



**NEWLY UPDATED & REVISED FOR 2011**

# **BAD MEDICINE**

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**A GUIDE TO THE REAL COSTS AND CONSEQUENCES  
OF THE NEW HEALTH CARE LAW**

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Cover design by Jon Meyers.

Printed in the United States of America.

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Washington, D.C., 20001  
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## Executive Summary

It has been a year since President Obama's health care reform bill was signed into law. 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 length and complexity of the legislation, combined with a debate that often generated more heat than light, has led to massive confusion about the law's likely impact. But it is now possible to analyze what is and is not in it, what it likely will and will not do. In particular, we now know that

- While the new law will increase the number of Americans with insurance coverage, it falls significantly short of universal coverage. By 2019, roughly 21 million Americans will still be uninsured.
- The legislation will cost far more than advertised, more than \$2.7 trillion over 10 years of full implementation, and will add more than \$823 billion to the national debt over the program's first 10 years.

- 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.
- The new law will increase taxes by more than \$569 billion between now and 2019, and the burdens it places on business will significantly reduce economic growth and employment.
- While the law contains few direct provisions for rationing care, it nonetheless sets the stage for government rationing and interference with how doctors practice medicine.
- Millions of Americans who are happy with their current health insurance will not be able to keep it.

In short, the more we have learned about what is in this new law, the more it looks like bad news for American taxpayers, businesses, health care providers, and patients.



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## *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.<sup>1</sup> 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.<sup>2</sup>

More than 2,500 pages and 500,000 words long,<sup>3</sup> 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.<sup>4</sup> The employer mandate is far less onerous than the 8 percent payroll tax once championed by the House.<sup>5</sup> And a proposed income tax surtax on the wealthy was dropped.<sup>6</sup> 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).

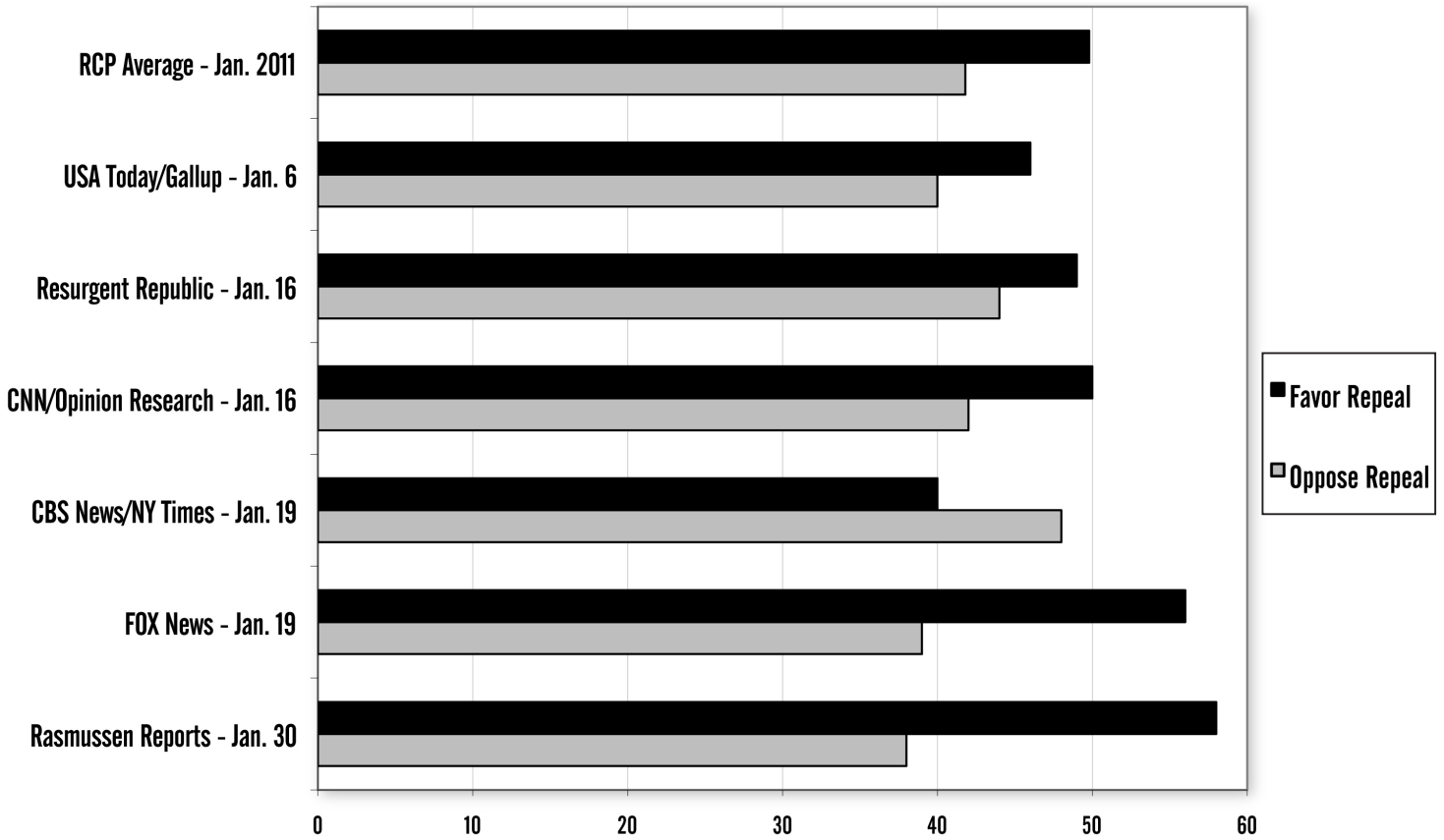
Republicans ran on a platform of “repeal” or “repeal and replace” during the 2010 midterm elections, and surveys suggest that opposition to the health care law was an important reason that they recaptured the House and gained six Senate seats. On health care, exit polls showed that at least half of voters 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 oversampling Democratic voters, an even better measure might be an election-night Rasmussen telephone poll that found 59 percent of voters in favor of repeal.<sup>7</sup> 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.<sup>8</sup> Another post-election survey found that 45 percent saw their vote as a specific message of opposition to the health care bill.<sup>9</sup>

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.<sup>10</sup> 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.<sup>11</sup>

**The individual  
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unprecedented in  
U.S. governance.**



**Figure 1**  
**Repeal of Health Care Law**



Source: Real Clear Politics.

Meanwhile, outside of Washington, opposition remains active. Seven states—Arizona, Idaho, Louisiana, Missouri, Oklahoma, Utah, and Virginia—have passed variations of the Health Care Freedom Act prohibiting mandatory health insurance.<sup>12</sup> 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.<sup>13</sup>

Plaintiffs include 28 states, as well as individuals, business groups, and others.<sup>14</sup> To date, the outcome of those suits has been mixed. In two minor lawsuits in Michigan and Virginia, courts have upheld the mandate.<sup>15</sup> 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.<sup>16</sup> 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?”<sup>17</sup> 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.”<sup>18</sup> 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.<sup>19</sup>

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 resi-

dence in the United States.”<sup>20</sup> Moreover, the individual mandate raises serious constitutional questions.<sup>21</sup> Even the Congressional Research Service was not able to conclude it was constitutional!<sup>22</sup>

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.<sup>23</sup> 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.<sup>24</sup> 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.<sup>25</sup>

According to the CBO, roughly four million Americans will be hit by penalties in 2016, with the penalties averaging slightly more than \$1,000.<sup>26</sup> In fact, the federal government expects to raise \$17 billion from penalties by 2019.<sup>27</sup>

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

**Simply having insurance is not necessarily enough to satisfy the mandate.**

**More than two-thirds of companies could be forced to change their current coverage.**

for children.<sup>28</sup> The secretary of HHS is given the authority to define the meaning of those terms and ultimately to set the minimum benefits package.<sup>29</sup> 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.<sup>30</sup>

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.<sup>31</sup> They will even be able to 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.<sup>32</sup>

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 non-complying 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)<sup>33</sup> 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.<sup>34</sup> 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.<sup>35</sup> 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.<sup>36</sup> 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.<sup>37</sup> 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.<sup>38</sup>

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.<sup>39</sup> 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.<sup>40</sup>

The law also contains an employer mandate. Beginning in 2014, if a company with 50 or more full-time employees (or the equivalent<sup>41</sup>) 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.<sup>42</sup> CBO estimates that those penalties will cost businesses \$52 billion from 2014 to 2019.<sup>43</sup>

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.<sup>44</sup> 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.<sup>45</sup>

Even offering the correct benefits will not necessarily exempt companies from penal-

ties. 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.<sup>46</sup>

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.”<sup>47</sup>

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.<sup>48</sup> In fact, a survey by Towers Watson shows that employers are preparing to take exactly those steps.<sup>49</sup>

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.”<sup>50</sup> As an internal document prepared for Verizon explains “Even though the pro-

**Some of the regulatory changes are likely to have unintended consequences.**

**Such a rigid cap  
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posed assessments [on companies that do not provide health care] are material, they are modest when compared to the average cost of health care.”<sup>51</sup> In fact, CBO estimates that at least 10 to 12 million workers could lose their current employer-provided health insurance.<sup>52</sup> Approximately 8 to 9 million could end up on Medicaid, with the rest purchasing subsidized coverage through the exchanges (see below).<sup>53</sup> 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.<sup>54</sup>

## **Insurance Regulations**

Since the advent of the McCarran-Fergusson Act in 1945, health insurance has been primarily regulated at the state level.<sup>55</sup> 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.<sup>56</sup>

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.<sup>57</sup>

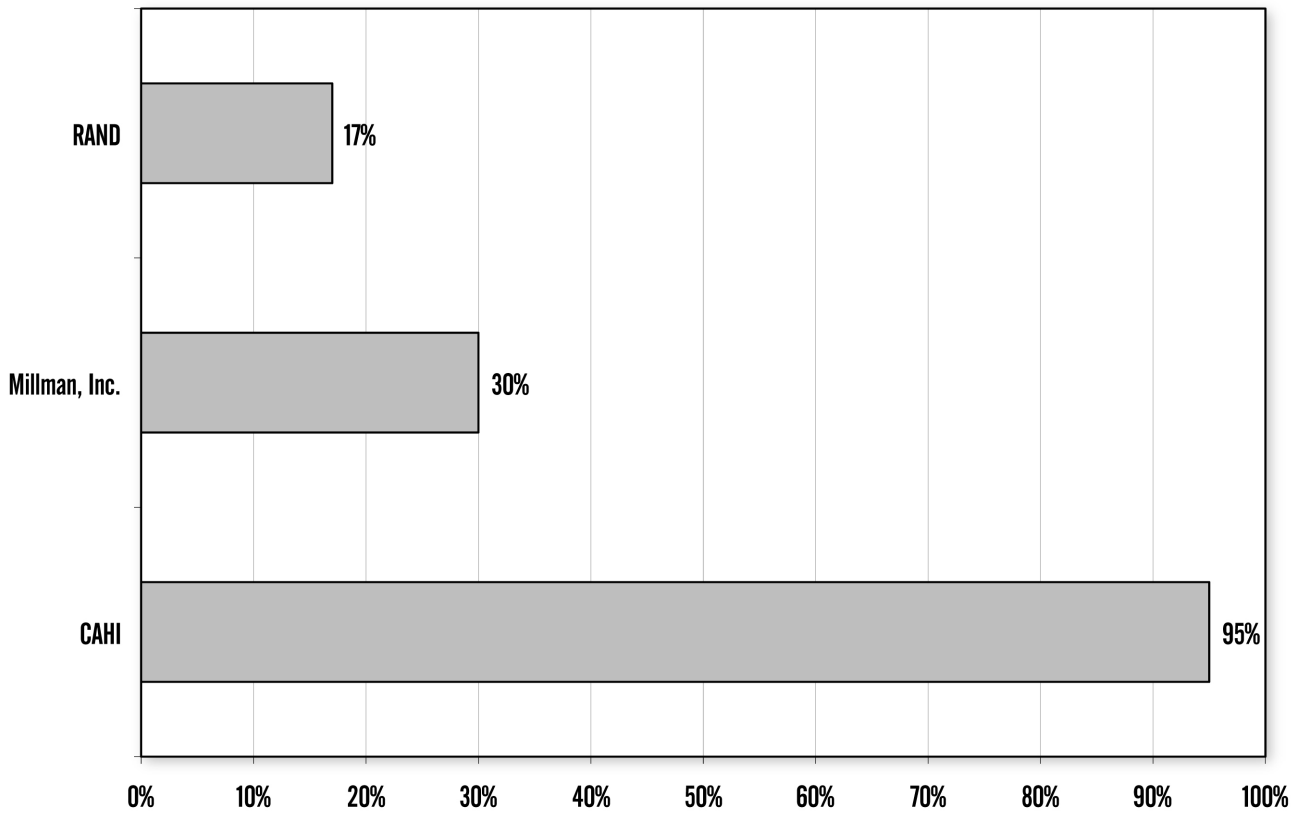
Specifically, the law would require insurers to “accept every employer and individual . . . that applies for such coverage.”<sup>58</sup> Insur-

ers are also forbidden to cancel insurance if a policyholder becomes sick.<sup>59</sup> 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.<sup>60</sup> Insurers may consider age in setting premiums, but those premiums cannot be more than three times higher for their oldest than their youngest customers.<sup>61</sup> Smokers may also be charged up to 50 percent more than nonsmokers.<sup>62</sup> 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.<sup>63</sup>

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.<sup>64</sup> Until then, adults with preexisting conditions will be eligible to participate in federally sponsored high-risk pools.<sup>65</sup> 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.<sup>66</sup> 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 pools. In fact, by the end of 2010, only 8,011 people had signed up nationwide.<sup>67</sup> 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.<sup>68</sup> However, a bigger problem may be the structure of the program, which is incompatible with existing state high-risk pools.<sup>69</sup> 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.

**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.

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.<sup>70</sup> 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.<sup>71</sup> 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).<sup>72</sup>

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.

**Tennessee's  
experience with  
TennCare  
provides a  
cautionary tale.**

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.<sup>73</sup>

In a similar vein, the law also bans “rescissions,” or the practice of insurers dropping coverage for individuals who become sick.<sup>74</sup> 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.<sup>75</sup> 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.<sup>76</sup>

A second new insurance regulation would prohibit insurers from imposing lifetime limits on benefit payouts.<sup>77</sup> 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.<sup>78</sup> 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.<sup>79</sup>

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.<sup>80</sup>

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.<sup>81</sup> 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.<sup>82</sup> 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.<sup>83</sup> However, at least 50 companies have had their requests for waivers denied. (The administration will not divulge the names of those companies.)<sup>84</sup>

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.<sup>85</sup> 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.<sup>86</sup>

In addition, the law requires insurers to maintain a medical loss-ratio (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.<sup>87</sup> 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.<sup>88</sup> 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).<sup>89</sup> 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.<sup>90</sup>

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.<sup>91</sup> 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.<sup>92</sup>

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.<sup>93</sup> And Aetna has announced that it is pulling out of the individual market in

Colorado.<sup>94</sup> 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.<sup>95</sup> 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).<sup>96</sup> 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.<sup>97</sup> 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

**The phase-out of these benefits creates a high marginal tax penalty.**



**All together the law represents a massive increase in the welfare state.**

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.<sup>98</sup> Despite this massive increase in spending, health outcomes did not improve. Even the state's Democratic governor Phil Bredesen called the program "a disaster."<sup>99</sup> 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.<sup>100</sup> 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.<sup>101</sup>

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).<sup>102</sup> States must maintain their current income eligibility levels for the program.<sup>103</sup>

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.<sup>104</sup>

There are actually two separate credits designed to work more or less in conjunction with one another. The first is a "premium tax credit."<sup>105</sup> 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.<sup>106</sup> 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.<sup>107</sup>

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.<sup>108</sup> 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.<sup>109</sup> The program

will reimburse insurers for 80 percent of retiree claims between \$15,000 and \$90,000.<sup>110</sup> Insurers are required to pass those savings on to employers through lower premiums, though how that will be enforced remains a question.<sup>111</sup>

The law also increases funding for community health centers by \$11 billion.<sup>112</sup> 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.<sup>113</sup>

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 the exchanges are "the most important element in the plan."<sup>114</sup> 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."<sup>115</sup>

However, one should be skeptical of claims that the exchange will reduce premiums. In

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Massachusetts, supporters of the “Connector” claimed that it would reduce premiums for individual insurance policies by 25 to 40 percent.<sup>116</sup> Instead, premiums for policies sold through the Connector have been rising, up 11 percent for the lowest cost plans since the program began.<sup>117</sup>

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.<sup>118</sup> 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.<sup>119</sup> 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.<sup>120</sup> The pools would also include individual or small-group policies sold outside the exchange.<sup>121</sup> Existing plans could not be included in those pools, however.<sup>122</sup>

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.<sup>123</sup> However, beginning in 2017, states have the option of opening the exchange to large employers.<sup>124</sup>

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.<sup>125</sup> 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.<sup>126</sup>

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).<sup>127</sup> 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.<sup>128</sup> 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.)<sup>129</sup>

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.<sup>130</sup> The multi-state plans must meet the licensing and regulatory requirements of each state in which they are offered.<sup>131</sup> 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.<sup>132</sup>

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

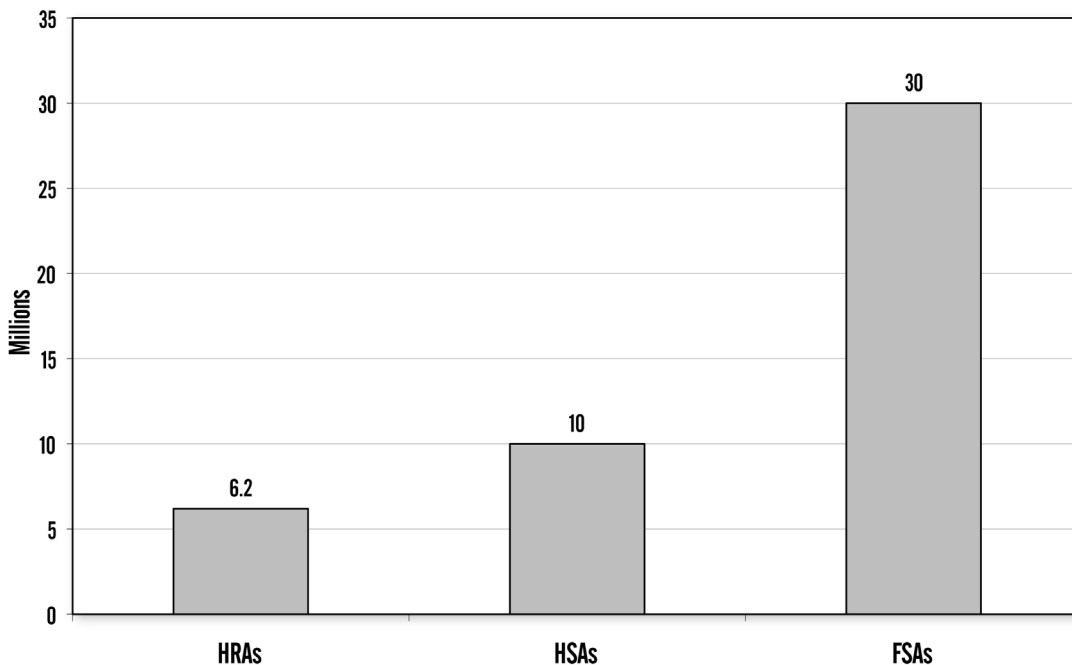
the progress in recent years toward more consumer-directed health care.

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.<sup>133</sup> 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.<sup>134</sup> More than 46 million workers currently participate in consumer-directed health plans (see Figure 3).

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

**The fate of HSAs is therefore dependent on a regulatory ruling by the Secretary of HHS.**

**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.

**The legislation  
does cut  
Medicare—  
and it should!**

need.”<sup>135</sup> 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.<sup>136</sup> 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.<sup>137</sup> 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.”<sup>138</sup>

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.<sup>139</sup> 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.<sup>140</sup> 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 cur-

rent 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.”<sup>141</sup> 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.<sup>142</sup> 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.

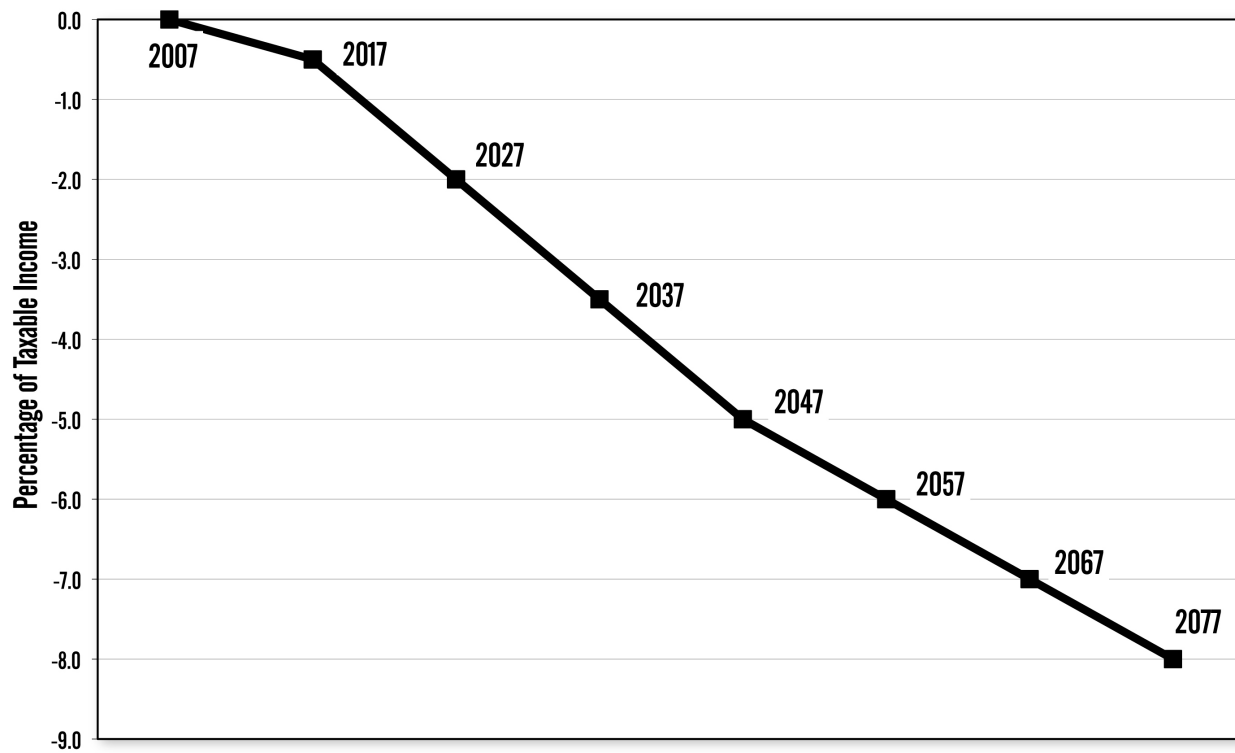
Finally, insurers must make certain that their high-deductible plans are designed so as to comply with the law’s limits on out-of-pocket expenses.

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 high-deductible policies.<sup>143</sup> 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.<sup>144</sup> Starting this year, the maximum tax-exempt contribution to an FSA was cut in half, from \$5,000 annually to just \$2,500.<sup>145</sup> 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.<sup>146</sup>

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 repre-

**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.

sents 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.<sup>147</sup> 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.<sup>148</sup> Still, that should not obscure the necessity for dealing with Medicare’s looming financial crisis (see Figure 4).

The legislation anticipates a *net* reduction in Medicare spending of \$416.5 billion over 10 years.<sup>149</sup> 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.<sup>150</sup>

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.<sup>151</sup> 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

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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.<sup>152</sup> 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,<sup>153</sup> something that Democrats have derided as wasteful.<sup>154</sup> 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.<sup>155</sup>

The law imposes a new competitive bidding model on the Medicare Advantage program that will effectively end the 14 percent overpayment.<sup>156</sup> 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.<sup>157</sup> 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.<sup>158</sup>

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.<sup>159</sup> 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.<sup>160</sup> 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.<sup>161</sup> This change is expected to reduce total imaging expenditures by as much as \$2.3 billion over 10 years.<sup>162</sup> Other Medicare cuts include freezing reimbursement rates for home health care and inpatient rehabilitative services and \$1 billion in cuts to physician-owned hospitals.<sup>163</sup>

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.<sup>164</sup> Medicare spending varies wildly from region to region, without any evidence that the variation is reflected in the health of patients or procedural outcomes.<sup>165</sup> 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.<sup>166</sup> In fact, it could be argued that Medicare is particularly unsuited for such a policy.<sup>167</sup>

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.<sup>168</sup> Some of President Obama's health care advisers, such as former senator Tom Daschle have recommended that it be extended to private insurance plans.<sup>169</sup> 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.<sup>170</sup>

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.<sup>171</sup> 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.<sup>172</sup> Proponents justified the subsidy on the grounds that companies would otherwise dump workers into Medicare, raising the cost of the Part D, prescrip-

tion 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.<sup>173</sup> The health care legislation retains the subsidy but eliminates the tax break beginning in 2013.<sup>174</sup>

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.<sup>175</sup>

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.<sup>176</sup> 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."<sup>177</sup> 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

**Savings from the cuts will not be used to deal with Medicare's looming budget shortfalls.**



**The legislation does nothing to reform the program's unsustainable structure.**

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).<sup>178</sup> That leaves IPAB with few options beyond reductions in provider payments. Hospitals and hospices would be exempt from any cuts until 2020.<sup>179</sup> 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.<sup>180</sup>

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.<sup>181</sup>

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.<sup>182</sup>

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.<sup>183</sup> 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.<sup>184</sup> 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."<sup>185</sup> 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.”<sup>186</sup>

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.<sup>187</sup> 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.<sup>188</sup>

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.<sup>189</sup>

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.”<sup>190</sup> 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.<sup>191</sup> 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.<sup>192</sup> 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.<sup>193</sup> 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.”<sup>194</sup>
- **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.<sup>195</sup> The payroll tax hike would mean that in eight states, workers would face marginal tax rates in excess of 50 percent (see Figure 5).<sup>196</sup>

**The combination of taxes and subsidies in this law results in a substantial redistribution of income.**

**Figure 5**  
**States with Marginal Tax Rates over 50 percent after PPACA**



Source: Tax Foundation, Private Report.

- **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.<sup>197</sup> 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.<sup>198</sup> The increased threshold would be postponed until 2016 for taxpayers age 65 or older.<sup>199</sup>
- **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.<sup>200</sup> The structure of this tax almost guarantees that it will be passed along to consum-

ers 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.<sup>201</sup> The secretary of HHS has the authority to waive this tax for items that are “sold at retail for use by the general public.”<sup>202</sup> 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.”<sup>203</sup> 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.<sup>204</sup>
- **Additional Taxes on Insurers.** Similar to the tax on pharmaceutical companies, the legislation imposes a tax on health insurers based on their market share.<sup>205</sup> 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.<sup>206</sup> 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.<sup>207</sup> However, some insurers in Michigan and Nebraska received a special exemption.<sup>208</sup> 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.)<sup>209</sup>
- **Tax on Tanning Beds.** The legislation imposes a 5 percent tax on tanning salons.<sup>210</sup> 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.<sup>211</sup> In contrast, those earning \$18,000–\$55,000 per year will see a net income increase of roughly \$2,000 per family.<sup>212</sup>

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.<sup>213</sup> 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.<sup>214</sup>

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.<sup>215</sup>

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.<sup>216</sup> However, the CBO estimates that will be roughly

**The Patient Protection and Affordable Care Act is a tax and regulatory nightmare.**

\$123 per month for the average worker.<sup>217</sup> Other estimates suggest that the premiums could be much higher, perhaps \$180–\$240 per month.<sup>218</sup> Workers must contribute to the program for at least five years before they become eligible for benefits.<sup>219</sup> (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.)<sup>220</sup> There is no health underwriting of participation or premiums.

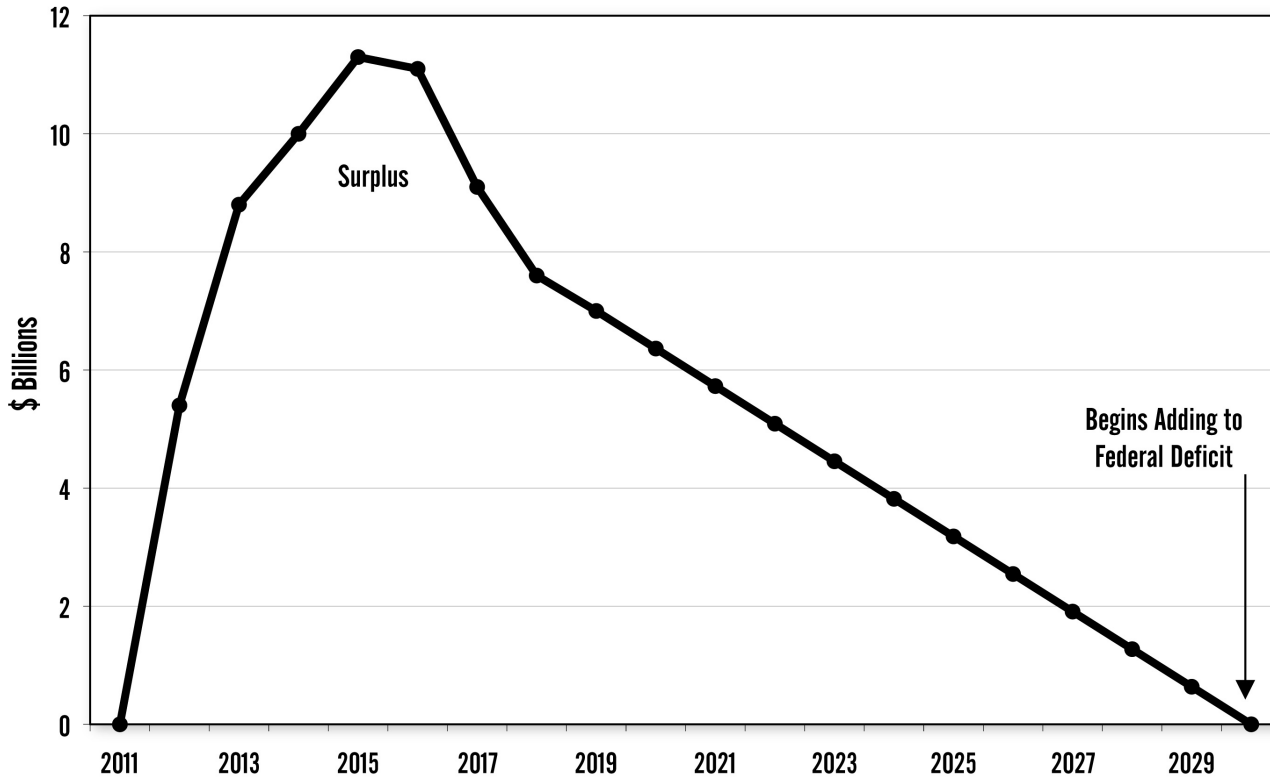
The actual benefits to be provided under the program are among the many details that remain to be determined but will not be “less than an average of \$50 daily adjusted for inflation.”<sup>221</sup> Some estimates suggest that benefits will average roughly \$75 per day, or slightly more than \$27,000 per year.<sup>222</sup> 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.<sup>223</sup> Benefits may be paid daily, weekly, monthly, or deferred and rolled over from month to month at the beneficiary’s discretion.<sup>224</sup> 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.<sup>225</sup> The secretary of HHS may also develop different or additional eligibility requirements.<sup>226</sup>

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

**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.

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).

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.<sup>227</sup> 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.”<sup>228</sup> 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.<sup>229</sup> 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.”<sup>230</sup> 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.”<sup>231</sup> 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.”<sup>232</sup>

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.<sup>233</sup> 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.<sup>234</sup> And, Richard Foster suggests that just 2 percent of workers will participate after three years.<sup>235</sup> 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.”<sup>236</sup>

Making matters worse, the legislation caps premiums for low-income workers and undergraduate students and prohibits future premium hikes for some groups of retirees.<sup>237</sup> 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

**The CLASS Act may represent one of the health care legislation’s biggest fiscal time bombs.**

**Some estimates suggest we will face a shortage of more than 150,000 physicians.**

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.<sup>238</sup> 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.<sup>239</sup> More than 200,000 establishments will be affected by the change.<sup>240</sup> The law also requires nutrition information to be posted on food and beverage vending machines.<sup>241</sup>

There is no doubt that the United States has a serious obesity problem.<sup>242</sup> 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.<sup>243</sup>

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.<sup>244</sup> 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.<sup>245</sup>

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.<sup>246</sup> 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."<sup>247</sup>

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.<sup>248</sup> Other grants would provide incentives for states to shift Medicaid beneficiaries away from nursing homes and toward care in the home or community.<sup>249</sup>

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.<sup>250</sup>

Of greater concern is a provision to establish a private, nonprofit institute to con-

duct comparative effectiveness research.<sup>251</sup> 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.<sup>252</sup> In fact, by some estimates as much as 30 percent of all U.S. health spending produces no discernable value.<sup>253</sup> 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.<sup>254</sup> 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.<sup>255</sup> 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.<sup>256</sup> 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.<sup>257</sup>

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.<sup>258</sup> 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.<sup>259</sup>

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.<sup>260</sup> It would also fund new educational centers in geriatric care, chronic-care management, and long-term care.<sup>261</sup> 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.<sup>262</sup> 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 kick-back” (a provision that committed the federal government to picking up the cost of Nebraska’s Medicaid expansion forever) was removed by the reconciliation bill.<sup>263</sup> However, much other pork remains. For example, the legislation included \$100 million in special funding for a hospital in Connecticut;<sup>264</sup> and money for asbestos abatement in a Montana town.<sup>265</sup> 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.<sup>266</sup>

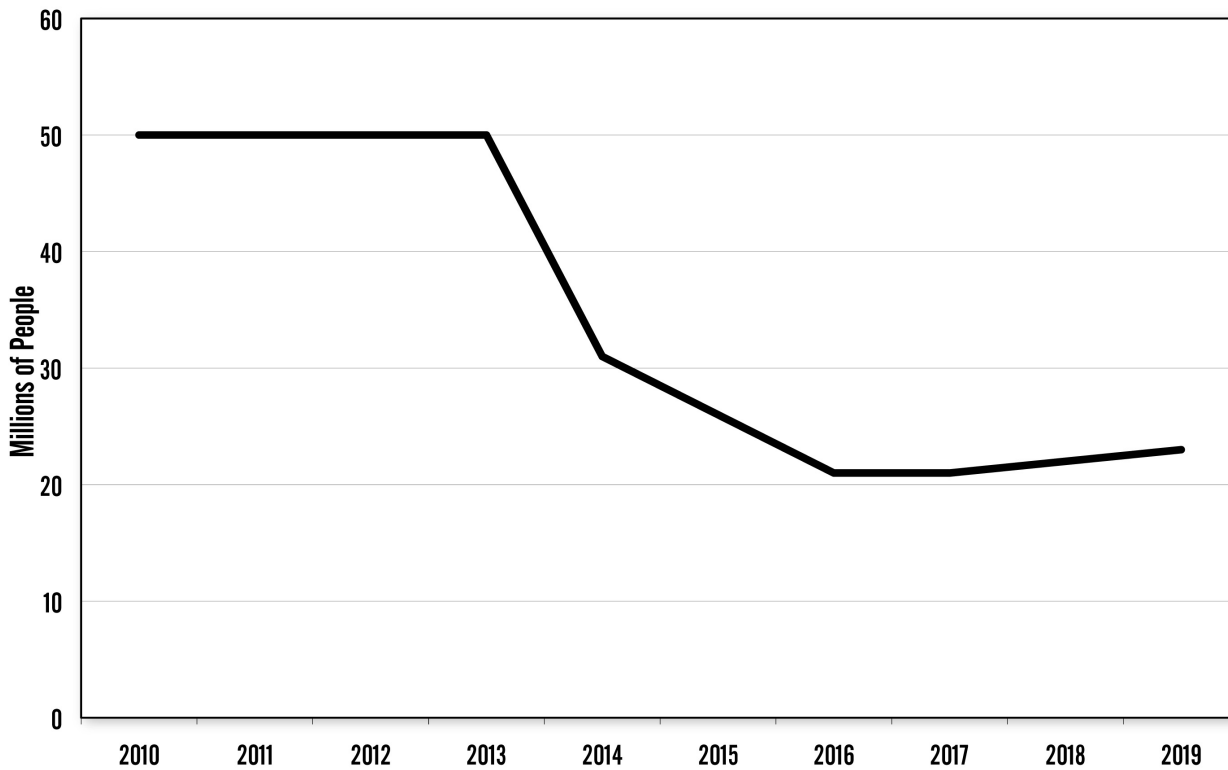
## ***Part II:*** ***Costs and Consequences*** **Expanded, Not Universal, Coverage**

Passage of health care reform was heralded by some in the media as providing “near

**By 2019, CBO  
expects there to  
be more than  
23 million  
uninsured.**



**Figure 7**  
**Number of Uninsured under PPACA**



Source: Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010.

universal coverage.”<sup>267</sup> 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.”<sup>268</sup> 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.<sup>269</sup> 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).<sup>270</sup> 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.

Supporters of the legislation point out that that would decrease the number of un-

insured Americans to roughly 6–8 percent of non-elderly Americans, a far cry from universal coverage, but undoubtedly better than today’s 15 percent.<sup>271</sup>

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.<sup>272</sup> RAND also estimates that increases in coverage would occur somewhat more slowly than does the CBO.<sup>273</sup>

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.<sup>274</sup> 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.<sup>275</sup> 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.<sup>276</sup> 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.<sup>277</sup> Given that roughly a third of physicians no longer accept Medicaid patients,<sup>278</sup> 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.<sup>279</sup> 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.<sup>280</sup>

## **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.<sup>281</sup>

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.<sup>282</sup> 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.<sup>283</sup>

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).<sup>284</sup>

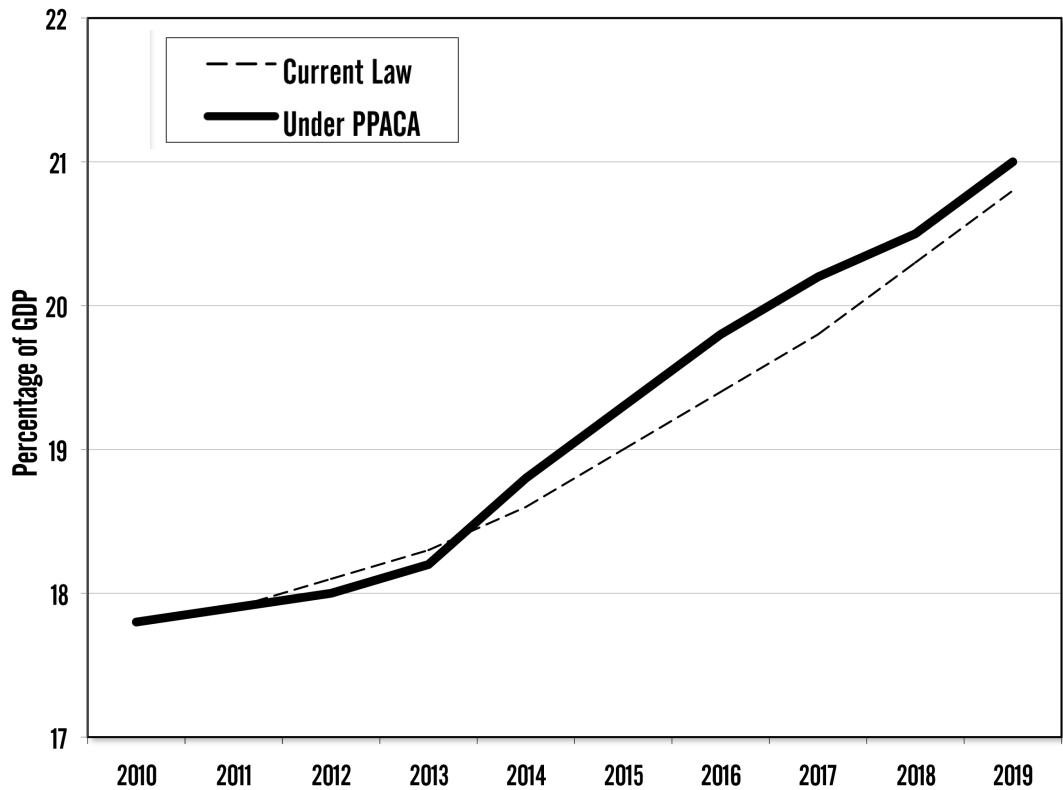
This should not come as a big surprise. The primary focus of the legislation was to expand insurance coverage. Giving more people access to more insurance, not to mention mandating that current insurance cover more services, will undoubtedly result in more spending. In fact, we should not be surprised 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.<sup>285</sup> 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 earli-

**If utilization increases substantially spending could likewise skyrocket.**

**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.

er 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.<sup>286</sup>

The Congressional Budget Office scored the Senate-passed Patient Protection and Affordable Care Act as costing \$875 billion over 10 years.<sup>287</sup> The changes passed under reconciliation increased that cost to \$938 billion.<sup>288</sup> 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.<sup>289</sup> However, since program costs will be on an

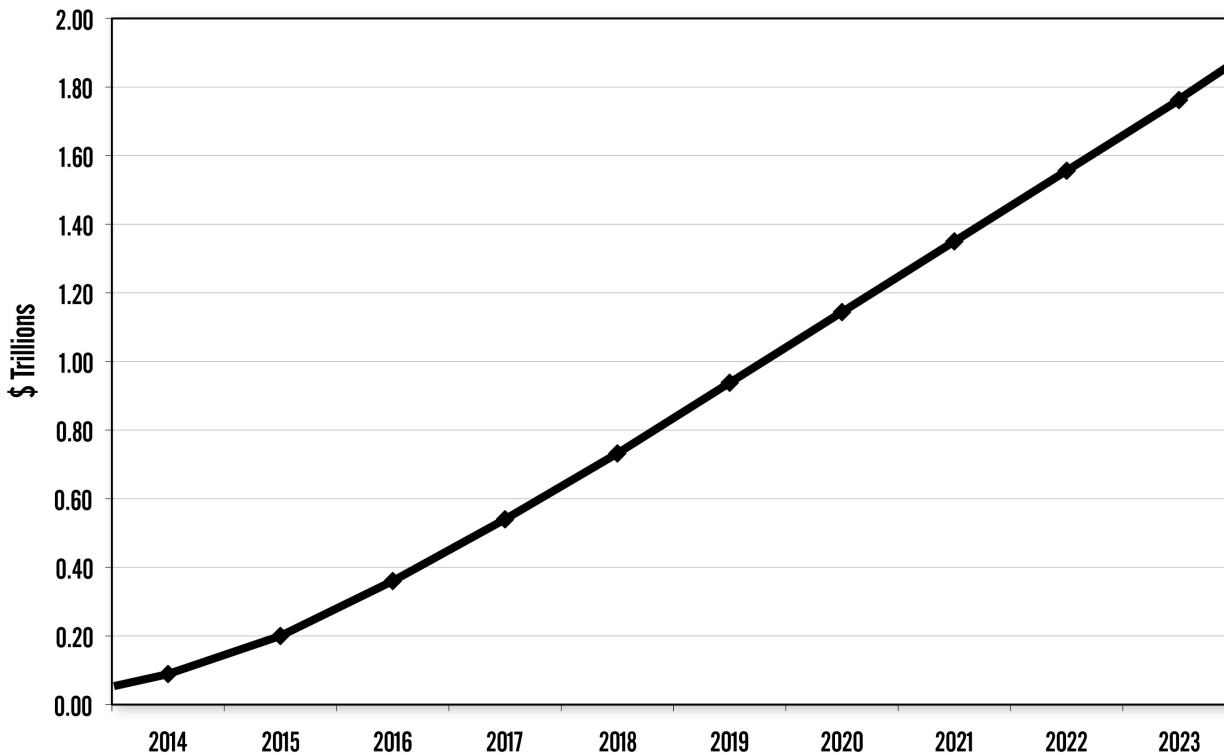
upward trajectory through 2019 (see Figure 9), it expects the cost of the program to continue to grow rapidly after 2019.

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.

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*.<sup>290</sup> In reality, however, that scoring is achieved through the use of yet another budget gimmick.

**Much of the bill’s cost is shifted onto businesses, individuals, and state governments.**

**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.

As mentioned above, the legislation anticipates a 23 percent reduction in Medicare fee- for-service reimbursement payments to providers, yielding \$196 billion in savings.<sup>291</sup>

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.<sup>292</sup> 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.<sup>293</sup> However, other sources, including the Obama administration have suggested the cost could go as high as \$371 billion.<sup>294</sup>

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.<sup>295</sup>

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 au-

thorizes “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.<sup>296</sup>

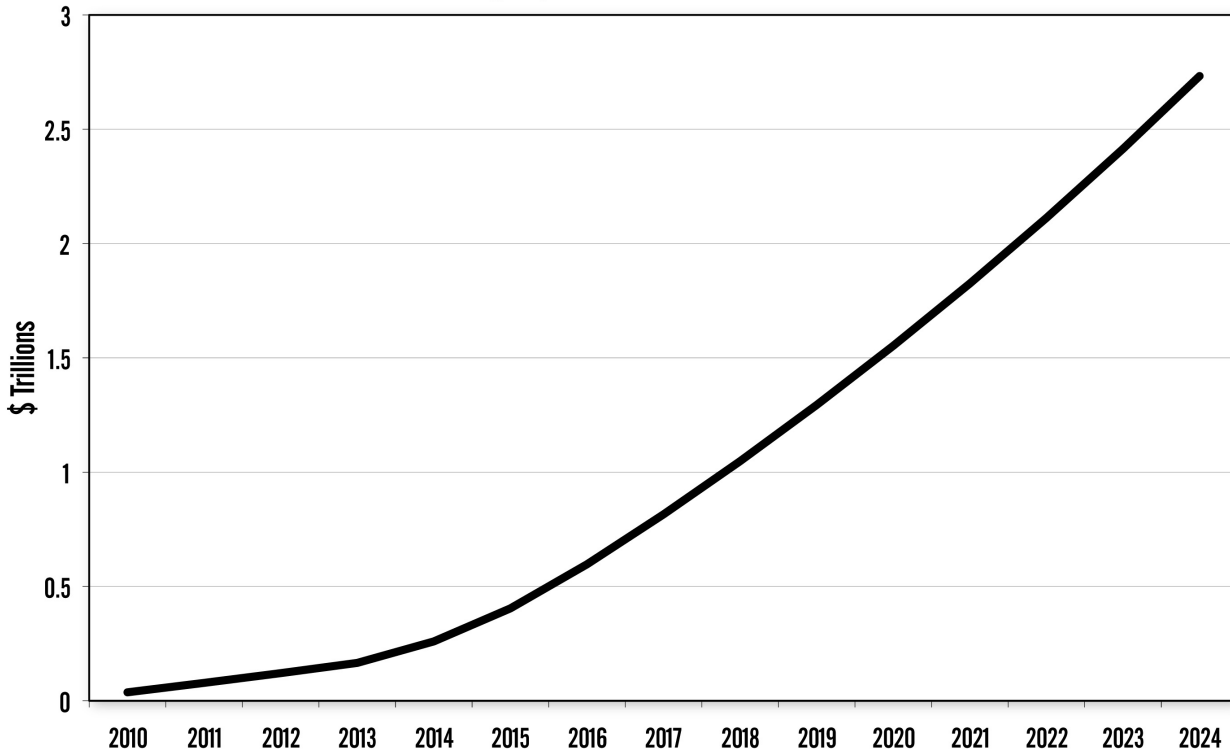
As Figure 10 shows, adding the cost of the doc-fix, discretionary costs, and other costs that were not originally included in CBO’s score to the legislation brings the total cost over 10 years of actual operation to over \$2.7 trillion.<sup>297</sup>

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.<sup>298</sup> 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 pur-

**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.

chase 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.<sup>299</sup> 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."<sup>300</sup>

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 be 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.<sup>301</sup>

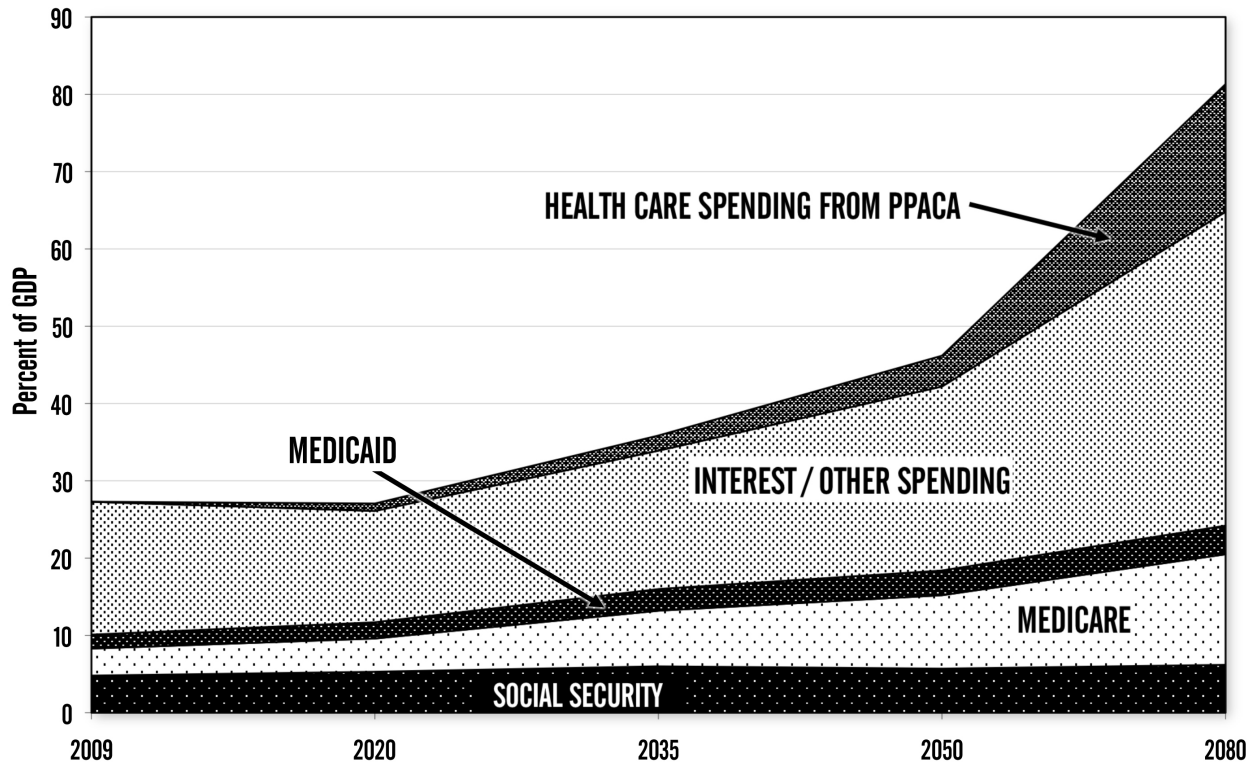
Finally, it is important to point out that much of the bill's cost is shifted off the federal books onto businesses, individuals, and state governments through mandates and other regulatory requirements. These business and individual mandates are the equivalent of tax increases, but those costs aren't 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.<sup>302</sup> 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.<sup>303</sup>

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.<sup>304</sup> 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.<sup>305</sup> 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.<sup>306</sup> If the current estimates for the cost of Obamacare are off by similar

**Millions of Americans who purchase insurance on their own will actually be worse off.**

**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.”

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.”<sup>307</sup> Another study, by former CBO director Douglas Holtz-Eakin and Cameron Smith warns that shifting employees to government-subsidized coverage could increase the legis-

lation’s cost by as much as \$1.4 trillion over 10 years.<sup>308</sup> 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.<sup>309</sup> Under current projections, government spending will rise from its traditional 20–21 percent of our gross domestic product to 43 percent by 2050.<sup>310</sup> That would require more than a doubling of the tax burden just to keep up.

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.<sup>311</sup> 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.<sup>312</sup> 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.<sup>313</sup> In the nongroup—that is employer-based—market, premiums average \$4,825 for an individual, and \$13,375 for a family.<sup>314</sup> 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.<sup>315</sup> 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.<sup>316</sup>

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.<sup>317</sup> 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.<sup>318</sup> 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.<sup>319</sup>

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.<sup>320</sup> Thus, this bill will cost a family buying their own health insurance an additional \$2,100 per year in higher premiums (see Table 1).

Indeed, premiums for 2011 have risen rapidly due to factors both related and unrelated to the PPACA.<sup>321</sup> Early estimates suggest that the bill itself has been responsible for a premium hike of roughly 9 to 12 percent.<sup>322</sup>

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,

**The new law makes government rationing far more likely in the future.**



**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.

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.”<sup>323</sup> But Richard Foster, the government’s own chief actu-

ary, has testified that that statement is “not true.”<sup>324</sup> 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 debate over health care reform is far from over.**

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,"<sup>325</sup> 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.<sup>326</sup> 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.<sup>327</sup>

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.<sup>328</sup> 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.*"<sup>329</sup>

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 gov-

**The Patient Protection and Affordable Care Act will cost more than \$2.7 trillion . . . and add more than \$823 billion to the national debt.**

**The law's individual mandate continues to pose a threat to people being able to keep their current coverage.**

ernment-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.<sup>330</sup> 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**

<b>2010</b> (already in place)	<p>Five percent tax imposed on tanning salons.</p> <p>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.</p> <p>\$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.</p> <p>Insurers required to provide coverage for children regardless of preexisting conditions. The prohibition on excluding preexisting conditions does not apply to adults until 2014.</p> <p>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.</p> <p>Parents may keep children on their insurance plan until the child reaches age 26.</p> <p>Lifetime caps on insurance benefits prohibited.</p>
<b>2011</b>	<p>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.</p> <p>A three-year phase-out of subsidies to Medicare Advantage begins. Some seniors may be forced back into traditional Medicare.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Workers begin contributing to the CLASS Act long-term care program, or may opt out of the program.</p> <p>\$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.</p>
<b>2012</b>	<p>Businesses required to complete 1099 forms for every business-to-business transaction of \$600 or more.</p>

*Continued next page*

**Table 2 Continued**  
**Patient Protection and Affordable Care Act Timeline for Implementation**

<b>2013</b>	<p>2.3 percent excise tax imposed on sale of medical devices.</p> <p>Floor for deducting medical expenses from income taxes rises from 7.5 percent of income to 10 percent.</p> <p>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.</p> <p>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.</p> <p>An \$8 billion tax is imposed on insurers, based on market share. The tax rises to \$14.3 billion by 2018.</p>
<b>2014</b>	<p>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.</p> <p>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.</p> <p>All insurance must meet federal minimum benefit requirements.</p> <p>Prohibition on preexisting condition exclusions applies to adults.</p> <p>Health plans prohibited from imposing annual limits on coverage.</p> <p>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.</p> <p>Insurance exchanges become operational.</p>
<b>2015</b>	<p>Independent Medical Advisory Commission (IMAC) established.</p>
<b>2016</b>	<p>Individuals may begin collecting benefits from CLASS Act long-term care program.</p>
<b>2017</b>	<p>States have option to allow large employers to participate in exchanges.</p> <p>States must begin covering part of the cost of Medicaid expansion.</p>
<b>2018</b>	<p>“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.</p>

## 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\\_poll\\_results](http://www.rasmussenreports.com/public_content/politics/elections/election_2010/election_night/election_night_2010_exit_poll_results).
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 "minimum essential coverage," meaning individuals in this program would face penalties for failing to satisfy the mandate. Sen. Jim Webb (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 of an 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 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 itself on 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 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.* The decisions of whether and when (or not) to buy a house, a car, a television, a dinner, or even a morning cup of coffee also have a financial impact that—when aggregated with similar economic decisions—affect the price of that 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, of course, 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 of the 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 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." *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 seem to much more closely fit the definition of a fine than a tax. As Jeff Rowes and Robert McNamara of the 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. If the 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 of Obamacare," National Review Online, April 20, 2010. And, as Judge Vinson and others have noted, prior to passage of the bill, supporters of the mandate, including President Obama, insisted that the penalty was not a tax. The change from penalty 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 if one 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 of either an income or excise tax, and if it 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 of regulating 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 of its 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 of objects" that are not within Congress's enumerated powers." Of course final determination of the consti-

tutionality of the 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 of Chapter 48 of the Internal Revenue Code of 1986.

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](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 health 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](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 Mulling 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 Mulling 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](http://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, "Memoran-

- dum 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/re-scission\\_supplemental.pdf](http://energycommerce.house.gov/Press_111/20090616/re-scission_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](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](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 Aleson, “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](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](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 Health-care 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/menuitem.3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c\\_ws\\_MX&javax.portlet.prp\\_2fdfb140904d489c8781176033468a0c\\_viewID=content&javax.portlet.prp\\_2fdfb140904d489c8781176033468a0c\\_docName=executive%20director%20message&javax.portlet.prp\\_2fdfb140904d489c8781176033468a0c\\_folderPath=/About%20Us/Executive%20Director%20Message/&javax.portlet.begCacheTok=com.vignette.cachetoken&javax.portlet.endCacheTok=com.vignette.cachetoken](http://www.mahealthconnector.org/portal/site/connector/template.MAXIMIZE/menuitem.3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_viewID=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_docName=executive%20director%20message&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_folderPath=/About%20Us/Executive%20Director%20Message/&javax.portlet.begCacheTok=com.vignette.cachetoken&javax.portlet.endCacheTok=com.vignette.cachetoken).

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 Mulling 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 from being 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 whom it 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 Reconcil-

- iation 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](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 Grips,” 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 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.”
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/donut-hole.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 from several other provisions of the 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 of what was already expected to accrue to families in the top 1 percent of incomes.
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 of 1986, 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 of HHS.
217. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010.
218. Foster, "Estimated Financial Effects of the '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 from Douglas 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 from Douglas 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](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](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 KeyFindings, 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\\_campaign=Fix%2BHealth%20Care&p=1034](http://cboblog.cbo.gov/?utm_source=Newsletter&utm_medium=Email&utm_campaign=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](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/>.
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305. Ibid.
306. Ibid. In fairness, it should be pointed out that, so far, Medicare Part D is costing less than estimated.
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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](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 non-group 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/](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/](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/>.









# Cato Institute

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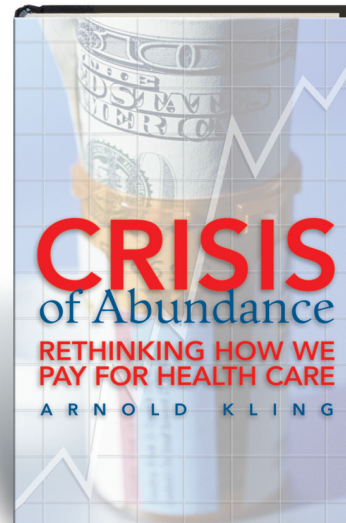
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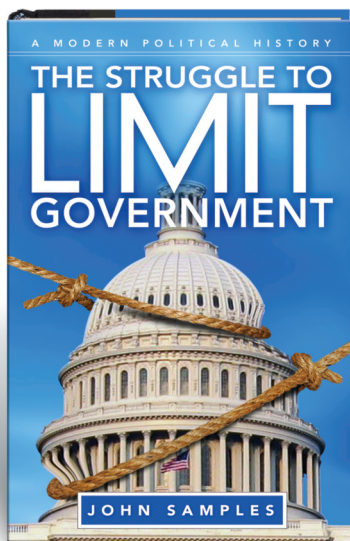
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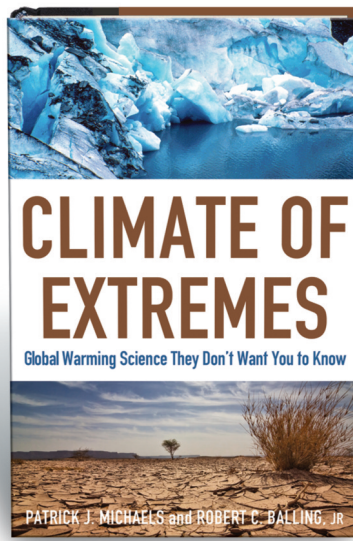
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