

Obamacare to Come Seven Bad Ideas for Health Care Reform

by Michael Tanner

Executive Summary

President Obama has made it clear that reforming the American health care system will be one of his top priorities. In response, congressional leaders have promised to introduce legislation by this summer, and they hope for an initial vote in the Senate before the Labor Day recess.

While the Obama administration has not, and does not seem likely to, put forward a specific reform plan, it is possible to discern the key components of any plan likely to emerge from Congress:

- At a time of rising unemployment, the government would raise the cost of hiring workers by requiring employers to provide health insurance to their workers or pay a fee (tax) to subsidize government coverage.
- Every American would be required to buy an insurance policy that meets certain government requirements. Even individuals who are currently insured—and happy with their insurance—will have to switch to insurance that meets the government’s definition of “acceptable insurance.”
- A government-run plan similar to Medicare would be set up in competition with private insurance, with people able to choose either private insurance or the taxpayer-subsidized public plan. Subsidies and cost-shifting would en-

courage Americans to shift to the government plan.

- The government would undertake comparative-effectiveness research and cost-effectiveness research, and use the results of that research to impose practice guidelines on providers—initially, in government programs such as Medicare and Medicaid, but possibly eventually extending such rationing to private insurance plans.
- Private insurance would face a host of new regulations, including a requirement to insure all applicants and a prohibition on pricing premiums on the basis of risk.
- Subsidies would be available to help middle-income people purchase insurance, while government programs such as Medicare and Medicaid would be expanded.
- Finally, the government would subsidize and manage the development of a national system of electronic medical records.

Taken individually, each of these proposals would be a bad idea. Taken collectively, they would dramatically transform the American health care system in a way that would harm taxpayers, health care providers, and—most importantly—the quality and range of care given to patients.

It is possible to discern the outlines of a health care reform proposal that would be acceptable to the White House.

Introduction

President Obama has made it clear that reforming the American health care system will be one of his top priorities. Administration officials have repeatedly referred to health care reform as Obama's "top fiscal priority" and called the need to restrain the growth in health care costs "the single most important thing we can do to improve the long-term fiscal health of our nation."¹ In his first address to Congress, President Obama said, "Health care reform cannot wait, it must not wait, and it will not wait another year."² And at a February 2009 White House Summit on health care reform that included many of the congressional and industry stakeholders, President Obama insisted that health care reform must be passed "this year."³ Obama's proposed 2009 budget included \$634 billion as a "down payment" to pay for health care reform, although it contains no details about how that money would be spent.⁴

In response, congressional leaders have promised to introduce legislation by this summer, and they hope for an initial vote in the Senate before the Labor Day recess.⁵

President Obama apparently does not plan 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. As Obama's budget director, Peter Orszag, told a congressional committee, "On exactly what the administration does and does not favor on the benefits and coverage side, you should not expect and you will not be receiving definitive answers from me."⁶

This strategy stems from the belief of many administration analysts that one reason for the failure of President Clinton's attempt at health care reform was that the Clinton administration developed a specific plan in secret, without congressional input, then attempted to force Congress to accept it. As President Obama told ABC News, "They went behind closed doors and tried to come up with a plan all by themselves."⁷

Still it is possible to discern the outlines of what a health care reform proposal acceptable to the White House will look like. President Obama outlined his ideas in considerable detail during the campaign. His first choice for secretary of health and human services, former South Dakota senator Tom Daschle, wrote a book on health care reform last year.⁸ While Daschle's nomination had to be withdrawn due to his failure to pay income taxes, his coauthor, Jeanne Lambrew, remains as deputy director of the White House Office of Health Reform, ensuring that Daschle's views remain prominent. And Obama's second choice for secretary of Health and Human Services, Kathleen Sebelius, pushed several health initiatives during her time as governor of Kansas.⁹

In Congress, Sen. Max Baucus (D-MT), chairman of the Senate Finance Committee, has released the outlines of a proposal.¹⁰ Since any health care legislation will have to pass through his committee, Baucus will help shape any final bill. Baucus has been working closely with Sen. Edward Kennedy (D-MA), who sees health care reform as his final legacy.¹¹ Senator Kennedy has been meeting with industry stakeholders and is preparing to draft legislation. While the meetings have been held in secret, some conceptual outlines have leaked out.¹² In addition, a bipartisan bill, sponsored by Sens. Ron Wyden (D-OR) and Robert Bennett (R-UT), has drawn White House attention.¹³

And finally, the \$1.3 trillion stimulus bill, officially known as the American Recovery and Reinvestment Act, contained a number of provisions laying the groundwork for President Obama's vision of health care reform.¹⁴

If one looks at these various proposals, outlines, and statements, the broad parameters of the final proposal begin to emerge. It would not initially create a government-run, single-payer system such as in Canada or Britain. Private insurance would still exist, at least for a time, but it would be reduced to little more than a public utility, operating much like, for example, the electric company, with the government regulating and controlling every aspect of its operation.

Coverage would be mandated, both for employers and individuals. A government-run plan, similar to Medicare, would be set up in competition with private insurers. People could choose either private insurance or the public plan. The government would undertake comparative-effectiveness and cost-effectiveness research, and use the results of that research to impose practice guidelines on providers—initially in government programs such as Medicare and Medicaid, but possibly eventually extending such rationing to private insurance plans. Private insurance would face a host of new regulations, including a requirement to insure all applicants and a prohibition on pricing premiums on the basis of risk. Subsidies would be available to help low- and (most likely) middle-income people purchase insurance. And the government would subsidize and manage the development of a national system of electronic medical records.

The net result would be an unprecedented level of government control over one-sixth of the U.S. economy and some of the most important, personal, and private decisions that Americans make. This approach sets the stage for the eventual evolution into a single-payer system. The result would be disastrous for American taxpayers, the health care industry, and most importantly, health care consumers.

Let us look at some of the likely provisions of a health care reform plan in more detail.

An Employer Mandate

As a candidate, Barack Obama said he would require all employers to provide their workers with insurance through a “play or pay” mandate. Employers who do not provide “meaningful coverage” for their workers would be required to pay a penalty equal to some percentage of their payroll into a national fund that would provide insurance to those uncovered workers.¹⁵

This is an idea that will almost certainly find favor with congressional Democrats. Senator Baucus, for example, has endorsed such an

approach, using a sliding scale for the required contribution with small and mid-sized companies paying less than large firms.¹⁶ And Senator Kennedy has long supported an employer mandate. In the House, the chairmen of the three most relevant committees—Charles Rangel (D-NY) of the Ways and Means Committee, Henry Waxman (D-CA) of the Energy and Commerce Committee, and George Miller (D-CA) of the Education and Labor Committee—are all backers of an employer mandate.¹⁷

It is easy to understand why reformers would consider an employer mandate. Health insurance through their employers is already the way that roughly 70 percent of Americans under the age of 65 get their health insurance, which makes it an obvious platform on which to build.¹⁸ In addition, large group purchasers, such as employers, enjoy economies of scale that may reduce average administrative costs.

However, there are several problems with an employer mandate. First, 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 mandate would not flow directly through the public budgets does not detract from the measure’s status of a bona fide tax.”¹⁹

And although 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 that 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 costs by: raising prices (the most unlikely 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.

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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, which looks 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.²⁰ 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.²¹

On the other hand, 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 health insurance, which seems likely for many of the currently uninsured.²² 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."²³

Mark Pauly of the Wharton School suggests that mandated employer health benefits are particularly pernicious because the cost of paying premiums is likely to rise over time, building in a de facto cost of living escalator, and the cost of benefits is also likely to rise as employees age and have families with higher health care expenses. Thus the elasticity of employment, or increase in unemployment, would likely be higher with regard to mandated health insurance than with some other mandated benefits, such as an increase in minimum wage.²⁴

Moreover, not all of those who would be covered under an employer mandate were previously uninsured. To cite just one example, they might currently be covered under a spouse's policy. The mandate would also fall

on firms that were providing insurance, but whose employer contribution fell below the minimum required amount, or who provided benefits that differed from the minimum benefit package specified by the government. For instance, high-deductible policies or health savings accounts might be prohibited. And it is not just the direct cost of insurance that would be imposed on employers: business would also incur significant administrative costs.²⁵

Low-skilled and low-wage workers would be particularly at risk. Roughly 43 percent of uninsured workers are working within three dollars of the minimum wage. The mandated insurance costs will represent a proportionately significant increase in the cost of employing those workers. At the same time, since their wages are already low, and those workers receive few other employment benefits, employers' ability to shift costs will be constrained. The most likely outcome will be greater unemployment for workers whose lack of skills does not justify the increased cost. Economists Katherine Baicker of Harvard and Helen Levy of the University of Michigan estimate that a nationwide employer health insurance mandate would result in the loss of approximately 315,000 low-skill jobs.²⁶

Others put the number of potential job losses much higher. In a study for the National Federation of Independent Business, Michael Chow and Bruce Phillips estimate that as many as 1.6 million jobs could be lost in the first five years after an employer mandate was imposed, of which two-thirds would be from small businesses with fewer than 500 employees. Of those small businesses, 55 percent are companies with fewer than 100 employees, and 28.9 percent are companies with just 20 employees or fewer.²⁷ An analysis of a proposed employer mandate for California businesses suggested a potential job loss in that state alone of more than 70,000.²⁸ Projecting that estimate nationwide would mean a loss of 630,000 jobs.

Limiting the mandate to large firms would undoubtedly reduce the harm but would also reduce the mandate's effectiveness. Congressional Budget Office estimates that a mandate

limited to large companies would increase the number of insured Americans by only about 300,000 people.²⁹ Therefore, any mandate is likely to include “all but the smallest businesses,” as President Obama said during the campaign.³⁰

A second problem with an employer mandate is that it would further lock us into our current employer-based health care system. Employer-based health insurance is a historical accident, stemming from a combination of labor shortages and wage-price controls initiated during World War II.³¹ It limits consumer choice by giving decisions over insurance coverage to employers rather than workers. It means that workers who lose their jobs lose their insurance.

And it means that individuals who do not receive employer-provided insurance face an increased financial burden when they try to purchase insurance on their own. Indeed, the *New York Times* recently pointed out in a story titled, “When a Job Disappears, So Does the Health Care,” that the poor economy and rising unemployment are leading to an increase in the number of people without insurance.³² According to a study by Georgetown University’s Center for Children and Families, 4.1 million people lost their employer-sponsored health insurance in 2008.³³

We should be moving away from an employment-based system toward one where workers have personal and portable insurance that is not linked to their employer’s preference or their employment status. Therefore, an employer mandate would actually represent a step backwards in terms of a more effective and compassionate health policy.

An Individual Mandate

During the presidential campaign, Barack Obama opposed a requirement that every American buy health insurance. Indeed, Obama’s opposition to an individual mandate was a principal area of disagreement with Hillary Clinton during the Democratic primaries.³⁴ However, administration sources are

now indicating that, while President Obama will not propose such a mandate, he will accept one if Congress includes it.³⁵

And it is extremely likely that the final bill will include an individual mandate. Senator Baucus calls for one, saying that as a matter of “individual responsibility . . . it will be each individual’s responsibility to have coverage.”³⁶ In the House, Rangel, Waxman, and Miller support it, although they prefer to phrase it as “everyone will participate, and everyone will benefit.”³⁷ Not surprisingly, the idea of an individual mandate has been endorsed by several key industry groups and stakeholders, particularly those who stand to benefit most by such a mandate—health insurers and physicians.³⁸

An individual mandate also has at least some Republican support. Former Republican presidential candidate Mitt Romney signed into law the nation’s first—and so far, only—individual mandate for health insurance when he was governor of Massachusetts.³⁹ Former House Speaker Newt Gingrich also supports an individual mandate.⁴⁰ An individual mandate is included in the bipartisan Wyden-Bennett bill.⁴¹ And analysts from some conservative groups, such as the Heritage Foundation, have endorsed an individual mandate.⁴²

As is the case with an employer mandate, an individual mandate is simply a disguised tax. After all, if the government takes money directly from person A and gives the money to person B, everyone would agree that it is a tax. It is no different if the government mandates that person A simply pay the money directly to person B. At the end of the day, Person A has less money to spend as he chooses.

Advocates of an individual mandate generally give two reasons for supporting such a proposal. Neither is without merit, but ultimately both are unpersuasive. The first is to prevent cost-shifting from the uninsured. As Senator Baucus points out, when an individual without health insurance becomes sick or injured, he or she still receives medical treatment.⁴³ In fact, hospitals have a legal require-

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ment to provide emergency care regardless of the patient's ability to pay. Physicians do not face the same legal requirement, but few are willing to deny treatment because a patient lacks insurance. However, such treatment is not free. The cost is simply shifted to others—those with insurance, or more often—taxpayers.⁴⁴ In fact, although Baucus does not put a dollar amount on such uncompensated care, others estimate the cost to be as much as \$40.7 billion per year, with 85 percent of that cost borne by federal, state, and local governments.⁴⁵

But it is important to keep this cost in perspective. The United States currently spends roughly \$2.4 trillion annually on health care.⁴⁶ By Baucus's own estimates, uncompensated care, then, amounts to about 1.7 percent of the total U.S. health care spending. Other estimates put it slightly higher, at 3–5 percent.⁴⁷ While that cost should not be casually dismissed, neither is it so grave a problem as to justify the distortions and regulations that will inevitably flow from an individual mandate.

Second, advocates argue that bringing all Americans into the insurance pool would “ensure that insurance markets function effectively.”⁴⁸ Those most likely to go without health insurance are the young and relatively healthy. For example, although 18-to 24-year-olds are only 10 percent of the U.S. population, they are 21 percent of the long-term uninsured.⁴⁹ For these young, healthy individuals, going without health insurance is often a logical decision. However, this becomes a form of adverse selection. Removing the young and healthy from the insurance pool means that those remaining in the pool will be older and sicker. This results in higher insurance premiums for those who are insured.

However, this argument is true only if there are cross-subsidies in existing pools. If everyone's rates are actuarially fair, then young people's explicit or implicit premiums do not result in lower or higher premiums for anyone else. There are legitimate arguments about how to best subsidize the needy within the health care system, but an individual

mandate would be an excessive response to what is, in essence, an artificial problem.

The most obvious question about an individual mandate is how it would be enforced. The government would need some way to determine whether Americans are insured or not and to penalize those who have not complied with the mandate.

It seems likely that the mandate suggested by Senator Baucus “would be enforced possibly through the tax system or some other point of contact between individuals and the U.S. government.”⁵⁰ But about 18 million Americans are not required to file income taxes, mostly because their incomes are too low.⁵¹ Another 9 million Americans who are required to file tax returns nonetheless fail to do so.⁵² That is potentially 27 million Americans who would not be providing proof of insurance. Moreover, only about 30 percent of uninsured Americans have been uninsured for a full year. In fact, nearly 45 percent will regain insurance within four months.⁵³ Therefore, many people who lack health insurance at some point throughout the year, will in fact be insured at the time they file their taxes. Presumably, the “proof of insurance” could include of the length of time that the person was insured, but that would raise the complexity of compliance procedures considerably. It would also increase the incentive to lie.

If the government were able to determine that someone has not purchased health insurance, what penalty would apply? Presumably, some sort of tax penalty is the most likely approach. But that is much easier said than done. Eugene Steuerle, currently with the Peterson Foundation, has noted that the administrative and enforcement costs of collecting the penalty would be enormous. The IRS relies largely on voluntary compliance backed up by a slow and cumbersome legal process to collect taxes. And it does not require those with very small amounts of income to file. Even so, as noted above, millions of Americans cheat or fail to file. Collecting a penalty for failure to insure would be much more difficult. “The [IRS] is simply incapable of going to millions of households, many of modest means, and collecting

significant penalties at the end of the year,” Steuerle warns.⁵⁴

Many of those who fail to comply with the mandate will indeed be low-income Americans. Of those without health insurance today, nearly one-quarter have household incomes of less than \$25,000 per year.⁵⁵ These individuals will almost certainly lack the resources to pay any penalty, particularly a lump-sum penalty assessed at year’s end.

While implementation of an individual mandate creates a number of practical difficulties, an even more significant issue is that it represents the first in a series of dominoes that will inevitably lead to greater government control of the health care system.

To implement an insurance mandate, the government will have to define what sort of insurance fulfills that mandate. As the CBO puts it, “An individual mandate . . . would require people to purchase a specific service that would have to be heavily regulated by the federal government.”⁵⁶ At the very least, deductible levels and lifetime caps will have to be specified, and some form of specific minimum benefit package will likely be spelled out. That means that the often repeated promise that “if you are happy with your current insurance, you can keep it” is simply untrue. Millions of Americans who are currently satisfied with their coverage will have to give up that coverage and purchase the insurance that the government wants them to have, even if the new insurance is more expensive or covers benefits that the buyer does not want.

Whatever the initial minimum benefits package consists of, special interests representing various health care providers and disease constituencies can certainly be expected to lobby for inclusion under any mandated benefits package. To see this in action, one simply has to look to state mandates for health insurance benefits. The number of laws requiring that all insurance policies sold in a state provide coverage for specified diseases, conditions, and providers has been skyrocketing. In the 1960s there were only a handful of such mandates, but today there are more than 1,800.⁵⁷ And when the Clinton administration

proposed a minimum benefits package as part of its 1993 health care reform plan, provider lobbying groups spent millions of dollars in advertising calling for the inclusion of specific provider groups or coverage of specific conditions.

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 lawmakers for inclusion under any minimum benefits package. The public at large will likely see resisting the small premium increase caused by any particular additional benefit as unworthy of a similar effort. It is a simple case of concentrated benefits and diffuse costs.

Massachusetts’s experience provides a cautionary tale on both counts. In 2005, Massachusetts became the first—and so far only—state to mandate that nearly all residents purchase health insurance as part of a comprehensive health care reform plan. Since then, Massachusetts has significantly reduced the number of people in the state who lack health insurance. However, it has not achieved, nor does it expect to reach, universal coverage. (The best estimates suggest that more than 200,000 state residents remain uninsured).⁵⁸ Significantly, roughly 60 percent of newly insured state residents are receiving subsidized coverage, suggesting that the increase in insurance coverage has more to do with increased subsidies than with the mandate.⁵⁹

The cost of those subsidies in the face of predictably rising health care costs has led to program costs that are far higher than originally predicted (see below). And the mandate has indeed led to an increase in regulation and mandated benefits. The state is phasing in a requirement that all insurance plans cover prescription drugs and has limited both deductibles and lifetime payout limits. With the cost of the program rising, the state has been forced to raise taxes, and it is now considering imposing caps on insurance premiums.⁶⁰

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An individual mandate would be an unprecedented expansion of government power and intrusion into the lives of every American. While it is unlikely to achieve the desired goal of universal coverage, it sets the stage for increased regulation of the health care system in a way that will ultimately harm health care consumers.

The “Public Option”

Perhaps one of the most contentious issues in health care reform is whether the government should establish a government-run health care plan, similar to Medicare, which would compete with private insurance. The inclusion of such a government-run plan has become a line in the sand for many liberal health care reformers, especially those who would actually prefer a single-payer system.

When, at the White House Summit on Health Care Reform, Sen. Charles Grassley (R-IA) asked President Obama whether he still supported such a proposal, the president said that he was “not going to respond definitively.” But he then went on to note that “the thinking on the public option is that it gives consumers more choices and it helps . . . keep the private sector honest, because there’s competition out there.”⁶¹ House speaker Nancy Pelosi insists that a government-run plan be part of any final reform package.⁶² Senator Baucus is also on the record supporting such a “public option.”⁶³ And at her nomination hearing, HHS Secretary Kathleen Sebelius called for “a public option, side-by-side with private insurers.”⁶⁴

What exactly such a “public option” would be remains unsettled. Some proponents envision an expansion of the current Medicare program to those younger than 65. Others argue that an entirely new government program should be created, while still others would allow a buy-in to the Federal Employee Health Benefit Program. The program might be administered directly by the government, or claims management and other functions might be bid out to private insurers on a contractual basis.

Regardless of how it was structured or administered, such a government-run plan would have an inherent advantage in the marketplace because it would ultimately be subsidized by American taxpayers. The government plan could, for instance, keep its premiums artificially low or offer extra benefits since it can turn to the U.S. Treasury to cover any shortfalls. Consumers would naturally be attracted to the lower-cost, higher-benefit government program, which would undercut the private market.

A government program would also have an advantage since its enormous market presence would allow it to impose much lower reimbursement rates on doctors and hospitals.⁶⁵ Government plans such as Medicare and Medicaid traditionally reimburse providers at rates considerably below those of private insurance. Providers recoup the lost income by shifting costs onto those with private insurance. Indeed, it is estimated that privately insured patients pay \$89 billion annually in additional insurance costs because of cost-shifting from government programs.⁶⁶ If one assumes that the new public option would have similar reimbursement policies, it would result in additional cost-shifting as much as \$36.4 billion annually. Such cost-shifting would force insurers to raise their premiums, making them even less competitive with the taxpayer-subsidized public plan. The result would be a death spiral for private insurance.

Medicaid provides a useful example of how public programs “crowd out” private coverage. As income eligibility levels for Medicaid are raised, many of the newly eligible are already covered by employer-provided or individually purchased insurance. Many of these individuals shift from the private to the public systems. In fact, a Robert Wood Johnson Foundation survey of 22 studies of the relationship between government insurance programs and private coverage concluded that substitution of government for private coverage “seems inevitable.”⁶⁷ And the CBO estimates that between one-third and one-half of children who were added to the State Children’s Health Insurance Program under its recent expansion were already covered by private health insurance.⁶⁸

Companies, in particular, would have an incentive to try to shift workers into the public market. Even with an employer-mandate in place, companies could do so by maximizing employee contributions or moving to plans that restrict employee options. And if, as the Obama administration has discussed, limits are placed on the deductibility of employer-provided health insurance,⁶⁹ there will be an even greater incentive for companies to dump workers into the public plan.⁷⁰ That means tens of millions of workers who would rather stay with their current job-based plan would no longer have that as a choice. They would effectively be forced into the government plan.

The actuarial firm Lewin Associates estimates that, depending on how premiums, benefits, reimbursement rates, and subsidies were structured, as many as 118.5 million people would shift from private to public coverage.⁷¹ That would mean a nearly 60 percent reduction in the number of Americans with private insurance.⁷²

Some advocates of the public option compare it to states where the state government self-insures its state employee health plan, or an option under that plan.⁷³ However, in those cases, the state is simply assuming the financial risk of insurance in the same way that most large employers do. Roughly 89 percent of companies with more than 5,000 employees self-insure.⁷⁴ The self-insured state plans are administered by private insurers and, unlike existing federal government health plans, operate under the same rules as private insurance. As Paul Ginsberg, president of the Center for Studying Health System Change explains, “Although they specify the benefit structure and whether there should be disease management or wellness programs, they are basically buying into provider networks that the insurer has developed for all of its enrollees.”⁷⁵

It is virtually inconceivable that the new federal public option would operate under identical rules as private insurance. If that were the case, there would be no point to having such an option. Indeed, the biggest reason that advocates support such a plan is that it can use its monopsony purchasing power to

demand or impose reduced reimbursement rates. “A public plan is capable of using its concentrated purchasing power to reduce costs,” states a new study by Jacob Hacker for the Institute for America’s Future.⁷⁶

Moreover, how long could a Congress that is busy bailing out banks and automobile companies because they are “too big to fail” resist subsidizing the government’s insurance plan if it began to lose money? Could a Congress that has been unable to control the unsustainable cost of Medicare set and keep premiums at market levels? It seems unlikely.

Whatever rules the public plan started with, they would soon be changed to ensure its advantage over private insurance. Indeed, to gauge the attitude that public option supporters have toward private sector competition, we need look no farther than Medicare Advantage.⁷⁷ Democrats have raged against competition from those private plans, and President Obama has even suggested eliminating Medicare Advantage outright.⁷⁸ Most congressional Democrats also strongly opposed the inclusion of private insurance plans under the Medicare prescription drug benefit.

Given that many of the most outspoken advocates of the “public option” have, in the past, supported a government-run single-payer system, it is reasonable to assume that they support a public option precisely because it would squeeze out private insurance and eventually lead to a government-run single-payer system. President Obama himself has said that if he were designing a health care system from scratch, his preference would be for a single-payer system “managed like Canada’s.”⁷⁹ And he has suggested that, while he has proposed a less radical approach, “it may be that we end up transitioning to such a system.”⁸⁰

In this context, it is notable that congressional Democrats are also proposing to expand existing government programs. For example, leading Democratic proposals would increase eligibility levels for Medicaid and would eliminate the two-year waiting period for people with disabilities to become eligible for Medicare.⁸¹ Senator Baucus has also suggested that individuals between ages

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55 and 65 should be able to “buy in” to Medicare.⁸² Thus, private insurance would find itself squeezed by competition from the bottom (Medicaid), top (Medicare), and sides (the government option) at the same time that it is being subjected to heavy new regulation and costs are being increasingly shifted from public to private programs. It is unlikely that any significant private insurance market could continue to exist under such circumstances. America would be firmly on the road to a single-payer health care system with all the dangers that presents.

Government Playing Doctor

Buried in the giant \$1.3 trillion stimulus bill was a provision authorizing \$1.1 billion for the federal Agency for Healthcare Research and Quality to conduct a “comparative-effectiveness research program.”⁸³ The bill also created a Federal Coordinating Council for Comparative Effectiveness Research, to coordinate comparative-effectiveness research throughout various federal departments and agencies.⁸⁴ These provisions, seemingly inconsequential in themselves, represent the first building blocks in what is almost certain to be a key component of any comprehensive health care reform proposal.

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.⁸⁵ In fact, by some estimates as much as 30 percent of all U.S. health spending produces no discernable value.⁸⁶ 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.⁸⁷ The CBO suggests that we could save as much as \$700 billion annually if we could avoid treatments that do not result in the best outcomes.⁸⁸

It makes sense, therefore, to test and develop information on the effectiveness of various treatments and technology. But there

are a number of problems with having the government undertake this research.⁸⁹

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 mean to them, based on such things as a person’s pain tolerance, lifestyle, feelings 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.⁹⁰ Who is better suited to determine which of those procedures represents quality and value, a government board or the person directly affected?

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.

Third, comparative-effectiveness research can create a time lag for the introduction of new technologies, drugs, and procedures. The FDA, for example, has already caused delays in introducing drugs, which has resulted in unnecessary deaths.⁹¹ Depending on how the final program is structured, comparative-effectiveness research could create another layer of bureaucracy and testing between the development of a new drug and its introduction into the health care system. One only has to look at the difficulty in expanding Medicaid drug formularies to see how this could become a problem.

Finally, and perhaps most importantly, there is also the question of whether quality or value includes consideration of the relative cost of a treatment. Supporters of govern-

ment-sponsored comparative-effectiveness research strongly deny that it would ever be used to ration care simply on the basis of cost. As Elliott Fisher of Dartmouth Medical School says, “It’s an absurd mischaracterization of effectiveness research to equate it with cost-benefit analysis.”⁹²

Yet, there is reason to believe that that sort of cost-benefit analysis is exactly what some advocates of comparative-effectiveness research and practice guidelines support. For instance, House Appropriations Committee chairman David Obey (D-WI) inserted language in the report accompanying the original House version of the economic stimulus bill in which he said:

By knowing what works best and presenting this information more broadly to patients and health care professionals, those items, procedures, and interventions that are most effective to prevent, control, and treat health conditions will be utilized, while those that are found to be less effective *and in some cases more expensive*, will no longer be prescribed.⁹³

Acting National Institutes of Health director Raynard Kington told Congress that the NIH may include comparisons of the cost of medical treatments in its research.⁹⁴ Since the NIH will be conducting much of this research, that has raised a number of red flags. And, the Senate voted 44–54 against an amendment to the budget offered by Sen. Jon Kyl (R-AZ) that would have prohibited cost from being considered in comparative-effectiveness research.⁹⁵

Even this would not be a major cause for concern if the government’s goal were simply to provide information. After all, if a less expensive treatment provided the same results as a more expensive one, shouldn’t doctors—and consumers—know about it? However, a much more serious question arises when the question of cost-effectiveness bumps up against moral or values-based questions, when the positive nature of science and the normative nature of value and political systems are mixed.

For example, should there be a presumption that saving the life of a person in danger of dying automatically takes precedence over improving the quality of life for someone whose life is not in immediate danger? What about immediately saving a real life versus saving some number of hypothetical future lives? Or to put it more practically—and bluntly—what is the value of performing an expensive procedure such as, say, hip-replacement surgery on an elderly patient who might only survive for a few more years anyway? Should we use extraordinary means to extend the life of a cancer patient by a few months?

Such questions are by definition values-based and cannot be answered through the scientific process. As John Kraemer and Lawrence Gostin of Georgetown University wrote in a recent issue of the *Journal of the American Medical Association*, when people say that the cost of treating a condition is too expensive and therefore should not be used, they are actually making three separate assertions based on a mix of scientific and values-based claims: 1) the cost of treatment equals a certain amount (a positive or scientific claim), 2) treatments costing more than a certain amount are not cost-effective (both a positive claim and a normative or values-based claim), and 3) cost-effectiveness should be the basis for allocating health care resources (a normative claim).⁹⁶

If such questions cannot be answered scientifically, we should then ask whether they should be made by individuals or by the larger society through the political process. Advocates of government rationing explicitly favor the latter. For example, Knut Erik Tranoy, professor emeritus at the Centre for Medical Ethics of the University of Oslo, who is an original member of Norway’s Health Care Priorities Commission and a prominent philosophical advocate of rationing, decries “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.”⁹⁷ According to Tranoy “it is neither medically nor morally defensible to put scarce resources to uses which

Such questions are by definition values-based and cannot be answered through the scientific process.

National health care systems in other countries use comparative-effectiveness research as the basis for rationing.

will foreseeably yield less favorable outcomes than other uses—save fewer lives, cure fewer patients.”⁹⁸

This inevitably leads to the question of whether comparative-effectiveness research will simply be used to provide information, or whether it will be used to impose a government-dictated way to practice medicine.

For those seeking to use comparative-effectiveness research as a means to reduce overall health care spending, there is a good reason for making the use of such information the basis for mandatory practice guidelines. As the CBO notes, “[T]o 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.”⁹⁹ America’s Health Insurance Plans estimates that, if implemented on a purely voluntary basis, comparative-effectiveness research would produce a savings of only 0.3 percent in national health expenditures over 10 years.¹⁰⁰ The CBO estimates that the voluntary implementation of comparative-effectiveness research would reduce federal health spending by a mere “one one-hundredth of one percent” over the next 10 years.¹⁰¹

Therefore, if there is to be any significant cost savings, the results of the research would have to be imposed on a mandatory basis in a way that proscribes treatments deemed not cost-effective. Logically, the restrictions would start with government programs such as Medicare and Medicaid.¹⁰² However, it is noteworthy that Sen. Daschle has suggested that Congress should “link the tax exclusion for health insurance to insurance that complies with [comparative-effectiveness] recommendations.”¹⁰³

There is no doubt that national health care systems in other countries use comparative-effectiveness research as the basis for rationing. 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.”¹⁰⁴

It seems unlikely that most Americans are willing to accept the idea that government should make decisions about what types of treatments their doctor can provide. Moreover, even if such rationing were desirable, there is no evidence that the government would be able to make those decisions on a scientific basis. A government body deciding on the comparative-effectiveness or cost-effectiveness of medical treatments will inevitably base its decisions as much on politics as on science. As Uwe Reinhardt warns, government comparative-effectiveness research would be “vulnerable to lobbying by interest groups, because one or a few members of Congress could easily imperil [the research agency’s] existence through the appropriations process.”¹⁰⁵

Consider Oregon’s attempt to prioritize Medicaid services. In 1992, Oregon guaranteed all state residents under the poverty line a basic level of health care. At the same time, because funding was limited, the Oregon Health Services Commission drafted a priority-ranked list of medical services available to Oregonians. The state would fund services deemed priority on the basis of such factors as cost, duration of a treatment’s benefit, improvement in the patient’s quality of life, and community values. Services that did not qualify under these criteria would not be funded.¹⁰⁶ However, political calculations quickly became part of the ranking process, with the program becoming a battleground for special interests associated with various disease constituencies and health care specialties. Groups battled with each other to make sure that their needs or services were included in the list of covered services. The list was repeatedly revised to reflect not the best medical judgment but outside pressure. The legislature repeatedly intervened. The U.S. Office of Technology Assessment concluded that the Oregon’s prioritization plan “has not operated as the scientific vessel of rationing that it was advertised to be. Although initial rankings were based in large part on mathematical values, controversies around the list forced administrators to make political concessions and move medical services ‘by hand’ to satisfy constituency pressures.”¹⁰⁷

At the federal level, agencies like the Council on Health Technology, Agency for Health Care Policy and Research, and the Agency for Health Care Research and Quality have had their funding cut when their research conflicted with the desires of powerful interest groups.¹⁰⁸

The government even interferes with private sector attempts to make comparative-effectiveness decisions when those decisions impact powerful interest groups or voting blocks. For example, the Connecticut attorney general has attacked the Infectious Disease Society of America for recommending against the use of long-term antibiotics to treat chronic Lyme disease. Although the IDSA based its non-binding recommendation on the overwhelming scientific evidence, the International Lyme and Associated Diseases Society, a well-connected and media-savvy advocacy group for those with Lyme disease, protested by taking its case to the Connecticut political establishment. As a result, Connecticut attorney general Richard Blumenthal sued the IDSA under the state's anti-trust laws.¹⁰⁹

Already, special-interest groups are maneuvering to influence the outcome of comparative-effectiveness research. To cite just one example, the Partnership to Improve Patient Care is funded by groups such as Easter Seals, Friends of Cancer Research, the Alliance for Aging Research, the Advanced Medical Technology Association, and the pharmaceutical and biotech industry lobbies. It seeks to "refocus" the comparative-research debate to ensure that its members' interests are protected.¹¹⁰

There is no need for the government to get involved in comparative-effectiveness research: the private sector is already heavily involved in such research. As the CBO has pointed out, "private health plans—most commonly the larger or more integrated ones—conduct their own reviews of evidence and sometimes undertake new analysis of comparative effectiveness."¹¹¹ These companies use the research to "shape their policies regarding coverage and payment."¹¹² Most health plans, for example, have pharmacy and therapeutic committees

that make recommendations about which prescription drugs should be covered on the basis of comparative effectiveness. In addition, Blue Cross Blue Shield's Technology Evaluation Center; Hayes, Inc.; the ECRI Institute; the Tufts–New England Medical Center; the HMO Research Network; and InfoPOEMs perform or collect comparative research, and some even offer the information for sale.¹¹³ Universities and medical schools also perform such research and publish their results. Therefore, rather than produce new information on comparative-effectiveness, a government program is likely to simply crowd out private research that is already occurring.

To argue against government involvement in comparative-effectiveness research is not to argue against comparative-effectiveness research. Private sector research is occurring and should continue. Providers should make greater use of the information provided by such research. But government-directed research is unlikely to be effective, and it poses a distinct threat that it will evolve into government-imposed rationing of care. In fact, it is liable to yield the worst of all possible worlds—not only rationing, but rationing that is based on special-interest lobbying rather than science.

In short, the government should not be substituting its judgment for that of doctors and patients.

Community Rating/ Guaranteed Issue

It seems almost a certainty that any health insurance reform plan to emerge from Congress will contain a host of new insurance regulations. Among the likeliest is a requirement that insurers accept all applicants regardless of their health (guaranteed issue), and a stipulation that forbids insurers from basing premiums on risk factors such as health or age (community rating).

The regulations would be an attempt to deal with the problem of preexisting conditions. That is, people today who are uninsured, and who are suffering from expensive

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medical conditions, have great difficulty finding affordable health insurance, if they can get coverage at all.¹¹⁴ Congress, therefore, seeks to prohibit the practice of excluding people with preexisting conditions or charging them more.

Most big insurance companies, more concerned with other threats, seem willing to go along, especially if such a requirement were combined with an individual mandate.¹¹⁵ Nonetheless, imposing community rating and guaranteed issue would create far more problems than it would solve.

As the CBO has noted, community rating and guaranteed issue make it more likely that people will choose to go without health insurance.¹¹⁶ For example, in the year after New York imposed community rating in 1993, an estimated 500,000 people cancelled their insurance.¹¹⁷ This happens because community rating raises premiums for young and healthy individuals, whereas both community rating and guaranteed issue reduce or eliminate the penalty for waiting to purchase insurance until a person is older or sicker. As a result, the young and healthy make the very logical choice to forgo health insurance, assuming that they can always purchase insurance later when they need it. It is as if you could buy retroactive auto insurance *after* you've had an accident. As the healthy leave the insurance pool, the proportion of sick in the pool grows ever greater—leading to higher premiums which in turn causes the healthiest remaining individuals to leave in what amounts to an insurance death spiral.

Of course, an individual mandate will theoretically prevent the young and healthy from dropping out of the insurance market. On the other hand, combining community rating/guaranteed issue with a mandate will force young healthy individuals to purchase insurance with much higher premiums than would otherwise be the case.

In addition, by prohibiting insurers from pricing care on the basis of risk, community rating/guaranteed issue creates an incentive to over-provide care for the healthy, while under-providing it to the sick. That is because under

community rating, insurance premiums are based not on the expected cost of caring for a specific individual, but on the average cost of care for all patients. Because of the way health care costs are distributed, most of the insured under that plan will have actual costs that are lower than their premiums, while a few will have costs in excess of their premiums, and some far in excess (about 5 percent of the population accounts for nearly half of health care expenses).¹¹⁸

Therefore, for an insurance company to maximize its profitability, it will seek to do two things. First, it will want to reduce the cost of caring for its high-cost sick people, or—better yet—induce them to switch to another plan. The easiest way to do that is not to have the doctors and facilities sick people want. As Alain Enthoven has pointed out, “A good way to avoid enrolling diabetics is to have no endocrinologists on staff. . . . A good way to avoid cancer patients is to have a poor oncology department.”¹¹⁹

Second, an insurance company will seek to retain its low-cost healthy customers, and in fact, it will try to attract more such individuals. That means doing exactly the opposite of what the insurer does with sick people: it will offer services that will be attractive to healthy people, such as cancer screenings, sports medicine facilities, or even health club memberships.

Thus, while guaranteed issue and community rating may make health insurance more available and affordable for those with preexisting conditions, it may well have the perverse result of lowering the quality of care that those individuals receive.

Yet there are far less intrusive ways to deal with the admittedly pressing problem of providing a way to cover individuals with preexisting conditions. Some have suggested greater use of state-based high-risk pools. While imperfect, such proposals would represent a far less damaging way to cover those with preexisting conditions. A new and far more promising proposal is “health-status insurance,” which provides a lump-sum payment sufficient to pay the higher premiums that

insurers charge to those people with preexisting conditions. Health-status insurance covers the risk of premium reclassification, just as medical insurance covers the risk of medical expenses.¹²⁰

Middle-Class Subsidies

Almost any health care reform plan is going to contain a certain amount of subsidy to help low-income individuals obtain coverage. After all, the number one reason that people give for not purchasing insurance is that they cannot afford it.¹²¹ However, if such subsidies go too far up the income ladder, they can easily create more problems than they solve.

Until the actual legislation is finally unveiled, it is impossible to know just how extensive the subsidies will be. Yet, recent congressional actions provide cause for concern. Notably, Congress this year passed an extension of the State Children's Health Insurance Program that made it possible for states to subsidize families with incomes as high as 400 percent of the poverty level (\$83,000 for a family of four).¹²² Indeed, if one considers "income disregards" that deduct certain expenses such as mortgage payments, some families with annual incomes as high as \$100,000 could receive subsidies.¹²³ Democratic congressional leaders have indicated that they envision a further expansion of Medicaid eligibility as part of any comprehensive health care plan.¹²⁴

The expansion of subsidies will greatly increase the number of people dependent on government, extending government welfare programs well into the middle class. As with all means-tested government programs, we can expect this new middle-class welfare benefit to discourage work, family formation, wealth accumulation, and self-sufficiency, while creating a voting constituency that favors ever-expanding benefits.

And such subsidies are expensive. As part of its reform plan, Massachusetts agreed to subsidize families with incomes up to 300 percent of the poverty line (\$63,500 for a family of

four). Spending for the Commonwealth Care subsidized program has doubled, from \$630 million in 2007 to an estimated \$1.3 billion for 2009. Despite assessing insurers and hospitals, raising the penalty on noncompliant businesses, increasing premiums and copayments for consumers, and raising the state tobacco tax, the program's financing remains on an unsustainable course.¹²⁵

In addition, such subsidies are poorly targeted. Many of those eligible for coverage already have health insurance. As discussed above, this crowding-out phenomenon has been readily apparent with both the traditional Medicaid and SCHIP programs.

Therefore, the subsidies should not be seen just as a method of increasing coverage, but as a way of shifting a large portion of insurance costs from individuals to the tax system. It becomes simply another form of income redistribution. While many taxpayers may accept such redistribution to the truly poor, how will they feel about financing transfers to the middle class?

Government-Directed Health Information Technology

One area of health care reform where there is a broad-based consensus is the need for increased use of electronic medical records and other health information technologies.

Too many medical records are still maintained on paper, making it slow and difficult to pass needed information from physician to physician. Just 17 percent of U.S. physicians are currently using electronic medical records for their patients.¹²⁶ For hospitals, the numbers are even worse—just 9.1 percent have even a basic system, and just 1.5 percent have a comprehensive system.¹²⁷ Where electronic records do exist, hospital and physician systems are often incompatible. The unavailability and incompatibility of electronic medical records contributes to the unnecessary deaths of up to 8,000 people each year because of medication errors.¹²⁸

The expansion of subsidies will greatly increase the number of people dependent on government.

The government's track record on IT is not particularly inspiring.

In response, the Obama administration included \$19 billion in the stimulus bill for health information technology. Most of those funds will be used to subsidize and provide incentives for doctors and hospitals to move from paper to electronic recordkeeping. Beginning in 2011, both the Medicare and Medicaid programs will provide subsidies to physicians who adopt “meaningful use” of a “certified” electronic medical record system. Those payments could run as high as \$18,000 in the first year for those complying in 2011, with subsidies declining in future years. Hospitals will be eligible for a one-time \$2 million payment, plus an increase in their Medicare diagnosis-related group fees. However, in addition to the subsidy carrot, the stimulus bill also contained a stick. Those physicians who do not comply by 2015 will lose 1 percent of their Medicare fees, escalating to 3 percent by 2017. Noncompliant hospitals will have their DRG-based fees reduced.

More controversially, the stimulus bill also included funding to significantly expand and strengthen the office of the National Coordinator of Health Information Technology, initially created by the Bush administration, to coordinate federal efforts to ensure that every American has a “certified electronic health record” by 2014.

Some conservatives expressed concern that this provision, combined with the proposals for government-sponsored comparative-effectiveness research, would use such electronic records to “monitor treatments to make sure your doctor is doing what the federal government deems appropriate and cost-effective,” as Betsy McCaughey, an adjunct senior fellow at the Hudson Institute, wrote for Bloomberg.com.¹²⁹

While such concerns should not be dismissed out of hand, it seems more likely that the goal at this point is simply to make certain that government has “a seat at the table” as the private sector develops standards for electronic medical records, as a spokesman for the Obama administration has said.¹³⁰

That alone is reason enough for concern. The private sector is already mounting an

ambitious effort to develop electronic medical records. Health care IT spending is expected to exceed \$28.4 billion in 2009, an increase of 6.6 percent over 2008.¹³¹ And while the recession has forced a cutback in most types of IT spending, health care IT spending is expected to grow.¹³² In fact, health care IT spending in the future is expected to exceed IT spending in all other industry sectors.¹³³ Google Health Records Online has led the way, while Microsoft has teamed up with Kaiser Permanente to offer its own electronic medical record software.¹³⁴ Telemedicine companies, like TelaDoc, and patient advocacy organizations, like PinnacleCare, collect and digitize medical records for their customers.¹³⁵

On the other hand, the government’s track record on IT is not particularly inspiring. The FBI spent four years and \$170 million trying to computerize its case system, only to abandon the project in 2005. Before that, the Federal Aviation Administration wasted more than \$1 billion on a so-far unsuccessful attempt to overhaul the air traffic control computer system.¹³⁶

The stimulus bill did not define “meaningful use” or “certified electronic health records.”¹³⁷ A restrictive interpretation of these terms could well stifle private sector innovation. Moreover, imposing a single set of federal standards on health IT means the entire system will be locked in to those standards for very long time to come and future innovation will be limited. The federal government is not noted for its ability to respond rapidly to changing technology and circumstances.

Even if successful, there are reasons to question the administration’s estimates for the effectiveness of health IT, most notably projections for how much it can reduce health care spending. Proponents of government spending for health IT generally cite a RAND Corporation analysis from 2005 that predicted \$77 billion in annual savings and improved outcomes.¹³⁸ But the study also says that level of savings won’t be reached until 2019.

Moreover, numerous experts have disputed this estimate. For example, the CBO criti-

cized the RAND study as an overly optimistic, best-case scenario, and says that simply adopting electronic medical records “by itself, is generally not sufficient” to reduce costs.¹³⁹

Privacy advocates raise additional concerns about a nationwide network of electronic medical records, particularly one developed and monitored by the government. If fully implemented, the Obama blueprint would produce nationwide databases containing all of a patient’s medical information—including illnesses and genetic predispositions, alcohol and drug addiction, and medication—all attached to personal identifiers like Social Security numbers. The language in the stimulus bill appears to have significantly eroded patient privacy protections, allowing personal health data to be sold for public or private purposes.¹⁴⁰ The government has further always maintained that law enforcement must have access to otherwise private medical data.¹⁴¹

Even without deliberate government action, there are threats to patient privacy and the security of electronic medical records. As Robert Bazell of NBC recently reported, “There have been privacy breaches already: hackers getting into hospital systems, doctors losing laptops, and medical staff looking at records they don’t need to see.”¹⁴² The government, in particular, has had several notorious privacy breaches, such as the theft of a Veterans Administration laptop (which contained personal data, including Social Security numbers) and the National Institute of Health’s loss of a laptop (which contained sensitive medical information on 2,500 patients enrolled in NIH studies).¹⁴³

Such privacy breaches are probably unavoidable as health records naturally migrate to online formats. But a single nationwide network under government supervision would magnify the danger.

As with comparative-effectiveness research, health IT is desirable because it is something that could ultimately improve health care and reduce costs. However, just because something is worth doing does not mean, therefore, that

the government should do it. The private sector is already making strides in developing effective electronic medical records. Increased government involvement threatens to slow down this progress, creates new dangers for patient privacy, and potentially threatens both patient and physician choice.

A Brief Word about Cost

No one knows how much the final health care reform plan will cost. As mentioned above, the Obama administration’s proposed 2009 budget sets aside \$634 billion as a contingency “down payment.” Other estimates put the total costs in the range of \$1.5–1.7 trillion over a 10-year period.¹⁴⁴

However, 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.¹⁴⁵ 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.¹⁴⁶ 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.¹⁴⁷ If the current estimates for the cost of Obamacare are off by similar orders of magnitude, we would be enacting a new entitlement that could bury future generations under mountains of debt and taxes.

The administration has raised a number of ideas for how to pay for the program. Their budget would fund the \$634 billion down payment through a number of measures, including reducing payments to private insurers under the Medicare Advantage Program; reducing the rate at which taxpayers with over \$250,000 in annual income can itemize tax deductions; and a number of smaller proposals to increase efficiency and reduce waste.¹⁴⁸ However, these proposals were stripped out of

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the budget resolution that was approved by Congress. Reform supporters must now look for other funding mechanisms. For example, Sen. Kent Conrad (D-ND), chairman of the Senate Budget Committee, has suggested that he is open to “energy taxes” as a way to pay for health care reform.¹⁴⁹ However, such measures will fall far short of what is necessary to pay for the full costs of the reform plan. It will be necessary therefore to either 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.¹⁵⁰

As humorist P. J. O’Rourke once said, “If you think health care is expensive now, wait until you see what it costs when it’s free.”¹⁵¹

Conclusion

It is likely that Congress will vote on a health care reform bill before the end of the year.¹⁵² While the details of that bill have not yet been revealed, its broad outlines are readily apparent from the campaign promises and more recent statements of President Obama, the writings and statements of the Obama administration’s health care advisers, and proposals by the congressional Democrats who have been leading the administration’s efforts on Capitol Hill.

Unfortunately, it appears that the final proposal will be a cornucopia of bad policy ideas. It would impose an unprecedented level of government control over one-sixth of the U.S. economy and over some of the most important, personal, and private decisions that Americans make, while setting the stage for the eventual evolution into a single-payer system.

Given the problems facing our health care system—high costs, uneven quality, millions of Americans without health insurance—it sometimes seems that things couldn’t possibly get any worse. But if the final health care reform plan contains most or all of these bad ideas, things could indeed get worse—much worse.

For the economy, Obamacare could mean trillions of dollars in new taxes and the loss of

hundreds of thousands of jobs. Health care providers could find their ability to practice medicine constrained and directed by far away government bureaucracies. But for individual health care consumers the consequences could be far worse: they would face far fewer choices and the possibility of far poorer care.

Health care clearly needs reform—but getting that reform right is more important than just doing *something*.¹⁵³ Obamacare, unless it is drastically revised in the coming months, gets that reform wrong.

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