

The Prognosis for National Health Insurance: A Florida Perspective

A Study Prepared for The James Madison Institute
By Arduin, Laffer & Moore Econometrics

Foreword

Robert F. Sanchez, Policy Director, The James Madison Institute

Health care now comprises about one-sixth of the U.S. economy. Given the aging of the population, that portion is likely to grow. Therefore, making major changes in the system that delivers and funds health care requires especially careful analysis, not a rush to judgment.

True, this issue has been discussed for decades, especially since the advent of Medicare. Prior to that, the federal role was perceived primarily as battling communicable diseases such as yellow fever and smallpox. Medicare and the subsequent addition of Medicaid, the federal/state program to provide health care to low-income families, greatly increased the government's involvement.

That involvement escalated in recent years as healthcare costs rose faster than the general inflation rate. Many employers reduced or eliminated employee benefits. Even though most Americans still have health insurance and — polls show — like it, many others lack it. Still others have some form of health insurance but complain that their coverage is inadequate or too costly.

The growing pool of the uninsured has increased the clamor for "reform." Moreover, unlike some previous reform efforts, the current push has support from formerly resistant entities such as major employers eager to reduce the cost of benefits, elements in the pharmaceutical industry, and providers chafing under managed care's cost-containment policies and extensive red tape.

Much of the debate has been driven by raw data on the number of "uninsured," but those data can be misleading. For some people, the lack of coverage is only temporary, occurring briefly when they're between jobs. Others — especially healthy young people — may well make a conscious choice to avoid the expense. They may reasonably calculate that other forms of insurance — worker's comp for job-related injuries, automobile insurance for vehicle-related injuries — will cover most of the types of medical attention they're most likely to need.

Health-conscious younger people also may resent subsidizing care for folks who make unhealthy choices (i.e. smokers, drug abusers, the morbidly obese, the sexually promiscuous) and for older adults, who are more likely to suffer from chronic illnesses requiring costly long-term care. Many of the uninsured also know that a lack of health insurance won't necessarily deny them access to care, albeit care at the expense of the insured and other "paying patients."

This study, prepared by Arduin, Laffer & Moore Econometrics, indicates that Florida is especially vulnerable to the adverse effects of the healthcare proposals promoted by the White House and advancing in Congress. Given the magnitude of the changes being proposed — and given their potential effects on our daily life as well as the economy — the legislation now moving through Congress arguably violates a basic tenet of good medical practice: "First, do no harm."

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The Prognosis for National Health Insurance: A Florida Perspective

Executive Summary

In 1960 the private sector funded more than three-quarters of the nation's health care. Individuals paid nearly *one-half* of the total through out-of-pocket expenditures. Beginning in 1967, however, the way health care is purchased in the U.S. began to completely reverse itself:

- The private sector has been slowly funding less and less of the total national health expenditures; as of 2007, less than 54 percent of total national healthcare expenditures are paid for by the private sector.
- Reciprocally, the public sector has been slowly funding more and more of the total national health expenditures; as of 2007, public expenditures at the federal and state levels now fund nearly one-half of the total healthcare expenditures in the U.S.
- Total out-of-pocket expenditures as a share of total health expenditures have been plummeting at an even faster rate; today, only a bit more than \$1 out of every \$10 spent on health care is being funded by individuals through out-of-pocket expenditures.

This has resulted in a large and growing government *healthcare wedge* — an economic separation of effort from reward, of consumers (patients) from producers (healthcare providers), caused by government policies. Rising government expenditures on health care are the main factor driving the growth in the wedge. The wedge is a primary driver

in rising healthcare costs, i.e., inflation in medical costs.

President Barack Obama's principles drastically altering U.S. healthcare policy — a public health insurance exchange, mandating minimum coverage, mandating coverage of preexisting conditions, requiring purchase of health insurance — do not address the growing wedge and its role as the fundamental driver of healthcare costs. In fact, they will further increase the wedge, and can thus be expected to increase medical price inflation.

Specifically, the estimated \$1.0 trillion increase in federal government health subsidies over 10 years based on President Obama's principles will have the following consequences:

- Overall, total federal expenditures will be 5.6 percent higher than otherwise by 2019, adding \$285.6 billion to the federal deficit in 2019.
- National healthcare expenditures will increase by an additional 8.9 percent by 2019.
- Medical price inflation will increase by 5.2 percent above what it would have been otherwise by 2019.
- U.S. economic growth in 2019 compared to the baseline scenario will be reduced by 4.9 percent for the nation as a whole and 4.4 percent in Florida.
- Higher medical inflation and overall expenditures will ultimately lead to government expenditures that exceed the \$1.0 trillion in expenditures on

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“Adjusting for the growing U.S. population, the dollar level of expenditures on health care has exceeded the growth in overall consumer prices in the economy every year for nearly the past 50 years.”

health subsidies. The net present value of all additional federal government expenditures through 2019 that will occur as a result of a federal healthcare reform is \$1.2 trillion, or \$3,900 for every man, woman, and child in the U.S.

- In addition to federally-funded expenditures, the net present value of all Florida state government expenditures through 2019 that will occur as a result of a federal healthcare reform is \$5.9 billion, or \$320 for every man, woman, and child in Florida.
- The current net present value of funding healthcare reform based on President Obama’s priorities will be \$4,221 for every person in Florida. This comes to a total net present value of \$77.4 billion in total costs that Florida residents will have to bear.
- Despite the additional \$1 trillion in expected healthcare subsidies by the government, 30 million people would remain uninsured. The cost to reduce the number of uninsured by 16 million people is \$62,500 in subsidy expenditures per person insured.
- The cost on Florida could be higher, and the national cost lower, if the federal government pushes the financial responsibility for covering the expansion of lower income individuals’ health insurance coverage off to the states. While the federal costs will decline, Florida’s costs will increase by a total of \$18.6 billion (the net present value being \$14.3 billion).

Introduction

“In 2009, healthcare reform is not a luxury. It’s a necessity we cannot defer. Soaring healthcare costs make our current course unsustainable. It is unsustainable for our families ... It is unsustainable for businesses.”

– President Barack Obama

President Obama is correct when he says that “soaring healthcare costs make our current course unsustainable.” Adjusting for the growing U.S. population, the dollar level of expenditures on health care has exceeded the growth in overall consumer prices in the economy every year for nearly the past 50 years. Such a trend cannot continue forever.

Americans agree that healthcare reform is necessary. For instance, 55 percent of respondents to a recent CNN poll think the U.S. healthcare system needs a great deal of reform.¹ Yet, more than eight in ten Americans also said they’re satisfied with the quality of health care they receive.²

Such results are not contradictory. Consumers are satisfied with their current health arrangements because they are receiving quality medical care at little direct cost to themselves. Yet they understand that the runaway costs driven by this arrangement have to be addressed before the system collapses.

Part of the blame falls upon waste, fraud, and abuse in the healthcare system itself. These factors cost the system an estimated \$700 billion in 2007, or more than \$2,300 per legal U.S. resident. Another primary cost driver is a large and growing government healthcare wedge — an economic separation of effort from reward, or consumers (patients) from producers (healthcare providers), caused by government policies.

The healthcare wedge is one way of thinking about government involvement in the economy. When the government or a third party spends money on health care, the patient does not. The patient is then separated from the transaction in the sense that the costs are no longer his concern. This separation—how far the supplier and consumer are separated from one another—is what the economic wedge is measuring. The wedge measures the deadweight loss from this separation in higher costs that do not improve efficiency.

In the case of health care, the wedge also separates patients from doctors in determining what type of care should be provided. Decisions are made or influenced by government, by insurers, and by judges deciding medical

malpractice liabilities. The government, lawyer, and third-party wedge in our current healthcare system cause higher costs and diminished efficiency. Healthcare reform should be based on policies that diminish, not increase, this wedge.

From a macroeconomic perspective, a tax wedge diminishes incentives to work, save, and produce; the result is less work, fewer savings, and lower production. At the same time, the wedge increases incentives to consume and spend because the costs of consumption are not directly borne by the one making the decisions. Such basic fundamentals of economics are not repealed at the entrance to the hospital or the doctor's waiting room. The result: higher costs and diminished efficiency.

The primary government policy causing the wedge is the ever-increasing role of the government in funding health care, a factor that corresponds directly with the diminishing role of the private sector, particularly the consumers of health care.

Since 1967, the private sector has been funding less and less of total national health expenditures — less than 54 percent as of 2007. Public outlays (at the federal and state levels) now account for nearly one-half of total U.S. healthcare expenditures. Meanwhile total out-of-pocket expenditures have been plummeting even faster as a share of total health expenditures.

Taken together, these trends illustrate the complete reversal of the way health care is purchased in the U.S. In 1960, the private sector funded more than three-fourths of the national healthcare expenditures. Individuals paid from their own pockets nearly half of these costs. Today, the private sector funds slightly more than half of these expenditures. Individual patients cover just over \$1 of every \$10 spent on health care.

Although reform is necessary, ill-advised reforms can make things worse — much worse. Healthcare reformers should proceed in the same manner that doctors treat patients. Doctors must properly diagnose a patient's problem so as to understand the likely effects of a proposed treatment. Likewise, healthcare

reformers who have the public interest in mind will correctly diagnose the problem, showing how reform will restore a flagging healthcare system to robust health.

A proper diagnosis begins with the 70 percent of Americans who say they are satisfied with their current healthcare arrangements and remind us that we're not facing a crisis in access to health care or in health-insurance coverage. Reformers must ensure that any changes intended to help the 15 percent of Americans who do not have health-insurance coverage do not make the vast majority of Americans worse off.

The disease weighing down the healthcare industry is costs that are spiraling out of control. These care costs are driven to a large extent by the healthcare wedge. Rising government expenditures on health care are one of the main factors driving the growth in the healthcare wedge.

The President and his advisors have misdiagnosed the problems of the healthcare system. Healthcare reforms based on President Obama's criteria fail to address the fundamental driver of healthcare costs — the healthcare wedge.

The likely impact from the combination of generous federal subsidies and a new public insurance option is a significant reduction in people's incentives to monitor costs and a significant increase in the costs of administering the public program. In short, these policies will further increase the wedge. The growing health-expenditure wedge is strongly correlated with inflation in medical costs.

Reforms based on President Obama's priorities can thus be expected to weaken the healthcare system and increase medical price inflation. The actual healthcare reform proposal under consideration is fluid as of this writing. Proposals range from:

- A gross \$1.6 trillion expenditure contained in Sen. Edward M. Kennedy's healthcare reform proposal;
- A \$1 trillion expenditure in the House Tri-Committee Group reform; and
- A simple expansion of Medicaid eli-

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gibility at an estimated cost of \$600 billion, much or all of it borne by state governments.

The exact impact on Florida will vary depending upon which route is taken and whether the federal reform proposal attempts to cover the added costs or shift these costs to the states.

We assess here the impact of a reform proposal that significantly expands government’s role in the healthcare market through 1) providing an additional \$1 trillion in federal subsidies over 10 years and 2) offering incentives to move current Medicaid recipients into a new federal health insurance program.

Such a program would:

- Increase national healthcare expenditures by an additional 8.9 percent by 2019.
- Increase medical price inflation by 5.2 percent above what it would have been otherwise due to the higher national expenditures by 2019.
- Pressure the federal and Florida state budgets due to the increased expenditure levels and increased medical inflation:
 - * Higher medical inflation and overall expenditures will ultimately lead to government expenditures that exceed the \$1.0 trillion in expenditures on health subsidies. The net present value of all additional federal government expenditures through 2019 that will occur as a result of a federal healthcare reform is \$1.2 trillion, or a \$3,900 bill for every man, woman, and child in the U.S.
 - * In addition to federally-funded expenditures, the net present value of all Florida state government expenditures through 2019 that will occur as a result of a federal healthcare reform is \$5.9 billion, or a \$320 bill for every man, woman, and child in Florida.
 - * The current net present value of funding healthcare reform based on President Obama’s priorities will be \$4,221 for every person in Florida.

This comes to a total net present value of \$77.4 billion in total costs that Floridians must bear.

- Reduce economic growth in 2019 compared to the baseline scenario by 4.9 percent for the nation as a whole and 4.4 percent for Florida.
- The cost on Florida could be higher, and the national cost lower, if the federal government pushes the financial responsibility for covering the expansion of lower income individuals’ health-insurance coverage off to the states. While the federal costs will decline, Florida’s costs will increase by a total of \$18.6 billion (the net present value being \$14.3 billion).

Sharply higher healthcare costs would force people off private insurance and into the government plan. Further, as we know, the government rarely competes on a level playing field with private companies and firms. Rather, the government invariably tilts the field in its favor. A government plan embodying the Obama priorities would operate with guaranteed taxpayer subsidies. These would pressure the healthcare industry to price at uneconomical levels in order to meet political goals, regardless of economic merit or viability. This would further reduce the number of Americans with private healthcare insurance.

As a consequence, the increase in the number of people on the government plan would not reflect a corresponding decrease in the number of uninsured individuals. A \$1 trillion plan based on President Obama’s criteria would still leave 30 million people uninsured.³ The cost to reduce the number of uninsured, as estimated by the Congressional Budget Office, is \$62,500 per person.

Such a negative economic assessment is consistent with the Massachusetts experience following the state’s recent healthcare reforms. These share common ground with the Obama principles of a government-sponsored healthcare exchange, an individual mandate, and generous subsidies.

For all the hopeful rhetoric they occasioned,

the Massachusetts reforms have seriously strained the state budget. Although supporters claimed that the reforms would reduce the price of individual insurance policies, “insurance premiums rose by 7.4 percent in 2007, by 8 to 12 percent in 2008, and are expected to rise 9 percent this year.”⁴

The analysis below links the problems in our current healthcare system to the rising wedge between patients and medical providers. From this link it is clear that reforms based on President Obama’s priorities would only exacerbate our healthcare problems. Reform efforts need to be more carefully crafted and considered than have been the plans based on President Obama’s priorities.

Congress needs to focus on reform that promotes protection of what Americans most want and demand: immediate, measurable ways to make health care more accessible and affordable without jeopardizing quality, individual choice, or personalized care.

Diagnosing the Healthcare Industry: Strengths

Before addressing the adverse incentives and outcomes from the current U.S. healthcare system, it is worthwhile to quickly summarize its most important strengths. According to the U.S. Census, 45.7 million people in the U.S. did not have health insurance in 2007 (down from 47.0 million in 2006).⁵ Another way of putting it: 255.6 million people (or 85 percent of the population) had insurance in 2007, up from 251.4 million in 2006.⁶ A majority of these people are satisfied with their current coverage, which is offered by one of the approximately 1,300 separate health insurance companies that operate in the U.S.⁷ According to a recent CNN poll:

- *Most Americans like their healthcare coverage but are not happy with the overall cost of health care...*
- *More than eight in 10 Americans questioned in a CNN/Opinion Research Corp. survey ... said they're satisfied with the quality of health care they receive.*

- *And nearly three out of four said they're happy with their overall healthcare coverage.*
- *But satisfaction drops to 52 percent when it comes to the amount people pay for their health care, and more than three out of four are dissatisfied with the total cost of health care in the United States.*⁸

Such feelings are not new. A 2004 Harris Interactive poll found:

- *For the fifth time in six years, Harris Interactive has asked the insured public to rate their own insurance plans. Two thirds of them continue to give their plans an A or a B, with only 10% giving them a D or an F. Substantial but not overwhelming majorities continue to say that they would recommend their own health plans to family members who are basically healthy (76%) or who have a serious or chronic illness (68%).*⁹

Using the latest CNN and Census data, if 85 percent of Americans have health insurance, and 80 percent of Americans are satisfied with their current health quality, then more than approximately 70 percent of Americans are satisfied with their current arrangements. Care must be taken to ensure that changes to help 15 percent of Americans do not make the vast majority of Americans worse off.

The fact that such large percentages of the population are insured, and at the same time are satisfied with their insurance, is clear evidence that the U.S. healthcare system does not face a crisis of coverage or quality. Reforms that treat access to health care or health-insurance coverage as if they were in crisis fundamentally misread the positive aspects of the current healthcare system and, consequently, risk breaking the parts of the healthcare system that are currently working.

The Healthcare Wedge

The healthcare system is facing serious problems, however. These problems, which impose significant hardships on many

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individuals, need correction. Correcting the problems with the current healthcare system begins with an understanding of incentives to invest one’s money one way or another way. Incentives drive all economic behavior — including behavior in the healthcare industry. The cost and quality of healthcare goods and services respond to the interaction of consumers (patients) and suppliers (doctors and medical product suppliers).

The healthcare wedge is one way of thinking about government involvement in the economy. When the government or a third party spends money on health care, the patient does not. The patient is then separated from the transaction in the sense that the costs are no longer his concern. This separation—how far the supplier and consumer are separated from one another—is what the economic wedge is measuring. The wedge measures the deadweight loss from this separation in higher costs that do not improve efficiency.

In the case of health care, the wedge also separates patients from doctors in determining what type of care should be provided. Decisions are made by government, insurers, and judges deciding medical malpractice liabilities. The government,

lawyer, and third-party wedge in our current healthcare system causes higher costs and diminished efficiency.

One of the most basic axioms of economics examines changes in behavior when prices change. When the price of a product increases, consumers have an incentive to consume less while suppliers simultaneously have an incentive to produce more. When prices are obscured by government interference in the marketplace, neither consumers nor suppliers have the necessary knowledge to properly allocate society’s scarce resources. Economic wedges inevitably change economic incentives, oftentimes leading to undesirable outcomes. The burden of government on the growth of the private sector economy illustrates the costs associated with economic wedges.

Government spending relative to the size of the private-sector economy (the government expenditure wedge) is a proxy for the total burden of government activities on the economy. Figure 1 tracks the growth in the government’s expenditure wedge between 1951 and 2007 (the latest full data set available). As of 2007, total government expenditures were \$4.4 trillion. Net domestic business output (corporate and non-corporate income adjusted for

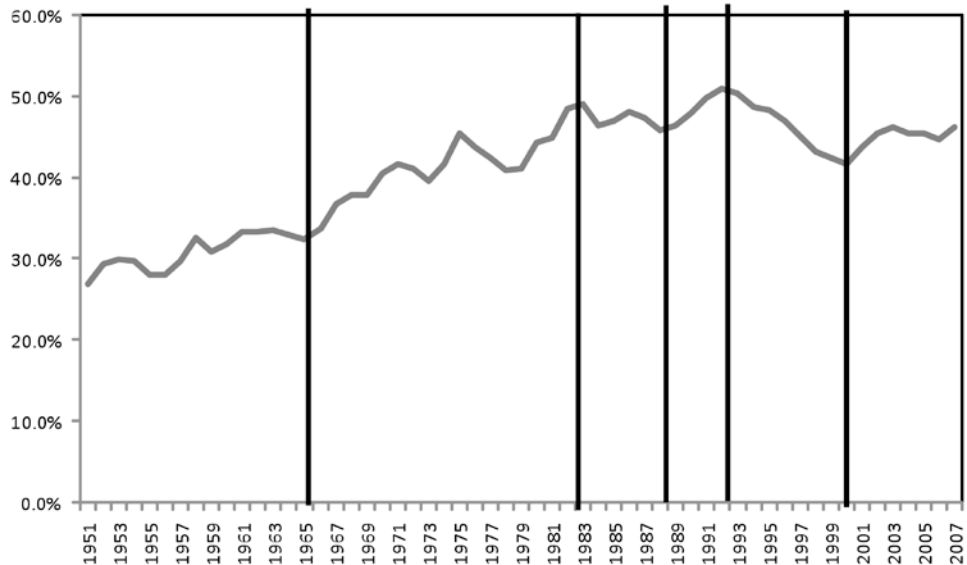


Figure 1: Total Federal, State and Local Government Expenditure Wedge, 1951 - 2007¹⁰

depreciation) for 2007 was \$9.5 trillion. The resulting government expenditure wedge for 2007 was 46.1%.

The vertical black lines in Figure 1 represent the years in which changes in the path of the government expenditure wedge are evident. For instance, total government expenditures between 1951 and 1965 ranged from relatively flat to more expansive. Beginning in 1966, there is a change in the rate of expenditure growth that continued until 1983. The growth in government expenditures then slowed until 1989. A renewed, but short-lived, pick-up in government expenditures occurred between 1989 and 1993. The trend toward lower government expenditures then resumed until 2001. Since then, total government expenditures have risen.

Table 1 illustrates the negative impact that a high and/or growing government expenditure wedge has on private sector activity, as well as the positive impact of a lower and/or declining expenditure wedge. Taking each period separately:

- Between 1950 and 1965, the government expenditure wedge was relatively low (32.4 percent) and grew slightly (+5.5 percentage points). Private sector expansion was a robust 3.6 percent per year during this period.
- Between 1965 and 1983, the government expenditure wedge grew quickly, rising

16.6 percentage points to 49.0 percent. Growth in the private sector slowed to 2.5 percent per year.

- Between 1983 and 1988, growth in the private sector accelerated to 5.1 percent per year as the government expenditure wedge fell 3.3 points back down to 45.7 percent.
- The brief reversal in the government expenditure wedge between 1988 and 1992 led to a 5.2 percentage point rise in the wedge to 50.9 percent. Growth in the private sector economy slowed again to 1 percent per year.
- Between 1992 and 2000, the government expenditure wedge fell 9.2 percentage points to 41.7 percent. Growth in the private sector economy accelerated again to 4.5 percent per year.
- Finally, between 2000 and 2007, the government expenditure wedge started growing again (by 4.5 percentage points to 46.1 percent) and the growth rate in the private sector cooled to 2.0 percent.

Taken together, Figure 1 and Table 1 illustrate the consequences from the overall government wedge on total economic growth. By separating effort from reward, a large or growing government wedge diminishes the incentive to work, save, and produce. The result is less work, fewer savings, and

“By separating effort from reward, a large or growing government wedge diminishes the incentive to work, save, and produce.”

Table 1: Negative Relationship Between Expenditure Wedge and Private Sector Growth, 1950 - 2007¹¹

	% Change Net Business Output (CAGR)	Wedge at end of period	Change Wedge (peak to trough, trough to peak)
1950 - 1965	3.6%	32.4%	5.5%
1965 - 1983	2.5%	49.0%	16.6%
1983 - 1988	5.1%	45.7%	-3.3%
1988 - 1992	1.0%	50.9%	5.2%
1992 - 2000	4.5%	41.7%	-9.2%
2000 - 2007	2.0%	46.1%	4.5%

“The current healthcare system blinds both patient and doctor to the actual cost of care.”

lower production. Such basic fundamentals of economics are not repealed at the healthcare industry’s doorstep.

In order to diagnose correctly the current problems in the healthcare industry, one must first understand the incentives driving the people and organizations participating in the healthcare market. Understanding the incentives pinpoints the current weaknesses of the U.S. healthcare industry, and provides the basis for developing a methodology to assess the impacts from proposed reforms on the problems in particular and the healthcare industry overall.

Our current third-party-payer system creates a wedge that separates consumers from suppliers. Larger wedges create larger gaps between consumers and suppliers and lead to greater market inefficiencies and a larger number of adverse incentives. Many of the problems with our current healthcare system stem from the adverse incentives created by the wedge between consumers and suppliers.

On the consumer side of the market, the wedge diminishes consumers’ incentives to monitor costs; after all, consumers bear only a fraction of the costs from any additional healthcare service (see below). On the supplier side, doctors and other medical providers receive no incentive to provide higher quality services for less cost. No positive financial benefit accrues to those who do so. There are costs to doctors, however. One of the most important disincentives for doctors to monitor costs is the tort liability threat. According to the American Medical Association, defensive medicine in response to the rising cost of tort liability added \$99 billion to \$179 billion in costs in 2005 alone.¹²

As a result, the current healthcare system blinds both patient and doctor to the actual cost of care. Meanwhile litigation risks incentivize doctors to run additional tests to limit their liability exposure. Government regulations and the third-party-payer system are also diminishing the market incentives to implement best practices programs that would help eliminate waste, fraud, and

abuse. Whether the payer is government or an insurance company, the process removes competition and the patient feedback that drives innovation.

Take as an example programs to implement best practices, or comparative effectiveness research. Comparative effectiveness research evaluates different medical procedures and treatments for the purpose of educating doctors and patients about which treatments are effective and economical and which treatments are not. An oft-cited complaint of the current U.S. healthcare system — a complaint not without merit — concerns the lack of effective comparative effectiveness research.

Cannon (2009) illustrates that removing government-created obstructions is a more effective policy reform to create comparative effectiveness research than the creation of a new government agency — the latter an important principle supported by the President. The President’s principles call for a government agency to provide comparative-effectiveness research, claiming a market failure has occurred. According to this theory, once comparative-effectiveness research is known, it is difficult to keep it out of the public domain. Organizations’ incentives to invest in this research are diminished by the prospect of competitors’ benefiting from their private research at no cost to themselves. Consequently, organizations will naturally under-invest in comparative-effectiveness research, according to this theory.

Cannon (2009) illustrates that the current lack of comparative-effectiveness research represents the failure, not of the market, but of government.¹³ For instance, prepaid group plans (PGPs) have a large incentive to provide comparative-effectiveness research to their members because the benefits of the research can be effectively captured within their networks of doctors and facilities. Government regulations and the complex web of state regulations discourage PGPs, however. On the demand side, the declining amount of out-of-pocket expenditures by consumers reduces their demand for comparative-effectiveness

research. Because consumers do not bear the costs or reap the benefits of ensuring the most cost-effective practices, their incentives to seek those benefits are accordingly lessened. Taken together, government interventions have deadened the incentives to create comparative-effectiveness research.

Cannon explains that, by definition, government agencies are subject to political influence. The record of government agencies from the Federal Reserve Bank, to the Securities & Exchange Commission, to the National Center for Health Care Technology shows that political influence has created periodic conflicts in which the agencies' missions and/or independence came under extreme pressure. Because more effective means exist to create this valuable research, the best way to create credible comparative-effectiveness research isn't to commission it from government but, rather, to remove the government obstructions preventing its creation.

Current Health Insurance Plans Worsen the Wedge

Most Americans do not have health *insurance* as the term is traditionally understood. Insurance is a tool for managing risk. In exchange for periodic payments from a customer, an insurance company provides protection against a large but uncertain potential cost.

Take disability insurance. A potential risk for many families is the possibility that the primary earner (or one of the dual-income earners) might meet with an accident that prevents him or her from working for a prolonged period of time. In such a case, a family could face potential financial ruin. To protect against this risk, many primary income earners will purchase a disability-insurance policy. In return for annual (or quarterly/monthly) payments to the insurance company, the company will pay a pre-determined amount of money to the income earner should an unfortunate accident or disabling illness occur.

Health insurance does not work this way. As opposed to covering only true health risks (the costs associated with broken arms

or major surgeries), health insurance pays the costs for routine health events that are not risks in the true sense of the word. An analogous situation would be for disability-insurance plans to pay an individual's disability claims for missing work due to a cold. The basic principles of risk and insurance have been distorted. The expected result from this distortion is diminished quality and increased prices.

Imagine if another form of insurance, automobile insurance, worked like health insurance. As opposed to covering the costs from major automobile accidents, costs of routine maintenance such as oil changes and tune ups would also be covered. Additionally, to ensure that car owners are all treated equally, insurance companies would be prohibited from charging different rates for specific drivers who cause more accidents, or from charging different rates to groups with different driving habits — married women in their 50s, for instance, who might qualify for lower rates than single 18-year-old males.

If indeed automobile insurance worked like health insurance, safe drivers would end up paying more for automobile insurance to subsidize the costs of unsafe drivers. Car consumers would also have no incentive to shop for the best deal when it came to changing the car's oil, getting a tune-up, or performing any other routine maintenance service. The cost for routine maintenance services would be expected to increase. Additionally, because a car owner would not bear costs resulting from improper maintenance, the incentive to properly maintain cars would decline. The number of major car repairs, and the cost of these repairs, would all be expected to increase as well.

Automobile insurance companies, trying to arrest the rising costs of car repairs and car maintenance would begin to increase the amount of rules and regulations. The result would be significant market distortions in the automobile-insurance market, skyrocketing costs of repairs, and an increase in the quantity of major repairs. In short, both the automobile-insurance market and

“Most Americans do not have health insurance as the term is traditionally understood.”

“The consistent excessive growth of healthcare expenditures, compared to the economy’s ability to pay, is the major weakness of the current healthcare system.”

the automobile-repair market would become much more inefficient to the point where people might even begin to wonder whether the automobile repair market is *special*, needing the government to mandate prices and repair schedules.

Empirical Existence of the Wedge

The empirical data confirm the expected outcomes from the wedge in the healthcare market: Healthcare expenditures and costs are rising faster than our economy. According to the Centers for Medicare & Medicaid Services, total national health expenditures accounted for more than 16 percent of our economy in 2007 (see Figure 2); and are expected to be about 18 percent of GDP in 2009.¹⁴

The rise in healthcare expenditures as a share of the U.S. economy has not been even. Significant growth has followed years of relative flat growth. In particular, healthcare expenditure growth was steady relative to overall U.S. economic growth in the mid-1970’s; early 1980’s; and through most of the 1990’s. In between the periods of steady health expenditures were years of rapid health expenditure growth.

Gross Domestic Product (GDP), or total national income, is a measure of people’s ability to pay for goods and services. The recent housing bubble vividly demonstrated that expenditures on a good or service cannot consistently outpace people’s ability to pay forever. The same is true for health care. The consistent excessive growth of healthcare expenditures, compared to the economy’s ability to pay, is the major weakness of the current healthcare system. All other problems (e.g., lack of insurance coverage and medical bankruptcy) find their genesis in the uncontrolled rise in healthcare expenditures. Consequently, beneficial healthcare reform must begin with an understanding of the trends and drivers of healthcare expenditures.

Part of the healthcare wedge is created by government expenditures substituting for private expenditures; another part by the private third-party-payment system. Figure 3 shows that the government-created wedge has been growing significantly since 1965.

The rise of government spending has been at the expense of private spending in the healthcare market. In 1960, more than 75 percent of total health expenditures in the U.S. were funded by private sources. Begin-

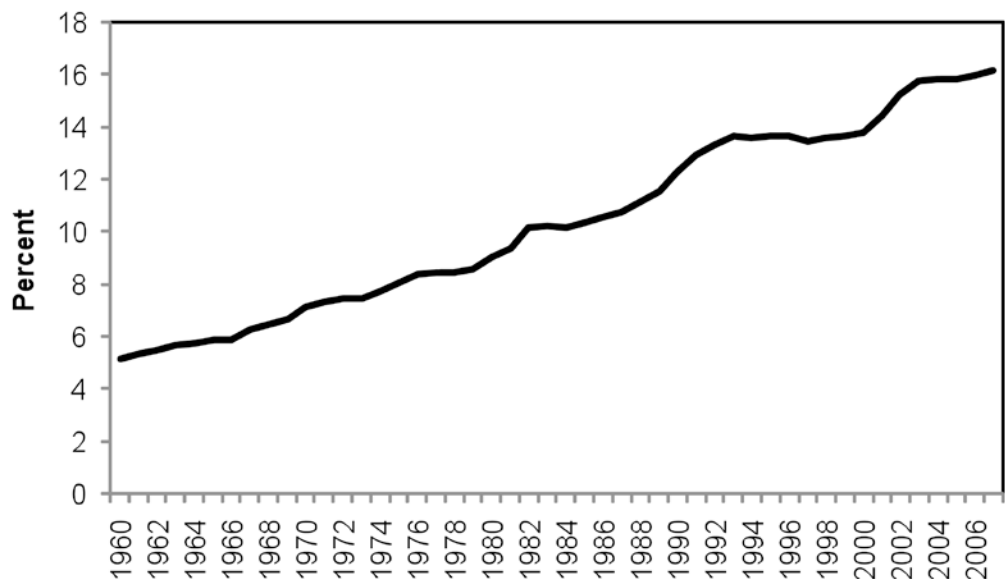


Figure 2: National Health Expenditures as a Percentage of GDP, 1960 - 2007¹⁵

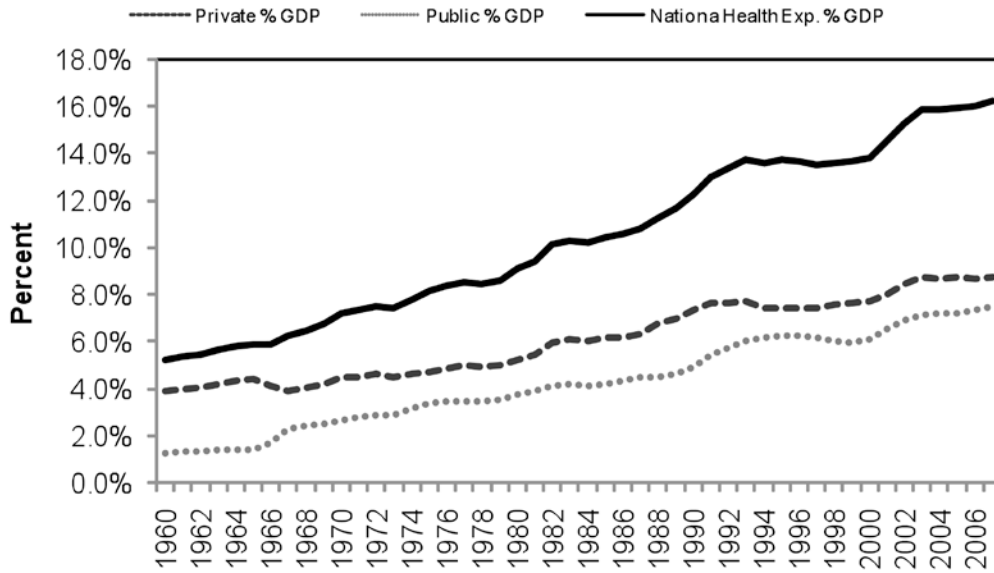


Figure 3: National, Private, and Public Health Expenditures as a Percentage of GDP, 1960 – 2007¹⁶

ning in 1966, with the passage of Medicare, the private sector’s role in the healthcare market began to change. In 1965, the private sector was still funding over 75 percent of total national health expenditures. This fell to 70 percent in 1966 and to 63 percent in 1967. Since 1967, the private sector has

been slowly funding less and less of the total national health expenditures; as of 2007 less than 54 percent of total national healthcare expenditures are paid for by the private sector.

Public expenditures (at the federal and state levels) now fund nearly one-half of the

“In 1965, the private sector was still funding over 75 percent of total national health expenditures.”

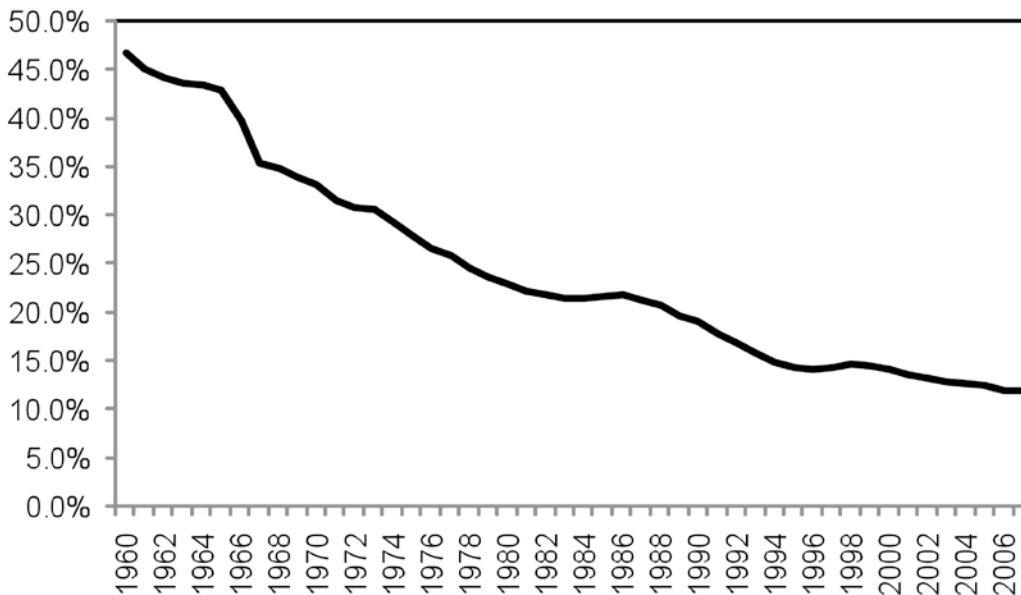


Figure 4: Out-of-Pocket Expenditures as a Percentage of Total National Health Expenditures, 1960 – 2007¹⁷

“Despite the government’s covering a larger and larger share of total healthcare expenditures, individuals continued to pay more than ever before in total dollar terms.”

total healthcare expenditures in the U.S. Along with these trends, total out-of-pocket expenditures have been plummeting even faster as a share of total health expenditures (see Figure 4). It is important to note that while total out-of-pocket expenditures have been declining as a share of total national health expenditures, they have grown in total inflation-adjusted terms. *Despite the government’s covering a larger and larger share of total healthcare expenditures, individuals continued to pay more than ever before in total dollar terms.*

Taken together, these trends illustrate a complete reversal of the way health care is purchased in the U.S. In 1960, the private sector funded over three quarters of national healthcare expenditures, with individuals responsible for nearly one-half of these costs through out-of-pocket expenditures. Today, the private sector funds just a bit more than one half of these expenditures, with only a bit more than \$1 out of every \$10 coming out of the consumer’s pocket.

Rising government expenditures on health care have been a primary driver of the

overall government-expenditure wedge illustrated in Figure 2. Figure 5 breaks down the government-expenditure wedge trends by government healthcare expenditures and all other government expenditures. Figure 5 demonstrates two important trends. First, the government-expenditure wedge outside of health care, although volatile, is currently only 5 percentage points higher than the 1960 wedge (35.3 percent compared to 30.1 percent).

Second, healthcare expenditures have been an important driving force in the overall government-expenditure wedge. The remaining 9.1 percentage point increase in the government-expenditure wedge is due to rising healthcare expenditures. Table 1 identified 3 main periods of a rising government expenditure wedge: 1965 – 1983, 1988 – 1992, and 2000 – 2007. Healthcare expenditures drove the rising government-expenditure wedge during each one of these periods, the importance of which has been growing over time:

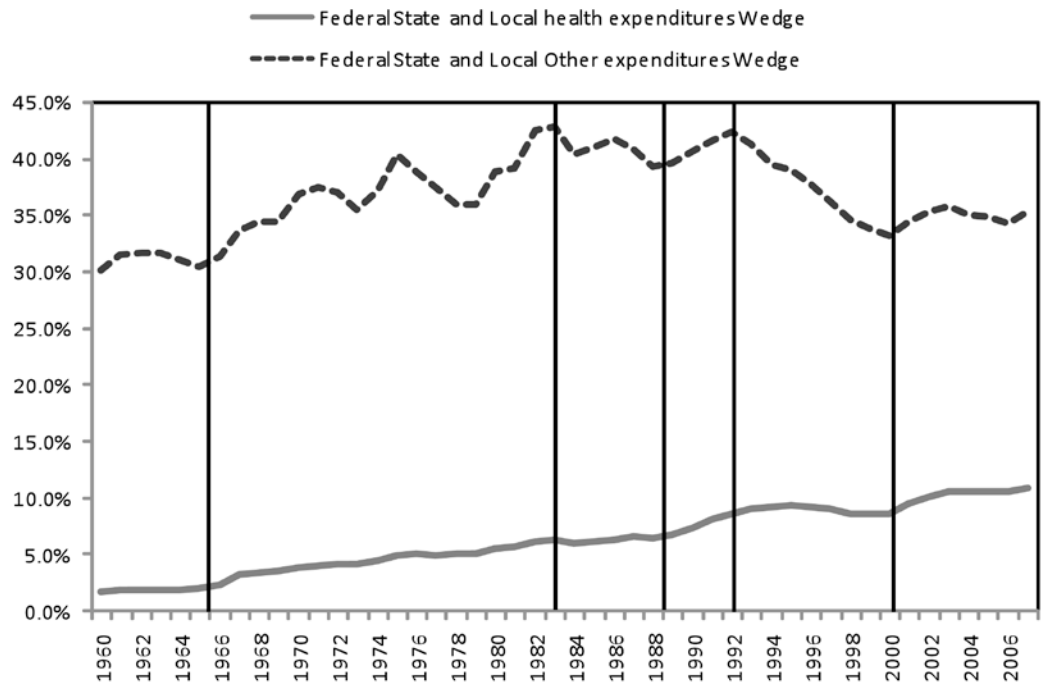


Figure 5: Total Federal, State, and Local Government Health Care Expenditure Wedge VS All Other Government Expenditures, 1960 - 2007¹⁸

- Between 1965 and 1983 the total government-expenditure wedge rose 16.6 percentage points, 26 percent of which was caused by rising healthcare expenditures.
- Between 1988 and 1992, the total government-expenditure wedge rose 5.2 percentage points, 41 percent of which was caused by rising healthcare expenditures.
- Between 2000 and 2007, the total government-expenditure wedge rose 4.5 percentage points, 51 percent of which was caused by rising healthcare expenditures.

Government healthcare expenditures are clearly driving the government-expenditure wedge higher. A rising government-expenditure wedge diminishes growth in the private sector economy, however. This link has important implications with respect to beneficial healthcare reforms. Healthcare reforms based on President Obama's priorities lead to large increases in government expenditures on health care without removing the

negative consumer and supplier incentives. The consequences are significant increases in government expenditures and subsequent decreases in economic growth.

The adverse incentives created by the growing separation between consumers and suppliers are manifested most prominently through the skyrocketing healthcare costs. The relatively larger growth in healthcare expenditures is outpacing growth in overall consumer prices in the economy (see Figure 6). Adjusting for the growing U.S. population, the dollar level of expenditures on health care has exceeded the growth in prices in the economy each year for nearly the past 50 years.

The cost of health care on individuals in the economy goes beyond simply the current dollar outlays individuals must pay themselves. The individual cost of health care includes the loss of monetary income to fund health insurance plans through employers and the extra tax burdens that have been levied in order to fund the public health expenditures.

Health-insurance expenditures have been

“The cost of health care on individuals in the economy goes beyond simply the current dollar outlays individuals must pay themselves.”

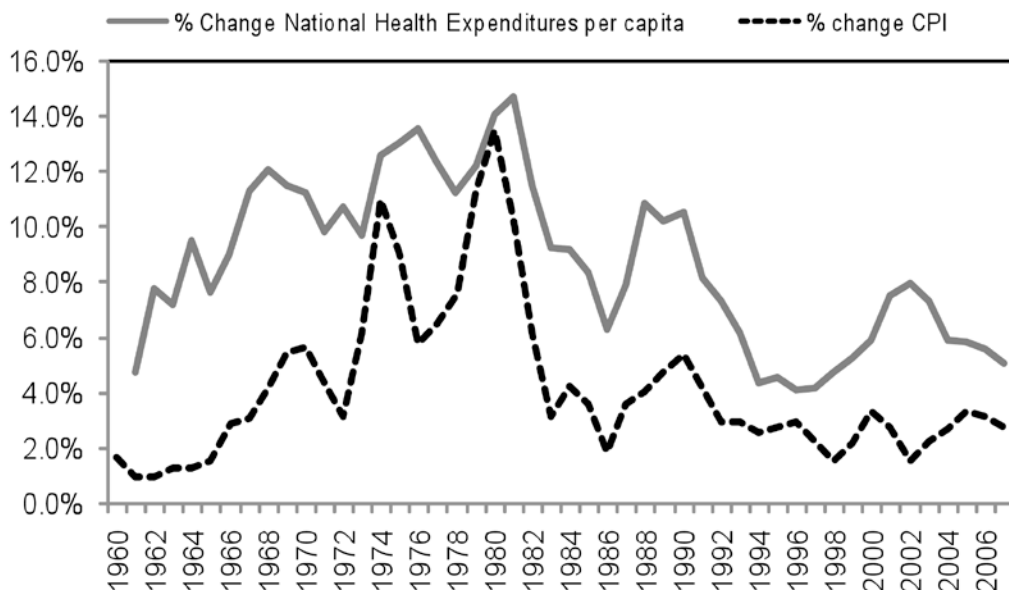


Figure 6: Percent Change in Per Capita National Health Expenditures Compared to Percent Increase in Consumer Prices, 1960 - 2007¹⁹

“In 1960, most of an employee’s compensation was in the form of actual cash.”

rising as a share of disposable personal income, with premiums “paid,” in large measure, by employers or other third parties such as the government. For instance, according to the U.S. Census Bureau, 59 percent of people under the age of 65 receive health insurance through work.²⁰ In 2006, the average employer cost for a family was \$11,941 (in 2008 dollars).²¹

The rising burden from increasing health-insurance costs can be seen as a share of total business costs and in government budgets. The Bureau of Economic Analysis tracks total costs on health care in a category called “supplements to wages.” These costs incorporate all of the expenses that firms pay to employees other than wages, with health insurance being a major component of these added costs.

In 1960, most of an employee’s compensation was in the form of actual cash. Of total personal income earned (a figure that includes wages, benefits, interest earnings, capital gains, dividends, etc.), wages accounted for approximately two-thirds (66.3 percent) of

total personal income. Supplements to wages, were a relatively small 5.7 percent. The share of income represented by wages fell over this time period to 54.5 percent by 2007, while supplements to wages rose steadily to 12.5 percent.

More important, perhaps, the decline in wages as a share of personal income increases when the growth in health expenditures accelerates, and it moderates when the growth in health expenditures moderates. Supplements to wages (e.g., health insurance) move in the opposite direction as wages. When growth in health expenditures accelerates, so does growth in supplements as a form of compensation. When growth in health expenditures moderates, growth in supplements as a form of compensation moderates likewise.

Figure 7 illustrates this trend visually. The solid line in Figure 7 is the percentage change in healthcare expenditures. The dotted line is the difference between the change in wages as a share of personal income and the change in supplements to wages as a share of personal income. When the dotted line is positive, the

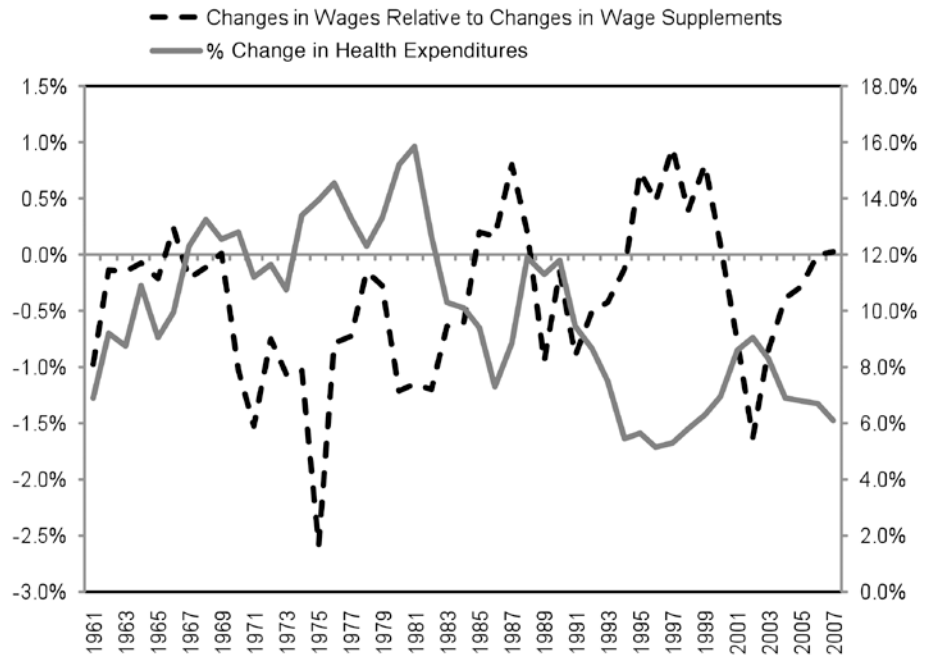


Figure 7: Percent Change in Health Care Expenditures Compared to Change in Wages as a Share of Personal Income and Change in Supplements to Wages (Health Insurance & Pensions) as a Share of Personal Income, 1961 – 2007²²

category of wages as a share of personal income is growing faster than supplements to wages. When the dotted line is negative, supplements to wages as a share of personal income grow faster than wages.

Figure 7 clearly shows that when healthcare expenditure growth accelerates, supplements to wages are growing faster than wages. The reverse happens when healthcare expenditure growth slows. This pattern illustrates the dampening impact that out-of-control health expenditures have been having on monetary wages for American workers. Growth in healthcare expenditures happens at the expense of growth in monetary wages, diminishing workers' financial welfare by reducing their spending power outside of healthcare services.

The same can be true of the federal and state governments. Figure 8 traces the growth in healthcare expenditures as a share of federal, state, and local expenditures. Whereas health expenditures made up only 4.5 percent of total government expenditures (or less than \$1 in \$20) in 1960, by 2007 they were 20.3 percent of total government expenditures (or more than \$1 in \$5). These expenditures alone required the government

to take 7.7 percent of all personal income earned in 2007 just to pay for the country's public health expenditures.

Rising healthcare expenditures have led to:

- *Rising tax burdens to fund the government portion of healthcare spending;*
- *Slower relative wage growth to fund the rising employer portion of this spending; and,*
- *Rising health- insurance outlays as a share of individuals' take-home pay.*

All of these costs more than overwhelm the reduction in direct out-of-pocket expenditures as a share of take-home pay, creating a larger, and accelerating, healthcare burden on individuals.

Studies Demonstrate That Government Policies Are the Problem

Research into the causes of the excessive healthcare-price increases concludes that government policies are the primary reason why prices are growing excessively and cover-

“Growth in healthcare expenditures happens at the expense of growth in monetary wages, diminishing workers' financial welfare by reducing their spending power outside of healthcare services.”

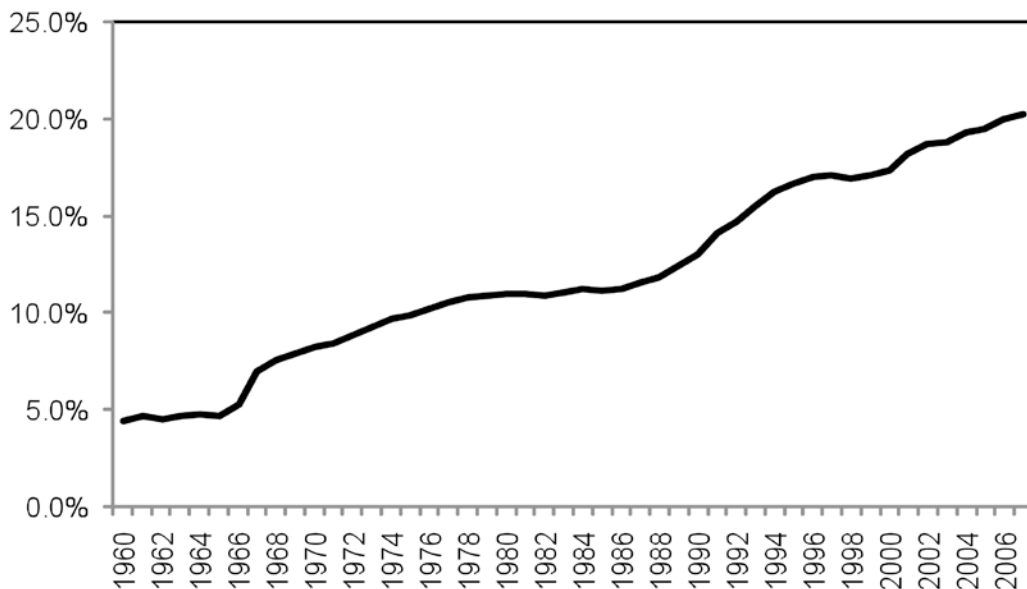


Figure 8: Total Federal, State and Local Health Expenditures as a Percentage of Total Government Expenditures, 1960 - 2007²³

“The real alternative is the removal of counter-productive government regulations and the consequent encouragement of robust competition among healthcare services and insurance products.”

age is so distorted. Consequently, the most effective method of controlling the excessive price increases is to remove those policies that are causing the excessive price increases in the first place.

The real alternative to today’s healthcare system isn’t the intrusion of federal power into the process, as currently proposed in Washington, D.C. The real alternative is the removal of counterproductive government regulations and the consequent encouragement of robust competition among healthcare services and insurance products.

The impact of government policies on the healthcare market is of two kinds — direct and indirect. The “direct impact” refers to the government’s medical-spending policies that are directly increasing healthcare costs. The “indirect impact” results from government interference that eliminates incentives for individuals or medical professionals to engage in economizing behavior that would increase quality and decrease costs in the healthcare field.

MIT economics professor Amy Finkelstein (2007) and University of Illinois economics professor Jeffrey Brown in collaboration with Ms. Finkelstein (2008), establish a direct link between government Medicare and Medicaid expenditures and rising healthcare prices or other distortions that limit the efficiency of the healthcare market.²⁴

Finkelstein (2007) illustrates that of the six-fold increase in per capita healthcare spending that occurred between 1950 and 1990, one-half of this increase could be explained by the impact of Medicare, along with Medicare’s impact on the spread of health insurance more generally.

Brown and Finkelstein (2008) show that Medicaid imposes a powerful crowding-out effect on private insurance purchases. Specifically, they find “that the provision of even very incomplete public insurance can crowd out more comprehensive private policies by imposing a large implicit tax on private insurance benefits, thus potentially increasing overall risk exposure for individuals.”²⁵ These results show that the growing government

involvement in the healthcare industry has helped drive up healthcare expenditures.

The President’s Council of Economic Advisors has cited the incentive problem as one of the key drivers of the excessive healthcare inflation, saying:

While health insurance provides valuable financial protection against high costs associated with medical treatment, current benefit designs often blunt consumer sensitivity with respect to prices, quality, and choice of care setting. There is well documented evidence that individuals respond to lower cost-sharing by using more care, as well as more expensive care, when they do not face the full price of their decisions at the point of utilization. Additionally, most insurance benefit designs do not include direct financial incentives to enrollees for choosing physicians, hospitals, and diagnostic testing facilities that are higher quality and lower cost.²⁶

Accordingly, it is necessary to change the adverse incentives on consumers so that they become price-sensitive when purchasing health care — and thus help, by their individual decisions, to contain out-of-control healthcare costs. The same logic holds for the adverse incentives the current system places on insurance companies, doctors, and other health providers.

The Consequences of Rising Healthcare Costs

Higher expenditure growth can arise for three reasons. Either the price of the service is increasing; the quantity of the services consumed is increasing; or a combination of both. In the case of health care, it is a combination of both, but especially due to rising prices. Specifically, the total quantity of goods in the U.S. economy increased 377 percent between 1960 and 2008. The total quantity of medical services increased 712 percent or approximately twice as much. However, prices in

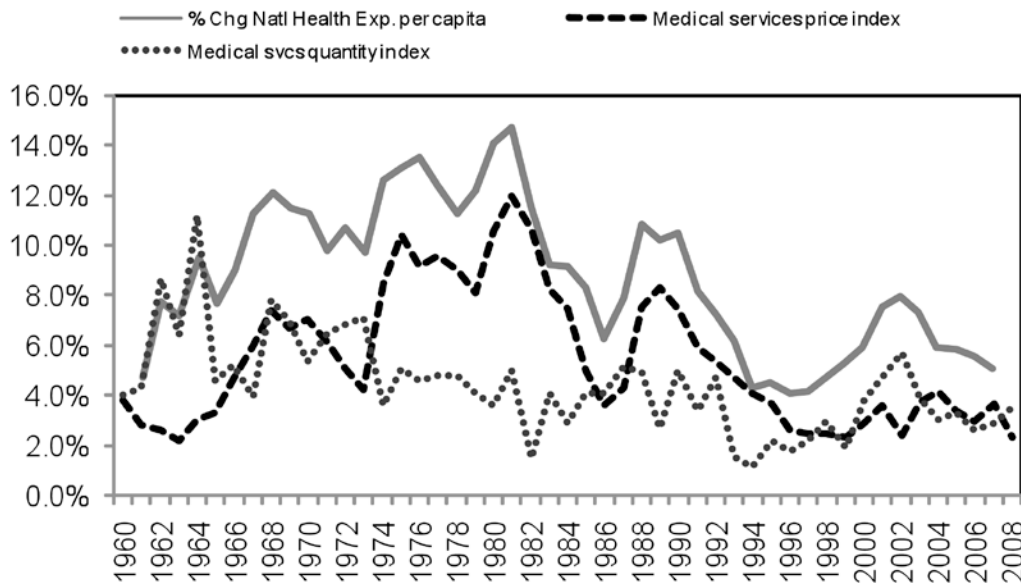


Figure 9: Percent Change in Per Capita National Health Expenditures Compared to Percent Increase in Medical Services Prices and the Quantity of Medical Services Consumed, 1960 - 2008²⁷

the U.S. economy increased just 490 percent, while prices of medical services soared 1,239 percent — nearly 2 ½ times as much.

Figure 9 compares the rising medical prices and medical consumption to total national medical expenditures. The rising level of national medical expenditures is

clearly a combination of both rising costs and rising consumption, but rising costs are clearly the major driver of rising healthcare expenditures.

Figure 10 illustrates the excessive growth in healthcare costs compared to inflation since 1998. Rising prices for medical and hospital

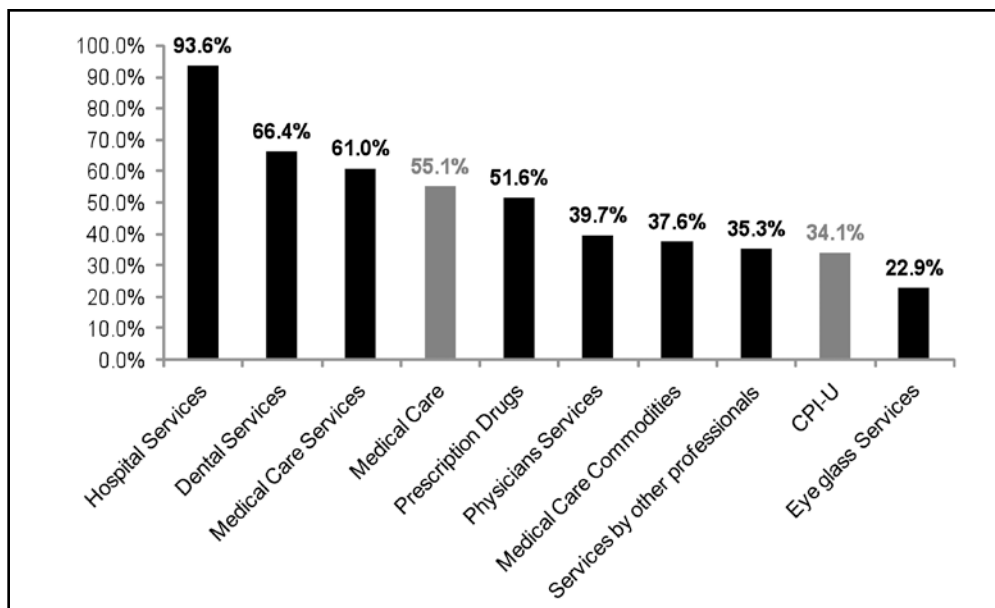


Figure 10: Cumulative Growth in Health Care Prices by Category 1998 - 2008²⁸

“The 15 most expensive health conditions account for 44 percent of total healthcare expenses.”

services are driving medical inflation. The fact that the cost of medical and hospital services is driving price increases for medical care is not unexpected. These are the sectors most burdened by regulations and most affected by the insurance market. It is, consequently, expected that the areas subject to the largest excessive price pressures are the markets most affected by the insurance issue. In fact, those markets least affected by insurance — medical services related to vision improvement, for instance — are precisely the healthcare costs exhibiting the least amount of price pressures.

Figure 11 relates the medical price inflation back to the wedge and the adverse incentives created by the current system. When expenditures that are covered by either the insurance company or the government increase relative to national health expenditures, medical price inflation accelerates. When these expenditures fall relative to national health expenditures, medical price inflation slows. Accelerating medical inflation, consequently, is strongly correlated with a growing separa-

tion (wedge) in the medical market between doctors and patients. Reform policies that increase this separation, such as those reforms based on President Obama’s priorities, can be expected to increase pressures on medical price inflation.

Distribution of Healthcare Spending

It is important to note that the distribution of total healthcare spending is not even. According to the Agency for Healthcare Research and Quality (AHRQ), “...actual spending [on health care] is distributed unevenly across individuals, different segments of the population, specific diseases, and payers. For example, analysis of healthcare spending shows that five percent of the population accounts for almost half (49 percent) of total healthcare expenses. The 15 most expensive health conditions account for 44 percent of total healthcare expenses. Patients with multiple chronic conditions cost up to seven times as much as patients with only one chronic condition.”³⁰

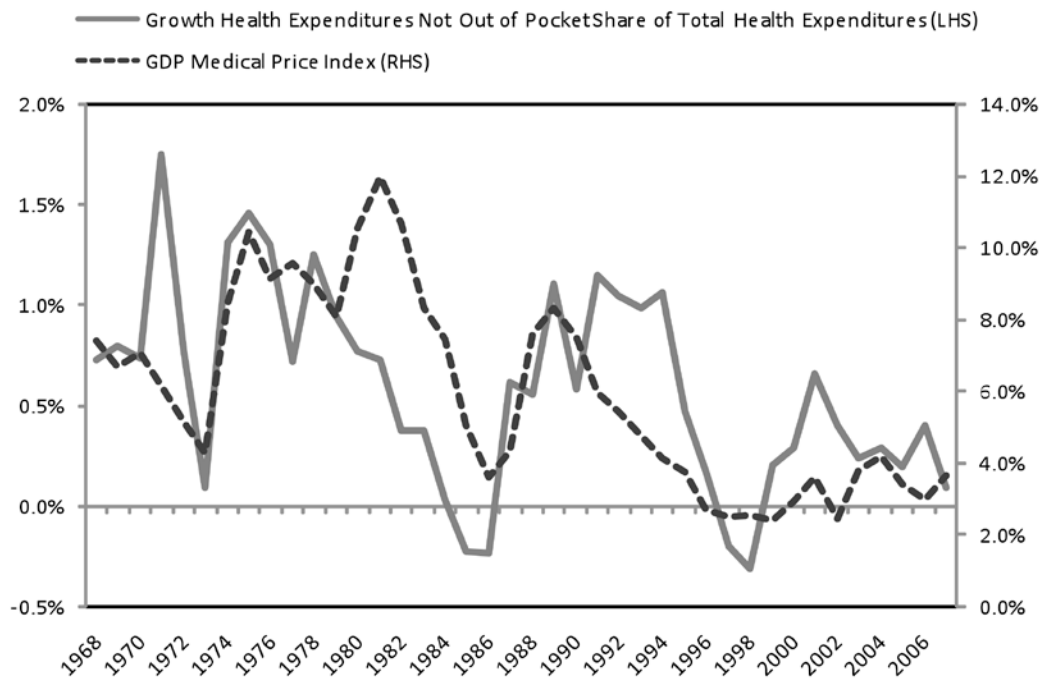


Figure 11: Growth in Health Expenditures Not Out of Pocket As a Share of National Health Expenditures vs. Medical Price Inflation, 1968 - 2007²⁹

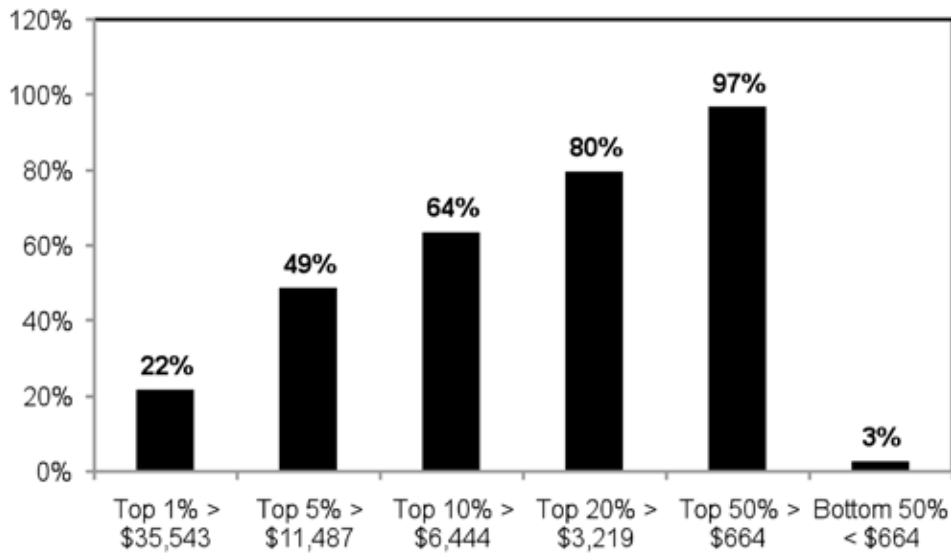


Figure 12: Percent of Total Healthcare Expenditures By Percent of the Population, 2002 ³²

The Kaiser Family Foundation notes that “At the other end of the spectrum, the one-half of the population with the lowest health spending accounts for just over 3 percent of spending”.³¹ Figure 12 reproduces the data from the AHRQ study illustrating how the vast majority of the total healthcare spending is created by a small percentage of the U.S. population. Controlling spending, therefore, requires controlling the spending by the 5 percent of the population spending one-half

of all healthcare expenditures.

Predictably, the elderly represent a large portion of the high spenders: “People 65-79 (9 percent of the total population) represented 29 percent of the top 5 percent of spenders. Similarly, people 80 years and older (about 3 percent of the population) accounted for 14 percent of the top 5 percent of spenders...”³⁴ Alemayehu and Warner (2004) found (see Figure 13) that over people’s lifetimes eight percent of healthcare expenses occurred

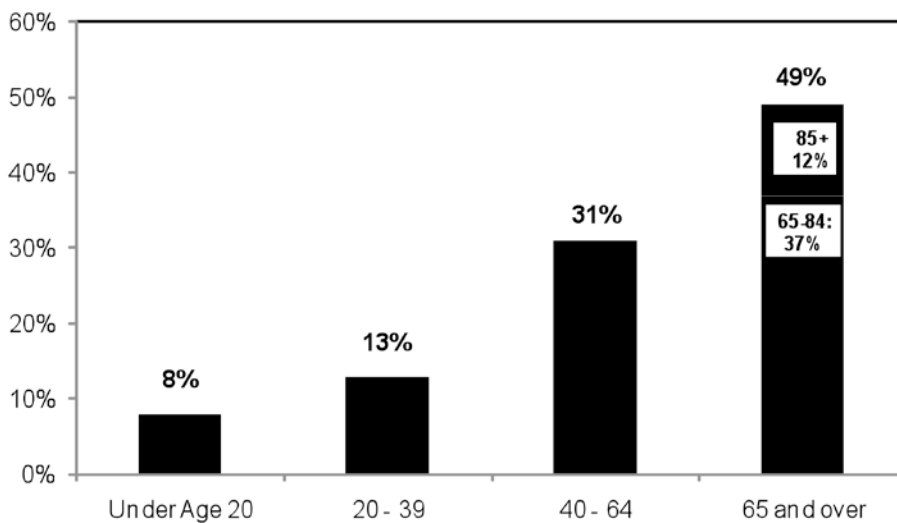


Figure 13: Percent of Total Healthcare Expenditures by Age, 2002 ³³

“The total per capita lifetime expense was calculated to be \$316,600.”

during childhood (under age 20), 13 percent during young adulthood (20-39 years), 31 percent during middle age (40-64 years), and nearly half (49 percent) occurred after 65 years of age. Among people age 65 and older, three-quarters of expenses (or 37 percent of the lifetime total) occurred among individuals 65-84 and the rest (12 percent of the lifetime total) among people 85 and over. The total per capita lifetime expense was calculated to be \$316,600.³⁵

Age aside, the primary factors for determining the largest-spending consumers of health care depended upon several other factors. For instance, the type of disease matters. According to the AHQR study, “The 15 most costly medical conditions in the United States accounted for 44 percent of total U.S. healthcare spending in 1996,” with heart disease, cancer, trauma, mental disorders, and pulmonary conditions being the five most expensive diseases to manage.³⁶ Chronic conditions, such as asthma, are the other major indicators of major expense.

Those who are high spenders in one year, however, are not necessarily high spenders over the next several years:

Over longer periods of time, a considerable leveling of expenses takes place. In a study of Medicare enrollees, researchers found that although the top 1 percent of spenders accounted for 20 percent of expenses in a particular year, the top 1 percent of spenders over a 16-year period accounted for only 7 percent of expenses. The researchers concluded that there is a substantial leveling of expenses across a population when looking over several years or more compared to just a single year. An acute episode of pneumonia or a motor vehicle accident might lead to an expensive hospitalization for an otherwise healthy person, who might be in the top 1 percent for just that year but have few expenses in subsequent years. Similarly, many people have chronic conditions, such as diabetes and asthma, which are fairly expensive

to treat on an ongoing basis for the rest of their lives, but in most years will not put them at the very top of healthcare spenders. However, each year some of those with chronic conditions will have acute episodes or complications requiring a hospitalization or other more expensive treatment.³⁷

The distribution of health expenditures provides important context from which to interpret the rising expenditure trends — especially with respect to which adverse incentives are driving the excessive cost increases. Due to the current demographic trends, the adverse incentives created by Medicare — as identified by Finkelstein (2007) — and especially the new Medicare prescription drug benefit are key focus areas for any healthcare reform effort to be effective.

President Obama's Reforms Don't Address the Problems' Root Causes

The facts presented above have established that rising healthcare expenditures are limiting income gains and thereby hurting family budgets, raising tax costs, raising individuals' dollar costs at a rate that is not sustainable, and damaging the U.S. economy. The economic costs from these inefficiencies are large. One study estimates that the inefficiencies of the current system alone could account for 30 percent of the total healthcare spending in 2007:

Examining Medicare records, researchers have found that per-beneficiary spending varies widely from one area of the country to the next. In some areas, Medicare spends twice as much per senior as it does in other areas. Researchers have also found that beneficiaries in high spending areas do not start out sicker, do not end up healthier, and are no happier with the care they receive, than beneficiaries in low-spending areas. That suggests that a significant amount of Medicare spending provides no discernible benefit to the

program's intended beneficiaries. Those researchers estimate that as much as 30 percent of total U.S. medical spending provides no discernible value. If so, then Americans spend more than \$700 billion each year, or 5 percent of gross domestic product, on medical services of no discernible value. ³⁸

Waste, fraud, and abuse created a large healthcare bill of \$700 billion in 2007. On a per capita basis, \$700 billion in waste, fraud, and abuse imposes a bill of over \$2,300 per legal resident in the U.S. The possibility that 30 percent of total healthcare spending is waste underscores the President's contention that reform is needed. However, successful reforms will directly address the root causes of the problems outlined above. The root cause is the adverse government policies that have diminished the incentives and the ability for either doctors or patients to control costs and experiment with alternative and more effective ways to deliver health care.

The Obama Administration reverses this cause-and-effect relationship, positing that large numbers of the uninsured are driving healthcare costs higher. In reality, rising costs and a distorted health-insurance market are limiting the insurance opportunities for millions of Americans. Implementing reforms true to President Obama's healthcare reform principles will create negative economic impacts that will exceed those negative impacts created by the current system.

As of this writing, neither the President nor the Democratic majority in Congress has settled on a specific and detailed health-reform plan. However, there are several general concepts that guide their approaches. These concepts include:

- A public health-insurance option to compete with the private sector.
- A mandate to individuals and/or employers requiring health-insurance coverage.
- The establishment of healthcare exchanges where individuals can purchase health insurance, at discounted rates for

certain individuals.

- Prohibition on rate differentiation based on health status, although differentiation by age is allowed (guaranteed issue).
- Best practices mandates (such as electronic medical records or an administrative body that disseminates comparative effectiveness information) and the elimination of waste, fraud and abuse

None of these approaches addresses the problem at hand. The centerpiece of the Obama plan is the creation of a public health-insurance option that supposedly would ensure that private insurance companies provide a fair product at a reasonable price. Such a solution is predicated on the notion that the main problem with the current system is ineffective pricing and services from health insurance companies. As shown above, this is not the problem.

The government rarely competes on a level playing field with private industry; instead, it tilts the field in its favor. A public health-insurance option, with guaranteed taxpayer subsidies, would pressure the private health insurers to price at uneconomical levels in order to meet political goals, regardless of their economic merit or viability. Private insurers would have no choice but to follow the government's lead — until they're forced to close up shop.

Florida's experience with windstorm insurance exemplifies the fate of healthcare insurance under the Obama plan. As everyone knows, hurricanes frequently batter Florida. Sometimes a given hurricane is particularly severe. Windstorm insurance provides protection for residents against significant or catastrophic wind damage caused by the occasional strong hurricane.

Originally, windstorm insurance plans were offered by both private insurers and the state government. Under Gov. Charlie Crist, the Office of Insurance Regulation lowered the storm-insurance rates that private insurers could charge to an actuarially unsound level. Under any reasonable scenario, the costs from storm-insurance claims from the next large storm would overwhelm the insurance

“The centerpiece of the Obama plan is the creation of a public health-insurance option that supposedly would ensure that private insurance companies provide a fair product at a reasonable price.”

“Creating another government insurance plan would not address the problem of rising healthcare costs.”

premiums collected and bankrupt any insurance fund that relied on those rates. When combined with other market restrictions, the state all but ensured that many of the private insurance companies operating in Florida would lose money on their Florida operations. As a result, these companies have been leaving Florida, whereupon the state government has become the primary provider of property insurance in Florida. The state of Florida is now insuring millions of people and faces a potential financial crisis when the next major hurricane comes ashore.

The end result of the Obama plan on the health-insurance market would be much the same as in Florida’s property-insurance market. The public insurance program would drive out the private sector and become the primary health insurer in the United States. The U.S. health system would effectively become a single-payer, government-run healthcare system.

Fannie Mae (the Federal National Mortgage Association) and Freddie Mac (the Federal Home Loan Mortgage Corporation) provide examples of how federal influence over public companies distorts the market and decreases its efficiency. While academics and researchers are still struggling to allocate blame over the housing bubble, it already is clear that too many homes were sold to too many individuals who could not afford them. In response, Fannie Mae and Freddie Mac tightened standards on the types of mortgages it would guarantee and/or purchase. The latest initiative, announced in March 2009, has the effect of tightening credit standards for condominium purchasers, especially for purchases in developments likely soon to experience financial difficulties. After years of too-lax credit standards, tightening lending standards is the correct economic response, although it comes a bit late. It is the incorrect political response, however.

U.S. Reps. Barney Frank and Anthony Weiner complained to the CEOs of Fannie Mae and Freddie Mac that these new restrictions “may be too onerous.”³⁹ Whatever the congressmen’s motives, their actions illustrate

that when public companies make hard economic decisions, the political overseers inevitably intervene and second-guess the company’s decisions. The interference — or threat of interference — in the daily operations of public companies forces these companies to consider the political ramifications of their actions, in addition to their economic viability. Having to incorporate the latest political considerations decreases the effectiveness of Fannie Mae and Freddie Mac, and it is but another real-world example of how public corporations, subject to the whims of politicians, distort the markets in which they operate.

Similarly, future congressmen and senators will have an incentive to pressure the CEO of some public health-insurance company whenever premium increases are viewed by their political constituents as “too onerous.” Greater economic inefficiencies will be the result.

Creating another government insurance plan would not address the problem of rising healthcare costs. It will exacerbate other problems by further diminishing consumer incentives to monitor healthcare costs. Brown and Finkelstein’s research (2008) suggests that the likely impact from a public insurance option is a significant reduction in people’s incentives to monitor costs and a significant increase in the costs of administering the public program.

In addition to the public insurance option, the President’s healthcare reform priorities would create public health-insurance exchanges. In theory, health-insurance exchanges provide people with the resources and information to make efficient insurance purchases. When combined with guaranteed issue⁴⁰ or some form of individual mandate, such policies are designed to ensure that all Americans have insurance coverage. Sometimes health-insurance exchanges are sold as a free lunch that will simultaneously increase efficiency; expand coverage; and lower costs — at least over the “next decade.”

Sen. Edward Kennedy asked the Congressional Budget Office (CBO) to evaluate a

plan, the Affordable Health Choices Act, which includes these policies. The CBO's reply dispels the myths that health-insurance exchanges, combined with an individual mandate, constitute effective healthcare reform. Specifically, the CBO stated:

According to that assessment, enacting the proposal would result in a net increase in federal budget deficits of about \$1.0 trillion over the 2010–2019 period. Once the proposal was fully implemented, about 39 million individuals would obtain coverage through the new insurance exchanges. At the same time, the number of people who had coverage through an employer would decline by about 15 million (or roughly 10 percent), and coverage from other sources would fall by about 8 million, so the net decrease in the number of people uninsured would be about 16 million.⁴¹

Since the U.S. Census currently estimates that 45.7 million people did not have insurance in 2007, the net \$1 trillion in additional spending (\$1.6 trillion gross spending) would reduce the number of uninsured by only 35 percent. The initiative would thus leave more than 30 million people uninsured, despite the government's expenditure of an additional \$1 trillion on net.⁴² The cost to reduce the number of uninsured by 16 million people is \$62,500 per each additional person insured.

That assessment is consistent with experience in Massachusetts following that state's recent healthcare reforms. The Massachusetts reforms embodied the same main principles promoted by the Obama Administration — the health exchange, individual mandate, and generous subsidies. The state's Legislature provided for:

- Cost control by increasing the number of insured through both an individual and employer mandate;
- Generous middle-class subsidies to cover insurance costs; and,
- The creation of the Massachusetts Health Connector, which is an exchange de-

signed to connect individuals with the right insurance policy.

The individual mandates of Massachusetts did reduce the number of uninsured. A recent summary of the reforms put it this way:

In mid-2008, just 2.6 percent of state residents lacked insurance coverage, down from 9.8 percent in 2006, according to a state report.

Overall, 439,000 were newly insured. These included 72,000 added to MassHealth, the state's Medicaid program, which raised eligibility from 100 percent to 150 percent of the federal poverty level; and 176,000 in CommCare, a new subsidized program for those between 150 percent and 300 percent of poverty. Another 18,000 obtained insurance through CommChoice, the new state insurance "connector" offering standardized plans to individuals and small businesses, while 14,000 more bought individual policies on the open market. Many more obtained employer-sponsored coverage, particularly among lower-income workers.⁴³

But, the same report also documents that these same reforms are bankrupting the state and creating many unintended and unwanted consequences including:

...escalating costs, growing concerns about underinsurance for some low- and middle-income groups, and an unintended but severe impact on some safety-net providers. If anything, many of these issues will be even more pronounced in states with higher uninsured rates and fewer available Medicaid dollars...

Original budget projections for the Massachusetts program were \$160 million in fiscal year 2007, \$400 million in FY2008, and \$725 million in FY2009. At \$133 million, actual costs came in lower for 2007, but shot up to \$625 million in 2008. The state funding request for 2009 was \$869 million, with

“The initiative would thus leave more than 30 million people uninsured, despite the government's expenditure of an additional \$1 trillion on net.”

“The last concept supported by President Obama addresses the outcomes of the adverse incentives (the symptoms) and not the actual adverse incentives themselves (the disease).”

some estimating that actual costs could reach \$1.1 billion. Much of the increase results from higher than expected enrollment in MassHealth and the subsidized CommCare programs, possibly because of underestimates of how many people would qualify. With the state about \$4 billion short of a balanced budget this year, sustaining these numbers is a huge challenge.⁴⁴

The benefits from expanding insurance coverage are also questionable. A recent Cato Institute report found that uncompensated care provided by hospitals and other medical facilities has not declined in proportion to the increase in the number of insured.⁴⁵ “In fact, one of the original selling points behind the Massachusetts reform was that it would shift subsidies for uncompensated care from hospitals to individuals. Uncompensated care subsidies were supposed to fade away, with the state using the savings to help low- and middle-income residents buy insurance instead. But hospitals now say that the rate of uncompensated care continues to be so high that they cannot dispense with their subsidies. The taxpayers end up paying twice.”⁴⁶

The resultant pressure isn’t on taxpayers and state budget architects alone. Although supporters claimed

... that the reforms would reduce the price of individual insurance policies by 25–40 percent... [i]n reality, insurance premiums rose by 7.4 percent in 2007, 8–12 percent in 2008, and are expected to rise 9 percent this year. By comparison, nationwide insurance costs rose by 6.1 percent in 2007, just 4.7 percent in 2008, and are projected to increase 6.4 percent this year. On average, health insurance costs \$16,897 for a family of four in Massachusetts, compared to \$12,700 nationally.⁴⁷

The Massachusetts reform is a case study that demonstrates the negative economic impact of health reform based on the Presi-

dent’s principles of expanding coverage. Such an approach not only fails to address the adverse incentives driving up costs, it makes these incentives worse. The impact from the worsened economic incentives creates the additional adverse economic outcomes that will result from the President’s reform concepts.

The last concept supported by President Obama addresses the outcomes of the adverse incentives (the symptoms) and not the actual adverse incentives themselves (the disease). The President discusses the need for best practices (such as electronic medical records and/or an administrative body that disseminates comparative-effectiveness information) to be better shared across the medical profession. He also pledges the elimination of waste, fraud, and abuse. As an indication of his commitment to this cause, the American Recovery and Reinvestment Act (the stimulus package) invested \$19 billion in health-information technology, which included \$17 billion in incentives to encourage healthcare providers to use electronic medical records and \$1.1 billion for comparative-effectiveness research.

As Cannon (2009) illustrated, the medical profession lacks adequate comparative-effectiveness research and other best practice initiatives because government programs and price insensitive consumers have eliminated the incentive to do so. Throwing money at this problem will not appreciably change this incentive. What it will do is create new problems such as the possibility that the “best practices” will come to mean politically best rather than medically best. The more effective policy, which should be apparent by now, is to address the problem directly by correcting the adverse incentives that are causing the inefficient result.

Quantifying the Potential Economic Impacts

Because the concepts behind the Obama Administration’s healthcare reform plans do not address the incentives in the current healthcare system — indeed, they often worsen these incentives — health reforms

based on these concepts will have a significant negative economic impact. To quantify the impacts from reforms based on the Obama Administration’s concepts, we focus on the impacts from a reform proposal that:

- *Creates another public healthcare option that will directly compete with private health insurers;*
- *Establishes an individual mandate that requires all individuals to obtain health insurance coverage; and*
- *Creates a healthcare exchange.*

We base our analysis on the CBO’s assessment of the Kennedy healthcare plan mentioned above.⁴⁸ Because it is unlikely that the Kennedy plan as currently written will be the final healthcare reform bill, we modify the CBO’s analysis to reflect the impact on the healthcare reform market from a cumulative \$1 trillion in healthcare subsidies spent over the next 10 years. We assume that the \$1 trillion in healthcare subsidies will be spent in a similar manner, with similar timing, and

will have impacts on the uninsured similar to those noted in the CBO analysis.

The purpose of the subsidies is to extend health-insurance coverage to the current uninsured. Some of this money is duplicative, replacing private-sector dollars currently being devoted toward health-insurance coverage. By 2019, approximately \$4 out of every \$10 in the new subsidies would be devoted toward those individuals who did not have coverage previously.

On net, assuming that the subsidies would be effective in 2012, the number of uninsured Americans would be approximately 25 percent smaller than it would have been otherwise without these subsidies. Thus 13.3 million people who currently lack health insurance would acquire it. But, as demonstrated above, expanding health-insurance coverage fails to address the fundamental adverse incentives driving healthcare cost inflation. Consequently, reforms based on the President’s priorities would not only prove costly and ineffective at achieving his goals, but they would actually aggravate current

“By 2019, approximately \$4 out of every \$10 in the new subsidies would be devoted toward those individuals who did not have coverage previously.”

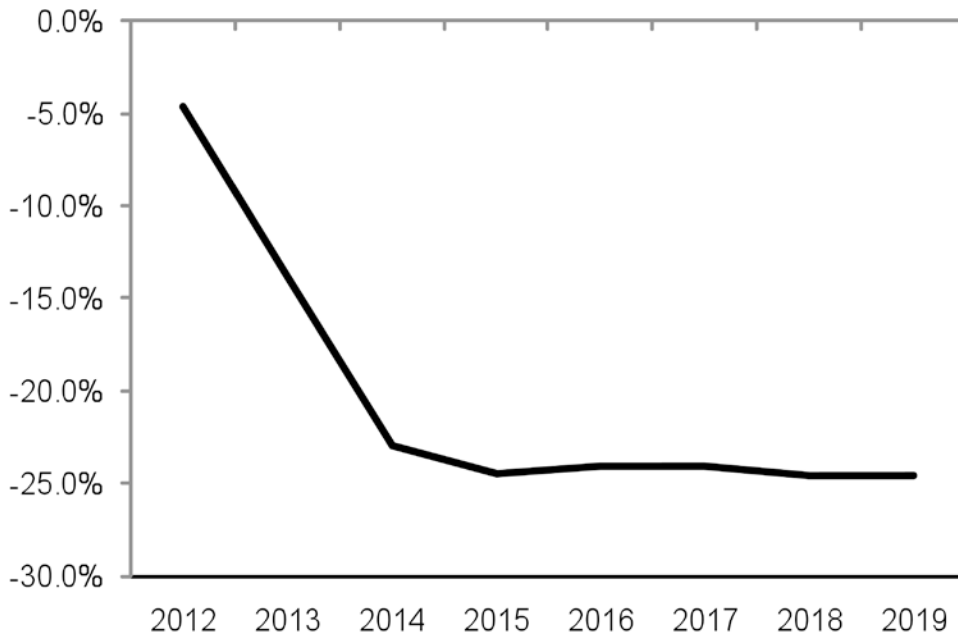


Figure 14: Projected Reduction in Uninsured From \$1 Trillion In Federal Subsidies, 2012 – 2019⁵⁰

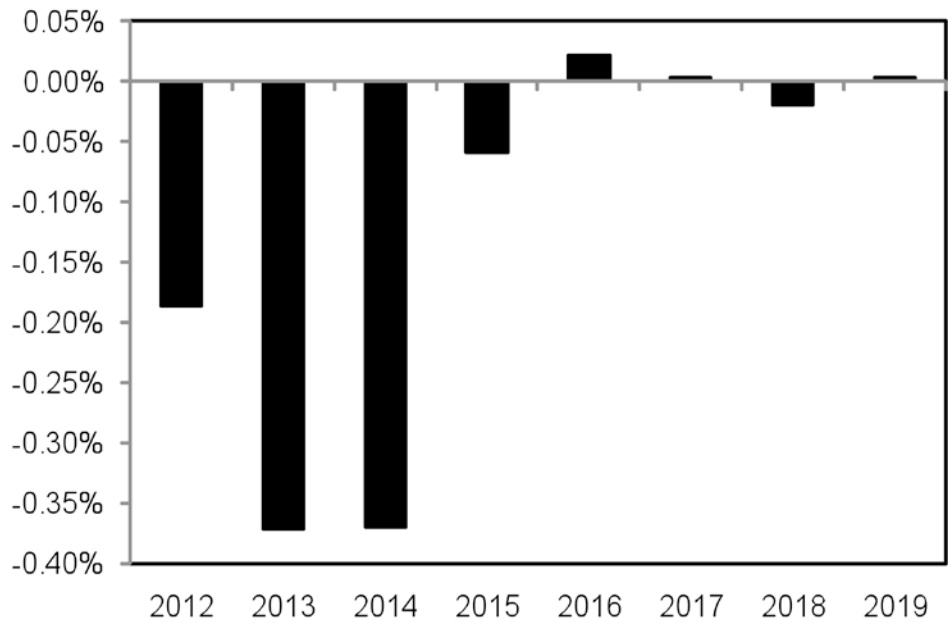


Figure 15: Annual Percentage Change in Connection Rate Due to Increased Health Care Subsidies, 2012 – 2019⁵¹

problems with the healthcare system. Expanding coverage in this manner would worsen the incentives by increasing the number of dollars spent that are insensitive to costs.

Finkelstein (2007) demonstrated that, historically, healthcare expenditures increase rapidly when medical consumers are insulated

from the financial costs of using the medical system (connection rate).⁴⁹ We estimate that the increased government subsidies would reduce the expected connection rate by approximately one percentage point. Figure 15 illustrates a year-by-year breakdown of the changes in the connection rate due to the new

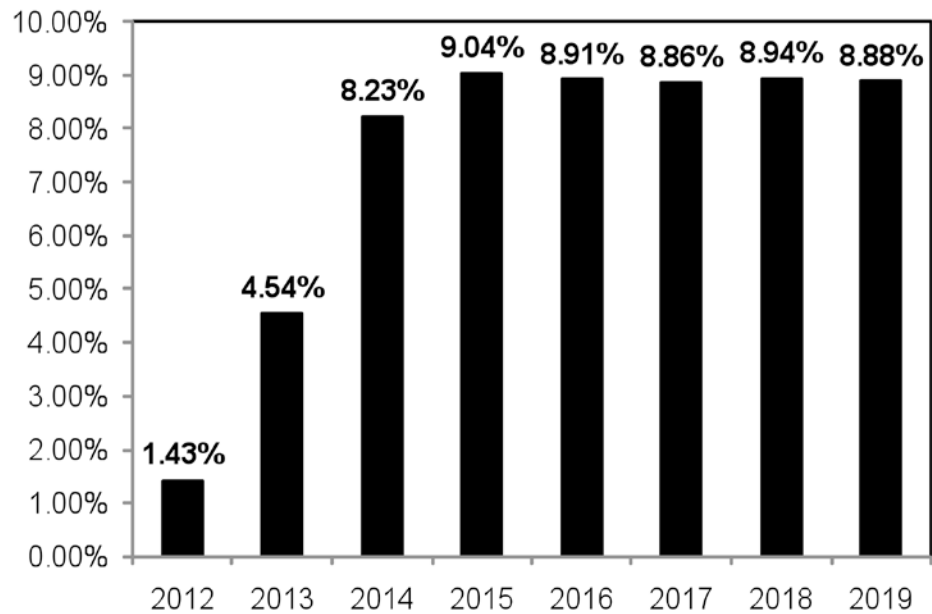


Figure 16: Additional Increase in Healthcare Expenditures Due to Increased Health Care Subsidies, 2012 – 2019⁵²

government subsidies.

The reduction in the connection rate directly creates incentives for additional medical expenditures that are insensitive to price. Based on the elasticity calculations from Finkelstein (2007), due to the reduced connection rates (and the additional adverse incentives created by the lower connection rates), total medical expenditures would actually accelerate. Figure 16 illustrates the estimated additional annual increases in medical expenditures caused by the reduced connection rates. By 2019, medical expenditures would be 8.9 percent higher if Obama-style healthcare reforms were implemented compared to the baseline expenditures. Note that such increases are the exact opposite of what the proponents of President Obama's healthcare priorities predict.

This impact illustrates that healthcare reform that does not directly address the adverse incentives of the healthcare system will merely trade one set of bad alternatives for another.

In this case, if we assume \$1 trillion in government subsidies, an additional 13.3 million individuals who would not have had

health insurance would have it — at a high cost, nonetheless: accelerating healthcare expenditures that increase healthcare inflation, pressure on federal and state budgets, reduction in workers' wage growth, and lower overall economic growth.

A more fruitful approach addresses the root cause of the problem first — the adverse incentives driving the excessive growth in healthcare expenditures. Only when this problem is addressed can the larger insurance problem be solved without transferring the costs from one group to another.

The increase in healthcare expenditures represents a shift out in the demand for medical services, but does not change any incentives that would simultaneously increase the supply of medical services. Rising demand in the face of stable supply leads to increasing prices. The historic relationship between rising expenditures and rising medical inflation indicates that by 2019, increased government intervention will drive healthcare inflation 5.2 percentage points higher than would have been the case without such intervention. (See Figure 17)

Higher healthcare expenditures will also

“A more fruitful approach addresses the root cause of the problem first — the adverse incentives driving the excessive growth in healthcare expenditures.”

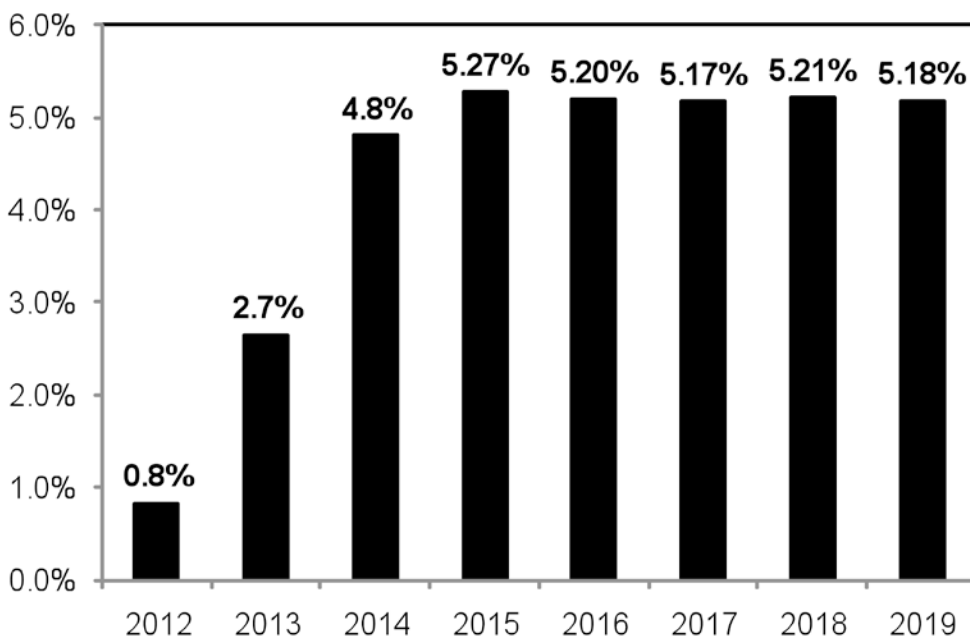


Figure 17: Additional Increase in Medical Inflation Due to Increased Health Care Subsidies, 2012 – 2019⁵³

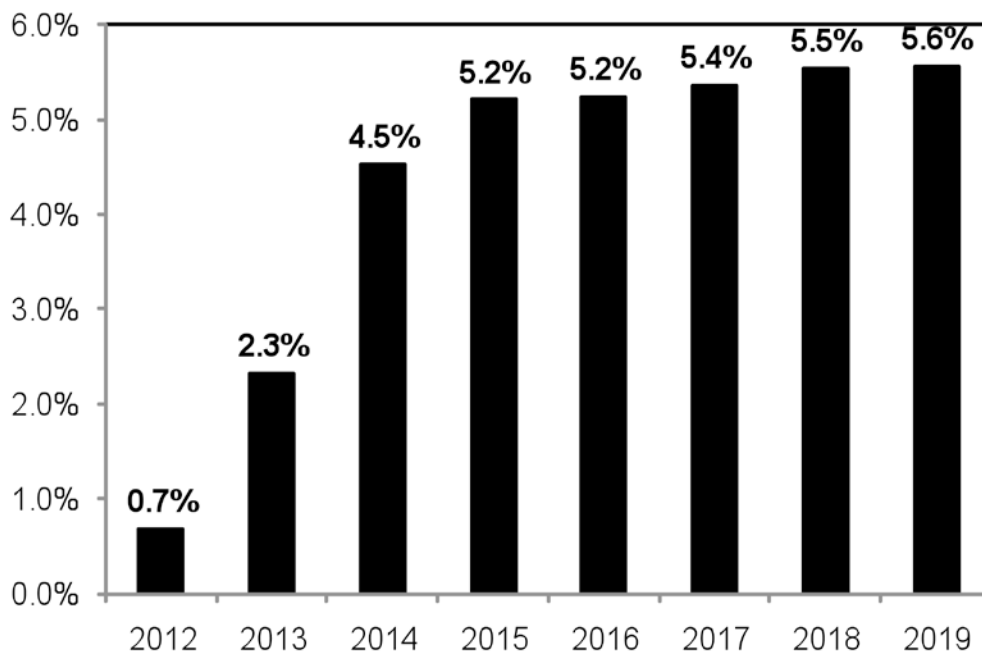


Figure 18: Increase in Federal Government Expenditures as a Percentage of Total Estimated Government Expenditures Due to Increased Health Care Subsidies, 2012 – 2019⁵⁴

have disagreeable effects on federal and state budgets. Figure 18 shows that due to increased healthcare subsidies, total federal expenditures will increase to more than 5.5

percent of total government expenditures. These include not only the direct expenditures on the new subsidies but also the higher Medicare, Medicaid, and SCHIP expenditures

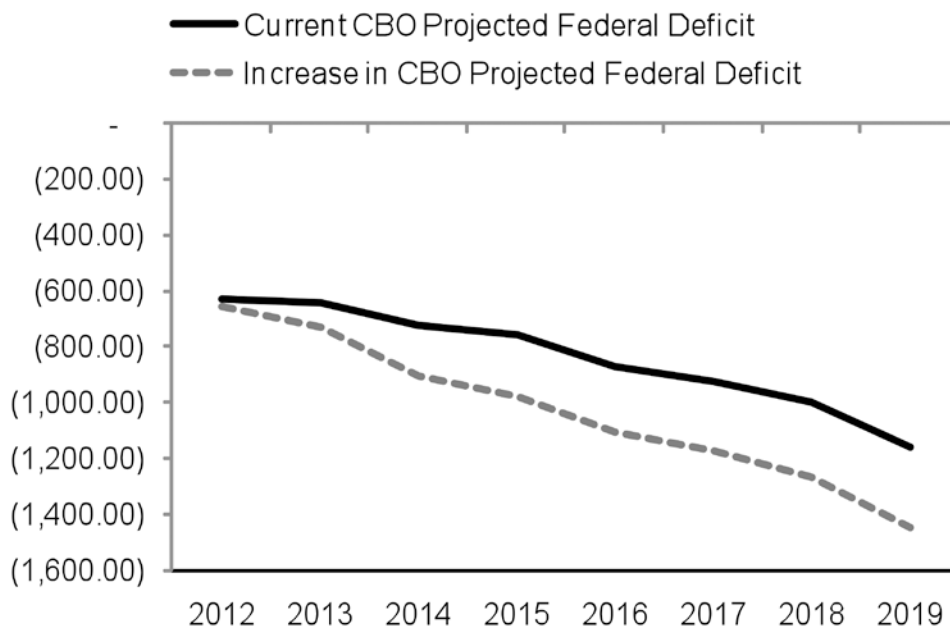


Figure 19: Increase in Federal Government Deficit with Increased Healthcare Subsidies Compared to Current Expected Federal Government Deficit 2012 – 2019 (billions \$)⁵⁵

that would accompany higher medical costs.

The additional government expenditures must be financed through either higher taxes or higher federal government deficits. Based on the CBO's expectation that the government deficit will increase over this period, we assume that these additional expenditures will simply increase the deficit dollar for dollar. This implies that by 2019, the federal budget deficit would be \$285.6 billion larger (+24.6 percent larger) than it would have been without the healthcare reform. (See Figure 19) The present value of the total additional federal spending that would occur based on the President's healthcare reforms would be \$1.2 trillion or \$3,900 for every man, woman and child in the country.

Figure 20 summarizes the overall impact on the economy due to the increased government intervention in the healthcare market by comparing the total increase in government healthcare expenditures following reforms based on President Obama's healthcare reform to the total reduction in economic output that these reforms will cause.

Meanwhile, the proposed reform would crowd out private economic activity due to

higher taxes and the larger federal deficit needed to accommodate new spending for health care. (See Figure 19) The higher government burden that would have to be borne by the private sector would diminish total economic activity.⁵⁷ By 2019, Obama-style health care would shrink economic activity (GDP) by 4.9 percent compared to the baseline scenario.

The Economic Impacts of Obama-Style Health Care on Florida

Healthcare reforms based on President Obama's priorities would affect each state differently. Florida, specifically, would experience lower overall economic activity as well as increased fiscal pressures on the state budget. In assessing the impact of Senator Kennedy's proposed healthcare reform, the CBO declares that:

...although the proposal would not change federal laws regarding Medicaid and SCHIP, it would affect outlays for those programs. CBO assumes that states that had expanded eligibility for Medicaid

“Florida, specifically, would experience lower overall economic activity as well as increased fiscal pressures on the state budget.”

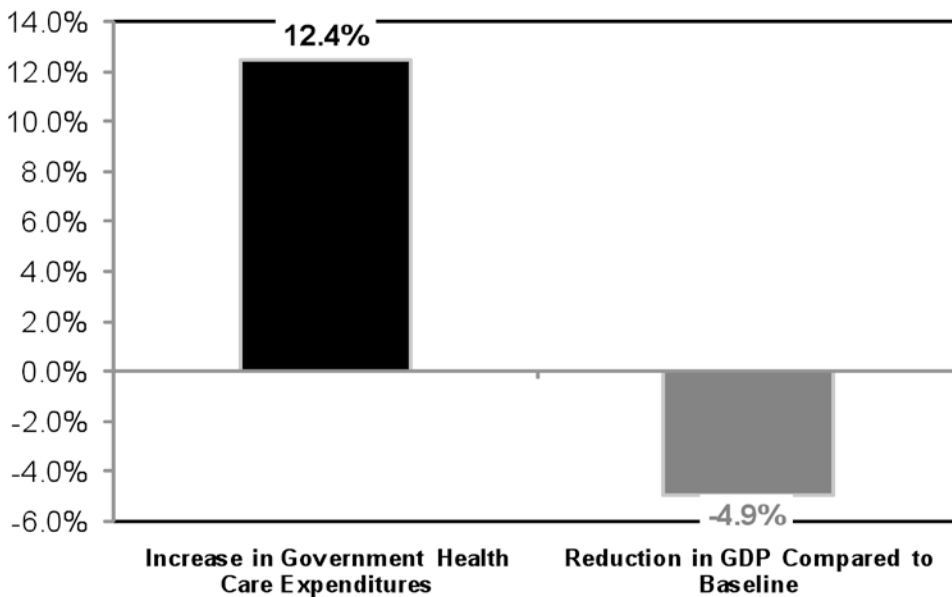


Figure 20: Reduction in GDP and Increase in Government Healthcare Expenditures Due to Increased Healthcare Subsidies Compared to Baseline Scenario Cumulative Impact by 2019⁵⁶

“Medicaid coverage would cost the federal government in this instance an additional \$438 billion over 10 years, with the 10-year total cost of the health reform program still in the \$1 trillion range.”

and SCHIP to people with income above 150 percent of the federal poverty level would be inclined to reverse those policies, because those individuals could instead obtain subsidies through the insurance exchanges that would be financed entirely by the federal government.

Other proposals address in different ways the situations of families in need. The House Tri-Committee Reform Proposal would force states to expand Medicaid eligibility to 150 percent of the poverty level and lock in current benefit levels. Although the federal government would cover new Medicaid enrollees under the plan, the lack of flexibility could damage Florida’s ability to manage its growing Medicaid costs. According to the CBO, the additional Medicaid coverage would cost the federal government in this instance an additional \$438 billion over 10 years, with the 10-year total cost of the health reform program still in the \$1 trillion range.

The Senate’s current HELP plan also would force states to expand Medicaid eligibility to 150 percent of the poverty level — without compensating them for the increased expen-

ditures. Should that proposal pass, the CBO estimate of total national Medicaid costs suggests that Florida could be forced to spend an additional \$18.6 billion based on current spending patterns, and assuming the Federal government does not reduce its current share of Medicaid spending.

We include the potential state Medicaid cost in the federal budget estimate rather than in the Florida budget estimate calculated below because it is unknown how the health-care reform package will ultimately address this issue. Our calculations are based on the assumption that the costs of the expanded Medicaid population are covered by the federal subsidies. Consequently, the additional costs are reflected in the \$3,900 per person federal cost estimate.

The present value of the non-federally funded additional healthcare expenditures that Florida’s state government will have to pay if a healthcare reform based on President Obama’s priorities were passed is \$5.9 billion, or \$320 for every resident in Florida. Figure 21 illustrates the annual increased medical expenditures that Florida would have to pay. These additional expenditures will need to

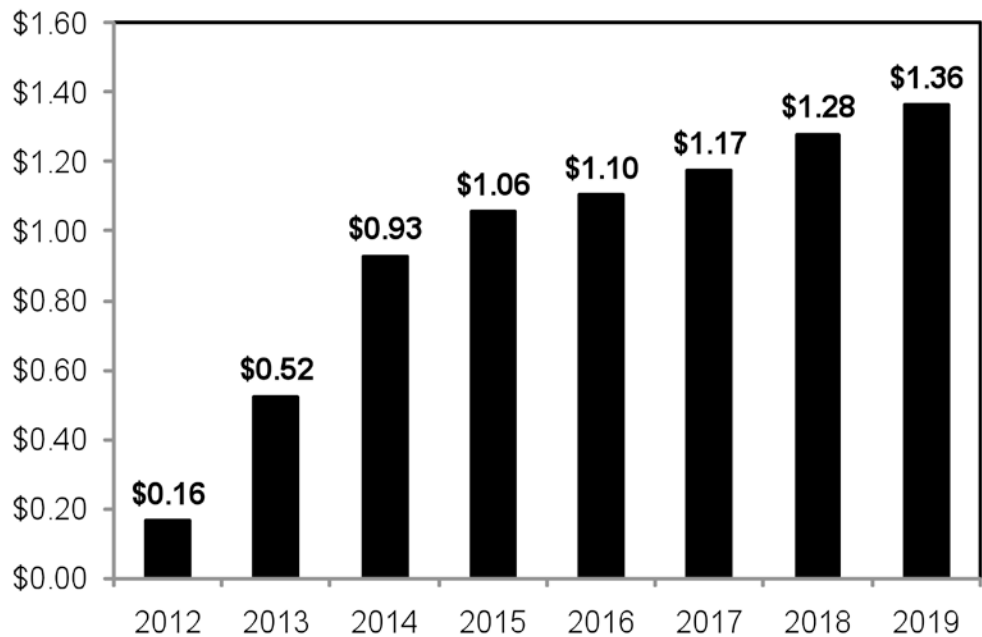


Figure 21: Additional Non-Federally Funded Florida State Government Spending Due to Increased Health Care Subsidies, 2012 – 2019 (in billions)⁵⁸

be paid for through either higher taxes or spending cuts elsewhere in the budget.

All told, combining the per person federal costs with the per person Florida costs, the present value of new government expenditures will cost every resident in Florida \$4,221.

While this figure will hold true regardless of whether the federal or state government picks up the costs for expanding Medicaid, the ultimate decision concerning the source of funding for Medicaid expansion will have a major impact on Florida's state budget.

Regardless of the funding mechanism, Florida taxpayers and the Florida economy would suffer from the heavy costs imposed under these healthcare proposals. The economic impact on Florida illustrated in Figure 22 is similar to the national impact in Figure 20. Florida's economy would shrink by 4.4 percent. This is slightly less than the impact on the national economy, due to Florida's more competitive economic landscape.

Additionally, because Florida does not have the option to run trillion dollar deficits, Figure 22 illustrates the cost of the additional \$1.36 billion in healthcare expenditures as

a percentage of total tax revenues. Florida's tax collections would have to be 1.6 percent larger in order to cover the additional \$1.36 billion in healthcare expenditures in 2019. Again, this number does not include the additional cost to Florida of expanding Medicaid if the federal government fails to pick up the tab.

Findings and Conclusions

The core problem behind the major crisis in the U.S. healthcare system is poor incentives for patients and medical providers. Neither patients nor medical providers have the proper incentives to increase healthcare quality or, especially, to decrease its costs. In fact, consumers and medical providers have the opposite incentive due to issues such as defensive medicine or the government incentives that thwart the development of comparative-effectiveness research.

The result is skyrocketing healthcare costs that limit dollar wage growth, accelerate medical inflation, and increase the total government burden on the private sector. These costs impose a large burden on the U.S.

“Florida’s tax collections would have to be 1.6 percent larger in order to cover the additional \$1.36 billion in healthcare expenditures in 2019.”

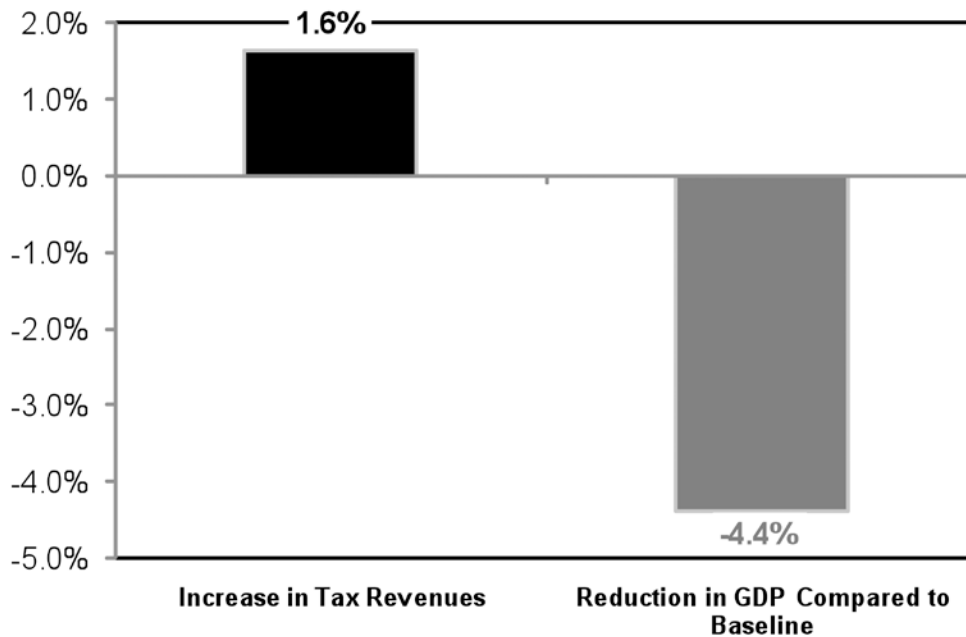


Figure 22: Reduction in Florida GDP and Increase in Florida Healthcare Expenditures Due to Healthcare Subsidies Compared to Baseline Scenario, Cumulative Impact by 2019 ⁵⁹

“The guiding principle of beneficial healthcare reform should be that the current third-party, government driven healthcare system needs to be changed, not enhanced.”

economy and underscore the importance of effective healthcare reform.

An effective approach to reforming the healthcare system begins by addressing the incentives driving the unsustainable rise in healthcare expenditures. Reforms based on President Obama’s priorities fail to do this. Instead, those priorities, if adopted, would exacerbate what is wrong with the current healthcare system, causing total national healthcare expenditures and healthcare inflation to increase. Lower economic growth and increased government deficits would result.

Our analysis has shown that reform in the Obama manner would render Florida residents poorer and their state government (along with the federal government) sorely pressed for revenues. Just as important, the reforms based on the President’s priorities are cost-ineffective with respect to expanding health-insurance coverage, one of the primary goals of reform.

Curing the problems in the current U.S. healthcare system is too important to do incorrectly. The guiding principle of beneficial healthcare reform should be that the current third-party, government driven healthcare system needs to be changed, not enhanced. One of the objectives of reform should be a simpler system. The extraordinary complexity of the current system not only frustrates healthcare providers and patients alike, but it also adds to the cost. This complexity is also responsible for much of the waste in the system, which is estimated to be 30 percent of healthcare spending.

Rather than expanding the role of government in the healthcare market, Congress should implement a patient-centered approach to healthcare reform. A patient-centered approach focuses on the patient-doctor relationship and empowers the patient and the doctor to make effective and economical health choices. A patient-centered healthcare reform would:

- **Begin with individual ownership of insurance policies.** The tax deduction that allows employers to own your

insurance should instead be given to the individual;

- **Leverage Health Savings Accounts (HSAs).** HSAs empowers individuals to monitor their healthcare costs and create incentives for individuals to use only those services that are necessary;
- **Allow interstate purchasing of insurance.** Policies in some states are more affordable because they include fewer bells and whistles; consumers should be empowered to decide which benefits they need and what prices they are willing to pay;
- **Reduce the number of mandated benefits that insurers are required to cover.** Empowering consumers to choose which benefits they need is effective only if insurers are able to fill these needs;
- **Reallocate the majority of Medicaid spending into simple vouchers for low-income individuals to purchase their own insurance.** An income-based sliding scale voucher program would eliminate much of the massive bureaucracy needed to implement today’s complex and burdensome Medicaid system. It would also produce considerable cost savings;
- **Eliminate unnecessary scope-of-practice laws and allow non-physician healthcare professionals to practice to the extent of their education and training.** Retail clinics have shown that increasing the provider pool safely increases competition and access to care and empowers patients to decide from whom they receive their care;
- **Reform tort liability laws.** Defensive medicine needlessly drives up medical costs and creates an adversarial relationship between doctors and patients.

By empowering patients and doctors to manage healthcare decisions, a patient-centered healthcare reform would directly address the distortions weakening our current healthcare system and would simultaneously control costs, increase health outcomes, and improve the overall efficiency of the health-

care system.

Conversely, any healthcare reform based on President Obama's priorities would worsen the current inefficiencies in the healthcare system due to incorrect diagnosis of the problems with our current system. If implemented, the President's reforms would significantly harm the healthcare system, patient welfare, and the economy overall.

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- 52 ALME calculations.
- 53 ALME calculations.
- 54 ALME calculations based on CBO estimates of federal budget between 2012 and 2019 based on President Obama's 2010 budget submission.
- 55 ALME calculations based on CBO estimates of federal budget between 2012 and 2019 based on President Obama's 2010 budget submission.
- 56 ALME calculations.
- 57 For a detailed analysis of the negative impact between higher government tax burdens (specifically the government expenditure tax wedge) and economic activity please see: Arduin, Laffer & Moore Econometrics (2009) "The Economic Impact of Federal Spending on State Economic Performance: A Texas Perspective" *The Texas Public Policy Foundation*, April 2009.
- 58 ALME calculations based on data from the U.S. Census.
- 59 ALME calculations.

About This Study

The noted economists at the firm of Arduin, Laffer & Moore recently completed their study of the potential nationwide impact of the healthcare reforms now under consideration in Congress. They then augmented their nationwide study with analyses of the impact on selected states. This version of that study, which includes material specific to Florida, was authorized, formatted, and edited by The James Madison Institute as one in its series of “Backgrounders,” peer-reviewed studies of major issues of concern to Floridians.

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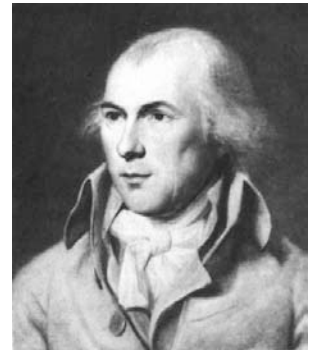
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