

BAD MEDICINE

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

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Executive Summary

For better or worse, President Obama's health care reform bill is now 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 \$352 billion to the national debt over that period.

- 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 non-group market will actually see their premiums go up faster as a result of this legislation.
- The new law will increase taxes by more than \$669 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 learn 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.¹ The bill had earlier passed the Senate on Christmas Eve 2009. Not a single Republican in either chamber voted for the bill. Four days later, the Senate, using a parliamentary tactic known as reconciliation to avoid a Republican filibuster, gave final approval to a package of changes designed to “fix” the bill.²

More than 2,500 pages and 500,000 words long,³ the Patient Protection and Affordable Care Act (PPACA) 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 is, in some ways, an improvement over earlier versions. It is not the single-payer system sought by many liberals. Nor did it include the interim step of a so-called “public option” that would likely have led to a single-payer system in the long run.⁴ The employer mandate is far less onerous than the 8 percent payroll tax once championed by the House.⁵ And the proposed income tax surtax on the wealthy has been dropped.⁶ But that does not mean that this is, as the president has claimed, a “moderate” bill.

It mandates that every American purchase a government-designed insurance package, while fundamentally reordering the insurance market and turning insurers into something resembling public utilities, privately owned while their operations are substantially regulated and circumscribed by Washington. Insurance coverage will be extended to millions more Americans as government subsidies are expanded deep into the middle class. Costs will be shifted between groups, though ultimately not reduced. And a new entitlement will be created, with the threat of higher taxes and new debt for future generations. In many ways, it

has rewritten the relationship between the government and the people, moving this country closer to European-style social democracy.

The legislation remains deeply unpopular. Recent polls show substantial majorities support repealing it. For example, a Rasmussen poll in late May showed that 63 percent of likely voters supported repeal, with 46 percent “strongly” supporting repeal. Just 32 percent wanted to keep the law (see Figure 1).⁷

It seems likely that “repeal” or “repeal and replace” will be the centerpiece of Republican campaigns this fall.⁸ Numerous court challenges have also been filed, raising questions about the constitutionality of various aspects of the legislation, especially its individual mandate.⁹ 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?”¹⁰ 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.

House speaker Nancy Pelosi once famously told us that “We have to pass the bill so you can find out what's in it.”¹¹ With the bill now law, 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.

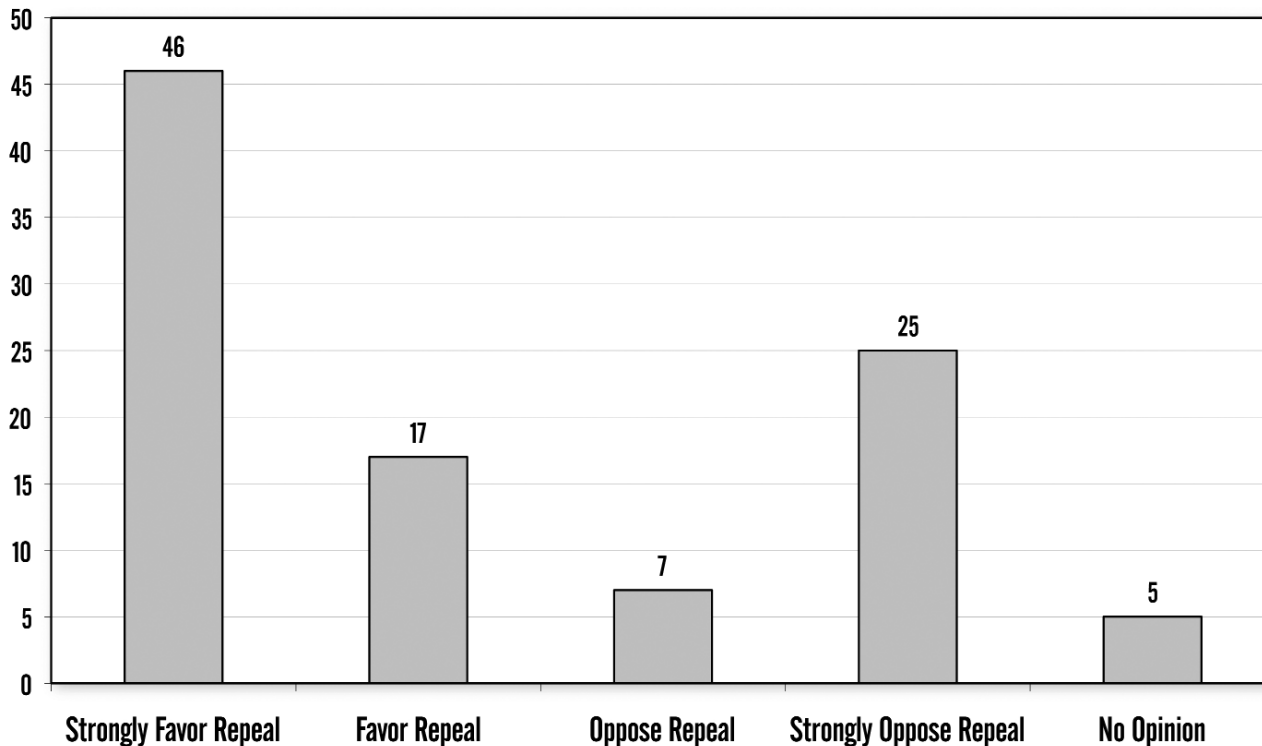
Part I: The Patient Protection and Affordable Care Act

Individual and Employer Mandates

Perhaps the single most important piece of this legislation is its individual mandate, a

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

Figure 1
May 22–23 Rasmussen Poll



Source: Rasmussen Reports, poll of 1,000 likely voters, May 22–23, 2010, margin of error +/- 3 percentage points, with a 95% level of confidence.

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.¹²

This individual mandate is unprecedented in U.S. governance. Back in 1993, when the Clinton health care plan was under consideration, the Congressional Budget Office noted “A mandate requiring all individuals to purchase health insurance would be an unprecedented federal action. The government has never required people to buy any good or service as a condition of lawful residence in the United States.”¹³ Moreover, the individual mandate raises serious constitutional questions.¹⁴ Even the Congressional Research Service was not able to conclude it was constitutional!¹⁵

Under the new law, beginning in 2014, those who fail to obtain insurance so 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.¹⁶ 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), and pro-rated based on the number of months that the person was uninsured over the course of the year.¹⁷ 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.¹⁸

According to the CBO, roughly four million Americans will be hit by penalties in 2016, with the penalties averaging slightly more than \$1,000.¹⁹ In fact, the federal government expects to raise \$17 billion from penalties by 2019.²⁰

Simply having insurance, however, is not necessarily enough to satisfy the mandate. To qualify, insurance would have to meet certain government-defined standards for “minimum essential coverage.” For example, in order to qualify, plans would be required to cover: ambulatory patient services, emergency services, hospitalization; maternity and newborn care, mental health and substance abuse treatment; prescription drugs; rehabilitative and habitative services; laboratory services; preventative services; wellness services; chronic disease management; pediatric services, and dental and vision care for children.²¹ The secretary of HHS is given the authority to define the meaning of those terms and ultimately to set the minimum benefits package.²² In addition, plans must meet the new insurance regulatory requirements below.

Unlike in 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.²³ 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. This raises questions of whether something as simple as an increase in co-payments

meets the threshold, or whether it would require something more substantive, such as a change in carrier. HHS is expected to issue rules later this year.²⁴

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 non-complying 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 16,500 additional agents, auditors, and examiners for enforcement²⁵) 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.²⁶ 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 billions of dollars between 2014 and 2019.²⁷ And according to a RAND Corporation study, those remaining uninsured after implementation are likely to be younger and healthier as a group than

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.

today's uninsured.²⁸ Massachusetts' 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 35.²⁹ 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.³⁰

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.³¹ 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.³²

The new law also contains an employer mandate, although it is watered down from the proposal that passed the House last year. The House bill would have required employers with payrolls of more than \$250,000 to pay 72.5 percent of the premium for individual coverage and 65 percent for family coverage, or pay a tax equal to 8 percent of their payroll.³³ Under the final bill, however, beginning in 2014, if a company with 50 or more full-time employees (or the equivalent³⁴) 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.³⁵ CBO estimates that

those penalties will cost businesses \$52 billion from 2014 to 2019.³⁶

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 and increases in deductibles or co-payments.³⁷ 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.³⁸

Even offering the correct benefits will not necessarily exempt companies from penalties. Companies that offer coverage, but which have employees that 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 a subsidy or not for every employee receiving a subsidy or \$2,000 for every full-time worker. 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.³⁹

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."⁴⁰

And while it might be politically appealing to claim that business will bear the new tax burden, nearly all economists see it quite dif-

ferently. 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.⁴¹ In fact, a survey by Towers Watson shows that employers are preparing to take exactly those steps.⁴²

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.”⁴³ As an internal document prepared for Verizon explains, “Even though the proposed assessments [on companies that do not provide health care] are material, they are modest when compared to the average cost of health care.”⁴⁴ In fact, CBO estimates that at least 10 to 12 million workers could lose their current employer-provided health insurance.⁴⁵ Approximately 8 to 9 million could end up on Medicaid, with the rest purchasing subsidized coverage through the exchanges (see below).⁴⁶ But this may vastly underestimate the actual number of workers who could be dumped from their current coverage. Several large US corporations, have indicated that they may drop their current coverage.⁴⁷

Insurance Regulations

Since the advent of the McCarran-Ferguson Act in 1945, health insurance has been primarily regulated at the state level.⁴⁸ 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 busi-

ness. 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.⁴⁹

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.⁵⁰

Specifically, the law would require insurers to “accept every employer and individual . . . that applies for such coverage.”⁵¹ Insurers are also forbidden to cancel insurance if a policyholder becomes sick.⁵² 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.⁵³ Insurers may consider age in setting premiums, but those premiums cannot be more than three times higher for their oldest than their youngest customers.⁵⁴ Smokers may also be charged up to 50 percent more than nonsmokers.⁵⁵ 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.⁵⁶

It is also worth noting that, while a ban on preexisting conditions for children starts within six months, the rules will not apply to adults until 2014.⁵⁷ Until then, adults with preexisting conditions will be eligible to participate in federally sponsored high-risk pools.⁵⁸ 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

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

capped at \$5,950 a year for an individual or \$11,900 for a family. The risk pools are supposed to be in place no later than the end of June 2010.⁵⁹ The law provides \$5 billion to establish the pools and subsidize coverage, but many experts worry about future funding shortfalls.⁶⁰ In fact, some analysts suggest that the risk pools could ultimately cost up to as much as eight times as much.⁶¹

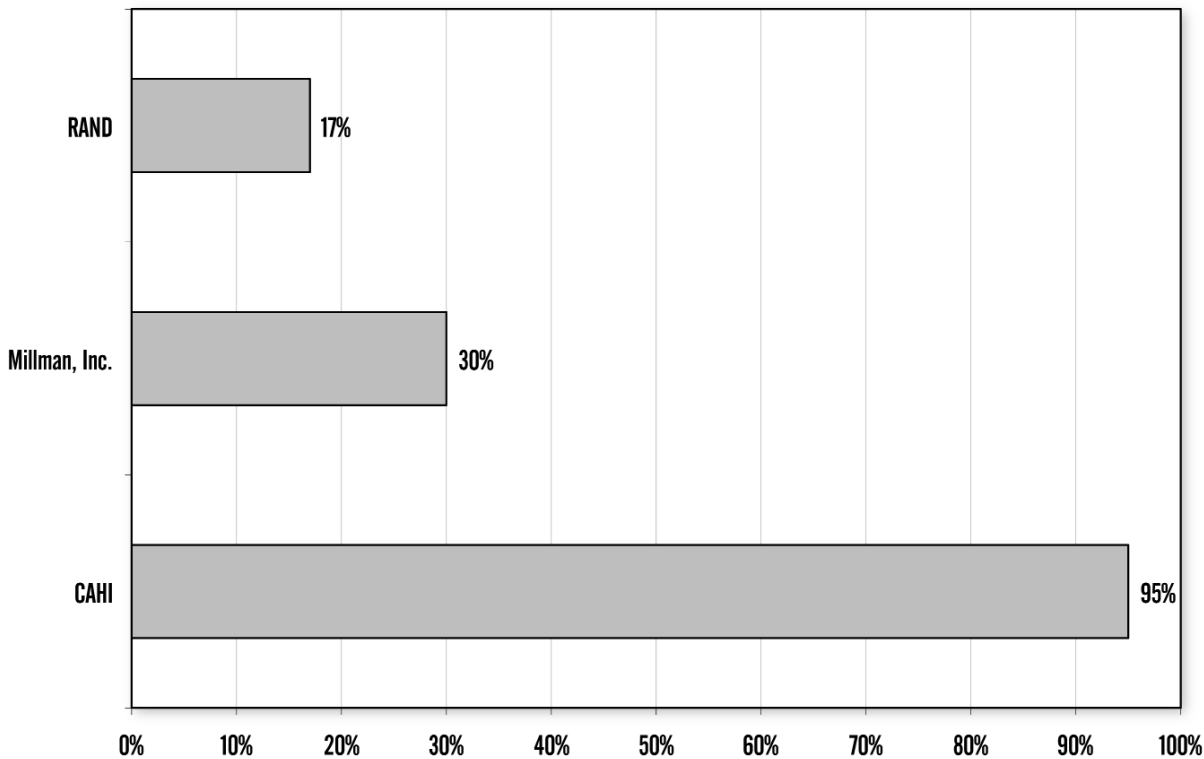
While the ban on medical underwriting may make health insurance more available and affordable for those with preexisting conditions and reduce premiums for older and sicker individuals, it will also increase premiums for younger and healthier individuals. The RAND Corporation recently conducted a study 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.⁶² Other studies suggest the increase could be much higher. For example, a study by the independent

actuarial firm Milliman, Inc., concluded that premiums for young men could increase by 10 to as much as 30 percent.⁶³ 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).⁶⁴

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.

In a similar vein, the law also bans “rescissions,” or the practice of insurers dropping coverage for individuals who become sick.⁶⁵

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.

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.⁶⁶ 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 were 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.⁶⁷

A second new insurance regulation would prohibit insurers from imposing lifetime limits on benefit payouts.⁶⁸ 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 million and \$5 million, with many running as high as \$8 million, amounts that very few people ever reached.⁶⁹ 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 re-insuring policies, leading ultimately to higher premiums, but most insurers predict the increase will be modest.⁷⁰

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.⁷¹

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.⁷² 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 plan.⁷³

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.⁷⁴ Insurance companies who pay out benefits less than the required proportion of premiums, must rebate the difference to policy holders on an annual basis beginning in 2011. 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).⁷⁵ 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 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.⁷⁶

Finally, the legislation would also allow parents to keep their dependent children on their policies until the child reaches age 27.

As many as a million workers could lose the coverage they have now.

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

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.⁷⁷ Although this provision would not go into full effect until next year, most large insurers have indicated that they would be willing to begin covering dependent children sooner, perhaps as early as this summer. Employers, however, have indicated that they will be reluctant to add dependent children to the coverage they provide, even if insurers offer it, until they are required to in January 2011.⁷⁸

Overall, most of the law's insurance reforms are likely to be among the more politically popular aspects of the new law, though 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.⁷⁹ 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 in 2011, 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).⁸⁰ 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.⁸¹ Most other low-income chil-

dren were covered through SCHIP (up to 250 percent of poverty).

Thus, the primary result of the law's Medicaid expansion would be to extend coverage to the parents in low-income families and to childless adults. In particular, single, childless men will now be eligible for Medicaid. This raises potentially serious concerns. Low-income, childless, adult men in particular are a high-risk, high-cost health care population. That means costs may run higher than expected, a problem that may be exacerbated by adverse selection within that population.

Tennessee's experience with TennCare provides a cautionary tale. In 1994, Tennessee expanded Medicaid eligibility to uninsured citizens who weren't able to get health insurance through their employers or existing government programs and to citizens who were uninsurable because of preexisting 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.⁸² Despite this massive increase in spending, health outcomes did not improve. Even the state's Democratic governor Phil Bredesen called the program "a disaster."⁸³ 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: 5 percent of the cost in 2017, gradually increasing to 10 percent by 2020. States will also receive a slight (0.15 percent) increase in the federal match toward coverage of existing Medicaid recipients.

The impact on state budgets would vary dramatically (see Table 1). The biggest losers in terms of total dollars would be California, whose Medicaid costs would increase by nearly \$5 billion between 2014 and 2019, and Texas, whose costs would rise by nearly \$4.5 billion. Taken as a percentage of a state's General Funds, the hardest hit states would be Texas (1.8 percent), Mississippi (1.7 per-

Table 1
Medicaid on State Budgets

| State | Unfunded Medicaid Liability | Percent of State General Funds |
|----------------|-----------------------------|--------------------------------|
| Texas | \$746.2 | 1.88% |
| Mississippi | \$87.6 | 1.70% |
| Nevada | \$55.8 | 1.62% |
| Arizona | \$155.0 | 1.54% |
| Arkansas | \$64.4 | 1.48% |
| Florida | \$401.2 | 1.45% |
| Colorado | \$106.2 | 1.43% |
| Oklahoma | \$88.6 | 1.37% |
| Michigan | \$131.8 | 1.33% |
| Louisiana | \$110.2 | 1.14% |
| South Carolina | \$79.7 | 1.11% |
| Missouri | \$88.5 | 1.10% |
| Oregon | \$73.5 | 1.05% |
| Alabama | \$90.3 | 1.05% |
| Georgia | \$200.1 | 1.03% |
| Montana | \$20.9 | 1.01% |
| Tennessee | \$104.6 | 0.95% |
| North Carolina | \$181.5 | 0.88% |
| South Dakota | \$10.3 | 0.87% |
| New Mexico | \$51.8 | 0.86% |
| West Virginia | \$32.2 | 0.86% |
| Kentucky | \$81.0 | 0.86% |
| Illinois | \$225.0 | 0.83% |
| Idaho | \$22.9 | 0.82% |
| California | \$833.0 | 0.81% |
| New Hampshire | \$12.3 | 0.80% |
| Nebraska | \$23.7 | 0.73% |
| North Dakota | \$8.6 | 0.72% |
| Kansas | \$43.5 | 0.71% |
| Indiana | \$88.3 | 0.69% |
| Utah | \$39.5 | 0.68% |
| Virginia | \$109.6 | 0.63% |
| New York | \$309.0 | 0.58% |
| Ohio | \$150.9 | 0.57% |
| Iowa | \$33.5 | 0.57% |
| Maryland | \$81.2 | 0.56% |
| Washington | \$78.6 | 0.54% |
| Pennsylvania | \$139.8 | 0.52% |

Continued next page

Table 1 Continued
Medicaid on State Budgets

| State | Unfunded Medicaid Liability | Percent of State General Funds |
|---------------|-----------------------------|--------------------------------|
| Wisconsin | \$58.9 | 0.44% |
| New Jersey | \$137.2 | 0.41% |
| Wyoming | \$7.2 | 0.40% |
| Maine | \$11.3 | 0.36% |
| Rhode Island | \$10.4 | 0.31% |
| Delaware | \$10.2 | 0.30% |
| Minnesota | \$50.2 | 0.30% |
| Connecticut | \$36.6 | 0.22% |
| Alaska | \$10.6 | 0.19% |
| Hawaii | \$10.1 | 0.19% |
| Massachusetts | \$52.9 | 0.16% |
| Vermont | -\$6.0 | -0.50% |

Source: Author's calculations based on Heritage Foundation's "State Costs for ObamaCare Medicaid Expansion" and data from the National Association of State Budget Officers, 2008 State Expenditure Report.

cent), Nevada (1.6 percent), Florida (1.5 percent), and Arizona (1.5 percent).

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).⁸⁴ States must maintain their current income eligibility levels for the program.⁸⁵ 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 \$449 billion between 2014, when individuals are first eligible for the payments, and 2020.⁸⁶

There are actually two separate credits designed to work more or less in conjunction with one another. The first is a "premium tax credit."⁸⁷ 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.⁸⁸

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.

The net result of this rather complex formula is that a family of four with an annual income of \$30,000 per year, purchasing an insurance policy that cost \$9,435, would receive a federal subsidy of \$8,481, and have to

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

pay \$954 themselves. If the same family had an income of \$65,000 per year, they would receive a subsidy of \$3,358 and pay \$6,077 themselves.⁸⁹

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.⁹⁰

In addition to the individual subsidies, there will also be new government subsidies for some small businesses. Beginning next year, businesses with fewer than 25 employees and average wages below \$50,000 will be eligible for a tax credit to help offset the cost of providing insurance to their workers.⁹¹ 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.⁹² The program will reimburse insurers for 80 percent of retiree claims

between \$15,000 and \$90,000.⁹³ Insurers are required to pass those savings on to employers through lower premiums, though how that will be enforced remains a question.⁹⁴ The program is supposed to begin by June 23 of this year and expire on January 1, 2014.⁹⁵

The law also increases funding for community health centers by \$11 billion.⁹⁶ Approximately \$1.5 billion would be used for the construction of new health centers in inner-city or rural low-income neighborhoods, 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.⁹⁷

All together, this law represents a massive increase in the welfare state, adding millions of Americans to the roll of those dependent, at least to some extent, on government largess. Yet for all the new spending, the Patient Protection and Affordable Care Act falls short of its goal of achieving universal coverage (see below).

The Exchanges

Perhaps the most fundamental reordering of the current insurance market is the creation of “exchanges” in each state. Ezra Klein, one of the bill’s most prominent liberal supporters, maintains that that the exchanges are “the most important element in the plan.”⁹⁸ 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.”⁹⁹

However, one should be skeptical of claims that the exchange will reduce premiums. In Massachusetts, supporters of the “connector”

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

Plans offered through the exchange must meet the federal requirements for minimum benefits.

claimed that it would reduce premiums for individual insurance policies by 25 to 40 percent.¹⁰⁰ Instead, premiums for policies sold through the connector have been rising, up 11 percent for the lowest cost plans since the program began.¹⁰¹

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.¹⁰² 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.¹⁰³ 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.¹⁰⁴ The pools would also include individual or small-group policies sold outside the exchange.¹⁰⁵ Existing plans could not be included in those pools, however.¹⁰⁶

Initially, only businesses with fewer than 50 employees, or 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.¹⁰⁷ However, beginning in 2017, states have the option of opening the exchange to large employers.¹⁰⁸

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.¹⁰⁹ 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.¹¹⁰

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. 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). The reductions in out-of-pocket expenses would occur within the plan in such a way as not to 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.¹¹¹ 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.

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.¹¹² The multi-state plans must meet the licensing and regulatory requirements of each state in which they are offered.¹¹³ At least one plan must not include abortion coverage, and one must be offered by a nonprofit insur-

er. The legislation also provides start-up funds for states to establish health insurance cooperatives which may participate in the state's exchange.¹¹⁴

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.

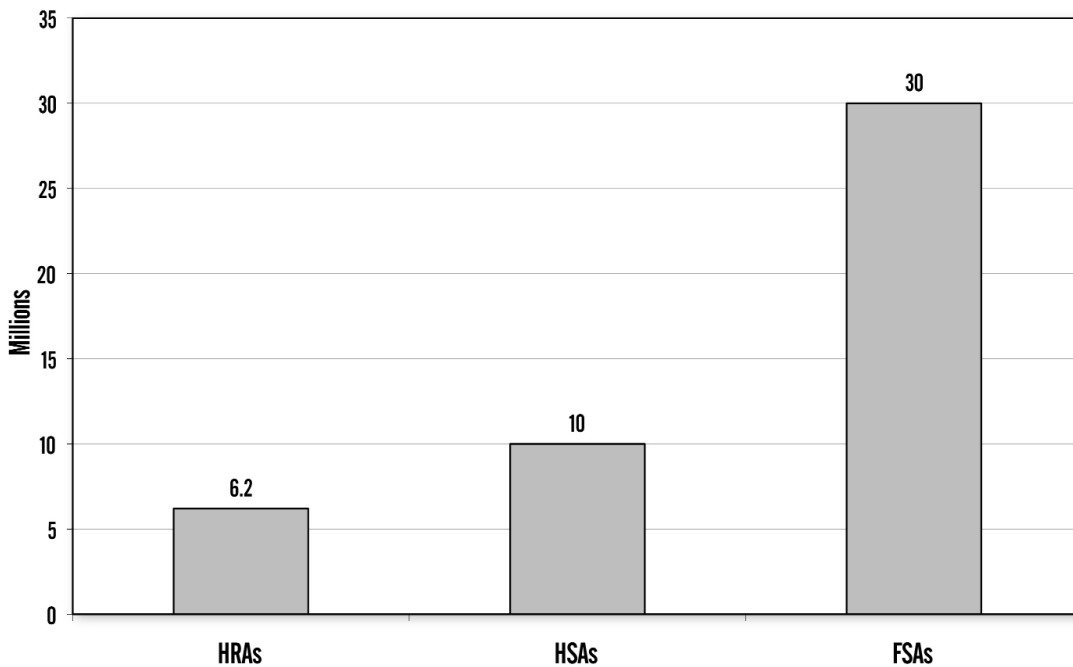
Consumer-directed health care is a broad term used to describe a variety of insurance

arrangements, including health savings accounts (HSAs), 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 healthcare dollars.¹¹⁵ 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.¹¹⁶ 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 need.”¹¹⁷ That hostility is reflected in the final legislative language. Notably, the legislation puts substantial new restrictions on such consumer-

President Obama has always been hostile to consumer-directed health care.

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

oriented innovations as Health Savings Accounts and Flexible Spending Accounts.

Roughly 10 million Americans currently have health savings accounts.¹¹⁸ 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 in 2011.¹¹⁹ In addition, the definition of “qualified medical expense” has been made more restrictive. Among other things, over-the-counter medications will no longer be considered a “qualified medical expense.”¹²⁰

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.¹²¹ 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.¹²² Whether or not HSA contributions are included can make as much as a 10–20 percent difference in a plan’s actuarial value. As a result, if the contributions are not included, many, if not most, high-deductible plans will not qualify. The fate of HSAs is therefore dependent on a regulatory ruling by the secretary of HHS in an administration avowedly hostile to HSAs.

The 80 percent minimum medical loss ratio required of insurance plans could also prove problematic for HSAs. Again, how this provision will work in practice will depend on rules to be developed by the secretary of HHS. But, the legislation makes no distinction between traditional and high-deductible insurance plans. Few if any current high-deductible policies meet this requirement.

In addition, there is reason to wonder whether high-deductible insurance plans will

likely be able to meet the law’s requirement that insurance plans provide first-dollar coverage for all “preventive services.”¹²³ 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.¹²⁴ 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.¹²⁵ 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.¹²⁶ Starting in taxable year 2013, the maximum tax-exempt contribution to an FSA will be cut in half, from the current \$5,000 annually to just \$2,500.¹²⁷ The new definition of “qualified medical expense” will also be applied to FSAs, meaning that as with HSAs, FSAs could not be used to pay for over-the-counter medications.¹²⁸

The impact of these provisions extends well beyond their impact on workers who currently take advantage of such innovative products as HSAs and FSAs. More significantly, the assault on these products represents a fundamental philosophical shift in the health care debate. Through this legislation, the president and democrats in Congress reject consumer-oriented health care reform in clear favor of government control.

Medicare Cuts

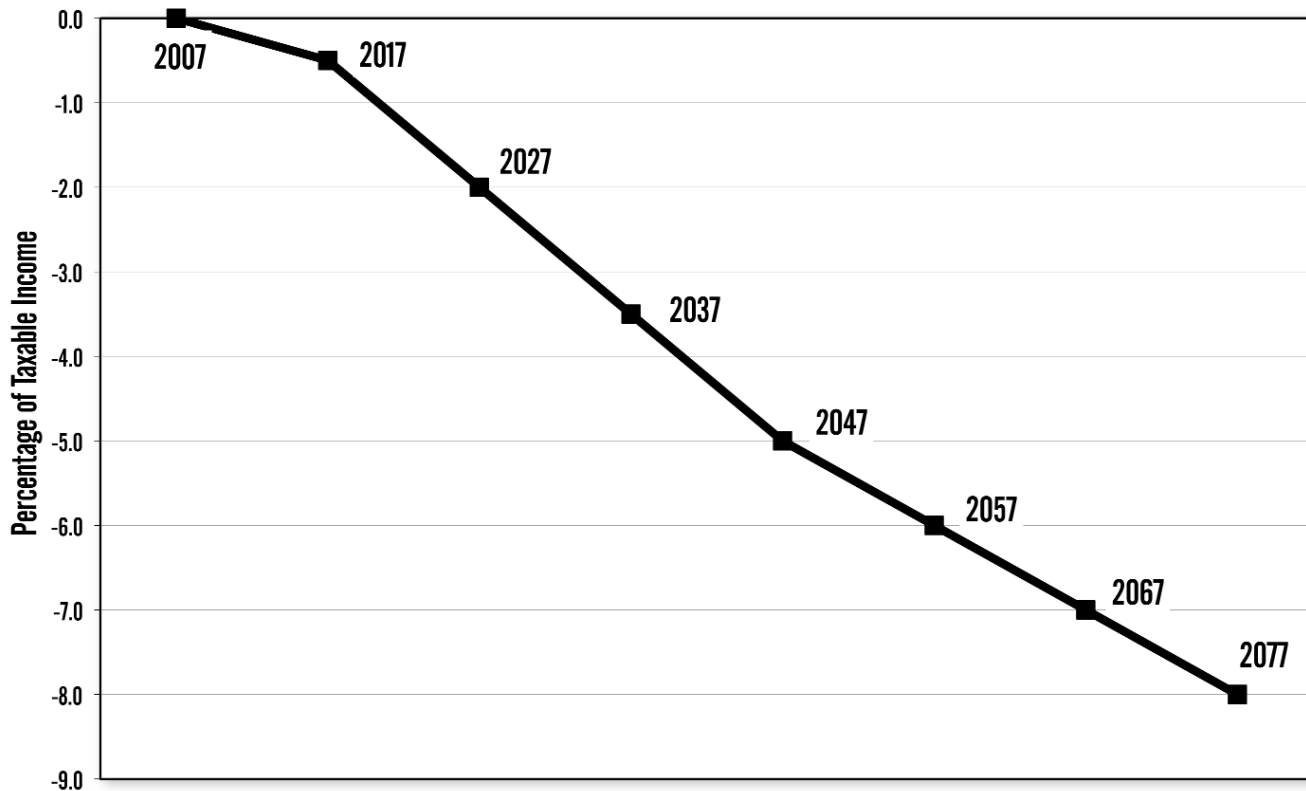
Despite denials from the Obama administration and Democrats in Congress, the legislation *does* cut Medicare—and it should! Medicare is facing unfunded liabilities of \$50 trillion to \$100 trillion depending on the accounting measure used, making future benefit cuts both inevitable and desirable.¹²⁹ 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.¹³⁰ 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.¹³¹ 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.¹³²

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, yielding \$196 billion in savings.¹³³ But Medicare has been supposed to make reductions to those payments since 2003, yet, each year, Congress has voted to defer the cuts. There is no reason to believe that Congress is now more likely to follow through on such cuts. In fact, in a perfect exercise in cynicism, the House has already passed separate legislation to repeal them.

Figure 4
Medicare Cash Flow



Source: 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Figure II.E2.

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

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.¹³⁴ 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,¹³⁵ something that Democrats have derided as wasteful.¹³⁶ 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.¹³⁷

The law imposes a new competitive bidding model on the Medicare Advantage program that will effectively end the 14 percent overpayment.¹³⁸ 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. Analysis of similar proposals in the past, have suggested that 1.5 to 3 million seniors could be forced out of their current insurance plan and back into traditional Medicare.¹³⁹ 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.”

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.¹⁴⁰ 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 \$156.6 billion over 10 years.¹⁴¹ There would also be \$3 billion in cut-backs 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.¹⁴² This change is expected to reduce total imaging expenditures by as much as \$2.3 billion over 10 years.¹⁴³ Other Medicare cuts include freezing reimbursement rates for home health care and inpatient rehabilitative services and \$1 billion in cuts to physician-owned hospitals.¹⁴⁴

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.¹⁴⁵ Medicare spending varies wildly from region to region, without any evidence that the variation is reflected in the health of patients or procedural outcomes.¹⁴⁶ 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 would be 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.¹⁴⁷ In fact, it could be

argued that Medicare is particularly unsuited for such a policy.¹⁴⁸

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.¹⁴⁹ Some of President Obama's health care advisers, such as former Sen. Tom Daschle, have recommended that it be extended to private insurance plans.¹⁵⁰ 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.¹⁵¹

While 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 include prescription drug coverage in retiree health plans.¹⁵² 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.¹⁵³ The subsidy was justified on the grounds that companies would otherwise dump workers into Medicare, raising the cost of the Part D, prescription drug plan. However, not only did 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, University of California–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.¹⁵⁴ The health care legislation retains the subsidy but eliminates the tax break beginning in 2013.¹⁵⁵

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 SEC filings. Altogether those charges could total more than \$4.5 billion, reflecting future tax costs to those companies.¹⁵⁶

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.¹⁵⁷ 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 Medical Advisory Committee (IMAC) 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.”¹⁵⁸ 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), IMAC must submit recommendations bringing spending back in line with that target. Beginning in 2018, the annual spending target becomes the rate of GDP growth plus 1 percent. Once IMAC 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

Many other proposed cuts are actually steps in the right direction.

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

independent commission, and a requirement that Congress vote on the issue, could prove beneficial. Unfortunately, IMAC is prohibited from making any recommendation that would “ration care,” increase revenues, or change benefits, eligibility, or Medicare beneficiary cost-sharing (including Medicare premiums).¹⁵⁹ That leaves IMAC with few options beyond reductions in provider payments. Hospitals and hospices would be exempt from any cuts until 2020.¹⁶⁰ Thus, most of the cuts would fall on physicians. With Medicare already under-reimbursing providers, further such cuts would have severe consequences, including driving physicians from the program and increased cost-shifting to private insurance. More likely, therefore, IMAC will end up as neutered as previous attempts to impose fiscal discipline on government health care programs.¹⁶¹

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 \$250. Thereafter, Medicare pays 75 percent of costs between \$250 and \$2,250 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 \$2,250 but below \$3,600 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 \$3,600.¹⁶²

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.¹⁶³ 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, who 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.¹⁶⁴ 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. For example, according to Medicare's chief actuary, if the cuts were to occur as projected, as many as 15 percent of U.S. hospitals could close.¹⁶⁵

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.

The new funds would indeed be routed through the Medicare Trust Fund, where government trust fund accounting methodology would count them as extending the trust fund's solvency. However, as has been pointed out with regard to the Social Security Trust Fund, the government is structurally incapable of actually saving the money. In fact, the funds would be used to purchase special issue treasury bonds. When the bonds are purchased, the funds used to purchase them become general revenue, and are spent on the government's annual general operating expenses. What remains behind in the trust fund are the bonds, plus an interest payment attributed to the bonds (also paid in bonds, rather than cash). Government bonds are, in essence, a form of IOU. They are a promise against future tax revenue. When the bonds become due, the government will have to repay them out of general revenue.¹⁶⁶ 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.

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."¹⁶⁷

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."¹⁶⁸ 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."¹⁶⁹

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.¹⁷⁰ 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.¹⁷¹

However, Medicare is still facing a \$50 trillion–\$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 2002, 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.¹⁷²

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."¹⁷³ 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 \$669 billion in new or increased taxes over the first 10 years.¹⁷⁴ 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.¹⁷⁵ 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.¹⁷⁶ However, the tax is indexed to inflation rather than the faster-rising medical inflation, which drives insurance

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

Figure 5
States with Marginal Tax Rates over 50% after PPACA



Source: Tax Foundation, Private Report.

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.”¹⁷⁷

- **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.¹⁷⁸ The payroll tax hike would mean that in eight states, workers would face marginal tax rates in excess of 50 percent (see Figure 5).¹⁷⁹

- **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 \$250,000.¹⁸⁰

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.

It is also worth noting that the Obama administration has also proposed allowing the Bush tax cuts on cap-

ital gains to expire. Combining that increase with the one contained in the health care legislation would raise the tax rate on capital gains from 15 percent today to nearly 24 percent.¹⁸¹ Similarly, the top tax rate for interest on taxable bonds could rise to 43.4 percent.¹⁸² 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.¹⁸³ The increased threshold would be postponed until 2016 for taxpayers age 65 or older.¹⁸⁴
- **Tax on Prescription Drugs.** The legislation would levy 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.¹⁸⁵ The structure of this tax almost guarantees that it will be passed along to consumers through higher prices.
- **Tax on Medical Devices.** A 2.9 percent federal sales tax is imposed on medical devices, which includes everything from CT scanners to surgical scissors.¹⁸⁶ The secretary of HHS has the authority to waive this tax for items that are "sold at retail for use by the general public."¹⁸⁷ 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 with those on pharmaceutical manufacturers

and insurers "would generally be passed through to health consumers."¹⁸⁸ 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.¹⁸⁹

- **Additional Taxes on Insurers.** Similar to the tax on pharmaceutical companies, the legislation imposes a tax on health insurers based on their market share.¹⁹⁰ 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.¹⁹¹ 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.¹⁹² However, some insurers in Michigan and Nebraska received a special exemption.¹⁹³ This tax is also expected to be passed through to consumers through higher premiums.
- **Tax on Tanning Beds.** The legislation imposes a 10 percent tax on tanning salons.¹⁹⁴ 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 goes into effect immediately.

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.¹⁹⁵ In contrast, those earning \$18,000–55,000 per year will see a net income increase of roughly \$2,000 per family.¹⁹⁶

The new law also 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

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

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

vendor with whom they do more than \$600 worth of business over the course of a year.¹⁹⁷ Of course businesses already have to file 1099s for outlays on items like consultants. But the new rule will mean that even the smallest of businesses will have to issue a form—and file with the IRS—for virtually every purchase or payment. The burden falls on the other partner in the transaction, too. The business providing the goods and services would have to collect 1099s from all its customers and integrate them with the rest of its tax records. This would be a significant burden even for businesses with computerized record keeping. For the millions of small businesses that still do bookkeeping by hand, the cost in both time and money will be devastating. Furthermore, businesses will be required to collect all the requisite information from everyone they do business with, including their taxpayer ID, to file the required form. This, in turn, poses a whole new set of threats to privacy.

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.¹⁹⁸

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 that participate will pay a monthly premium that has not yet been determined.¹⁹⁹ However, the CBO estimates that will be roughly \$123 per month for the average worker.²⁰⁰ Other estimates suggest that the premiums could be much higher, perhaps \$180–240 per month.²⁰¹ Workers must contribute to the program for at least five years before they become eligible for benefits.²⁰² (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.)²⁰³ There is no health underwriting of participation or premiums.

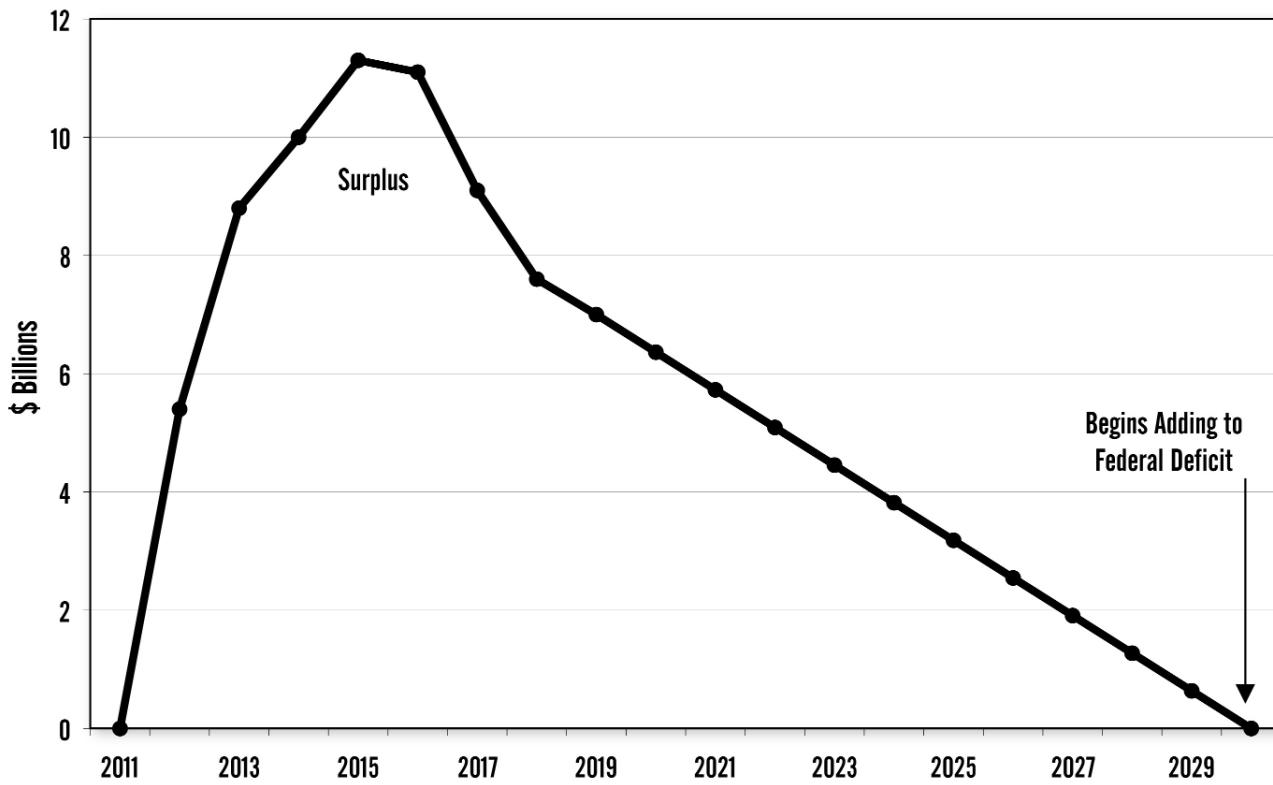
The actual benefits to be provided under the program are among the many details that remain to be determined but will not be “less than an average of \$50 daily adjusted for inflation.”²⁰⁴ Some estimates suggest that benefits will average roughly \$75 per day, or slightly more than \$27,000 per year.²⁰⁵ 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.²⁰⁶ Benefits may be paid daily, weekly, monthly, or deferred and rolled over from month to month at the beneficiary's discretion.²⁰⁷ There is no lifetime limit to benefits.

Theoretically, the program will begin to collect premiums in 2011, although so many aspects of the program remain to be determined that many experts predict implementation could be delayed until as late as 2013.²⁰⁸ As mentioned, there is a five-year vesting period for benefits, so there will be no payouts until at least five years after the start of premium collections.

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.²⁰⁹ The secretary of HHS may also develop different or additional eligibility requirements.²¹⁰

During the law's first five years it will collect premiums, but not pay benefits. As a result, over the first 10 years, the period conveniently included in the budget scoring window, the CLASS Act will run a surplus, collecting more in premiums than it pays out in benefits (see Figure 6).

Figure 6
Effect of CLASS Act on Federal Budget



Source: Letter from Douglas Elmendorf, Director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010, and Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Sen. Tom Harkin, November 25, 2009.

Those premiums will accrue in a CLASS Act Trust Fund, similar to the Social Security and Medicare trust funds. Using trust fund accounting measures, the premium payments will reduce the federal deficit over that period by roughly \$70.2 billion.²¹¹ 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.”²¹² 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.²¹³ 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.”²¹⁴

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

**The CLASS Act
may represent
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that is virtually certain to create financial instability in any insurance program unless there are other important provisions to control risk.”²¹⁵

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.²¹⁶ 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.²¹⁷ And, Richard Foster suggests that just 2 percent of workers will participate after three years.²¹⁸ Given such low participation levels, the covered population will almost certainly be far sicker than the general insurance pool. Foster warns that “there is a very serious risk that the problem of adverse selection will make the CLASS program unsustainable.”²¹⁹

Making matters worse, the legislation caps premiums for low-income workers and undergraduate students and prohibits future premium hikes for some groups of retirees.²²⁰ Therefore, if the program is to remain self-sustaining, other workers will have to bear a disproportionate share of future premium hikes. That in turn increases the risk that program premiums will exceed those for products available in the private market. Healthier individuals, in particular, would have an incentive to flee the program for less expensive private alternatives, leaving only the sickest and most expensive participants in the government plan. The adverse selection death spiral would be in full force, which could tempt the government to solve the problem by making participation mandatory, forcing Americans into a program they may not want and to which there are superior private alternatives.²²¹ The only other alter-

native 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.²²² More than 200,000 establishments will be affected by the change.²²³ The law also requires nutrition information to be posted on food and beverage vending machines.²²⁴

There is no doubt that the United States has a serious obesity problem.²²⁵ 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.²²⁶

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.²²⁷ 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.²²⁸

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.²²⁹ 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.”²³⁰

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.²³¹ Other grants would provide incentives for states to shift Medicaid beneficiaries away from nursing homes and toward care in the home or community.²³²

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.²³³

Of greater concern is a provision to establish a private, nonprofit institute to conduct comparative effectiveness research.²³⁴ 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.²³⁵ In fact, by some estimates as much as 30 percent of all U.S. health spending produces no discernable value.²³⁶ Medicare spending, for instance, varies wildly from region to region, without any evidence that the varia-

tion is reflected in the health of patients or procedural outcomes.²³⁷ 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.²³⁸ 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.²³⁹ 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.²⁴⁰

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.²⁴¹ 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.²⁴²

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.²⁴³ It would also fund new educational centers in geriatric care, chronic-care management, and long-term care.²⁴⁴ It also takes more controversial steps toward increasing the supply of primary-care physicians by shifting reimbursement rates

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

**By 2019, CBO
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23 million
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for government programs, such as Medicare and Medicaid, to reduce payments to specialists while increasing reimbursement for primary care.²⁴⁵ Yet, what possible reason is there to believe that the federal government can (a) know the proper mix of primary-care physicians and specialists, and (b) fine-tune reimbursements in a way that will produce those results? Nothing in the government's previous activities suggests that such central planning would be effective.

Finally, there is a host of special interest provisions. The so-called "cornhusker kickback" (a provision that committed the federal government to picking up the cost of Nebraska's Medicaid expansion forever) was removed by the reconciliation bill.²⁴⁶ However, much other pork remains. For example, the legislation includes \$100 million in special funding for a hospital in Connecticut;²⁴⁷ and money for asbestos abatement in a Montana town.²⁴⁸ There is 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.²⁴⁹

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

Passage of health care reform was heralded by some in the media as providing "near universal coverage."²⁵⁰ 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."²⁵¹ But by this standard, the Patient Protection and Affordable Care Act falls far short of its goals.

According to the Congressional Budget Office, the legislation would reduce the number of uninsured Americans by about 32 million people by 2019.²⁵² 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).²⁵³ 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.

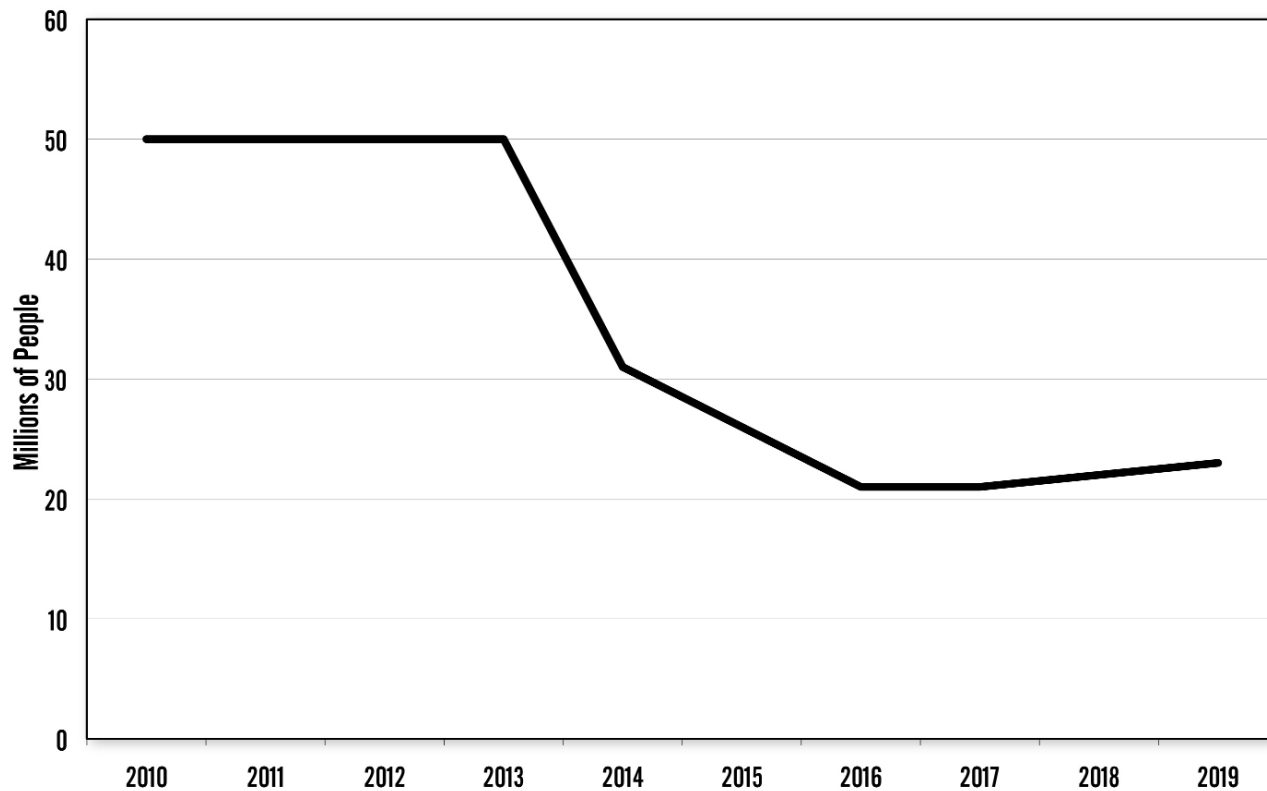
Supporters of the legislation point out that that would decrease the number of uninsured Americans to roughly 6–8 percent of non-elderly Americans, a far cry from universal coverage, but undoubtedly better than today's 15 percent.²⁵⁴

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.²⁵⁵ RAND also estimates that increases in coverage would occur somewhat more slowly than does CBO.²⁵⁶

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.²⁵⁷ 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.²⁵⁸ 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.²⁵⁹ 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.²⁶⁰ Given that roughly a third of physicians no longer accept Medicaid patients,²⁶¹ these individuals may still find significant barriers to access, despite their newly insured status.

Figure 7
Number of Uninsured Under PPACA



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

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.²⁶² 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.²⁶³

Increased Spending, Increased Debt

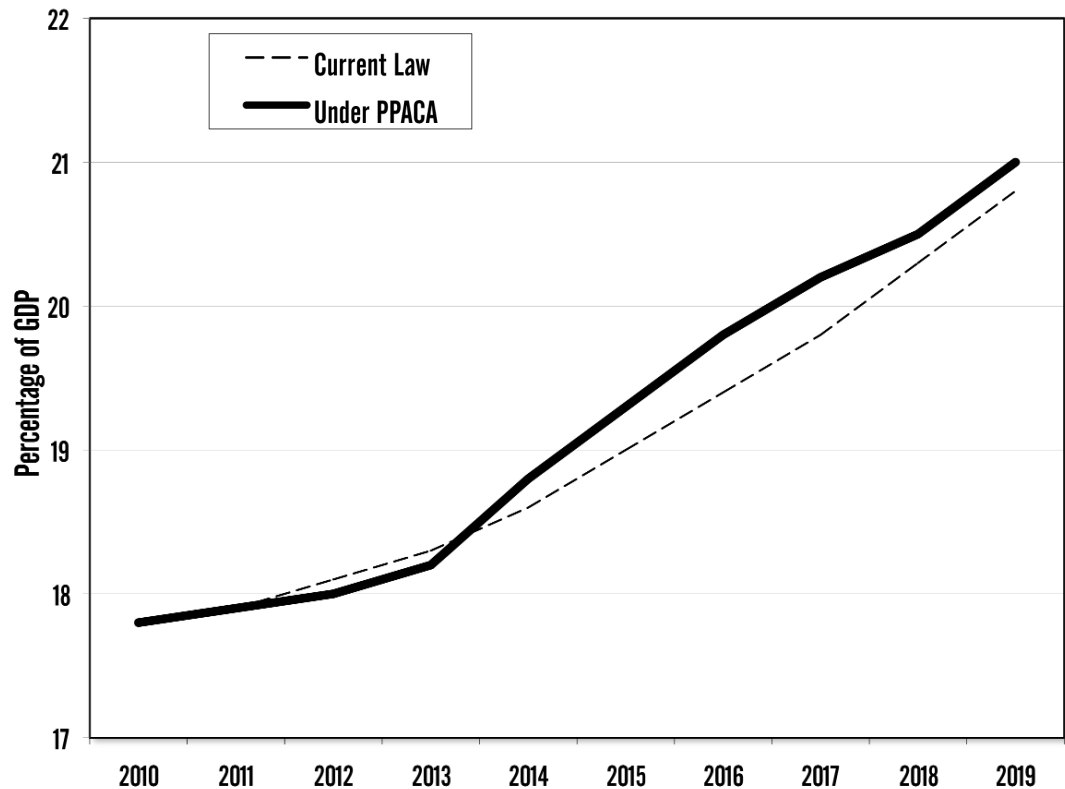
Throughout the health care debate, President Obama emphasized the need to

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.²⁶⁴

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.²⁶⁵ Health-care costs are rising faster than GDP growth and now total more

Figure 8
Estimated Increases in National Health Expenditures under PPACA



Source: Richard S. Foster, chief actuary, Centers for Medicare & Medicaid Services, “Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended, April 22, 2010.

than \$1.8 trillion—more than Americans spend on housing, food, national defense, or automobiles.²⁶⁶

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).²⁶⁷

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.²⁶⁸ If utilization increases substantially as a result of the coverage expansions in this legislation, spending could likewise skyrocket.

The failure to restrain costs will have serious consequences for government spending under the legislation. As CBO director Douglas Elmendorf noted in his official blog:

The rising costs of health care will put tremendous pressure on the federal budget during the next few decades and beyond. . . . In CBO’s judgment, the health legislation enacted earlier this year does not substantially diminish that pressure. In fact, CBO estimated that the health legislation will

If utilization increases substantially spending could likewise skyrocket.

increase the federal budgetary commitment to health care.²⁶⁹

The Congressional Budget Office scored the Senate-passed Patient Protection and Affordable Care Act as costing \$875 billion over 10 years.²⁷⁰ The changes passed under reconciliation increased that cost to \$938 billion.²⁷¹ However, those numbers do not tell the whole story, nor do they reveal the law's true cost.

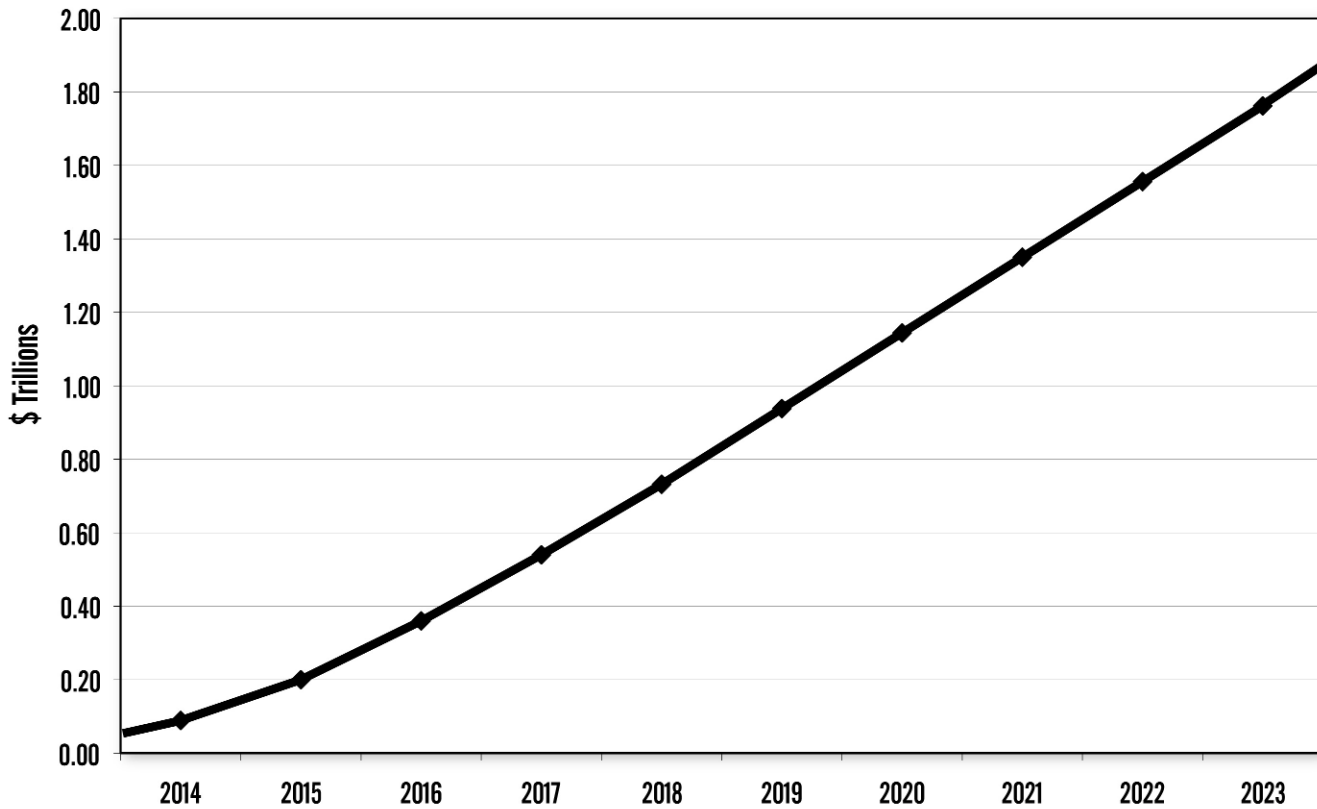
The CBO does not provide formal budget analysis beyond the 10-year window, pointing out that any calculation made beyond 2020, "reflects the even greater degree of uncertainty" regarding those years.²⁷² However, since program costs will be on an upward trajectory through 2019 (see Figure 9), it expects the cost of the program to continue to grow rapidly after 2019.

Moreover, as Figure 3 makes clear, most of the spending under this legislation doesn't take effect until 2014. So the "10-year" cost projection includes only six years of the bill. However, as Figure 2 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*.²⁷³ In reality, however, that scoring is achieved through the use of yet another budget gimmick.

As mentioned above, the legislation anticipates a 23 percent reduction in Medicare fee-for-service reimbursement payments to pro-

Figure 9
Total Spending under PPACA Through 10 Years of Implementation



Author's calculations based on Letter from Douglas Elmendorf, Director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

viders, yielding \$196 billion in savings.²⁷⁴

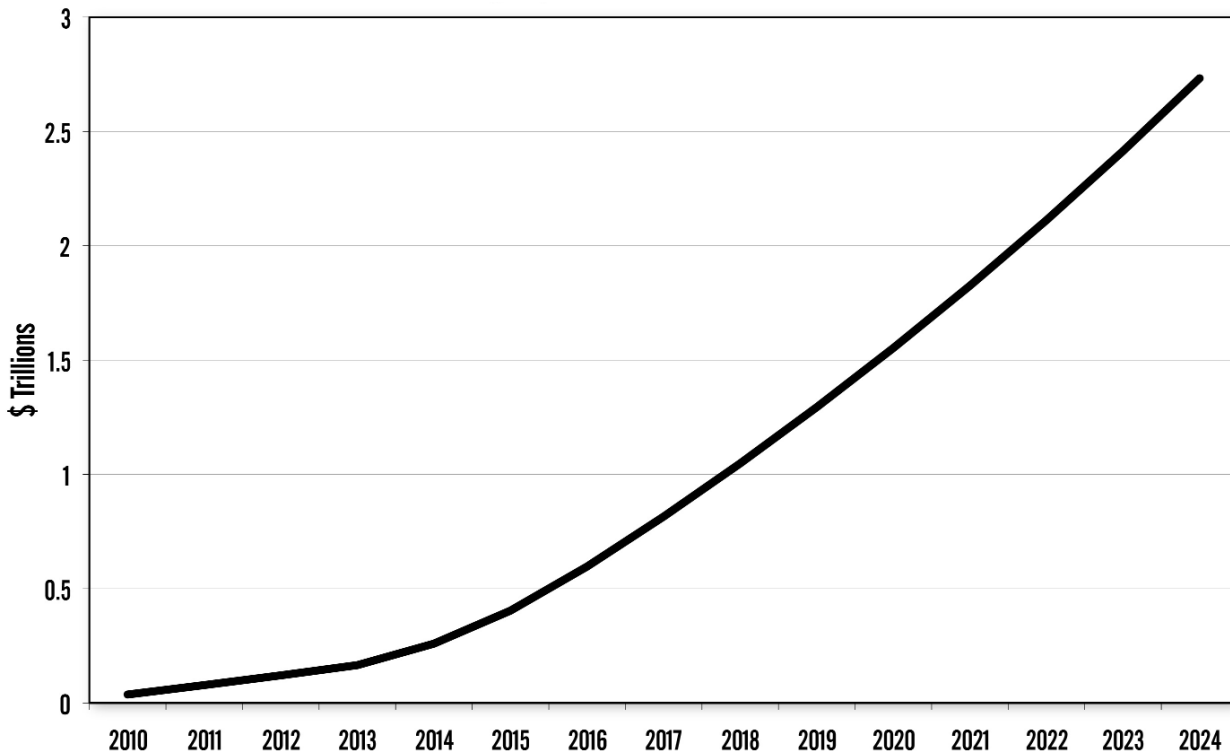
Those cuts were part of a Medicare reimbursement reduction first called for in 2003, as part of changes to the sustainable growth rate required by the Balanced Budget Act of 1997.²⁷⁵ However, as discussed earlier, the cuts have never actually been implemented, with Congress regularly postponing their effective date. Current law would reduce payment rates for providers by 21 percent beginning in January 2011, and by an average of two 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.²⁷⁶ However, other sources, including the Obama administration have suggested the cost could go as high as \$371 billion.²⁷⁷

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.²⁷⁸

Moreover, the initially projected cost failed to include discretionary costs associated with the program's implementation. The legislation does not provide specific expenditures for these items, but simply authorizes "such sums as may be necessary." Therefore, because the costs are subject to annual appropriation and the actions of future congresses are difficult to predict, it may be

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.

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.²⁷⁹

As Figure 10 shows, adding the cost of the doc-fix and discretionary costs to the legislation brings the total cost over 10 years of actual operation to over \$2.7 trillion, and will add \$352 billion to the national debt over that period.²⁸⁰

Finally, and perhaps most important, 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.²⁸¹ 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.²⁸²

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.²⁸³ 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.²⁸⁴ 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.²⁸⁵ If the current estimates for the cost of Obamacare are off by similar orders of mag-

nitude, 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."²⁸⁶ Another study, by former CBO director Douglas Holtz-Eakin and Cameron Smith warns that shifting employees to government-subsidized coverage could increase the legislation's cost by as much as \$1.4 trillion over 10 years.²⁸⁷ 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.

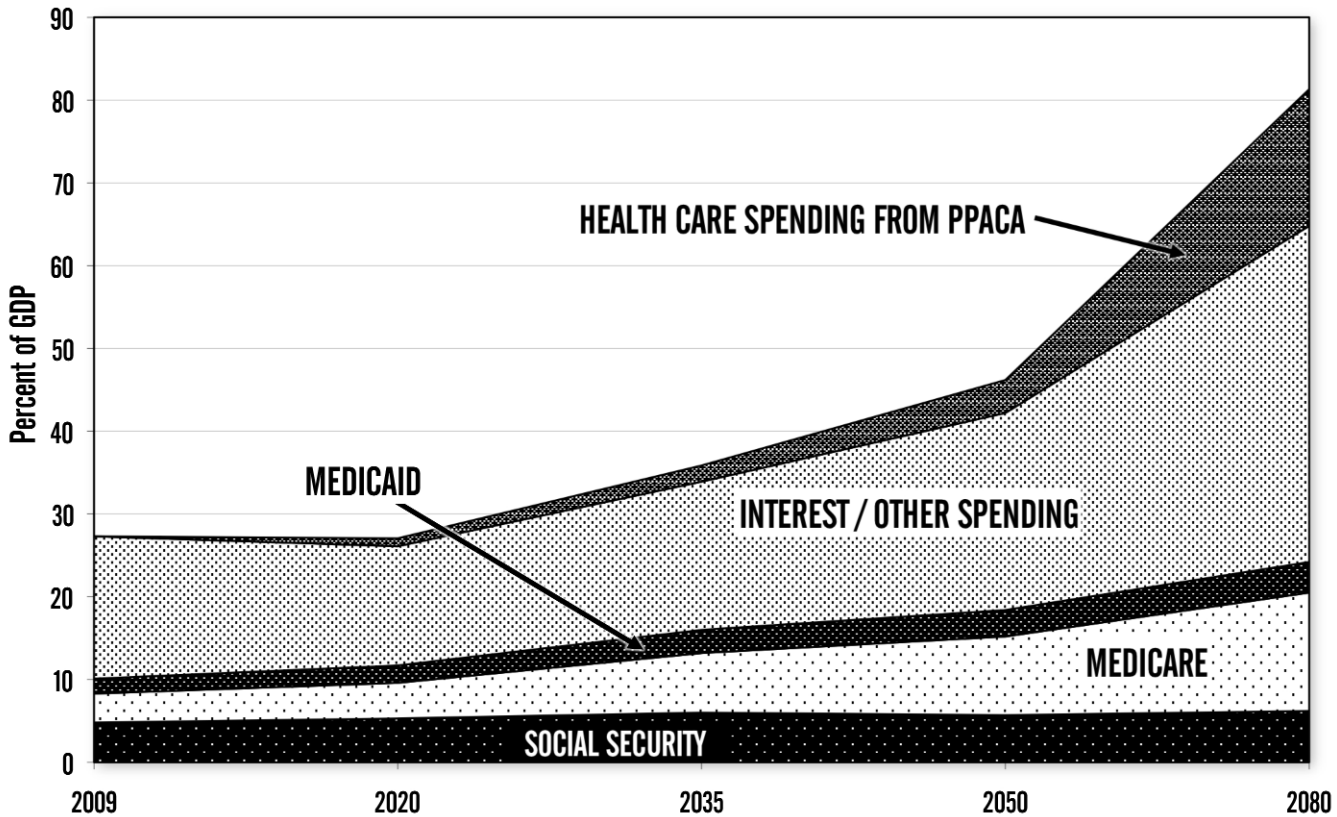
This is all taking place at a time when the government is facing an unprecedented budgetary crisis. The U.S. budget deficit hit \$1.4 trillion in 2009, and we are expected to add as much as \$9 trillion to the national debt over the next 10 years, a debt that is already in excess of \$12 trillion and rising at a rate of nearly \$4 billion per day.²⁸⁸ Under current projections, government spending will rise from its traditional 20–21 percent of our gross domestic product to 40 percent by 2050.²⁸⁹ That would require 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, approaching 80 percent of GDP.

By any measure, therefore, the Patient Protection and Affordable Care Act dramatically increases government spending, the

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

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.”

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.²⁹⁰ 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.²⁹¹ 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 non-group-insurance plan costs \$2,985 for an individual and

\$6,328 for a family.²⁹² In the nongroup—that is employer-based—market, premiums average \$4,825 for an individual, and \$13,375 for a family.²⁹³ 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.²⁹⁴ 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 3 percent less than would otherwise occur.²⁹⁵ That means that

Table 2
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.

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.²⁹⁶ 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.²⁹⁷ 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 \$100.²⁹⁸

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 \$13,100.²⁹⁹ Thus, this bill will cost a family buying their own health insurance an additional \$2,100 per year in higher premiums (see Table 2).

Of course, for low- and some middle-income Americans, any increase in premiums will be offset by government subsidies. But

individuals whose income falls in the range where subsidies begin to phase out, and those not receiving subsidies will likely see significant increases in what they have to pay.

The bill’s proponents also point out that most of the increased cost is due to increased benefits mandated by the new law, and the new insurance reforms. It is not that the per unit cost of insurance will have risen faster than the baseline, but that individuals will be purchasing more insurance. That, however, does not change the bottom line. Individuals will be paying more, and not because they choose to do so. If everyone was mandated to trade their current car for a new BMW, people would have a better car—but they would still be poorer.

That is not at all what the president promised.

Conclusion

Health care reform was designed to accomplish three goals: (1) provide health insurance coverage for all Americans, (2) reduce insurance costs for individuals, businesses, and government, and (3) increase the quality of health care and the value received for each dollar of health care spending. Judged by these goals, the new law should be considered a colossal failure. The president and the law’s supporters in Congress also promised that the legislation would not increase the federal budget deficit

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

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

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.”³⁰⁰ On these grounds too, the Patient Protection and Affordable Care Act fails to 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 mostly results 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 21 million Americans will still be uninsured by 2019. On this dimension, therefore, the new law is an improvement over the status quo, but a surprisingly modest one.

The law also makes some modest insurance reforms that will prohibit some of the industry’s more unpopular practices. However, those changes will 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,”³⁰¹ 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 \$352 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 non-group 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 her Facebook posting.³⁰² 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.³⁰³

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.³⁰⁴ 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.*”³⁰⁵

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 \$669 billion in new or increased taxes, the

The debate over health care reform is far from over.

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 purchasing their insurance through the government-run exchanges. CBO’s estimate of 10–12 million workers being dropped from their current employer coverage is probably conservative. With other, and much larger, businesses now reportedly considering such an approach, the number of workers forced out of their current plans could increase significantly.

Finally, the law’s individual mandate continues to pose a threat to people being able to keep their current coverage. While the final bill grandfathered current plans—a significant improvement over previous versions—individuals will still be forced to change coverage to a plan that meets government requirements if they make any changes to their current coverage. And, by forbidding noncompliant plans from enrolling any new customers, the law makes those plans non-viable 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.³⁰⁶ Elections this fall are likely to see candidates campaigning in favor of repealing all or parts of the legislation.³⁰⁷ And while institutional barriers such as the filibuster and presidential veto make an actual repeal unlikely, there will almost certainly be efforts by future congresses to delay, de-fund, or alter many aspects of the law.³⁰⁸

One thing is certain—the debate over health care reform is far from over.

Appendix I: Timeline

Anyone expecting to see major changes to the health care system in the next few months or years is liable to be disappointed. While some insurers and businesses may raise rates or take other preemptive actions in anticipation of changes to come, most of the major provisions of the legislation are phased in quite slowly. As Table 3 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 will begin this year, notably a provision allowing parents to keep their children on the parent’s policy until the child reaches age 27 and a ban on preexisting-condition exclusions for children. There will also be a \$250 rebate to seniors whose prescription drug costs fall within the Medicare Part D “donut hole.” The small business tax credits will kick in next year. After that, there will be few benefits from the law until 2014 or

Table 3
Patient Protection and Affordable Care Act Timeline for Implementation

2010

| | |
|------------------|--|
| Already in place | <p>Ten 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 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> |
| September | <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 27.</p> <p>Lifetime caps on insurance benefits prohibited.</p> <p>Restaurants and vending machines required to post calorie counts.</p> |

2011

A three-year phase-out of subsidies to Medicare Advantage begins. Some seniors may be forced back into traditional Medicare.

States must expand Medicaid eligibility to all individuals with incomes below 133 percent of the poverty line. The federal government will cover the cost of this expansion until 2017.

Businesses with fewer than 25 employees and average wages below \$50,000 become eligible for a tax credit to help offset the cost of providing insurance to their workers. The credit applies to 2010 taxes filed in 2011.

Workers begin contributing to the CLASS Act long-term care program, or may opt-out of the program.

\$2.5 billion in new taxes are imposed on the pharmaceutical industry. The tax, or assessment, rises to \$4.2 billion by 2018, and is imposed on manufacturers according to a formula based on the company's aggregate revenue from branded prescription drugs.

An \$8 billion tax is imposed on insurers, based on market share. The tax rises to \$14.3 billion by 2018.

2012

Businesses required to complete 1099 forms for every business-to-business transaction of \$600 or more.

2013

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.

2.3 percent excise tax imposed on sale of medical devices.

Floor for deducting medical expenses from income taxes rises from 7.5 percent of income to 10 percent.

The Employer Medicare Part D subsidy deduction for employers eliminated. Employers will lose the tax deduction for subsidizing prescription drug plans for Medicare Part D-eligible retirees. The 3.8 percent Medicare tax is applied to capital gains and interest and dividend income, if an individual's total gross income exceeded \$200,000 or a couple's income exceeds \$250,000.

Maximum contributions to Flexible Spending Accounts (FSAs) reduced from \$5,000 to \$2,500. FSAs and health savings accounts cannot be used to purchase over-the-counter medications.

2014

Individual mandate imposed. With few exceptions, every American is required to have a government designed minimum insurance package. Failure to comply will result in a fine equal to 1 percent of income. The penalty increases to 2 percent in 2015, and finally to 2.5 percent in 2016.

Employer mandate imposed. Companies with 50 or more employees must offer coverage to employees or pay a \$2,000 penalty per employee after their first 30 if at least one of their employees receives a tax credit. Employers who offer coverage but whose employees receive tax credits will pay \$3,000 for each worker receiving a tax credit.

An \$8 billion tax is imposed on insurers, based on market share. The tax rises to \$14.3 billion by 2018.

All insurance must meet federal minimum benefit requirements.

Prohibition on preexisting condition exclusions applies to adults.

Health plans prohibited from imposing annual limits on coverage.

Subsidies begin for individuals and families with incomes up to 400 percent of the poverty line. Refundable tax credits limit the percent of income that must be paid for either insurance premiums or out-of-pocket expenses.

Insurance exchanges become operational.

2015

Independent Medical Advisory Commission (IMAC) established.

2016

Individuals may begin collecting benefits from CLASS Act long-term care program.

2017

States have option to allow large employers to participate in exchanges.

States must begin covering part of the cost of Medicaid expansion.

2018

“Cadillac” insurance tax imposed on high-cost, employer-provided health plans with an actuarial value exceeding \$27,500 for family coverage and \$10,200 for individual coverage.

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 will be 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.

Notes

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. See http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/march_2010/health_care_law.

8. Jake Sherman, “John Boehner: Repeal Number One Priority,” *Politico*, April 12, 2010.

9. John Schwartz, “Health Measure’s Opponents Plan Legal challenges,” *New York Times*, March 22, 2010.

10. Margaret Talev, “Health Care Overhaul Spawns Mass Confusion in Public,” *McClatchy Newspapers*, April 6, 2010.

11. Nancy Pelosi, “Remarks to the 2010 Legislative Conference for National Association of Counties,” March 9, 2010, <http://www.speaker.gov/newsroom/pressreleases?id=1576>.

12. 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.

13. Robert Hartman and Paul van de Water, “The Budgetary Treatment of an Individual Mandate to Buy Health Insurance,” Congressional Budget Office Memorandum, August 1994.

14. 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 section . . . is commercial and economic in nature, and substantially affects

interstate commerce,” 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 chooses. Patient Protection and Affordable Care Act—Title I, sec. 1501(a)(1). 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. 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 Rows 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 Rows 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. 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 Robert Levy, “The Taxing Power of Obamacare,” National Review Online, April 20, 2010.

15. Jennifer Staman and Cynthia Brougher, “Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis,” Congressional Research Service, July 24, 2009.

16. “The Patient Protection and Affordable Care Act (Public Law 111-148), Subtitle F, Part I, sec. 1501, as amended by the Health Care and Edu-

cation Affordability Reconciliation Act,” sec. 1002. Note this amends Subtitle D of Chapter 48 of the Internal Revenue Code of 1986.

17. *Ibid.*

18. 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 (\$27,500) of the Federal poverty line 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) therefore depends not just on income, but also age, family size, smoking status, and location.

19. Congressional Budget Office and the staff of the Joint Committee on Taxation, “Payments of Penalties for Being Uninsured Under PPACA,” April 22, 2010.

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

21. The Patient Protection and Affordable Care Act, Subtitle D, sec. 1302(b)(1).

22. The Patient Protection and Affordable Care Act, sec. 1302(b)(2)(A).

23. The Patient Protection and Affordable Care Act, sec. 1251.

24. David Hilzenrath, “Health-Care Laws Face Test

as Regulators Settle Which Plans Must Do What,” *Washington Post*, May 24, 2010.

25. J. P. Freire, “16,500 More IRS Agents Needed to Enforce Obamacare,” *Washington Examiner*, March 18, 2010. This is a rough estimate by the Republican staff of the Joint Economic Committee of the number of agents that could be hired with the \$10 billion that the IRS has requested to administer or enforce the health care law. There is no specification, however, that the appropriation would be used in its entirety to hire additional agents. 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.

26. Martin Vaughn, “IRS May Withhold Tax Refunds to Enforce Health-Care Law,” *Wall Street Journal*, April 16, 2010.

27. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

28. Jeanne S. Ringel, et al., “Analysis of the Patient Protection and Affordable Care Act, HR 3590,” Rand Corporation, March 2010.

29. Sharon Long, “On the Road to Universal Coverage: Impacts of Reform in Massachusetts,” *Health Affairs* (July/August 2008): w270-w284, Exhibit 6.

30. 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.

31. Kay Lazar, “Short-Term Customers Boosting Health Care Costs,” *Boston Globe*, April 4, 2010.

32. The penalty in Massachusetts is up to half the cost of a standard insurance policy. Chapter 58 of the Acts of 2006, sec. 13.

33. HR 3200, sec. 313.

34. For instance two half-time workers are considered the equivalent of one full-time employee for purposes of determining a company’s size. A full time worker is considered to work 30 hours per week.

35. The Patient Protection and Affordable Care Act, sec. 4908H(a), as amended by the Health Care and Education Affordability Reconciliation Act,” sec. 1003.

36. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

37. David Hilzenrath and N.C. Aizenman, “New Health-Care Rules Could Add Costs, Benefits to Some Insurance Plans,” *Washington Post*, June 15, 2010.

38. Ibid.

39. Robert Pear, “Study Points to Health Law Penalties,” *New York Times*, May 23, 2010.

40. Quoted in Lawrence H. Summers, “Some Simple Economics of Mandated Benefits,” *American Economic Review* 79, no. 2 (May 1989): 177-83.

41. 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_1006_AYEP.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.

42. “The Impact of Health Reform on Employers,” Towers Watson, May 2010, <http://www.towerswatson.com/united-states/research/1935>.

43. 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.

44. Jennifer Haberkorn, "Four Companies Muddled Dropping Health Insurance Plans," *Politico*, May 7, 2010.

45. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

46. *Ibid.*

47. Haberkorn, "Four Companies Muddled 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.

48. 15 U.S.C. secs. 1011-1015.

49. Interestingly though, for all the hype about insurance reform, the most commonly cited insurance provisions take up roughly 20 pages, or less than 1 percent of the 2,409-page bill.

50. 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.

51. 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.

52. *Ibid.*

53. 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.

54. 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.

55. 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.

56. 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.

57. The legislation appears to include a loophole that would allow insurers to continue excluding many children with preexisting conditions. Section 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.

58. 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.

59. 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.
60. Anna Wilde Matthews, “High-Risk Polls Face Start-Up Hurdles,” *Wall Street Journal*, March 27, 2010. This has led several states, including Georgia, Indiana, Nebraska, Nevada, and Wyoming, to choose not to participate in the program. Robert Pear, “States Decide on Running New Pools for Insurance,” *New York Times*, April 30, 2010.
61. Thomas Tobin, “ObamaCare’s Fuzzy Math: High Risk Pools Will Cost 8 Times What Is Budgeted,” *Forbes’ Science Business Blog*, May 12, 2010, <http://blogs.forbes.com/sciencebiz/2010/05/obamacares-fuzzy-math-high-risk-pools-will-cost-8-times-what-is-budgeted/>.
62. Carla Johnson, “Health Premiums Could Rise 17 Percent for Young Adults,” Associated Press, March 29, 2010.
63. *Ibid.*
64. Brian McManus, “Universal Coverage + Guaranteed Issue + Modified Community Rating= 95% Rate Increase,” Council for Affordable Health Insurance, August 2009.
65. 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.
66. Henry Waxman and Joe Barton, “Memorandum to Members and Staff of the Subcommittee on Oversight and Investigations: Supplemental Information Regarding the Individual Health Insurance Market,” June 16, 2009, http://energycommerce.house.gov/Press_111/20090616/rescision_supplemental.pdf.
67. *Ibid.*
68. Public Health Service Act, sec. 2711, as amended by the Patient Protection and Affordable Care Act, Title X, Subtitle A, sec. 10101.
69. Brie Zeltner, “How Will Removing Lifetime Caps on Health Coverage Affect You? Health Care Fact Check,” *Cleveland-Plain Dealer*, March 24, 2010.
70. Emily Bregel, “Lifting the Cap on Coverage,” *McClatchy Newspapers*, April 12, 2010.
71. Jennifer Haberkorn, “Health Bill Could Ban Low-Cost Plans,” *Politico*, June 8, 2010.
72. The Patient Protection and Affordable Care Act, sec. 1302(c)(2)(A).
73. The Patient Protection and Affordable Care Act, sec. 1302(c)(1)(b)(ii).
74. Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9016(a).
75. While 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.
76. 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.
77. Ricardo Alonso-Zaldivar, “New Coverage For Young Adults Will Raise Premiums,” Associated Press, May 10, 2010.
78. Michelle Andrews, “Graduates May See Coverage Gap After All,” *New York Times*, May 31, 2010.
79. “The Uninsured: A Primer, Key Facts about Americans Without Health Insurance,” Kaiser Family Foundation, December 2003.
80. The Patient Protection and Affordable Care Act, Title II, Subtitle A, sec. 2001(a).
81. 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>.
82. Patient Protection and Affordable Care Act, section 2001(b)(2)(gg)(2).
83. Quoted in Marsha Blackburn and Phil Roe, “TennCare Lessons for Healthcare Reform,” *Real ClearPolitics.com*, July 22, 2009, http://www.realclearpolitics.com/articles/2009/07/22/tenncare_lessons_for_modern_health_care_reform_97570.html.
84. Patient Protection and Affordable Care Act, sec. 2101, as amended by the Health Care and Education Affordability Reconciliation Act,” sec. 10201.

85. Patient Protection and Affordable Care Act, Title II, Subtitle B, sec. 2101(b). Healthcare Reform,” PowerPoint Presentation, April 10, 2006.
86. 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.
87. The Patient Protection and Affordable Care Act, Title I, Subtitle E, Part I, Subpart A, sec. 1401.
88. Based on the lowest cost Silver Plan available. See below.
89. Examples courtesy of Kaiser Family Foundation’s Health Reform Subsidy Calculator, <http://healthreform.kff.org/SubsidyCalculator.aspx>.
90. 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.
91. The Patient Protection and Affordable Care Act, Title I, Subtitle E, Part II, sec. 1421.
92. The Patient Protection and Affordable Care Act, Title I, Subtitle B, sec. 1102.
93. The Patient Protection and Affordable Care Act, Title I, Subtitle B, sec. 1102 (c)(3).
94. The Patient Protection and Affordable Care Act, Title I, Subtitle B, sec. 1102 (c)(4).
95. The Patient Protection and Affordable Care Act, Title I, Subtitle B, sec. 1102 (a)(1).
96. The Patient Protection and Affordable Care Act, Title X, Subtitle E, sec. 10503.
97. Doug Trapp, “Health Reform May Mean 40 Million Health Center Patients in 5 Years,” *American Medical News*, April 13, 2010.
98. Ezra Klein, “The Most Important, Undernoticed Part of Health Reform,” http://voices.washingtonpost.com/ezra-klein/2009/06/health_insurance_exchanges_the.html.
99. Ezra Klein, “Health Care Reform for Beginners: The Many Flavors of the Public Option,” *Washington Post*, June 8, 2009.
100. Office of the Governor, “Massachusetts Healthcare Reform,” PowerPoint Presentation, April 10, 2006.
101. 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.
101. The Patient Protection and Affordable Care Act, sec. 1321.
103. The Patient Protection and Affordable Care Act, sec. 1311(d)(1).
104. The Patient Protection and Affordable Care Act, sec. 1312(c)(3).
105. The Patient Protection and Affordable Care Act, sec. 1312(d)(1).
106. The Patient Protection and Affordable Care Act, sec. 1312(c)(1).
107. The Patient Protection and Affordable Care Act, sec. 1312(d)(3)(D).
108. 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 (see above). 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.
109. The Patient Protection and Affordable Care Act, sec. 1302(d)(1)(A-D).
110. The Patient Protection and Affordable Care Act, sec. 1302(e)(2).
111. Estimates are for 2016. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Sen. Olympia Snowe, January 11, 2010.
112. Patient Protection and Affordable Care Act, Title I, Subtitle D, Part IV, sec. 1334(g)(2), as amended by sec. 10104(q).

113. 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).

114. 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 ultimate went out of business in 2000.

115. See, for example, John Goodman, "What is Consumer-Directed Health Care?" *Health Affairs* 25 (Nov-Dec 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).

116. 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.

117. Barack Obama, *The Audacity of Hope: Thoughts on Reclaiming the American Dream* (New York: Three Rivers Press, 2006), p. 179.

118. "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.

119. 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.

120. The Patient Protection and Affordable Care Act, sec. 9003.
121. “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.
122. The Patient Protection and Affordable Care Act, sec.1302(d)(2)(B).
123. The Patient Protection and Affordable Care Act, sec. 10406.
124. The Patient Protection and Affordable Care Act, sec. 4003.
125. 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/>.
126. 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 employees FSA is not subject to income or payroll taxes. Unlike health savings accounts, funds deposited in an FSA may not be rolled-over from here to year. Unused funds revert back to the plan administrator under what is commonly known as the “use it or lose it” rule.
127. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9005.
128. 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).
129. Social Security and Medicare Board of Trustees, “A Summary of the 2009 Annual Reports.”
130. For a discussion of how Cato scholars believe Medicare should be reformed, see Michael Cannon, “Medicare,” in *Cato Handbook for Policy Makers*, ed. Edward H. Crane and David Boaz (Washington: Cato Institute, 2009), pp. 125–31, <http://www.cato.org/pubs/handbook/hb111/hb111-12.pdf>.
131. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.
132. Ibid.
133. Ibid.
134. Kaiser Family Foundation, “Medicare Advantage Fact Sheet,” April 2009.
135. “The Medicare Advantage Program,” Testimony of Peter R. Orszag, director, Congressional Budget Office, before the Committee on the Budget, U.S. House of Representatives, June 28, 2007.
136. 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.
137. 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>.
138. 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.
139. Ken Thorpe and Adam Atherly, “The Impact of Reductions in Medicare Advantage Funding on Beneficiaries,” Blue Cross Blue Shield Association, April 2007.
140. Ibid.
141. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.
142. “ACR Strongly Opposes Imaging Cuts in Health Care and Education Affordability Reconciliation Act,” March 19, 2010, <http://www.dotmed.com/news/story/12058/>.
143. Letter from Douglas Elmendorf, director,

- Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.
144. Patient Protection and Affordable Care Act, Title III, Subtitle B, Part III, sec. 3131.
145. Certainly it is impossible to draw any sort of direct correlation between the amount of health care spending and outcomes. Anderson and Chalkidou, pp. 2444–45. In fact, by some estimates as much as 30 percent of all U.S. health spending produces no discernable value. Fisher.
146. See, for example, Fisher, Bynum, and Skinner, pp. 849–52.
147. 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.
148. Michael Cannon, “A Better Way to Generate and Use Comparative-Effectiveness Research,” Cato Institute Policy Analysis no. 632, February 6, 2009.
149. 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.
150. 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.
151. Jennifer Haberkorn, “GOP: Medicare Pick Favors ‘Rationing,’” *Politico*, May 12, 2010.
152. Patient Protection and Affordable Care Act, Title IX, sec. 9012.
153. See http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:h1enr.txt.pdf.
154. Cited in Jon Healey, “The Healthcare Reform Exposes an Extraordinary Tax Subsidy,” *Los Angeles Times*, March 21, 2010.
155. 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.
156. Kris Maher, Ellen Schultz, and Bon Tita, “Companies Take Health Care Charges,” *Wall Street Journal*, March 26, 2010.
157. “Dems Cancel Hearing on Business Health Grips,” Associated Press, April 14, 2010.
158. The Patient Protection and Affordable Care Act, Title III, Subtitle E, sec. 3403.
159. The Patient Protection and Affordable Care Act, Title III, Subtitle E, sec. 3403(c)(2)(a)(ii).
160. Social Security Act, sec. 1899A(c)(2)(A)(iii), as amended by the Patient Protection and Affordable Care Act, sec. 3403.
161. See Cannon, “A Better Way to Generate and Use Comparative Effectiveness Research.”
162. The Henry J. Kaiser Family Foundation, “Fact Sheet: The Medicare Prescription Drug Benefit,” September 2005, <http://www.kff.org/medicare/upload/7044-04.pdf>; Jim Mays, Monica Brenner et al., *Estimates of Medicare Beneficiaries Out-of-Pocket Spending: Modeling Impact of MMA* (Washington: The Henry J. Kaiser Family Foundation), 2004, p. 5.
163. 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.
164. 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.

165. Richard Foster, "Estimated Financial Effects of the Patient Protection and Affordable Care Act," Centers for Medicare and Medicaid Services, April 22, 2010.

166. 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.

167. Foster.

168. Ibid.

169. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

170. 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.

171. 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.

172. HR 3961.

173. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.

174. Ibid.

175. 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.

176. Foster.

177. "Cadillac Health Plan Tax to Penalize Majority of Employers by 2018," Towers Watson, press release, May 19, 2010.

178. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9015.

179. California, Hawaii, Maryland, New Jersey, New York, Oregon, Rhode Island, and Vermont. Data provided by Tax Foundation.

180. Health Care and Education Affordability Reconciliation Act, Title I, Subtitle E, sec. 1411.

181. See http://www.edwardjones.com/en_US/re-sources/news/news_wide/WEB223248.html.

182. Ibid.

183. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9013.

184. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9013(b).

185. 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.

186. 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.

187. 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).

188. Foster.

189. "New Tax Could Boost Small Business Premiums by \$1,000 per Year," Joint Economic Committee, Republican staff, April 22, 2010.

190. 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).

191. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9010, as amended by the Health Care and Education Affordability Rec-

- conciliation Act, sec. 1406.
192. The Patient Protection and Affordable Care Act, Title IX, Subtitle A, sec. 9010(b)(1)(A).
193. 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).
194. 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.
195. 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.
196. *Ibid.* Those with incomes below \$18,000 per year gain relatively little because they already receive government assistance under Medicaid and other programs.
197. Internal Revenue Code of 1986, Chapter 32, as amended by the Health Care and Education Affordability Act, Title I, Subtitle E, sec. 1405.
198. The Patient Protection and Affordable Care Act, sec. 8002(a)(1).
199. They will eventually be set by the Secretary of HHS.
200. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.
201. Foster.
202. Public Health Service Act, sec. 3202(6)(i), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).
203. Public Health Service Act, sec. 3202(6)(ii), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).
204. Public Health Service Act, sec. 3203(a)(1)(D)(i), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).
205. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Senator Kay Hagan, July 6, 2009.
206. 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).
207. 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.
208. See <http://www.aaltci.org/long-term-care-insurance/learning-center/CLASS-Act.php/#cost>.
209. Public Health Service Act, sec. 3203(a)(1)(C)(i), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).
210. Public Health Service Act, sec. 3203(a)(1)(C)(iii), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).
211. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.
212. *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.
213. June O'Neill, "The Trust Fund, the Surplus, and the Real Social Security Problem," Cato Institute Social Security Paper no. 26, April 9, 2002.
214. Lori Montgomery, "Proposed Long-Term Insurance Program Raises Questions," *Washington Post*, October 27, 2009.
215. Allen Schmitz, "Adverse Selection and the CLASS Act," Milliman Health Reform Briefing Paper, December 2009.
216. Public Health Service Act, sec. 3203(b)(1)(E), as amended by Patient Protection and Affordable Care Act, sec. 8002(a).
217. 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.
218. Foster.
219. *Ibid.*
220. 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).

221. Mandatory participation seems entirely in line with arguments that the bill's individual mandate for health insurance was necessary to prevent adverse selection.
222. Patient Protection and Affordable Care Act, sec. 4205.
223. Ed Ou, "Health Care Bill Requires Calories on Menus at Chain Restaurants," Associated Press, March 23, 2010.
224. Patient Protection and Affordable Care Act, sec. 4205.
225. About a third of the U.S. population is considered obese. Nanci Helmich, "US 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 US Health System \$147 Billion: Study," Reuters, July 28, 2009.
226. Roni Caryn Rabin, "How Posted Calories Affect Food Orders," *New York Times*, November 2, 2009.
227. Bryan Bollinger, Phillip Leslie, and Alan Sorenson, "Calorie Posting in Chain Restaurants," Stanford University and National Bureau of Economic Research, January 2010.
228. National Automatic Merchandise Association Legislative Alert, October 30, 2009. http://www.vending.org/pdf/NAMA_October_3_2009_Leg_Ale rt.pdf.
229. Patient Protection and Affordable Care Act, Title II, Subtitle I, secs. 3023, 2705, and 2706.
230. Patient Protection and Affordable Care Act, Title III, Part III, sec. 3021.
231. Patient Protection and Affordable Care Act, Title II, Subtitle E, sec. 2401.
232. Patient Protection and Affordable Care Act, Title II, Subtitle E, sec. 2402.
233. Patient Protection and Affordable Care Act, Title III, Part III, sec. 3025.
234. Public Health Service Act, Title III, sec. 399HH, as amended by the Patient Protection and Affordable Care Act, sec. 3011.
235. 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.
236. Elliott Fisher, "Expert Voices: More Care Is Not Better Care," National Institute for Health Care Management, January 2005.
237. 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.
238. "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.
239. 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.
240. 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.
241. Susan Sataline and Shirley Wang, "Medical Schools Can't Keep Up," *Wall Street Journal*, April 12, 2010.
242. Terry Jones, "45% of Doctors Would Consider Quitting If Congress Passes Health Care Overhaul," *Investors Business Daily*, September 15, 2009.
243. Patient Protection and Affordable Care Act, Title X, Subtitle E, sec. 10503, Title V, Subtitle C, secs. 5202, 5203, 5204, and 5205.
244. Patient Protection and Affordable Care Act, Title V, Subtitle D, sec. 5305.
245. Social Security Act, Title XVIII, sec. 1833, as amended by the Patient Protection and Affordable Care Act, Title V, Subtitle F, sec. 5501.
246. 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.
247. Patient Protection and Affordable Care Act, Title X, Subtitle E, sec. 10502.
248. Patient Protection and Affordable Care Act,

- Title X, Subtitle C, sec. 10323.
249. 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).
250. See for example, “Health Bill to Bring Near Universal Coverage,” Associated Press, March 22, 2010.
251. “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>.
252. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.
253. *Ibid.*
254. *Ibid.*, Table 4.
255. Jeanne S. Ringel, et al., “Analysis of the Patient Protection and Affordable Care Act (HR 3590),” Rand Corporation, March 2010.
256. *Ibid.*
257. *Ibid.*
258. *Ibid.*
259. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.
260. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 18, 2010.
261. The Physicians’ Foundation, “The Physicians’ Perspective: Medical Practice in 2008,” Survey KeyFindings, November 18, 2008.
262. Long, pp. w270-w284.
263. Kevin Sack, “In Massachusetts, Universal Care Strains Coverage,” *New York Times*, April 5, 2008.
264. 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>.
265. “OECD Health Data 2007: Statistics and Indicators for 30 Countries,” Organization for Economic Cooperation and Development, July 2007.
266. C. Borger et al., “Health Spending Projections Through 2015: Changes on the Horizon,” *Health Affairs Web Exclusive* W61: February 22, 2006. 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 U.S. 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.
267. Richard Foster, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Amended,” Centers for Medicare and Medicaid Services, April 22, 2010.
268. Amy Finkelstein, “The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare,” *Quarterly Journal of Economics* 122, no. 3 (2007): 1–37.
269. 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.
270. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Senate Majority Leader Harry Reid, March 11, 2010.
271. 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.
272. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 18, 2010.
273. 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>.

274. Letter from Douglas Elmendorf, director, Congressional Budget Office, to House speaker Nancy Pelosi, March 20, 2010.
275. Balanced Budget Act of 1997, sec. 4502.
276. Congressional Budget Office, "Summary of Medicare Physician Payment Reform Act of 2009," November 4, 2009.
277. Cited in Shawn Tully, "Health Care: Going from Broken to Broke," Cnnmoney.com, March 12, 2010. Congress has since passed a six month \$6.4 billion postponement of the required cuts.
278. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Rep. Paul Ryan, March 19, 2010. Note that the change is not a matter of simply adding the cost of the doc-fix to the cost of the health bill, because of the interaction of the doc-fix with changes in the Medicare Advantage program. Some proponents of the bill argue that it is unfair to assign the cost of the doc-fix to the health care bill since it almost certainly would have occurred anyway. See, for example, Ezra Klein, "One More Time with the Medicare Doc-Fix," *Washington Post* Online, April 28, 2010, http://voices.washingtonpost.com/ezra-klein/2010/04/one_more_time_with_the_medicar.html. But the question isn't one of assigning cost, but whether projections of the bill's cost and impact on future deficits uses an unrealistically low baseline.
279. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Rep. Jerry Lewis, May 11, 2010.
280. Authors calculations, assuming a 6 percent growth rate in both revenues and expenditures after 2019.
281. Robert Reischauer "An Analysis of the Administration's Health Proposal," Congressional Budget Office, February 1994.
282. 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/>.
283. Stephen Dinan, "Entitlements Have a History of Cost Overruns," *Washington Times*, June 16, 2006.
284. Ibid.
285. Ibid. In fairness, it should be pointed out that, so far, Medicare Part D is costing less than estimated.
286. Shawn Tully, "Documents Reveal AT&T, Verizon, Others Thought about Dropping Health Care Plans," *Fortune*, May 6, 2010.
287. Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform: New Results," American Action Forum, May 2010.
288. Congressional Budget Office, "Budget and Economic Outlook: Fiscal Years 2010 to 2020," January 2010.
289. See http://www.whitehouse.gov/omb/assets/omb/financial/reports/citizens_guide.pdf.
290. "Obama Health Care Plan," Memorandum from David Blumenthal, David Cutler, and Jeffrey Liebman, 2007.
291. "Will Health Care Bill Lower Premiums?" Associated Press, March 17, 2010, <http://www.cbnews.com/stories/2010/03/17/politics/main6306991.shtml>.
292. "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.
293. John Fritze, "Average Family Health Insurance Policy \$13,375, Up 5%," *USA Today*, September 16, 2009, citing survey data from the Kaiser Family Foundation.
294. 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 of 2010 that "the effects of the enacted legislation are expected to be quite similar," <http://www.cbo.gov/publications/collections/health.cfm>. Premiums for employer-policies usually have lower deductibles and more comprehensive benefits, accounting for the higher employer-based premiums. Premiums for identical policies are generally higher in the nongroup market.
295. Letter from Douglas Elmendorf, director, Congressional Budget Office, to Sen. Evan Bayh, November 30, 2009.
296. Ibid.
297. Ibid.

298. Ibid.

299. Ibid.

300. 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/.

301. 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/.

302. Mark Thiessen, "Palin Says Obama's Health Care Plan is 'Evil,'" Associated Press, August 8, 2009.

303. 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 dis-

cussion on consumer-directed health care above) and therefore would ultimately put the government in charge of those decisions.

304. 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.

305. Report of the Special Commission on the Health Care Payment System, March 25, 2009 (emphasis added).

306. "14 States Sue to Block Health Care Law," CNN.com, March 23, 2010.

307. Penny Bacon, "GOP Lawmakers, Candidates Pledge to Repeal Health Care Legislation," *Washington Post*, March 18, 2010.

308. In fact, legislation (HR 5424) has already been introduced by Reps. Boehner, Cantor, Pence, Blunt, and at least 16 others to repeal the entire bill except the ban on preexisting conditions, and would enact a number of republican health care reform proposals such as malpractice reform and allowing people to purchase health insurance across state lines. Molly Hooper, "GOP Moves to Repeal Health Care Law," Politico, May 27, 2010.

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