protection can spur insurers to change their behavior. All told, free markets provide considerably better health coverage than critics suggest.

Should Markets Provide Universal Coverage?

Critics are correct that markets will not provide health insurance to everyone. Voluntary insurance pools often will not cover medical conditions that are known to exist at the time an individual enrolls.

Health insurance markets are completely justified in not covering pre-existing conditions—and it is crucial that government not force them to do so. Were government to force insurers to cover pre-existing conditions, few would purchase insurance until they had an expensive medical condition, and the pool would unravel. Thus, there is a very good reason why markets will not deliver universal coverage.

That still leaves a problem. Risk-based premiums will encourage most people to purchase insurance before they become ill. Yet there will always be some people who either did not join a pool while they were still healthy or never had the opportunity because they are indigent or because their high-cost condition has been with them since birth.

Assuming they cannot afford medical care, individuals with expensive pre-existing conditions require *subsidies*, which is not to say they need *insurance*. Insurance is merely one way—and a very expensive way—of subsidizing pre-existing conditions. More than other types of subsidies, insurance resembles a blank check. In general, strangers do not voluntarily give blank checks to other strangers, again with good reason: strangers are difficult to monitor, and the beneficiaries (encouraged by their health care providers) may take more than they need. Other ways of subsidizing the needy include limited amounts of cash, vouchers, or in-kind subsidies from providers, private charities, or government. Compared with the alternatives, the added costs of subsidizing pre-existing conditions with insurance outweigh the added benefits.

Exclusions for pre-existing conditions do not indicate a lack of compassion by insurance companies or consumers. They are the consumers' way of telling us that consumers do not want to subsidize people with pre-existing conditions *through insurance*. They do not preclude other options for subsidizing the needy, both public and private.[17]

Does Compulsion Improve the Picture?

Introducing compulsion into the mix disrupts the market process and thereby reduces the ability of consumers to meet each others' needs. Congress is currently considering the introduction of three principal forms of compulsion into health insurance markets: imposing price controls on health insurance premiums; making health insurance compulsory for most or all U.S. residents; and compelling taxpayers to fund, at a minimum, the start-up costs of a new government-run health insurance scheme.

Price Controls

Compelling insurers to charge all consumers the same premium is a form of price control. According to National Economic Council chairman Larry Summers, "Price and exchange controls inevitably create harmful economic distortions. Both the distortions and the economic damage get worse with time."[18]

In a free market, insurers innovate and compete to provide high-quality health insurance to everyone at the lowest possible price. If Congress demands that insurers sell $50,000 policies and $5,000 policies for $10,000, however, insurers will compete to attract only those customers that represent a $5,000 profit and to avoid customers that represent a $40,000 loss.

Congress cannot police the thousands of subtle ways that insurers would respond to price controls by courting the healthy and avoiding the sick. Health economist Alain Enthoven notes: "A good way to avoid enrolling diabetics is to have no endocrinologists on staff in the county. A good way to avoid cancer patients is to have a poor oncology department."[19]

Price controls punish insurers who provide quality coverage to the sick. In 2008, an Aetna plan in the price-controlled Federal Employees Health Benefits Program dropped coverage for the 12-hour-a-day nursing care on which spinal muscular dystrophy patients like 11-year-old Shelby Rogers depend. An Aetna spokesman explained the company dropped the benefit because other insurers do not offer it, which caused the $50,000 patients to gravitate to Aetna's plan.[20]

In the end, price controls will eliminate the plans that sick people find most attractive. President

Obama's economic advisor David Cutler finds that the price controls in Harvard University's health insurance exchange reduced choice by eliminating comprehensive insurance.[21]

Compulsory Health Insurance

The $5,000 of profit that insurers would receive from low-cost patients is in fact a $5,000 tax on the healthy. To prevent the healthy from avoiding that tax, President Obama and others propose to make health insurance compulsory for most or all Americans, either through an "individual mandate," an "employer mandate," or both.[22]

The Massachusetts experience demonstrates that at a national level, compulsory health insurance would effectively prohibit low-cost health plans and force tens of millions of already insured Americans to purchase more expensive coverage.

Massachusetts belies the claim that making health insurance compulsory will bring down health care costs. Federal, state, and private-sector health care spending have all increased under compulsory health insurance. Private health insurance premiums are growing 21 percent to 46 percent faster than the national average.[23] A report funded by the BlueCross BlueShield Foundation of Massachusetts indicates that overall public and private spending on health insurance has grown 66 percent faster than it would have otherwise.[24]

In 2009, Massachusetts' compulsory health insurance scheme covered previously uninsured families of four at a cost of at least $20,000, which is 50 percent greater than the nationwide average cost of employer-sponsored family coverage.[25] That estimate should be considered conservative, because it does not include the cost of the additional coverage that Massachusetts requires already insured residents to purchase. It is even more exorbitant considering that 86 percent of uninsured Massachusetts adults were in "good, very good, or excellent" health[26] and therefore should have cost less to insure than the average person.

Summers writes, "If policymakers fail to recognize the costs of mandated benefits because they do not appear in the government budget, then mandated benefit programs could lead to excessive spending on social programs."[27].

Finally, compelling Americans to purchase private insurance would give incumbent insurers a guaranteed customer base and would protect incumbent insurers from competition by standardizing product design.

Government Programs

Congress is also contemplating a new government health insurance program as an option for some or all U.S. residents under the age of 65. For my thoughts on those proposals, I refer the committee to the attached study I recently authored for the Cato Institute.[28]

To the argument I make in that study, I would merely add: It can be difficult to make private insurers to keep their commitments to provide care to the sick. Yet making government honor its commitments to the sick may be more difficult, because government wields the sole, legal, and unilateral power to breach its commitments without compensating those it harms.[29]

Conclusion

Whatever our disagreements about government health insurance programs, however, I hope we can

agree that private insurers do not deserve the sort of massive bailout represented by proposals to make private health insurance compulsory.

Thank you for holding this important hearing. I look forward to discussing with the subcommittee how to provide secure health insurance to American consumers.

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2. See, for example, Michael F. Cannon, "Medicaid and SCHIP," *Cato Handbook for Policymakers*, 7th edition, ch. 13, p. 133, http://www.cato.org/pubs/handbook/hb111/hb111-13.pdf.

3. See Michael F. Cannon, "Medicare," *Cato Handbook for Policymakers*, 7th edition, ch. 12, p. 125, http://www.cato.org/pubs/handbook/hb111/hb111-12.pdf.

4. See Michael F. Cannon, "Large Health Savings Accounts: A Step toward Tax Neutrality for Health Care," Forum for Health Economics & Policy, Vol. 11, issue 2 (Health Care Reform), Article 3 (2008), http://www.bepress.com/fhep/11/2/3/.

5. Mark V. Pauly and Bradley Herring, "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market," *Health Affairs* 26, no. 3 (May/June 2007): 770–79, http://content.healthaffairs.org/cgi/content/abstract/26/3/770.

6. Mark Pauly, Allison Percy, and Bradley Herring, "Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons," *Health Affairs*, vol. 18, no. 6, December 1999, pp. 28–44, http://content.healthaffairs.org/cgi/reprint/18/6/28.pdf.

7. Bradley Herring and Mark V. Pauly, "Incentive-Compatible Guaranteed Renewable Health Insurance Premiums," *Journal of Health Economics*, vol. 25, no. 3, May 2006, pp. 395–417.

8. Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks* (Washington: American Enterprise Institute, 1999), p. 18.

9. Mark V. Pauly and Robert D. Lieberthal, "How Risky Is Individual Health Insurance?" *Health Affairs* Web Exclusive, May 6, 2008, http://content.healthaffairs.org/cgi/reprint/hlthaff27.3.w242v1.pdf.

10. Mark V. Pauly, "How Private Health Insurance Pools Risk," NBER Reporter Research Summary, Summer 2005, http://www.nber.org/reporter/summer05/pauly.html.

11. M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226–w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

12. M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226–w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

13. M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226–w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

14. M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226–w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

15. M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226–w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

16. Karl Vick, "When Your Insurer Says You're No Longer Covered," *Washington Post*, September 8, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/09/07/AR2009090702455.html.

17. See Michael F. Cannon, "Medicaid and SCHIP," *Cato Handbook for Policymakers*, 7th edition, ch. 13, p. 133, http://www.cato.org/pubs/handbook/hb111/hb111-13.pdf.

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

19. Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs* 12, supplemental (1993): 35, http://content.healthaffairs.org/cgi/reprint/12/suppl_1/24.pdf

20. Joe Davidson, "Caught by a Change in Health Care," *The Washington Post*, November 27, 2008, http://www.washingtonpost.com/wp-dyn/content/article/2008/11/26/AR2008112604131.html.

21. See Thomas C. Buchmueller, "Consumer Demand for Health Insurance," *NBER Reporter*, Summer 2006, http://www.nber.org/reporter/summer06/buchmueller.html.

22. In his recent address to Congress on health care reform, President Obama said, "And unless everybody does their part, many of the insurance reforms we seek—especially requiring insurance companies to cover pre-existing conditions—just can't be achieved. That's why under my plan, individuals will be required to carry basic health insurance." Transcript of Obama's Address to Congress, MSNBC.com, September 9, 2009, http://www.msnbc.msn.com/id/32765453/ns/politics-health_care_reform/.

23. Cathy Schoen, Jennifer L. Nicholson, and Sheila D. Rustgi, "Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes," The Commonwealth Fund, August 2009, p. 8, http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2009/Aug/1313_Schoen_paying_the_price_db_v3. and author's calculations.

24. Robert Seifert and Paul Swoboda, "Shared Responsibility: Government, Business, and Individuals: Who Pays What for Health Reform?" Blue Cross Blue Shield of Massachusetts Foundation, March 2009, http://bluecrossfoundation.org/~/media/Files/Policy/Policy%20Publications/090406SharedResponsibilityFINAL.pdf

25. Author's calculations based on Alan G. Raymond, "Massachusetts Health Reform: The Myth of Uncontrolled Costs," Massachusetts Taxpayers Foundation, May 2009, http://www.masstaxpayers.org/files/Healthcare-NT.pdf; personal correspondence with Massachusetts Taxpayers Foundation president Michael J. Widmer, July 20, 2009 (available on request); and Cathy Schoen, Jennifer L. Nicholson, and Sheila D. Rustgi, "Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes," The Commonwealth Fund, August 2009, p. 8, http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2009/Aug/1313_Schoen_paying_the_price_db_v3.

26. Sharon K. Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," *Health Affairs* Web Exclusive, June 3, 2008, p. w281, http://content.healthaffairs.org/cgi/reprint/27/4/w270.pdf

27. Lawrence Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review* 79, no. 2 (May 1989): 177–83, http://www3.amherst.edu/~jwreyes/econ77reading/Summers.pdf

28. See Michael F. Cannon, "Fannie Med? Why a 'Public Option' Is Hazardous to Your Health," Cato Institute Policy Analysis no. 642, July 27, 2009, http://www.cato.org/pubs/pas/pa642.pdf

29. *Flemming v. Nestor*, 363 U.S. 603 (1960). See also U.S. Social Security Administration, "Supreme Court Case: *Flemming vs. Nestor*," http://www.ssa.gov/history/nestor.html. ("There has been a temptation throughout the [Social Security] program's history for some people to suppose that their FICA payroll taxes entitle them to a benefit in a legal, contractual sense . . . Under this reasoning, benefits under Social Security could probably only be increased, never decreased . . . Congress clearly had no such limitation in mind when crafting the law.")

Chapter 64

Health-Status Insurance: How Markets Can Provide Health Security

by John H. Cochrane

Cato Institute Policy Analysis no. 633 (February 18, 2009)

The Problem of Long-Term Insurance

None of us has health insurance, really. Most Americans have coverage through their employer, or the employer of a parent or spouse. But suppose you get cancer, heart disease, HIV, have a stroke, discover a genetic defect, or develop any other long-term expensive health problem—and then lose your job, divorce, outgrow your parents' plan, or your employer or insurer goes out of business. You lose your health coverage. You now have a preexisting condition, and insurance will be enormously expensive—if it's available at all. This happens to real people. A significant and expensive health problem is a common root cause of catastrophic economic descents in the United States. Many people stick with bad jobs or bad marriages just to keep their health insurance.

The lack of secure, long-term, portable health insurance is the greatest single problem with our current health care system. Solving this problem is a central goal of every health care reform proposal from all parts of the political spectrum. There are plenty of other problems with our health sector: the uninsured, hospitals' hotel-minibar pricing policies, poor information, the drudgery of useless paperwork, cost recovery of new medicines, optimal copayment levels, and so on. But all of these are fairly clear problems, each limited in its reach, with fairly clear remedies. The lack of long-term insurance, by contrast, seems a harder nut to crack. And unlike, say, the plight of the uninsured, it is a problem that faces each of us directly.

Free and competitive markets are the best way to spur innovation, provide better service, and reduce costs. So far, however, many people have thought that competition undermines long-term insurance, leading to the extensively regulated market we now face and to proposals for further regulation. Health-status insurance lets us break out of this dilemma. Health-status insurance can give us both completely portable, lifetime health insurance *and* great individual freedom of choice in a deregulated, competitive—and hence—efficient and innovative market.

Unsurprisingly, health-status insurance requires a thoughtful deregulation of insurance markets, starting with an end to the strong tax and regulatory preference for employer-provided group coverage. It does not need a new layer of regulation. The small individual insurance market is already starting to feel its way toward health-status insurance. The deregulatory path will allow this effort to blossom fully.

Health-Status Insurance

Market-based lifetime health insurance has two components: medical insurance and health-status insurance.[1] Medical insurance covers your medical expenses in the current year, minus deductibles and

copayments. Health-status insurance covers the risk that your medical insurance premiums will rise. If you get a long-term condition that moves you into a more expensive medical insurance premium category, health-status insurance pays you a lump sum large enough to cover your higher medical insurance premiums, with no change in out-of-pocket expenses.

Why can't medical insurers just charge everyone the same premium? In a competitive market, medical insurers must charge sick people higher premiums, and charge healthy people lower premiums. If an insurer charged everyone the same price, then a competitor could woo away healthy low-cost customers, and the original insurer would go out of business. Furthermore, the main reason insurance companies refuse coverage, deny coverage for preexisting conditions, or more subtly avoid or mistreat people with long-term expensive conditions, is that they cannot charge those people enough to cover their costs. If medical insurers can charge enough, they will compete for the business of every customer, even the sickest. Freely risk-rated, competitive medical insurance gives everyone access, albeit at a cost. It leaves people vulnerable to the financial risk of large premium increases, but health-status insurance would fill that gap.

The combination of health-status insurance and competitive, freely priced medical insurance solves the central problem of our current health insurance market: the lack of real, long-term, portable health security. With health-status insurance, you can always get medical insurance, no matter if you get sick, change or lose jobs, move, divorce, take some time out of the labor force, or even let your medical insurance lapse. The lump-sum payment from the health-status insurer means you can always pay your medical insurance premiums.

Health-status insurance would also give each of us much greater freedom and choice. No matter how sick you become, you would always be free to change medical insurers. You could always afford the higher premiums a new medical insurer will demand, just as you could afford the higher premiums your current insurer will require. You would not depend on the good treatment of one insurer, the vagaries of one group, the link to one employer, or the bureaucratic decisions of one government-provided plan.

Best of all, when every consumer is free to switch insurers at any time, medical insurance companies will compete for everyone's business. They will compete for the business of expensive, high-risk customers, rather than try to get rid of them or "contain their costs." They can also compete for the business of people who are currently healthy, as such competition will not undermine the implicit cross-subsidy to people with preexisting conditions. Constant competition for every consumer will have the same dramatic effects on cost, quality, and innovation in health care as it does in every other industry.

In sum, health-status insurance can simultaneously give us complete and portable long-term insurance, great individual choice, and cost-containment beyond the dreams of any health policy planner. And, as I show below, it doesn't cost consumers anything. The combined health-status and medical insurance premiums are the same as those of a lifetime individual insurance contract, and the same in present value terms as those of a (hypothetical) successful group or pooling program, even before we factor in cost savings from greater competition.

An Illustration

Suppose that a healthy 25-year-old male will incur $2,000 worth of medical expenses in a year, on average. A competitive medical insurance market will offer him insurance with a $2,000 premium, plus administrative costs and profit.

Suppose that, along with potential short-term illnesses, he has a 1 percent chance of developing a chronic condition that will raise his average medical expenses to $10,000 per year. If he develops this

condition, a competitive medical insurance market will still cover him in following years, but his annual medical insurance premium must rise to $10,000, plus costs and profit. This is a large financial setback.

To be covered over the long term, then, he needs a lump-sum payment large enough to cover $8,000 per year in additional medical insurance premiums. At a 5 percent interest rate, that sum is $148,370.[2] The premium for health-status insurance is 1 percent of that value, $1,483.70, plus administrative costs and profit. In sum, he pays $2,000 for one year of medical insurance, plus $1,483.70 for health-status insurance, for a total of $3,483.70 in out-of-pocket expenses in the first year. Now he is completely covered, for short-term and for chronic medical expenses. If he gets sick, he is also still free to change medical insurers, with no change in out-of-pocket expenses.

This example is simplistic, of course. Bradley Herring and Mark Pauly use data on the incidence of a long list of chronic diseases to provide a realistic estimate of the sum of medical and health-status insurance premiums.[3] Their estimate of annual medical insurance premiums for a low-risk male rises from $800 at age 25 to $3,038 at age 55, while a high-risk male pays $2,300 at age 25 and rises to $10,023 at age 55. Clearly, jumping from the low-risk to the high-risk category implies a large financial penalty. They estimate that the combined medical and health-status premium starts at $1,487 at age 25 and rises to $3,936 at age 55. Subtracting, health-status premiums are $687 at age 25, and rise to $898 at age 55. Total premiums for younger people are lower than for older people, unlike in my example. That fact reassures us that young healthy people, who typically have lower incomes than older people, will not shy away from purchasing insurance.

Health-Status Insurance Accounts

Lump-sum payments from health-status insurers should go into a special "health-status insurance account" that can only be used to pay medical insurance premiums or medical expenses. This contractual requirement solves many problems associated with large lump-sum payments, and it makes health-status insurance less expensive, for three reasons. First, large lump sums are a temptation to fraud—get a fake diagnosis, take the money, and disappear. That's much less tempting if all you can do with the money is buy medical insurance. Second, people who receive a large lump-sum payment may choose to spend it on other things and then show up in the emergency room, unable to pay their bills. It is in both consumers' and insurers' interest to pre-commit against this option. Third, this provision makes it feasible to require that you return the lump sum if your medical insurance premiums decline because you become unexpectedly healthier. In this circumstance, you no longer need the lump sum, so promising its return does not hurt you. Returning the unneeded lump sum lowers costs and thus reduces premiums for everyone. Of course, if your health status deteriorates again, you will receive another lump sum.

Health-status insurance accounts are not the same as health savings accounts. Health savings accounts are tax-preferred savings vehicles. You choose when to put money into a health savings account, you can withdraw money for nonmedical purposes (with a penalty), and you can pass the assets on to your heirs. Health-status insurance accounts are funded by payments from an insurance company, they can only be used for medical insurance premiums, and they should not be inheritable. Legally, health-status insurance accounts would be set up like a trust account.

However, health savings accounts are a great first step, as they establish a legal and regulatory framework for accounts that are limited in some ways to health-related uses. Now, markets only need to create (and regulators need to allow) a variant of something that already exists, rather than something completely new.

Calculating Payments

Calculating present values of premiums sounds complicated. However, in the real world we don't insure people down to the last dollar, so it is not necessary to key health-status payments precisely to the exact present value of each person's premium for a given plan's premium schedule. Home insurance markets work, even though the payment is never equal to the exact value of the home.

Health-status insurance companies could offer three or four levels of coverage, keyed to surveys of the costs of three or four standard levels of medical coverage. Similarly, medical insurers would probably have a short number of classifications, say a 1–10 scale of "low risk" to "high risk," rather than publish a premium schedule for every conceivable disease history. This would make their job and the health-status insurer's job much easier at a small cost.

A health-status insurance contract could then be very simple. For example, the policy could say "pays $50,000 if you are reclassified from category 3 to category 5." A simple table could advise people in a given medical insurance plan that this is the right level of coverage.

Interruptions

Health-status insurance can provide long-term security through interruptions or changes in medical insurance.

As soon as you stop making premium payments with a conventional insurance contract, you lose any right to low premiums and to continued coverage of your (now preexisting) medical conditions. This happens. People who lose their jobs often can continue their health insurance under COBRA—if they pay the entire premium, including what used to be the employer's portion. But this privilege doesn't last forever, and people who just lost their jobs often have trouble paying premiums, especially if the job loss coincides with an expensive illness.[4] People who take time off from work to raise a family, or lose their connection to health insurance through divorce, don't have any right to continue coverage in the first place.

By contrast, anyone with a health-status insurance account can switch to a lower-cost medical plan, or miss some period of medical coverage entirely in a time of economic misfortune, and retain protection against the costs of their long-term illnesses. When they're ready to reestablish medical insurance, or move to a more expensive medical insurance plan, the health-status account is there and waiting. If they maintain health-status insurance, even without medical insurance, they can be protected against any new long-term illness.

Changing Tastes and Quality

Suppose you purchase an economical medical plan and health-status insurance. You contract a high-cost condition. What if you then decide you want to move to a more expensive medical plan?

Insurance can cover misfortune, but it can't cover changing tastes. If you want to move to a more expensive plan, you're going to have to pay more. However, insurance companies could sell, and you could buy, economical medical insurance together with health-status insurance that covers changes in a more expensive medical plan's premiums. In the above example, you could opt for a policy that pays $70,000 rather than $50,000 if you are reclassified from category 3 to category 5. That would cost a little bit more, but if you get sick, a larger sum will be deposited in your health-status insurance account. This option would be attractive for young people or people in temporarily reduced circumstances. Home and car insurers will not let you be "overinsured," declaring a $100,000 value for a $20,000 car, for obvious reasons. But since you can't do anything but buy medical insurance with the pay-outs, there is no such

worry with health-status insurance.

What about People Who Are Already Sick?

Private insurance cannot cover events that have already happened. You can't tell an insurance company, "My house just burned down. How about some insurance?"

Many people feel that government should insure events that have already happened, especially when no insurance was available and the unfortunate are in some sense blameless. Health-status insurance accounts offer a good way to help people who are already sick. The government could simply deposit money in an individual's health-status insurance account and then get out of the way. Private charities could help people in the same way. This is much more straightforward, flexible, and less distortionary of markets than directly running a government-sponsored health insurance plan, or forcing private insurers to take such patients and treat them well.

The problem of people who have preexisting conditions is most critical at startup, when people will not yet have had a chance to buy health status insurance. Once health-status insurance is widely available, people will be able to insure against more events than one might think. Parents could buy family insurance that provides health-status insurance accounts for their children. Then, children who develop rare long-term diseases would be covered for life without government intervention. Health-status insurance could even apply to unborn children, and thus insure against genetic defects from birth.

Having the government set up such accounts for people with preexisting conditions might also be useful in getting the whole process going. This step would establish the legal and regulatory framework for health-status insurance accounts, and it could be done at the same time government deregulates premiums: regulators and legislators would be more willing to allow free risk-rating if they knew that the most vulnerable populations could afford the extra payments.

Other Implementations

The contracts I have described, combining competitive one-year medical insurance policies with health-status insurance payments held in a custodial account, show most clearly how free-market long-term insurance can work. However, markets may devise many other implementations that may be more attractive to consumers, insurers, and regulators—even if they don't seem as elegant to economists.

Consumers could purchase health-status insurance and medical insurance from different companies. Since health-status insurance is largely a financial transaction, a financial services company might be able to handle it better than a medical insurance company. On the other hand, consumers may prefer to have the two forms of insurance bundled as "long-term health insurance" and not worry about two separate contracts.

The health-status insurance account need not be settled up every year. For example, you could have a long-term medical insurance policy in which health-status payments occur only when you leave. On the other hand, with insurance—as in all social endeavors, there is less chance of a dispute if long-term debts are settled up more frequently and in smaller chunks, rather than in one large chunk after one party has already decided to leave.

Rather than an account with a dollar figure in it, your health-status insurer could simply promise to pay any increases in medical insurance premiums. The exact kinds of payment would have to be spelled out in some detail, either by specifying the qualifying plans or by specifying how much extra will be paid out for various risk conditions, but that's fairly straightforward in practice. In this implementation, we wouldn't have to worry about the insurer retrieving lump-sum payments if a person gets healthier. You

would still be dependent on a long-term contract, but it is much more reliable to receive an annuity from a financial services company than it is to rely on a long-term promise from a medical insurance company. Plus, you would still have the right to choose any medical insurer you want.

You could just have a transferability right rather than a health-status insurance account. Your current insurer could agree that, when you want to leave, it will pay a lump sum to any new insurer, such that the new insurer will now be willing to take you in a plan of similar quality with no change in your out-of-pocket expenses. The lump sum could be the same amount that your current insurer charges to take on a new customer of your age and health status. Transferability obviously would not give consumers quite as much freedom as a health-status insurance account with real money in it, but it might work almost as well in practice and might be simpler for consumers to understand.

Choice and Security

Why not just mandate that premiums cannot rise when you get sick? As it happens, federal law already requires that individually purchased medical insurance be "guaranteed renewable," meaning that the insurance company cannot drop you or increase your premiums if you get sick.

There are two problems with this arrangement. First, as with all pooling arrangements, simple long-term insurance policies are undermined by competition. Second, if you get sick you depend on the good graces of one company, for the rest of your life, as nobody else will take you. It is possible to fix the first problem, and markets are heading in that direction already. The second problem remains, and health-status insurance is the natural remedy.

To see the first problem, return to the above illustration, in which there is a 1 percent probability that a person's expected medical expenses would transition from $2,000 per year to $10,000 per year in the first year of an insurance contract. The average medical costs for all individuals would be

$$(0.99 \times \$2{,}000) + (0.01 \times \$10{,}000) = \$2{,}080.$$

It seems the insurer could break even by offering guaranteed-renewable policies for $2,080 per year. However, if there is any competition, this arrangement will fall apart after the first year. Another insurer charging just $2,000 per year could woo away all the healthy people. The same competitive pressures unravel forced-pooling arrangements, as discussed below.

Fortunately, markets can solve this problem by front-loading the premiums.[5] If each person pays $3,483.70 in the first year and $2,000 in subsequent years, the insurer will still break even, but healthy people will no longer have an incentive to leave. Even if another insurer lures them away, the additional first-year premiums would cover the long-term costs of the people who got sick. Bradley Herring and Mark Pauly call this an "incentive-compatible" guaranteed-renewable contract.[6]

Notice that the premiums and calculations of an incentive-compatible guaranteed-renewable insurance policy are exactly equal to the combined premiums of a medical insurance policy plus a health-status insurance policy, and the present value of both is the same as those of a $2,080-per-year pooling arrangement, if the latter could be made to work. More importantly, a health-status plus medical insurance policy is exactly equivalent to an incentive-compatible guaranteed-renewable policy, in which the insurance company periodically "marks to market" its long-term obligations to the customer, or the two parties occasionally settle up the long-term debt implied by the promise to treat the expensive customer. At the end of the first year, the insurance company selling guaranteed-renewable coverage should look at each patient who developed a long-term illness and say, "This person is going to cost us

(say) $8,000 per year. We should write down the company's value by $148,370"—the present value of $8,000 per year in my example. In the health-status insurance model, the insurer would pay out $148,370. The company would then have no more long-term obligations and the consumer would have no long-term contract to enforce.

The implications of periodically settling up a long-term contract are profound, and they solve the second problem of long-term individual contracts. Sick people must stay with their original insurer forever in a guaranteed-renewable contract, whereas a health-status insurance payment frees them to choose another insurer. People value choice. As Thomas Buchmueller and colleagues write:

> People do not want to be locked into the same health insurance plan year after year. When new medical services are developed, people want access to those services. . . . If people move, they want to be covered by new providers, not the providers in the town they moved from. Under guaranteed-renewable policies, only those who remain healthy can hope to switch coverage.[7]

If people are bound to one insurance carrier, furthermore, the original insurer doesn't have any incentive to treat sick people well. Yes, reputation and court enforcement of contracts can help to prevent insurers from treating sick people badly. But the freedom to leave is a much more effective force to keep insurers and providers on their toes. Competition for people with long-term diseases will also induce the whole medical industry to improve treatment of those diseases.

Finally, insurance companies don't last forever. They can go bankrupt, change owners, change policies, and so forth. Periodically retrieving the present value of long-term promises adds to the safety of any contract.

We do not have to have a policy debate between guaranteed-renewable and health-status insurance, however. Market participants can decide how often it is optimal to settle up, as long as both options are permitted by law and regulation. Guaranteed-renewable individual insurance is also a great start, because it provides a natural stepping stone to health-status insurance without requiring major policy shifts.

What about Adverse Selection?

People who know they are sick and can hide it tend to buy more insurance, which the-oretically can cause insurance markets to unravel. Realistically, however, "adverse selection" is not a serious problem for long-term health insurance markets. True adverse selection refers to things patients know that the insurer cannot know—what economists call "asymmetric information." But does a patient who knows his or her aches and pains really know more than an insurer can learn by looking at his or her entire medical history and a careful health exam? (Hiding one's history is fraud, and can invalidate a contract.)

If we observe adverse selection in today's marketplace, it is because government *artificially* forbids insurers from using information they do posses to charge more for people whom everyone knows are going to be more expensive. This fact does not represent a fundamental information problem that would stop a less-regulated market from working.

Adverse selection is exactly the same issue for health-status insurance as it is for long-term insurance with a single company. The portability engineered by lump-sum payments doesn't make adverse selection any better or worse. So at a minimum, this isn't a special issue for health-status insurance.

What Needs to Be Done

What policy steps should be taken instead to allow health-status insurance to emerge? The basic message is "get out of the way," but we need to describe a set of steps that nervous regulators and politicians could actually take.

First, we should eliminate the tax and regulatory preferences for employer-provided group health insurance. Employers can still pay for insurance, or even provide medical insurance. We could even retain the tax-advantaged status of health insurance payments by companies or individuals. Those features cause many distortions, but those distortions don't harm long-term insurance. It is crucial that the employee owns any health-status insurance account, just as he or she owns defined-contribution retirement accounts and health savings accounts. That way, if the employee gets sick and leaves, he or she always has the resources to purchase a medical insurance policy. If long-term health insurance is bundled with medical insurance, it is important that this is an individual, portable policy—no matter who pays for it.

Second, we need to allow and encourage insurers to adjust medical insurance premiums freely, so that anyone can get coverage, albeit at a price, and so that healthy people will not flee the market. Finally, we should lift the many other competitive restraints on insurers.[8]

We do not need a carefully planned and choreographed deregulation. Once we remove the tax and regulatory preferences for employer-based group insurance, much of the rest will follow naturally. We will first see much more individual insurance emerge, and that insurance is already incentive compatible, guaranteed renewable, and portable. Competition and consumer demand for the freedom to change insurers will push insurers toward the incentive-compatible front-loaded premium structure with periodic settling-up clauses. Health-status insurance accounts will follow quickly if you think about how the insurance contracts are written. As health-status insurance develops, there will be no reason not to allow insurers to fully risk-rate medical insurance policies and compete ruthlessly. Each step can coexist with the last and can happen as quickly or slowly as regulators are willing to let go.

Regulators could help, too. They could encourage medical insurers to publish explicit premium schedules based on health risk, so that health-status payments can be more easily calculated. Insurers may rightly fear that publication of such a premium schedule now would draw all sorts of political and regulatory ire. Hearing the opposite would help.

Markets Are Showing the Way

It is encouraging that even in our highly regulated environment, the individual market is already moving in the direction of health-status insurance. Three-quarters of private medical insurance policies were guaranteed renewable even before this feature was mandated in 1996.[9] Bradley Herring and Mark Pauly find evidence that individual health insurance premiums are beginning to reflect the front-loaded "incentive-compatible" structure,[10] which exactly mimics medical plus health-status insurance premiums. Most encouraging of all, the UnitedHealth Group, one of the nation's largest health insurers, just announced a product that gives customers the right to buy medical insurance in the future. The future premium will be based on the customer's *current* health status, even if their health worsens in the interim. The *New York Times* reports:

> "What this product is designed to do, for a very modest premium, is to essentially protect your insurability for the future," said Richard A. Collins, the president of UnitedHealth's individual

insurance unit, who says he is the first policy holder. His monthly fee is $50.[11]

This product only gives customers the right to buy a UnitedHealth policy, rather than a policy from any insurance company. But it is clearly a big step toward full health-status insurance. Further steps may be forthcoming. The *Times* continues:

> Private insurers are increasingly interested in coming up with new plans that offer coverage even to those individuals with pre-existing conditions, said Bob Vineyard, an insurance broker in Atlanta. He said he expected such plans to be introduced next year.[12]

Markets *can* provide long-term, portable insurance—but only if we allow them to do so.

Competition and Regulation

Why then do we have such a regulated system? If deregulation would quickly solve our most pressing health insurance problem, why haven't we deregulated it already? There is in fact a clear story for how we got stuck where we are. Understanding this story can give us confidence that the deregulatory path outlined above will work, and it shows us why further regulation will not cure the health insurance system.

Employer-provided group insurance is the dominant form of medical insurance in the United States, encouraged by a strong tax advantage and regulatory pressure. The tax advantage emerged in WWII, as a way for firms to attract workers in the face of federal wage and price controls,[13] not from any careful study of long-term health insurance.

Group insurance is a long-term pooling arrangement. The premiums of healthy people cross-subsidize the expenses of those with long-term illnesses over long periods. Competition undermines long-term pools. A competitive insurer can woo the healthy away with a lower premium, leaving the original insurer with only sick people.[14] And people with long-term illnesses who lose their job or other tie to the pool won't be able to join another pool in a competitive market.

However, these problems were not evident when health insurance markets first emerged and health expenses were largely temporary. There wasn't much one could do about the chronic conditions for which we now have expensive treatments. The long-term insurance problem emerged as expensive treatments for long-term conditions became available.

A lot of health insurance regulation makes some sense when viewed as a patchwork aimed at trying to prohibit competitive forces from undermining long-term pools. The federal tax exemption for employment-based group insurance does not allow healthy workers to direct their employer's pre-tax premium contributions, or their own pre-tax dollars, to an individual plan. This fact forces healthy workers to stay in their employer's plan and to cross-subsidize the sick. Additional regulations to encourage employer-sponsored group insurance help workers with illnesses to get coverage at a new job if they leave their old one. Regulations that limit risk-rating and exclusions for preexisting conditions or that mandate coverage of certain conditions try to force the individual market to be a catch-all for people who have lost group coverage. Restrictions on competition attempt to keep insurers from poaching each other's healthy customers.

Most policy proposals aimed at providing better long-term health insurance try to further limit competition and expand forced pooling. They strengthen incentives for employer-provided group

insurance, create pools based on geography (e.g., the Clinton administration's 1993 proposal), force insurers to take all comers at the same price, assign high risks to insurers, prohibit competition for healthy customers, force (or "mandate") healthy people to buy high-priced insurance, mandate payment levels and treatments for expensive diseases, and so forth.

Alas, each of these steps reduces competition, and reduces people's freedom to choose the insurers and providers that best serve their needs. That reduction begets poor service, higher costs, and less innovation. Reducing competition and choice is not an unfortunate side effect of the regulatory approach to long-term insurance—it is the *point* of that approach. Competition undermines forced pooling arrangements, so to strengthen forced pooling, you have to reduce competition.

Even these sterner measures will not be enough, so long as people have any need or freedom to change pools. National health insurance—a single, mandatory pool—is the only way to provide ironclad long-term insurance following this logic. But national health insurance completely eliminates consumer choice and insurer competition.

We seem to face an unpalatable tradeoff between competition and choice on one hand and better long-term insurance on the other. Health-status insurance removes this unpleasant tradeoff. With health-status insurance, a completely deregulated market with complete freedom and competition can also provide lifetime portable health insurance.

The Obama Plan

As I write, the most relevant health care reform proposal is the one presented by President Barack Obama's campaign. It is a good specific example of these general points.

The Obama campaign plan promised to bring "portability and choice" to health insurance. It promised that Americans "will be able to move from job to job without changing or jeopardizing their health care coverage." It called for "stable premiums that will not depend on how healthy you are," and promised that "no American will be turned away from any insurance plan because of illness or preexisting conditions."[15] Those goals are exactly what health-status insurance can accomplish.

Unfortunately, the Obama campaign proposals go in the standard direction of reduced competition, forced pooling, and mandates. For example, the Obama campaign plan proposes a "National Health Insurance Exchange" through which the federal government would ban pre-existing condition clauses and force insurance companies to take everyone at the same price. The campaign plan proposes to mandate coverage for children and most workers. It foresees, and indeed promises, the inevitable result of a nationalized health-insurance system:

> Obama will make available a new national health plan . . . The plan will cover all essential medical services, including preventive, maternity, and mental health care. . . . Individuals and families who . . . need financial assistance will receive an income-related federal subsidy to buy into the new public plan.[16]

Clearly, President Obama and his health policy advisers are genuinely concerned about long-term insurance, and they recognize that choice, competition, and lower costs are desirable in health care. They are neither for nor against health-status insurance in any meaningful sense. They simply have never heard of it. They advocate more regulation and nationalized health insurance simply because they, like most people, think they have to choose between long-term insurance and competition. They do not know that

a market alternative that delivers both is possible. If they knew about it, there is no reason they should not embrace it.

Conclusion

With health-status insurance, a completely private, less-regulated, and competitive insurance market can solve the central problem of health insurance in America: the lack of secure long-term portable protection from health risks. We need not choose between freedom and competition on one hand, and long-term health security on the other. Markets can deliver both.

Getting there requires us to move in exactly the opposite direction of current regulation and most policy proposals. We need to end the tax and regulatory preference for employer-provided group insurance over portable individual insurance, not strengthen that pressure. We need to allow medical insurers to compete—to charge more for people with long-term expensive conditions and less for healthy people—not prohibit them from doing so. We need to allow health-status insurance to emerge so that people can be insured against higher costs.

Any good policymaker looks for market failure before regulating something. Where is the market failure behind bans on risk-based premiums, medical insurance competition, or tax preferences favoring employer-provided group health insurance? No one has seriously documented natural monopoly, missing property rights, adverse selection, asymmetric information, or any conventional source of market failure motivating these interventions, or preventing the emergence of private long-term health insurance. Those regulations emerged as a patchwork response to the historical accident of employer-provided group insurance, not as a coherent regulatory program to address market failure. However, we have not so far had a vision of how a completely free market could provide long-term and fully portable health insurance. Without that vision, one could have a nagging sense that there is some hidden market failure.

At a minimum, the possibility of health-status insurance gives us that vision, reassuring us that there are no such failures, and that these are needless regulations. Free-market economists no longer need to hem and haw, saying, "Well you have a point there, but do we have to make the regulation quite so intrusive?" We can instead say with confidence, "We *can* have long-term insurance with a less-regulated health insurance market, and here's how."

Of course, I also hope that it actually happens: that our government takes the simple steps necessary to let long-term health insurance emerge in place of highly regulated long-term pooling systems. We could then watch with delight as the resulting competition does its usual magic of raising quality, lowering costs, and spurring innovation in both health care delivery and finance.

Notes

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1. The contracts in this article are described more fully in John H. Cochrane, "Time-Consistent Health Insurance," *Journal of Political Economy* 103 (June 1995): 445–73.

2. To keep the math simple, I assume that he wants medical insurance only until age 65, when he will transition to Medicare, and that he is certain to live that long. A realistic calculation should include the actuarial probability of death at each age, and can therefore handle the absence of Medicare. Of course, Medicare would be unnecessary with an effective long-term health insurance market.

3. Bradley Herring and Mark V. Pauly, "Incentive-Compatible Guaranteed-Renewable Health Insurance Premiums," *Journal of Health Economics* 25 (2005): 395–417. As I explain below, the "GR" or guaranteed-renewable premiums shown in their Figure 3

and Table 3 are identical to the combination of health and health-status insurance payments described here.

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

5. Mark V. Pauly, Howard Kunreuther, and Richard Hirth, "Guaranteed Renewability in Insurance," *Journal of Risk and Uncertainty* 10 (1995) 143–56; Mark Pauly, Andreas Nickel and Howard Kun-reuther, "Guaranteed Renewability with Group Insurance," *Journal of Risk and Uncertainty* 16 (1998): 211–21.

6. Herring and Pauly, pp. 395–417.

7. Thomas Buchmueller, Sherry A. Glied, Anne Royalty, and Katherine Swartz, "Cost and Coverage Implications of the McCain Plan to Restructure Health Insurance," *Health Affairs* 27, no. 6 (September 16, 2008), web exclusive, http://content.healthaffairs.org/cgi/reprint/hlthaff.27.6.w472v1.pdf.

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

9. Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks* (Washington: American Enterprise Institute, 1999), p. 18.

10. Herring and Pauly, pp. 395–417.

11. Reed Abelson, "UnitedHealth to Insure the Right to Insurance," *New York Times*, December 2, 2008, http://www.nytimes.com/2008/12/03/business/03insure.html

12. Ibid.

13. See, e.g., Robert Helms, "The Tax Treatment of Health Insurance," in *Empowering Health Care Consumers through Tax Reform*, ed. Grace-Marie Arnett, ed. (Ann Arbor, MI: University of Michigan Press, 1999), pp. 1–25.

14. Tom Daschle, Scott S. Greenberger, and Jeanne M. Lambrew give a splendid description of how competition for healthy people undermined the Blue Cross/Blue Shield "community rating" (i.e., pool) system of the 1940s, helping to create "the flawed system we are saddled with today." See 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), pp. 56–57.

15. All quotes are from Obama '08, "Barack Obama's Plan for a Healthy America: Lowering Health Care Costs and Ensuring Affordable, High-Quality Health Care for All," p. 7, http://www.barackobama.com/pdf/HealthPlanFull.pdf.

16. Ibid.

Chapter 65

Large Health Savings Accounts: A Step toward Tax Neutrality for Health Care

by Michael F. Cannon

I. Introduction

Various provisions of the federal tax code alter relative prices within the health sector, as well as the relative prices of health versus non-health expenditures. The most notable of these provisions, both in terms of its impact on the health care sector and the federal budget, is the exclusion of employer-sponsored health benefits from federal income and payroll taxes. While cash wages are generally subject to both types of tax, compensation in the form of employer contributions to employee health benefits is not. The projected revenue loss to the federal treasury from the exclusion of employer-paid health benefits in 2007 was $147 billion. That was nearly twice the size of the projected loss from the second largest revenue loser, the mortgage interest deduction (OMB, 2006).

Excluding employer-sponsored health benefits from the income and payroll tax bases lowers the effective price of employer-sponsored health coverage relative to coverage obtained outside an employment setting. (If we measure prices in terms of units of labor, the effective price of employer sponsored coverage falls by a percentage equal to the worker's marginal tax rate.)

The price of employer-provided health benefits falls relative to other uses of cash wages as well, including saving, out-of-pocket medical expenditure, and other forms of consumption. The exclusion therefore distorts prices in three principal ways:

1. It reduces the price of health expenditures relative to non-health expenditures;
2. It reduces the price of financing medical care through third-party health insurance relative to self-insurance (i.e., saving) and direct out-of-pocket expenditure; and
3. It reduces the price of employer-sponsored health insurance relative to insurance purchased from other sources.

These price distortions helped to create America's employment-based system of private health insurance (Helms, 2006). An estimated 60 percent of Americans are covered by such insurance (DeNavas-Walt et al., 2006). Critics identify several problems created by this feature of the tax code.

First, the exclusion leaves workers with less control over their health insurance decisions and their compensation. Because most workers have their health insurance chosen for them by an employer, workers are less likely to obtain coverage that matches their preferences. Second, economists argue that the exclusion reduces efficiency by encouraging excess health insurance coverage, encouraging consumption of low-value medical care, and distorting the labor market. Third, economists and other commentators criticize the exclusion as inequitable, both in terms of horizontal and vertical equity.

For these and other reasons, some have advocated eliminating the exclusion (Friedman, 2001). Doing

so would eliminate the tax-induced distortion of workers' health insurance decisions by requiring workers to pay income and payroll taxes on the value of their employer-sponsored health benefits just as they pay taxes on income devoted to other purposes. Others have proposed reducing such distortions by limiting the exclusion; for example, by imposing a cap on the value of health benefits that may be excluded from taxation. Such a cap would require workers to pay taxes on the amount of employer-sponsored health benefits that exceed the cap. Assuming a worker prefers health insurance with premiums that exceed the level of the cap, the cap would eliminate the distortion of that worker's health insurance decisions at the margin. A recent presidential commission on tax reform proposed capping the exclusion at the average value of employer-sponsored health benefits: $5,000 for individual health coverage and$11,500 for family coverage (Mack et al., 2005). Most recently, President George W. Bush proposed limiting the exclusion by replacing it with a standard deduction for health insurance that would be available to all taxpayers regardless of where they obtain coverage (Burman et al., 2007).

Efforts to eliminate, or even limit the exclusion typically meet significant political opposition. Either option would impose taxes on previously untaxed activity. Those who argue that the exclusion encourages greater cross-subsidies to less-healthy workers—i.e., greater "pooling"—argue that eliminating or limiting the exclusion would reduce such pooling by diminishing the incentive to purchase health insurance through employment-based groups. Opposition from various groups has defeated attempts to limit the exclusion for over 20 years.

The creation of tax-free health savings accounts (HSAs) presents a new opportunity to limit the exclusion and facilitate its elimination. This paper argues that altering the rules governing HSAs could better satisfy individual preferences than the current exclusion and improve the efficiency, and possibly the equity, of the federal tax code's treatment of health-related uses of income. The same changes could cap the exclusion as well, and do so in a way that may be more politically feasible than past proposals. Though these changes would raise a number of objections, including concerns regarding free-riders and revenue loss to the federal treasury, those problems could be addressed by adjusting different parameters.

II. Health Savings Accounts

HSAs offer a foundation for transitioning to a tax system that is neutral toward health expenditures. In 2003, the federal government created tax-free health savings accounts (HSAs), allowing taxpayers who are under age 65 and covered by a qualified high-deductible health plan1 to save a limited amount of income in an account (the HSA) for medical expenditures. Individuals with qualified coverage may contribute up to $2,900 to their HSA in 2008. Families with qualified coverage may contribute up to $5,800.[2]

HSAs represent a significant change in the tax treatment of different ways of financing medical care. Traditionally, federal tax law has bestowed the most preferential tax treatment on employer-sponsored, third-party health insurance.

Deductions for out-of-pocket medical expenditures, for example, are narrowly tailored and less widely utilized.[3] Prior to the creation of Archer medical savings accounts (a more restrictive precursor to HSAs) in 1997, no tax breaks existed for self-insurance—that is, saving for one's future medical expenses.[4]

The tax treatment of HSA contributions roughly mirrors the tax treatment of employer-sponsored health insurance (Cannon, 2006).[5] HSAs are truly a savings vehicle, in that HSA funds remain the property of the account holder even when she changes jobs or insurance companies. Thus, HSAs reduce

the tax code's disincentive against financing medical expenses by pooling one's own resources over the course of a lifetime (Herrick, 2005).

Because HSAs expand health-related tax deductions, they may distort consumers' allocation decisions even further. However, HSAs arguably do less to encourage greater health care spending than proposals to extend tax deductibility solely to out-of-pocket expenditures (Cogan et al., 2005), since HSAs offset (at least in part) the added incentive to increase medical consumption by presenting consumers with a tax-neutral tradeoff between additional consumption and saving. While some economists have argued for HSAs as a second-best alternative to eliminating health-related tax preferences (Friedman, 2001), others question (Pauly, 1994) and even reject (Furman, 2006) the wisdom of extending preferential tax treatment to even more out-of-pocket medical expenditures and self-insurance.

Other objections to HSAs include those based on perceived inequities and concerns about risk segmentation (Cannon, 2006). HSAs allow high-income earners to reduce their tax liability more than low-income earners. In addition, some argue that leveling the playing field between employer-sponsored third party insurance and self-insurance will reduce cross-subsidies to less-healthy workers.

III. Large Health Savings Accounts

HSAs present a new opportunity for restructuring and limiting the tax exclusion of employer-sponsored health insurance that may appeal to its various critics. Changing three parameters of current HSA law could create a substitute for the exclusion and other health-related federal tax preferences that would improve efficiency within the health care sector while possibly reducing the inequities created by the exclusion. These changes also offer a way to limit health-related tax preferences that may be more politically feasible than past proposals. Finally, these changes could serve as a transitional step toward a tax system that is neutral toward health expenditures, and therefore increases allocative efficiency across economic sectors.

This paper proposes changes to current HSA law that would allow most workers to contribute the full amount both they and their employer spend on their health benefits to the worker's HSA. Three principal changes are proposed:

1. Increase HSA contribution limits dramatically. For illustrative purposes, assume the maximum annual contribution limits would be roughly tripled, from $2,850 to $8,000 for individuals and from $5,500 to $16,000 for families.

2. Remove the requirement that HSA holders be covered by a qualified high-deductible health plan. HSAs would be open to those covered by any type of insurance, as well as the uninsured.

3. Allow HSA holders to purchase health insurance, of any type and from any source, tax-free with HSA funds.

These changes would allow all individuals to set up a "large" HSA. Subject to the new contribution limits, workers could contribute as much income as they choose. Those Large HSA funds would finance workers' health insurance premiums and any other qualified medical expenses. These changes would eliminate the tax code's influence over tradeoffs between self-insurance and third-party insurance, and between employer-sponsored insurance and other sources of insurance. A hypothetical can illustrate how Large HSAs could work. Suppose a worker currently receives family coverage through her employer. The total premium is $12,000 per year, of which the employer pays $9,000 and the worker

pays $3,000.[6] Rather than set aside $9,000 for the worker's health benefits, the employer would add that amount to the worker's salary. As with an FSA, the worker could then direct the employer to deposit a portion of her salary, pre-tax, into her HSA. Those Large HSA contributions would be exempt from both income and payroll taxes, just as employer contributions to workers' HSAs are today. The combined contributions from a worker and her spouse would be limited, for example, to $16,000.

The worker could then use her Large HSA funds to establish levels of third-party insurance and self-insurance that satisfy her preferences. She could use her Large HSA funds to continue paying premiums under her employer's health plan. Alternatively, she could use those funds to purchase lessor more-comprehensive coverage through her spouse's employer, through another group, or the non-group market. The federal tax code would no longer reward or punish her for choosing a particular mix of self-insurance and third-party insurance, or for choosing third-party insurance from a particular source. Whatever Large HSA funds she does not spend in the present would be available to cover future out-of-pocket medical expenses or health insurance premiums. As with current-law HSAs, she could withdraw those funds for non-medical purposes, subject to income taxes and a 10-percent penalty, which would be waived if the distribution occurs after she suffers a disability or reaches age 65.

Employers who currently do not offer health benefits might be willing to arrange Large HSA payroll deductions for their workers, since administering direct deposits is less burdensome than administering health benefits. Nevertheless, some workers would not be able to arrange Large HSA contributions via payroll deduction. If workers could not exempt Large HSA contributions from payroll taxes, that would preserve an inequity where the federal government effectively levies higher taxes on individuals whose employers do not offer health benefits. That problem could be addressed by creating an income tax credit to offset the payroll taxes paid on non-employer HSA contributions (CEA, 2006). Allowing such a credit for non-employer Large HSA contributions would provide tax neutrality to those who contribute to a Large HSA other than through a payroll deduction. The Bush administration's proposed standard deduction for health insurance provides another mechanism for achieving tax neutrality: after workers certified the amount they deposit into their Large HSA, employers could deduct that amount from the workers' payroll tax base (see Burman et al., 2007).

These changes to current HSA rules would improve efficiency, and potentially equity, within the health care sector. At the same time, they would facilitate a move toward tax neutrality for health-related expenditures. Large HSAs will also raise concerns regarding vertical equity and other issues, many of which can be addressed by adjusting parameters such as the maximum allowable contributions.

A. Individual Preferences

One consequence of the preferred tax treatment granted to employer-sponsored health insurance is that workers are often unable to obtain their preferred type of health coverage. Most workers' health insurance choices are limited to the options offered by their employer. (Workers who purchase coverage outside an employment setting lose the benefit of the exclusion and also must pay the higher administrative costs associated with non-group insurance.) In 2007, 51 percent of covered workers had only one health plan choice; only 17 percent of covered workers had more than two choices (Kaiser/HRET, 2007). Because it is rare that a firm can satisfy the diverse preferences of all its employees, an employment-based system of health insurance leaves many workers' preferences unsatisfied. The mismatch between the coverage that employees prefer and what they get creates a welfare loss estimated at 5–10 percent of health insurance expenditures (Pauly et al., 1999).

As they exist today, HSAs do little to improve this situation. HSAs only slightly reduce the tax penalties imposed on those who obtain their preferred level of health coverage. For example, if a consumer obtains more (or less) coverage than may be combined with an HSA, she is penalized because she is ineligible to make tax-free HSA contributions. If she obtains coverage outside an employment setting, she is penalized even if her preferred coverage qualifies her to open an HSA: her HSA contributions are deductible only against her income taxes (not payroll taxes), and she must purchase her health plan with dollars subject to both income and payroll taxes. In effect, HSAs enable a consumer to avoid tax penalties only when (1) her coverage preference falls within the statutory parameters of an HSA-qualified health plan and (2) she obtains coverage in an employment setting.

Restructuring the exclusion with Large HSAs would allow a closer fit between each individual's preferences and her health insurance coverage. Once funds are contributed to a Large HSA, they may be put to any health-related use without penalty. A worker could use her Large HSA funds to purchase coverage from her employer, her spouse's employer, a non-employment group, or the non-group market. She could purchase HMO, PPO, POS, or fee-for-service coverage. Within those categories, she could select any combination of deductibles and coinsurance. She could also choose not to purchase any third-party insurance and instead accumulate savings in her Large HSA. Her coverage options would no longer be confined to those offered by her employer or those defined by Congress. A Large HSA would give her ownership of her health benefits, in particular the portion of her compensation that even existing HSAs do not enable her to control: the funds that purchase her health insurance.

B. Efficiency

Economists criticize the exclusion for reducing economic efficiency. This occurs in two principal ways. First, economists credit the exclusion with encouraging excess health insurance coverage (Feldstein, 1973; Feldstein and Friedman, 1976; Feldstein and Gruber, 1995; Gruber and Poterba, 1996). An individual reaches the optimal amount of insurance when the cost of an additional unit of coverage (including, in particular, the cost of additional moral hazard) is equal to the benefit of an additional unit of risk protection (Feldstein and Friedman, 1976). The exclusion traditionally upset that balance by artificially lowering the price of an additional unit of employer-sponsored coverage relative to the prices of other group insurance, non-group insurance, self-insurance, direct (out-of-pocket) medical expenditures, and non-health expenditures. Because health insurance itself alters the price of medical care to consumers, lowering the relative price of health insurance encourages even greater consumption of medical care whose cost exceeds its value. By diverting resources from other activities to the health care sector, where those resources often purchase low-value, zero-value, and even harmful care (Newhouse et al., 1994), the tax exclusion creates a welfare loss most recently estimated at $106 billion in 2002 (Conover, 2004). Excessive coverage may also be described as a suboptimal mix of self-insurance and third-party insurance.

Second, by tying health insurance to employment, the exclusion reduces efficiency by making labor less mobile than if health insurance were portable. Research suggests that workers make employment decisions in part based on their demand for health insurance (Glied, 1994). The unwillingness to change jobs for fear of losing one's health insurance is known as "job lock." Although "the economic costs of job lock may be modest" (Gruber and Madrian, 2004), workers might allocate their labor more efficiently in the absence of a tax penalty on fully portable health insurance.

HSAs make only modest improvements in efficiency. First, by reducing somewhat the tax preference for third-party insurance over self-insurance, HSAs could reduce the welfare loss associated with excess

coverage. However, that depends on employers providing HSA coverage to workers who prefer high-deductible insurance—and only to such workers. To the extent that employers do not offer HSAs, the welfare loss from excess coverage will persist. Moreover, to the extent that employers impose HSAs on workers who do not want high-deductible coverage, HSAs may create new welfare losses. Second, the welfare losses associated with workers changing coverage (or losing coverage altogether) when they change jobs persist despite the availability of HSAs. Though the funds accumulated in a worker's HSA remain the worker's property through changes in employment, the same cannot be said of the high-deductible health plan. Workers with HSA coverage still face the loss of their health insurance when they change jobs, because the tax code continues to penalize insurance that is tied to the consumer.

Large HSAs would provide even greater tax benefits for self-insurance than do current-law HSAs. This is not necessarily advantageous (Pauly, 1994; Furman, 2006). On balance, however, Large HSAs could reduce economic distortions and improve efficiency, given the set of tax provisions they would replace.

First, Large HSAs would reduce distortions *within* the health sector. Large HSAs would improve efficiency within the health sector primarily by reducing excessive medical spending. By giving workers ownership of the money that purchases their health benefits and presenting them with undistorted tradeoffs between third-party insurance and self-insurance, Large HSAs would make consumers more cost-conscious when purchasing their health insurance. Thus, Large HSAs would encourage plan features aimed at reducing low-value services, such as higher deductibles and coinsurance, care management, electronic medical records, and other health information technologies. Since Large HSAs would place no limit on out-of-pocket exposure, in many cases they would encourage greater cost-sharing than existing HSAs. Plan features such as care management and health information technologies can also improve efficiency by enhancing quality. In addition to creating financial incentives to choose such features, Large HSAs would give consumers the agility necessary to do so.

Second, Large HSAs could also lead to greater allocative efficiency *across* economic sectors. Allowing individuals to adjust their Large HSA contributions, much like workers can adjust contributions to an FSA, would enable workers to allocate their income between health-related and non-health-related uses more flexibly than at present. Workers who prefer less health insurance could more easily allocate income to non-health uses than under the current exclusion, where it is costly to purchase less coverage than one's employer offers. More importantly, Large HSAs would limit the price distortion between health- and non-health-related uses of income by limiting health-related tax preferences (discussed further below).

Creating tax parity between health insurance and health savings is an important part of reducing distortions both within the health sector and across economic sectors. Many health-tax reform proposals pursue parity between third-party and first-party *payment* for medical services; that is, between health insurance and out-of-pocket expenditures. Such parity, however, might preserve a tax bias that favors third-party over first-party *pooling*. Saving allows consumers to self-insure against future medical expenses by pooling their own income over the course of a lifetime. If a dollar of income is untaxed when used to purchase health insurance but taxed if saved for future medical expenses, then at the margin the tax system will encourage taxpayers to finance their medical consumption by pooling their income with others rather than by saving. Eliminating that distortion would promote efficiency within the health sector by enhancing consumers' cost-consciousness when purchasing third-party insurance (and when purchasing medical services out-of-pocket). Likewise, because such parity would encourage less insurance and more savings, it would increase the probability that income initially devoted to health-

related uses will be re-allocated to non-health uses. Unlike income spent on insurance premiums, funds deposited in a Large HSA can be withdrawn, taxed, and spent on non-health items.

C. Equity

Critics fault the exclusion for violating both horizontal and vertical equity. Horizontal equity requires that similar individuals be treated the same. Most agree that the exclusion violates this principle with regard to both workers and firms. Though two workers may have identical incomes, one may be able to purchase health insurance tax-free, while the other must do so with after-tax dollars solely because of where she works. Workers who are temporarily unemployed suffer under the same inequity. The exclusion may further create horizontal inequities if, by diverting consumers away from non-group insurance, it results in higher administrative costs in that market (Pauly et al., 1999). The exclusion also creates horizontal inequities between firms, as firms that do not offer health benefits may be at a disadvantage when competing for workers against firms that do offer health benefits. At the same time, firms that offer health insurance may suffer a competitive disadvantage if they hire disproportionate numbers of workers with expensive medical conditions, or with dependents who have expensive medical conditions.

There is less agreement about vertical equity. Generally, vertical equity is the principle that policies should help those who most need assistance; that benefits should flow to those with lower incomes and burdens should disproportionately fall on those with higher incomes. Unlike horizontal equity, observers disagree about what constitutes vertical equity and whether redistribution is even desirable (Hall and Rabushka, 1995; Slemrod, 2000).

Some consider the exclusion to be regressive (Furman, 2006) because the *benefits* of the exclusion—reduced tax liabilities—are clearly tilted toward those with higher incomes. Equivalently, one can say the exclusion reduces effective marginal tax rates for many high-income individuals. However, others argue that higher marginal tax rates reduce efficiency (Pauly and Goodman, 1995; Hall and Rabushka, 1995), which may mean that high marginal tax rates themselves are inequitable if they reduce the standard of living of future generations—and particularly of low-income individuals— below what it otherwise would be. Some argue that the effects of high marginal tax rates on efficiency and liberty make them undesirable even for current generations (Hall and Rabushka, 1995).

At the same time, some argue the exclusion promotes vertical equity based on need by making coverage more affordable to workers with costly medical conditions. The exclusion encourages employment-based insurance, which many believe enables greater pooling of health risks (i.e., subsidies across risk categories) than non-group health insurance would allow (Furman, 2006; Fronstin, 2006; Custer, 1999). The result is that more high-cost individuals are able to obtain health coverage. However, others question whether employment-based insurance pools risk more broadly than non-group insurance. Some note that employers and workers engage in numerous strategies to reduce pooling in employer-sponsored health plans (Glied, 1994; Pauly et al., 1999; Bhattacharya and Bundorf, 2005; Strunk et al., 2005). Moreover, Pauly and others find significant pooling in non-group markets (Marquis et al., 2006), and question whether much additional pooling takes place in employment-based pools (Pauly and Herring, 1999; Pauly et al., 1999).

A final example of vertical inequity is that the exclusion deprives lower-income individuals of benefits a less-distorted market might provide. Linking health insurance to employment may narrow the coverage choices of unskilled workers relative to skilled workers. First, any firm that offers comprehensive health benefits risks adverse selection; that is, it runs the risk of attracting less-healthy workers who desire

comprehensive health benefits. Because workers can generally obtain jobs beneath, but not above, their skill level, firms that hire predominantly unskilled labor are more vulnerable to adverse selection than firms that hire skilled workers. When firms such as Wal-Mart protect themselves against adverse selection by offering less comprehensive health benefits (Hall, 2005) or no health benefits at all, that restricts the coverage choices of unskilled workers relative to those of skilled workers. The result is that unskilled workers are more likely not to be offered health benefits than skilled workers, are more likely to have fewer insurance choices than if insurance were not linked to employment, and are more likely to be offered less coverage than they would prefer. Second, unskilled workers are therefore more likely to have no option for coverage but what is available in the non-group market, where the exclusion contributes to high administrative costs.

HSAs offer only marginal improvements in horizontal equity. The income tax deductibility of non-employer HSA contributions brings the tax treatment of those without access to employer-sponsored coverage somewhat closer to that of workers with such access. HSAs also improve horizontal equity by reducing tax penalties on those who prefer more self-insurance and less third-party insurance. Insofar as HSAs make it easier for employers to offer coverage, HSAs reduce horizontal inequities between firms. Insofar as HSAs spur growth in the non-group market, they may help make such coverage more affordable by reducing administrative costs. However, each of these improvements is slight, and large horizontal inequities remain.

Judgments about HSAs' impact on vertical equity are mixed. Some criticize HSAs for expanding a tax exclusion whose benefits were already heavily tilted toward the wealthy (CBPP, 2006). Others note that many low-income workers would benefit from HSA-like coverage (Nichols et al., 1996). Again, insofar as HSAs expand non-group coverage or make it easier for firms to begin offering coverage, low-income workers will benefit.

By comparison, Large HSAs could generate dramatic improvements in both horizontal and vertical equity. All workers at a given income level could deposit the same amount into their Large HSA and face the same tax consequences—regardless of their place of employment or insurance preferences. Workers would no longer be penalized for purchasing coverage from someone other than an employer. Moreover, those who purchase non-group insurance could expect to see reduced loading costs in a thicker non-group market (Pauly et al., 1999). Large HSAs would also reduce horizontal inequities between firms. Those that do not offer health benefits could arrange to make pre-tax deposits into workers' Large HSAs, which would better enable those firms to compete for workers.

Large HSAs would have ambiguous effects on vertical equity, however they could be designed to satisfy the concerns of those who value vertical equity. Some will see greater vertical inequity in contribution limits of $8,000 and $16,000. Indeed, many high-income earners would be able to shelter more income from taxation with a Large HSA than they do now. However, Large HSAs for the first time would limit the amount of health benefits that workers can exclude from taxation. Contribution limits of $8,000 for individuals and $16,000 for families would have required about 3 percent of covered workers in 2006 to pay taxes on a portion of their health benefits (Sheils, 2005). Workers with health benefits whose value exceeds those caps are likely to be higher-income workers. If the contribution limits were not indexed, then over time an increasingly large share of disproportionately high-income workers would pay taxes on a growing portion of their health benefits. Finally, that share could be increased by setting lower contribution limits, for example $5,000 for individuals and $10,000 for families.

At the same time, Large HSAs would offer significant benefits to low-income earners, many of whom

receive no health-related tax breaks. Large HSAs would grant low-income workers universal access to the exclusion. Whether through employer contributions or another mechanism, all workers could use pretax income either to purchase health insurance or to save for future medical expenses. Individuals could take advantage of the tax exclusion to the extent they need and are able to do so, rather than to the extent their employer will allow. Again, low-income workers would benefit insofar as Large HSAs expand their coverage choices or help reduce the administrative costs of non-group insurance.

Another vertical equity issue involves the effect of Large HSAs on pooling. Insofar as Large HSAs reduce pooling, that would benefit low-risk insureds at the expense of sicker individuals. Some suggest that greater reliance on non-group insurance may not reduce pooling much, if at all (Pauly et al., 1999). However, even if Large HSAs were to reduce subsidies across risk categories, they would still provide expanded tax benefits to many high-risk individuals, particularly those currently without access to employer-sponsored insurance. Importantly, unlike proposals that offer tax benefits only for health insurance itself (tax credits, a standard health insurance deduction, etc.) or that condition other tax benefits on the purchase of insurance (current-law HSAs), Large HSAs would benefit even the uninsurable, who could set thousands of dollars aside, completely tax-free, for their medical expenses.

Finally, Large HSAs raise issues of intergenerational equity. If Large HSAs expand the revenue loss due to the exclusion, and with it the federal deficit, that inequitably shifts the burden of current government outlays from current to future generations. On the other hand, encouraging current generations to save for future medical expenses could reduce the burden of entitlements on future generations. If Large HSAs increase the efficiency of the health care sector in the present, that too benefits future generations.

D. A Step toward Neutrality

Large HSAs present an opportunity to limit the tax exclusion and other health-related deductions that may be more politically feasible than past proposals. If so, this reform may also facilitate a transition to tax neutrality for health expenditures.

The Large HSA approach could help overcome the two main obstacles to eliminating or limiting the exclusion. First, eliminating the exclusion would tax currently untaxed economic activity by subjecting all employer-sponsored health benefits to both income and payroll taxes. Capping the exclusion would do the same insofar as the value of one's health benefits exceeds the specified cap. Those whose tax liability would rise naturally resist such proposals, while anti-tax activists resist on principle. The second obstacle is more technical. Capping or removing the exclusion would require employers to determine the value of each worker's health benefits for the purpose of calculating the taxes due. Determining the value of each worker's health benefits could be a difficult task for many employers.

Large HSAs could help overcome both obstacles. First, Large HSAs could reduce political opposition to a cap. The higher the contribution limits, the smaller the number of workers who would see any of their current health benefits subject to taxation. As noted earlier, contribution limits of $8,000 for individuals and $16,000 for families would have required only about 3 percent of covered workers in 2006 to pay taxes on a portion of their health benefits. Indeed, workers whose health benefits are less expensive than the contribution limits would be able to exclude more income than they do now.

More important, however, is that workers would gain greater control over their earnings. If a worker who currently excludes $9,000 worth of health benefits is suddenly subject to an $8,000 Large HSA contribution limit, she would have to pay taxes on $1,000 of her premiums. However, she would have far more control over the first $8,000. Her employer's influence over those earnings would disappear. The

exclusion causes workers to lose a significant amount of control over their earnings and health care decisions, which itself is akin to a tax. Large HSAs would eliminate that tax, and therefore arguably could reduce taxes even for those whose benefits exceed the contribution limits.

Second, Large HSAs could reduce the difficulties involved in calculating the value of health benefits for individual workers. Though many firms attribute a premium cost to each worker's health benefits, not all do. Self-insured plans pay claims as they occur, therefore there may be no premium already assigned to each worker (Fronstin, 2006).

Assigning premiums in such cases would be a delicate task. Whatever premium the firm assigns to a worker would become part of that worker's income. Younger workers would prefer that employers assign premiums (and "cash them out") as though premiums had been community-rated; that is, uniform across workers. Older workers would prefer that employers cash them out as though premiums had been risk-adjusted; doing so would assign higher premiums, and therefore a greater increase in cash wages, to older workers. Older workers would have a strong argument to make, given that wages appear to vary across firms according to easily observable risk factors such as age (Pauly et al., 1999). That suggests that, in effect, premiums for employer-sponsored coverage are not community-rated within firms, and that high-cost workers currently pay more than low-cost workers for the same coverage, because high-cost workers also pay in the form of lower wages.

Employers might choose whatever method of assigning premiums they believe would be least disruptive to their workforce. Though the least disruptive strategy would vary across firms, most employers likely would choose some form of risk-adjustment, given that health benefits are a particularly important part of the employment contract for high-cost workers. Employers could assign premiums based on the cost of the worker's current plan, the number of family members covered by the plan, the worker's age, seniority, past claims, or some combination of these factors. Firms are unlikely to assign premiums that are 100-percent actuarially fair, as doing so could alienate young and healthy workers. However, even if employers favor high-cost workers in that process, labor markets would eventually dissipate any supra-competitive wages.

Simply eliminating or capping the exclusion would force firms and workers to confront these difficulties at the same time they confront a significant tax increase. In contrast, Large HSAs could minimize the likelihood that any worker would face a tax increase. Moreover, Large HSAs could make that process more transparent, by creating a moment (such as the beginning of a calendar year) when employers would be expected to convert their contribution to each workers' health benefits into a wage increase. By forcing that process to occur in the open, Large HSAs could generate more information and predictability about those conversions, thereby enabling employers and workers to plan for and adjust to those changes.

Like other proposals to achieve parity between group and non-group coverage, Large HSAs would raise additional concerns. In converting the employer's premium contribution to cash wages, would firms shortchange particular groups of workers? Would they shortchange workers as a whole? Would employers continue to offer health insurance? What other coverage options would be available?

Large HSAs would allow workers and firms to sort through these issues gradually. On the first day the tax code substitutes Large HSAs for the current exclusion, workers and firms could continue operating as if nothing had changed. Most workers would receive the full value of their health benefits as a cash contribution into their Large HSA. Healthy workers would see no jarring increase in their tax liability that might encourage them to pare back on coverage by leaving the firm's health plan. Over time, labor

markets would push employers to pay workers according to their market value, thereby reducing the likelihood that workers would suffer as a result of an employer's arbitrary valuation of the workers' health benefits. Finally, as health insurance markets matured, workers would grow more familiar and comfortable with other coverage options.

Large HSAs would thus develop the health insurance and labor market conditions necessary to move to a tax system neutral toward health-related uses of income. Allowing those changes to occur before making a transition to full neutrality would make that final transition less opaque or jarring. A revenue-neutral transition would essentially require eliminating tax breaks for Large HSA contributions and lowering tax rates concomitantly. Large HSAs would make the size of each worker's tax break more transparent, thus workers could readily calculate how they would be affected by (1) increasing their base of taxable income and (2) taxing that income at a lower rate. There will be winners and losers in any attempt at fundamental tax reform, yet Large HSAs could reduce the opacity of, and therefore much opposition to, such a transition. Likewise, after the transition, workers would be better equipped to navigate the level playing field between employer-provided and other types of insurance, because the playing field already would have been level for some time.

IV. Additional Effects

Large HSAs would have additional economic effects of interest to citizens and policymakers. Large HSAs could influence the cost of different insurance choices (including the choice not to purchase insurance), aggregate demand for medical care, economic output, and federal revenues.

A. Insurance Premiums & the Number of Uninsured

By altering the relative prices of various ways of financing medical expenses, Large HSAs could affect the availability and affordability of different insurance options. Large HSAs would reduce the cost of non-group coverage relative to group coverage, benefiting many individuals with non-group coverage, as well as many uninsured.

At the same time, that change could increase the cost of insurance for sicker-than-average households. Establishing tax parity between group and non-group coverage could make it easier for healthier households to find less costly coverage in the non-group market. To the extent that healthier households abandon employment-based groups, the risk profile of those groups will deteriorate, which could cause premiums to rise to the point that some sicker-than-average households might no longer be able to afford coverage.

Though some risk segmentation is likely, Large HSAs are unlikely to cause many employment-based groups to unravel or many currently insured individuals to lose coverage. Marquis and colleagues estimate that reducing the price of non-group coverage by 20 percent would motivate less than 0.05 percent of workers to leave their employment-based health plan, and that substantial shares of households with health problems not only obtain coverage in the non-group market but pay standard premiums as well (Marquis et al., 2006).

That is consistent with Congressional Budget Office projections of the effects of a similar proposal, the Bush administration's standard health insurance deduction. The CBO projects that proposal would cause 6.3 million people to move from group to non-group coverage. Migration from employer-sponsored insurance to non-group insurance would be limited, the CBO writes, because "the former has significantly lower administrative costs and advantages in forming insurance pools with more predictable costs." An estimated 1.5 million people with group coverage would go uninsured, yet that number would

be swamped by 7 million previously uninsured people who would obtain non-group coverage and a further 1.3 million who would obtain job-based coverage. On balance, the CBO projects that a standard deduction would reduce the number of uninsured residents by a net 6.8 million, though these estimates are "highly uncertain" (CBO, 2007). Given the similarities between the two proposals, Large HSAs are likely to have similar effects.

Large HSAs would affect the cost of going uninsured, however, in ways that a standard deduction would not. Large HSAs would not require that the account holder carry insurance. That would reduce the cost of that option for many uninsurable households—including any households that may lose coverage due to risk segmentation induced by Large HSAs—because it would dramatically expand the tax benefits available for the uninsurable. A standard deduction, like many other proposed health-tax reforms, would provide no tax benefits to this group.

At the same time, the lack of any insurance requirement could encourage people to forgo coverage, build up savings, and rely on uncompensated care if they ever exhausted those funds. Though this concern is valid, Large HSAs would not so much attract free-riders as savers. Most Americans already have the option of forgoing health insurance and relying on uncompensated care.[7] The only inducement added by Large HSAs would be the ability to save tax-free for one's medical expenses. If the lack of an insurance requirement would increase the number of uninsured, that necessarily means there are currently covered workers who do not drop that coverage *solely because* they do not have the opportunity to accumulate tax-free health savings without purchasing insurance.

Large HSAs nevertheless provide a considerable incentive for such individuals to purchase health insurance. Over time, these savers could accumulate substantial balances, which they would want to protect from being wiped out by a serious illness or injury (Phelps, 2003). The most obvious way to protect those assets is with health insurance. Even if the savers did not purchase insurance, they would have (at a minimum) their Large HSA balances to help pay for any needed medical expenses.

Finally, insofar as Large HSAs make consumers more price-sensitive, they can be expected to generate greater price transparency and competition, reducing costs for both the insured and the uninsured.

B. Demand for Medical Care

Large HSAs could increase or decrease overall demand for medical care. Their effect on each consumer's demand for medical care would depend on the consumer's Large HSA contribution limit, current income, insurance status, insurance premiums, risk-aversion, marginal tax rate, and any resulting changes in her overall compensation. Given that Large HSAs' greatest effect would arguably be to reduce the cost of self-insurance and out-of-pocket expenditures relative to third-party insurance, it seems reasonable to predict that Large HSAs would reduce overall demand for medical care.

To isolate some of the complicated effects that Large HSAs would have on the demand for medical care, assume that: (A) Large HSAs with contribution limits of $8,000 per individual and $16,000 per family would replace all existing federal tax preferences for health-related uses of income; (B) those Large HSA contribution limits would remain constant in nominal terms; and (C) each worker's overall compensation would remain constant—i.e., employers would "cash-out" each worker on an actuarially fair basis. Given those conditions, Large HSAs would:

1. Increase the inframarginal cost of third-party insurance relative to self-insurance for 160 million U.S. residents with employer-sponsored coverage. This would tend to reduce the demand for medical care.

2. Reduce the cost of self-insurance and out-of-pocket medical expenditures relative to other uses of income for 160 million residents with employer-sponsored insurance. This would tend to increase the demand for medical care.[8]

3. Encourage greater savings, as a result of (1) and (2). The resulting wealth effect would tend to increase demand for (health insurance and therefore medical care) over time, though this effect is likely to be small.[9]

4. Reduce the marginal cost of third-party insurance relative to non-health uses of income—but also relative to self-insurance and out-of-pocket medical expenditures—for most of the 160 million with employer-sponsored insurance. In 2006, approximately 97 percent of covered workers excluded from taxation less than they would have been able to under the proposed Large HSA contribution limits. Insofar as such workers prefer more coverage than their employer currently offers, this would tend to increase the demand for medical care.[10]

5. Increase the marginal cost of third-party insurance relative to other uses of income for those who exempt premiums in excess of the Large HSA contribution limits. In 2006, approximately 3 percent of covered workers would have fallen into this group. This would tend to reduce the demand for medical care.

6. Reduce the cost of third-party insurance, self-insurance, and out-of-pocket medical spending, relative to other uses of income, for an estimated 16 million residents with non-group coverage and 47 million uninsured residents. This would tend to increase the demand for medical care. However, that effect would be dampened to the extent that such households already deduct from their taxable income contributions to current-law HSAs or medical expenses in excess of 7.5 percent of their adjusted gross income (AGI). Moreover, medical expenses in excess of both 7.5 percent of AGI and applicable Large HSA contribution limits would be newly subject to income taxes, which would tend to reduce the demand for medical care. (See Appendix.)

7. Reduce the cost of leaving an employer's health plan by removing the attendant tax penalty. Insofar as they encourage healthier-than-average households to leave employment-based plans, Large HSAs would increase the cost of health insurance for sicker-than-average households. This would tend to reduce the demand for medical care.[11]

Altering the initial Large HSA contribution limits or their rate of growth would influence these effects. Lower initial contribution limits would do more to reduce the demand for medical care than higher contribution limits. If contribution limits grow at a slower rate than health insurance premiums, that would tend to reduce the demand for medical care by reducing the demand for health insurance. If contribution limits grow at a rate slower than medical inflation, that likewise would tend to reduce the demand for medical care. Higher initial contribution limits and growth rates would put less downward pressure on demand for medical care, and at some point would increase overall demand.

If employers "cash out" all covered workers within a firm the same dollar amount, then sicker-than-average households would effectively suffer a loss in total compensation. This would tend to reduce the demand for medical care. Increasing cash wages in proportion to the expected benefit that each worker derives under the employer's health plan, on the other hand, would have a more neutral effect on overall demand. Nevertheless, the labor market would eventually dissipate any supra-competitive wages, which

could ultimately reduce sicker households' incomes and reduce their demand for medical care.

How Large HSAs would affect the demand for medical care is ultimately an empirical question. Given that Large HSAs would dramatically reduce the cost of self-insurance relative to third-party insurance for the bulk of the population and cap federal tax preferences for medical care, it is reasonable to predict that on balance Large HSAs would reduce overall demand for medical care.

C. Economic Output & Consumer Welfare

Large HSAs would affect overall economic output and consumer welfare. By limiting federal tax breaks for health-related uses of income, Large HSAs could increase marginal tax rates for some workers, which implies a reduction in the quantity of labor supplied and lower economic output. At the same time, Large HSAs would reduce marginal tax rates for many workers, which implies the opposite. By expanding existing tax incentives to save for future medical expenses, Large HSAs would encourage greater national saving and higher future economic output. By reducing the existing tax-based distortions of workers' health spending and saving decisions, Large HSAs could increase overall consumer welfare in ways that standard measures of economic output would not capture.

Large HSAs could increase (or reduce) a worker's federal marginal tax rate by increasing (or reducing) a worker's taxable income, thereby moving the worker into a different tax bracket. To the extent that workers respond to Large HSAs by excluding additional income from taxation, that would reduce workers' taxable incomes, and thereby move many into lower tax brackets. Conversely, Large HSAs could move some workers into higher tax brackets by forcing some workers to reduce the amount of income they exclude from taxation for health-related purposes.

Assuming no change in a worker's tax bracket, Large HSAs would increase federal marginal tax rates to the extent that workers demand coverage more costly than the applicable Large HSA contribution limit. Likewise, to the extent that the last dollar of income a worker devotes to health-related uses falls below the applicable contribution limit, Large HSAs would reduce the worker's federal marginal tax rate.

Again, the effects that a standard deduction would have on the broader economy can illuminate the potential effects of Large HSAs. The CBO projects that a standard deduction would increase effective federal marginal tax rates by 1.2 percentage points in 2009 and 1.8 percentage points in 2017, and would somewhat increase national saving. On net, the CBO projects the proposal would reduce gross national product by less than 0.5 percent per year (CBO, 2007).

Two differences make it plausible to predict that Large HSAs would reduce future economic output less than a standard deduction. First, Large HSAs would increase marginal tax rates for fewer workers. While a standard deduction would create a large incentive to purchase a basic insurance policy, any marginal tax preference disappears after that initial margin. Large HSAs would preserve a tax preference for health-related uses of income up to the contribution limits, which suggests fewer workers would experience higher marginal tax rates. Second, even if Large HSAs were calibrated to have the same impact on federal revenues (and thus national saving) as a standard deduction, Large HSAs would still create an additional tax incentive for households to increase their savings. That could increase national saving and future economic output beyond what a standard deduction would achieve.

Finally, as with a standard deduction, Large HSAs would reduce the tax code's distortions of how workers allocate their earnings. Thus even if economic output were to remain constant, overall consumer welfare would rise because consumers would allocate their earnings to more highly valued uses.

D. Federal Revenues

Large HSAs would also affect federal revenues. If contribution limits are set sufficiently high, Large HSAs would reduce federal revenues for a number of years by exempting a greater share of workers' earnings from income and payroll taxes. Those contribution limits, however, would act as a cap on tax preference for health-related uses of income and would subject an ever-increasing share of earnings to taxation. Like the proposed standard deduction for health insurance (CBO, 2007), over the long term Large HSAs would increase federal tax revenues compared to current law.

V. Implementation Options

As suggested above, Large HSAs offer a number of implementation options. One is the level of the contribution limits, which can be calibrated to strike a politically viable balance between, for example, efficiency and equity. Higher contribution limits would hold more taxpayers harmless; reduce political resistance by workers, employers, and anti-tax activists; allow sicker people to set aside more money tax-free; and enable more workers to save for their future health needs. Higher contribution limits would also result in a larger revenue loss for the federal government; provide larger tax breaks for high-income earners; and expand distortions between health-related and non-health-related expenditures. Low contribution limits would reduce economic distortions; increase the tax burden for more workers; reduce federal revenue losses; and encounter greater political opposition from anti-tax activists.

An important part of setting contribution limits would be the question of whether and how those limits would change over time. Different approaches would offer advantages and disadvantages, both political and economic. Contribution limits could be fixed in nominal terms or indexed to overall inflation, which tends to grow less rapidly than medical inflation. Such an approach effectively phases in lower contribution limits over time, with all the attendant advantages and disadvantages. In contrast, contribution limits indexed for medical inflation could reduce political opposition to Large HSAs by requiring fewer workers to pay taxes on a portion of their health benefits. However, that political benefit would come at the cost of preserving economic distortions that would be eliminated by contribution limits that rose more slowly.

These parameters could be adjusted to enable legislative approval. If a political equilibrium requires that Large HSAs redistribute more of the tax benefits from rich to poor, or result in a smaller revenue loss, or do more to limit the distortion of consumers' allocation decisions; then contribution limits may be adjusted downward, whether initially, over time, or both. If equilibrium requires that Large HSAs subject fewer currently untaxed expenditures to taxation, or encourage greater saving for future health needs, or provide unhealthy individuals greater ability to purchase medical care tax-free; then contribution limits may be adjusted upward. If policymakers wish to dampen demand for medical care, they may reduce or eliminate the 10-percent penalty for non-medical withdrawals from a Large HSA.

VI. Conclusion

The tax exclusion for employer-sponsored health benefits engenders considerable inefficiencies and inequities, and has earned critics of all political stripes. At the same time, the exclusion is the foundation of America's employment-based health care system, and therefore has defenders who are averse to unsettling the status quo. HSAs, as enacted in 2003, represent a rather modest step toward reducing price distortions within the health care sector, but do so at the expense of magnifying price distortions between the health care sector and other sectors.

HSAs create an opportunity, however, to restructure the exclusion in a way that would enable more individuals to obtain health insurance that matches their preferences, increase efficiency, eliminate the

horizontal inequities created by the exclusion, and could even create improvements in vertical equity. Additionally, Large HSAs could serve as a step toward a tax system that offers no preferred treatment to health expenditures, and thereby forces the health care sector to accomplish more with the resources devoted to it.

Appendix

To illustrate the complicated and countervailing effects that substituting Large HSAs for the current set of health-related federal tax breaks would have on the demand for medical care, consider households for whom 7.5 percent of adjusted gross income (AGI) is either greater than or less than the relevant Large HSA contribution limit:

Table I.

	If 7.5% of a Household's AGI Is Less than the Household's Large HSA Contribution Limit, then Qualified Medical Expenses that Fall…		
	Between $0 & 7.5 percent of AGI	*Between 7.5 percent of AGI & the Large HSA Contribution Limit*	*Above the Large HSA Contribution Limit*
Are Currently Subject to	Income & payroll taxes	Payroll tax	Payroll tax
And under Large HSAs Would Be	Newly exempt from both income & payroll taxes	Newly exempt from payroll tax	Newly subject to income tax
Which Would Tend to	**Increase the demand for medical care**	**Increase the demand for medical care**	**Reduce the demand for medical care**
	…within that margin.		

Table II.

	If 7.5% of Household's AGI Exceeds Household's Large HSA Contribution Limit, then Qualified Medical Expenses that Fall…		
	Between $0 & the Large HSA Contribution Limit	*Between the Large HSA Contribution Limit & 7.5 percent of AGI*	*Above 7.5 percent of AGI*
Are Currently Subject to	Income & payroll taxes	Income & payroll taxes	Payroll tax
And under Large HSAs Would Be	Newly exempt from both income & payroll taxes	Unchanged	Newly subject to income tax
Which Would Tend to	**Increase the demand for medical care**	**Have no effect on the demand for medical care**	**Reduce the demand for medical care**
	…within that margin.		

Notes

1. In 2008, a qualified self-only health plan may have a deductible of no less than $1,100 and no more than $5,600. A qualified family policy may have a deductible of no less than $2,200 and no more than $11,200. HSA-qualified high-deductible health plans are generally prohibited from covering medical services below the plan's deductible. A statutory exception exists for preventive are, which qualified health plans may cover below the deductible. IRS regulations further permit below-the-deductible coverage for treatment "that is incidental or ancillary to a preventive care service" and delivered under circumstances "where it would be unreasonable or impracticable to perform another procedure to treat the condition" (IRS, 2004). Total out-of-pocket exposure is limited to $5,600 for self-only coverage and $11,200 for family coverage.

2. HSA holders ages 55 to 64 may make additional "catch-up" contributions of $900 in 2008 (Treasury, 2005). The minimum and maximum deductibles, maximum out-of-pocket exposure, and maximum HSA contribution limits are indexed annually to reflect changes in the cost of living. The maximum catch-up contribution amount rises by $100 annually until 2009.

3. Medical expenses in excess of 7.5 percent of adjusted gross income, for example, are deductible for income tax purposes. Certain workers can purchase medical services tax-free through employer-sponsored flexible spending accounts (FSAs). In 2002, the IRS allowed employers to make tax-free contributions on behalf of an employee to a health reimbursement arrangement (HRA), from which the employee can purchase medical services tax-free.

4. Though FSAs and HRAs use something resembling a savings account, both "accounts" are subject to a use-it-or-lose-it rule.

Workers forfeit funds left in their FSA at the end of the year, while workers with an HRA forfeit leftover balances when they leave their employer. Thus workers cannot save the funds involved. Moreover, HRAs need not even be funded. Employers may set up HRAs as notional accounts, covering HRA liabilities only as they are incurred.

5. HSA contributions made by employers are excluded from income and payroll taxation. Workers with access to a Section 125 cafeteria plan may themselves make HSA contributions that are excluded from both income and payroll taxation. Workers without access to a cafeteria plan may only deduct HSA contributions for income tax purposes. HSA funds remain untaxed if they are left in the account (interest accrues tax-free) or withdrawn to pay qualified medical expenses (IRS, 2005a). HSA distributions for non-medical expenses are taxed as income and assessed a 10-percent penalty, though the penalty is waived if the distribution occurs after the account holder dies, suffers a disability, or reaches age 65. Upon death of the account holder, the HSA either reverts to the account holder's spouse; becomes part of the account holder's estate, where the value of the HSA is taxed as income; or is taxable to the beneficiary (IRS, 2005b).

6. These figures are close to the nationwide averages for employer-sponsored family coverage in 2007 (Kaiser/HRET, 2007).

7. That option is still legal in at least 48 states.

8. Reducing the cost of out-of-pocket medical spending relative to non-medical uses of income would tend to increase the demand for medical care. However, that effect would be mitigated to some extent by a concomitant reduction in the cost of saving for future medical consumption (and in the cost of saving for non-medical consumption after the worker turns 65) relative to other uses of income. (After age 65, the 10-percent penalty for non-medical withdrawals disappears and such withdrawals are taxed as regular income, much like 401(k)s and some IRAs.)

9. "In most studies using individual data, estimated income elasticities [for health insurance] are generally positive, but less than 1 for almost any measure of insurance chosen" (Phelps, 2003).

10. The cost of obtaining more coverage than one's employer currently offers is higher than the additional premium and the worker's marginal tax rate would suggest. Purchasing additional coverage generally involves either declining the plan offered by one's employer or switching jobs. Therefore, the cost of obtaining additional coverage includes forgoing the tax break available under the employer's plan, or alternatively, the costs involved in obtaining a different job that offers the desired level of coverage. Large HSAs would enable workers to purchase more coverage than their employer offers without sacrificing that tax break or changing jobs. Thus, although Large HSAs would reduce the cost of self-insurance and out-of-pocket spending relative to third-party insurance in most cases, Large HSAs could likewise dramatically reduce the marginal cost of third-party insurance for workers who prefer more coverage than their employer offers.

11. The impact on demand among healthier-than-average households is captured by (1) and (4).

References

Bhattacharya, Jayanta and M. Kate Bundorf, "The Incidence of the Healthcare Costs of Obesity," 2005, National Bureau of Economic Research, Working Paper No. W11303.

Burman, Leonard, et al., "The President's Proposed Standard Deduction for Health Insurance: An Evaluation," 2007, Urban Institute and Brookings Institution Tax Policy Center.

Cannon, Michael F., "Cato Institute Policy Analysis no. 569: Health Savings Accounts: Do the Critics Have a Point?" 2006, Cato Institute.

Center on Budget and Policy Priorities (CBPP), "A Brief Overview of the Major Flaws with Health Savings Accounts," 2006.

Cogan, John F., et al., *Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System* , 2005, AEI Press/Hoover Institution, Washington, DC.

Conover, Christopher, "Cato Institute Policy Analysis no. 527: Health Care Regulation: A $169 Billion Hidden Tax," 2004, Cato Institute.

Custer, William F., et al., "Why We Should Keep the Employment-Based Health Insurance System,"

Health Affairs, Vol. 18, No. 6.

DeNavas-Walt, Carmen, et al., "U.S. Census Bureau Current Population Reports: Income, Poverty, and Health Insurance Coverage in the United States: 2005," 2006, U.S. Census Bureau.

Feldstein, Martin, "The Welfare Loss of Excess Health Insurance," *Journal of Political Economy*, 1973, Vol. 81, No. 2, Part 1.

Feldstein, Martin and Bernard Friedman, "Tax Subsidies, the Rational Demand for Insurance and the Health Care Crisis," *Journal of Public Economics*, 1977, Vol. 7, No. 2.

Feldstein, Martin, and Jonathan Gruber, James Poterba, ed., "A Major Risk Approach to Health Insurance Reform," *Tax Policy and the Economy*, Volume 9, 1995, MIT Press, Cambridge, MA.

Friedman, Milton, "How to Cure Health Care," *Public Interest*, 2001, No. 3.

Fronstin, Paul, "The Tax Treatment of Health Insurance and Employment-Based Health Benefits," Employee Benefit Research Institute Issue Brief, No. 294, 2006, Employee Benefit Research Institute.

Furman, Jason, "Our Unhealthy Tax Code," *Democracy*, 2006, Issue #1.

Furman, Jason, "Two Wrongs Do Not Make a Right," *National Tax Journal*, 2006, Vol. 59.

Glied, Sherry, *Revisiting the Tax Treatment of Employer-Provided Health Insurance* , AEI Press, 1994, Washington, DC.

Gruber, Jonathan, and James Poterba, Martin Feldstein and James Poterba, eds., "Tax Subsidies to Employer-Provided Health Insurance," *Empirical Foundations of Household Taxation*, University of Chicago Press, 1996, Chicago, IL.

Hall, Cheryl, "A Novel Idea: Health Insurance You Take with You," *Dallas Morning News*, March 27, 2005.

Hall, Robert E., and Alvin Rabushka, *The Flat Tax*, Hoover Institution Press, 1995, Stanford, CA, 2nd edition.

Helms, Robert, "Mission Improbable: No One Is Going to Blow up Health Insurance," *Tax Notes*, 2006.

Herrick, Devon M., "Health Insurance: Why Rent When You Can Own?" *Health Care News*, May 1, 2005, http://www.heartland.org/Article.cfm?artId=16866.

Kaiser Family Foundation and the Health Research and Educational Trust (HRET), *Employer Health Benefits: 2007 Annual Survey*, 2007.

Mack, Connie, et al., "Simple, Fair, and Pro-Growth: Proposals to Fix America's Tax System," Report of the President's Advisory Panel on Federal Tax Reform, 2005, http://www.taxreformpanel.gov/finalreport/TaxReform_Intro.pdf.

Marquis, M. Susan, et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 2006, Vol. 25, No. 3.

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

Nichols, Len M., et al., "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," 1996, Urban Institute.

Pauly, Mark V., "An Analysis of Medical Savings Accounts: Do Two Wrongs Make a Right?" 1994, AEI Press, Washington, DC.

Pauly, Mark V., and Bradley Herring, *Pooling Health Insurance Risks*, 1999, The AEI Press, Washington, DC.

Pauly, Mark V., and John C. Goodman, "Tax Credits for Health Insurance andMedical Savings Accounts," 1995, *Health Affairs*, Vol. 14, No. 1.

Pauly, Mark et al., "Individual versus Job-Based Health Insurance: Weighing the Pros and Cons," 1999, *Health Affairs*, Vol. 18, No. 6.

Phelps, Charles E., *Health Economics*, 2003, Addison Wesley, Boston, MA, 3rd edition.

Sheils, John F., "Percent Distribution of Covered Workers by Premium Amount Per Month for Those with Single and Family Coverage," personal correspondence to Michael F. Cannon, January 7, 2005, author's files.

Slemrod, Joel B., ed., *Does Atlas Shrug? The Economic Consequences of Taxing the Rich*, 2000, Russell Sage Foundation/Harvard University Press, Cambridge, MA.

Strunk, Bradley C., et al., "Tracking Health Care Costs: Declining Growth Trend Pauses in 2004," 2005, *Health Affairs* Web Exclusive.

U.S. Congressional Budget Office, "Appendix C—The President's Proposal for a Standard Tax Deduction for Health Insurance," in *An Analysis of the President's Budgetary Proposals for Fiscal Year 2008*, 2007.

U.S. Council of Economic Advisers (CEA), *Economic Report of The President, Together With The Annual Report of The Council Of Economic Advisers*, U.S. Government Printing Office, 2006.

U.S. Department of the Treasury, "Indexed Amounts for Health Savings Accounts," October 28, 2005, press release.

U.S. Internal Revenue Service (IRS), "Notice 2004-50 - Part III - Administrative, Procedural, and Miscellaneous," July 23, 2004 (corrected version posted August 10, 2004).

U.S. Internal Revenue Service (IRS), "Publication 502: Medical and Dental Expenses (Including the Coverage Tax Credit) for Use in Preparing 2005 Returns," 2005a.

U.S. Internal Revenue Service (IRS), "Publication 969 (2005), Health Savings Accounts and Other Tax-Favored Health Plans," 2005b.

U.S. Office of Management and Budget (OMB), *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2007*, U.S. Government Printing Office, 2006.

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Chapter 66

Medicare

by Michael F. Cannon

Cato Handbook for Policymakers, 7th Edition, Chapter 12

12. Medicare

Congress should

- establish, in all parts of Medicare, premiums proportionate to lifetime earnings;
- allow seniors to opt out of Medicare completely, without losing Social Security benefits;
- give Medicare enrollees a means-tested, risk-adjusted voucher with which they may purchase the health plan of their choice;
- limit the growth of Medicare vouchers to the level of inflation;
- allow workers to save their Medicare taxes in a personal, inheritable account dedicated to retirement health expenses; and
- fund any "transition costs" by reducing other government spending, not by raising taxes.

Medicare is the federal entitlement program that provides health insurance to the elderly and disabled. Despite its popularity with seniors, the disabled, and those who might otherwise have to care for them, Medicare infringes on the right of workers to control their retirement savings and on the freedom of seniors to control their own health care. Medicare has done enormous damage to the U.S. health care sector and to individual liberty. Absent congressional action, that damage will only increase over time. Medicare reform is the nation's highest health-policy priority.

Rising Costs and Restricted Freedom

Congress created Medicare in 1965 on premises both morally suspect and impractical. (The same legislation created Medicaid; see Chapter 13.) One premise is that government should tax young workers to pay for the health care needs of their elders, many of whom do not need it and many of whom never contributed to the program. The first generation of Medicare beneficiaries essentially got something for nothing, receiving subsidies without having contributed to the program. As if to celebrate this inequity, the first Medicare beneficiary was a man who neither contributed to Medicare nor needed it: former president Harry S. Truman. Since Medicare's enactment, each generation of seniors has demanded that its children and grandchildren pay the debt it is owed by its elders. Yet successive generations of seniors have voted themselves greater subsidies to be financed by younger taxpayers. The most recent example is Medicare Part D, the prescription drug benefit created by Congress and President Bush in 2003. Less expensive benefit expansions occur routinely, without congressional action, every time Medicare approves an expensive new technology for coverage. In 2004, the Bush administration unilaterally announced that Medicare would cover obesity treatments. The growing generosity of Medicare benefits is the principal reason why Medicare has been responsible for at least a dozen tax increases in its 43-year history. Medicare thus enables each generation to extract more from its children and grandchildren than it gave to its parents and grandparents.

Medicare's obligations and financing structure are unsustainable. A number of factors will fuel growth in Medicare spending in the coming years. Demographic trends will reduce the number of workers available to finance Medicare relative to the number of beneficiaries. According to Medicare's trustees, the ratio will fall from about 4 workers per beneficiary in 2003 to about 2.4 workers per beneficiary in 2030 and will continue to fall until there are only 2 workers per beneficiary in 2078. Health care costs will continue to climb. In 2003, the Congressional Budget Office estimated that 30 percent of Medicare's future growth would be due to society's aging, while 70 percent would be due to the rising cost of health care. Existing revenue streams for Medicare are insufficient to keep the promises that Congress has made to future beneficiaries. Medicare's trustees estimate that Congress would need to put over $80 trillion in an interest-bearing account in 2008 to cover those future funding gaps. In 2008, the entire economic output of the United States was less than $15 trillion. The $700 billion bailout of the financial sector enacted by Congress in late 2008 is less than 1 percent of the amount required to bail out Medicare. The Congressional Budget Office estimates that if Congress were to meet that shortfall by raising income taxes, federal individual income tax rates would roughly double by 2050, with the top marginal rate reaching 66 percent. The CBO further estimates that tax increases of that magnitude could suppress national income by as much as 20 percent.

A second suspect premise is that participation in Medicare is voluntary. In fact, Medicare greatly restricts the freedom of workers, seniors, and entrepreneurs. Medicare crowds out other health insurance options for seniors and forces seniors who decline Medicare benefits to forfeit all past and future Social Security benefits. It prohibits participating providers from delivering Medicare-covered services to beneficiaries on a private basis, an affront to the right of patients and doctors to make mutually beneficial exchanges that affect no one else. And of course funding Medicare is hardly voluntary; Americans are required to pay the 2.9 percent

Medicare payroll tax and other federal taxes, which finance the program through general revenues.

A third premise is that government can or should devise a one-sizefits-all package of health insurance benefits for tens of millions of senior citizens. To reduce opposition within the health care industry and ensure enactment, Medicare's sponsors modeled Medicare coverage on Blue Cross Blue Shield coverage as it existed in 1965. The industry wanted Medicare to pay physicians on a fee-for-service basis and to have little ability to refuse payment for low-value or inefficient services. That sounds appealing on the surface—few people like the idea of having government ration medical care. Yet Medicare ends up committing the opposite sin—wasting money on useless services—which can be just as harmful as government rationing. There is considerable evidence that Medicare wastes vast sums of money on low-value services and that fee-for-service payment is a prime contributor to such waste. Researchers at Dartmouth Medical School estimate that 30 percent of Medicare spending does nothing to make beneficiaries healthier or happier. That suggests that Medicare spends about $150 billion each year—roughly the entire economic output of South Carolina—on medical services of no discernible value. Political pressure from the industry prevents Congress or the Medicare bureaucracy from dealing with those problems. (Every dollar of wasteful Medicare spending is a dollar of income to *somebody*, and that somebody typically has a lobbyist.) Having locked in a payment system based on fee-for-service reimbursement and a fragmented delivery system, Medicare suppresses competition from alternative payment and delivery systems (see also Chapter 15, "Health Care Regulation").

When Medicare was enacted, it effectively destroyed a large and growing private market for health insurance for seniors that would have enabled greater experimentation and competition. By 1962, an estimated 60 percent of seniors had voluntary health insurance coverage, up from 31 percent in 1952. Today, seniors essentially have only one place to go for health insurance. They may augment their Medicare coverage by enrolling in a private Medicare Advantage health plan or by purchasing Medicare supplemental or "Medigap" coverage. Medigap plans typically make seniors even less price sensitive and more likely to overconsume care. Medicare Advantage plans (previously known as Medicare + Choice plans) tend to provide an unstable alternative to traditional Medicare, as Congress frequently adjusts payment levels and private plans enter and exit the program on the basis of the (perceived) adequacy of those payments.

Supporters claim that Medicare is more efficient than private insurance because it has lower administrative costs. To reach that conclusion, they ignore many of Medicare's administrative costs, in particular the "excess burden" or reduced economic output caused by Medicare taxes. Those costs are estimated at 20 to 100 percent of Medicare's expenditures, dwarfing any administrative costs of private firms. And decades of reports by government watchdogs demonstrate that the main way Medicare avoids administrative costs is by failing to scrutinize claims to prevent fraud or to ensure value. The Government Accountability Office found that in 2004 Medicare call centers answered providers' billing questions accurately and completely only 4 percent of the time. It is no wonder, then, that the Department of Health and Human Services reports improper Medicare payments of $12.1 billion in 2001. Medicare's avoidance of administrative expenses is a vice, not a virtue.

Reform of Priorities

Medicare should be policymakers' top health care priority, and the program demands immediate reform. Congress should focus immediately on two steps. First, it should charge premiums for all parts of Medicare, charging higher premiums to seniors with higher lifetime earnings (i.e., "means-tested" premiums). Generally, seniors pay premiums only for Part B (physician insurance) and Part D (prescription drug coverage), not for Part A (hospital insurance). Those combined premiums currently account for about 13 percent of total Medicare spending. Congress should increase premiums for high earners until premiums cover at least 25 percent of total outlays.

Increasing premiums on high-income earners creates a problem: it discourages high-income seniors from working by penalizing them with higher premiums. Charging higher premiums to seniors with high *lifetime* incomes can mitigate that problem. (If *past* earnings are the primary factor influencing Medicare premiums, strategic behavior becomes more difficult. Seniors would be unable to alter their past earnings, and reducing their current earnings would have less of an effect on their premiums. The Social Security Administration already possesses the data necessary to calculate seniors' lifetime earnings.)

Second, Congress should allow seniors to opt out of Medicare without losing their Social Security benefits.

Broader means-testing and permission for seniors to opt out of Medicare would achieve only modest progress in shoring up the program's finances and restoring seniors' freedom. They would have an enormous effect, however, on the politics of Medicare. As well-to-do seniors see their premiums rise, many will decide that Medicare is a bad deal and will leave the program. If they are allowed to retain their Social Security benefits, even more will exit the program. Today, Medicare covers nearly all seniors, whose medical care is heavily subsidized by younger workers. Reducing those subsidies, and reducing the share of seniors dependent on Medicare, will change the political dynamics of the program and build a constituency among seniors for further and more substantial Medicare reforms.

Critics will object to broader means-testing and permission for seniors to opt out of Medicare for those very reasons. Yet the history of Medicare is one of politically powerful seniors uniting against the interests of younger workers. If such reforms can improve Medicare's financial picture as well as weaken the political coalition that persistently and increasingly raids the paychecks of working Americans, then those are two arguments in their favor.

Next, Congress should end federal micromanagement of the health care sector and replace Medicare with a prefunded system where workers invest their Medicare taxes in personal accounts dedicated to their health needs in retirement. There is no need for Congress to dictate what health insurance benefits seniors should obtain or how physicians, hospitals, and so forth should be paid. Congress should grant all Medicare beneficiaries a voucher that they may use to purchase the health plan of their choice. Overall, the amount that Congress allots to Medicare vouchers should grow no faster— and could grow more slowly—than overall inflation. To enable the poor and sick to obtain a minimum level of coverage, Congress could provide larger vouchers to them, and smaller vouchers to healthy and wealthy beneficiaries. Seniors who desire more expensive health insurance could supplement their vouchers with

private funds, just as they do now with Medicare Advantage and Medigap plans. Medicare vouchers would let the market—rather than the Medicare bureaucracy—determine prices, payment systems, delivery systems, and how to reward quality.

Finally, Congress should stop the looting of the young by the old. Congress should allow workers to put their full 2.9 percent Medicare payroll tax in a personal savings account dedicated to their retirement health needs. Workers could invest those funds in a number of vehicles and augment those funds in retirement with other savings. This proposal for Medicare personal accounts is similar to many Social Security reform proposals (see Chapter 17).

One similarity is that diverting workers' tax payments into personal accounts makes it difficult to pay current benefits. Congress can make up much of those "transition costs" by cutting Medicare outlays. As noted earlier, an estimated 30 percent of Medicare outlays do nothing to improve beneficiaries' health or make them any happier, which suggests that Medicare spending could be reduced by as much without harming seniors' health. Identifying and eliminating those wasteful expenditures will be extremely difficult, and Congress has proved spectacularly inept at the task. Yet competition can achieve what Congress cannot: giving seniors vouchers and the freedom to make their own health care decisions would encourage them to select health plans that eliminate those unnecessary costs. In giving vouchers to seniors, Congress could cut overall Medicare outlays by as much as 30 percent, again with little if any adverse effect on health outcomes. If Congress is unable or unwilling to cover all transition costs by reducing Medicare outlays, it should make up the gap by cutting other government spending (see Chapter 4)—not by raising taxes.

Suggested Readings

Brown, Kent Masterson. "The Freedom to Spend Your Own Money on Medical Care: A Common Casualty of Universal Coverage." Cato Institute Policy Analysis no. 601, October 15, 2007.

Cannon, Michael F. "Bill Gates Doesn't Need Any Help from Younger Workers." In *Should Medicare Be Means-Tested? A Symposium*. Minneapolis: Center of the American Experiment, 2007.

Cannon, Michael F., and Alain Enthoven. "Markets Beat Government on Medical Errors." *American Spectator*, May 13, 2008. http://www.cato.org/pubdisplay.php?pub_id=9394.

Cannon, Michael F., and Michael D. Tanner. *Healthy Competition: What's Holding Back Health Care and How to Free It*. Washington: Cato Institute, 2007.

Christianson, Jon B., and George Avery. "Prepaid Group Practice and Health Care Policy." In *Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice,* edited by Alain C. Enthoven and Laura A. Tollen. San Francisco: Jossey-Bass, 2004.

Hyman, David A. *Medicare Meets Mephistopheles*. Washington: Cato Institute, 2006.

Kling, Arnold. *Crisis of Abundance: Rethinking How We Pay for Health Care*. Washington: Cato Institute, 2006.

Pauly, Mark V. *Markets without Magic: How Competition Might Save Medicare.* Washington: American Enterprise Institute, 2008.

Saving, Thomas S., and Andrew Rettenmaier. *The Diagnosis and Treatment of Medicare*. Washington: American Enterprise Institute, 2007.

Zycher, Ben. "Comparing Public and Private Health Insurance: Would A Single-Payer System Save Enough to Cover the Uninsured?" Manhattan Institute Medical Progress Report no. 5, October 2007.

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Chapter 67

Medicare Reforms

by Michael F. Cannon and Chris Edwards

Overview

The federal government subsidizes medical care for more than 45 million elderly and disabled Americans through Medicare. Medicare is the third-largest federal program after Social Security and defense, and it will cost taxpayers about $430 billion in fiscal year 2010.[1] Medicare is one of the fastest-growing programs in the federal budget, with spending likely to double over the next decade and to surpass Social Security spending by 2028.[2] Numerous studies suggest that about one-third of Medicare spending is wasted.

At the signing ceremony for the new Medicare program in 1965, President Lyndon Johnson declared, "No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents."[3] Since then, taxes to support the program's skyrocketing outlays have grown steadily for 45 years, eating away at the incomes and hopes of young families—exactly the opposite of what Johnson promised.

Medicare's spending needs to be controlled, but high costs aren't the only problem with the program. Medicare reduces individual freedom, and its price and exchange controls increase costs and reduce the quality of medical care for all patients. The program is also subject to high levels of waste, fraud, and abuse.

Polling data that show public support for Medicare do not prove that the program is a success. Such polls reflect the fact that the government has made enrollees dependent on Medicare by taking away their freedom to choose better health insurance options. It is only natural that Medicare enrollees would want to protect the only source of health insurance coverage they have left to them.

Medicare reforms that allow individuals to control their health care dollars would eliminate wasteful spending, would provide enrollees better choices and better medical care, and would do so at a lower cost to taxpayers. Congress should move retiree health care from today's dysfunctional system of central planning to an innovative system based on personal savings, individual choice, and competition. Medicare vouchers and expanded health savings accounts would dramatically improve the nation's health care system.

Medicare Basics

In the 20th century, Congress replaced personal savings, family obligations, and charity with giant centralized programs to support the elderly.[4] Congress funds the two main programs for the elderly—Social Security and Medicare—primarily by taxing younger workers. That intergenerational funding structure has set the nation on a financial collision course because the number of elderly people in the nation will grow 75 percent by 2030, while the number of working-age people supporting them will grow by just 11 percent.[5]

Congress created Medicare in 1965 as part of President Lyndon Johnson's Great Society agenda and has expanded the program almost continuously since. Medicare subsidizes medical care for 45 million Americans who are age 65 and older, are disabled, have end-stage renal disease, or have amyotrophic lateral sclerosis. Today, Medicare provides coverage for hospital care (Part A), physician services and outpatient care (Part B), and prescription drugs (Part D). Researchers call Parts A and B "traditional" Medicare because they date back to 1965. Many enrollees augment traditional Medicare by purchasing private supplemental insurance called Medigap coverage. In lieu of traditional Medicare, about 20 percent of enrollees choose to participate in the Medicare Advantage program (Part C), where Medicare pays private insurers to deliver Medicare's standard package of subsidized services, as well as additional coverage.[6]

About 10 percent of Medicare revenue comes from enrollee premiums, but most Medicare revenue comes from taxes on younger workers. The main funding sources are a 2.9 percent federal payroll tax and general revenues, which are mainly income tax revenues.[7]

Medicare is less a "sacred bond between the generations" than a pyramid scheme allowing each generation to take advantage of the next.[8] Since the elderly are a politically powerful group, each generation has been able to secure larger Medicare subsidies at the expense of young working-age Americans. Medicare has spawned an average of one tax increase every three years for the past 45 years.[9]

This pyramid scheme cannot last. Medicare spending is rising much faster than tax revenue, thanks to the escalating retirement of the baby-boom generation, increasing longevity, and rising outlays per enrollee. The ratio of workers paying Medicare taxes to Medicare enrollees was four to one not long ago. It has fallen to 3.7 workers today. It will reach 2.4 by 2030 and will continue to fall after that.[10]

The gap between projected Medicare spending and dedicated revenues is mind-bogglingly large. In 2009, Medicare's trustees reported that if Congress wanted to cover all future gaps in Medicare's finances, it would have to deposit a staggering $86 trillion in an interest-bearing account.[11] For comparison, the U.S. gross domestic product was about $14 trillion in 2009. The Medicare financing gap dwarfs the federal government's public debt from accumulated deficits of about $9 trillion.[12]

Younger workers will face massive tax increases unless Congress cuts Medicare spending. Jagadeesh Gokhale has estimated that Congress would have to increase the Medicare payroll tax *six fold*—from 2.9 percent to 17.8 percent of all wages—to pay for all of Medicare's current promises.[13] Martin Feldstein estimates that such a tax increase would so damage the economy that the total burden would equal nearly 25 percent of wages.[14]

Congress cannot solve the Medicare-financing problem by borrowing money. Government debt is just a promise to raise taxes in the future. It obliges future generations to pay the cost of today's spending, plus interest. Not only would additional government debt damage the economy and risk a Greek-style default crisis, but also it is unjust to saddle future generations with that burden. Lawrence Kotlikoff and Jagadeesh Gokhale write that debt financing of the entitlement programs amounts to "borrowing from our grandchildren and their children without their consent."[15] Joe Antos and Mark Pauly note, "The older generation made a generous promise to itself—then imposed the cost of keeping [Medicare] on its children and grandchildren."[16]

The Congressional Budget Office provides another perspective on Medicare's finances.[17] If Congress

fails to reform entitlement programs, and other federal programs remain at their current shares of GDP, federal spending will double from 21 percent of GDP in 2008 to a staggering 42 percent by 2050. Given that state and local taxes consume more than 10 percent of GDP, the size of government in the United States would climb to more than half of the economy. The largest factor driving that growth is Medicare, which would grow from 3.2 percent of GDP in 2008 to 9.5 percent by 2050.

Contrary to President Johnson's pledge, it is Medicare that is eating away at the incomes and hopes of young families. It will continue to do so unless Congress dramatically reduces Medicare spending.

Causes of Rising Costs

Since the creation of Medicare in 1965, the program's basic structure has caused spending to grow rapidly decade after decade. Even aside from the role of general inflation and demographic factors in rising health costs, there are at least four additional cost drivers built into Medicare's current design.

First and foremost, Medicare allows enrollees and health care providers to spend other people's money. That all but eliminates any incentive for either party to economize and invites waste, fraud, and abuse. Researchers at the Dartmouth Atlas Project and elsewhere estimate that about 30 percent of Medicare spending does nothing to make patients healthier or happier.[18] That estimate does not include Medicare spending that provides some value, but whose benefits are smaller than the costs. This research suggests that Medicare wastes well over $100 billion per year. A study by health economists Amy Finkelstein and Robin McKnight found that "in its first 10 years, [Medicare] had no discernible impact on elderly mortality."[19] Crudely put, the $300 billion (in today's dollars) that Medicare spent between 1966 and 1975 may not have saved a single life.[20]

Second, Medicare spending grows because the government keeps expanding the list of goods and services that Medicare subsidizes. Congress created the huge Part D prescription drug program in 2003, which has added hundreds of billions of dollars to the federal debt because legislators provided no funding source. Other expansions occur, without any congressional action or approval, when Medicare officials deem new procedures eligible for subsidies. In 2004, the Bush administration unilaterally announced that Medicare would begin subsidizing obesity treatments.

Third, Medicare overpays for many items because it often sets prices higher than a free market would. In the 1990s, for example, ambulatory surgical centers (ASCs) increased their productivity. A competitive market would have quickly translated those gains into lower prices for consumers. Yet Medicare took 16 years to lower the prices it paid ASCs. Those artificially high prices encouraged excessive use of ASC services with taxpayers footing the bill.[21] Medicare sets prices too high in many other areas of medicine, including cardiovascular care.[22]

Fourth, Medicare's fee-for-service structure—based on price and exchange controls—encourages providers to deliver too many services because that is what the structure rewards. That fact does not imply any greediness on the part of providers. Medicine entails considerable uncertainty, and Medicare encourages providers to respond to that uncertainty by delivering more services.

These factors help explain why actual Medicare spending usually surpasses projections. When Congress created Medicare in 1965, officials projected Part A would cost $9 billion by 1990; it ended up costing $67 billion. In 1967, official estimates projected the cost of the entire Medicare program would reach $12 billion in 1990; it cost $110 billion that year. When Congress created Medicare's home-care subsidies in 1988, official estimates projected it would cost $4 billion in 1993, but it ended up costing

$10 billion.[23]

So when the Congressional Budget Office projects that Medicare spending will grow at an annual rate of 7.0 percent during the next decade, it is important to take that projection with a grain of salt, given that Medicare grew at an average annual rate of 9.3 percent over the past decade.[24]

Fraud and Abuse

Taxpayers foot the bill for an alarming amount of fraudulent and improper Medicare spending. Medicare's massive size and the huge numbers of doctors and hospitals in the system make it very difficult to police. The government processes 1.2 billion Medicare claims each year by computer, generally without human eyes checking them for accuracy.

The Government Accountability Office estimates that Medicare makes about $17 billion in improper payments each year, defined as fraudulent or erroneous overpayments to health care providers.[25] That figure does not include the Part D prescription drug program, which auditors believe is highly susceptible to abuse.[26]

Other estimates of improper Medicare payments are higher. Malcolm Sparrow of Harvard University, a top specialist in health care fraud, argues that estimates by federal auditors do not measure all types of improper payments. He believes improper payments account for as much as 20 percent of federal health spending, which would be about $85 billion a year for Medicare.[27]

Sparrow says that criminals can easily rip off federal health care programs by carefully filling out and submitting the proper electronic forms, because the "claims will be paid in full and on time, without a hiccup, by a computer, and with no human involvement at all."[28] The abuses do not stem just from occasional overbilling by doctors but also from organized looting of health care programs by criminals. The *Washington Post* reported a good example in 2008. A high-school dropout in Miami with a laptop computer single-handedly cheated taxpayers out of $105 million by electronically submitting 140,000 fraudulent Medicare claims for equipment and services over a four-year period.[29]

There are many ways that Medicare allows people to rip off taxpayers: "Billing by health care providers for services not rendered, billing for products not delivered, misrepresenting services, unbundling services, billing for medically unnecessary services, duplicate billing, increasing units of service which are subject to a payment rate, falsifying cost reports resulting in increased payment to the health care provider, kickbacks, and on and on."[30]

One area of rampant fraud is Medicare's medical equipment subsidies.[31] One scam occurs when doctors steer patients to purchase (Medicare-subsidized) motorized wheelchairs that they don't really need, for which the doctors receive "kickbacks" from wheelchair supply companies or other operatives.

A 2008 report by Senate investigators found that 30 percent of medical equipment payments that they examined appeared to be fraudulent.[32]

Fraud appears to be an important cause of the growth in Medicare home health care spending.[33] Medicare pays for home visits by health professionals under certain limited conditions, but patients find ways to skirt those limits. Criminal gangs have simply looted this program by submitting false claims.[34] The costs of Medicare home health care coverage soared 44 percent over five years to 2009, and fraud appears to be an important cause of the increase.[35]

Efforts to combat Medicare fraud frequently fail, and they can involve a vicious cycle. Cracking down

on fraud may open new opportunities for fraud.[36] And fighting fraud often involves new layers of complex regulations that may "discourage organizational innovation and market entry, and [ensnare] innocent providers."[37] To get out of the vicious cycle of government health care fraud, we should move toward a consumer-driven system where patients and providers would have strong incentives to be frugal with health care dollars and crack down on waste.

Central Planning

Medicare is a centrally planned economic system, and it has many of the failings of centrally planned economies in communist and socialist countries. Congress and Medicare administrators dictate prices and other terms of exchange for thousands of different medical services that Medicare purchases from about 650,000 physicians and 30,000 health care facilities.[38] These price and exchange controls fill more than 100,000 pages of regulations and related guidance, and the controls have a large effect on the availability and quality of medical goods and services in the United States.[39]

Medicare operates 16 different pricing systems for different types of health care services.[40] Physician services provided under Part B, for example, use a complex pricing scheme based on the "resource-based relative value scale" (RBRVS). The government assigns each of 6,700 distinct physician services a value, which is then adjusted for each of 89 regions in the United States and converted to dollars. The result is that the government sets about 600,000 different prices for just this part of Medicare. A 29-member board of doctors sets the "relative values" of medical procedures under the RBRVS. The values are based on the inputs to medical care, such as the cost of procedures, but they do not take into account consumer-side factors, such as the quality or outcomes of procedures, or the demand.

Medicare's Part A, which covers hospital services, has its own centralized pricing scheme based on the diagnosis-related group (DRG) classification system, which includes more than 500 different types of patient cases. Other Medicare pricing schemes include those for ambulance services, home health agencies, skilled nursing facilities, and long-term care facilities. Each is a hugely complex price-setting system that generates a range of economic distortions.

Free-market prices are much different from these government-set prices. Market prices emerge through the voluntary interaction of consumers and competing producers, and they guide consumers to use resources wisely and guide producers to make goods and services more efficiently and more widely available. The Medicare Payment Advisory Commission notes that "competitive markets demand continual improvements in processes and quality."[41]

Medicare's price and exchange controls stymie improvements in efficiency and innovation because controlled prices cannot capture the information that producers and consumers reveal when they buy and sell items in open markets. Even if a government bureaucracy could capture this information at a point in time, economic conditions change too frequently for the government to keep pace. Larry Summers, a key economic adviser to President Obama, has observed: "Price and exchange controls inevitably create harmful economic distortions. Both the distortions and the economic damage get worse with time."[42]

Harvard Business School professor Clayton Christensen and his colleagues write that Medicare's price and exchange controls "reek of the pricing algorithms and backroom negotiations used in communist systems. . . . Not surprisingly, we reap the same inefficient results that characterized communism."[43] In a joint report, the Federal Trade Commission and Department of Justice explained that the "unintended consequence of [Medicare's] administered pricing systems has been to make some hospital services

extraordinarily lucrative and others unprofitable. As a result, some services are more available (and others less available) than they would be in a competitive market."[44]

When setting medical prices, the government causes damage when it sets prices either too high or too low. If Medicare sets prices too low, it creates shortages of goods and services. For example, Medicare's pricing structure has helped create a shortage of primary care physicians relative to specialist doctors because specialist procedures generally receive high Medicare reimbursements.

If Medicare sets prices too high, resources are wasted on services that provide less value than their cost, as is the case for ambulatory surgical centers and cardiovascular care. The FTC-DOJ report noted, "This pricing distortion creates a direct economic incentive for specialized cardiac hospitals to enter the market; such entry reflects areas that government pricing makes most profitable, which may or may not reflect consumers' needs and preferences."[45]

Excessive Medicare prices can also have a negative effect on quality. Research suggests that Medicare overpays specialists, leading to an excess of specialists, even though having a high proportion of specialists increases spending and may reduce quality.[46] When Medicare sets prices too low, the FTC and DOJ write, it creates shortages, "lowers the quality of the services that are provided, and diminishes the incentives for innovation."[47]

Medicare's *exchange* controls are even more harmful. Researchers describe Parts A and B as "fee-for-service" Medicare because those programs dictate that providers receive a fee for each individual service or hospitalization, rather than for each patient or illness they treat.[48] That locks most of the U.S. health care sector into fee-for-service payment, which encourages providers to deliver unnecessary and expensive services because providers make more money the more services they deliver. Medicare's fee-for-service exchange controls also penalize providers who adopt many quality-improvement efforts—such as coordinated care, electronic medical records, comparative-effectiveness research, and error reduction—because those efforts result in fewer services.[49] The Medicare Payment Advisory Commission reports that Medicare pays providers "even more when quality is worse, such as when complications occur as the result of error."[50] Providers cannot reduce errors as much as they should because, as Christensen and his coauthors write, "there literally is no money to be made from doing it."[51] Medicare is, therefore, helping fuel America's epidemic of medical errors, which may claim as many as 100,000 lives each year.[52]

Researchers are well aware of Medicare's poor record on quality. Former Medicare administrator Tom Scully notes that within a region, Medicare pays "the exact same amount for hip replacement and the same amount for a heart bypass, if you're the best hospital or the worst hospital."[53] The FTC-DOJ report notes that Medicare does "not reward providers who deliver higher-quality care or punish providers who deliver lower-quality care."[54] Even as Medicare spends hundreds of billions of dollars on unnecessary and harmful services, it fails to deliver high-quality services to many enrollees. One study estimated that for 16 indicators, Medicare enrollees receive recommended care less than two-thirds of the time.[55] Harvard economists Katherine Baicker and Amitabh Chandra found that across states, higher Medicare spending "is not merely uncorrelated with the quality of care provided" but "negatively correlated with the use of effective care."[56] When politicians and health care analysts complain about the harms created by America's fee-for-service payment system, they are complaining about Medicare's price and exchange controls.

Those price and exchange controls harm more than just Medicare enrollees. Medicare is the largest purchaser of medical services in the world. Thus, its price and exchange controls shape the entire U.S. health care sector. Non-Medicare patients use the same hospitals as Medicare patients, and all hospitals operate according to the incentives created by their largest customer. Tom Scully has noted:

> Sadly, Medicare and Medicaid are such dominant players that the private sector has been forced to follow along—shadow pricing [Medicare's price and exchange controls] in recent years. . . . In the long run, government price fixing for services has never worked in any system in any society, and I don't think it can work here, either. Having federal price fixing, no consumer information or pricing sensitivity, and no measurement of quality has led to predictable results: artificially high prices and uneven quality.[57]

Forty-five years of central planning have increased costs and reduced the quality of care for patients both inside and outside the Medicare program, leaving Americans with medical care that is inferior to what they would have otherwise received. Making health care better and more affordable requires eliminating Medicare's price and exchange controls, letting consumers choose the payment system that best serves their needs, and letting prices emerge through competition.

Restricting Freedom

Medicare's supporters erroneously describe it as a voluntary program. In fact, Medicare is a compulsory program that restricts the freedom of taxpayers, the elderly, and health care providers.

Taxpayers have less economic freedom as a result of the Medicare program. The trillions of dollars that they pay in income and payroll taxes to support Medicare leaves them with less income to pay for food, clothing, and other items.

The elderly can, in theory, opt not to enroll in Medicare. However, the reality is that the government forces people who opt out of the program to forfeit all their Social Security benefits, past and future. That makes Medicare enrollment essentially compulsory for all but the wealthiest seniors.[58]

The introduction of Medicare showered massive subsidies on seniors, but it largely destroyed their freedom to choose alternative health insurance plans. Before 1965, about half of elderly Americans already had health insurance, and the private health insurance market had been growing and covering an increasing share of seniors.[59] But thanks to the federal government, the elderly ultimately lost their private health insurance upon retirement because Medicare crowded out private options.

Medicare even restricts its enrollees' ability to control their health care decisions. Similar to Britain's National Health Service, the federal government's Centers for Medicare and Medicaid Services has the legal authority to deny patients services that they and their doctor think are medically necessary, based on the Medicare bureaucracy's arbitrary valuation of those patients' lives.[60]

Medicare also restricts enrollees' freedom to choose their doctor and spend their own money on medical care. If a Medicare enrollee purchases medical services with his or her own funds, the government bans his or her health care provider from the Medicare program for two years. Few providers can survive without Medicare patients. Thus, this regulation effectively prohibits most enrollees from spending their own money on medical care as they see fit.[61] Canada's socialized health care system maintained a similar prohibition on purchasing private health insurance until Canada's Supreme Court struck down that measure in 2005 as a violation of Canadians' human rights.[62]

Finally, Medicare denies producers and consumers the freedom to engage in mutually beneficial exchanges. Only the wealthiest Americans can afford to decline Medicare coverage, and if entrepreneurs step outside Medicare's price and exchange controls, those are the only patients they will be able to serve. Medicare, therefore, denies entrepreneurs—including doctors and health plans— the freedom to devise new and better ways of financing and delivering medical care. This situation denies Medicare enrollees the benefits of robust competition between clinicians, medical facilities, medical suppliers, and health plans, and the innovations that competition would bring.

Cutting Spending

Congress must cut Medicare spending, both to avert a fiscal crisis and to reduce the huge and unfair government transfers from the young to the old. At the same time, the vast amounts of waste in the current Medicare structure indicate that Congress can cut spending without harming the health of enrollees.

The elderly are more prosperous today than ever before. When Congress created Medicare, the elderly poverty rate (28.5 percent) was nearly double the overall poverty rate (14.7 percent). But today, the elderly poverty rate (9.7 percent) is lower than the overall poverty rate (13.2 percent).[63] The average net worth of Americans aged 65 to 74 is also the highest of any age group.[64] Even though the elderly's ability to work has risen, today's elderly are working less and consuming more than in the past. This is all good news for the elderly, but it's not clear why the young should bear an increasing tax burden to support the elderly's lifestyles.

How Congress reduces Medicare spending is extremely important. Using comparative-effectiveness research to ration care or tweaking Medicare's price and exchange controls does not improve quality and usually doesn't contain outlays.[65] One reason is that every dollar of wasteful Medicare spending is a dollar of income to someone, and that someone always hires a lobbyist to protect him or her. The larger reason, however, is that health care is too complex and personal to be planned by a central authority. Even if some central authority—such as the newly created Independent Payment Advisory Board—could run Medicare insulated from political pressure, it could not possibly collect or use all the necessary information about available resources and consumers' needs.[66]

A variety of Medicare proposals would create modest taxpayer savings, but these reforms would not address the program's fundamental problems.

- ***Increasing premiums.*** Part B premiums originally covered 50 percent of Part B outlays, but today they cover just 25 percent with taxpayers picking up the other 75 percent.[67] Enrollees currently pay for about 10 percent of Medicare's overall outlays, so it's not unreasonable to ask them to pay a larger share.[68] Were Congress to increase Part B premiums to 35 percent of outlays, the 10-year savings would be $217 billion.[69]
- ***Increasing cost sharing.*** In 2009, Part B had a deductible of just $135 annually and 20 percent coinsurance above that.[70] Such low cost sharing leads to overconsumption, as do Medigap policies that often provide first-dollar coverage.[71] The Congressional Budget Office estimates that increasing and conforming the deductibles for Parts A and B and Medigap policies would save taxpayers $73 billion by 2020.[72] Those changes would reduce Medigap premiums, which would partly offset enrollees' higher out-of-pocket costs.

- ***Increasing the eligibility age.***[73] Average life expectancy in the United States has risen from about 70 in 1965 to 78 today, and it may reach 80 by 2020.[74] In 1983, Congress began gradually increasing Social Security's normal retirement age from 65 to 67. The Congressional Budget Office estimates that doing the same with Medicare could reduce federal outlays by $92 billion over 10 years.[75]
- ***Means-testing premiums.*** Congress currently requires higher-income Medicare enrollees to pay for a larger share of their Part B and Part D coverage than other enrollees pay.[76] In 2009, for example, Medicare enrollees with incomes above $213,000—a very small segment of enrollees—paid 80 percent of the cost of their Part B coverage, compared to the usual 25 percent. The Congressional Budget Office estimates that expanding means testing to just 5 percent of Part B enrollees could save $21 billion over 10 years.[77] Extending Part B's current means test to Part D could save $10 billion over 10 years.[78] Congress should expand "means testing" to more higher-income enrollees and require those enrollees to shoulder a larger share of the cost of their coverage.

Some of these modest changes would make the public more receptive to more fundamental Medicare reforms because they would help expose what a lousy deal the current program provides.[79] In terms of fixing the system, however, these changes amount to bailing water from a sinking ship rather than repairing the hull.

Congress won't eliminate wasteful health care spending or substantially reduce the growth rate in Medicare spending as long as enrollees and their health care providers are spending other people's money. Nor can Congress improve the quality of care for enrollees or the rest of us until it frees the marketplace from Medicare's price and exchange controls.

The next two sections describe the fundamental Medicare reforms that Congress should enact: individual vouchers and large health savings accounts. Those changes promise to dramatically reduce health care costs and improve the quality of care for Medicare enrollees and other Americans. They would also help put the nation in a position to phase out federal health care subsidies in the long run in favor of a system built around personal savings, individual choice, and competition.

Medicare Vouchers

Congress should end traditional Medicare and give each enrollee a voucher to purchase the health plan of his or her choice. Subsidizing Medicare enrollees through fixed-dollar vouchers would give enrollees more control over their medical care, encourage them to be more cost conscious, spur innovation by eliminating Medicare's price and exchange controls, and contain federal spending.

Vouchers would also promote all dimensions of health care quality by allowing open competition between fee-for-service and other payment systems. If fee-for-service health plans allowed too many medical errors, for example, consumers would switch to prepaid plans. If prepaid plans refuse to cover all necessary services, patients would flee to fee-for-service plans.

Congress should provide larger vouchers to sick and poor enrollees to put them on a similar footing with healthy and wealthy enrollees when shopping for health insurance. Congress could adjust voucher amounts for health status using methods already in use by the Centers for Medicare and Medicaid Services, and for lifetime income using data already on hand at the Social Security Administration.

Enrollees could purchase a more expensive plan by supplementing the Medicare voucher with their own funds. Alternately, enrollees could choose a lower-cost plan and deposit unspent voucher funds in a personal health savings account that could be used for out-of-pocket medical expenses and future

premiums. Unlike today's Medicare program, vouchers would give enrollees an incentive to choose health plans that weed out wasteful spending.

Vouchers are the *only* way to protect Medicare enrollees from government rationing of medical care. Congress has no choice but to reduce Medicare spending. Only vouchers can give Medicare enrollees the freedom to retain the coverage and medical services they value most. Otherwise, politicians and government officials will decide which medical services enrollees will and will not receive.

Vouchers would enable Congress to contain runaway Medicare spending. Each year, Congress would be able to adjust total Medicare outlays for the growth in enrollees and overall inflation. That change would put Medicare outlays on a reasonable and predictable path and would permit current and future enrollees to adjust over time. Given that the best evidence suggests that about one-third of Medicare spending does nothing to make enrollees happier or healthier, slowing the growth of Medicare outlays should not harm enrollees' health.

Congress should allow Medicare enrollees—and all consumers—to purchase any health insurance plan licensed by any of the 50 states. That change would tear down barriers that currently prohibit purchasing health insurance across state lines, and it would enable Medicare enrollees to purchase health insurance that provides them the coverage and consumer protections they demand at an affordable premium. Restoring the freedom to choose one's own health plan would also deny Congress and state governments the power to impose unwanted regulatory costs on Medicare enrollees.

Congress should provide vouchers to current Medicare enrollees, not just future enrollees. Delaying implementation would deny enrollees the benefits of greater choice and higher-quality health care. Delay would also unnecessarily burden current and future workers with higher taxes and greater debt. Today's seniors are enjoying more in Medicare subsidies than they ever paid in Medicare taxes, and they have already left their descendants with a greater tax burden than they ever faced.[80] It is unreasonable *not* to ask today's seniors to start being more careful with their grandchildren's money.

Some voucher proposals would preserve traditional Medicare (Parts A, B, and D) as one of the insurance plans from which enrollees would choose. But Congress simply cannot offer such a "public option" that does not enjoy some implicit taxpayer subsidies. Moreover, supporters of a single-payer health care system would agitate to expand those subsidies, which would enable traditional Medicare to undercut private insurance options despite offering an inferior product.[81] Vouchers would offer enrollees a wide array of private plans from which to choose, and the freedom to leave health plans that fail to meet their needs, rendering traditional Medicare unnecessary.

Medicare enrollees should have the freedom to place their full Medicare voucher into a personal account dedicated to out-of-pocket medical expenses and future premiums. Giving Medicare enrollees the freedom to save their vouchers rather than purchase health insurance is essential to making and keeping health insurance affordable. That freedom would force insurance companies to compete against banks and other financial institutions to manage enrollees' health care dollars. Having to compete with non-consumption would place enormous pressure on insurers and health care providers to reduce the cost of coverage and medical care. That pressure would most benefit lower-income Medicare enrollees. With vouchers designed this way, few enrollees would choose not to purchase coverage. Seniors and the disabled need and want health insurance, and innovation would make health insurance more affordable. Those people who did forgo coverage would accumulate large balances in their accounts, which they would then want to protect by purchasing health insurance.

Another advantage of letting Medicare enrollees save their vouchers is that it would limit the ability of

politicians and government bureaucrats to micromanage the health insurance market. Any mandate that Medicare enrollees must purchase health insurance would give politicians and bureaucrats the power to design enrollees' health insurance. Experience at both the federal and state levels has shown that when politicians possess the power to decide what goes into your health plan, interest groups capture that power and force consumers to purchase unwanted coverage, driving premiums higher.[82]

Rep. Paul Ryan (R-WI) has offered a detailed proposal for Medicare vouchers.[83] The Ryan plan would affect only people who are currently age 55 or younger. When those individuals start reaching age 65 after 2020, the federal government would give them a fixed voucher to buy private insurance. The Ryan plan sets the average voucher amount by taking Medicare spending per enrollee in 2010 (about $11,000) and adjusting annually by the average of the general inflation rate and the medical inflation rate. Sicker and poorer enrollees would receive larger vouchers. Low-income enrollees would receive an additional payment into a health savings account to cover out-of-pocket expenses.

The Ryan proposal would neither give vouchers to current enrollees nor give enrollees the freedom to save their entire voucher in a personal account.[84] Correcting these shortcomings would substantially improve the Ryan plan.

As it is, however, the Ryan plan illustrates the power of market-oriented Medicare reforms to avert a coming fiscal crisis. A related essay presents Congressional Budget Office projections of the possible budget savings from the Ryan plan.

Large Health Savings Accounts

At the same time policymakers begin transitioning Medicare to a voucher-based system, they should take steps to expand the ability of younger Americans to save for their future medical needs. As a first step, Congress should expand current health savings accounts (HSAs) to give workers ownership over all their health care dollars, including the portion that their employers now control. As a second step, Congress should give workers the freedom to deposit their Medicare payroll taxes into these "large HSAs" to fund their medical needs in retirement.

Nine out of 10 Americans with private health insurance obtain that insurance through an employer. Federal tax laws encourage employers to reduce workers' wages and use the funds to purchase health benefits. Thus, most Americans with private health insurance do not get to choose their own health plan. In 2003, Congress let workers control a portion of those wages when it created tax-free health savings accounts. Workers who have a qualified high-deductible health plan may deposit up to $6,150 of their earnings tax-free into an HSA every year and may make tax-free withdrawals for medical expenses.[85] HSAs create incentives for consumers to economize because account holders keep whatever HSA funds they do not spend, and earnings on unspent balances are also tax-free. About 10 million Americans have HSA-compatible high-deductible health plans, but only a portion of those people open HSAs.[86]

Congress can encourage individuals to build larger health care nest eggs during their working years by taking three steps that would turn today's health savings accounts into large HSAs.[87] First, Congress should roughly triple the current HSA contribution limits to allow nearly all workers to take the full amount of their employer's premium payments as a tax-free deposit into their HSA. Second, Congress should let HSA holders purchase health insurance, from any source, tax-free with their HSA funds. That capability would dramatically expand consumer choice and competition in health insurance markets. Third, Congress should remove any requirements that HSA holders obtain health insurance, including the

individual mandate set to take effect in 2014.[88] As with Medicare enrollees, we predict that few large HSA holders would choose not to purchase health insurance, in part because forcing insurers to compete for every customer would make insurance better and more affordable for everyone.

Large HSAs are an important component of reforming Medicare and the entire health care sector. When workers are free to own their health care dollars and free to choose their health plans, they will gravitate toward more economical plans because they will reap the savings. Those savings would grow tax-free in their large HSAs and would be available for their future medical needs. Such prefunding of future health benefits would help avert the coming fiscal crisis.

As an additional step toward a prefunded Medicare system, Congress should give workers the freedom to deposit their full 2.9 percent Medicare payroll tax into their large HSAs. Those deposits would grow tax-free along with their regular deposits. Upon retirement, balances in large HSAs would be used to pay health insurance premiums and out-of-pocket expenses, or to purchase annuities that would cover these expenses in perpetuity. Any leftover balances in these accounts would be inheritable. To ensure compliance with this proposal for mandatory savings, Congress could impose stiff penalties for withdrawal of payroll-tax contributions prior to age 65.

Before the creation of Part D, Harvard University's Martin Feldstein calculated that personal savings accounts financed by worker deposits averaging 1.4 percent of wages would be enough to make up Medicare's future funding shortfall.[89] That percentage would certainly be higher today, but the basic idea hasn't changed: if workers spend their working lives saving for their health care needs in retirement, the power of compound interest would allow the payroll contribution to be modest. Economists at the National Center for Policy Analysis have also proposed ideas for retirement health savings accounts.[90]

In the near term, diverting Medicare taxes into workers' health savings accounts would leave less federal revenue to finance vouchers for current enrollees. Congress should fill that gap with major cuts across the federal budget, as outlined elsewhere on this website. In the long run, Congress could phase out Medicare vouchers, since balances in large HSAs would rise to a point where most Americans could completely prefund their retirement medical expenses.

As Congress phases out Medicare vouchers, there would be a small number of Americans who would not be able to afford the medical care they need, whether because they did not or could not save enough or because they managed their savings poorly. This problem is similar to that faced by many Medicare enrollees today, who cannot afford their Medicare premiums or cost sharing. A reformed Medicaid program would encourage states to offer help to the truly needy, while discouraging non-needy people from abusing that generosity.[91]

Conclusions

Medicare spending will skyrocket in coming decades absent fundamental reform. Yet it is unlikely that Congress could increase taxes to match this projected rise in spending. For one thing, the level of taxation in America has been about the same share of the economy for decades, and voters would surely reject changes that increased the tax burden very much. Furthermore, every effort to fill Medicare's funding gap with higher taxes would damage the economy, increase tax avoidance, and shrink the federal tax base, which, in turn, would create economic and political barriers to further tax increases.

Congress must cut Medicare spending substantially and give enrollees the freedom to choose the coverage and services that mean the most to them, rather than subject them to government rationing. The way to do so is to transform Medicare into a system based on individual savings, choice, and vigorous

private competition, using individual vouchers and large HSAs. Doctors, hospitals, and insurance firms would have strong incentives to innovate and reduce prices to serve their newly cost-and quality-conscious consumers. We might see greater use of retail clinics, telemedicine, integrated delivery systems, electronic medical records, comparative-effectiveness research, care coordination, and other innovations.[92]

Cutting Medicare is a fiscal necessity, but it's also a great opportunity for structural reforms that could improve medical care for all Americans.

This article appeared in September 2010 on DownsizingGovernment.org.

1. Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2010 to 2020," January 2010, p. 48. Aside from the direct budget cost of Medicare, it imposes a large additional burden because of the economic distortions caused by the higher taxes needed to support it. This hidden burden of Medicare may cost the U.S. economy about $100 billion a year. See Christopher J. Conover, "Congress Should Account for the Excess Burden of Taxation," Cato Institute Policy Analysis, forthcoming.

2. Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2010 to 2020," January 2010, p. 48. And see U.S. Department of the Treasury, "Statement by Secretary Geithner on the Releases of Social Security and Medicare Trustees Reports," press release, May 12, 2009.

3. U.S. Department of Health and Human Services, Health Care Financing Administration, "Medicare 2000: 35 Years of Improving Americans' Health and Security," July 2000, p. 6.

4. Jonathan Gruber and Aaron Yelowitz, "Public Health Insurance and Private Savings," *Journal of Political Economy* 107, no. 6, part 1 (December 1999): 1259. And see Jonathan Gruber and Daniel M. Hungerman, "Faith-Based Charity and Crowd-Out during the Great Depression," *Journal of Public Economics* 91, no. 5–6 (June 2007): 1043–69.

5. *The 2009 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds* (Washington, DC: Government Printing Office, May 12, 2009), Table V.A.2.

6. Medicare also contracts with private insurers to deliver prescription drug coverage through Part D.

7. In 2013, the 2.9 percent Medicare payroll tax will rise to 3.8 percent on wages over $200,000 for single filers and $250,000 for joint filers, and a new 3.8 percent tax will apply to investment income above those thresholds. Those thresholds are not indexed for inflation. Patricia A. Davis et al., "Medicare Provisions in PPACA (P.L. 111-148)," Congressional Research Service Report no. R41196, April 21, 2010, p. 83.

8. Social Security also operates on the basis of intergenerational transfers and creates the same perverse incentives.

9. Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009, p. xiv. *Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: Government Printing Office, May 12, 2009), Table III.B.2, p. 45.

10. *The 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: Government Printing Office, May 12, 2009), p. 63.

11. U.S. Department of the Treasury, "2008 Financial Report of the United States Government," 2009, pp. 10, 136, 137.

12. Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2010 to 2020," January 2010, p. 48.

13. Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It* (Washington, DC: Cato Institute, 2007), p. 90. Gokhale produced this estimate in 2004. Congress would need to impose a larger tax increase today.

14. Martin Feldstein, "Prefunding Medicare," National Bureau of Economic Research Working Paper no. 6917, January 1999, p. 4.

15. Jagadeesh Gokhale and Laurence J. Kotlikoff, "Is War between Generations Inevitable?" National Center for Policy Analysis, November 2001, p. 3.

16. Joseph Antos and Mark V. Pauly, "Saving Medicare," American Enterprise Institute, May 9, 2008.

17. Congressional Budget Office, "The Long-Term Budget Outlook," June 2009. We are referring to the CBO's "alternative fiscal scenario."

18. Elliott S. Fisher and Jonathan Skinner, "Reflections on Geographic Variations in U.S. Health Care," Dartmouth Institute for Health Policy and Clinical Practice, March 31, 2010.

19. Amy Finkelstein and Robin McKnight, "What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out of Pocket Medical Spending," 2008, *Journal of Public Economics* 92: 1644–69. The authors find that the risk protection Medicare provided to seniors can justify only two-fifths of the program's cost. Note that Medicare may have generated other health improvements that would not appear in mortality figures.

20. *Budget of the United States Government, Fiscal Year 2011, Historical Tables* (Washington, DC: Government Printing Office, 2010), Table 3.2 and Table 10.1. We used the nondefense deflator to convert to 2010 dollars.

21. U.S. Federal Trade Commission and U.S. Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, p. 25, note 1.

22. U.S. Federal Trade Commission and U.S. Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, p. 16.

23. Joint Economic Committee, "Are Health Care Reform Cost Estimates Reliable?" July 31, 2009.

24. Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2010 to 2020," January 2010, pp. 48, 134.

25. Government Accountability Office, "Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments," GAO-09-628T, April 22, 2009.

26. Nathan Vardi, "Rx for Fraud," *Forbes*, June 20, 2005, p. 124. See also Government Accountability Office, "Medicare Part D: Some Plan Sponsors Have Not Completely Implemented Fraud and Abuse Programs, and CMS Oversight Has Been Limited," GAO-08-760, July 2008.

27. Malcolm Sparrow, "Criminal Prosecution as a Deterrent to Health Care Fraud," Testimony before the Senate Committee on the Judiciary, Subcommittee on Crime and Drugs, May 20, 2009.

28. Malcolm Sparrow, "Criminal Prosecution as a Deterrent to Health Care Fraud," Testimony before the Senate Committee on the Judiciary, Subcommittee on Crime and Drugs, May 20, 2009.

29. Carrie Johnson, "Medical Fraud a Growing Problem," *Washington Post*, June 13, 2008, p. A1.

30. Medical Fraud 101 blog, http://medicare-fraud.net. You can read about the different types of fraud on Medicare's website. See http://www.stopmedicarefraud.gov.

31. See Government Accountability Office, "Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process," GAO-08-955, July 2008.

32. Estimate cited in Associated Press, "Probe: Medicare Paid Billions in Suspect Claims," FOXNews.com, September 24, 2008.

33. See Government Accountability Office, "Medicare: Improvements Needed to Address Improper Payments in Home Health," GAO-09-185, February 2009.

34. See Stop Medicare Fraud website, http://www.stopmedicarefraud.gov.

35. See Government Accountability Office, "Medicare: Improvements Needed to Address Improper Payments in Home Health," GAO-09-185, February 2009.

36. Scott Higham and Dan Keating, "Review Heightens Concerns over Medicare Billing at Nursing Homes," *Washington Post*, March 29, 2010.

37. David A. Hyman, *Medicare Meets Mephistopheles* (Washington, DC: Cato Institute, 2006), p. 35.

38. John Goodman, "A Framework for Medicare Reform," National Center for Policy Analysis, September 2008, p. 5.

39. In 2001, the Mayo Foundation estimated 110,000 pages. See Mayo Foundation Testimony before the Subcommittee on Health,

House Ways and Means Committee, March 23, 2001, http://waysandmeans.house.gov/Legacy/health/107cong/3-15-01/record/mayo.htm

40. For an overview, see Mark E. Miller and A. Bruce Steinwald, "Medicare Payment System Design: An Overview," National Health Policy Forum, January 15, 2009. And see Darshak Sanghavi, "The Fix Is In," *Slate*, September 2, 2009.

41. Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009, p. xiv.

42. Lawrence H. Summers, U.S. Department of the Treasury, "No Short-Cuts to Development" (remarks to the Inter-American Development Bank Conference on Development Thinking and Practice, Washington, DC, September 4, 1996).

43. Clayton M. Christensen, Jerome H. Grossman, and M. D. Jason Hwang, *The Innovator's Prescription: A Disruptive Solution for Health Care* (New York: McGraw-Hill, 2008), Loc. 5167-70, Kindle edition.

44. U.S. Federal Trade Commission and U.S. Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, p. 9, note 1.

45. U.S. Federal Trade Commission and U.S. Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, p. 16.

46. Medicare Payment Advisory Commission, "Report to Congress: Aligning Incentives in Medicare," June 2010, p. 117. See also Kate Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* (April 2004): W4-184–W4-197.

47. U.S. Federal Trade Commission and U.S. Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, p. 29.

48. Parts C and D, by contrast, employ price and exchange controls that pay private insurers a government-determined fee per *enrollee*. This differs from capitation in that the government pays this fee to insurers rather than providers.

49. Fee-for-service payment performs well on other dimensions of quality, like giving patients a wide choice of providers and encouraging providers to deliver all necessary care. See Arnold Kling and Michael F. Cannon, "Does the Doctor Need a Boss?" Cato Institute Briefing Paper no. 111, January 13, 2009; and see Michael F. Cannon, "A Better Way to Generate and Use Comparative-Effectiveness Research," Cato Institute Policy Analysis no. 632, February 6, 2009.

50. Medicare Payment Advisory Commission, "Report to Congress: Variation and Innovation in Medicare," June 12, 2003.

51. Clayton M. Christensen, Jerome H. Grossman, and M. D. Jason Hwang, The Innovator's Prescription: A Disruptive Solution for Health Care (New York: McGraw-Hill, 2008), Loc. 4659, Kindle edition.

52. See Michael F. Cannon and Alain Enthoven, "Markets Beat Government on Medical Errors," *American Spectator*, May 13, 2008. Other payment systems—such as paying health care providers a fixed fee for all the medical care that a consumer needs, known as "prepayment" or "capitation"—reward error reduction, effectiveness research, and care coordination. Prepayment allows providers to profit from reducing unnecessary services and medical errors because whatever money they save, they get to keep. Fee for service, capitation, and all hybrids of the two are each strong on some dimensions of quality but weak on others. A free market promotes all dimensions of quality by forcing diverse payment systems to compete on a level playing field. If fee-for-service plans allow too many medical errors, consumers will switch to prepaid plans; if prepaid plans refuse to cover all necessary services, patients will flee to fee-for-service plans.

53. U.S. Federal Trade Commission and U.S. Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, p. 30, note 1.

54. U.S. Federal Trade Commission and U.S. Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, p. 16.

55. Out of 40 indicators studied. Steven M. Asch, Elizabeth M. Sloss, Christopher Hogan, Robert H. Brook, and Richard L. Kravitz, "Measuring Underuse of Necessary Care among Elderly Medicare Beneficiaries Using Inpatient and Outpatient Claims," *Journal of the American Medical Association* 284, no. 18 (November 8, 2000): 2325–33.

56. Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* (April 7, 2004): 192.

57. Uwe E. Reinhardt, "The Medicare World from Both Sides: A Conversation with Tom Scully," *Health Affairs* 22, no. 6 (November–December 2003): 168.

58. Several citizens have filed suit to overturn this unconstitutional requirement. See *Brian Hall, et al. v. Kathleen Sebelius, et al.*, http://medicarelawsuit.org.

59. Sue A. Blevins, *Medicare's Midlife Crisis* (Washington, DC: Cato Institute, 2001), p. 42, note 14.

60. Michael F. Cannon, "Sorry Folks, Sarah Palin Is (Partly) Right," *Detroit Free Press*, August 19, 2009.

61. See Kent Masterson Brown, "The Freedom to Spend Your Own Money on a Common Casualty of Universal Coverage," Cato Institute Policy Analysis no. 601, October 15, 2007.

62. The immediate impact of the ruling was confined to the province of Quebec. See Jacques Chaoulli, "A Seismic Shift: How Canada's Supreme Court Sparked a Patients' Rights Revolution," Cato Institute Policy Analysis no. 568, May 8, 2006.

63. U.S. Census Bureau, "Historical Poverty Tables—People" Tables 2 and 3, www.census.gov/hhes/www/poverty/data/historical/people.html.

64. Brian Bucks, Arthur Kennickell, Traci Mach, and Kevin Moore, "Changes in U.S. Family Finances from 2004 to 2007: Evidence from the Survey of Consumer Finances," *Federal Reserve Bulletin* 95 (February 2009), Table 4. Data for 2007.

65. See Michael F. Cannon, "A Better Way to Generate and Use Comparative-Effectiveness Research," Cato Institute Policy Analysis no. 632, February 6, 2009; Christopher Weaver and Kate Steadman, "Medicare Experiments to Curb Costs Seldom Implemented on a Broad Scale," Kaiser Health News, November 3, 2009; and Michael F. Cannon, "Fannie Med? Why a "Public Option" Is Hazardous to Your Health," Cato Institute Policy Analysis no. 642, July 27, 2009.

66. Such an authority would present a threat to both economic and political freedom See generally Michael F. Cannon, "Daschle Care," *National Review Online*, January 30, 2009.

67. Congressional Budget Office, "Budget Options, Volume I: Health Care," December 2008, p. 570.

68. Andrew J. Rettenmaier and Thomas R. Saving, "Medicare: Past, Present and Future," National Center for Policy Analysis, June 2007, Table II.

69. U.S. Congressional Budget Office, "Budget Options, Volume I: Health Care," December 2008, p. 160.

70. Medicare.gov Support Center, "Medicare Premiums and Coinsurance Rates for 2009," April 2009, http://questions.medicare.gov/app/answers/detail/a_id/2100.

71. Medigap policyholders consume about 25 percent more services than other enrollees. Congressional Budget Office, "Budget Options, Volume I: Health Care," December 2008, p. 155.

72. Congressional Budget Office, "Budget Options, Volume I: Health Care," December 2008, p. 156.

73. In 1999, the National Commission on Retirement Policy favored raising the retirement age to 70 by 2029. Also in 1999, the National Bipartisan Commission on the Future of Medicare considered proposals to increase the eligibility age in step with the retirement age.

74. U.S. Census Bureau, "Statistical Abstract of the United States: 2010," Table 102. Expectation of Life at Birth, 1970 to 2006, and Projections, 2010 to 2020, www.census.gov/compendia/statab/2010/tables/10s0102.pdf.

75. Congressional Budget Office, "Budget Options, Volume 1: Health Care," December 2008, p. 37.

76. Mark V. Pauly, "Means-Testing in Medicare," *Health Affairs* (December 8, 2004): W4-546–W4-557, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.546v1.pdf.

77. U.S. Congressional Budget Office, "Budget Options, Volume 1: Health Care," December 2008, p. 166.

78. U.S. Congressional Budget Office, "Budget Options, Volume 1: Health Care," December 2008, p. 164.

79. See Michael F. Cannon, "Bill Gates Doesn't Need Any Help from Younger Workers," in *Should Medicare Be Means-Tested? A Symposium* (Minneapolis: Center of the American Experiment, May 2007), pp. 11–12.

80. See Michael F. Cannon, "Bill Gates Doesn't Need Any Help from Younger Workers," in *Should Medicare Be Means-Tested? A Symposium* (Minneapolis: Center of the American Experiment, May 2007), pp. 11–12.

81. See Michael F. Cannon, "Fannie Med? Why a 'Public Option' Is Hazardous to Your Health," Cato Institute Policy Analysis no. 642, July 27, 2009. The premiums for traditional Medicare would be a constant political battleground, much like the ongoing and highly partisan fight over how much to pay Medicare Advantage plans, in which single-payer advocates often prevail.

82. See Michael F. Cannon, "All the President's Mandates: Compulsory Health Insurance Is a Government Takeover," Cato Institute Briefing Paper no. 114, September 23, 2009.

83. Rep. Paul Ryan (R-WI), House Committee on the Budget, "A Roadmap for America's Future, Version 2.0," January 2010.

84. Douglas Elmendorf, Congressional Budget Office, Analysis of "A Roadmap for America's Future," letter to Rep. Paul Ryan, January 27, 2010.

85. U.S. Department of the Treasury, "Treasury, IRS Issue 2009 Indexed Amounts for Health Savings Accounts," >www.treas.gov/offices/public-affairs/hsa/pdf/2010-HSA-%20indexed-amts.pdf.

86. America's Health Insurance Plans, Center for Policy and Research, "January 2010 Census Shows 10 Million People Covered by HSA/High-Deductible Health Plans," May 2010.

87. For more on large health savings accounts, see Michael Cannon, "Combining Tax Reform and Health Care Reform with Large HSAs," Cato Institute Tax and Budget Bulletin no. 23, May 2005, and see Michael F. Cannon, "The Tax Treatment of Health Care," *Cato Handbook for Policymakers*, 7th ed. (Washington: Cato Institute, 2009), Chapter 14.

88. See Michael D. Tanner, "Bad Medicine: A Guide to the Real Costs and Consequences of the New Health Care Law," Cato Institute White Paper no. 29, July 12, 2010.

89. Martin Feldstein, "Prefunding Medicare," National Bureau of Economic Research Working Paper no. 6917, January 1999, p. 8.

90. John C. Goodman, "A Framework for Medicare Reform," National Center for Policy Analysis, September 2008, p. 9. And see Andrew J. Rettenmaier and Thomas R. Saving, "A Medicare Reform Proposal Everyone Can Love," National Center for Policy Analysis, December 2007.

91. See Michael F. Cannon, "Medicaid and SCHIP," *Cato Handbook for Policymakers,* 7th ed. (Washington, DC: Cato Institute, 2009), Chapter 13.

92. Michael F. Cannon, "Innovation Best Alternative to Obamacare," *Orange County Register*, March 19, 2010.

Chapter 68

Personal Medical Accounts: An Alternative to Compulsory Health Insurance

by Michael F. Cannon

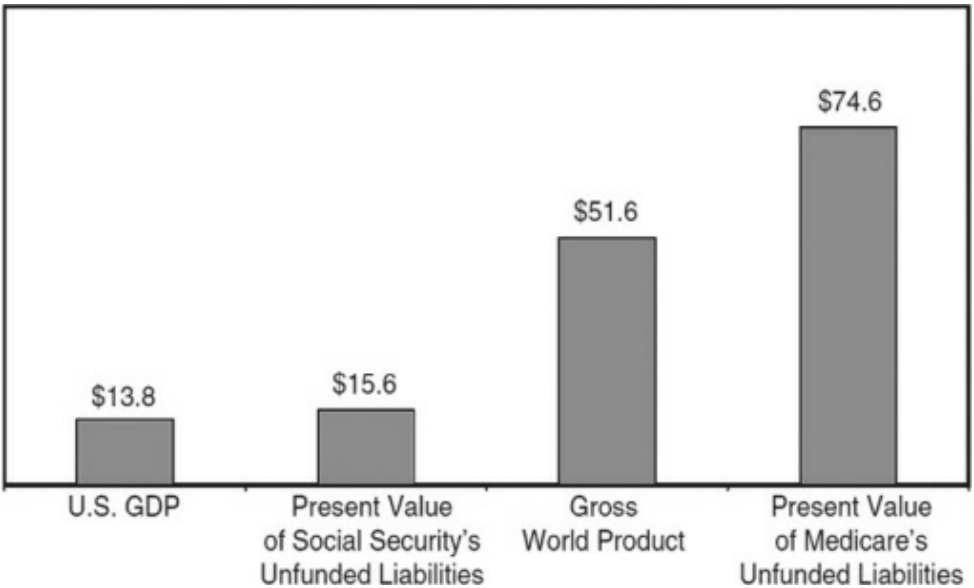
This article explains how personal medical accounts can offer a better guarantee against sickness and privation to the poor in the United States and all nations struggling under compulsory health insurance schemes.

This article proceeds as follows. The first section describes the advantages of personal medical accounts. The second and third sections draw on the experience of the United States to demonstrate the importance of innovation in saving lives and making medical care available to the poor, and how compulsory health insurance blocks such innovation. The fourth section describes how to design personal medical accounts, and a final section concludes.

I. Advantages of personal medical accounts

In November of this year, Chile will celebrate the 30th anniversary of its Social Security reforms, which privatized the largest single government program in Chile by creating a system of personal retirement accounts. I am reliably informed, by my Cato Institute colleague José Piñera, that those reforms have been a resounding success. We in the United States, in contrast, face an enormous problem with our state-run pension system, known as Social Security. That program has an unfunded liability larger than our annual economic output (see Figure No. 1). The United States should follow the path Chile has blazed: personal retirement accounts expand human freedom, improve economic performance, and fund what are currently unfunded commitments to the elderly.

Figure 1:
Medicare's Unfunded Liabilities Compared with Other Measures, 2007 (USD Trillions)



The United States' state-run health insurance program for the elderly—known as Medicare—presents a much larger problem. Medicare's fiscal imbalance is nearly six times greater than Social Security's. As I will explain, Medicare creates additional problems for the sick, whether elderly or non-elderly, by increasing the cost of medical care and reducing the quality of care.

Reforming the U.S. Medicare program and other compulsory health insurance schemes with personal medical accounts offers a number of advantages. Personal medical accounts are advantageous for many of the same reasons as the personal retirement and unemployment accounts adopted in Chile. They respect the workers' fundamental human right to control the fruits of their labor and the decisions affecting them and their families. Personal accounts expand the "investing class," create new opportunities for financial institutions, and broaden the political constituency for sound economic policies. They help lift families out of poverty by letting workers pass unspent balances to their heirs.

Personal medical accounts are advantageous for another, equally important reason. The price controls and other regulations that inevitably accompany compulsory health insurance schemes block innovations that improve the quality of medical care and bring medical care within the reach of low-income workers. By eliminating these harmful government controls, personal medical accounts will enable better medical care for the average worker and the poor. Put simply, personal medical accounts offer a better guarantee against sickness and privation than any compulsory or state-managed system. Since this is perhaps the most important and the least appreciated benefit of personal medical accounts, it will be the focus of my remarks.

II. Innovation

To support this claim, I will draw from the experience of the United States. Let me be clear: I do not offer the United States as a model of how to design a health care market. Contrary to international opinion, the United States emphatically does not have a free market in health care. Before this year, the

U.S. health care sector was more than half-socialized; President Obama has merely socialized the rest. But because the United States' health care sector was perhaps less socialized than those of other advanced nations, it offers a glimpse into the marvelous innovations that a truly free market would create.

New Treatments

Patients worldwide suffer because there are no treatments for their illness. The United States develops most of the beneficial new medical treatments produced in the world because, more than any other nation, the United States allows innovators to profit by saving lives.

Figure 2
Top Medical Innovations by Country of Origin, 1975–2000

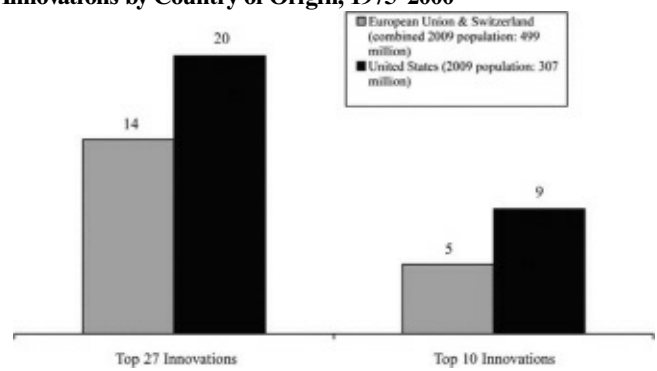
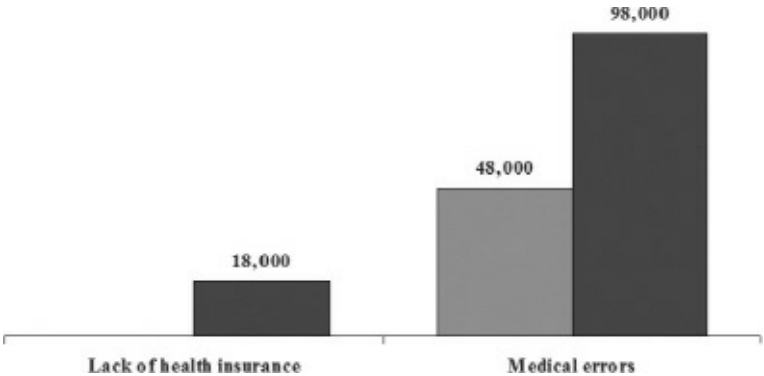


Figure No. 2 shows the top medical innovations from the past 40 years by country of origin. The United States has produced more than the whole of Europe. Some of these innovations include magnetic resonance imaging and computed tomography scanners (CT scanners); angiotensin-converting enzyme (ACE) inhibitors, used in the treatment of hypertension and congestive heart failure; balloon angioplasty; statins to lower cholesterol levels; mammography; and coronary artery bypass graft (CABG) surgery. These innovations were developed in whole or in part in the United States, and have been improving the lives of people around the world.

Error Reduction

Other patients suffer because medicine is too often unsafe. A leading research organization in the United States estimates that 20,000 Americans die each year because they lack health insurance. The same research organization estimates that as many as five times that number of Americans die each year due to medical errors (see Figure No. 3).

Figure 3
Annual Preventable Deaths, United States



Entrepreneurs in the United States have developed private health insurance medical plans that discourage medical errors.

Secure Health Insurance

Decades ago, private health insurance companies in the United States developed innovative products that protect workers from the cost of medical care and protect them from high health insurance premiums when they become ill. The private sector is close to developing health insurance products that go further by enabling insurance companies to compete to cover the sickest patients, rather than avoid them.

Greater Accessibility

Entrepreneurs in the United States are developing new ways of making medical care and health insurance less costly, such as substituting lower-cost nurses for physicians and lower-cost general practitioners for specialists where appropriate. These innovations also include health insurance plans that keep premiums low by avoiding unnecessary services.

Electronic Medical Records, Coordinated Care and Effectiveness Research

Additional examples of private-sector innovation include: electronic medical records, which make medical care safer and more convenient; health systems where doctors improve quality by coordinating the services they provide to shared patients; and research on the effectiveness of medical treatments, which helps patients avoid unnecessary services and get the best available treatments.

III. Compulsory Health Insurance Blocks Innovation

Patients in my country and in yours suffer because the price controls and other regulations that inevitably accompany compulsory health insurance schemes block these and other innovations.

Price Controls

Research in the United States shows that having a high proportion of general practitioners reduces Medicare spending (see Figure No. 4) and increases the quality of health care for Medicare patients (see Figure No. 5).

Figure 4

Relationship between Provider Workforce and Medicare Spending: General Practitioners per

10,000 and Spending per Beneficiary in 2000

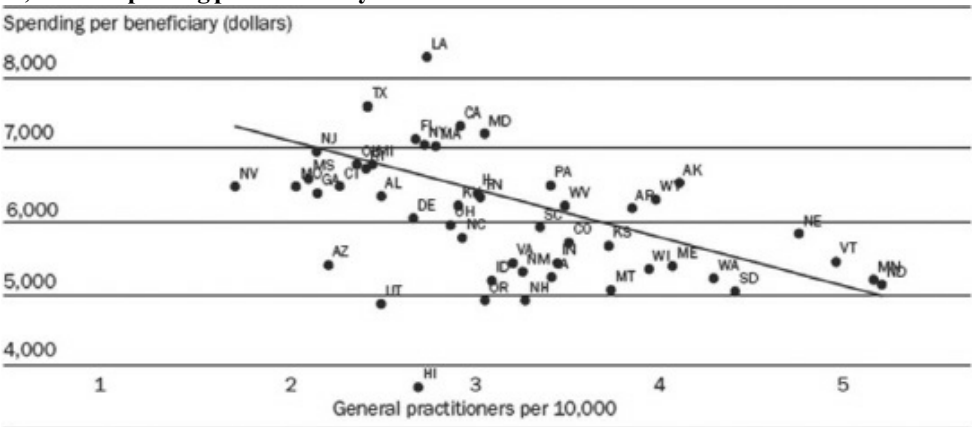
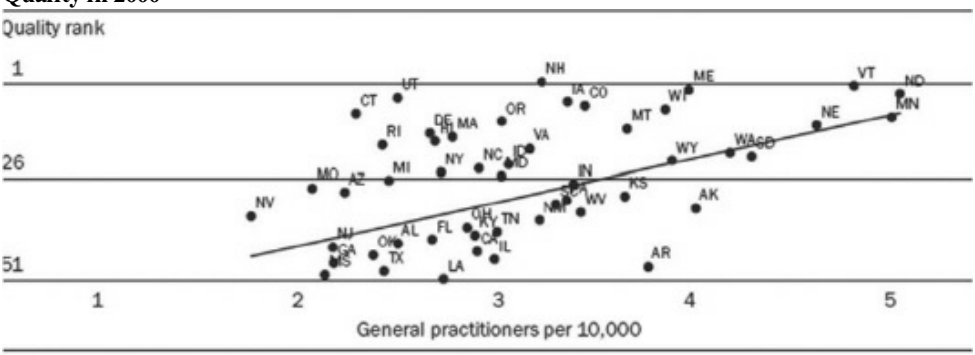


Figure 5
Relationship between Provider Workforce and Quality: General Practitioners per 10,000 and Quality in 2000



Yet the U.S. Medicare program's price controls encourage doctors to become specialists, rather than general practitioners—even though research shows that a high proportion of specialists increases Medicare spending (see Figure No. 6) and reduces quality (see Figure No. 7).

Figure 6
Relationship between Provider Workforce and Medical Spending: Specialists per 10,000 and Spending per Beneficiary in 2000

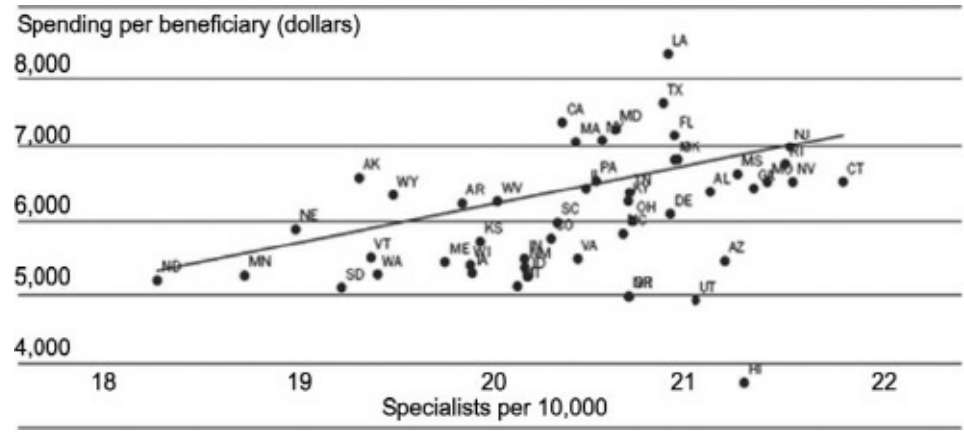
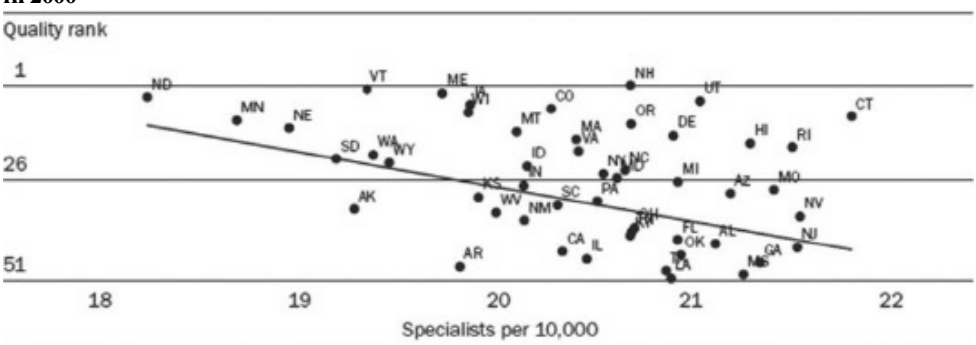


Figure 7
Relationship between Provider Workforce and Quality: Specialists per 10,000 and Quality Rank in 2000



Medicare is the largest purchaser of medical care in the world. These harmful effects of Medicare's price controls therefore spill over into the private market place, increasing the cost and reducing the quality of care for privately insured patients as well.

Compulsory health insurance schemes guarantee access to medical care, but government price controls undermine that guarantee. A 12-year-old American boy named Deamonte Driver died in 2007 essentially because the U.S. Medicaid program set its prices so low that his mother could not find a dentist.

In nations with private insurance, governments impose price controls that force insurance companies to sell insurance for USD 5,000 even if a person costs USD 10,000 to insure. That creates a USD 5,000 incentive for insurers to avoid, mistreat, and dump the sick, often by denying them care. That is what happened to a 14-year-old girl in the United States named Shelby Rogers, who has spinal muscular atrophy. Shelby is so weak, she needs a nurse to turn her in bed at night and help her with other daily tasks. But her insurance company stopped paying for round-the-clock nursing care because that benefit attracted too many sick people. Those government price controls block the innovative products that would have private insurance companies competing to serve her.

Exchange Controls

The U.S. Medicare program's payment systems are de facto exchange controls that penalize health care providers who innovate by coordinating care, or using electronic medical records, or conducting effectiveness research, or reducing medical errors. Medicare is the driving force behind the epidemic of medical errors in the United States.

These controls render medical care more costly and deprive societies of resources that could be used to provide medical care to the needy. President Obama has brought even more of the U.S. market under the dominion of government price and exchange controls, however, because they are necessary under his state-run system.

IV. Designing Personal Medical Accounts

Personal medical accounts offer a better guarantee against sickness and privation because they can avoid government price and exchange controls, and thereby permit innovation to make medical care of ever-increasing quality available to ever-increasing numbers of workers.

A well-designed system of personal medical accounts would reduce each worker's tax burden by a percentage of income sufficient for the median wage earner to fund health insurance both now and in retirement. Those former tax payments would fund each worker's account. Chile is an example: workers must pay seven percent of their taxable salary to either a state plan (FONASA) or to a private insurance company (ISAPRE). Workers would invest their savings under rules similar to those that exist for personal retirement or unemployment accounts.

Workers would use their personal medical accounts to purchase health insurance, or to purchase medical care directly. Withdrawals for non-medical expenses would be penalized or prohibited. The difficulty of delineating between "medical expenses" and "non-medical expenses" will inevitably be messy. In the United States, we have an analogue to personal medical accounts that we call health savings accounts (HSAs); President Obama has just moved some medical expenses from the favored to the unfavored category. But this regulatory process is less distortionary than having the state decide what services health insurance must cover.

The financial institutions that manage personal medical accounts could be the same institutions that manage pensions, which already have experience in this area. These institutions would have the additional duty, however, of verifying that withdrawals are for approved medical expenses.

Importantly, a well-designed system would not require workers to purchase health insurance. This feature is controversial, but crucial. Preserving the workers' freedom to save their money, rather than purchase health insurance, is essential to make health insurance affordable for low-income workers. Preserving the freedom to save forces insurance companies to compete with banks and other financial institutions for workers' savings. That places enormous pressure on insurance companies to reduce the cost of health insurance. The freedom not to purchase health insurance is therefore most important to the poorest workers, because it brings the price of health insurance within their reach.

Requiring workers to purchase health insurance increases the cost of insurance because governments inevitably force workers to purchase more and more insurance coverage. In the United States and other nations, the entire medical sector lobbies governments to require workers to purchase more comprehensive insurance, because such insurance channels more money to the medical sector. Specific health care providers likewise seek to force workers to purchase insurance that covers the goods and services that they provide.

The freedom to save ensures that workers will receive value for their insurance premiums, because it

preserves the workers' right to refuse insurance if they consider it a bad deal.

No doubt some workers will use this freedom to make poor decisions. Some will not purchase health insurance, and then will fall ill and not have enough savings to meet their medical expenses. I believe this problem will be small, for two reasons. First, health insurance will be less expensive, leading most workers to purchase it. Second, the very workers who might avoid health insurance will build up considerable savings in their personal medical accounts. They will want to protect those savings from the cost of illness. The way to protect those savings is to purchase health insurance.

Preserving the people's freedom not to purchase health insurance will do far less harm than giving the state the power to force people to purchase health insurance.

V. Conclusion

In designing health care markets, perfection is not an option. Under any system, whether state-run or the free market, some patients will inevitably fall through the cracks. Personal medical accounts can help fill in those cracks by enabling innovations that improve medical care and bring it within reach of the poor. Yes, some will not earn enough to provide for themselves. And when we are free to make our own decisions, a small number of people will make poor decisions. I believe we have a moral duty to care for patients who could not or would not provide for themselves. Personal medical accounts will make it easier for us to meet that moral duty.

Under compulsory health insurance schemes, those cracks widen, and more people fall through. Price and exchange controls block innovation. Governments waste resources on low-value medical care. Some would describe these as the unavoidable costs of creating an equitable society. But those wasted resources do not purchase solidarity. They purchase sickness and poverty.

If we seek to save lives, if we wish to bring medical care within reach of the sick and the poor, if we want to lift the poor out of poverty, then our task is to restore the workers' fundamental human rights and use personal medical accounts to let them control the fruits of their labor. Let the workers own what they have earned. Let them make their medical decisions free from coercive constraints, with all the benefits that innovation and competitive markets offer. Nations laboring under compulsory health insurance schemes should evaluate replacing those systems with personal investment accounts for medical purposes.

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Chapter 69

Curb Medicare Spending the Ryan Way

by Michael F. Cannon

Nothing presents as great a threat to the federal budget—and therefore to economic growth—as the persistent and rapid growth of Medicare spending.

The problem appears intractable. Congress has enacted modest cuts, yet everyone from Medicare's chief actuary to the Congressional Budget Office to the International Monetary Fund declares even those cuts to be politically implausible.

Rep. Paul Ryan's (R-Wis.) "Roadmap for America's Future" proposes even tighter limits on Medicare's growth, leading columnist Bruce Bartlett to opine, "the Medicare actuaries have shown the absurdity of the Ryan plan by denying that Medicare cuts already enacted into law are even worthy of projecting into the future."

On the contrary, experience and public choice theory suggest that the Ryan plan has a better shot at reducing future Medicare outlays than past efforts, because the Roadmap would change the lobbying game that fuels Medicare's growth.

Medicare dictates the prices it pays clinicians, facilities, medical suppliers and private health plans through more than a dozen different price-control schemes. Efforts to reduce those prices typically fail because of what Tom Daschle calls the "patient-provider pincer movement": Medicare enrollees and health care providers join forces to undo those cuts.

Each producer that depends on Medicare for its income faces an enormous incentive to lobby for higher prices. The prices for, say, hospital services could make or break a lot of hospitals. And if the hospitals don't lobby to increase those prices, who will? Enrollees like the easy access to medical care that comes with higher Medicare spending.

So when the Balanced Budget Act of 1997 reduces the prices Medicare pays physicians (through the "sustainable growth rate" formula), or ObamaCare reduces the prices for hospital services, home health care and Medicare Advantage plans, we can predict—and experience has shown—that intense lobbying by enrollees and the affected producers will thwart these measures.

Viewed from this perspective, today's Medicare program seems practically designed to protect health care providers.

The Roadmap, in contrast, would substantially diminish each producer group's incentive to lobby for greater subsidies. The Roadmap would give enrollees a voucher with which to purchase insurance. Sicker and poorer enrollees would get larger vouchers, and the average voucher would grow more slowly than Medicare spending has grown in the past.

Larger vouchers would mean greater demand for medical care. Yet each producer group's incentive to lobby for a higher growth rate would be much less than their incentive to lobby to increase the prices Medicare pays them today.

If hospitals lobby for a higher voucher growth rate, how will they know that the added subsidies will

come back to them, rather than ambulatory surgical centers? Many groups would just free-ride on the lobbying efforts of other groups.

The fact that more producer groups would care about this growth rate than about each of Medicare's current price-control schemes paradoxically means that each group would spend fewer resources on lobbying. That gives the Roadmap's spending restraints a better shot at surviving the political process than the SGR or ObamaCare's cuts.

The same thing goes for the Roadmap's risk-adjustment formula. If geriatric endocrinologists lobby to give larger vouchers to diabetics, how can they be certain those subsidies will come back to geriatric endocrinologists?

A voucher system would also put downward pressure on prices across the entire spectrum of care. It will be far more difficult for producer groups to obtain or protect excessive risk-adjustment weights when markets are constantly showing how to deliver care more efficiently.

Seniors spend their Social Security checks on lots of things, but we don't see golf courses or metal-detector manufacturers lobbying to increase Social Security spending the way health care providers lobby to increase Medicare spending. This largely explains why, on a per-capita basis, Social Security outlays grow at roughly the rate of the economy, while Medicare outlays grow about 2 percentage points faster.

Income-adjusted vouchers would also change the game on the "patient" side, by diminishing well-to-do enrollees' incentive to lobby for higher Medicare spending.

Vouchers are the most plausible way to restrain Medicare spending. They are also the most humane way, because they let enrollees retain the benefits that mean the most to them. Ryan is the only member of Congress taking this problem seriously.

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Chapter 70

A Medicare Reform Model Everyone Can Love

by Michael F. Cannon

Democrats and Republicans may not be able to agree on whether to increase taxes as part of a deal to raise the federal debt ceiling. But they can at least agree on this much: Congress must restrain Medicare spending. The trick is how to do it without sacrificing access to necessary care?

As luck would have it, we have a home-grown model for Medicare reform that would contain spending and *improve* the quality of care. This model appeals to both Republican and Democratic ideals: it satisfies the Republican desire for individual ownership and control, but emulates a social insurance program revered by Democrats. The key to improving health care for seniors is . . . to make Medicare look more like Social Security.

Consider: Medicare subsidizes the elderly and disabled by giving them a health plan designed and typically administered by government. Social Security does a better job of meeting seniors' individual preferences because it gives them cash and lets them decide how to spend it. They can spend more on housing and less on food, or vice versa.

Medicare enrollees have little incentive to avoid wasteful spending, because the savings revert to the government. Seniors spend their Social Security subsidy more carefully, because they themselves keep the savings.

Medicare issues endless regulations that dictate prices and other terms for 1.2 billion health care transactions each year. It's tempting to think this micromanagement is necessary because health care is special. Yet a steady stream of research shows this command-and-control approach leads to mispricing, rampant medical errors, unnecessary hospital readmissions, uncoordinated care and massive waste. It also blocks innovations, such as accountable care organizations, that would solve these problems.

If Social Security subsidized food the way Medicare subsidizes health care, seniors would dine out every night; they would go to a separate restaurant for each course; portions and waistlines would be enormous; everything would be overcooked; the bills would make your jaw drop; and tipping more than 9.25 percent would be illegal.

"Medicare gives very good health care very inefficiently," says Sen. Chuck Schumer, D-NY. At least he's half right.

Suppose that rather than send $574 billion to providers and insurers, Congress divvied it among Medicare's 48.9 million enrollees and send each of them a check. The average enrollee would get $11,700 —more if they're sick, poor or disabled. Call it a "bundled payment to enrollees."

Enrollees could use that cash to purchase medical care or any health insurance plan licensed by any state. Whatever they saved by being prudent shoppers, they could keep and pass to their kids and grandkids.

If 50 million high-end health care consumers suddenly started caring about *every dime* they spent, they would wring unnecessary services and administrative costs out of the health care sector.

One concern would be that these Social Security-like subsidies would not be large enough for enrollees to purchase decent coverage. The evidence shows they would.

First, they would come with a built-in margin of safety. The Dartmouth Atlas of Health Care estimates that 30 percent or more of Medicare spending is pure waste, meaning that enrollees Medicare checks would include what Medicare currently spends on worthwhile medical care, plus an additional 40-50 percent. That cushion would also protect against inadequate risk- and income-adjustments.

Second, 77 percent of enrollees have Medicare supplemental coverage that they purchase directly or through an employer. That often amounts to thousands of dollars that they could use to supplement their Medicare check.

Third, these 50 million Medicare enrollees would demand cost-saving innovations—in the immortal words of George Costanza—"like an old man trying to send back soup at a deli."

There's a lot more to be said about why Congress should reform Medicare in the image of Social Security. But the most important reason may be that it is the only way to restrain Medicare spending while meeting the Democratic goal of preserving Medicare *benefits*. Again, Sen. Schumer: "there are savings to be wrought out of Medicare . . . [but] actual cuts in the benefits, are not something we would want to entertain."

Cutting Medicare spending through a command-and-control approach, such as by reducing provider payments, may inadvertently eliminate access to services that enrollees really want.

If Congress wants to preserve what matters most to Medicare enrollees—you know, the people the program is supposed to serve—then there's no better way than to give them the money and let them decide which benefits are most important. Who better to judge what benefits seniors than seniors themselves?

That's how FDR subsidized them, anyway.

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MEDICAL MALPRACTICE

Chapter 71

Reforming Medical Malpractice Liability through Contract

by Michael F. Cannon

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I. Introduction

Patients typically have little information about the quality of medical care in advance of seeking treatment. One way the law seeks to overcome that information problem is by allowing patients injured by sub-standard care to recover from the responsible health care provider through an action for negligence. Rules for medical malpractice liability are determined by the courts and legislatures and are uniform within a state. That is, the medical malpractice "system" requires the same level of protection for all patients.

There is near-universal agreement that the current medical malpractice system does not achieve its aims. In theory, that system is supposed to encourage providers to deliver high-quality care by transferring to negligent providers a large portion of the costs that their negligence imposes on patients. Insofar as that system makes the provider suffer financially when her negligence injures her patient, it aligns the incentives of the provider with the needs of the patient. In practice, however, the medical malpractice system achieves that goal rather imperfectly. Research suggests that only a small fraction of patients injured by provider negligence actually recover and that many who do recover from providers are not victims of negligence.[1] Such imprecision is one reason why a recent study estimates that in 2002, the medical liability system provided benefits of $33.0 billion, but carried far greater costs of $113.7 billion, thereby imposing a net loss of $80.7 billion on society.[2]

The costs of the medical liability system are passed on to patients through higher prices for medical care, which can make care unaffordable for those with below-average incomes and/or above-average medical expenses. The above-mentioned study further suggests that the net cost of the medical liability system made health insurance unaffordable for over three million individuals in 2002.[3] Physicians and other providers—who have seen often dramatic increases in malpractice insurance premiums—have intermittently declared the medical liability system to be in "crisis" for over 30 years.[4]

This "crisis" has spawned numerous proposals to reform medical malpractice liability rules. The American Medical Association (AMA) advocates a nationwide cap on non-economic damages similar to the $250,000 cap enacted in California. The AMA claims that three-quarters of the public favor such a limit on non-economic damages.[5] Other proposals include legislative limits on contingency fees for plaintiffs' attorneys; "no-fault" compensation systems for medical injuries, such as the limited programs adopted in Florida and Virginia; alternative forms of dispute resolution, such as arbitration and special medical courts; the English rule of costs; and reform of the collateral source rule. Each of these reforms

has the characteristic that it would leave some plaintiffs better off—typically by reducing prices for medical care—at the cost of leaving other plaintiffs worse off. For example, a cap on non-economic damages would reduce health care costs for non-injured patients, but at the expense of leaving some injured patients with uncompensated losses. Likewise, limits on contingency fees would reduce costs for non-injured patients, but at the cost of denying compensation to injured patients whose cases plaintiffs' attorneys deem too expensive to pursue.

An alternate approach to medical liability reform would allow patients and providers to determine in advance the rules that govern how patients will be compensated in the event they are injured by simple negligence. Contractual liability rules could employ greater or lesser protections than current tort liability rules crafted by the judiciary and legislatures. For instance, a patient and provider could agree to some combination of caps on non-economic damages, the English rule of costs (or "loser pays"), and so forth. The contract could also alter the standard of care used to determine negligence. Alternatively, the contract could specify greater protections against negligence than are currently available through tort liability. A patient could demand a higher standard of care than customary practice within a region and specialty, or a California patient could insist on being able to collect more than the $250,000 statutory limit on non-economic damages.

The economic appeal of contract liability is that competent adults vary in their preferences for risk and their ability to pay for medical care. Requiring all patients to accept a uniform level of protection against negligence may price health care out of the reach of low-income patients and force others to "purchase" more malpractice protection than they would prefer. The opportunity to contract around tort liability rules could enable providers to lower their prices, thereby enabling more low-income patients to afford medical care, as well as reducing the cost of care for patients who demand less protection against negligence than tort rules require. At the same time, contract liability would allow risk-averse patients to bargain for greater protection from negligence than current tort rules offer. As discussed further in Section II, the ability to vary malpractice protections could also provide patients with a useful tool for judging the quality of different providers.

Despite this appeal, contractual limitations on providers' liability for malpractice are largely unenforceable. The main criticisms will be touched on here, and discussed at greater length below. Scholars and courts, in particular the court in *Tunkl v. Regents of the University of California*, consider such agreements to be contracts of adhesion due to the lopsided nature of the relationship between provider and patient. Some contend that such contracts violate vertical equity by suggesting that low-income individuals are due a lesser standard of care than those with greater means. Others maintain that allowing some individuals to accept less protection against malpractice would harm those who prefer higher levels of protection, in that a net loss of liability exposure could encourage providers to reduce their investments in quality.

This paper proceeds in the same fashion as the foregoing discussion. Section II presents the arguments for moving control over liability protections from tort law, the courts, and legislatures, to contract law, where liability protections may be determined by the market. Section III presents and evaluates select criticisms of contract liability that appear in the literature and case law. Section IV offers possible limitations on the right to contract around tort liability rules that might assuage the major concerns of critics. Section V concludes.

II. Contractual Liability for Medical Malpractice

This section provides the economic rationale for enforcing contracts between patients and providers

that specify malpractice protections different from those available in tort. It then examines possible contract terms, as well as areas where tort liability should continue to govern provider misconduct.

Though tort law has traditionally governed medical malpractice liability, the relationship between a patient and a health care provider may be distinguished from the relationships in many actions for tort. The classic tort suit typically involves two individuals who were unknown to each other prior to the tort; for example, the pedestrian struck by a falling barrel when walking past a warehouse owned by another.[6] In contrast, patients and health care providers are typically known to one another and form a contract before the provider plies her trade. Before any negligence can occur, patient and provider typically have the opportunity to negotiate the various aspects of their relationship, in particular the quality guarantees offered by the provider. The protection that a patient enjoys against negligence by the provider is one component of quality assurance. Thus, those protections often could be one of the contractual terms negotiated by the two parties.[7]

Given the amenability of the patient-provider relationship to negotiating liability protections as one aspect of quality assurance, there are several reasons *why* a patient and provider would want to negotiate over those terms. First, patients vary in their ability to pay for medical care and their preferences for risk. As noted above, the cost of the medical malpractice "system" is widely considered to be one reason behind the rising cost of medical care and health insurance.[8] Insofar as existing tort liability rules make medical care more expensive, they likely make medical care unaffordable for those with below-average incomes. Patients who have difficulty affording medical care might wish to contract for a reduced level of protection against negligence if doing so enables them to obtain a greater degree of protection against illness. Indeed, that tradeoff could leave many patients much better off, particularly if the alternative is a high degree of protection against negligence in the delivery of medical care that they cannot afford. Distinct from issues of affordability, patients differ in their preferences for risk. Put differently, some patients value the protection against medical negligence offered by tort liability much less than other patients do. Such patients would prefer additional income in the here-and-now to the marginal reduction in risk provided by tort liability, and therefore would benefit from the opportunity to contract for a lower level of malpractice protection. By the same token, some patients may prefer *more* protection against medical malpractice than is afforded by the tort liability rules in their state. Although such patients may currently purchase additional protection in the form of disability or life insurance, they may also benefit from being able to contract with providers for an even greater level of malpractice protection. (There does not seem to be any judicial impediment to contracts that provide more protection than tort liability rules do. Nevertheless, judicial impediments to contracts providing less protection undoubtedly suppress the practice, and therefore may leave patients ignorant of that option.)

A second reason why patients and providers may prefer contract liability to tort liability is that the former would allow greater experimentation with different liability rules, which could lead to more efficient sets of rules. The political pressure currently expressing itself in state capitols and in Congress for reforms such as caps on non-economic damages is a manifestation of pent-up demand for different malpractice liability rules, at least on the part of health care providers, purchasers, and insurance companies. At present, the search for more efficient rules proceeds only in fits and starts as legislatures alter the rules of tort liability. Once new rules are enacted, it again becomes difficult for those who are dissatisfied to make alterations. Doing so again requires judicial or legislative intervention. In contrast, contract liability would allow dissatisfied patients and providers to make instant corrections. That agility makes it more likely that disfavored rules would be discarded under contract liability than under tort

liability, where interest groups can pressure the legislature to preserve their preferred rules.

A third appeal of contract liability is that it could improve the quality of care. To differentiate themselves from low-quality providers, high-quality providers must offer patients credible signals of quality. That is, high-quality providers must signal the quality of their services in a way that low-quality providers cannot emulate. For instance, both high- and low-quality providers can make unsupported claims about the quality of their services, making such claims not credible. An example of a credible quality signal is a high rating from an independent organization, such as the web site HealthGrades or *Consumer Reports*, although at present such organizations have little quality information to offer regarding individual providers. Another credible quality signal would be an enforceable contract wherein high-quality providers agree to furnish more protections against malpractice for the same price that low-quality providers charge, or identical liability protections at a lower price.

In the current system of tort liability, providers who are less likely to injure patients through negligence have little ability to convey that information in a credible manner. There are a number of reasons. First, the fact that a provider has been sued for malpractice, whether successfully or not, appears to be a poor indicator of the quality of care. The incidence of malpractice claims appears to bear little relation to the incidence of injuries due to negligence. It is estimated that some 98 percent of potentially valid malpractice claims are never filed; some 80 percent of those claims that are filed are invalid; and nearly 50 percent of filed claims result in a payout, which implies that many invalid claims result in payouts.[9] Second, because providers insure against malpractice claims, and insurers tend not to vary malpractice premiums according to the quality of care, high- and low-quality providers tend to pay the same malpractice premiums. Thus high-quality providers cannot differentiate themselves by offering the same level of liability protection at a lower cost. Liability rules that prevent (only) invalid claims could enhance the ability of insurers to price malpractice coverage according to an individual provider's risk of injuring a patient through negligence. However, uniform tort liability frustrates the discovery and adoption of such rules.

In contrast, contract liability offers considerable flexibility to experiment with liability rules designed to reduce frivolous claims, such as the English rule of costs, which requires the losing party in litigation to pay some or all of the litigation costs of the winning party. Insofar as contract liability would allow discovery and implementation of rules that discourage frivolous claims, the share of claims that are valid would grow. That in turn should enhance malpractice liability insurers' ability to price coverage according to a provider's risk of being sued for negligence. In such an environment, high-quality providers would have a credible way of signaling quality. They would face smaller malpractice insurance premiums, and thus could differentiate themselves from low-quality providers by offering more liability protections for the same price, or identical liability protection for a lower price. By providing the freedom to experiment with different liability rules, contract liability presents an opportunity to improve the quality of care by rewarding high-quality providers and punishing low-quality providers.

Contract liability could facilitate quality improvements in other ways as well. Many providers are reluctant to collect or release data on medical errors for fear that those data could expose providers to greater liability. As a result, a potentially important tool for measuring and improving quality may go under-utilized. Allowing providers and patients to create contractual safe harbors for medical error data could encourage its collection.

What liability rules might providers and patients adopt if they knew that courts would enforce such contracts? Early candidates would include the very rules that interest groups currently seek to impose

legislatively: caps on non-economic damages, limits on contingency fees, mandatory arbitration, medical courts, the English rule of costs, and changes to the collateral source rule. Those who lobby for caps on damages for pain and suffering could insist on such limits in their own contracts with health care providers.[10] Caps on damages could be set as low as $0 for the indigent faced with the prospect of otherwise receiving no medical care. Simply capping overall damages would provide a variant of collateral source rule reform for those who are elsewhere insured against disability. Contract liability could employ all, some, or none of the above-mentioned rules. The ability to experiment would generate novel combinations of these rules and even novel rules. Insofar as these innovations leave both patient and provider better off, they would be retained, while rules that proved intolerable to either side would be discarded.

Enforcing contractual limitations on providers' liability for medical malpractice would not obviate the need for tort liability. Contract liability is well-suited to supplant tort liability for many injuries caused by simple negligence. Tort liability could still deter and punish acts of gross negligence, and would still be necessary to deter and punish willful misconduct, which should vitiate any contract where a provider promises to exercise reasonable care. Moreover, contract liability is not an option for some patients. This group includes incompetents and those who choose not to contract. Tort liability could and should provide a set of background rules around which patients and providers may contract if they are able and willing.

III. Obstacles to Contract Liability

When advocating an idea that has no hope of being adopted, it is customary to blame those dim prospects on powerful vested interests rather than the idea itself. Certainly, there are organized interests who might suffer financially were patients and providers able to make binding ex ante agreements that limit the frequency and/or size of liability payouts. The trial bar comes to mind. Yet contract liability also meets resistance from open-minded skeptics. Nevertheless, such arguments against contract liability still fall short of demonstrating that tort liability affords patients greater overall protection than contract liability would. This section critiques three arguments against contract liability: that such agreements constitute contracts of adhesion due to providers' superior bargaining power; that patients are too poorly informed about different liability rules for such agreements to be upheld; and that contract liability would reduce investments in quality.

A leading case regarding contract liability for medical malpractice is *Tunkl v. Regents of the University of California*.[11] Tunkl was a charity patient at the University of California at Los Angeles Medical Center. Upon admission, he was asked to sign and did sign a document that waived his right to recover from the Regents or the hospital for injury due to the negligent acts of the hospital's employees. Tunkl was subsequently injured by the negligence of two physician employees. At trial, the jury upheld the release, reasoning that even though the plaintiff was in pain and sedated when he signed, Tunkl "either knew or should have known the significance of the release."[12] On appeal, the Supreme Court of California invalidated the release as contrary to public policy. The court gave the following test for deciding when contracts that relieve an actor of liability for his own negligence affect the public interest, and are thus invalid:

> The attempted but invalid exemption involves a transaction which exhibits some or all of the following characteristics:

1. It concerns a business of a type generally thought suitable for public regulation.

2. The party seeking exculpation is engaged in performing a service of great importance to the public, which is often a matter of practical necessity for some members of the public.

3. The party holds himself out as willing to perform this service for any member of the public who seeks it, or at least for any member coming within certain established standards.

4. As a result of the essential nature of the service, in the economic setting of the transaction, the party invoking exculpation possesses a decisive advantage of bargaining strength against any member of the public who seeks his services.

5. In exercising a superior bargaining power the party confronts the public with a standardized adhesion contract of exculpation, and makes no provision whereby a purchaser may pay additional reasonable fees and obtain protection against negligence.

6. Finally, as a result of the transaction, the person or property of the purchaser is placed under the control of the seller, subject to the risk of carelessness by the seller or his agents . . . .

In this situation, the releasing party does not really acquiesce voluntarily in the contractual shifting of the risk, nor can we be reasonably certain that he receives an adequate consideration for the transfer.[13]

Though *Tunkl* does not provide a precise rule for when an exculpatory contract is invalid, this passage illustrates that the court was concerned primarily with contracts of adhesion, where the provider wields "superior bargaining power" over the patient and can therefore compel the patient to waive protection against negligence contrary to the patient's own interest. This is consistent with the courts' handling of exculpatory contracts in other circumstances.[14]

That focus suggests that the reasoning in *Tunkl* need not invalidate all contractual limits on liability for malpractice. Certainly there are many transactions where the patient has ample time to choose from between a number of providers, drastically reducing the bargaining power of each provider and correspondingly increasing the patient's bargaining power. One can think of cosmetic surgery or any of a number of other elective procedures. If provider offers patient a range of protections against negligence (including traditional tort liability) from which to choose, as competition might force providers to do, the *Tunkl* court's fears are further assuaged.[15] If the patient ultimately agrees to a limit on recovery for non-economic damages equal to 80 percent of the state's cap on such damages, or to no changes to tort liability rules save the English rule of costs, the public's interest in the contract shrinks further.[16]

Even in the situations the court most fears, however, *Tunkl* fails as an argument against contract liability. First, the court expresses understandable reservations about allowing a patient to contract away liability protections right before she submits to complete vulnerability at the hands of a provider or multiple providers. The court's language evokes feelings of vulnerability before a careless and possibly malevolent provider who, exculpatory contract in hand, may do with the patient as he wishes. But of course this is not the case. As noted in the previous section, honoring contractual limitations on liability for simple negligence would still leave in place tort remedies for gross negligence and willful misconduct.

Contract liability could reduce the patient's ability to recover in the event of slight but not egregious deviations from the standard of care. Moreover, in cases where a contract limits recovery for simple negligence, judges and juries would police more carefully the boundary between simple and gross negligence just as they have used other tools at their disposal to invalidate exculpatory contracts.[17]

Yet the fatal flaw of *Tunkl* is that the court assumes that liability protection it mandates for indigent patients either has no cost, or that the cost is not passed on to those patients (e.g., through higher prices or by discouraging providers from practicing in low-income areas). The former is obviously not true, and the latter is almost certainly not true. In effect, *Tunkl* raises the cost to providers of delivering care to indigent patients above what it otherwise might be. If the resources available to provide care to the indigent are finite, the additional liability costs prevent providers from caring for additional indigent patients.[18] Thus the *Tunkl* court thoughtlessly dictates that some indigents must go without medical care so that others may receive medical care plus protection against the small probability of injury from substandard care. An attempt to protect the poor from negligence thus leaves them more vulnerable to illness.

Rather than adopt an inkblot-like test for determining the validity of exculpatory contracts, the courts should afford patients and providers the certainty that comes with a bright- line test. Where that line should be drawn can be found in the history of *Tunkl* itself. Courts should uphold contractual liability rules agreed to by competent patients and should continue to invalidate limits on liability agreed to by incompetent patients. This is how the *Tunkl* jury approached the question at trial, before the California Supreme Court invalidated as violating public policy a contract that Tunkl's peers considered valid.

A related objection to contract liability is that patients lack sufficient information to bargain with providers over liability protections.[19] That patients lack such information today is undeniable, but that's because information about the value of alternate liability rules is of little use—and thus is seldom supplied—to consumers who cannot legally contract for non-standard rules. Able to choose alternate rules, consumers' demand for such information would increase markedly, creating profit opportunities for those in a position to supply such information. Markets could route the information to consumers as it does information about other products. To reduce patient confusion, providers may offer a small number of standardized contracts, perhaps drafted or approved by medical societies or independent groups. Employers, unions, and even health insurers[20] could act as the patient's agent in negotiations with providers, recommending or even demanding certain liability protections. Independent organizations such as *Consumer Reports* could evaluate the importance of discrete liability protections and standardized contracts, including the liability protections offered by corporate entities such as Kaiser Permanente and HCA.

Moreover, at the same time critics of contract liability exaggerate the information problems confronting patients,[21] they ignore the information problems facing judges and legislators. Legislators obtain information on malpractice liability rules from groups that are relatively easy to organize and have a large stake in their preferred rules (e.g., the trial bar, providers, employers, etc.). Legislators tend not to receive information from those whose stake is relatively small and who are more difficult to organize (i.e., individual patients, particularly the indigent). For the individual patient, the costs of obtaining information about the potential effects of legislative reforms, organizing, and conveying one's views to the legislature would overwhelm the expected benefits of a given rule. Courts have a distinct advantage over legislatures in crafting tort liability rules, in that courts are better equipped than legislatures to

collect information from individuals adversely affected by a legal rule, are less subject to political influence, and have more opportunities to experiment with and revisit a legal rule.[22] Nevertheless, as *Tunkl* illustrates, the indigent patient is privy to information that courts and lawmakers are not. Specifically, the patient who agrees to waive liability may know—in a way that a court cannot appreciate—that the cost of the court's preferred rule could require the patient to forgo medical care. Judges, much less legislators, should not dismiss the possibility that the indigent possess information that lawmakers do not.

A third objection to contract liability is that such a system could not generate the investments in quality that a functional tort liability system would generate. This case is made forcefully by Jennifer Arlen of New York University School of Law.[23] Arlen argues that a uniform tort liability system that forces providers to bear the cost of their negligence encourages providers to invest in quality—in both human and physical capital, and both before and after forming a contract with a particular patient. Under a system where the parties can bind themselves to a lower level of liability protection, providers would face diminished incentives to invest in quality. Quality investments would thus fall, to the detriment of patients who preferred the level of quality investment spurred by uniform tort liability rules. Even if those patients were to contract for the same level of malpractice protection previously afforded under tort liability, they could not replicate the incentives for providers to invest in quality that come from exposing providers to that degree of liability for all patients. As a result, even if all patients were fully informed, those patients would be worse off under contract liability.

As an argument against contract liability, Arlen's analysis fails for two reasons. The first reason is that it faults markets for doing something that markets are supposed to do. Insofar as there are patients who would be worse off under contract liability than under an optimal tort liability system, that means that uniform tort liability confers subsidies on those patients—subsidies extracted from patients who would prefer less liability protection, but whose right to contract for less protection has been denied by the courts. The monetary and autonomy losses suffered by that latter group of patients must be entered in the ledger along with the losses borne by the indigent who are denied medical care. An important function of markets is to eliminate such cross-subsidies, particularly those that travel up the income scale, as these subsidies appear to do. Moreover, patients who lose these cross-subsidies are certainly not without recourse. They could obtain their preferred level of quality the old-fashioned way: by paying for it. Demanding even greater liability protections than tort liability currently provides would encourage some providers to make the desired investments in quality.

The second reason is that Arlen demonstrates that contract liability would be inferior only to an idealized, "optimal" system of tort liability. Though Arlen adds much to our understanding of how contract liability would affect the health care sector, her critique compares contract liability only to an optimal system of tort liability, which she acknowledges does not exist. Nor does Arlen articulate a strategy for moving our actual tort liability system toward optimality, or compare such a strategy to the process of experimentation and learning that contract liability would provide. As a result, Arlen does not show contract liability to be any more flawed than our current tort liability system, or any other human institution. It is hardly a damning criticism to say that contract liability fails in comparison to an ideal.[24] Most human endeavors do.

It is that process of experimentation with different rules that gives contract liability its greatest advantage in the pursuit of optimality. Indeed, the process by which liability rules are selected is likely more important than which rule will be tried next. Presumably, Arlen would prefer to retain the current

system's uniformity while pushing toward optimality through judicial and/or legislative intervention. However, an optimal selection process would reduce the cost of gathering and making use of new information. The fact that contract liability reduces the cost of adopting and discarding liability rules – including rules designed to deal with the problems Arlen identifies—gives contract liability a distinct advantage over experimentation by courts and legislatures. A full appraisal of the information problems under the three available reform processes—contract, judicial, and legislative— suggests that contract provides the least-imperfect route toward optimality.

IV. Allaying Concerns with Contract Liability

Limitations on the right of competent adults to contract for protection against medical negligence are likely to be either unnecessary (because no patient and provider would choose the prohibited terms) or harmful (because the limitation would foreclose a preferred option). Yet the dim prospect that courts will begin to enforce such contracts suggests that some limitations might be tolerated in order to reduce the harm currently imposed by complete prohibition. What contracts might courts or legislatures be persuaded to declare valid? One possibility is to enforce only those contracts produced by someone other than providers themselves. Requiring that contract liability rules will only be enforced when written by those at arms-length from providers, and only when offered as a part of a menu of standardized contract liability protections, would provide a much needed, if ultimately inadequate, dose of experimentation and relief. Alternatively, legislatures could permit patients and providers to negotiate within boundaries set by other legislatures, such as by enforcing only those contracts that employ limits on malpractice liability enforceable in one of the other 49 states. Legislatures could overcome concerns that patients would forgo all malpractice protections by setting a lower bound on maximum awards, such as $250,000 for non-economic damages. Concerns about uninformed patients signing away their rights could be remedied by initially confining the right to contract only to those patients who are judges, lawyers, physicians, statisticians, actuaries, high-income earners, or who carry third-party insurance against such injuries. As *Tunkl* suggests, courts have not developed a clear rule to decide which contracts will be upheld and which invalidated. That indeterminacy suggests courts are not hostile to all exculpatory contracts,[25] and opens the door to limited reforms such as these.

V. Conclusion

Public policy currently allows patients to assume the very large risks involved with forgoing treatment for fatal yet treatable diseases.[26] It further permits patients to select different liability protections by traveling abroad for medical care.[27] Judges and lawmakers respect the right to refuse treatment even when the risks are large, but deny the right to limit one's ability to recover for negligence even when the risks are small. Patients already have the right to choose different malpractice liability protections, but only if they are willing to travel out-of-state or out- of-country. If consumers are too poorly informed to allow them to bind themselves to different liability rules, a consistent approach to contract liability would have to prohibit traveling abroad for medical care.[28]

Proponents of uniform tort liability argue that the provider owes a duty to the patient upon the two forming a special legal relationship.[29] Yet the problem of malpractice protection has a positive economic component as well as a normative legal component. That is, where shall we invest resources: in protection from negligence, or in protection from illness? Certainly, society should not completely sacrifice either in pursuit of the other. Ignoring the tradeoff, however, is dangerous precisely because in

doing so we may inadvertently reduce protection overall, particularly for the poor. The threat posed by our current system of tort liability for medical malpractice is that we have struck a balance that demands greater protection from simple negligence than many patients would prefer, that is uniform and inescapable, that reduces protections against illness, and that may only be altered through Herculean efforts in a process that guarantees that some voices will not be heard.

Where, then, to strike the balance? As the foregoing discussion suggests, that question is subordinate to the threshold question: who decides?[30] It is here that contract liability offers advantages that tort liability cannot. Contract liability offers a means to drive the imperfections out of the medical malpractice liability system through a process that selects liability rules based on their ability to deliver improvements in both cost and quality. Our present system of uniform and rigid tort liability offers no such process, and thus provides less overall protection than we could achieve.

Notes

1. Mark A. Hall et al., *Health Care Law and Ethics* 270 (6th ed 2003). *See also* Patricia Danzon, *Liability For Medical Malpractice*, in HANDBOOK OF HEALTH ECONOMICS (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) at 1354, 1358.

2. Christopher Conover, *Health Care Regulation: A $169 Billion Hidden Tax* (Cato Institute, 2004).

3. *Id*.

4. *See generally* Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1 AM. BAR. FOUND. RESEARCH. J., 87, 87-89 (1976). *But see* Bernard S. Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 JOURNAL OF EMPIRICAL LEGAL STUDIES, 207 (2005) ("We do not find evidence in claim outcomes of the medical malpractice insurance crisis that produced headlines over the last several years and led to legal reform in Texas and other states.").

5. American Medical Association, *Medical Liability Reform: Q&A* (March 2006), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/399/mlr_tp.pdf (last visited Nov. 29, 2006).

6. Epstein, *supra* note 4 at 92, 140, citing *Byrne v. Boadle*, 2 H. & C. 722, 159 Eng.Rep. 299 (Court of Exchequer, 1863).

7. *Id*.

8. PricewaterhouseCoopers' Health Research Institute, *Top Seven Health Industry Trends in '07* 2 (2006) *available at* http://pwchealth.com/cgi-local/hregister.cgi?link=reg/topseven.pdf (last visited Dec. 1, 2006) (finding that 61 percent of consumers believe medical malpractice costs are a "big factor" behind rising health care costs, and a further 31 percent of consumers believe them to be "somewhat of a factor").

9. Hall et al., *supra* note 1 at 270. *See also* Danzon *supra* note 1 at 1358 ("Overall, only 43 percent of claimants receive any payment").

10. *But see* Frank Cornelius, *Crushed by My Own Reform*, NEW YORK TIMES (October 7, 1994) (former lobbyist for caps on damages is left with uncompensated losses after suffering injuries from medical negligence).

11. *Tunkl v. Regents of the University of California*, 60 Cal.2d 92, 383 P.2d 441, 32 Cal.Rptr. 33 (Cal. 1963).

12. *Id*. at 95.

13. *Id*. at 98–101 (formatting added).

14. *See* 175 A.L.R. 8 (1948) at § 9 ("Validity is almost universally denied to contracts exempting from liability for its negligence the party which occupies a superior bargaining position").

15. *See Id*. at § 10 ("In some instances an artificial equality of bargaining power has been produced so far as agreements to exculpate are concerned by giving the party occupying the inferior bargaining position the option to secure the other's unlimited liability at a price set by governmental regulation at a 'reasonable' level, and where this has been done, exemption provisions have been held valid").

16. *See Id.* at § 3, citing 2 AM.L INST RESTATEMENT, CONTRACTS, § 574 ("A bargain for exemption from liability for the consequences of negligence *not falling greatly below the standard established by law* for the protection of others against unreasonable risk of harm, is legal except in the cases stated in § 575," emphasis added). *But see Id.* at § 3 ("No such clear-cut rule can be deduced from the various decisions of the courts").

17. *See e.g., Id.* at § 11 ("Where there is no, or no great, disparity of bargaining power between the parties, contracts limiting liability for negligence will, as a rule, be upheld on the theory of freedom of contract. As stated before, *this fundamental rule, while correct in theory, has been changed in nearly all cases which do not expressly mention negligence, into the opposite rule through the principle of strict construction of exculpatory clauses against the person seeking to exculpate himself*," emphasis added).

18. Richard A. Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, 74 VA. L. REV. 1451, 1460-1461 (Nov. 1988).

19. *See, e.g.,* P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 LAW & CONTEMP. PROBS. 287, 295 (Spring 1986). *See also* Jennifer Arlen, *Private Contractual Alternatives to Malpractice Liability*, in MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM: NEW CENTURY, DIFFERENT ISSUES (William M. Sage & Rogan Kersh, ed.) (Cambridge University Press, 2006).

20. Provided a health insurer has an arm's length relationship with (1) the provider and (2) the carrier from whom the provider purchases malpractice liability insurance.

21. Indeed, critics of contract liability have used the information problems caused by the effective prohibition of contractual liability to dismiss the appeal of contract liability. At the same time Atiyah argues that consumers are poorly informed about different liability rules, he notes a "marked lack" of evidence that consumers demand reform of existing liability rules. Atiyah, *supra* note 19 at 295-296, 298. Yet a lack of demand for reform is meaningful only if consumers are well-informed about reform options.

22. *See generally* John Hasnas, *What's Wrong with a Little Tort Reform?*, 32 IDAHO L. REV. 557 (1996).

23. *See* Arlen *supra* note 19.

24. *See generally* Harold Demsetz, *Information and Efficiency: Another Viewpoint*, 12 J.L. & ECON. 1, 1 (1969).

25. *See* A.L.R. at § 3.

26. *See, e.g., Matter of Conroy*, 98 N.J. 321, 486 A.2d 1209, 53 USLW 2372, 48 A.L.R.4th 1 (N.J. 1985) at 353 ("On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death").

27. *See, e.g.,* Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It*, (Cato Institute, 2005) at 8–9, 141–143.

28. One hesitates to give the legislature ideas.

29. Atiyah *supra* note 19, at 296–297.

30. Epstein, *supra* note 18, at 1451–1452.

Chapter 72

Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?

by Shirley Svorny

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Introduction

Supporters of capping court awards for medical malpractice argue that caps will make health care more affordable. It may not be that simple. First, caps on awards may result in some patients not receiving adequate compensation for injuries they suffer due to physician negligence. Second, because caps limit physician liability, they can also mute incentives for physicians to reduce the risk of negligent injuries. Supporters of caps counter that this deterrent function of medical malpractice liability is not working anyway—that awards do not track actual damages, and medical malpractice insurance premiums do not reward high-quality care or penalize errant physicians with higher premiums.

This paper proceeds as follows. I begin with a review of the structure and regulation of the medical professional liability insurance industry. Next, for those unfamiliar with studies of the tort system and concerned that it fails to identify malfeasant physicians, I review the empirical literature that has found malpractice awards generally track injuries resulting from negligence. The next section reviews the conventional wisdom that says medical malpractice insurance companies do not "experience rate" (i.e., charge higher premiums to physicians who are more likely to injure patients). Drawing on interviews with underwriters and brokers, published sources, and an extensive review of state insurance company rate filings in California and elsewhere, I explain how the malpractice insurance industry uses underwriting and other tools to provide oversight and reduce adverse medical events. I conclude that important consumer protections could be lost were caps on economic and noneconomic damages to reduce insurance industry incentives to evaluate and minimize risk associated with the practice of medicine.

The findings in this paper have implications for several other public policies, including laws that shield government-employed physicians from malpractice claims, state malpractice insurance subsidies for high-risk physicians (via state joint underwriting associations), and state licensing of medical professionals.

The Medical Malpractice Insurance Industry

Medical professional liability insurance is commonly referred to as malpractice insurance. State governments regulate medical malpractice insurance. Companies approved by state insurance departments are called admitted carriers. Admitted carriers must demonstrate financial stability and adhere to state regulations. They must seek state department of insurance approval for rates and forms. State guarantee programs protect injured patients against insurer insolvency.

Since the mid-1970s, the share of the medical professional liability insurance market held by traditional, for-profit, commercial insurers has declined as not-for-profit, physician-owned insurers' share has grown. Other risk-transfer entities provide insurance to medical societies or physician groups.[1]

Physicians denied coverage or dropped by admitted carriers turn to surplus-lines carriers. This includes physicians who have lost hospital privileges, those with a history of medical malpractice claims or drug or alcohol abuse, and physicians sanctioned by state medical boards. Medicare or Medicaid fraud can also be a ticket to the surplus-lines market.[2] Doctors with clean clinical records may be in the surplus-lines market because they practice in more than one state, have gone without insurance coverage for a time, or are using a new procedure not yet widely in use.

For the most part, surplus-lines carriers are not as heavily regulated as admitted carriers nor backed by a state guarantee fund.[3] Because they are not required to file forms and rates, they may change rates or policy terms as conditions warrant. This allows them to design insurance products for nonstandard risks.[4]

The number of physicians in the surplus-lines market depends on the medical malpractice insurance cycle.[5] In a buyers' market, the so-called soft market, admitted carriers take on more risky physicians. Today, an aging soft market has led many admitted carriers to expand the set of physicians they will cover, crowding out the surplus-lines carriers. CNA HealthPro underwriting director Tim Vlazny estimates that the share of premiums attributed to doctors in the surplus-lines market can be as low as 1 percent in a soft market and as high as 10 percent in a hard market.[6]

Are Malpractice Awards and Settlements Haphazard?

Tort law serves two functions. The first is to compensate individuals who are harmed by others. The second is to deter harmful behavior. If the medical malpractice system is working properly, court verdicts (and settlements motivated by previous verdicts) would not only compensate patients who suffer due to physician negligence but would also deter future harmful events. The medical malpractice system's ability to deter negligence depends first on the accuracy of court judgments and awards.[7] If awards and settlements are random, there can be no deterrent effect, making the whole system a costly way to compensate victims of negligence.[8]

Researchers have found that awards are not haphazard. The medical malpractice system generally awards damages to victims of negligence and fails to reward meritless claims. Plaintiffs' attorneys, paid on a contingency basis, filter out weak cases. Patients who file valid claims are likely to collect, generally through out-of-court settlements. Though some unfounded claims do result in settlements or the rare court award, the dollar amounts are smaller than they would be for similar injuries that result from physician negligence.[9]

The fact that settlement is common suggests courts are providing good signals as to when plaintiffs will prevail. Under these conditions, insurance companies assess the validity of claims and settle valid claims rather than go to court. The fact that defendants win most court trials makes sense if defendants (providers and insurers) generally settle valid claims out of court.

Another common criticism of the medical malpractice system is that few cases of negligence result in claims. This could be partially explained by the fact that in most cases of negligence the damages are minimal. A prominent study found that nearly 80 percent of patients who suffered a negligent injury either recovered fully within six months or were very old. Both factors indicate relatively small financial losses, which can discourage patients from filing a claim.[10] The evidence suggests that the majority of claims are heavily concentrated among a small percentage of practicing physicians.[11] So if more cases of negligence or substandard care were to result in claims, the set of defendants would not likely differ significantly from the set of high-risk professionals that the current system already identifies.

Critics of the system point to the fact that many initial claims do not involve negligence. This can be explained by patients and their attorneys seeking to gather information about the level of negligence associated with an injury. Once discovery shows a small likelihood of success, many plaintiffs drop their claims.[12]

Critics of the medical malpractice system point to its high administrative costs.[13] High legal fees may reduce the system's efficiency by leading insurers to settle meritless claims and by deterring some injured patients from filing valid claims. Yet, as economist Patricia Danzon observes, the bulk of administrative costs are limited to the small fraction of cases that go to court. Meanwhile, the deterrent effect influences all medical practice.[14]

Although the conventional wisdom is that lawsuits keep doctors from discussing problems and reporting errors, David Hyman and Charles Silver credit lawsuits with starting discussions that improve care.[15] They write that high malpractice premiums motivated the American Society of Anesthesiologists to launch a patient safety campaign that resulted in a dramatic reduction in surgical anesthesia-related injuries and deaths in the United States. They point to a hospital that did not take efforts to reduce infection rates until it faced significant costs of litigation; it was litigation costs that motivated the

hospital to improve sanitary procedures and resulted in a near elimination of hospital-borne infections.

The Conventional Wisdom: Malpractice Insurance Is Not Experience Rated

If the tort system is to steer providers in the direction of higher-quality care, accurate awards are necessary but not sufficient. Physicians must receive information about how to avoid liability risk and face incentives to act on that information.[16] If malpractice insurance premiums reflect a physician's or a physician group's claims experience or other factors related to the risk of injuring a patient through negligence, then premiums will act as signals that steer physicians toward higher-quality care: the hope of reducing their premiums will encourage high-risk physicians to reduce their risk of injuring patients. If insurers do not experience rate premiums, those signals would not exist and the tort system's deterrent effect would be muted.

The decades-old conventional wisdom holds that medical malpractice insurers rarely adjust premiums to reflect an individual physician's risk. An influential 1981 article by economist John Rolph concluded that "merit rating" was "a practice not now employed in the malpractice insurance industry to a significant degree."[17] About the same time, Patricia Danzon reviewed a nationwide sample of premiums paid between 1974 and 1976 and found no surcharges based on claims histories, concluding, "these data suggest that, at least in the group programs, more merit rating is feasible than in fact occurs."[18] In the early 1990s, economist Frank Sloan and colleagues reported the findings of a 1980s survey of 14 medical malpractice insurance companies, in which the majority of firms had "either completely abandoned experience rating . . . or maintained a program of limited scope."[19] Sloan concluded that "there has been considerable resistance to experience rating in the medical malpractice line."[20] Paul Weiler and colleagues concluded, "experience rating has not found much favor with the carriers that insure individual doctors against malpractice suits."[21] In 1998 Sloan and Randall Bovbjerg wrote, "there is little experience-rating in the medical malpractice field, even where there are claims."[22] In 2001 economists Gary Fournier and Melayne McInnes wrote that experience rating "is rarely found."[23] In 2008, Sloan and Lindsey Chepke wrote, "experience rating of premiums is rare for medical malpractice insurance. Thus, in general, physicians with relatively adverse medical malpractice records pay the same premiums as others."[24] Among other places, the conventional wisdom appears in literature reviews by the Robert Wood Johnson Foundation ("experience rating is not widely used. . . . Physician malpractice premiums . . . are usually priced according to the physician's specialty and geographic location") and U.S. Congressional Budget Office ("premiums for malpractice insurance generally are not adjusted on the basis of an individual physician's claim history").[25]

Economic Theory vs. the Conventional Wisdom

Economic theory predicts that the practice of charging the same average premium to low-risk and high-risk physicians would not persist for long in a competitive market. Eventually, a competing insurer would lure away low-risk physicians with the promise of lower premiums, and premiums for high-risk physicians would rise as a result. Economic theory also predicts carriers will continue to invest in underwriting so long as spending an additional dollar on underwriting yields more than one dollar of revenue. Economists generally acknowledge that experience rating could improve the quality of care and the functioning of the tort system.[26]

The apparent lack of experience rating therefore presents something of a puzzle. To explain why experience rating has not taken hold in this market, some cite carriers, who say that experience rating "would not work well with low-frequency, high-severity losses as occur in medical liability, which may take a long time to settle."[27] Others cite the high cost of underwriting.[28] I will address these explanations after reviewing the evidence of experience rating.

When I was told by an insurance industry professional that medical malpractice insurance is experience rated, I undertook an intensive investigation.[29] I conducted lengthy interviews with underwriters and brokers, scoured published sources, and read all of the medical malpractice insurance rate filings in California. It turns out that the conventional wisdom is wrong. The malpractice insurance market does in fact adjust premiums to reflect physician risk, both within and across carriers. This forces high-risk physicians to bear the cost of the added risk they pose and creates incentives for those physicians to practice safer medicine. Carriers engage in other activities, often tied to underwriting, that also reduce patients' risk of negligent injury.

Underwriting

Initially, when physicians seek insurance, and then on an annual basis, medical malpractice insurers require them to provide information that allows the insurance underwriter to assess liability risk. Insurers ask physicians questions about their practice profile, including whether they perform or assist with surgery, the type of medicine they practice, the number of patients they treat, specific medical techniques and procedures they use, and where they practice.[30] Applicants describe their education and provide a list of hospitals where they are permitted to practice. Applicants must report whether they have ever been denied status as a medical student, a license to practice medicine, a license to prescribe narcotics, hospital privileges, membership in a professional society, or medical professional liability insurance and whether any one of these has ever been restricted, suspended, revoked, or voluntarily surrendered. Physicians must report whether they are specialty-board certified, have ever failed a specialty board certification test, or have ever been denied certification by a specialty board. Physicians must complete a form for every claim filed against them, including information about damages paid and defense costs to their insurer at the time, and any claims they expect to be filed. Physicians must report any history of alcoholism, mental illness, or narcotics addiction, or any criminal history. Lying on one's application is grounds for denial of a claim.[31]

Insurance underwriters scrutinize the information in a physician's application. According to Tim Vlazny, the underwriter's job is to "verify, verify, verify."[32] Preferred carriers, those with the strictest underwriting guidelines, may go so far as to search county records. This alerts them to claims before they are reported to public databanks.[33] Information also comes from the so-called "loss runs" provided by a physician's previous medical liability insurer. Loss runs document prior claims, damages, and defense costs. Surplus-lines carriers require applicants to produce loss runs for every company with which they have been insured.[34] Insurers reevaluate physicians annually.

Underwriters may even review the equipment a physician uses. A clinician may have had problems with claims in the past, but if he or she has adopted newer techniques or purchased safer equipment, that may allow the physician to secure a policy with a lower premium.[35] In Colorado and in Nebraska, the medical malpractice liability carrier COPIC performs a standardized review for significant safety and risk aspects of all the offices of the physicians it insures biannually (nearly 2,400 such reviews a year).[36]

Underwriters occasionally have access to information that is not available publicly. For example, they might obtain information such as physician-specific utilization reports from a managed care company intent on negotiating a lower rate for its physicians.[37]

Experience Rating

Experience rating refers to the practice of charging physicians with a history of risky behaviors higher premiums than their same-specialty, same-location peers. As a first step in experience rating, a standard-lines carrier may impose premium surcharges on physicians whose claims histories do not meet the company's standards, or offer discounts to physicians with clean histories. A 1989 survey of insurance companies commissioned by the Institute of Medicine reported the use of experience rated surcharges at 6 carriers (of 10 that answered the question about use of experience rating and surcharges).[38]

Insurance company rate filings in California show that admitted carriers routinely incorporate surcharges and credits in their rate manuals. Table A–1 lists surcharge provisions found in the most recent California rate filings. The last filing that made any changes to experience rating provisions is listed.[39] Florida filings are similar to those in California. A filing by Florida's second largest insurer includes surcharges between 50 and 500 percent of standard premiums based on a physician's seven-year claim history.[40] A survey of Vermont companies reported surcharges as high as 400 percent.[41]

Just as surcharges may be used to punish poor risk management, premium credits reward physicians who avoid lawsuits. As Table A–2 shows, almost all California filings include claims-free credits, where the size of the credit—from 5 to 25 percent of a physician's base premium—is often a function of how long a physician has been claims free. Similar credits showed up in Florida rate filings and were reported in the 2005 survey of Vermont companies.[42]

Longevity credits also reward good claims experience, as continued eligibility for insurance indicates risk concerns have not changed substantially. One California insurance company offered a 5 percent credit to physicians insured for five or more consecutive years.[43]

Rate filings may provide only weak evidence of experience rating. Filing surcharges with the state gives insurance companies the flexibility to use them as they see fit, but filings do not indicate how often carriers actually apply those surcharges. Some carriers report that only a small percentage of insureds face surcharges at any point in time.[44] For example, an admitted carrier might decide to surcharge a physician with the intention that continuing education and enrollment in risk management seminars (see below) would move a physician to a position where the carrier is comfortable insuring him at standard rates.[45]

One carrier reports that if the required surcharge would be much above 25 percent, the company is more likely to reject a physician's application, fail to renew a policy, or impose reductions in coverage upon renewal.[46] Some carriers' filings explicitly state that surcharges may substitute for nonrenewal or cancellation of a policy.[47]

A 2008 study of malpractice premiums in Massachusetts offers a rare opportunity to see statistics on actual surcharges. A state-regulated mutual insurer in Massachusetts, ProMutual (with an estimated market share of the physician liability insurance market of between 40 and 50 percent in 2005), reports that it began underwriting within-practice specialties based on individual risk factors in 1990, offering discounts for lower-risk physicians. In 2000 the company began surcharging higher-risk physicians. By 2005, roughly 6 percent of ProMutual's policies carried surcharges. Four-and-a-half percent of physicians faced surcharges of less than 25 percent and 1.4 percent paid surcharges over 25 percent. At ProMutual, all physicians in a particular high-risk specialty paid identical premiums in 1990. By 2005, due to refined risk rating, the highest-risk physicians in these high-risk specialties paid premiums three

times higher than their same-specialty, lower-risk, peers.[48]

Experience Rating across Carriers

Though some experience rating takes place among physicians insured by a specific carrier, most experience rating takes place across carriers. Insurance carriers specialize in serving physicians with similar risk profiles. Physicians who do not meet one carrier's risk profile must seek insurance elsewhere. This allows insurance carriers to specialize in underwriting certain risks.

Some companies who insure only the least-risky physicians do little underwriting. They pick physicians with spotless records. This keeps their costs and premiums low. In California, the Cooperative of American Physicians provides coverage through Mutual Protective Trust, a company whose underwriting guidelines are known to be particularly strict.[49] Preferred Physicians Medical Risk Retention Group advertises that, in more than 30 states, it insures only high-quality anesthesia practices.[50] General Star's Physicians Advantage Program insures only those physicians with a good loss history, specialty board certification, and no practice impairments.[51] When such carriers reject an application because they are unwilling to assume that physician's liability risk, that itself is a clear example of experience rating.

Other companies underwrite physicians with somewhat higher risk. When admitted carriers deny coverage to physicians who present too much risk, those physicians must turn to surplus-lines carriers, who typically charge more. Premiums in the surplus-lines market are generally between 150 to 500 percent of those in standard markets.[52] A physician paying $10,000–$15,000 in the admitted market might pay $25,000–$50,000 in the surplus-lines market if he had been sued many times.[53] Tim Vlazny reports that premiums in the surplus-lines market average twice the level of those in admitted markets in the hard part of the medical malpractice cycle (a seller's market) and 1.25 times the admitted rate in a soft market (buyer's market).[54] In addition to higher premiums in the surplus-lines market, it is common to require deductibles between $5,000 and $25,000 per claim.[55] With deductibles, physicians bear the first dollar of damage costs, creating additional incentives for physicians to reduce their risk.[56]

Physicians denied or dropped by admitted companies not only pay higher premiums and bear more financial risk, but when they retire or are disabled, they pay substantially more than other physicians for Extended Reporting Period (tail) coverage. Tail coverage is important to retired physicians because, while practicing, physicians buy "claims-made" coverage. This type of coverage only protects them against claims made during the period the insurance is in effect. When a physician retires, liabilities for past adverse events are not covered unless the physician has tail coverage.[57] Physicians in the admitted market are offered tail coverage at no charge or at a significantly reduced premium.[58] In contrast, physicians who retire from the surplus-lines market find tail coverage expensive. Premiums may range from 500 percent of the physicians' previous year's premium for five years of tail coverage to 125 percent for one year of tail coverage. Physicians enrolled in "Tribute Plan," a medical malpractice policy offered by the carrier The Doctors Company, face an additional penalty if dropped—they lose access to their Tribute Plan retirement benefit, which includes a retirement payment.[59]

There is stratification of risk within the surplus-lines market as well. For example, General Star has two programs in the surplus-lines market, its Physician Select Program and its Special Risk Program.[60] CNA's surplus-lines company targets only those physicians who have the potential to return to the

admitted market.[61] Darwin National Assurance Company specializes in writing so-called "grey docs," physicians who don't have bad claims records but are in the surplus-lines market because they need more underwriting than the standard market is willing to provide. They may have gaps in coverage, practice in two or more states (as with a radiologist involved in telemedicine), have a large claim that is relatively old, or be involved in clinical research.[62] Some companies underwrite more extensively than others. Whereas Markel evaluates the validity of claims against physicians (appealing to doctors with invalid claims), RSUI treats every claim equally.[63] Only a very few companies have the expertise to underwrite physicians in the extreme risk category.[64]

Once in the surplus-lines market, physicians are motivated to reduce their perceived risk.[65] For many, being placed in the surplus-lines market is a "major wake-up call."[66] Physicians know that if their insurance is not renewed they will not be allowed to practice in most hospitals or be affiliated with most health maintenance organizations.[67] In some states, they are not allowed to practice at all. Most doctors return to the admitted market after showing that their problems have been resolved. For some, the passage of time suffices to demonstrate to the admitted market that they bring with them no unusual risk.[68]

Specialization across companies in the level of risk they choose to insure provides a second level—and stronger evidence—of experience rating. Outside observers may see little evidence of experience rating among physicians insured by a particular carrier, but that is because those physicians have already been selected for common risk characteristics. According to a leading health economics textbook, "markets produce 'experience rating' even when firms don't":

> Even if individual insurance firms don't use experience rating to price their insurance, the market may produce an equivalent result. That is, every firm might charge each of its customers the same price, yet each firm may accept different classes of risk. This can readily lead to high-risk customers paying higher rates and low-risk customers paying low rates, even if no single firm charges different rates to different risk classes.[69]

Experience rating across carriers also occurs in other insurance markets, including automobile insurance.[70]

Experience rating of this sort—where admitted carriers deny coverage to high-risk physicians who then must turn to surplus-lines carriers or the government—also appears in some of the very research that helped form the conventional wisdom about the infrequency of experience rating.[71] In 2000 Danzon referred to this process as a "crude" form of experience rating.[72]

When told that the common view is that medical malpractice is not experience rated, CNA's Tim Vlazny replied:

> I'm surprised that people have difficulty believing physicians' malpractice premiums are impacted by the practitioner's loss experience. Virtually every professional liability line has a premium modification formula for prior losses. Virtually every insurance coverage line discerns on the basis of price risks with and without claims. Large risks—with credible experience—are specifically loss rated by actuaries. Smaller risks or risks without enough credibility on a stand-alone basis are pooled with other like/kind risks and within that pool, risks with prior losses will pay more.[73]

Reconsidering the Conventional Wisdom

If medical professional liability insurance is experience rated, how did the conventional wisdom arise? One explanation is that researchers looking for evidence of experience rating have focused on premium surcharges and discounted the experience rating that occurs as different firms specialize in different levels of risk.[74]

Another explanation is that the conventional wisdom took hold before competitive forces began changing the industry. As Danzon notes, in the 1970s the market was dominated by medical society-sponsored insurance programs that guaranteed coverage to their members. By the 1980s, the entry of physician-owned mutual insurance companies, who used peer review to assess the validity of malpractice claims against physicians, had changed the market.[75] Competition from new entrants would tend to encourage underwriting.

Finally, the declining cost of data retrieval, data management, and record keeping have made it easier for underwriters to assess the claims history of individual physicians, and thus a particular physician's level of risk. All else equal, declining data costs increase a carrier's return on investment in underwriting.

Direct Risk Management

Beyond the incentives experience rating creates for physicians to reduce the risk of harming patients, the medical malpractice liability insurance industry further protects patients by offering physicians direct guidance on how to reduce that risk. Reviews of malpractice claims and other peer-review efforts have enabled carriers to identify clinical practices that pose a risk to patient health.[76] The Physicians Insurers Association of America (PIAA) Data Sharing Project alerts insurance companies to areas and patterns of practice with a high incidence of claims or suits.[77] This helps hospitals and other health care providers identify patterns of practice where malpractice risk is substantial.[78] Another example is CNA's Physical Therapy Claims Study, which offers risk-management suggestions for physical therapists.[79] In Colorado, COPIC, which insures the majority of physicians and many of the hospitals in the state, engages in extensive risk management training. The company has a 22-employee patient safety and risk management department, delivers over 400 seminars a year, and over 80 percent of all resident physicians in training programs in Colorado rotate through a one-week COPIC-run patient safety and risk-management program prior to completing their residency.[80]

To encourage risk management, most medical professional liability insurance companies offer premium discounts to physicians who engage in risk-management activities or comply with medical specialty-based risk-management requirements. Some firms offer credits for the use of electronic medical records.[81] Several California carriers offer a 5-percent credit to physicians who attend a company-approved risk-management/loss-prevention workshop. PHICO has offered credits of up to 5 percent to physicians who comply with federal guidelines regarding mammography testing, on-site laboratory testing, and employee exposure to blood-borne pathogens. The Doctors Company, one of the nation's largest malpractice insurers, offers moderate discounts for physicians who participate in risk-management activities or comply with specialty-based risk-management program requirements.[82] A 1989 Institute of Medicine survey of 20 commercial and physician-owned carriers found four types of risk-management strategies to be prevalent: (1) data gathering and analysis, (2) development of clinical standards and protocols, (3) educational programs, and (4) premium discounts for risk-management activities. Many carriers employed all four.[83] When Congress enacted the Federally Supported Health Centers Assistance Act of 1992, extending malpractice insurance coverage to community and migrant health centers under the Federal Tort Claims Act, many of the health centers did not want to cancel their private insurance because they did not want to lose the tailored risk-management services the private carriers supplied.[84]

Surplus-lines carriers often require physicians to take specific remedial actions.[85] These can include upgrading equipment, working under the supervision of another professional, limiting the scope of a physician's practice, and other safety measures. Some surplus-lines companies offer risk-management services on a case-by-case basis.[86] For example, MedPro/Frontier's program for high-risk physicians included "specialized risk management designed to 'rehabilitate' those physicians and return them to the standard market."[87] Conventus Inter-Insurance Exchange recently announced a program designed to get marginal physicians back in the admitted market:

> We will provide a full suite of . . . risk-management services including a practice assessment . . . [providing] specific guidelines and steps the practice must take, and standards the practice must meet, in order to qualify for a transfer from this program into Conventus.[88]

Practice Constraints

Unlike state licensure, which does not restrict a physician's practice to a particular specialty or area, malpractice insurers sometimes limit the scope of duties a physician may perform by excluding specified medical services from coverage. For example, California rate filings include forms to exclude performing surgery, administering anesthesia, treating pregnancy, and practicing over the Internet.[89]

In some cases, insurance policies dictate evidence-based standards of care that must be met for coverage to apply. For example, the Utah Medical Insurance Association developed guidelines for underwriting and loss prevention for obstetrical practice, and its insured physicians are required to follow specific protocols.[90] Due to the much-celebrated advances in safety associated with delivering anesthesia, some medical professional liability insurers have adopted protocols for anesthesia developed by the profession. For example, the Medical Insurance Exchange of California includes an Anesthesia Restrictive Endorsement that dictates how many certified registered nurse anesthetists a physician may supervise and lays out mandatory standards for monitoring patients:

> Blood pressure and heart rate should be recorded every five minutes; respiratory rate and oximeter reading every 15 minutes; carbon dioxide recordings every 15 minutes only if the endotracheal tube is placed.

The restrictive endorsement includes specific equipment that must be available, including

> an audible device that detects disconnection of any component of the breathing system when an automatic ventilator is used [and] an oxygen analyzer that will detect the concentration of oxygen and has a low concentration of oxygen alarm.[91]

The Doctors Company has a similar endorsement form.[92] Malpractice insurers impose these constraints because they believe such practices reduce the risk of patient injury.

Practice constraints are often part of negotiated malpractice insurance policies in the surplus-lines market. Underwriters verify that physicians adhere to the restrictions in their policies when the policies are renewed each year and by looking at the doctor's website or advertisements aimed at consumers. Physicians who fail to comply are financially liable to pay any related malpractice claims.[93] To preclude risky practice patterns, a physician with a policy limit of a million dollars per claim for most services might be offered a policy with a lower, or even zero, limit for certain specified surgical services.[94]

Evaluating Novel Treatments

Not all physicians in the surplus-lines market are there because they have gotten in trouble. Some are there because they offer fairly unique or risky services that companies in the admitted market do not have the expertise to underwrite. In 2002, for example, GE Medical Protective declined to cover general surgeons taking on gastric bypass surgeries on morbidly obese people or ear, nose, and throat (ENT) doctors offering tummy tucks.[95]

The surplus-lines market plays a major role when doctors are accumulating experience with a novel procedure.[96] If there are numerous claims, policies issued through the admitted market impose exclusions for novel proced-ures and physicians performing those proced-ures must turn to the surplus-lines market. Examples include the introduction of laporo-scopic gallbladder surgery (cholecystectomy), bariatric procedures (including gastric bypass and lap band), the da Vinci prostatectomy (a minimally invasive, robotic-assisted surgical procedure for prostate cancer), and the first LASIK eye surgeries to correct vision.[97] Surplus-lines carriers monitor claims stemming from new procedures and verify a physician's training to see if it is appropriate to the task.[98]

Putting Teeth in State Board Sanctions

It is common for a physician sanctioned by a state board to be denied coverage by admitted carriers. A substantial number of physicians in the surplus-lines markets are in this category. In response to a question posed by this author, Vlazny calculated that of all hard-to-place physicians reviewed by CNA between 2004 and 2009, 22.6 percent had been the subject of a state medical board action at least one time in their career.[99] Nancy Davies, an underwriter at RSUI, and John Dow, a broker at Tegner-Miller, estimated that about half the nonstandard physicians they dealt with had state board sanctions in effect.[100]

It is general practice in the surplus-lines industry to write any state medical board stipulations that restrict the practice patterns of physicians into a physician's professional liability insurance contract.[101] A number of physicians resolve drug or alcohol issues under state board stipulations requiring rehabilitation.[102] When a state medical board sanctions a physician for drug or alcohol abuse, the physician's policy may include an endorsement form requiring notification if drug or alcohol use resumes. The physician may be monitored to ensure participation in a diversion program.[103]

Supporting Other Private Quality-Improvement Efforts

Private privileging and credentialing organizations rely on medical malpractice insurance industry oversight. For example, a hospital credentialing board considering whether to grant admitting privileges to a physician might ask why she is insured in the surplus-lines market or why her policy has a fairly recent retroactive date, signaling lack of coverage for prior periods.[104]

Even if a state board allows a physician to practice, insurers may decline to offer coverage.[105] Since many hospitals and health maintenance organizations require physicians to be insured, denying coverage to such physicians can effectively bar them from practicing medicine.[106] Courts have ruled that hospitals and health maintenance organizations may require physicians to purchase medical malpractice insurance as long as the requirement is not arbitrary and capricious.[107] In such cases, patients, hospitals, and health maintenance organizations all benefit from the oversight provided by medical malpractice insurers, which is more comprehensive than that provided by direct government regulation.

Better Tort Results

As noted above, the efficiency of the medical malpractice liability system depends on the accuracy of court judgments and awards.[108] Efforts by medical professional liability insurance companies to evaluate the validity of claims contribute to the efficiency of the system as a whole.

Since the mid-1970s, the growth of physician-owned professional liability insurance companies has led to more extensive peer review of claims.[109] Companies advertise that they will defend physicians in cases where peer review indicates that adverse outcomes are not the result of physician negligence.[110] Similarly, traditional commercial insurers have come to rely on expert witnesses and experienced malpractice attorneys to judge whether a claim involves physician negligence or substandard care.[111] For example, Darwin National Assurance Company relies on registered nurses (some of whom are also lawyers) to assess the validity of claims.[112] These efforts by medical professional liability insurance companies to investigate claims not only work to preserve the reputation of a physician falsely accused of negligence, but lead to more accurate penalties for negligence and substandard care.

Policy Implications

The evidence presented here suggests that actions of medical malpractice insurance companies transmit the risk of liability in a way that encourages providers to take steps to reduce the risk of negligent harm. This conclusion has implications for policy at both the federal and state levels, including caps on malpractice awards, medical professional licensing requirements, malpractice immunity for government employees, and state subsidies to high-risk physicians through joint underwriting associations.

Capping Damages

Tort reform is a major topic in current discussions of health care reform. Lawmakers at both the federal and state levels have sought to limit malpractice awards by placing caps on damages, whether economic, noneconomic, or both. Every year since 2002 House Republicans have submitted a bill that would cap noneconomic damages in cases of malpractice. The 2011 version would put a $250,000 cap on noneconomic damages.[113] Many states already have caps on noneconomic damages and some states have caps on both economic and noneconomic damages.[114] In many cases, the caps are not adjusted for inflation, so they become progressively more constraining. For example, in 1975 California's Medical Injury Compensation Reform Act set a $250,000 cap on noneconomic damages. Since then, the average price level has risen more than 200 percent, causing the cap to decline in real terms and increasing the severity of the cap.

Supporters claim that reducing the size of medical malpractice awards reduces spending on defensive medicine—expensive tests and procedures motivated by the fear of malpractice suits—and with it the cost of health insurance. Researchers have confirmed the existence of defensive medicine in some situations, though its overall prevalence remains controversial.[115] State-level award caps have reduced spending on heart disease and mammograms in the Medicare population, and reduced caesarean section rates.[116]A Congressional Budget Office analysis of the House Republicans' Help Efficient, Accessible, Low-Cost Timely Healthcare (HEALTH) Act of 2011 predicted that, by eliminating defensive medicine, the bill would reduce federal spending on health care by $34 billion and increase federal tax revenues (as firms respond to lower health insurance costs by increasing wages) by about $6 million over a 10-year period.[117]

Some observers are skeptical that medical malpractice awards are the driving force behind excessive tests and procedures, claiming that physicians deliver these services because they are risk-averse, to please patients, or to generate additional income rather than to avoid liability.[118]

Furthermore, defensive medicine is not necessarily undesirable. A well-functioning malpractice system would not eliminate defensive medicine. Rather, it would discourage the use of *inefficient* defensive medicine, where the expected costs of a test or treatment exceed the expected benefits, and promote *efficient* defensive medicine, where expected benefits exceed expected costs.[119]

Opponents of damage caps rightly point out that caps shift the costs of malpractice injuries from negligent providers to their victims.[120] In 1989 an Indiana lobbyist, who had helped establish that state's $500,000 cap on damages, found himself the victim of negligent care. He later wrote:

> The cost of this cascading series of medical debacles is painful to tally: I am confined to a wheelchair and need a respirator to keep breathing. I have not been able to work. I have continuous physical pain in my legs and feet. . . . At the age of 49, I am told that I have less than two years to live. My medical expenses and lost wages, projected to retirement age if I should live that long, come to more

> than $5 million. . . . The kicker, of course, is that I fought to enact the very law that limits my compensation. . . . Make no mistake, damage caps . . . remove the only effective deterrent to negligent medical care.[121]

The foregoing analysis suggests that in addition to shifting the costs of negligence, capping medical malpractice awards could increase the frequency of injuries due to negligence. When damage caps shift part of the cost of provider negligence to patients, they reduce the incentives for malpractice insurers and health care providers to assess and reduce the risk of injuring patients. The smaller the potential liability, the fewer resources medical malpractice insurers will invest in monitoring and reducing risk.

If the quantity of tests and procedures are a concern, reforms that make patients more cost-conscious or that increase managed care enrollment could improve the situation without triggering a reduction in the patient protections created by the medical malpractice system. If advocates of damage caps believe the courts do not compensate individuals appropriately, an alternative would be to improve the legal process that determines awards, perhaps through nonbinding arbitration or better instructions to jurors.[122] Michael Cannon argues consumers should be allowed to contract with providers for the level of malpractice protection they prefer. In other words, doctors would compete on the basis of liability protection and consumers could choose a level of protection along with other provider characteristics.[123]

An Alternative to Licensing

Elsewhere, I have advocated eliminating government licensing of medical professionals on the grounds that state licensing is ineffective and adds little if any protection to the quality safeguards that would continue to exist in its absence, including the tort system, the malpractice insurance market, private specialty boards, and hospital credentialing.[124] This paper elaborates on the medical professional liability insurance industry's role in protecting patients.

State board sanctions do not appear to be a crucial tool for identifying negligent or incompetent physicians. Medical malpractice underwriters know substantially more about physicians at any point in time than do state medical boards. As noted above, Tim Vlazny reports that only 22.6 percent of physicians that CNA reviewed for surplus-lines coverage between 2004 and 2009 had a state board action filed against them at least one time in their career. This suggests the medical malpractice system, including carriers evaluating prior claims, identifies more high-risk physicians than state licensing boards do. Vlazny further reports that only about one third of the state-sanctioned physicians had no malpractice claim on record. Claims histories alone therefore identified two-thirds of state-sanctioned physicians, and state medical boards were instrumental in identifying at most 8 percent of physicians applying for surplus-lines coverage from this carrier. Even that figure may overstate the benefits of licensing. It is possible that carriers would identify such physicians for some other reason, including loss of hospital privileges, actions taken against them by another provider (e.g., being dismissed from a physician group), gaps in coverage, or the nature of their practice (e.g., employing untested procedures). Carriers may also identify those physicians due to the very behaviors that led to state board sanctions, including illegal drug use or sexual abuse. Malpractice insurers already deny coverage to troubled physicians overlooked by state licensing boards, precluding them from practicing in some states and affiliating with many hospitals and health care providers. Moreover, Vlazny reports that "many standard markets will also insure a physician with a prior board action, but [who] is loss-free," which calls into question whether state board actions are even a useful indicator of physician quality.[125]

State medical boards do a poor job of informing the public about high-risk physicians, often to the point of protecting those physicians from public scrutiny.[126] Another mark against the state system is that the regulatory apparatus can be manipulated by special interest groups to limit competition through scope-of-practice restrictions. Physician groups have been the most successful using licensing to protect themselves from competition by limiting the scope of services that state-licensed nonphysician clinicians may perform, despite no evidence that consumers benefit from more restrictive scopes of practice.[127] This is not trivial; it makes medical care more expensive and reduces access, particularly for the poor. Absent state licensing, decisions about clinicians' scopes of practice would rest with hospitals, other providers, and malpractice carriers—parties less susceptible to pressure from special-interest groups.[128]

Requiring Medical Malpractice Insurance

Seven states already require physicians to purchase professional liability insurance. Another seven states require it as a condition to qualify for caps on damages or to participate in a state compensation fund.[129] Table A–3 lists the states with requirements and describes the relevant state laws. Florida is not included because a doctor may practice without the required insurance if he posts a sign advising patients of the fact.[130]

At present, these requirements exist in addition to these states' licensing requirements. Given the resources of the medical malpractice insurance industry, its detailed efforts to identify physicians at risk of hurting consumers, and the financial incentives embedded in the structure of malpractice premiums—and given the success of physician groups in keeping many state board sanctions hidden from the public[131]—states could save money and improve consumer protection by eliminating state boards and instead requiring physicians to secure malpractice insurance.

In May of 2011 Georgia became the first state to pass a law to require physicians to disclose whether they have medical malpractice insurance. Physicians must let the Georgia Composite Medical Board know if they are insured and the board must publish the information on its website. A similar law passed the Illinois Assembly in 2011.[132]

Malpractice Immunity for Government Employees

The 1946 Federal Tort Claims Act (FTCA) shields government-employed physicians from medical malpractice claims.[133] This includes medical professionals who work for the Department of Veterans Affairs, the Indian Health Service, the Department of Defense, and other federal agencies.[134] The FTCA makes the federal government responsible for defending federal employees when malpractice claims arise, and makes taxpayers liable for harm due to negligence. The Federally Supported Health Centers Assistance Act of 1992 extended FTCA medical malpractice insurance coverage to community and migrant health centers. The goal was to allow health centers to shift money from medical malpractice insurance to expanding patient treatment.[135]

Shifting liability for malpractice from physicians to taxpayers shields government physicians from underwriting and oversight by private insurers. Federal agencies, such as the Department of Defense and the Indian Health Service, do often create risk-management programs. Yet government agencies have less of an incentive to reduce the risk of negligent injuries than private malpractice insurers do, because the money at risk in a malpractice suit is a common resource (federal revenues), rather than a privately owned one. Because private malpractice insurers have more at stake in a malpractice suit than government agencies do, the government's risk-management efforts are likely to be less rigorous. Indeed,

federal investigators have found that in some cases, such as community and migrant health centers, the government is ill-equipped to provide risk management.[136] In most cases, consumers would be better off were government agencies not to shield their physicians from malpractice immunity.

Joint Underwriting Associations

It is rare that private markets deny a physician insurance coverage for malpractice.[137] When this does occur, however, physicians in some states can turn to the state's Joint Underwriting Association (JUA). JUAs are state-sponsored risk-sharing pools that act as insurers of last resort.[138] The structure varies by state, but generally all insurers authorized to sell malpractice insurance must participate by underwriting the highest-risk physicians. Though JUAs set premiums with the objective of covering their costs, participating carriers are liable for losses based on their share of premiums written in the state.[139] In effect, this means high-quality physicians pay higher premiums to cover the costs of negligent injuries inflicted by low-quality physicians. In 2007 JUAs were operational in 13 states.[140] In some states, such as South Carolina, the JUA insures the majority of physicians in the state.[141] Many states have the statutory authority to activate a medical malpractice JUA, but have chosen not to or have shuttered their JUAs.[142]

In some cases, JUAs protect physicians who should only practice with restrictions or who should not be practicing medicine at all. In the 1980s the New York Department of Insurance wrote of its JUA, "A merit rating plan is not intended to be used to remove poor doctors by pricing them out of business."[143] That raises the question: why not? Why should physicians with good claims histories pay higher malpractice premiums to subsidize physicians with bad claims histories, especially when this practice puts patients at greater risk? In the mid-1990s, amid talk of shutting down New York's JUA, the New York Department of Insurance offered further proof that its program exists largely to protect low-quality physicians. The agency concluded that were its JUA to fold, "there is a possibility that some physicians with truly disastrous loss histories would be uninsurable."[144] Where JUAs protect "disastrous" physicians at the expense of patients and good physicians, states should eliminate them.

Conclusion

When asked how consumers benefit from medical malpractice insurance, industry executives typically mention only patient compensation. Yet much more is at work.

Competition in the market for medical malpractice insurance, and each insurer's interest in reducing its exposure to malpractice awards, leads insurers to provide oversight that protects consumers from physician negligence. Malpractice underwriters review physicians annually. They evaluate claims histories and investigate loss of hospital privileges, substance abuse, and loss of specialty board certification. They alert the medical community to situations that result in bad outcomes and offer advice on how to reduce such outcomes. The evidence presented here shows that physicians pay a price for putting patients at risk. Carriers reward claims-free physicians and physicians who take part in risk-management activities. The industry provides oversight of risky practitioners, dictates patterns of practice, monitors the introduction of new procedures, imposes policy exclusions for specific activities, and denies coverage in the most egregious cases, precluding affiliations that require insurance.

More broadly, patients derive protection from an interdependent system of physician evaluation, penalties, and oversight that includes hospital and health maintenance organization credentialing and privileging activities, specialty boards, and the medical malpractice insurance industry.[145] Underlying nearly all of these activities is the threat of legal liability for negligent injuries. Reducing physician liability for negligent care by capping court awards, all else equal, will reduce the resources allocated to medical professional liability underwriting and oversight and make many patients worse off. Legislators who see mandatory liability caps as a cost-containment tool should look elsewhere.

As noted above, state licensing of medical professionals is ineffective. A cheaper, more effective approach to consumer protection would be for states to require public reporting of malpractice coverage. Medical professional liability insurance companies know considerably more about physicians than do state medical licensing boards, and the level of oversight dwarfs what state medical boards have had the resources, the incentive, or even the capability to accomplish. Hospitals and health maintenance organizations already inquire about physicians' medical professional liability insurance coverage. Requiring public reporting of malpractice coverage would encourage consumers to inquire about it when searching for independent physicians.

Finally, government agencies should not assume malpractice liability risk for physicians they employ. Profit-maximizing insurers have stronger incentives to promote effective risk-management efforts. State legislatures should shut down state joint underwriting associations. If medical malpractice insurers are unwilling to bet their own money on a particular physician, legislatures should not force taxpayers or other physicians to take the same bad wager, particularly since doing so exposes patients to a higher risk of adverse medical events.

Appendix

Table A–1
Experience Rating Provisions in California Rate Filings

Rate filing reference	Credit or Debit/Surcharge to Base Premium	Note
Allianz (2000)	Debit to 94.5 percent, credit to 30 percent	Based on number of years since claim(s) made and total amount paid in indemnity and expense. Physicians with more than five claims or total payments and/or reserve(s) exceeding $150,000 are set aside for special underwriting review.
AIG (1999)	± 25 percent	Applicable to those insured who, in the opinion of the company, uniquely qualify due to factors not contemplated in the filed rate structure of the company. A debit or credit of up to 15 percent may apply based on the claims experience. Additional debit or credit for loss history.
Chubb Group (1999)	Credit to 25 percent, surcharge to 75 percent	Compares actual to expected loss ratio to determine credit or surcharge.
CNA Insurance Companies Companies (1996)	None	
First Professionals Insurance Company (2001)	Maximum credit of 50 percent of premium, maximum debit of 200 percent	Only applies to risks with five full-time physician exposures and an annual basic limits manual (2006) manual premium of $100,000 or more.
GE Global/MedPro (2007)	± 25 percent to maximum debt of 200 percent	Under the schedule rating plan, ± 25 percent maximum modification to recognize risk characteristics that are not reflected in the otherwise applicable premium. Considerations include unusual frequency or severity of claims, cumulative years of patient experience, and other measures not related to experience rating. In addition, there is a nondiscretionary debit-rating rule which assigns debits based on history of loss payments on claims and the number of claims pending against the physician. The highest debit rating, 200 percent, would apply to a physician who, in the past five years, had at least one loss payment in the $100,000–$250,000 range and another in the $250,000–$500,000 range.

Rate filing reference	Credit or Debit/Surcharge to Base Premium	Note
Medical Insurance Exchange of California (2006)	Surcharge up to 100 percent	In those individual situations where the risk of loss is materially higher than contemplated by the standard classification and rate because of unusually high loss frequency or severity, unusually hazardous practice pattern, or failure to comply with risk-management/loss-prevention recommendations.
Northwest Physicians Mutual Insurance Company (2002)	Surcharge of 10 to 25 percent	Allows NPM to recognize, through the use of a surcharge, a physician whose claims experience is below the norm of the company and allows NPM to charge a lower premium to those physicians with a superior claims history. Looks at 36-month history of claims. Surcharge kicks in with three claims (open or closed without payment) or paid claims totaling $100,000. With paid claims totaling over $750,000, the surcharge is 25 percent.
PHICO (1995)	≤ 15 percent	Based on history of incurred loses.
The Doctors Company (2008)	Surcharge up to 400 percent; beyond that "Nonrenew"	In lieu of declining or not renewing a risk. Considers frequency and severity of claims, drug or alcohol impairment, government agency actions (public reprimand, fine, citations, failure to report investigation, criminal and civil indictments/convictions, Medicare/Medicaid investigation, loss of Medicaid/Medicare privileges, inappropriate patient contact, privileges, gaps in practice, payment history and other characteristics). Some points go to characteristics that are not experience rating, such as not being board certified. The Florida rate filing (07-07147) in 2007 looks the same.
Zurich (2000)	Surcharge up to 60 percent	Factors that may be used in determining the surcharge include adverse claims frequency and severity, loss of hospital privileges, performance of a procedure outside of standards, and weak or nonimplemented credential procedures.

Sources: Allianz of America, Chicago Insurance Company (2000), *State of California Department of Insurance Application for Approval of Insurance Rates*, File 00-15362, California Department of Insurance, RateFilings.com File CAC10327 and CAC11265; AIG, National Union Fire Insurance Company of Pittsburgh (1999), *State of California Department of Insurance Application for Approval of Insurance Rates, New Program*, File 99-13489, California Department of Insurance, RateFilings.com, File CAC05592; Chubb Group of Insurance Companies, Executive Risk Indemnity Inc. (1999), *State of California Department of Insurance Application for Approval of Insurance Rates*, File 99-3293, California Department of Insurance, RateFilings.com, File CAC02796;CNA Insurance Companies, National Fire Insurance Company of Hartford (1996), *File 96-5126*, California Department of Insurance, Ratefilings.com File CAC37767; First Professional Insurance Company (2001), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #01-14462, California Department of Insurance, Ratefilings.com File CAC13409; GE Global, Medical Protective Company (MedPro) (2007), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #07-2132, California Department of Insurance, Ratefilings.com, File CAC34889; Medical Insurance Exchange of California (2006), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #06-4652, California Department of Insurance, RateFilings.com, Files CAC32341 and CAC32789; Northwest Physicians Mutual Insurance Company (2002), *State of California Department of Insurance Application for Approval of Insurance Rates, File #02-38372, California Department of Insurance*, RateFilings.com, File CAC18439; PHICO (1995), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #95-10432, California Department of Insurance, RateFilings.com, File CAC3782918439; The Doctors Company (2008); *Physicians, Surgeons and Ancillary Healthcare Providers, Countrywide Rules and Rates* Manual in California Rate and Rule Revision-Introduction of New Endorsements, File 08-11851, California Department of Insurance, RateFilings.com, File CAC40789; Zurich Insurance Group, Truck Insurance Exchange and Mid-Century Insurance Company (2000), *State of California Department of Insurance Application for Approval of Insurance Rates Medical Malpractice Physicians and Surgeons New Program Filing*, File #00-15368, California Department of Insurance. RateFilings.com, File CAC10328.

Table A–2
Claim-Free Credits in California Rate Filings

Rate filing reference	Claim-free credit (%)	Note
CNA (1996)	5	Applies when physicians have had no claims with an incurred indemnity amount greater than $5,000 in the past three years.
First Professionals Insurance Company (2001)	10 to 20	Offers a claim-free discount of 10 percent with five to nine loss-free years; 20 percent with 15 or more loss-free years.
GE Global/Med Pro (2007)	5 to 20	Offers a claim-free credit of 5 percent at three years, 10 percent at five years and 20 percent at 10 years. In a 2008 Florida rate filing, Med Pro revised its claim-free credit, bringing the maximum to 25 percent for 10 years (The Medical Protective Company, 2008).
Northwest Physicians Mutual Insurance Company (2002)	5	For physicians with three years of claim-free history.
The Doctors Company (2008)	12.5; 17.5	TDC offers a claims-free discount of 12.5 percent for policyholders who have been with the company for at least three years, whose cumulative outstanding claim reserves fall below $20,000 and whose three-year cumulative claim payments are less than $10,000. Surgical specialties qualify for a 17.5 percent claim-free discount.
Zurich (2000)	10	For physicians with five years claim-free, no incurred indemnity or expense amount greater than $5,000, and an aggregate incurred indemnity for all claims reported less than $5000.

Sources: CNA Insurance Companies, National Fire Insurance Company of Hartford (1996), *File 96-5126*, California Department of Insurance, Ratefilings.com, File CAC37767; First Professional Insurance Company (2001), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #01-14462, California Department of Insurance. Ratefilings.com, File CAC13409; GE Global, Medical Protective Company (MedPro) (2007), *State of California Department of Insurance Application for Approval of Insurance* Rates, File #07-2133, California Department of Insurance, Ratefilings.com File CAC34889; Northwest Physicians Mutual Insurance Company (2002), *State of California Department of Insurance Application for Approval of Insurance Rates*, File #02-38372, California Department of Insurance, RateFilings.com File, CAC18439; The Doctors Company (2008), *Physicians, Surgeons and Ancillary Healthcare Providers, Countrywide Rules and Rates Manual* in California Rate and Rule Revision-Introduction of New Endorsements, File 08-11851, California Department of Insurance, RateFilings.com, File CAC40789; Zurich Insurance Group, Truck Insurance Exchange and Mid-Century Insurance Company (2000), *State of California Department of Insurance Application for Approval of Insurance Rates Medical Malpractice Physicians and Surgeons New Program Filing*, File #00-15368, California Department of Insurance, RateFilings.com, File CAC10328.

Table A–3
States that Mandate Minimum Levels of Professional Liability Insurance for Physicians

State	Rule (The first number is required coverage per incident or claim, the second number is required coverage for all claims in a year)
Required in these states:	
Colorado	$500,000/$1,500,000 or equivalent bond
Connecticut	$500,000/$1,500,000
Kansas	$200,000/$600,000
Massachusetts	$100,000/$300,000 or equivalent bond
New Jersey	$1,000,000/$3,000,000; if you don't have extended reporting endorsement coverage (tail coverage) a $500,000 letter of credit is required
Pennsylvania	$1,000,000/$3,000,000
Wisconsin	$1,000,000/$3,000,000
Not mandatory:	
Indiana	To participate in the state Patient Compensation Fund (a system of excess insurance): 250,000/$750,000 in coverage.
Louisiana	To qualify for caps on damages: $100,000 coverage per claim or equivalent bond.
Missouri	Physicians on the medical staff of a hospital in a county with a population over 75,000 and not employed by the hospital: $500,000 in coverage.
Nebraska	To qualify for cap on damages: $500,000/$1,000,000.
New Mexico	To qualify for cap on damages: $200,000 per occurrence or $600,000 bond; must buy "occurrence-made" rather than "claims-made" policy.
New York	To participate in the excess liability pool: $1.3 million/$3.9 million.
Wyoming	To participate in the state Medical Malpractice Compensation Fund (a system of excess insurance): $50,000 per occurrence.

Source: American Medical Association, Advocacy Resource Center, "Summary of Select State Laws Mandating Minimum Levels of Professional Liability Insurance," February 2008, http://www.ama-assn.org/ama1/pub/upload/mm/378/mlrpreliains.pdf.

Table A–4
2008 California Market Shares for Medical Malpractice Insurers, Top Ten by Written Premium

Group/Company Name	Notes	Written Premium ($)	Market Share (%)	Cumulative Market Share (%)
Norcal Mutual Insurance Company		163,317,374	26.8	26.8
The Doctors Company		151,261,024	24.8	51.5
SCPIE Indemnity Company	SCPIE was purchased by The Doctors Company in 2007	87,751,988	14.4	65.9
Medical Insurance Exchange of California		37,864,332	6.2	72.1
Dentists Insurance Company*	Dentists	28,532,495	4.7	76.8
Medical Protective Company		28,123,839	4.6	81.4
American Healthcare Indemnity Indemnity Company (SCPIE Group)	Acquired by SCPIE in 1996; insurance for non-California physician physicians	25,983,208	4.3	85.6
National Union Fire Insurance Company of Pittsburg (AIG Group)		16,378,872	2.7	88.3
American Casualty Company of Reading PA (CNA Group)		14,923,219	2.4	90.8
Professional Underwriters Liability Insurance Company	Surplus-lines insurance only; wholly owned subsidiary of The Doctors Company	10,799,148	1.%	92.5

Source: California Department of Insurance, Rate Specialist Bureau, April 30, 2009, http://www.insurance.ca.gov/0400-news/0200-studies-reports/0100-market-share/Marketshare2008/upload/IndMktShr2008Alpha.pdf.
* Rate filings for this company were not reviewed for this paper as only dentists are insured.

Notes

Thanks to insurance industry professionals Robert Allen (Darwin), Denise Coleman (Swiss Reinsurance America Corporation), Nancy Davies (RSUI), John Dow (Tegner-Miller Insurance Brokers), Stephen Freedman (PULIC), Chad C. Karls (Milliman), Timothy Morse (CNA HealthPro), Alan Lenbitz (COPIC), Kim Nibbe (NAS Insurance), Fran O'Connell (Markel), Cheri A. Priddy (PULIC), Bruce Swicker (Bruce R. Swicker), and Tim Vlazny (CNA HealthPro) for helping me to understand medical malpractice insurance underwriting and answering my questions about the industry. Thanks to Michael F. Cannon and Robert Krol for comments on an earlier version of this paper. Also, thanks to Charles Pitts at Perr&Knight for facilitating access to the California rate filings of medical malpractice insurance companies. Of course, these individuals are not responsible for any errors herein.

1. These include captives and risk-retention groups. A risk-retention group comprises similar businesses that join together to create an insurance company to self-insure. Captives also self-insure the risk of their owners but are not restricted to insure similar risks. For example, they are not restricted to insure only against medical malpractice liability. Most commonly, captives insure the risks of a parent company or a group of companies. Richard J. Hillman and Lawrence Cluff, *Risk Retention Groups, Common Regulatory Standards and Greater Member Protections Are Needed,* U.S. Government Accountability Office, GAO-05-536, August 2005, http://www.gao.gov/new.items/d05536.pdf.

2. Dennis H. Pillsbury, "Where Do You Turn If One of Your Physician Insureds Has Claims Problems?" *Rough Notes*, March 1995, p. 50.

3. There are exceptions. PULIC is a surplus-lines carrier admitted in California. In New Jersey, surplus-lines policies are covered by the New Jersey Surplus-Lines Guaranty Fund offering protection should insurance companies become insolvent. Many of the surplus-lines companies doing business as nonadmitted carriers in one state are admitted and regulated in another.

4. Elisabeth Boone, "Rx for Doctors: Hard-to-Place Malpractice Risks May Find a Home with Professional Underwriters Liability and Bernard Warschaw Insurance Sales," *Rough Notes,* April 2002; Brian S. Martin, "Legal Beat: A Short Walk through Surplus Lines," *Insurance Journal,* July 22, 2002, www.insurancejournal.com/magazines/southcentral/2002/07/22/legalbeat/21759.htm; Timothy Morse, senior vice president–health care professional liability at CNA HealthPro, conversation with author, August 26, 2009 (Morse is on the board of directors of the National Patient Safety Foundation); and William B. Schwartz and Daniel N. Mendelson, "Physicians Who Have Lost Their Malpractice Insurance: Their Demographic Characteristics and the Surplus-Lines Companies that Insure Them," *Journal of the American Medical Association* 262, no. 10 (1989): 1335–41.

5. Boone; Nancy Davies, RSUI, conversation with author, July 29, 2009. Davies works for RSUI, which works on a surplus lines basis in every state, writing under Landmark America and has 25 years of experience underwriting in the surplus lines market; Larry G. France, "What Goes Around Comes Around," *Rough Notes,* March 2005, p. 112; Larry G. France, "Professional Liability," *Rough Notes*, October 2007, p. 112; Michelle M. Mello, "Understanding Medical Malpractice Insurance: A Primer," Research Synthesis Report no. 8, The Robert Wood Johnson Foundation Synthesis Project, January 2006, http://www.rwjforg/pr/synthesis/reports_and_briefs/pdf/no10_primer.pdf; Kim Nibbe, senior underwriter at NAS insurance, conversation with author, August 21, 2009. NAS insurance has worked as a managing general agent, underwriting surplus lines policies for Lloyds of London; Vermont Medical Malpractice Study Committee, "Medical Malpractice Liability Insurance in Vermont: A Report to the General Assembly," December 15, 2005, http://www.bishca.state.vt.us/sites/default/files/MedMal-final-report.pdf.

6. Tim Vlazny, underwriting director, CNA HealthPro, conversation with author, September 2, 2009. Vlazny has more than 10 years experience in the hard-to-place physician market.

7. Perry Beider and Stuart Hagen, *Limiting Tort Liability for Medical Malpractice,* Congressional Budget Office Economic and Budget Issue Brief, 2004, http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf.

8. Patricia M. Danzon, "Liability for Medical Malpractice," in *Handbook of Health Economics*, ed. A. J. Culyer and J. P. Newhouse (Amsterdam, The Netherlands: Elsevier Science, 2000).

9. Frederick W. Cheney et al., "Standard of Care and Anesthesia Liability," *Journal of the American Medical Association* 261, no. 11 (1989): 1599; Henry S. Farber and Michelle J. White, "Medical Malpractice: An Empirical Examination of the Litigation Process," *The RAND Journal of Economics* 22, no. 2 (1991):199–217; Paul C. Weiler et al., *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* (Cambridge, MA: Harvard University Press, 1993); David M. Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *The New England Journal of Medicine* 354, no. 19 (2006): 2024–33; Jun Zhou, "Economic Determinants of Noneconomic Damages in Medical Malpractice Claims," working paper, Bonn University (2011).

10. Weiler et al.

11. John E. Rolph, "Some Statistical Evidence on Merit Rating in Medical Malpractice Insurance," *The Journal of Risk and Insurance* 48, no. 2 (1981): 247–60; Mark I. Taragin et al., "Physician Malpractice: Does the Past Predict the Future?" *Journal of General Internal Medicine* 10, no. 10 (1995): 550–56; Seth Oldmixon, "The Great Medical Malpractice Hoax: NPDB Data Continue to Show Medical Liability SystemProduces Rational Outcomes," Public Citizen Congress Watch, January 2007.

12. Farber and White, pp. 199–217.

13. Danzon, "Liability for Medical Malpractice"; David M. Studdert, Michello M. Mello, and Troyen A. Brennan, "Medical Malpractice," *The New England Journal of Medicine* 350, no. 3 (2004): 283–92; Studdert et al., pp. 2024–33, label the overhead costs "exorbitant."

14. Danzon, "Liability for Medical Malpractice."

15. David A. Hyman and Charles Silver, "The Poor State ofHealth Care Quality in the U.S.: Is Malpractice Liability Part ofthe Problemor Part ofthe Solution?" *Cornell Law Review* 90, no. 4 (2005): 893–93.

16. See, for example, Patricia M. Danzon, *Medical Malpractice; Theory, Evidence, and Public Policy* (Cambridge, MA: Harvard University Press, 1985); Lori L. Darling, "The Applicability ofExperience Rating to Medical Malpractice Insurance," *Case Western Law Review* 38, no. 255 (1987): fn. 81; and Frank A. Sloan and Lindsey M. Chepke, *Medical Malpractice* (Cambridge, MA: MIT Press, 2008).

17. Rolph, pp. 247–60.

18. Danzon, *Medical Malpractice; Theory, Evidence, and Public Policy*, p. 130.

19. Frank A. Sloan, Randall R. Bovbjerg, and Penny B. Githens, *Insuring Medical Malpractice* (New York: Oxford University Press, 1991), p. 176.

20. Frank A. Sloan, "Experience Rating: Does It Make Sense for Medical Malpractice Insurance?" *American Economic Review* 80, no. 2 (1990): 128.

21. Weiler et al., p. 115.

22. Randall R. Bovbjerg and Frank A. Sloan, "No-Fault for Medical Injury: Theory and Evidence," *University of Cincinnati Law Review* 67 (1998): 55–123.

23. Gary M. Fournier and Melayne Morgan McInnes, "The Case for Experience Rating in Medical Malpractice Insurance: An Empirical Evaluation," *The Journal of Risk and Insurance* 68, no. 2 (2001): 255–76.

24. Sloan and Chepke, p. 213.

25. Mello; U.S. Congressional Budget Office, *Medical Malpractice Tort Limits and Health Care Spending*, Background Paper, Publication 2668, 2006, p. 7.

26. See, for example, Fournier and McInnes, pp. 255–276.

27. Darling.

28. Weiler et al., p. 115. ("[I]t simply has not proved feasible to develop a formula that is an actuarially credible measure ofthe relative risk posed by individual doctors.") Paul C. Weiler, *Medical Malpractice on Trial* (Cambridge, MA: Massachusetts: Harvard University Press, 1991), p. 79. (Experience rating is "possible, though expensive.")

29. Denise Coleman, senior vice president, Swiss Reinsurance America Corporation, conversation with author, 2008.

30. This section is based on a review ofmedical professional liability insurance applications: AIG, National Union Fire Insurance Company ofPittsburgh, "State ofCalifornia Department ofInsurance Application for Approval ofInsurance Rates, New Program," File 99-13489, California Department ofInsurance, 1999, RateFilings.comFile CAC05592; Chubb Group ofInsurance Companies, Executive Risk Indemnity Inc., "State ofCalifornia Department ofInsurance Application for Approval ofInsurance Rates," File 03-1042, California Department ofInsurance, 2003, RateFilings.comFile CAC19150; First Professional Insurance Company, "State of California Department ofInsurance Application for Approval ofInsurance Rates," File 01-14462, California Department ofInsurance, 2001, Ratefilings.comFile CAC13409; Medical Insurance Exchange ofCalifornia, "Applications & Forms," 2008,

http://www.miec.com/RESOURCES/APPLICATIONSFORMS/tabid/83/Default.aspx#phys; PHICO, "State of California Department of Insurance Application for Approval of Insurance Rates," File 95-10432, California Department of Insurance, 1995, RateFilings.com File CAC3782918439; Valient Insurance Company, "Physicians and Surgeons Professional Liability," File 09-3715, California Department of Insurance, 2009, RateFilings.com File CAC42790; Zurich Insurance Group, Truck Insurance Exchange and Mid-Century Insurance Company, "State of California Department of Insurance Application for Approval of Insurance Rates, Medical Malpractice Physicians and Surgeons, New Program Filing," File 00-15368, California Department of Insurance, 2000, RateFilings.com File CAC10328; The Doctors Company application online: http://www.thedoctors.com/ecm/groups/public/@tdc/@web/documents/form/con_id_001892.pdf. Application forms for physicians in the surplus-lines market are similar. RSUI's application is online at http://www.rsui.com/Applications/PSD%20Application.doc, and Markel Shand's application is at http://broker.markelshand.com/documents/docs_dump/20090813-172152212D9BF7B6DA1A4E7BA200FC28BAF38683/0-MM-30000-04.rtf

31. John Dow, broker with Tegner-Miller in Santa Monica, California, conversation with author, August 27, 2009. Dow began specializing in medical malpractice insurance in 1982. He finds coverage for hard-to-place physicians in the surplus lines market; Fran O'Connell, managing director—medical professional at Markel, conversation with author, August 31, 2009.

32. Vlazny, September 2, 2009.

33. Dow.

34. Ibid.; Vlazny, September 2, 2009.

35. Robert Allen, vice president, healthcare, Darwin National Assurance Company, conversation with author, September 16, 2009. Allen has 20 years experience in the industry.

36. Alan Lembitz, vice president for patient safety and risk management at COPIC, conversation with author, March 24, 2011.

37. Allen.

38. Institute of Medicine, Division of Health Promotion and Disease Prevention, Committee to Study Medical Professional Liability and the Delivery of Obstetrical Care, *Medical Professional Liability and the Delivery of Obstetrical Care,* vol. 1 (Washington: National Academy Press, 1989).

39. Perr&Knight's proprietary RateFilings.com is the source of all California filings. Some Florida filings were also examined. For manageability, only the California filings are summarized in Table A–1. Table A–4 lists the top 10 medical malpractice insurance companies in California in 2008; all of these company filings were examined, plus others. Table A–4 lists the major California insurers to assure the reader that rate filings reviewed in California are not a subset of the market and, therefore, not representative.

40. Florida filings are available from the Florida Department of Financial Services online at http://www.floir.com/edms/.

41. Vermont Medical Malpractice Study Committee.

42. First Professional Insurance Company, File 08-26024, Florida Department of Financial Services, 2008, Forms & Rates Search, http://www.floir.com/edms; The Medical Protective Company, File 08-15430, Florida Department of Financial Services, Forms & Rates Search, 2008, http://www.floir.com/edms; Vermont Medical Malpractice Study Committee.

43. CNA Insurance Companies, National Fire Insurance Company of Hartford, File 96-5126, California Department of Insurance, 1996, Ratefilings.com File CAC37767.

44. The Doctors Company, "Claims-Made Professional Liability Insurance Express Application for Health Professionals (Physicians and Surgeons)," 2009, http://www.thedoctors.com/Join/Apply/index. htm

45. Allen.

46. Morse.

47. Norcal, "Norcal Mutual Insurance Company Physicians and Surgeons Program-Forms and Rules Rate Filings," File 05-2063 and 05-1279, California Department of Insurance, 2005, RateFilings.com File CAC27354; The Doctors Company, "Physicians, Surgeons and Ancillary Healthcare Providers, Countrywide Rules and Rates Manual in California Rate and Rule Revision-Introduction of New Endorsements," File 08-11851, California Department of Insurance, 2008, RateFilings.com File CAC40789; Zurich Insurance Group, Truck Insurance Exchange and Mid-Century Insurance Company, "State of California Department of Insurance Application

for Approval of Insurance Rates, Medical Malpractice Physicians and Surgeons, New Program Filing," File 00-15368, California Department of Insurance, 2000, RateFilings.com File CAC10328.

48. Marc Rodwin, Hak J. Chang, Melissa M. Ozaeta, and Richard J. Omar, "Malpractice Premiums in Massachusetts, A High-Risk State: 1975 to 2005," *Health Affairs* 27, no. 3 (May/June 2008): 835–44.

49. Davies.

50. Preferred Physicians Medical, "Customer Service and Underwriting," ppmrrg.com, 2006, http://ppmrrg.com/ppmrrg.aspx?pgID=922.

51. General Star Management Company, "Physicians and Surgeons," generalstar.com, July 31, 2009, http://www.generalstar.com/mpl_spnsplp.php.

52. Davies; Dow; Stephen Freedman and Cheri A. Priddy, Freedman directs the operations of Professional Underwriters Liability Insurance Company and Priddy is vice president of underwriting, conversation with author, September 10, 2009. Each has over 20 years experience in the medical professional liability insurance industry; Morse; Nibbe; Bruce R. Swicker, independent insurance agent and broker, conversation with author, July 23, 2009, Swicker serves hard-to-place physicians and lawyers with offices in New York City and Nassau County, http://www.insurance4docs.com/nonstandard.htm

53. Nibbe.

54. Vlazny, September 2, 2009.

55. Davies; Dow; Morse; Nibbe; PULIC, "State of California Department of Insurance Application for Approval of Insurance Rates," File 04-4298, California Department of Insurance, 2004, Rate Filings.com File CAC23949. Concern about the ability to collect puts an upper limit on deductibles.

56. Boone; Davies; Freedman and Priddy; O'Connell.

57. Under "claims-made" policies, insurance covers claims made during the period a physician is insured. In contrast, "occurrence" policies cover any claim made at any time that results from an event during a period a physician is insured. As occurrence policies left insurance companies with uncertain liabilities, most medical professional liability insurers switched from occurrence to claims-made policies. This created a demand for tail coverage by retired physicians seeking protection against claims arising from past behavior.

58. Allianz of America, Chicago Insurance Company, "State of California Department of Insurance Application for Approval of Insurance Rates," File 00-15362, California Department of Insurance, 2000, RateFilings.com File CAC10327 and CAC11265; CNA Insurance Companies, National Fire Insurance Company of Hartford, File 96-5126, California Department of Insurance, 1996, Ratefilings.com File CAC37767; Norcal, "Norcal Mutual Insurance Company Physicians and Surgeons Program-Forms and Rules Rate Filings," File 05-2063 and 05-1279, California Department of Insurance, 2005, RateFilings.com File CAC27354; Northwest Physicians Mutual Insurance Company, "State of California Department of Insurance Application for Approval of Insurance Rates," File 02-38372, California Department of Insurance, 2002, RateFilings.com File CAC18439; and The Doctors Company, "Physicians, Surgeons and Ancillary Healthcare Providers, Countrywide Rules and Rates Manual in California Rate and Rule Revision-Introduction of New Endorsements," File 08-11851, California Department of Insurance, 2008, RateFilings.com File CAC40789; Zurich Insurance Group, Truck Insurance Exchange and Mid-Century Insurance Company, "State of California Department of Insurance Application for Approval of Insurance Rates Medical Malpractice Physicians and Surgeons New Program Filing," File 00-15368, California Department of Insurance, 2000, RateFilings.com File CAC10328.

59. Marketing materials for the program say that, after 15 years, a physician with an annual medical professional liability premium of $25,000 could expect a retirement payment of $30,000. The Doctors Company, "About the Tribute Plan," 2009, http://www.thedoctors.com/ecm/fragments/tribute/downloads/tribute_faq.pdf.

60. General Star Management Company, "Physicians and Surgeons," generalstar.com, July 31, 2009, http://www.generalstar.com/mpl_spnsplp.php.

61. Morse.

62. Allen.

63. Davies; O'Connell.

64. Cynthia Shaw, "Covering 'Hard-to-Place' Physicians: Excess and Surplus Lines Update," *Best's Review* (Property/Casualty

Insurance Edition), no. 5 (1998): 81.

65. Boone.

66. Swicker.

67. Freedman and Priddy.

68. Morse.

69. Charles E. Phelps, *Health Economics*, 4th ed. (Boston: Addison-Wesley, 2010), p. 456.

70. Ibid.

71. Danzon, *Medical Malpractice; Theory, Evidence, and Public Policy*, p. 130; Sloan, Bovbjerg, and Githens, p. 178 (carriers could deny coverage, forcing physicians into the surplus-lines market that charged "premiums many times the standard rates,"); Studdert, Mello, and Brennan, p. 283 ("Physicians . . . generally are not risk rated unless they have been repeatedly sued, in which case they may be forced to obtain coverage fromhigh-cost insurers or may have trouble obtaining any coverage"); U.S. Congressional Budget Office, Medical *Malpractice Tort Limits and Health Care Spending,* p. 7 ("being sued repeatedly may make malpractice coverage difficult to obtain and more expensive"); Sloan and Chepke.

72. Danzon, "Liability for Medical Malpractice."

73. Tim Vlazny, underwriting director, CNA HealthPro, e-mail message to author, May 12, 2011.

74. See, for example, Sloan and Chepke.

75. Danzon, *Medical Malpractice; Theory, Evidence, and Public Policy*, p. 130.

76. U. S. General Accounting Office, *Medical Malpractice: Federal Tort Claims Act Coverage Could Reduce Health Centers' Costs*, Report to the U.S. Committee on the Judiciary, U.S. Senate, and the Committee on Commerce, U.S. House of Representatives, GAO/HEHS-97-57, April 1997, http://www.gao.gov/archive/1997/he97057.pdf.

77. Physicians Insurers Association of America, "Data Sharing Project," piaa.us, 2011, http://www.piaa.us/AM/ContentManagerNet/HTMLDisplay.aspx?ContentID=7244&Section=Data_Sharing_Project.

78. Allen. Allen describes the PIAA closed claimdata reviews as one of the most valuable sources of trends and claimactivity.

79. CNA, "Physical Therapy Claims Study: An Analysis of Physical Therapist Professional Liability Claims and Risk Management Recommendations, December 1, 1993, through March 31, 2006," September 2006, http://www.cna.com/vcm_content/CNA/internet/Static%20File%20for%20Download/Risk%20Control/Medical%20Services/Physi

80. Lenbitz.

81. Morse.

82. CNA Insurance Companies, National Fire Insurance Company of Hartford, "State of California Department of Insurance Application for Approval of Insurance Rates," File 96-5126, California Department of Insurance, 1996, Ratefilings.com File CAC37767; GE Global, Medical Protective Company (MedPro), "State of California Department of Insurance Application for Approval of Insurance Rates," File 07-2133, California Department of Insurance, 2007, Ratefilings.com File CAC34889; Norcal, "Norcal Mutual Insurance Company Physicians and Surgeons Program-Forms and Rules Rate Filings," File 05-2063 and 05-1279, California Department of Insurance, 2005, RateFilings.com File CAC27354; Zurich Insurance Group, Truck Insurance Exchange and Mid-Century Insurance Company, "State of California Department of Insurance Application for Approval of Insurance Rates Medical Malpractice Physicians and Surgeons New Program Filing," File 00-15368, California Department of Insurance, 2000, RateFilings.com File CAC10328; and PHICO, "State of California Department of Insurance Application for Approval of Insurance Rates," File 95-10432, California Department of Insurance, 1995, RateFilings.com File CAC3782918439; The Doctors Company, "California Rate and Rule Revision-Introduction of New Endorsements," File 08-11851, California Department of Insurance, 2008, Ratefilings.com File CAC40789.

83. Institute of Medicine.

84. U. S. General Accounting Office.

85. Chad C. Karls, conversation with author, June 2008. Karls is a principal and consulting actuary with the Milwaukee office of Milliman. He joined the firm in 1993. He has published numerous articles on medical professional liability issues.

86. Boone.

87. Neil D. Levin, "The Status of the Primary and Excess Medical Malpractice Market and the Future Need for the Medical Malpractice Insurance Association," A Report to the Governor and the Legislature by the Superintendent of Insurance, State of New York, December 1, 1997, appendix 1, p. 28.

88. "NIP Management Co. Announces Non-Standard Program for Conventus," *Business Wire*, February 7, 2011, http://www.allbusiness.com/services/business-services/3963097-1.html.

89. AIG, National Union Fire Insurance Company of Pittsburgh, "State of California Department of Insurance Application for Approval of Insurance Rates, New Program" File 99-13489, California Department of Insurance, 1999, RateFilings.com File CAC05592; CNA Insurance Companies, National Fire Insurance Company of Hartford, File 96-5126, California Department of Insurance, 1996, Ratefilings.com File CAC37767; The Doctors Company, "State of California Department of Insurance Application for Approval of Insurance Rates," File 05-1983, California Department of Insurance, 2005, RateFilings.com File CAC26653; Zurich Insurance Group, Truck Insurance Exchange and Mid-Century Insurance Company, "State of California Department of Insurance Application for Approval of Insurance Rates Medical Malpractice Physicians and Surgeons New Program Filing," File 00-15368, California Department of Insurance, 2000, RateFilings.com File CAC10328.

90. Institute of Medicine; Steven L. Clark, medical director, Women and Newborn Services, Hospital Corporation of America, confirmed that this is still the case today in e-mail communication with author, March 20, 2011.

91. Medical Insurance Exchange of California, "State of California Department of Insurance Application for Approval of Insurance Rates," File 03-6081, California Department of Insurance, 2003, RateFilings.com Files CAC21204.

92. The Doctors Company, "State of California Department of Insurance Application for Approval of Insurance Rates," File 05-1983, California Department of Insurance, 2005, RateFilings.com File CAC26653.

93. Freedman and Priddy.

94. Ibid.; Shaw, p. 81.

95. Christopher Guadagnino, "Impact of PA Malpractice Law," *Physician's News Digest*, 2002, http://www.Physiciansnews.com/cover/502.html.

96. Davies; Nibbe.

97. Davies.

98. Freedman and Priddy.

99. Vlazny, September 2, 2009.

100. Davies; Dow.

101. Davies; Nibbe; O'Connell; Vlazny, September 2, 2009.

102. Davies.

103. Boone.

104. O'Connell.

105. Freedman and Priddy.

106. Unfortunately, the precise number of providers that require physicians to carry malpractice insurance is not available. Edward E. Hollowell and Jennifer L. Smith, "Coproviders and Institutional Practice," in *Legal Medicine*, 7th ed. (American College of Legal Medicine, Textbook Committee, Mosby Elsevier, 2007), pp. 89–114, report that a 1977 survey by the American Hospital Association of U.S. community hospitals found 26 percent required physicians to have a minimum level of malpractice insurance. The AHA does not currently collect this information. American Hospital Association (AHA), e-mail communication with author, August 21, 2009.

107. Hollowell et al., pp. 89–114.

108. Beider and Hagen.

109. Danzon, *Medical Malpractice; Theory, Evidence, and Public Policy*; William B. Schwartz and Daniel N. Mendelson, "The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence," *Journal of the American Medical Association* 262, no. 10 (1989): 1342–46.

110. Physician Insurers Association of America, "PIAA History," 2009, http://www.piaa.us/AM/ContentManagerNet/HTMLDisplay.aspx?ContentID=3979&Section=History (link no longer works).

111. Morse; Vlazny, September 2, 2009.

112. Allen.

113. Robert L. Lowes, "Tort Reform Bill Would Reduce Deficit by $40 Billion," *Medscape Medical News,* March 11, 2011, http://www.medscape.com/viewarticle/738839.

114. Congressional Budget Office, *Medical Malpractice Tort Limits and Health Care Spending; National Conference of State Legislatures*, "Medical Liability/Malpractice Laws," summarizes state laws regarding damage award limits or caps, September 23, 2010, http://www.ncsl.org/default.aspx?tabid=18516.

115. Congressional Budget Office, *Medical Malpractice Tort Limits and Health Care Spending,* critiques physician surveys as a means to assess the level of defensive medicine. U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H—602 (Washington: Government Printing Office, 1994).

116. See for example, Katherine Baicker and Amitabh Chandra, "The Effects of Malpractice Liability on the Delivery of Health Care," *Forum for Health Economics and Policy* 8, no. 4 (2005) (mammograms); Daniel P. Kessler and Mark B. McClellan, "Do Doctors Practice Defensive Medicine?" *The Quarterly Journal of Economics* 111, no. 2 (1996): 353–90 (heart disease); Lisa Dubay, Robert Kaestner, and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics* 18, no. 4 (1999): 491–522 (cesarean section rates).

117. Congressional Budget Office, *Cost Estimate H.R. 5, Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011*, March 10, 2011, http://www.cbo.gov/ftpdocs/120xx/doc12095/hr5.pdf.

118. Beider and Hagen; Congressional Budget Office, "Letter to Honorable Orrin G. Hatch from CBO Director Douglas W. Elmendorf," October 9, 2009, http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf; Hyman and Silver, pp. 893–993. Also see Danzon, "Liability for Medical Malpractice."

119. Thanks to Michael Cannon, director of health policy studies at the Cato Institute, for this insight.

120. See, for example, Public Citizen, "The Inequitable Impact of Non-Economic Damage Caps: Three Academic Studies Demonstrate Severely Injured and Female Patients Are Hurt the Most," http://www.citizen.org/documents/HarvardRandFactsheet.pdf.

121. Frank Cornelius, "Crushed by My Own Reform," *New York Times*, October 7, 1994, in Mark A. Hall et al., *Health Care Law and Ethics,* 6th ed. (New York: Aspen, 2003), p. 471.

122. Analysis by Farber and White, pp. 199–217, suggests the value of nonbinding arbitration.

123. Michael F. Cannon, "Reforming Medical Malpractice Liability through Contract," Cato Institute Working Paper no. 3, November 10, 2010, http://www.cato.org/pub_display.php?pub_id=12552.

124. See, for example, Shirley Svorny, "Medical Licensing: An Obstacle to Affordable, Quality Care," Cato Institute Policy Analysis no. 621, September 17, 2008, http://www.cato.org/pub_display.php?pub_id=9640; and Shirley Svorny, "Physicians and Non-Physician Clinicians: Where Does Quality Assurance Come From?" in *What Can States Do to Reform Healthcare,* ed. John Graham (San Francisco: Pacific Research Institute, 2006).

125. Vlazny, September 2, 2009.

126. Svorny, "Medical Licensing."

127. Ibid.

128. Ibid.

129. American Medical Association Advocacy Resource Center, "Summary of Select State Laws Mandating Minimum Levels of Professional Liability Insurance," February 2008, http://www.ama-assn.org/ama1/pub/upload/mm/378/mlrproliains.pdf.

130. McMillan Law Firm, "Do All Doctors Have Insurance?" http://www.floridamalpractice.com/med20.htm

131. Svorny, "Medical Licensing."

132. Alicia Gallegos, "Georgia Physicians Must Reveal If They Don't Have Liability Insurance," June 6, 2011, amednews.com

133. Thanks to Linda Gorman, senior fellow and director of the Health Care Policy Center at the Independence Institute, for this insight.

134. U. S. General Accountability Office.

135. Ibid.

136. Ibid.

137. Davies; Dow; O'Connell; Swicker, Vlazny, September 2, 2009.

138. Jan M. Ambrose and Anne Carroll, "Medical Malpractice Reform and Insurer Claims Defense: Unintended Effects?" *Journal of Health Politics, Policy and Law* 32, no. 5 (2007): 843–65.

139. See State of New Hampshire, 2009. In Rhode Island and Florida, firms that write personal injury liability insurance must be Joint Underwriting Association members, see Rhode Island JUA, "About Us," 2007, http://rhodeislandjua.com/about-us/, and Florida Medical Malpractice Joint Underwriting Association, "Welcome to the FMMJUA Website," 2004, http://www.fmmjua.com New York's assigned-risk pool is a variant of a JUA. With state-imposed premium surcharge limits, the state's medical malpractice insurers share the burden of insuring those physicians whose expected risk exceeds the premium they pay.

140. Ambrose and Carroll reported JUAs were operational in 13 states. They do not cite a source nor do they indicate the set of states. The 1989 IOM report listed the following 13 states: Florida, Kansas, Massachusetts, Minnesota, New Hampshire, New York, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Texas, Virginia, and Wisconsin.

141. South Carolina Medical Malpractice Liability Insurance Joint Underwriting Association, "Why Choose the SCJUA?" scjua.com, August 13, 2008, http://www.scjua.com/why_choose_scjua.shtml.

142. Virginia State Corporation Commission, Bureau of Insurance, *The Feasibility of Creating a Liability Insurance Residual Market Facility and Joint Underwriting Association*, Report of the State Corporation Commission's Bureau of Insurance to the Governor and the General Assembly of Virginia, Senate Document no. 12, 1988.

143. Sloan, Bovbjerg, and Githens, p. 172.

144. Levin, p. 23.

145. See Svorny, "Medical Licensing: An Obstacle to Affordable, Quality Care" for evidence on the false assurances and supply constraints (limits to access that raise the cost of health care) that arise due to state regulation of medical professionals.

Health Care Regulation

by Michael F. Cannon

Cato Handbook for Policymakers, 7th Edition, Chapter 15

15. Health Care Regulation

State governments should

- eliminate licensing of medical professionals or, as a preliminary step, recognize licenses issued by other states;
- eliminate "corporate-practice-of-medicine" laws;
- eliminate "certificate-of-need" laws; and
- enforce private contracts that include medical malpractice reforms.

Congress should

- eliminate states' ability to use licensing laws as a barrier to entry by medical professionals licensed by other states,
- eliminate the U.S. Food and Drug Administration's efficacy requirement for new drugs, and
- reject federal medical malpractice reforms.

A widely accepted premise of most health care reform debates is that health and medicine are special areas of the economy where markets are plagued by failure. For example, economists describe medicine as a "credence"—good because it is difficult for consumers to judge its quality before *and even after* they have consumed it. It is also difficult for producers

(e.g., doctors, hospitals, etc.) to judge the quality of their services, even after the fact. A doctor might *think* his actions were responsible for a good outcome, or not responsible for a bad outcome, but it is difficult to know for sure. Nevertheless, doctors tend to know more about the need for, and quality of, various services than patients do. That asymmetry of information creates an unequal relationship between patient and physician and causes much concern among health care reformers.

In 1963, Nobel Prize–winning economist Kenneth Arrow penned an influential article for the *American Economic Review* that described government intervention in health care markets as a response to the problems of uncertainty and asymmetric information in medicine. Lobbyists and health care reformers ritually cite Arrow's article as justification for their preferred government interventions.

The reality of health care markets, government intervention, and, indeed, Arrow's article is not that simple. Pulitzer Prize–winning sociologist Paul Starr notes that many government interventions benefit producers of medical care at the expense of consumers and *exacerbate* the problem of uncertainty. Health economist James C. Robinson writes:

> The central proposition of [Arrow's] article, that health care information is imperfect and asymmetrically distributed, has been seized upon to justify every inefficiency, idiosyncrasy, and interest-serving institution in the health care industry…. It has served to lend the author's unparalleled reputation to subsequent claims that advertising, optometry, and midwifery are threats to consumer well-being, that nonprofit ownership is natural for hospitals though not for physician practices, that price competition undermines product quality, that antitrust exemptions reduce costs, that consumers cannot compare insurance plans and must yield this function to politicians, that price regulation is effective for pharmaceutical products despite having failed in other applications, that cost-conscious choice is unethical while cost-unconscious choice is a basic human right, that what consumers want is not what they need, and, more generally, that the real is reasonable, the facts are functional, and the health care sector is constrained Pareto-efficient.

Robinson concludes:

> The most pernicious doctrine in health services research, the greatest impediment to clear thought and successful action, is that health care is *different*…. 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…. The uniqueness doctrine hence proves too much.

Consistent with Robinson's observation, producers have been the driving force behind or have subsequently captured most health care regulations, and have used them to protect themselves from market competition at the expense of consumers. Physicians sought and used

licensing and corporate-practice-of-medicine laws to prevent competition from less remunerative prepaid health plans or integrated delivery systems that curtail physician autonomy. Recently, nonphysician clinicians have used licensing, scopeof-practice, and minimum-education requirements to increase their incomes by reducing the supply of, and substitutes for, their services. Hospitals use government regulation to block competition from other, often innovative, medical facilities. Pharmaceutical and medical device manufacturers rely on the U.S. Food and Drug Administration to erect high barriers to entry into those markets.

Perhaps the one area of health care regulation that fails to fit this mold is the courts' refusal to enforce contracts where patients waive some or all of their right to sue for malpractice in return for a reduced price. Nevertheless, the effect of that regulation is the same as all others: lower quality and higher costs.

Medical Professionals

How might markets make medicine better, cheaper, and safer? Harvard Business School professor Clayton Christensen and his colleagues offer this insight: "Many of the most powerful innovations that disrupted other industries did so by enabling a larger population of less-skilled people to do in a more convenient, less-expensive setting things that historically could be performed only by expensive specialists in centralized, inconvenient locations." In medical care, that process of using fewer inputs to achieve greater health outputs would come in large part from allowing less-trained clinicians, such as nurse practitioners and physician assistants, to perform tasks that were once performed only by highly trained (and more costly) physicians.

State licensing of medical professionals allows physicians and others to block that market process. To practice medicine in a state, physicians, nurse practitioners, physician assistants, and other clinicians must obtain a license from that state. To obtain a license, they must satisfy specified minimum-education requirements. For each type of clinician license, each state specifies the tasks the license allows clinicians to perform. That list of tasks is called the clinician's "scope of practice." (Physicians' scope of practice is plenary.)

Licensing allows physicians to restrict entry into their profession and to restrict the supply of substitutes for their services. By lobbying legislatures to restrict the scopes of practice of nurse practitioners and physician assistants, physicians can reserve certain tasks for themselves. Such restrictions increase the demand for physician services and increase physician incomes. They also make medical care more expensive and reduce access.

Licensing also enables midlevel clinicians to do the same. Nurse practitioners, for instance, can restrict entry into their profession (and thereby increase their incomes) by pushing states to increase the education requirements for a nurse practitioner's license. They can block competition from substitutes for their services by lobbying to restrict the scopes of practice of other nonphysician clinicians.

Physicians typically argue that they seek to restrict the scopes of practice of nonphysician clinicians because broader scopes of practice would threaten patient safety. Yet study after study has shown that midlevel clinicians provide a level of quality equal to that of physicians performing the same services. The American Medical Association, the nation's largest lobbying

group representing physicians, acknowledges this:

> More than 50 journal articles and reports comparing physician and non-physician services have been reviewed. These were in peer-reviewed journals though not, for the most part, peer-reviewed journals with a physician readership. The articles and reports usually look at one procedure or at the treatment of one kind of patient, usually a patient with an uncomplicated disorder or the need for routine treatment. These studies almost uniformly conclude that in the particular instances studied, a non-physician clinician in defined circumstances can provide an acceptable level of care.

Typically, midlevel clinicians also provide those services at a much lower cost.

Moreover, licensing does little to discipline clinicians who actually harm patients. A study by the consumer watchdog Public Citizen found that between 1990 and 2005, "only 33.26 percent of doctors who made 10 or more malpractice payments were disciplined by their state board— meaning two-thirds of doctors in this group of egregious repeat offenders were not disciplined at all."

There is a limit, of course, to every clinician's competence. Market forces and medical malpractice liability already do much more than licensing to protect patients. In the absence of licensing, private credentialing and the desire to protect brand names and reputations would do even more to safeguard patients from incompetent providers.

The standard, static economic analysis suggests that, on balance, licensing has little if any positive effect on health outcomes. Economists generally agree that licensing increases the quality of medical services *actually delivered*. Economists also agree that licensing increases the cost of medical care and therefore reduces the *quantity* of services delivered. For example, access to care will almost certainly fall if physicians secure regulations that inhibit nurse practitioner–staffed clinics such as MinuteClinic and RediClinic, which provide convenient and affordable access to routine care in retail stores such as CVS and Wal-Mart. Thus, licensing may do nothing to improve overall health.

A more dynamic analysis further suggests that licensing may in fact lead to *worse* health outcomes. Prepaid group practices such as Kaiser Permanente and Group Health Cooperative combine an integrated delivery system with prepayment. These plans make greater use of midlevel clinicians, preventive and primary care, and electronic medical records than other types of insurance or delivery systems. As a result, they have shown remarkable success at increasing the delivery of high-quality services, reducing low-value and harmful services (including medical errors), and making health insurance more affordable. As noted earlier, however, physicians have used licensing to block competition from integrated delivery systems and prepaid health plans, in large part because prepaid group practices are generally less remunerative for physicians and restrict physician autonomy. Thus, licensing may be reducing the overall quality of care by inhibiting higher-quality forms of health care delivery.

Reform is an inadequate response to licensing's pathologies. Whether licensing authority is vested in a legislature or regulatory agency, state or federal, there is no way to insulate that authority from influence by those whose incomes hang in the balance. Even absent political pressure, a government body is inherently unable to strike the proper balance between access and safety for millions of patients across billions of encounters with medical personnel. Such

an authority would inevitably restrict access to care and block innovations that make medicine better, cheaper, and safer.

Instead, state governments should eliminate medical licensing. Many things would not change. Hospitals, health plans, and other organizations would continue to rely on board certification, private credentialing organizations, and their own internal processes to evaluate the competence of clinicians. Courts would continue to hold health care organizations and individual clinicians accountable for harm caused by negligence.

What would change is that providers would seek innovative ways to use midlevel clinicians to bring quality care within reach of more low-income Americans. And greater competition between different delivery and payment systems would drive the medical marketplace toward providing greater health for more Americans at a far lower cost.

Medical Facilities

Another way markets might make medical care better, cheaper, and safer is through rigorous competition among medical facilities, including clinics, physician offices, urgent care clinics, ambulatory surgical centers, specialty hospitals, and full-service hospitals. State laws that require government approval of new medical facilities are a leading barrier to competition between medical facilities.

For most of the 20th century, federal and state governments encouraged greater spending on medical care. Medical expenditures—especially by government—truly exploded after the creation of Medicare and Medicaid in 1965. In the 1960s and 1970s, state governments attempted to contain those rapidly growing outlays essentially by engaging in centralized economic planning. Their primary tools were laws requiring hospitals, nursing homes, and even physician offices to obtain a "certificate of need" (CON) from a state planning agency before opening a new facility or investing in new equipment. The rationale behind CON laws was that by restraining the supply of hospital beds, government could restrain medical spending. By 1976, the federal government mandated CON planning nationwide.

CON laws failed to slow the growth of medical spending. In a survey of the empirical literature on CON laws, health economist Michael Morrisey writes that those studies "find virtually no cost-containment effects…. If anything, CON programs tended to increase costs." The failure of CON laws to achieve their stated aims led the federal government to lift its CON-planning mandate in 1987 and led many states to eliminate their laws also. Yet other states have maintained and even expanded their CON requirements. Why?

Although CON laws have done nothing to contain spending, they have been a boon for incumbent health care providers. Though the stated purpose of CON laws is cost containment, those regulations also protect existing health care facilities from competition. Morrisey concludes:

> A reasonably large body of evidence suggests that CON has been used to the benefit of existing hospitals. Prices and costs were higher in the presence of CON, investor-owned hospitals were less likely to enter the market, multihospital systems were less likely to be formed, and hospitals were less likely to be managed under for-profit contract…. The

> continued existence of CON and, indeed, its reintroduction and expansion despite overwhelming evidence of its ineffectiveness as a cost-control device suggest that something other than the public interest is being sought. The provider self-interest view is worthy of examination.

CON laws increase health care costs and deny patients the benefits of new forms of health care delivery. There is no justification for these laws, and no place in a market economy for Soviet-style economic planning. States should eliminate CON laws immediately. If state officials are concerned about runaway health expenditures, they should reduce or eliminate the government subsidies that fuel such spending.

Pharmaceutical Regulation

The Food and Drug Administration is the federal agency tasked with implementing the federal Food, Drugs, and Cosmetics Act of 1938, which Congress enacted in response to drug-related poisonings that killed over 100 children. That act requires pharmaceutical manufacturers to demonstrate to the federal government that their products are safe. Originally, if the FDA did not reject the application within 180 days, the firm could proceed to market its product.

Another drug-related tragedy occurred in 1962 when pregnant women taking the tranquilizer thalidomide gave birth to children with severe deformities. Though thalidomide victims numbered over 10,000 worldwide, there were relatively few in the United States, as the FDA had not yet approved thalidomide for marketing. Congress nevertheless responded to this tragedy by enacting the 1962 amendments to the Food, Drugs, and Cosmetics Act. Those amendments require firms to prove to the FDA's satisfaction that their products are efficacious for the indication for which approval is sought and require firms to obtain an affirmative approval from the FDA before marketing a new drug.

Economists have long acknowledged a fundamental tension in the FDA's regulation of pharmaceuticals. According to MIT economist Ernst Berndt and colleagues:

> A central tradeoff facing the FDA involves balancing its two goals— protecting public health by assuring the safety and efficacy of drugs, and advancing the public health by helping to secure and speed access to new innovations.

Failure to meet the first goal—assuring the safety of new drugs—results in what is called a "Type I error." Failure to meet the second goal— speeding access to effective new drugs—results in a "Type II error."

As Table 15.1 illustrates, the FDA succeeds in its mission when it either timely approves an effective drug (quadrant 1) or blocks a harmful drug (quadrant 4). The FDA commits a Type I error when it approves an unsafe drug (quadrant 2). Type I errors harm patients by exposing them to dangerous or even deadly products. The FDA commits a Type II error when it delays or denies approval of a beneficial drug (quadrant 3). Type II errors harm patients by withholding products that would protect them from illness or death.

Table 15.1
FDA Type I, Type II Error Problem

		Correct Decision: Approve	Correct Decision: Delay/Reject
FDA Decision	Approve	(1) **Success** (Helpful drug approved)	(2) **Type I Error** • Harmful drug approved • Patients harmed • Error traced to FDA officials
	Delay/Reject	(3) **Type II Error** • Helpful drug withheld • Patients harmed • Error *not* traced to FDA officials	(4) **Success** (Harmful drug withheld)

The FDA faces starkly different consequences for Type I and Type II errors. Type I errors bring swift and certain retribution on the agency. The victims of a Type I error are easily identifiable. Victims, their loved ones, the media, and Congress can discipline FDA officials for approving a harmful product. FDA officials know that a Type I error will lead to congressional hearings and public disgrace, and may even end their careers.

In contrast, FDA officials are rarely disciplined for Type II errors. Delaying or denying approval of a beneficial drug harms patients no less than approving an unsafe drug, yet victims of Type II errors are much harder to identify. Neither the Type II victim, nor their loved ones, nor FDA officials know exactly which patients might have been helped by a beneficial drug whose approval was delayed or denied. The patients and their families may never have heard of the drug. Indeed, the FDA may never have heard of the drug either: Type II errors include beneficial drugs that are never developed due to the high cost of winning FDA approval. Because of this information asymmetry, the political system does not— indeed cannot— discipline FDA officials for Type II errors the way it disciplines them for Type I errors.

Dr. Henry Miller, a former FDA official, offers an account of how those incentives affect the behavior of FDA reviewers:

> In the early 1980s, when I headed the team at the FDA that was reviewing the [new drug application, or NDA] for recombinant human insulin, the first drug made with gene-splicing techniques, we were ready to recommend approval a mere four months after the application was submitted (at a time when the average time for NDA review was more than two and a half years)…. My supervisor refused to sign off on the approval—even though he agreed that the data provided compelling evidence of the drug's safety and effectiveness. "If anything goes wrong," he argued, "think how bad it will look that we approved the drug so quickly." … The supervisor was more concerned with not looking

bad in case of an unforeseen mishap than with getting an important new product to patients who needed it.

The tradeoff between Type I and Type II errors is unavoidable. Reducing either type of error results in more errors of the other type. The FDA must commit a certain number of each.

The asymmetric information the FDA receives about Type I and Type II errors leads the agency to support policies that *increase* morbidity and mortality. Suppose the FDA were considering a new regulation that would prevent 1,000 deaths due to adverse drug reactions but that would slow down the approval of new drugs such that 10,000 patients would die while waiting for life-extending drugs that otherwise would have been approved. The FDA would implement the new regulation, even though it would result in 9,000 additional deaths.

Every effort to quantify the costs and benefits of FDA regulation supports that conclusion. Economist Sam Peltzman published the first such analysis in 1973. In 2005, Peltzman wrote:

> I found that the unregulated market was very quickly weeding out ineffective drugs prior to 1962. Their sales declined rapidly within a few months of introduction, and there was thus little room for the regulation to improve on market forces…. Most of the subsequent academic research reached conclusions similar to mine…. I concluded that the proof-of-efficacy requirement was a public health disaster, promoting much more sickness and death than it prevented. Nothing I have seen since has moved me to change that conclusion—the disaster is ongoing.

A study by Tulane University economist Mary K. Olson estimated that when additional revenue from user fees enabled the FDA to review drugs more quickly, the health benefits of quicker access to new drugs were roughly 12 times as great as the costs from additional adverse drug reactions. Another study, by University of Chicago economist Tomas Philipson and colleagues, found that quicker reviews brought significant health benefits, but "did not, in fact, have *any* effect on drug safety." That is, there appeared to be no additional adverse drug reactions. Those findings imply that the FDA will tolerate additional deaths due to Type II errors even if doing so were to produce little or no reduction in deaths due to Type I errors. Indeed, despite such research, Congress has in recent years sought to give the FDA additional powers to reduce Type I errors.

Little is to be gained from minor reforms such as user fees. The asymmetry of information available to the FDA guarantees that the agency will always behave in this manner.

Nobel Prize–winning economist Gary Becker advocates eliminating the efficacy standard and returning the FDA to the status quo *ante* 1962. Peltzman suggests, however, that even the safety requirement delivered more harm than benefit. Another Nobel Prize–winning economist, the late Milton Friedman, proposed eliminating the FDA entirely.

At a minimum, Congress should eliminate the FDA's efficacy standard. Eliminating the efficacy standard would not leave patients unprotected. The FDA would still have the power to keep from the market drugs that have not been proved safe to the agency's satisfaction. Moreover, private certification of pharmaceutical safety and efficacy, which already exists informally, would expand. Patients harmed by pharmaceuticals would continue to have recourse to the courts, which (along with liability insurers) would create powerful incentives

for pharmaceutical manufacturers to conduct appropriate testing.

The United States already has an essentially unregulated, albeit informal, process for certifying drug efficacy. The FDA approves a drug for one particular use, which goes on the drug's label. Yet physicians may—and do—prescribe drugs for other, "off-label" uses. An example is aspirin. Though designed for pain relief, doctors have long prescribed aspirin to prevent heart attacks.

Lack of FDA certification does not mean such uses are dangerous or unproven. Off-label uses are suggested or discovered by doctors and scientists; tested; and discussed worldwide in medical journals and symposia, and (if validated) appear in medical textbooks, the *U.S. Pharmacopeia Drug Information*, the *American Hospital Formulary Service Drug Information*, and other authoritative sources. Off-label uses often become the standard of care, particularly in fighting cancer and other diseases. Absent the FDA, those private organizations would play a greater role in certifying safety and efficacy.

Moreover, additional organizations would step forward to meet the demand for safety and efficacy certification. Underwriters Laboratories certifies the safety of thousands of consumer products, many inherently dangerous. That organization's charter states that it will certify the safety of any consumer product submitted to it. Underwriters Laboratories or other consumer advocates, such as *Consumer Reports*, could perform that vital function. Most likely, however, integrated and prepaid health plans such as Kaiser Permanente and Group Health Cooperative would perform that function as an agent for their enrollees. Prepaid group plans lead the industry in the use of electronic medical records, which are essential to tracking accurately a drug's effects on patients. When the FDA wanted to study whether the pain reliever Vioxx was causing heart attacks, it turned to Kaiser Permanente of Northern and Southern California.

Market-based certification respects the freedom of doctors and patients to make treatment decisions according to individual circumstances. It also provides them with information more quickly than government certification. Economist J. Howard Beales III found that off-label uses that were later certified by the FDA had been certified by the *U.S. Pharmacopeia Drug Information* an average of 2.5 years sooner. Market-based certification can also do more for patients than government certification can. The FDA is prohibited by law from considering cost-effectiveness as a criterion for approval. In contrast, prepaid group plans face financial incentives to ensure that their enrollees receive maximum value for their money, and can condition their seal of approval on whether a drug provides benefits that are worth the cost.

Two things must be made clear. First, if Congress were to eliminate FDA regulation of pharmaceuticals—or just the agency's efficacy standard—more patients would likely be harmed by new drugs. That unfortunate fact will lead to greater skepticism of new drugs by doctors and patients, as well as innovations that would more quickly detect and stop adverse drug reactions. Second, many more lives would be saved through greater innovation and quicker access to helpful drugs than would be lost to harmful ones.

Medical Liability Reform

The right to sue health care providers for medical malpractice is an important tool for protecting patients from injury due to negligent care. Patients typically have little information

about the quality of care. By imposing the costs of negligent care on providers, the medical malpractice "system" can align the incentives of providers with those of patients

Nevertheless, many people complain—with some justification—that the medical liability system in the United States performs poorly. Research suggests that malpractice liability does little to discourage negligent care, that only a small fraction of patients injured by provider negligence actually recover damages from providers, and that many who do recover are not victims of negligence. Many specialists (neurosurgeons and obstetricians, to name two) report that they cannot afford the rising cost of medical liability insurance. Duke University professor Christopher Conover estimates that in 2002, the U.S. medical liability "system" cost Americans $81 billion net of benefits. Physicians and other providers—who have seen often-dramatic increases in malpractice insurance premiums—have intermittently declared the medical liability system to be in "crisis" for over 30 years.

This "crisis" has spawned numerous proposals to reform medical malpractice liability rules. The American Medical Association advocates a nationwide cap on noneconomic damages similar to the $250,000 cap enacted in California. Other proposals include legislative limits on contingency fees for plaintiffs' attorneys; "no-fault" compensation systems for medical injuries, such as the limited programs adopted in Florida and Virginia; alternative forms of dispute resolution, such as arbitration and special medical courts; the English rule of costs; and reform of the collateral source rule.

Each of these reforms would leave some patients better off—typically by reducing prices for medical care—at the cost of leaving other patients worse off. So-called loser pays reforms would often reallocate the costs of frivolous lawsuits to the correct party. However, that rule deters less affluent patients from seeking legal redress for legitimate grievances. A cap on noneconomic damages would reduce health care costs for noninjured patients, but at the expense of leaving some injured patients with uncompensated losses. Limits on contingency fees would reduce costs for noninjured patients, but at the cost of denying compensation to injured patients whose cases plaintiffs' attorneys deem too expensive to pursue.

Many observers have called on the federal government to enact such reforms. As discussed in Chapter 11, Congress is not constitutionally authorized to impose substantive rules of tort law on the states. Although the federal government may enact technical procedural changes, state legislatures are the proper venue for correcting excesses in their civil justice systems. The fact that medical professionals can avoid states with inhospitable civil justice systems gives them significant leverage when advocating state-level medical liability reforms, and gives states incentives to enact such reforms. That some states have done so demonstrates that they have the ability.

Yet state-imposed medical malpractice reforms share two flaws with federally imposed rules. As noted earlier, imposing one set of limits on the right to sue for medical malpractice on all patients and providers will help some patients while hurting others. And the fact that those rules are written into statutes makes harmful rules extremely difficult to remove.

A more patient-friendly and liberty-enhancing approach would allow patients and providers to write their own medical malpractice reforms into legally enforceable contracts. For cases of ordinary negligence, patients could choose the level of protection they desired, rather than have a uniform level of protection (and the resulting price) imposed on them by the courts.

Providers could offer discounts to patients who agree to limits on compensation in the event of an injury. If not, the patient could pay the higher price or seek a better deal from another provider. Insurance companies could facilitate such contracts on behalf of their enrollees. Those companies would have strong incentives to ensure that those contracts provide adequate protection, else the insurers could face higher claims from injured patients who could not collect the full extent of their damages. The regular tort rules would continue to apply in cases where patients and providers did not contract around those rules, where patients were subject to duress, or where providers were guilty of intentional wrongdoing or reckless behavior.

Freedom of contract would make medical care more affordable to many low-income patients. It would also enhance quality competition. Providers who know they are less likely to injure patients could offer more expansive malpractice protections, or equivalent malpractice protections at a lower cost. Low-quality providers would not be able to do the same and would face strong financial incentives to improve their processes of care.

Such contracts are not possible today because courts have invalidated them as "against public policy." That policy has restricted the freedom of adults to make mutually beneficial exchanges that hurt no one else. It has also increased the cost of providing medical care to the indigent, which has undoubtedly reduced their access to care.

To remedy this costly restriction on liberty, courts should abandon their current policy and enforce contractual limitations on the right to sue for medical malpractice. If courts refuse, state legislatures should require them to do so. Economist Richard Thaler and law professor Cass Sunstein write:

> In our view, state lawmakers should think seriously about increasing freedom of contract in the domain of medical malpractice, if only to see whether such experiments would reduce the cost of health care without decreasing its quality. Increasing contractual freedom won't solve the health care crisis. But it might well help—and in this domain every little bit of help counts.

As noted earlier, the medical malpractice system does a poor job of providing relief to injured patients, preventing frivolous lawsuits, or discouraging negligence. The remedies for these shortcomings are not obvious. A dynamic marketplace that allows parties to experiment with —and abandon—different malpractice rules is the quickest and surest way to find those solutions.

Suggested Readings

Arrow, Kenneth J. "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review* 53 (1963).

Cannon, Michael F., and Michael D. Tanner. *Healthy Competition: What's Holding Back Health Care and How to Free It.* Washington: Cato Institute, 2007.

Christensen, Clayton M., Richard Bohmer, and John Kenagy. "Will Disruptive Innovations Cure Health Care?" *Harvard Business Review On Point: Curing U.S. Health Care*, 3rd ed., September–October 2000.

Conover, Christopher J. "Health Care Regulation: A $169 Billion Hidden Tax." Cato Institute Policy Analysis no. 527, October 4, 2004.

Enthoven, Alain C., and Laura A. Tollen, eds. *Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice*. San Francisco: Jossey-Bass, 2004.

Epstein, Richard A. "Medical Malpractice: The Case for Contract." *American Bar Foundation Research Journal* 1, no. 1 (1976).

Friedman, Milton. *Capitalism and Freedom*. Chicago: University of Chicago Press, 1962, chapter 9, "Occupational Licensure."

Hamowy, Ronald. "The Early Development of Medical Licensing Laws in the United States, 1875–1900." *Journal of Libertarian Studies* 3, no. 2 (1979).

Kessel, Reuben. "Price Discrimination in Medicine." *Journal of Law and Economics* 1 (1958).

Morrisey, Michael. "State Health Insurance Reform: Protecting the Provider." In *American Health Care: Government, Market Processes, and the Public Interest* , edited by Roger Feldman. New Brunswick, NJ: Transaction, 2000.

Olson, Mary K. "Are Novel Drugs More Risky for Patients than Less Novel Drugs?" *Journal of Health Economics* 23, no. 6 (2004).

Peltzman, Sam. "An Evaluation of Consumer Protection Legislation: The 1962 Drug Amendments." *Journal of Political Economy* 81, no. 5 (1973).

_____. *Regulation and the Natural Progress of Opulence*. Washington: AEI Press, 2005.

Philipson, Tomas J., and others. "Assessing the Safety and Efficacy of the FDA: The Case of the Prescription Drug User Fee Acts." National Bureau of Economic Research Working Paper no. 11724, 2005.

Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, 1984.

Svorny, Shirley. "Medical Licensing: An Obstacle to Affordable, Quality Care." Cato Institute Policy Analysis no. 621, September 17, 2008.

Thaler, Richard H., and Cass R. Sunstein. *Nudge: Improving Decisions about Health, Wealth, and Happiness*. New Haven, CT: Yale University Press, 2008, chapter 14, "Should Patients Be Forced to Buy Lottery Tickets?"

—Prepared by Michael F. Cannon

Chapter 74

Medical Licensing: An Obstacle to Affordable, Quality Care

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Introduction

In the United States, the authority to regulate medical professionals lies with the states. To practice within a state, clinicians must obtain a license from that state's government.

State statutes dictate standards for licensing and disciplining medical professionals. They also list tasks clinicians are allowed to perform (called a clinician's "scope of practice"). One view is that state licensing of medical professionals assures quality. Another view is that licensing is ineffective and makes consumers worse off. States first began to license physicians in the early part of the 20th century. In effect, states handed the administration of physician-licensing laws to state boards composed of physicians. Likewise, states vested oversight of medical school accreditation in the American Medical Association, which represents the interests of physicians.

Many observers have suggested that licensing laws give physicians too much power. Leading economists—including Nobel Laureate Milton Friedman and University of Chicago professor Reuben Kessel—have argued that state licensing laws unnecessarily restrict the supply of medical care.[1] In his 1963 article on health economics in the *American Economic Review*, Nobel Laureate Kenneth Arrow noted that state licensing laws were needlessly restrictive, requiring physicians to perform tasks that could be performed ably and less expensively by less-skilled professionals.[2] From this point of view, liberalizing state licensing laws could make health care more available and less expensive without harming quality.

It took growing healthcare costs to motivate partial liberalization. Following the passage of Medicare and Medicaid legislation in the United States in 1965, the demand for physician services increased dramatically. To keep costs down, politicians at the federal level reduced entry barriers for foreign-trained physicians.[3] In 1972, nearly 45 percent of newly licensed physicians in the United States were foreign-trained, up from approximately 20 percent in the 1960s.[4]

Slowly, the states followed by expanding the scopes of practice of nonphysician clinicians. Many states adopted laws to allow nurse practitioners to practice independently and to prescribe controlled substances—tasks historically reserved for physicians. The fact that nonphysician clinicians could provide certain types of care for less money than physicians led to the broader use of such mid-level professionals in all aspects of health care.

Organizations representing mid-level clinicians— including nurse practitioners, physician assistants, nurse midwives, physical therapists, podiatrists, and optometrists, among many others—continue to advocate broader scopes of practice for their members, ostensibly to increase access to care. However,

these same groups are less concerned about access to care when it comes to the role of other clinicians. And they are anxious to raise education requirements for new entrants to their professions. Such requirements clearly reduce access.

An important question is whether such determinations even belong in the political arena, where decisions are subject to intense lobbying by parties whose interests might not align with those of consumers. Researchers at the University of California, San Francisco, Center for the Health Professions observe, "Interest groups with strong lobbies play a significant role in shaping [scope-of-practice] legislation."[5]

Any group of mid-level clinicians that can sway legislators can get its scope of practice expanded or increase education requirements for new entrants. Alternatively, a powerful physician lobby can block changes to the scopes of practice of mid-level practitioners that would impinge on its members' turf.

In this paper, I argue that these determinations do not belong in the political arena. State oversight of medical licensing and scope of practice has negative consequences for consumers. Consumers would benefit were states to eliminate professional licensing in medicine and leave education, credentialing, and scope-of-practice decisions to the private sector and the courts.

The Importance of Mid-Level Clinicians

Nonphysician clinicians have made significant inroads in the practice of medicine, despite opposition from the American Medical Association and state medical associations. By 2004, there were more than 240,000 advanced practice nurses[6] and 60,000 physician assistants[7] working in the United States, compared with about 800,000 active physicians.[8] These two professions did not exist prior to the 1960s.[9] Medicare and Medicaid, which together account for nearly half of all health care spending in the United States,[10] routinely reimburse nonphysician clinicians, including physical therapists, audiologists, optometrists, podiatrists, nurse anesthetists and many others, for a variety of tasks.

Today, 23 states permit nurse practitioners to practice independent of physician oversight or collaboration; the remaining states do not.[11] Most states allow nurse practitioners and physician assistants to prescribe controlled substances.[12] Though no states allow physician assistants to practice independently, it is not uncommon for physician assistants to have relative autonomy, conferring with a supervising physician as necessary.

Specialization is increasingly common among mid-level clinicians. For example, nurse practitioners training at the University of California, San Francisco, may choose from a wide variety of specialties, as listed below:[13]

- Acute Care
- Midwifery/Women's Health
- Acute Care Pediatrics
- Occupational and Environmental Health
- Adult Nursing
- Oncology
- Cardiovascular
- Pediatrics

- Advanced Community Health
- Neonatology
- Critical Care/Trauma
- Perinatology
- Family Practice
- Psychiatric/Mental Health
- Gerontology

In addition to nurse practitioners, advanced practice nurses include clinical nurse specialists, certified nurse midwives, and nurse anesthetists.

Despite the primary care emphasis in their education, many physician assistants work in specialty practices. The American Academy of Physician Assistants lists numerous specialty practices, as follows. None of these specialties are specifically licensed by the states.[14]

- Allergy and Immunology Medicine
- Oncology
- Cardiology
- Otolaryngology
- Dermatology
- Orthopedic Surgery
- Emergency Medicine
- Psychiatry
- Gastroenterology and Hepatology
- Radiology
- Nephrology
- Rheumatology
- Neurosurgery
- Pediatrics
- Obstetrics and Gynecology
- Surgery
- Occupational Medicine

Mid-Level Clinicians and Quality

By almost all accounts, the quality of services consumers get from nonphysician clinicians is at least on par with what they would get from a physician performing the same services. Dozens of peer-reviewed studies compare outcomes in situations where patients are treated by a physician, a physician assistant, or an advanced practice nurse. Outcomes appear similar[15] —an important factor, considering that nonphysician clinicians can provide many services at a much lower cost. There is also evidence that teams of clinicians outperform individual physicians. (Many physicians who are accustomed to working in teams are happy with the collaboration.)[16]

A review of more than 50 studies by the American Medical Association's Council on Medical Education found that the peer-reviewed studies "almost uniformly conclude that . . . a non-physician clinician . . . can provide an acceptable level of care."[17] The Council did note that some observers find

serious flaws in the literature, including small samples, lack of control subjects, and failure to control for differences in the severity of illness treated by physicians and nonphysician clinicians. Nevertheless, physician groups are unable to point to studies showing worse health outcomes with mid-level clinicians. That may be the most persuasive evidence that the quality of care provided by nonphysician clinicians is on a par with that provided by physicians.

The Need for Workforce Flexibility

The flexibility to employ mid-level clinicians in new ways is an essential part of making medical care more affordable. As Harvard Business School professor Clay Christensen and his colleagues explain, "Many of the most powerful innovations that disrupted other industries did so by enabling a larger population of less-skilled people to do in a more convenient, less-expensive setting things that historically could be performed only by expensive specialists in centralized, inconvenient locations."[18]

Such disruption is already taking place in medicine. According to public health researcher and American Thoracic Society executive director Stephen Crane, "Fifty years ago . . . medicine was as much an art as a science. We've been able to codify a lot of that knowledge. That allows us to teach what's going on in a shorter period of time and to delegate that to others to perform."[19]

Hospitals and other providers use what workforce flexibility exists to determine the tasks a particular mid-level clinician may perform.[20] As their skills develop, mid-level clinicians are given greater responsibility and autonomy. Thus the effective delineation of their scopes of practice occurs outside the licensing process, and largely at the point of care. Tracy Klein, a clinical instructor of medicine at the Oregon Health and Sciences University, writes, "Experience and environment can and will stretch the [nurse practi-tioner's] knowledge and competence beyond that of the basic education level."[21]

The Indian Health Service (the federal health program for American Indians and Alaska Natives) grants clinical and prescribing privileges to physician assistants on the basis of education, training, experience, and current competence.[22] Relatively flexible scopes of practice enable physician assistants to alleviate workforce shortages as they emerge. According to the American Academy of Physician Assistants, about 20 percent of PAs change jobs annually, often moving across specialties.[23]

Despite the progress made in incorporating mid-level clinicians, licensing and scope-of-practice rules still restrict providers' ability to employ medical professionals to their full competence. Licensing restricts nurse practitioners and other mid-level clinicians whose competence exceeds the legislatively imposed scope of practice.

The Politics of Medical Licensing

Groups representing mid-level professionals are currently threatening to erode what little workforce flexibility exists. Like physicians in the early part of the 20th century, lobbying groups of mid-level clinicians are working to secure legislation that would allow them to stake a claim to specific areas of practice, excluding all others from providing services in those areas. In addition, many clinician groups are lobbying to increase education requirements for new entrants to their field. When government issues licenses to medical professionals, it creates a regulatory apparatus that organized clinicians can manipulate to increase their incomes.

Is More Education Always Better?

Mid-level medical professions have been successful in increasing the amount of education required to obtain a license. For example, states increasingly require new NPs to obtain a master's degree. All states require physical therapists to have a master's degree.[24] The American Association of Colleges of Nursing wants states to require a Doctor of Nursing Practice degree of all new advance practice nurses by 2015.[25] A new law requires physician assistants to have a masters or higher degree to practice in Ohio.[26] Every state has required a master's degree of occupational therapists since 2007.[27]

Starting in 2012, California will require new audiologists to have obtained a doctorate (Au.D.), raising concerns that the legislation would exacerbate a shortage of audiologists. The legislation followed a move by the American Speech-Language-Hearing Association, the organization that accredits college audiology programs, to require a doctorate for professional certification. Questioning both why California legislators rushed to comply and whether even a master's degree is necessary to test someone's hearing, the *Sacramento Bee* called the requirement for a doctorate an "extraordinary and costly mandate."[28]

Ostensibly, increasing education requirements would improve quality. But the relationship between educational inputs and better health outcomes is not that straightforward. Stricter education requirements limit entry into the medical professions, increase prices, and reduce access to care, which can result in worse health outcomes.

As with the audiology legislation in California, it is not clear that those excluded by these higher barriers to entry would not be competent practitioners. When hiring, hospitals and other employers can and do specify the level of education or training required of clinicians. Not every job requires the same level of skills. Increasingly strict education requirements deprive health care providers of a range of education and training options from which to choose. Forcing providers to use more highly educated—and thus more costly—practitioners increases prices and limits access to care.

Scope-of-Practice Turf Wars

Debates among competing groups of clinicians over scopes of practice are increasingly common. In July 2003, the Federation of State Medical Boards established a Special Committee on Scope of Practice noting that "scope-of-practice changes are among the most highly charged policy issues facing state legislators and health care regulators."[29]

The American Medical Association has joined with other physician organizations (including state-level medical associations) to establish the Scope of Practice Partnership, an "organized medicine coalition" to monitor legislative efforts by other associations of health professionals.[30] The president of the American Medical Association, Ronald M. Davis, called the Scope of Practice Partnership a "watchdog of legislative, regulatory, and legal endeavors that seek to expand the scope of practice of non-physician providers into the practice of medicine."[31]

To counter efforts by organized medicine and the AMA's Scope of Practice Partnership in particular, a group of 34 organizations representing other licensed medical professionals formed the Coalition for Patients' Rights.[32]

Acknowledging the difficulties in reviewing scope-of-practice proposals and determining appropriate scopes of practice for various professionals, several states have established legislative committees to study scope-of-practice proposals and make recommendations. Statutes in Arizona and Iowa address the scope-of-practice review process. Arizona's statute requires consideration of the reason increased scope of practice is sought, the impact on consumers' access to health care, and implications for the interstate

migration of health care professionals.[33] In Virginia, the Board of Health Professions (with members from each of the 13 health regulatory boards in the state) evaluates regulatory proposals and recommends the appropriate level of regulation.[34] A Texas proposal (HB 3950) to establish a Health Professions Scope of Practice Review Commission failed in 2007.

In most cases, physicians (represented by the state medical association) are in one corner and organizations representing other clinicians are in the other.[35] But non-physician clinicians also step on each other's toes. For example, because of a strong nursing lobby that opposed the practice of physician assistants, Mississippi was the last state to allow physician assistants to practice.[36] Those groups that oppose broader scope for nonphysician clinicians call for extensive review by policymakers of scope-of-practice initiatives. For example, the guidelines set by the Federation of State Medical Boards calls for a "verifiable need" for the proposed change, along with a review of the "details, rationale, and ethics of any proposals to bypass licensing" and "the implications for other practitioners, and the effect on patient safety."[37] That standard would present a formidable barrier to reform. It is noteworthy that the Federation's desire for evidence runs in only one direction. The Federation only demands evidence of the patient-safety effects of proposed *expansions* of scope-of-practice rules. It does not call for evidence that the existing *limits* on midlevel clinicians' scopes of practice enhance patient safety. There is no such evidence.

Today's turf battles include a wide range of issues. Here are some examples:

- Optometrists seek to expand their scope of practice to include surgical procedures traditionally limited to ophthalmologists.[38]
- Physical therapists want to be able to treat patients without a physician's prior diagnosis.[39]
- Physician-anesthesiologists seek to limit the scope of practice of nurse anesthetists.[40]
- The American Medical Association opposes assessment and diagnosis of clinical and laboratory data by PhD clinical lab scientists.[41]
- Medical societies in California and Idaho amended naturopaths' scope of practice to require physician supervision or collaboration.[42]
- In Missouri, certified professional midwives aspire to work independent of physician collaboration.[43]
- Despite physicians' concerns about safety, California decided to expand the scope of practice for oral and maxillofacial surgeons to include elective facelifts, rhinoplasties, and eyelifts.[44]

Clinician groups that fail to achieve their goals through legislative means have found a second avenue to reform: working with state regulatory boards to alter scope-of-practice rules. Because it is expensive for physician groups to challenge board decisions in court, this path to scope-of-practice expansion is growing.[45] However, it is not always successful. In 2008 a Texas appeals court ruled that the Texas State Board of Podiatric Medical Examiners went beyond its power in 2001 when it expanded podiatrists' scope of practice. The appeals court determined that such a change would need to come from the state legislature.[46]

With all of these efforts, the concern for consumers is that licensing requirements and scope-of-practice determinations will reflect the political power of various clinician lobbies rather than the

patient's interest in affordable, quality care. For example, physician assistants now have prescribing authority over controlled drugs in 36 states, yet Alabama, Florida, Kentucky, and Missouri still do not allow physician assistants to prescribe any controlled substances.[47] As of 2001 physician assistants and nurse practitioners had parallel duties in many facilities in Louisiana, yet nurse practitioners were allowed to write prescriptions, whereas physician assistants were not.[48] Such outcomes are more likely the result of power politics than variation in the competence of physician assistants across states.

Licensing and scope-of-practice laws give the medical professions considerable control over whether other professions may compete with them. That frequently slows the spread of affordable care. Consumers are worse off if licensure and scope of practice laws unnecessarily limit access to care.

What Value Does Licensing Add?

State licensing boards' duties include checking the credentials of medical professionals, disciplining errant practitioners, and reporting their activities to the public. Yet, as will be explained in detail below, boards rely on private organizations for much of their credentialing activity, disciplinary efforts are largely ineffective, and consumers receive little information from licensing boards that helps them choose quality clinicians. It is legitimate to ask, what value does licensing add?

Checking Credentials

State boards establish education and training criteria (including post-graduate training) and require potential licensees to pass examinations to test their knowledge and skills. State boards also fingerprint applicants, checking criminal records with the Department of Justice and the Federal Bureau of Investigation. Credential verification and background checks account for a sizable share of state medical board spending.[49]

State medical boards don't do all the work themselves. They rely heavily on private organizations that accredit education and training programs and credential individual clinicians. For example, unique state tests for physicians have given way to common national test, the United States Medical Licensing Examination (designed and administered by two independent, private organizations: the Federation of State Medical Boards and the National Board of Medical Examiners). To assess physician training, all states rely on the American Medical Association's accreditation of U.S. medical schools.

Likewise, states depend on the Accreditation Review Commission on Education for the Physician Assistant to assess training programs for physician assistants and on the National Board for Certification of Occupational Therapists' examination to assess the skills of occupational therapists. Many states rely on the American Nurses Credentialing Center, which credentials individuals across 26 categories of nurses and nurse practitioners (advanced practice nurses).[50] These are just a few of the outside organizations on which states rely. In the absence of licensing laws, these organizations would continue to provide valuable credentialing services.

Disciplining Poor Performers?

Discipline is the second task of state medical boards and takes up most of the time of board staff. Disciplinary efforts generally focus on resolving complaints filed by the general public. When state board members and managers of state board disciplinary efforts were surveyed in 2004–2005, however, they expressed the concern that public complaints are not a good indicator of serious problems with

practitioners.[51] Those surveyed felt that physicians, nurses, hospitals, and other providers would provide better leads. Yet medical professionals tend to underreport quality problems. According to one survey: "Forty-five percent of [physicians] with direct personal knowledge of a physician in their hospital group or practice who was impaired or incompetent did not always report that physician. Of those with direct personal knowledge of a serious medical error, 46 percent did not report that error to authorities on at least 1 occasion."[52] Moreover, those who did report problem colleagues did not necessarily report them to a state medical board. Thus there are potentially many serious quality problems that licensing cannot even identify, much less remedy. Indeed, state medical boards "typically do not define prevention of injury as part of their responsibility."[53]

A second problem confronting state boards is that it is very difficult and expensive to establish substandard care, incompetence, or negligence.[54] Expert witnesses and lawyers are expensive. State boards don't have sufficient time or money to investigate the large number of malpractice settlements and judgments.[55]

As a result, state boards have a poor record of disciplining errant physicians. A study of Florida physicians with malpractice payouts over $1 million found that only 16 percent had been sanctioned by the state medical board.[56] Among physicians who made 10 or more malpractice payments between 1990 and 2005, only *one-third* were disciplined by their state boards.[57]

Further complicating the disciplinary process, state boards are reluctant to pull a license or make public the results of an investigation due to the financial consequences for the sanctioned professional. Just issuing formal charges against a physician, which become public record, affect a doctor's reputation and potential income.[58]

As a result of these forces, formal disciplinary actions typically do not focus on improper or negligent care. Instead, the bulk of disciplinary actions involve inappropriate prescription of controlled substances, drug and alcohol abuse, mental illness, sexual improprieties and other issues.[59] Researchers have found a high rate of repeat offenders among physicians sanctioned by state medical boards, suggesting that licensing does not deal with offenders in an effective way.[60]

Reporting Negative Outcomes to the Public?

The licensing system also comes up short in the area of reporting substandard care to the public. There are often long delays. California reports an average of 934 days in getting a case to judicial review.[61] To avoid the high costs of lengthy hearings, boards routinely negotiate voluntary settlements for lesser offenses. In the Federation of State Medical Boards' database, the nature of the investigation is not recorded in more than 65 percent of cases that ended in sanctions between 1994 and 2002. In those cases, the state board and the physician entered an agreement without the physician being found guilty.[62] These dynamics deny consumers information that would help them avoid low-quality physicians.

Licensing, then, does little to prevent clinicians from rendering improper or negligent medical care. Disciplinary actions are not primarily related to the quality of medical care per se, and many disciplinary actions are kept below the public radar. If, as some suggest, concerns about financial and reputational consequences diminish efforts to discipline clinicians formally or publicly, or encourage confidential consent agreements, then one might conclude that licensure offers more protection to malfeasant clinicians than to consumers.

Consumer Protections Offered by the Market and the Courts

A closer look suggests that most patient protections are unrelated to state licensing.[63] Concern over reputation and potential liability for medical malpractice creates incentives for private efforts to assess clinician knowledge, skills and competence that well exceed those associated with state licensing. Indeed, health care providers regularly review information on their clinicians that is broader and more up-to-date than information associated with licensure. At the point of care, hospitals and other institutions dictate what services each individual clinician may provide. On top of that, the structure of medical malpractice liability insurance rates creates some incentives for providers to avoid medical errors and other negligent care.

Medical Malpractice Liability

Hospitals, health maintenance organizations, and other healthcare providers may be liable for negligence in the credentialing, selection, retention, and supervision of health professionals.[64] Courts have established that a hospital or health maintenance organization has a "non-delegable duty to select and retain only competent physicians [and] to oversee all persons who practice medicine" in its facility or system.[65] The courts have ruled that healthcare organizations have a duty of proper selection and a duty to supervise clinicians.[66]

Therefore, hospitals and other health care providers are legally liable for the actions of clinicians whose background and skills they have assessed. When a negligent clinician is employed by a health care organization, the courts may hold the employer liable.[67] Even if the clinician is not employed by the provider, the provider may still be liable if there is any reason for patients to think that clinicians are tied to a provider, such as when a hospital advertises the quality of its clinicians. Similarly, managed care organizations may be liable for the actions of plan physicians.[68]

Malpractice Insurers

Private malpractice insurers also protect consumers by providing guidance and incentives for hospitals, other facilities, and individual clinicians to improve the quality of care. Most insurance companies offer discounts to physicians or physician groups willing to engage in practices known to reduce medical errors. For example, Medical Liability Mutual Insurance Company offers a premium discount of 5 percent to physicians and surgeons who complete a qualified risk-management program.[69]

Physicians with high claims experience may face premium surcharges (called "experience rating") or may have to turn to surplus-line carriers, which impose high premiums, have large deductibles, and may restrict practice or require additional training or supervision.[70] A 1985 survey of physician-owned insurance companies (which cover about 60 percent of the market for malpractice insurance)[71] found that these insurers penalize physicians who exhibit "negligence-prone behavior." During a one-year period, 0.66 percent of physicians had their insurance pulled. Insurers restricted coverage for or sanctioned another .7 percent of policyholders, and another 1.8 percent faced premium surcharges or deductibles if they wanted to continue to be insured. The survey's authors concluded that "the physician-owned companies are effective agents in identifying negligence-prone behavior . . . and play an important role in deterring substandard performance."[72] A study of malpractice premiums in Vermont found surcharges as high as 400 percent,[73] and all insurers reported having declined or refused to renew coverage for reasons

that include a history of adverse claims.[74] A look at one California malpractice insurer's rate filing shows the range of factors the insurer considers. Among other things, insurers impose surcharges for failed board examinations, lack of specialty board certification, lack of hospital privileges, and frequent malpractice claims.[75] These financial penalties discourage negligent care and help drive out of business physicians who repeatedly put patients at risk.

Hospitals need to be concerned about malpractice liability as well. Like physician-owned malpractice insurance companies, hospitals are in a prime position to monitor and evaluate clinicians. Hospitals generally self-insure, so they bear the costs of malpractice directly, creating incentives to be selective about medical professionals they hire and incentives to monitor clinicians over time. When hospitals buy insurance, it is "highly experience rated,"[76] thus a history of claims will cause their premiums to rise.

Private Credentialing

As noted above, many services provided by state licensing boards are redundant to efforts taken at the point of care. Hospitals and other institutions don't give clinicians free reign just because the clinician has a state license. A vice president of the Texas State Board of Podiatric Medical Examiners recently noted that the board is "only a licensing agency . . . We're not a credentialing agency . . . *It's up to the hospitals to decide who they'll credential—and for what.*"[77]

Hospitals, managed-care organizations, and other providers not only check the background of medical professionals to avoid liability for negligence but also to meet standards set by accrediting organizations and insurers. In addition, federal law requires hospitals to request information from the National Practitioner Data Bank at the time a health care practitioner applies for a position and then every two years. Among other things, the National Practitioner Data Bank includes entries on medical malpractice payments and whether a clinician has been denied privileges to practice in a hospital or other health care facility.[78]

Hospitals and other facilities are accredited by the independent Joint Commission,[79] whose clinician credentialing standards are sufficiently extensive to meet federal Medicare and Medicaid requirements. Clinicians are asked for indentifying information and a declaration of adverse legal actions and convictions.[80] Every organization accredited by the Joint Commission must meet standard HR 1.20, which requires a process in place "to ensure that a person's qualifications are consistent with his or her job responsibilities."[81] Therefore, every hospital or other healthcare facility has policies and procedures that delineate each clinician's scope of practice. These can be generic for groups of clinicians or written specifically for individual clinicians. The hospital medical staff observes and documents a clinician's skills before approving the clinician as competent to practice. Clinicians are supervised both concurrently and retrospectively as the basis for granting hospital privileges.

Managed care organizations, preferred provider organizations, and other health plans are accredited by the National Committee for Quality Assurance. The NCQA requires these organizations to credential clinicians as well.[82]

The demand for clinician-credentialing has grown to the point that a sophisticated industry now collects and verifies information about individual clinicians for hospitals and other clients. Credentials verification organizations (CVOs) verify clinicians' training and experience, and periodically review claims and adverse judgments against health care professionals. In addition to verifying a clinicians' professional education and training, CVOs verify whether a clinician has been certified to prescribe

controlled substances by the federal Drug Enforcement Agency, the clinician's malpractice claims history, any Medicare or Medicaid sanctions, and the clinician's work history. CVOs also monitor private actions against medical professionals, including loss of hospital privileges or other sanctions. To guide facilities and organizations in choosing a CVO, the NCQA—the same group that accredits managed care, health maintenance and preferred provider organizations—certifies independent CVOs.[83]

The private, nonprofit Federation of State Medical Boards' Credentials Verification Service offers a permanent repository for records for physicians and physician assistants:

> Applicants who complete the verification process establish a permanent, lifetime portfolio of primary source verified credentials [that] can be used throughout the applicant's career for state licensure, hospital privileges, employment, and professional memberships.[84]

Private specialty board certification is another voluntary form of credentialing and quality certification more rigorous than state licensing. Private specialty boards administer exams to test physicians' competence in a particular area of medicine; physicians may become board-certified in more than one specialty. According to the American Board of Medical Specialties, nearly 85 percent of U.S. physicians are independently certified by specialty boards.[85] In 2002, the 24 boards that are members of the American Board of Medical Specialties agreed to adopt common "Maintenance of Certification" standards. All boards are required to be in compliance by 2010. This new agreement not only requires a formal examination and an assessment of clinical skills in a supervised practice setting, but also periodic reevaluation.[86]

In the United States and abroad (in the burgeoning medical tourism industry), board certification guides hospitals and health plans in assessing physicians and is recognized by consumers as an indicator of quality. Physicians often advertise their specialty-board certifications, and patients often search for board-certified physicians. The value of independent board certification is suggested by a national study that found that managed care organizations are more likely to contract with board-certified physicians than with non-board-certified physicians.[87]

Nongovernmental organizations also certify the quality of nonphysician clinicians. As noted above, the independent National Commission on Certification of Physician Assistants certifies physician assistants. Another private group, the Accreditation Review Commission on Education for the Physician Assistant, accredits physician assistant programs. Many nurse practitioners seek certification from the American Nurses Credentialing Center. The ANCC offers nursing certification in 26 different specialties. According to that organization, more than 75,000 advanced practice nurses are currently certified.[88] Other organizations that certify nurse practitioners include the National Certification Board of Pediatric Nurse Practitioners and Nurses, the National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, the American Academy of Nurse Practitioners, and the National Association of Nurse Practitioners in Women's Health.[89] These organizations are known in the medical community and serve as a guide in hiring nurses.

If state licensing were eliminated tomorrow, consumers would continue to be protected by this sophisticated network of well-known private organizations that accredit health care facilities and credential medical professionals.

Brand Names: Would Additional Protections Arise without Licensing?

In many industries, markets assure quality through brand names and reputation.[90] Consumers rely on brand names as a quality signal in markets for restaurants, clothing, automobiles, computers, and air travel. Thanks to brand names, a hungry traveler in a strange city knows exactly the quality of cuisine he will get if he walks into a McDonald's versus a Chili's or a P.F. Chang's China Bistro.

Brand names have played a smaller role in health care than in other industries, perhaps because of preemption by licensing boards and the perception of quality assurance associated with licensure. However, brand name and reputation are growing as a basis for quality assurance in health care markets. Health plans that combine insurance and health care delivery under one roof, such as Kaiser Permanente, stake their reputations on the quality of their providers. The Cleveland Clinic, the Mayo Clinic, and other facilities have national reputations and are putting them to use in telemedicine.[91] Brand-name retail clinics, such as RediClinic and Minute Clinic, offer first-line health care, are staffed by nurse practitioners, and are opening up in CVS, Target, and Wal-Mart stores across the United States. These organizations have enormous incentives to maintain quality to protect their reputations. For example, Minute Clinic boasts of its adherence to evidence-based medicine guidelines.[92] Wal-Mart has bet on brand names as a proxy for quality in promoting its retail clinics. "The Clinic at Wal-Mart" brand will partner with local hospitals in "co-branded" walk-in clinics, relying on local hospitals' reputations to bring in consumers.[93] Without state licensing, brand names and reputation would play an even greater role in health care markets, such as by offering guidance to patients considering treatment in freestanding outpatient surgery centers.

Conclusion

Medical licensure fails to meet expectations in the area of discipline and consumer protection. State medical boards' disciplinary efforts can arguably be said to protect clinicians more than consumers. Many actions against clinicians are settled privately and after extended periods of time. Clinicians who have faced disciplinary actions often continue to practice, with no public disclosure of the reasons for the sanction. The persistent difference between the promise of licensing and its actual performance is summarized by one long-time observer of New York's licensing laws, who describes that state's statutory authority as "exemplary" but the state's use of that authority "shameful."[94]

Reforms that fail to appreciate the propensity of licensing authorities to place physician protection ahead of patient protection seem destined to repeat the failures of licensing. Drs. Lucian Leape and John Fromson call for sweeping changes to existing quality assurance measures, including "explicit [national] performance standards of behavior and competence" for physicians. While those standards would be based, as it happens, on the voluntary Maintenance of Certification standards developed by the private American Board of Medical Specialties, Leape and Fromson propose that reform be initiated and ultimately enforced by state medical boards.[95] Little in the state boards' decades-long record of failing to protect consumers suggests that state boards are well-suited to this task.

Those who favor replacing state regulations with national standards argue that national standards would encourage geographic mobility of medical professionals. Yet national standards for medical professional licensing would be a mistake for two reasons. First, variations across states let us see what works and what doesn't, allowing for innovation. Second, a shift toward national standards would *increase* special interest influence over licensing, leading to greater entry restrictions and less access. Eliminating licensure entirely would increase mobility as well, and would be a better policy option.

Quality assurance in today's medical marketplace doesn't come from state medical boards but from the fear of medical malpractice liability and from market mechanisms such as malpractice insurers; independent certification agencies like the Joint Commission, specialty boards, and credentials verification organizations; consumer guides such as *Consumer Reports*, HealthGrades, and Angie's List; and insurers' and providers' interest in protecting their reputations and brand names. A clinician may have a degree from an elite school, but if he has not kept abreast of the medical literature or his skills have deteriorated, his state license does almost nothing to protect patients. According to Dr. Derek van Amerongen, Chief Medical Officer of Humana Health Plans of Ohio and Indiana: "People and the legislatures read way too much into licenses. They are extremely poor proxies for quality and knowledge."[96] Oversight of medical professionals by state medical boards is at best redundant to those quality protections provided by courts and market processes. Because licensing reduces access to care and may give consumers a false sense of security, it may in fact do more harm than good.

If there were no state licensing of medical professionals, consumers would search more and demand more information, as they do with other goods. Patients could obtain as much quality assurance as licensure provides— and more—simply by looking for a board-certified physician. Brand names would play an increasing role in assuring quality care.

Additional protections likely would arise beyond the consumer's immediate purview. Credentials verification organizations would check criminal records and verify clinicians' education, training, and performance on national exams.[97] The specific information provided by licensure is not difficult to verify privately. Competition among credentials verification organizations would place such information, and potentially more, in the hands of providers and consumers. As noted above, the specialty boards already have plans to increase their monitoring of the continuing competence of board-certified physicians. When patients are injured by incompetent or negligent physicians—as some inevitably will be—they will continue to have recourse to the courts. The potential for liability, concern over reputation and brand name, and evolving standards of care would put continuous pressure on health plans, facilities, and clinicians to improve quality.

Without legislatively mandated education requirements or scope-of-practice restrictions, hospitals and other providers could better adjust their workforces when demand shifts, or when opportunities arise to reduce costs— either by making care more convenient or by saving patients money—while maintaining quality. Patients have little to lose, but much to gain, from eliminating medical licensing.

If eliminating licensing is politically infeasible, some preliminary steps might be generally acceptable. States could immediately increase workforce mobility by recognizing clinician licenses issued by other states, or Congress could require states to do so. For midlevel clinicians, such as physician assistants, physical therapists, and audiologists, eliminating education requirements beyond an initial degree (say a bachelors' degree) would let employers and consumers select the appropriate level of expertise. At the very least, state legislators should be alert to the self-interest of medical professional organizations that may lie behind the licensing proposals brought to the legislature for approval. When physician groups insist that changes in scope of practice be contingent upon evidence of improved outcomes, politicians should remember that, at present, there is no basis for the claim that patient safety is assured under the current system (an artificial construct of past legislative action) or the claim that patients are at greater risk when state regulation is relaxed.

Notes

1. Milton Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962); Reuben Kessel, "Price Discrimination in Medicine," *Journal of Law and Economics* 1 (1958): 20–53; Reuben Kessel, "The A.M.A. and the Supply of Physicians," *Law and Contemporary Problems* 35 (1970): 267–83. See also Shirley Svorny, "Licensing Doctors: Do Economists Agree?" *Econ Journal Watch* 1 (2004): 279–305. For an empirical test suggesting that physicians benefited at the expense of consumers in the 1960s, see Shirley Svorny, "Physician Licensure: A New Approach to Examining the Role of Professional Interests," *Economic Inquiry* 25 (1987): 497–509.

2. Kenneth J. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 53 (1963): 941–73, 957.

3. Shirley Svorny, "Foreign-Trained Physicians and Health Care in the United States," (Ph.D. Diss., University of California, Los Angeles, 1979); Shirley Svorny, "Consumer Gains from Physician Immigration to the U.S.: 1966–1971," *Applied Economics* 23 (1991): 331–38.

4. L. J. Goodman, *Physician Distribution and Medical Licensure in the US, 1976* (Chicago: Center for Health Services Research and Development, American Medical Association, 1977).

5. Catherine Dower, Sharon Christian, and Edward O'Neil, "Promising Scopes of Practice Models for Health Professions," Center for the Health Professions, University of California, San Francisco, 2007, p. 10, http://futurehealth.ucsf.edu/pdf_files/Scope%20Models%20Fall%202007.pdf.

6. Health Resources and Services Administration, "The Registered Nurse Population: Findings from the March 2004 National Sample Survey of Registered Nurses," ftp://ftp.hrsa.gov/bhpr/workforce/0306rnss.pdf.

7. American Academy of Physician Assistants, "2004 Physician Assistant Census Report," http://www.aapa.org/research/04census-intro.html.

8. U.S. Census Bureau, "2008 U.S. Statistical Abstract," Table 154, http://www.census.gov/compendia/statab.

9. American Academy of Nurse Practitioners, "Frequently Asked Questions," http://www.npfinder.com/faq.pdf; "Information about PAs and the PA Profession," http://www.aapa.org/geninfo1.html.

10. American Hospital Association, "2007 Chart-book" http://www.aha.org/aha/research-and-trends/chartbook/2007chartbook.html.

11. American College of Nurse Practitioners, "Nurse Practitioner Scope of Practice," http://www.acnpweb.org/i4a/pages/index.cfm?pageid=3465.

12. The Drug Enforcement Agency gives Schedule II status to drugs under the following conditions: "a high potential for abuse . . . a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions [and] abuse of the drug or other substances may lead to severe psychological or physical dependence." 21 USC Sec. 812, http://www.usdoj.gov/dea/pubs/csa/812.htm

13. University of California, San Francisco, School of Nursing, "Masters Specialty Areas," http://nurseweb.ucsf.edu/www/ix-ms.shtml.

14. American Academy of Physician Assistants, "Issue Briefs: PAs and Specialty Practice," http://www.aapa.org/gandp/issuebrief/index.html.

15. Richard O. Nenstiel et al., "Allied Health and Physician Assistants: A Progressive Partnership," *Journal of Allied Health* 26 (1997): 133–35; Teresa M. O'Connor and Roderick S. Hooker, "Extending Rural and Remote Medicine with a New Type of Health Worker: Physician Assistants," *Australian Journal of Rural Health* 15 (2007): 346–51; Justine Strand, Nancy M. Short, and Elizabeth G. Korb, "The Roles and Supply of Nurse-Midwives, Nurse Practitioners, and Physician Assistants in North Carolina," *North Carolina Medical Journal* 68 (2007): 184–85; Peter J. Zed, Peter S. Loewen, and Peter J. Jewesson, "A Response to the ACP-ASIM Position Paper on Pharmacist Scope of Practice," *American Journal of Health-System Pharm-acy* 59 (2002): 1453–57; Michael J. Dacey et al., "The Effect of Rapid Response Team on Major Clinical Outcome Measures in a Community Hospital," *Critical Care Medicine* 35 (2007): 2076–82; R. Tamara Konetzka, William Spector, and M. Rhona Limcang-co, "Reducing Hospitalizations from Long-Term Care Settings," *Medical Care Research and Review* 2007. F. J. van den Biggelaar, P. J. Nelemans, and K. Flobbe, "Performance of Radiographers in Mammogram Interpretation: A Systematic Review," *Breast*, 2007; James D. Woodburn, Kevin L. Smith, and Glen D. Nelson, "Quality of Care in the Retail Health Care Setting Using National Clinical Guidelines for Acute Pharyngitis," *American Journal of Medical Quality* 22 (2007): 457–62; Daisha J. Cipher, Roderick S.

Hooker, and Patricia Guerra, "Prescribing Trends by Nurse Practitioners and Physician Assistants in the United States." *Journal of the American Academy of Nurse Practitioners* 18 (2006): 291–96; Morton Kern, "Letter from the Editor: The Scope of Practice in the Cath Lab: Are There Limits as to What Cath Lab Staff Should Do?" *Cath Lab Digest* 14 (2006): 6–8; Leah S. Sansbury et al., "Physicians' Use of Nonphysician Healthcare Providers for Colorectal Cancer Screening," *American Journal of Preventive Medicine* 25 (2003): 179–86; G. Wivell et al. "Can Radiographers Read Screening Mammograms?" *Clinical Radiology* 58 (2003): 63–67; Roderick S. Hooker and Linda F. McCaig, "Use of Physician Assistants and Nurse Practitioners in Primary Care, 1995–1999," *Health Affairs* 20 (2001): 231–38; Roderick.S. Hooker and Linda F. McCaig, "Emergency Department Uses of Physician Assistants and Nurse Practitioners: A National Survey," *American Journal of Emergency Medicine* 14 (1996): 245–49; Gary M. Karlowicz and Jennifer L. McMurray, "Comparison of Neonatal Nurse Practitioners' and Pediatric Residents' Care of Extremely Low-Birth-Weight Infants," *Archives of Pediatrics & Adolescent Medicine* 154 (2000): 1123–26. For additional citations, see Shirley Svorny, "Physicians and Non-Physician Clinicians: Where Does Quality Assurance Come From?" in *What Can States Do to Reform Healthcare*, ed. John Graham (San Francisco: Pacific Research Institute, 2006), pp. 67–82.

16. Robert L. Phillips Jr. et al., "Can Nurse Practitioners and Physicians Beat Parochialism into Plowshares?" *Health Affairs* 21 (2002): 133–42; Carolyn Rogers, "AAOS Now, June 2007: Physician Assistant 'FAQs,'" American Academy of Orthopaedic Surgeons, http://www.aaos.org/news/bulletin/jun07/managing2.asp.

17. Richard Allen, "Physician and Nonphysician Licensure and Scope of Practice," Report of the Council on Medical Education, American Medical Association, CME Report 1-I-00, 2000, p. 5.

18. Clayton M. Christensen, Richard Bohmer, and John Kenagy, "Will Disruptive Innovations Cure Health Care?" *Harvard Business Review On Point: Curing U.S. Health Care*, 3rd ed., September-October 2000, p. 18.

19. Feldstein.

20. This paper uses the term "provider" to refer to any clinician, facility, or health plan directly involved in delivering medical care. The terms "clinician" and "professional" refer to individual practitioners.

21. Tracy A. Klein, "Scope of Practice and the Nurse Practitioner: Regulation, Competence, Expansion and Evolution," *Topics in Advanced Practice Nursing eJournal* 5 (2005), http://www.medscape.com/viewarticle/506277.

22. Dower, Christian, and O'Neil, p. 10.

23. American Academy of Physician Assistants, "Maintaining Professional Flexibility: The Case against Accreditation of Postgraduate Physician Assistant Programs," p.3, http://www.aapa.org/manual/03-MaintainProfession.pdf.

24. Dower, Christian, and O'Neil, p. 10.

25. American Association of Colleges of Nursing, "AACN Position Statement on the Practice Doctorate in Nursing," http://www.aacn.nche.edu/DNP/DNPPositionStatement.htm

26. Bricker & Eckler LLP, "Ohio's New Physician Assistant Law," Health Care Client Bulletin No. 06-01, 2006, Columbus, Ohio, 2006.

27. Mickie S. Rops, "White Paper on Occupational Regulation," *American Journal of Electroneurodiag-nostic Technology* 44 (2004): 244–90.

28. "Say What? Can You Hear the Sound of Money?" *Sacramento Bee*, April 20, 2005.

29. Federation of State Medical Boards, "Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety," http://www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf p. 1.

30. Myrle Croasdale, "Nonphysicians Bypass Legislatures, Use Own Boards to Expand Scope," *AMNews*, Feb 12, 2007.

31. Ronald M. Davis, "From the President," *AMA eVoice*, July 19, 2007.

32. Coalition for Patients' Rights, http://www.patientsrightscoalition.org.

33. Ronald L. Scott, "Scope of Practice Review Process," University of Houston Health Law and Policy Institute, *Health Law Perspectives*, April 21, 2005.

34. Dower, Christian, and O'Neil, p. 10 .

35. See, for example, American Academy of Pediatrics Committee on Pediatric Workforce, "American Academy of Pediatrics' Policy Statement, Scope of Practice Issues in the Delivery of Pediatric Health Care," *Pediatrics* 111, no. 2 (2003): 426–35.

36. Nenstiel et al.

37. Federation of State Medical Boards, "Assessing Scope of Practice in Health Care Delivery."

38. Ronald L. Scott, "Optometrists Seek to Expand Scope of Practice Privileges." University of Houston Health Law and Policy Institute, *Health Law Perspectives*, April 21, 2005.

39. Dower, Christian, and O'Neil, p. 10, .

40. American Society of Anesthesiologists, "The Scope of Practice of Nurse Anesthetists—January 2004."

41. Damon Adams, "AMA Wants Doctor Oversight for Diagnostic Tests," AMNews, December 4, 2006.

42. Myrle Croasdale, "State Medical Groups Resist Naturopaths' Licensure Push," *AMNews*, March 27, 2006.

43. Myrle Croasdale, "Physicians Sue Missouri over Midwifery Law," *AMNews*, August 13, 2007.

44. Myrle Croasdale, "California Expands Oral Surgeons' Scope of Practice," *AMNews*, November 6, 2006.

45. Myrle Croasdale, "Nonphysicians Bypass Legislatures."

46. Myrle Croasdale, "Texas Court Finds Board Exceeded Its Authority and Podiatrists' Scope," *AMNews*, May 5, 2008.

47. American Academy of Physician Assistants, "Where Physician Assistants Are Authorized to Prescribe," http://www.aapa.org/gandp/rxchart.html.

48. "The Helping Healers; Physician Assistants Have Become an Increasingly Common Healthcare Option for Times When There Isn't a Doctor in the House," *New Orleans Times-Picayune*, October 18, 2001, p. 1.

49. On the basis of a survey of medical boards, Bovbjerg et al. report median values for medical board spending as 21 percent for credentialing, 49 percent for investigation, and 27 percent for administration. Randall R. Bovbjerg, Pablo Aliaga, and Josephine Gittler, "State Discipline of Physicians: Assessing State Medical Boards through Case Studies." Prepared for Office of Disability, Aging, and Long-term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Contract #HHS-100-03-0011, February 2006.

50. American Nurse Credentialing Center, "Certification," http://www.nursecredentialing.org/cert/index.htm

51. Bovbjerg, Aliaga and Gittler.

52. Eric G. Campbell et al., "Professionalism in Medicine: Results of a National Survey of Physicians," *Annals of Internal Medicine* 147, no. 11 (2007): 795–802.

53. Lucian L. Leape and John A. Fromson, "Problem Doctors: Is There a System-Level Solution?" *Journal of Medical Licensure and Discipline* 93, no. 1 (2007): 109. Notably, the *Journal of Medical Licensure and Discipline* is a publication of the Federation of State Medical Boards.

54. Timothy S. Jost et al., "Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards," *Health Matrix: Journal of Law-Medicine* 3, no. 1 (1993): 309–38.

55. Bovbjerg, Aliaga, and Gittler.

56. Gary M. Fournier and Melayne Morgan McInnes, "Medical Board Regulation of Physician Licensure: Is Excessive Malpractice Sanctioned?" *Journal of Regulatory Economics* 12, no. 2 (1997): 113–26.

57. Seth Oldmixon, "The Great Medical Malpractice Hoax: NPDB Data Continues to Show Medical Liability System Produces Rational Outcomes," Public Citizen's Congress Watch, http://www.citizen.org/publications/release.cfm?ID=7497.

58. Bovbjerg, Aliaga, and Gittler.

59. Darren Grant and Kelly C. Alfred, "Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards," *Journal of Health Politics, Policy and Law* 32, no. 5 (2007): 867–85; Don Colburn and Steve Woodward, "Few Doctors Lose

Licenses for Missteps," *The Oregonian*, April 19, 2005.

60. Grant and Alfred.

61. Lin, Rong-Gong II, "Lag Widens in Medical Complaints; The State Board Now Takes an Average of 2 ½ Years to Resolve Cases," *Los Angeles Times*, March 17, 2008.

62. Grant and Alfred.

63. Shirley Svorny, "Should We Reconsider Licensing Physicians?" *Contemporary Policy Issues* [now *Contemporary Economic Policy*] 10 (1992): 31–38; Shirley Svorny, "The Changing Role of Licensure in Promoting Incentives for Quality in Health Care," in *American Health Care: Government, Market Processes, and the Public Interest*, ed. Roger D. Feldman (Oakland: Independent Institute, 2000).

64. Todd M. Ebersole, "Emerging Theories of HMO Liability for Negligence of Its Network Providers," *Orange County Lawyer* 41 (1991): 30–33; David L. Trueman, "Managed Care Liability: Current Issues and Trends," in *Health Law Handbook*, ed. A. Goslin (Eagan, MN: West Publishers, 2006), pp. 111–74, 191; Patricia M. Danzon, "Tort Liability: A Minefield for Managed Care?" *Journal of Legal Studies* 26, no. S2 (1997): 491–519; William M. Sage, "Enterprise Liability and the Emerging Managed Health Care System," *Law and Contemporary Problems* 60, no. 2 (1997): 159–210.

65. Trueman.

66. Ebersole; Trueman.

67. Ibid.

68. Ibid.

69. Medical Liability Mutual Insurance Company, "Physicians and Surgeons—New York State: Premium Discounts," http://www.mlmic.com/portal/UnderWritingPSNYS.aspx.

70. See Frank Sloan and Lindsay Chepke *Medical Malpractice* (Cambridge, MA: MIT Press, 2008), pp. 212–30; Derek A. Weycker and Gail A. Jensen, "Medical Malpractice among Physicians: Who Will Be Sued and Who Will Pay?" *Health Care Management Science* 3 (2000): 269–77. Sloan and Chepke cite a 1985 survey by Schwartz and Mendelson, that found most companies employ surcharges, but few physicians are subject to surcharges, as malpractice claims are concentrated among a small subset of physicians. William B. Schwartz and Daniel N. Mendelson, "Physicians Who Have Lost Their Malpractice Insurance: Their Demographic Characteristics and the Surplus-Lines Companies that Insure Them," *JAMA* 262 (1989): 1335–41.

71. U.S. General Accounting Office, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," GAO-030702, June 2003, p. 38, http://www.gao.gov/new.items/d03702.pdf. The authors suggest that physician-owned companies may have advantages in underwriting, as they may have "intimate knowledge of local doctors and hospitals and the legal customs and climate."

72. William B. Schwartz and Daniel N. Mendel-son, "The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence," *Journal of the American Medical Association* 262 (1989): 1342–46.

73. Vermont Medical Malpractice Study Commission, "Medical Malpractice Study Committee Meeting Minutes, January 26, 2005," p. 3, http://www.bishca.state.vt.us/InsurDiv/medmal_studygroup/Jan26meeting/minutes_Jan26.pdf.

74. Milliman Consultants and Actuaries, "Item 10: 'Whether Any Efforts Have Been or Should Be Undertaken to Reduce the Incidents of Medical Malpractice through the Underwriting Process'"; Vermont Medical Malpractice Study Commission, "Medical Malpractice Liability Insurance in Vermont; A Report to the General Assembly," Exhibit 61, pp. 70–84, http://www.bishca.state.vt.us/InsurDiv/medmal_studygroup/exhibits-secs/medmal_Section4.pdf.

75. State of California Department of Insurance, Application for Approval of Insurance Rates by Professional Underwriters Liability Insurance Company (Doctors Company Insurance Group), Filing number 06-2574, Filed April 17, 2006.

76. Sloan and Lindsay, pp. 212–30.

77. Karen Edwards, "Texas Court Rules Podiatry Scope of Practice Includes Ankle," *Podiatry Online*, http://www.podiatryonline.com/main.cfm?pg=pro_development&fn=Texasdecision. Emphasis added.

78. 45 CFR Subtitle A (10-1-06 Edition), Part 60 (pages 140–47), http://www.npdb-

hipdb.com/legislation/Final_Regulations_Title_IV.pdf. However, a 2000 report on the National Practitioner Data Bank by the U.S. Government Accountability Office found substantial underreporting. Most troubling to the report authors was underreporting of disciplinary actions (relative to malpractice settlements or judgments). The authors note that disciplinary actions are better indicators of clinician competence and should be a primary focus of data-gathering efforts. The GAO also noted severe problems related to data quality, problems with completeness, timeliness, and accuracy. Federal agencies themselves have ignored the requirement to report payment of malpractice claims in cases against government doctors. Officials decided not to report cases in which they felt the care met appropriate standards, despite the legal requirement to report. U.S. Government Accountability Office, "National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability." GAO-01-130, 2000; Daniel R. Levinson, "HHS Agencies' Compliance with the National Practitioner Data Bank Malpractice Reporting Policy," Office of the Inspector General, U.S. Department of Health and Human Services, OEI-12-04-00310, 2005.

79. "An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 15,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards." The Joint Commission, "About the Joint Commission," http://www.joint-commission.org/AboutUs/.

80. Sage; Joint Commission, "Benefits of Joint Commission Accreditation," http://www.jointcommission.org/HTBAC/benefits_accreditation.htm

81. For a discussion of competency validation, see Jane Alberico and Adrianne E. Avillion, *Competency Management for the Medical-Surgical Unit* (Marble-head, MA: HC Pro, 2005) and other books published by HC Pro.

82. National Committee for Quality Assurance, "CR Standards and Guidelines: Credentialing and Recredentialing," http://web.ncqa.org/tabid/407/Default.aspx.

83. National Committee for Quality Assurance, "CVO Certification Options," http://web.ncqa.org/tabid/418/Default.aspx.

84. Federation of State Medical Boards, "FCVS Benefits," http://www.fsmb.org/fcvs_benefits.html.

85. American Board of Medical Specialties, "American Board of Medical Specialties Board Certification Editorial Background," http://www.abms.org/news_and_events/media_newsroom/pdf/abms_editorialbackground.pdf.

86. Christine K. Cassel and Eric S. Holmboe, "Credentialing and Public Accountability: A Central Role for Board Certification," *Journal of the American Medical Association* 295 (2006): 939–40.

87. Ann S. O'Malley, and Ann S. and James D. Reschovsky, "No Exodus: Physicians and Managed Care Networks," Center for Studying Health Care System Change Tracking Report no. 14, 2006, http://www.hschange.org/CONTENT/838/.

88. American Nurse Credentialing Center.

89. Nurse Practitioner Alternatives, Inc., "NP FAQs," http://www.npedu.com/faq1.htm

90. Randall G. Holcombe, "Does Licensing of Health Care Professionals Improve Health Care?" *Journal of Medical Licensure and Discipline* 93 (2007): 13–19.

91. The Cleveland Clinic plays off of its reputation to offer remote second opinions: "MyConsult: Second Medical Opinions from Doctors at the Cleveland Clinic," http://www.eclevelandclinic.org/displayContent.jsp?productId=standard&document=document/productOverview.

92. Michael Howe, "Clinics a Key Part of Health Reform," *The Boston Globe*, September 10, 2007; Anne M. Snowden et al., "MN Community Measurement 2007 Health Care Quality Report," http://www.mnhealthcare.org/Resources/2006/FinalReport/2007%20Full%20Report.pdf. That report compared Minnesota providers' adherence to evidence-based medical guidelines. Minute Clinic performed above average for appropriate treatment for children with upper respiratory infection (86 percent compliance) and received the highest performance rating for appropriate testing for children with sore throat (99 percent compliance).

93. WalMartStores.com, "'The Clinic at Wal-Mart' to Open at Atlanta, Little Rock, and Dallas Super centers," http://walmartstores.com/FactsNews/NewsRoom/7922.aspx.

94. Mathew L. Lifflander, "Spitzer Has a Chance to Cut Medical Errors, Save Lives." *Times Union*, December 17, 2006; Lifflander is a lawyer and served as director of the state Assembly's Medical Practice Task Force from 1977 to 1979.

95. Leape and Fromson.

96. Personal correspondence, July 29, 2006. Copy in author's files. Dr. Amerongen is the author of "Physician Credentialing in a Consumer-Centric World," *Health Affairs* 21, no. 5 (2002): 152–56.

97. Shirley Svorny, "Medical Licensing: Examining the Desirability of Existing Public Policy in the Context of Technological Change," in *The Half-Life of Policy Rationales: How New Technology Affects Old Policy Issues*, ed. Fred. E. Foldvary and Daniel B. Klein (New York: New York University Press, 2003).

Chapter 75

Medicaid and SCHIP

by Shirley Svorny

Cato Handbook for Policymakers, 7th Edition, Chapter 13

13. Medicaid and SCHIP

State legislators should

- deregulate health care and health insurance, and
- demand that the federal government grant them flexibility, not additional funds, to administer their Medicaid and SCHIP programs.

Congress should

- reform Medicare and the tax treatment of health insurance,
- deregulate health care and health insurance,
- eliminate any federal entitlement to Medicaid or SCHIP benefits,
- freeze each state's Medicaid and SCHIP funding at 2009 levels,
- give states total flexibility to use Medicaid and SCHIP funds to achieve a few broad goals, and
- eventually phase out all federal funding of Medicaid and SCHIP.

Americans want to help the needy obtain medical care. Our first obligation to the needy, however, is not to increase their numbers. Thus, the first step lawmakers should take to assist the needy is to eliminate subsidies and regulations that impede market competition. By making

medical care of ever-increasing quality available to ever-increasing numbers of people, a free market would reduce the number of people needing assistance.

No matter how well a free market expands quality and access, however, there will always be seriously ill people who cannot afford medical care, or who could have purchased health insurance but chose not to do so. This chapter discusses how the federal and state governments might better address that problem.

The Samaritan's Dilemma

However we choose to help those in need, we confront what economists call "the Samaritan's dilemma": any effort to help the needy will induce others to take advantage of that assistance. Coined by Nobel Prize–winning economist James Buchanan, that term derives from the New Testament story of the Good Samaritan, who came to the aid of a traveler who had been beaten by thieves. Buchanan reasons that if the Samaritan decides to assist more unlucky travelers, travelers would likely take less care to avoid thieves and other hazards. Providing assistance to people can induce them to take less care of themselves.

For a modern manifestation of the Samaritan's dilemma, consider that in 1996 Congress reduced federal welfare benefits and cut millions of recipients from the welfare rolls. At the time, many predicted that cutting welfare would increase poverty. The opposite occurred. When people left the welfare rolls, poverty fell—often dramatically—for every racial category and age group, including children. In every year following 1996, the poverty rate has remained lower than at any point in the 17 years leading up to welfare reform. That fact suggests that the federal government had induced otherwise able-bodied people to become dependent on welfare.

The Samaritan's dilemma calls attention to the certainty that providing too little assistance will result in unnecessary suffering, but providing too much assistance will increase the burden of charity while it reduces society's ability to bear that burden. When assistance becomes more generous, more people will depend on it, and fewer will contribute to the economy and to charity, both public and private.

The Samaritan's dilemma is ubiquitous and unavoidable. It plagues both public and private charity.

To be effective, then, charitable efforts must attempt to distinguish between the truly needy and those who could care for themselves. No entity, public or private, can do that perfectly. Yet some approaches are more effective than others. Private charities, such as Habitat for Humanity, have the incentive and the ability to ensure that their resources assist only the truly needy. If it did not, Habitat could lose funding when donors learn their contributions are going to able-bodied people who don't need assistance.

Government, in contrast, has little ability or incentive to navigate carefully the Samaritan's dilemma. Politicians must craft broad eligibility rules for government welfare programs. Typically, these take the form of a legal entitlement to benefits for anyone who meets certain criteria. The bureaucrats who administer those programs must treat all qualifying individuals equally. If the bureaucracy identifies beneficiaries who technically meet those criteria, but nevertheless need no assistance, the bureaucrats have little ability or incentive to exclude them.

In fact, they have the opposite incentive since their careers depend on a thriving welfare program. Even if the bureaucrats were to exclude those non-needy beneficiaries, the beneficiaries could sue the government for withholding benefits to which they are legally entitled. Unlike private charity, public charities rarely see their funding reduced for providing assistance to those who don't need it, because taxpayers don't have the choice to withdraw their "contributions." Either they pay their taxes, or they go to jail. As a result, government charities, such as cash assistance, Medicaid, and the State Children's Health Insurance Program, tend to err on the side of providing too much assistance and subsidizing people who don't need it.

There are ways that government can make medical care and health insurance affordable for low-income Americans that do not involve a Samaritan's dilemma. Federal and state governments can reform Medicare (see Chapter 12) and the tax treatment of health care (see Chapter 14), as well as deregulate medicine (see Chapter 15) and health insurance (see Chapter 16).

Government can better navigate the Samaritan's dilemma, however, by reforming and reducing the size of Medicaid and the State Children's Health Insurance Program.

Medicaid

The federal government and state and territorial governments jointly administer Medicaid—or more precisely, the 56 separate Medicaid programs throughout the United States. Medicaid participation is ostensibly voluntary for states, if not for taxpayers. States that wish to participate (all states do) must provide a federally mandated set of health benefits to a federally mandated population of eligible individuals. In return, each state receives federal funds to administer its program. On average, 57 percent of Medicaid funding comes from the federal government and 43 percent comes from the states. States can make their Medicaid benefits more generous than the federal government requires and can also extend eligibility to more people than the federal government requires. For beneficiaries, Medicaid is an entitlement. So long as they meet the eligibility criteria, they can receive benefits.

According to the Kaiser Family Foundation, in 2005 Medicaid enrollment reached nearly 60 million individuals. Medicaid primarily serves four low-income groups: mothers and their children, the disabled, the elderly, and those needing long-term care. The elderly and disabled comprised 24 percent of beneficiaries, but accounted for 70 percent of expenditures on benefits. Half the enrollees were children, while other adults comprised the remaining 26 percent of enrollees. Those two groups— children and nonelderly, nondisabled adults—comprised 76 percent of enrollees but accounted for 30 percent of expenditures on benefits.

The federal government's method for distributing Medicaid funds to states encourages fraud, creates perverse incentives for state officials, and encourages states to expand their programs to people who don't need assistance. The federal government provides Medicaid funds to each state in proportion to what the state itself spends. The more a state spends on its Medicaid program, the more it receives from the federal government. States receive at least $1 from the federal government for every dollar the state spends. Some states, however, receive as much as $3 for each dollar they put forward. Thus, states can double, triple, or even quadruple their

money by spending more on Medicaid. Indeed, states that use fraudulent schemes, such as *pretending* to increase Medicaid spending in order to draw down federal matching funds, can increase their take even further. The federal Medicaid "match" is open-ended; Congress will match any amount a state puts forward.

The availability of matching federal funds creates perverse incentives for state officials to underfund other priorities. Spending $1 on police buys $1 of police protection, but spending $1 on Medicaid buys $2 or more of medical benefits. The federal match also makes lawmakers extremely reluctant to cut Medicaid spending. Cutting $1 of police protection causes $1 of political pain, but results in $1 of budget savings. Obtaining just $1 of budgetary savings through Medicaid cuts requires inflicting $2 to $4 worth of political pain.

Those perverse incentives combine to encourage states to expand their programs to millions of non-needy recipients. For example:

- According to the Urban Institute, about one-fifth of adults and children who are *eligible* for Medicaid nonetheless obtain private coverage. The fact that some 20 percent of those who fall within states' Medicaid eligibility criteria obtain private coverage suggests that many who are enrolled could obtain private coverage as well.
- Middle-class families frequently use Medicaid to pay for nursing-home and other long-term care expenses of their elderly members. A cottage industry of estate planners has emerged to help such individuals artificially impoverish themselves to become eligible for Medicaid. Many elderly Medicaid enrollees could have purchased private long-term care insurance. Economists Jeffrey Brown of the University of Illinois at Urbana-Champaign and Amy Finkelstein of MIT estimate that Medicaid's long-term care benefits discourage 66 to 90 percent of seniors from purchasing such insurance on the private market.
- The 1996 welfare reform law also cut eligibility to Medicaid for noncitizen immigrants. Harvard economist George Borjas found that, again contrary to expectations, health insurance coverage among noncitizen immigrants *increased* after their eligibility for Medicaid was reduced—an effect that could not be explained by the robust economy of the 1990s. Borjas argues that affected immigrants increased their work effort and found jobs with health benefits.
- Economists Jonathan Gruber of MIT and Kosali Simon of Cornell University estimate that when Medicaid expands eligibility to new groups, "the number of privately insured falls by about 60 percent as much as the number of publicly insured rises." That suggests that many people substitute Medicaid coverage for private coverage.

Medicaid's poor navigation of the Samaritan's dilemma has even permeated popular culture. The 2004 Oscar-winning film *Million Dollar Baby* showcased two forms of Medicaid abuse: One of the film's characters declined the gift of a new house so she could remain eligible for Medicaid (rather than sell the house and purchase her medication herself). Later, the family of a wealthy invalid encouraged the invalid to transfer her assets to the family so that taxpayers (through Medicaid) would pay the wealthy invalid's medical expenses.

Indeed, the more a state expands its Medicaid program, the more difficult it becomes for everyone to afford private insurance. Economists Mark Duggan of the University of Maryland

and Fiona Scott Morton of Yale University find Medicaid's drug-pricing controls effectively increase by 13 percent the prices that private purchasers pay for prescription drugs. If grandma's medications cost her $1,000 per year, some $117 of that is a hidden tax attributable to Medicaid.

The State Children's Health Insurance Program

What is true of Medicaid is true of the State Children's Health Insurance Program. Congress created SCHIP in 1997 to expand health insurance coverage among children in families that earned too much to be eligible for Medicaid but too little to afford private health insurance.

The federal government funds state SCHIP programs much as it funds Medicaid, but with two main differences. First, states receive a larger federal match under SCHIP than under Medicaid. Overall, the federal government funds 69 percent of the cost of state SCHIP programs, whereas states forward only 31 percent. Each state can *at least* triple its money by spending on SCHIP. Some states can "pull down" $4 or $5 from the federal government—really, from taxpayers in other states—for each $1 they spend on SCHIP. Second, the federal government limits the overall amount it will contribute to each state's SCHIP program, though that cap is not as binding as it may appear. States such as Georgia sometimes spend all their federal SCHIP funds before the end of the fiscal year, and then petition the federal government for additional funds. Another way to describe those states' behavior is to say that they demand more money and dare Congress to throw sick children off the SCHIP rolls. Congress has repeatedly bailed out such states, effectively rewarding them for committing to spend more federal dollars than they were allowed.

As a result of these perverse incentives, states such as New Jersey have expanded SCHIP eligibility to children in families of four earning as much as $72,000 per year. New York proposed expanding the program to families of four earning $82,000 per year. The Bush administration subsequently refused to provide federal SCHIP funds for families earning over 250 percent of the federal poverty level (about $51,000 for a family of four) unless a state enrolls in Medicaid and SCHIP 95 percent of eligible individuals below that threshold. (The future of that directive is uncertain.) Compared with Medicaid, SCHIP targets families higher up the income scale, who are therefore more likely to have private health insurance. As a result, SCHIP leads to even greater "crowd-out" of private insurance than Medicaid. The Congressional Budget Office reports that by 2006, some 670,000 *adults* had enrolled in the program.

Federal and state politicians devote significant resources to these programs even though expanding coverage may not be the best way to improve the health of targeted populations. Although Medicaid and SCHIP probably do improve health outcomes, economists have found no evidence that these programs produce the greatest possible health improvements for the money spent. Economists Helen Levy and David Meltzer write:

> It is clear that expanding health insurance is not the only way to improve health…. Policies could also be aimed at factors that may fundamentally contribute to poor health, such as poverty and low levels of education. There is no evidence at this time that money

aimed at improving health would be better spent on expanding insurance coverage than on any of these other possibilities.

Major reform of Medicaid and SCHIP is long overdue.

Congress Should Reform Medicaid and SCHIP as It Reformed Welfare

It makes little sense for taxpayers to send money to Washington, so those funds can be sent back to their state capitol with strings and perverse incentives attached. Congress should devolve control over Medicaid and SCHIP to the states. The states can then decide whether and how to maintain their own programs, and could learn from the successes and failures of one another's experiments.

In 1996, Congress eliminated the federal entitlement to a welfare check; placed a five-year limit on cash assistance; and froze federal spending on such assistance, which was then distributed to the states in the form of block grants with fewer federal restrictions. The results were unquestionably positive. Welfare rolls were cut in half, and poverty reached the lowest point in a generation.

The federal government should emulate this success by eliminating federal entitlements to Medicaid and SCHIP benefits, freezing federal Medicaid and SCHIP spending at current levels, and distributing those funds to the states as unrestricted block grants. That would eliminate the perverse incentives that favor Medicaid and SCHIP spending over other state priorities, and that encourage states to defraud federal taxpayers. According to Congressional Budget Office projections, freezing Medicaid and SCHIP spending at 2009 levels would produce $979 billion in savings by 2018. That would significantly reduce or even eliminate future federal deficits. In time, the federal government should give the states full responsibility for Medicaid by eliminating federal Medicaid spending while concomitantly cutting federal taxes.

States should hasten these reforms by pressuring the federal government for maximum flexibility in administering their Medicaid programs. With unrestricted Medicaid block grants, states that wanted to spend more on their Medicaid programs would be free to raise taxes to do so, and vice versa.

Suggested Readings

Borjas, George J. "Welfare Reform, Labor Supply, and Health Insurance in the Immigrant Population." *Journal of Health Economics* 22 (November 2003).

Cannon, Michael F. "Medicaid's Unseen Costs." Cato Institute Policy Analysis no. 548, August 18, 2005.

_____. "Sinking SCHIP: A First Step toward Stopping the Growth of Government Health Programs." Cato Institute Briefing Paper no. 99, September 13, 2007.

Cannon, Michael F., and Michael D. Tanner. *Healthy Competition: What's Holding Back Health Care and How to Free It.* Washington: Cato Institute, 2007.

Moses, Stephen. "Aging America's Achilles' Heel: Medicaid Long-Term Care." Cato Institute Policy Analysis no. 549, September 1, 2005.

—Prepared by Michael F. Cannon

SECTION SIX:

IT NOW FALLS TO CONGRESS

Chapter 76

It Now Falls to Congress

by Roger Pilon

ObamaCare was a mistake from the start, a massive effort by the federal government to take over and control one-sixth of the economy—indeed, the part that concerns the most complex and intimate details of life, our health. It's the most ambitious example to date of the political hubris progressives have displayed for over a century now, the belief that government can solve all of our problems.

Today, the Supreme Court had an opportunity to put a brake on that hubris. Four justices, led by Justice Kennedy, would have done so. But Chief Justice Roberts joined the four justices who are Exhibit A of the modern hubris, writing for the Court to uphold almost all of this monstrous intrusion on our liberty and on the very theory of the Constitution. And he did so on the flimsiest of rationales for deciding a constitutional question—precedent. If precedent carried the weight Roberts gave it today, we'd still be riding in segregated trains and sending our children to segregated schools.

So let's look a bit more closely at this decision—which, to be clear, will take some time to fully digest. The Court rejected the administration's main argument for the individual mandate, based on Congress's power to regulate interstate commerce: "The power to regulate commerce presupposes the existence of commercial activity to be regulated." But that's a slim victory for those of us who'd argued that "not buying insurance" is not an act of commerce. How often does Congress try to regulate "non-commerce" under its power to regulate interstate commerce? As best anyone could tell, this was the first time Congress had ever tried such an expansion of its power.

And because there's no "commerce," the Court rejected the parasitic Necessary and Proper Clause argument, too, which affords Congress the means to carry out its other powers.

But Robert's bought the administration's second fallback argument—that the penalty for not buying insurance is a tax, even though the administration abandoned that argument during the course of litigation, and even though calling it a "tax" would seem to implicate the Anti Injunction Act, which would preclude the Court from even deciding this case until someone was forced to pay the tax, which won't happen for another couple of years. Yet the Court apparently brushed aside that AIA impediment—talk about lawlessness—in its rush to uphold ObamaCare.

And so there's your foundation for the decision: the individual mandate is constitutional based on Congress's power to tax: Congress can "tax" those who don't buy government approved health insurance. Don't ask what kind of a "tax" that is! It's not an income tax. Nor is it a duty, impost, or excise tax, the only kinds of taxes recognized under the Tax Clause of the Constitution, where Roberts purports to rest Congress's power; and it certainly isn't "uniform throughout the United States," as is required for those taxes. It's sui generis, which is a polite way of saying it's unconstitutional—if we take the Constitution seriously.

But that's just the problem, isn't it? As James Madison, the principal author of the Constitution, Thomas Jefferson, and virtually everyone else at the Founding made clear, the power to tax, the first of

Congress's 18 enumerated powers, like the power to borrow, Congress's second enumerated power, was designed to enable Congress to obtain the funds needed to carry out its other enumerated powers or ends. It was not, as Madison made clear in Federalist 41, and often on the floor of Congress, an independent power to tax for any purpose at all. Search as you will through those 18 enumerated powers and you will find no power to enact ObamaCare or anything like it. And please don't say that the taxing power serves the commerce power which in turn authorizes the individual mandate, because the Court nixed that second leap today.

But all of that was lost in 1937 when the New Deal Court, cowed by Roosevelt's infamous Court-packing threat, suddenly "found" that Congress had an independent power to tax and spend for the "general welfare," a power that had escaped the Court's attention for 150 years. That's the "precedent" for today's decision—which, like the precedent itself, turn's the Constitution on its head, giving us effectively unlimited government.

It will fall to Congress, then, to undo this monstrosity, if it can. Under the Constitution, as written, health care would be provided like any other service that's stayed largely free from government control. But starting with World War II wage-and-price controls and the tax advantages that were given to employer-provided health insurance, it's been one government intrusion after another and a textbook example of how government can completely mess up what free markets plus voluntary charity can efficiently order while respecting the rights and dignity of people in the process. That's a vision, the Founders' vision, that Congress can restore, even if this Court has failed to do its part today.

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Chapter 77

We Won Everything but the Case

by Ilya Shapiro

I could never have imagined that the Supreme Court's ringing endorsement of the legal theory I'd pushed for more than two years could feel this hollow. That is, five justices agreed in no uncertain terms that the federal government cannot require people to buy something, cannot regulate inactivity, cannot impose economic mandates as a means of regulating interstate commerce. And yet, Obamacare stands.

The Court adopted the "frivolous" legal argument "concocted" by David Rivkin and Randy Barnett that there are judicially enforceable limits on federal regulatory authority over national economic affairs. It vindicated the "political opportunism" of Virginia Attorney General Ken Cuccinelli and then-Florida Attorney General Bill McCollum to file "sour grapes" lawsuits challenging the Affordable Care Act the same day President Obama signed the law. And yet, Obamacare stands.

Indeed, with the possible exception of Florida district judge Roger Vinson—whose magisterial opinion Cato put on the front page of its March/April 2011 *Policy Report*—the Supreme Court went farther than any lower court that ruled against the government. Not only did the Court for the first time endorse the activity/inactivity and regulate/mandate distinctions that our opponents derided as appearing "nowhere in the Constitution" but *seven* justices found the Medicaid expansion unconstitutionally coercive of state sovereignty. And yet, Obamacare stands.

How did this happen? Well, as even Fox News and CNN now know, Chief Justice John Roberts put a new gloss on Congress's taxing power just as he rediscovered the meaning of the Commerce, Necessary and Proper, and Spending Clauses. In 13 cryptic pages, Roberts fashioned a not-quite-silk purse out of a sow's ear, salvaging—to continue the porcine metaphor—Obamacare's bacon from the constitutional flames.

That is, the Chief Justice recharacterized a provision explicitly stating that people "shall" obtain health insurance or pay a "penalty" into a "choice," a "tax citizens may lawfully choose to pay in lieu of buying health insurance."

I wonder whether this means that the next time I'm driving I should consider whether to obey the speed limit or simply pay the "speeding tax." Surely I'll spend less time pondering that "choice" than the one a mugger would give me regarding my money or my life.

In any event, Roberts went on to cabin his taxing-power justification in such a way as to make it seem that this ticket would be good only for this train: the tax (if one chooses to pay it) is not so burdensome as to be punitive, is enforced through normal tax-collection means (with no threat of criminal sanctions), and merely encourages rather than requires certain behavior.

Moreover, this voluntary unicorn-like tax is not a "direct" tax—which the Constitution says must be drawn such that each state pays in proportion to its population—because it's neither a tax on property nor a "capitation" (defined as "a tax that everyone must pay simply for existing"). Instead, Roberts explains, this novel tax is triggered by a specific circumstance: "earning a certain amount of income but

not obtaining health insurance."

I guess that means it's not an income tax—where income itself is the trigger and sole basis for assessment—which leaves, among the exactions the Constitution authorizes only excises. (We can all agree that the non-punitive indirect voluntary tax incentive isn't a "duty" or "impost.")

But excises are taxes on a use of property, a transaction, privilege, or activity, and here Roberts has already recognized there's no property, transaction, or activity involved. You just have this *condition*—not owning health insurance—that triggers the tax. Does that mean that being free from a government command ("shall") to buy health insurance is a privilege?

I don't think that's what the Chief Justice meant at all, and I'm not trying to be cute. The point is that the opinion's taxing-power section is a complete head-scratcher. Even Justice Ruth Bader Ginsburg, who was skeptical about the taxing-power theory during oral arguments, expressed some disbelief at Roberts's theory in orally summarizing her partial dissent on behalf of the no-limits-on-federal-power bloc.

Quite beyond the direct/indirect/excise/whatever tax issue, it seems odd to have a result whereby Congress cannot make you buy something but can tax you for not buying it. As Roberts himself wrote, "If it is troubling to interpret the Commerce Clause as authorizing Congress to regulate those who abstain from commerce, perhaps it should be similarly troubling to permit Congress to impose a tax for not doing something."

Remember, we're not talking tax credits for installing solar panels—an incentive—as an alternative to a solar-panel mandate, but rather tax *debits* for not installing them. And that's after you suspend disbelief and hypothesize that Congress had actually structured its "minimum coverage provision" as a tax rather than regulation-plus-penalty.

Nevertheless we're left with a definitive ruling that Congress can't make you buy broccoli—Roberts was clear on that, explicitly rejecting the government's pooh-poohing of that infamous hypothetical—but can tax you for not buying broccoli. That's a constitutional distinction without a practical difference.

Where there may be a practical difference is in the fact that enacting new taxes—particularly for not buying things—is typically more difficult than creating new regulations. But that practical check does not obviate the constitutional ones that should be there: we don't trust our liberties to a political majority's sense of noblesse oblige. Indeed, the judiciary is by definition a counter-majoritarian institution.

And, of course, in this particular case, Congress and the president avoided even running that political gauntlet by explicitly disavowing any attempts to characterize Obamacare as raising taxes on the middle class.

Nor did John Roberts vindicate his constitutional legerdemain by rewriting the Medicaid expansion to tie only *new* federal funding to an acceptance of burdensome and fundamentally transformative regulations. While correct on its face—and a good exposition of the Spending Clause and what strings the federal government can attach to its funds—his analysis on that point is relevant only to a hypothetical statute, not the one that Congress actually passed.

In sum, we take away from *NFIB v. Sebelius* the comfort that the federal regulatory authority recognized in *Wickard* and *Raich* has not been expanded and that the federal government can't compel states to do its bidding. The size and warmth of that comfort will be determined in future cases, which will come when Congress inevitably again pushes the envelope of its enumerated powers.

But is federal overreach inevitable? Will the people ever rein in their elected representatives—or, more

fundamentally, the temptation to demand goodies from the public fisc. That's the ultimate question left by the baby-splitting of a chief justice who, after doing so much good work, ultimately refused the charge given him by his model, Chief Justice John Marshall, to say what the law is.

"It is not our job to protect the people," Roberts wrote, "from the consequences of their political choices."

Ok, then, people, the ball is in your court: How much longer will you allow Obamacare and other offenses against the Constitution and good sense to stand?

This article appeared on Scotusblog.com on June 29, 2012.

Chapter 78

John Roberts, Judicial Pacifist

by Ilya Shapiro

The Supreme Court's health-care ruling displayed an unfortunate convergence of two unholy strains of constitutional jurisprudence: liberal activism and conservative pacifism.

Liberal activism, typified by the four Democratic-appointed justices, finds in the Constitution no judicially administrable limits on federal power. Conservative pacifism, a knee-jerk reaction to the liberal activism of the 1960s and '70s, argues that we must defer to Congress as much as possible, presuming its legislation to be constitutional.

Neither approach considers that the Constitution's structural provisions—federalism, separation and enumeration of powers, checks and balances—aren't just a dry exercise in political theory, but a means to protect individual liberty against the concentrated power of popular majorities.

So, to avoid overturning the Affordable Care Act, Chief Justice John Roberts rewrote two important parts of it, turning the individual mandate into a tax and reworking the Medicaid expansion. Ever the good conservative, Roberts was attempting to show judicial "restraint."

Frankenstein's monster

Unfortunately, he failed on his own terms. As four justices wrote in a joint dissent, "The court regards its strained statutory interpretation as judicial modesty. It is not. It amounts instead to a vast judicial overreaching. It creates a debilitated, inoperable version of healthcare regulation that Congress did not enact and the public does not expect."

The chief justice's immodest pacifism, combined with the activism of the four liberal justices, created the Frankenstein's monster that was Thursday's decision.

It's certainly gratifying that a majority of the justices—Roberts and the other four Republican appointees—rejected the government's dangerous assertion of the power to compel commerce in order to regulate it. That at least vindicates those of us who led the constitutional challenge to the law on the grounds that the government cannot regulate inactivity—in this case, those declining to purchase health insurance. Congress' power to regulate interstate commerce is not, as Roberts wrote, "a general license to regulate an individual from cradle to grave."

Justifying the individual mandate to buy insurance under the taxing power, however, does not rehabilitate the government's constitutional excesses. As Justice Anthony Kennedy said in summarizing the joint dissent from the bench, "Structure means liberty." If Congress can avoid the Constitution's structural limits by simply "taxing" inactivity, its power is no more limited than if it were allowed to regulate at will under the Commerce Clause.

The court also rewrote the law's Medicaid expansion so that states stand to lose only new federal funding—instead of all their funding under the program—if they do not accept burdensome and transformative new regulations. While the court is correct in its analysis of the government's spending

power and the strings it can attach to funding, its ruling here is relevant only to a hypothetical statute, not the one Congress actually passed.

Moreover, allowing states to opt out of the new Medicaid regime while leaving the rest of the law in place will throw the insurance market into disarray, increase costs for individuals, and give the states a Hobson's choice between two undesirable alternatives—a different but no less unfair circumstance than the one they originally faced under the law.

A dark day

In short, liberal activism and conservative pacifism suspended their tired debate just long enough to agree on a decision that, while not without its bright spots, marks a dark day for constitutional governance.

The high court and the rest of the judiciary should instead be applying the Constitution regardless of whether it leads to upholding or striking down legislation. And a correct application of the Constitution inevitably rests on the Madisonian principles of ordered liberty and limited government that the document embodies.

Now the ball is in another court, that of the people—those who, in ratifying the Constitution, delegated certain limited powers to the federal government. They have opposed Obamacare all along, and now they must rein in the government whose unconstitutional actions have taken us to the brink of economic disaster.

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Chapter 79

Health Law a Loser despite Court Victory

by Michael F. Cannon

Unfortunately for supporters of President Obama's health law, yesterday's Supreme Court ruling does nothing to validate or lend the law legitimacy. Half of the ruling was a clear defeat for "Obamacare." And the portion that supporters are hailing as a victory will prove hollow.

The court invalidated a key part of the Obama health law designed to expand health insurance coverage. Each state has a Medicaid program that provides health insurance to the poor (among others). Federal grants to states cover 56 percent of overall Medicaid spending. That comes to an average 12 percent of a state's entire budget.

The Obama health law threatened to withhold the federal share of Medicaid funding—which amounts to hundreds of billions of dollars over a 10-year period—unless states dramatically expanded their programs. A Cato Institute colleague estimates that, for example, this mandate would cost New Jersey taxpayers $35 billion and New Yorkers $52 billion over the next 10 years. This mandate was so expensive that 26 states sued to block it.

The Supreme Court agreed. Though the particulars of the ruling will take some time to sort out, the court told states they can refuse to expand their Medicaid programs without sacrificing their existing Medicaid funding. It is difficult to interpret that holding as anything but a defeat for the Obama health law.

And while supporters hail the court's refusal to strike down the law's "individual mandate" requiring Americans to purchase a private health insurance plan, it is not the case that the court affirmed that mandate as constitutional.

During congressional debate, supporters of this law claimed that the individual mandate was an exercise of Congress' power to regulate commerce. Congress and the president swore up and down that the mandate was not a tax, because calling it a tax would have doomed the entire law. The statute frames the mandate as grounded in the Commerce Clause of the Constitution, and refers to the penalty for non-compliance as a "penalty"—not a tax. States and a handful of citizens filed suit against the mandate because forcing people to purchase a private product is not regulating commerce but compelling commerce.

Again, the court agreed. The justices ruled 5-4 that requiring citizens to purchase health insurance is not a valid use of the Commerce Power. But in a truly bizarre twist, they held that the mandate could be justified as a use of Congress' taxing power. The split decision came about because Chief Justice John Roberts sided with the court's conservatives on the commerce power question, but flipped his vote on the taxing power question. As a result, the court upheld the individual mandate as a valid use of the very taxing power that Congress swore it was not using.

What Congress said the individual mandate is—an exercise of the Commerce Power—the court said is not constitutional. But what Congress said the mandate is not—an exercise of the Taxing Power—the

court ruled is constitutional. Everybody got that?

This ruling has created two enormous problems for American democracy and the rule of law.

First, Roberts' flip-flop means the Supreme Court just upheld a law that Congress did not pass and never would have passed. If Congress had called the mandate a tax, the law never would have reached the president's desk.

Second, the Supreme Court just told Congress it is okay to lie to the people in order to get a bill passed. As a result of this ruling, a future Congress could enact a broccoli mandate by saying, "Don't worry, this isn't a tax. We're using our power to regulate commerce. And we're sure the Supreme Court will agree with us this time."

The Obama health law can't take many more victories like this.

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Chapter 80

Chief Justice Roberts Sold Out the Constitution for Less Than Wales

by Ilya Shapiro

In the 1966 film A Man for All Seasons (an Oscar-winning adaptation of a play about the life of Sir Thomas More), an ambitious young lawyer named Richard Rich perjures himself so that the Crown can secure More's conviction for treason. (Sir Thomas More was the 16th-century Lord Chancellor of England who refused to sign a letter asking Pope Clement VII to annul King Henry VIII's marriage to Catherine of Aragon and resigned rather than take an oath declaring the king to be the head of the Church of England.) Rich is promoted to Attorney General of Wales as a reward. Upon learning of Rich's connivance, More plaintively asks, "Why Richard, it profits a man nothing to give his soul for the whole world . . .but for Wales?"

So it is with John Roberts, who like his namesake Justice Owen Roberts changed his vote on Obamacare in service to political considerations. (That's actually unfair to Owen Roberts because his so-called "switch in time that saved nine," which provided the decisive vote to uphold the New Deal after years of reversals, came before FDR announced his Court-packing scheme.)

That is, at some point between the justices' initial conference the Friday of Obamacare-argument week in late March and when the first opinions were circulated in early June, Chief Justice Roberts changed from striking down the individual mandate, and with it the whole law, to upholding on the flimsy reed of the taxing power. Roberts's opinion ~~rewriting the law~~ "construing" the mandate as a tax is unconvincing, to say the least—even the liberal justices weren't so enthusiastic about it, though they were happy to go along with any ratification of federal power—but it's now apparent that he was simply grasping at any way to uphold Obamacare while not expanding the Commerce Clause.

There are many theories on why he did this—I don't think it's because Jeffrey Rosen wrote an op-ed, or even because President Obama and Senator Pat Leahy (D-VT) made speeches—but they mainly boil down to the idea of wanting to preserve the Supreme Court's reputation as an impartial arbiter, one that doesn't get involved in highly charged political disputes during a presidential election year.

Now, let's set aside the issue of whether Roberts's split-the-baby opinion actually helps the Court's institutional integrity—some polls already show a decline in approval for the Court from what was already a near-historic low—and consider *why* this sort of reputation-preservation matters and whether it's worth torturing the law to accomplish it. The way I see it, the federal judiciary (with the Supreme Court at its apex) is our system of government's premier counter-majoritarian institution, holding the political branches' feet to the constitutional fire. Courts are supposed to decide the law and let the political chips fall where they may. Implicit in the Constitution's careful separation of powers—and made explicit in the foundational case of *Marbury v. Madison*—is the idea of judicial review, that federal courts have the obligation, when "cases or controversies" are brought before them, to review them against the Constitution and, if they go beyond enumerated federal power or violate protected rights, to strike them down.

That's why it's so important that courts be independent and free from political pressure. Particularly with regard to major controversies that polarize the nation, courts—and especially the Supreme Court—need their reputation for dispassionate and independent legal reasoning so that their often unpopular opinions are followed and respected, rather than fomenting resistance and revolution.

The health care cases—or *Health Care Cases*, as they may become known—presented nothing if not one such singular moment. People across the country were anxiously awaiting a ruling, and would have accepted (if bitterly) a 5–4 decision on Commerce Clause grounds. I obviously think that upholding the mandate, and with it the rest of Obamacare, would have been wrong—and unpopular. Striking it down would similarly have provoked heated and fervent criticism, albeit only from the minority of Americans (but a majority of legal and media elites) who support the law. But in any event, the Court's decision would have "simply" been a very high profile legal ruling, just the sort of thing for which the Court needs all that accrued institutional respect and gravitas.

What we have instead, however, is a political decision dressed up in legal robes, judicially enacting a law Congress did not pass and would not have passed, all to "save" the Court to live to fight another day. But what is that other day? I just don't understand what Roberts is saving the Court for if not the sort of big, tough case that Obamacare exemplified.

In short, John Roberts, in refraining from making that hard balls-and-strikes call he discussed at his confirmation hearings, has sold out his legal soul for even less than Wales.

This article appeared on July 2, 2012 on Cato@Liberty.org.

Chapter 81

ObamaCare's Now a Bigger Mess

by Michael D. Tanner

If the new health care law wasn't enough of a mess before last week's Supreme Court decision, that ruling actually added another layer of cost, complexity and political contentiousness to the bill.

By striking down part of the law that required states to expand their Medicaid programs, the court tossed a very hot potato into the laps of state lawmakers everywhere.

ObamaCare required states to increase eligibility for Medicaid to 133 percent of the poverty line, or roughly $30,000 per year for a family of four. The expansion would also make childless single men (a notoriously high-cost group) eligible for Medicaid for the first time. In all, about 40 percent of all the people projected to gain coverage under ObamaCare would do so via Medicaid.

But this imposed real costs on states. For example, the Medicaid expansion would cost New Jersey taxpayers roughly $35 billion over 10 years, and New Yorkers as much as $52 billion.

Not surprisingly, many states balked—and now the high court has agreed: Congress can't strip *all* Medicaid funds from states that refuse the expansion, as the ObamaCare law threatened.

So what will state legislators do now?

If they agree to expand their Medicaid programs anyway, they'll be *choosing* to pile new costs on their state budgets and new taxes on their constituents.

And if a state *doesn't* expand its Medicaid program, most of those who would've been eligible for Medicaid will now become eligible for subsidies through ObamaCare's health-insurance exchanges. And *those* subsidies are paid in full by the *feds*.

Thus, New York, for example, would shift most of that $52 billion in new costs back to the federal government.

Of course, if states do shift those costs back to the feds, that will cause the federal cost of ObamaCare to skyrocket. If *every* state were to refuse to expand its Medicaid program, the feds would save roughly $130 billion in their share of Medicaid costs in 2014, but would have to pay $230 billion more in new exchange-based subsidies—for a net added cost of $100 billion. And that's just for the first year.

Remember, this is a law that already will cost as much as $2.7 trillion from 2014 to 2024, and will add more than $823 billion to the federal deficit—estimates that assumed state taxpayers would be picking up some Medicaid costs. How will Congress react if billions or perhaps trillions of dollars in new costs are added to the federal budget?

Here's another complicating factor: Most states have not yet set up an exchange. Many, especially ones with Republican governors or legislatures, may refuse altogether. By most estimates, as few as 15 states are likely to have exchanges in operation by the 2014 deadline.

ObamaCare gives the feds the authority to step in, setting up and operating an exchange in any state that doesn't set up its own—but there is reason to doubt that they have resources to do so in so many states.

Anyway, federal subsidies are available only through exchanges that the *states* set up. The feds can't offer subsidies through a federally run exchange.

Thus, if states neither expanded Medicaid nor set up exchanges, that would effectively block most of ObamaCare's new entitlement spending.

One last wrinkle: It is those subsidies that trigger the penalty under ObamaCare for employers who fail to provide workers with insurance. So states that don't set up exchanges could also escape the "employer mandate."

That is, ObamaCare requires employers with 50 or more workers to provide health insurance or pay a fine . . . er, tax. But that tax only kicks in if at least one employee qualifies for subsidies under the exchange. Since subsidies can only be provided via a state-authorized exchange, a state that refuses to set one up could end up blocking the employer mandate altogether. At the very least, expect some employers to sue on this point, leading to yet another Supreme Court challenge.

And if, as expected, ObamaCare drives up the cost of insurance, many employers could end up dropping their current health insurance. So the end result of all this could be even more uninsured than before the law passed.

In short, the Supreme Court's ruling not only guaranteed that ObamaCare will be an issue in this fall's federal elections; it dumped a mess in the laps of governors and state legislators, too.

This article appeared on **New York Post** *on July 3, 2012.*

Chapter 82

If ObamaCare Survives, Legal Battle Has Just Begun

by Jonathan H. Adler and Michael F. Cannon

Even if the Affordable Care Act survives its first Supreme Court test—a ruling is due as early as today—the lawsuits won't end. Citizens have already filed challenges to what critics call the law's "death panel" and its impact on privacy rights, religious liberty and physician-owned hospitals. Still another potential lawsuit poses as great a threat to the law as the case now before the high court.

Under the guise of implementing the law, the Internal Revenue Service has announced it will impose a tax of up to $3,000 per worker on employers whom Congress has not authorized a tax. To make things more interesting: If the IRS doesn't impose that unauthorized tax, the whole law could collapse.

The Act's "employer mandate" taxes employers up to $3,000 per employee if they fail to offer required health benefits. But that tax kicks in only if their employees receive tax credits or subsidies to purchase a health plan through a state-run insurance "exchange."

This 2,000-page law is complex. But in one respect the statute is clear: Credits are available only in states that create an exchange themselves. The federal government might create exchanges in states that decline, but it cannot offer credits through its own exchanges. And where there can be no credits, there is nothing to trigger that $3,000 tax.

States are so reluctant to create exchanges that Secretary of Health and Human Services Kathleen Sebelius estimates she might have to operate them for 15 to 30 states. Even if she manages that feat, the law will still collapse without the employer mandate and tax credits.

Unauthorized Tax

To prevent that from happening, on May 18 the IRS finalized a rule making credits available through federal exchanges, contrary to the express language of the statute.

Because those credits trigger penalties against employers, the IRS is literally taxing employers and spending billions without congressional authorization. Estimates by the Urban Institute indicate that had this rule been in effect in 2011, it would have cost at least $14.3 billion for HHS to run exchanges for 30 states. About 75% of that is new federal spending; the remainder is forgone tax revenue.

The IRS doesn't have a leg to stand on here. It has not cited any express statutory authority for its decision, because there is none. The language limiting tax credits to state-established exchanges is clear and consistent with the rest of the statute. The law's chief sponsor, Senate Finance Committee chairman Max Baucus (D-Mont.), is on record explaining creation of an exchange is among the conditions states must satisfy before credits become available. Indeed, all previous drafts of the law also withheld credits from states to push them to cooperate.

Employers Can Sue

Under the Congressional Review Act, Congress has 60 days from the date of issue to block the rule. Reps. Scott DesJarlais, R-Tenn., and Phil Roe, R-Tenn., have introduced a resolution. It may receive a

cold reception from President Obama, but "taxation without representation" is a difficult position to defend. If that approach fails, states that have refused to establish a health insurance exchange, and large employers the IRS will hit with this unauthorized tax, could challenge the rule in court.

The authors of the Affordable Care Act wrongly assumed states would be eager to implement it. If saving the law from that miscalculation requires letting the IRS tax Americans without authorization, then it is s not worth saving.

This article appeared in USA Today *on June 25, 2012.*

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MULTIMEDIA LINKS

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- Video: ObamaCare is RomneyCare 2.0
- Video: Who Understood RomneyCare Better: Mitt Romney or Ted Kennedy?

Section 4: ObamaCare

Versus the Constitution

- Video: Obamacare in the Supreme Court (Cato Institute Conference, 2012)
- Audio: Michael F. Cannon discusses Obamacare on NPR's Tell me More (2012)
- Video: Will Debate Constitutionality of Obamacare Anytime, Anywhere (2010)

The Folly of Centralized Economic Planning

- Podcast: Oregon's Medicaid Study and ObamaCare (2011)
- Video: The Oregon Health Insurance Experiment and Evidence-Based Health Reform (Cato Policy Forum, 2011)

Stopping Obama Care

- Video: States Should Flatly Reject ObamaCare Exchanges (2011)
- Video: Another ObamaCare Fatal Flaw (2012)

Section Five: Reforming Health Care

Private Health Insurance

- Video: Can the Market Provide Choice and Secure Health Coverage Even for High-Cost Illnesses? (Cato Policy Forum, 2009)

Section Six: It Now Falls to Congress

- Video: The Supreme Court's Obamacare Ruling: What Does It All Mean (Cato Policy Forum, 2012)

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