SHOW-ME INSTITUTE

POLICY STUDY

NUMBER 19 AUGUST 19, 2009

ADVANCING LIBERTY WITH RESPONSIBILITY BY PROMOTING MARKET SOLUTIONS FOR MISSOURI PUBLIC POLICY

THE PROGNOSIS FOR NATIONAL HEALTH INSURANCE: A MISSOURI PERSPECTIVE

By Arduin, Laffer & Moore Econometrics

Arduin, Laffer & Moore, an economic consulting firm, pools the talents of acclaimed experts who possess the knowledge and experience to understand the complex decisions faced daily by businesses and governments. The team combines decades of experience in the fields of public policy, public finance, and economics.

EXECUTIVE SUMMARY

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

- The private sector has been slowly funding less and less of total national health expenditures; as of 2007, less than 54 percent of total national health care expenditures were paid for by the private sector.
- Reciprocally, the public sector has been slowly funding more and more of total national health expenditures; as of 2007, public expenditures at the federal and state levels now fund nearly one half of the total health care expenditures in the United States.
- Total out-of-pocket expenditures have plummeted as a share of total health expenditures 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 "health care wedge" — an economic separation of effort from reward, of consumers (patients) from producers (health care providers) — caused by government policies. Rising government expenditures for health care are the main factor driving the growth of this wedge, which is a primary driver in rising health care costs, i.e., inflation in medical costs.

President Barack Obama's priorities in drastically altering U.S. health care policy — a public health insurance exchange, mandated minimum coverage, mandated coverage of preexisting conditions,

and required purchase of health insurance — do not address the growing health care wedge and its role as the fundamental driver of health care costs. In fact, they will further increase the wedge, and can thus be expected to further increase medical price inflation.

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

- Overall, total federal expenditures would be 5.6 percent higher than otherwise, adding $285.6 billion to the federal deficit in 2019.
- National health care expenditures would increase by an additional 8.9 percent by 2019.
- Medical prices would inflate by 5.2 percent above what they would have been otherwise by 2019.
- Economic growth by 2019 would be reduced in comparison to the baseline scenario, by 4.9 percent for the nation as a whole and 5.0 percent for Missouri.
- Higher medical inflation and overall expenditures would ultimately lead to government expenditures that exceed the estimated $1.0 trillion in expenditures on health subsidies. The net present value of all additional federal government expenditures through 2019 that would occur as a result of a federal health care reform is $1.2 trillion, or a $3,900 debt for every man, woman, and child in the United States.
- Despite the additional $1.0 trillion in expected health care subsidies by the federal government, 30 million people would remain uninsured. The cost to reduce the number of uninsured by 16 million people would be $62,500 in subsidy expenditures per person insured.
- In addition to federally funded expenditures, the net present value of all Missouri state government expenditures through 2019 that would occur as a result of a federal health care reform is $2.8 billion, or a $481 debt for every man, woman, and child in Missouri.
- The current net present value of funding health care reform based on President Obama's priorities would be $4,382 for every person in Missouri. This comes to a total net present value of $25.9 billion in total costs that Missouri residents would have to bear.
- The cost to Missouri residents could be higher, and the national cost lower, if the federal government were to push off to the states the financial responsibility for covering the expansion of lower income individuals' health insurance coverage. While the federal costs would decline, Missouri's costs would increase by a total of $9.0 billion (the net present value being $6.9 billion).

Higher medical inflation and overall expenditures would ultimately lead to government expenditures that exceed the estimated $1.0 trillion in expenditures on health subsidies.

INTRODUCTION

"In 2009, health care reform is not a luxury. It's a necessity we cannot defer. Soaring health care 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 health care 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 health care reform is necessary. For instance, 55 percent of respondents to a recent CNN poll think the U.S. health care system needs a great deal of reform.[1] Yet more than eight in 10 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 health care 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 health care wedge — an economic separation of effort from reward, or consumers (patients) from producers (health care providers), caused by government policies.

The health care 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 thereby 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 who decide medical malpractice liabilities. The wedge in our current health care system created by government, lawyers, and third parties causes higher costs and diminished efficiency.

Health care reform should be based on policies that diminish rather than increase this wedge.

From an economic perspective, a tax wedge diminishes incentives to work, save, and produce; consequently, less work, savings, and production results. Yet, 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 cause of 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 as the consumers of health care.

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national health expenditures — less than 54 percent as of 2007. Public outlays at the federal and state levels now account for more than 45 percent of total U.S. health care expenditures. Meanwhile, total out-of-pocket expenditures have plummeted even faster as a share of total health expenditures.

These trends together illustrate a complete reversal in the way health care historically has been purchased in the United States. In 1960, the private sector funded more than three quarters of national health care expenditures. Individuals paid from their own pockets nearly half of these costs. Today, the private sector funds slightly more than half of these expenditures and individual patients cover just over $1 of every $10 spent on health care.

Although reform is necessary, ill-advised reforms can make things much worse. Health care policy reformers should proceed in the same manner that doctors treat patients. Doctors must properly diagnose the disease or affliction so as to understand the likely effects of a proposed course of treatment. Likewise, health care reformers who have the public interest in mind must correctly diagnose the problem, showing how reform will restore a flagging health care system to robust health.

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

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

The president and his advisers have misdiagnosed the problems of the health care system. Health care reforms based on President Obama's criteria fail to address the fundamental driver of health care costs — the health care wedge.

The likely impact from the combination of proposed generous federal subsidies and a new public insurance option would be 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 would 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 health care system and increase medical price inflation.

The actual health care 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 health care reform proposal.
- A $1.0 trillion expenditure in the House Tri-Committee Group reform.
- A simple expansion of Medicaid eligibility, at an estimated cost of

$600 billion — much or all of it borne by state governments.

The exact impact on Missouri will vary, depending on which route is taken and whether the federal reform proposal attempts to cover the 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 health care market through: 1) providing an additional $1.0 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 health care expenditures by an additional 8.9 percent by 2019.
- Increase medical price inflation by 5.2 percent above what it would have been otherwise by 2019, because of the higher national expenditures.
- Pressure the federal and Missouri state budgets because of the increased expenditure levels and increased medical inflation:
  - – Higher medical inflation and overall expenditures would ultimately lead to government expenditures that exceed the estimated $1.0 trillion in expenditures on health subsidies. The net present value of all additional federal government expenditures through 2019 that would occur as a result of the proposed federal health care reform is $1.2 trillion, or a $3,900 debt for every man, woman, and child in the United States.
  - – In addition to federally funded expenditures, the net present value of all Missouri state government expenditures through 2019 that would occur as a result of the proposed federal health care reform is $2.8 billion, or a $481 debt for every man, woman, and child in Missouri.
  - – The current net present value of funding health care reform based on President Obama's priorities would be $4,382 for every person in Missouri. This comes to a total net present value of $25.9 billion in total costs that Missouri taxpayers would have to bear.
- Reduce economic growth by 2019 in comparison to the baseline scenario by 4.9 percent for the nation as a whole and 5.0 percent for Missouri.

The cost for Missouri could be higher, and the national cost lower, if the federal government were to push off to the states the financial responsibility for covering the expansion of lower-income individuals' health insurance coverage. While the federal costs would decline, Missouri's costs would increase by a total of $9.0 billion (the net present value being $6.9 billion).

A sharp increase in health care costs would force people off private insurance and onto the government plan. Further, as we know, the government rarely competes on a level playing field with private companies and firms, always tilting the field in its favor. A government plan embodying the president's stated priorities would operate with guaranteed taxpayer subsidies that would pressure the health care industry to price at uneconomical levels in order to meet political goals, regardless of economic

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

merit or viability. This would further reduce the number of Americans with private health care insurance.

As a consequence, the increase in the number of people enrolled in the government plan would not reflect a corresponding decrease in the number of uninsured individuals. A $1.0 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, would be $62,500 per person.

Such a negative economic assessment is consistent with the experience in Massachusetts, following that state's recent health care reforms. Those reforms share common ground with the president's stated priorities of a government-sponsored health care 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, 8–12 percent in 2008, and are expected to rise 9 percent this year."[4]

The analysis below links the problems in our current health care system to the rising wedge between patients and medical providers. This link makes it clear that reforms based on President Obama's priorities would only exacerbate our health care problems. Reform efforts need to be more carefully crafted and considered.

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

DIAGNOSING THE HEALTH CARE INDUSTRY: STRENGTHS

Before addressing the perverse incentives and outcomes inherent in the current U.S. health care system, it is worthwhile to provide a quick summary of its most important strengths. According to the U.S. Census, 45.7 million people in the United States 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 United States.[7] According to a recent CNN poll:

> *Most Americans like their health care 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 released Thursday 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 health care 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. health care 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 health care system, and, consequently, risk breaking the parts of the health care system that are currently working.

THE HEALTH CARE WEDGE

The health care system is facing serious problems, however. These problems, which impose significant hardships on many individuals, need correction. Correcting the problems with the current health care system begins with an understanding of the incentives that prompt people to invest their money in one way or another way. Incentives drive all economic behavior — including behavior in the health care industry. The cost and quality of health care goods and services respond to the interaction of consumers (patients) and suppliers (doctors and medical product suppliers).

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In the case of health care, the wedge also separates patients from doctors in determining what type of care should be provided. Decisions instead are made by government, insurers, and judges who decide medical malpractice liabilities. The wedge in our current health care system created by government, lawyers, and third parties causes higher costs and diminished efficiency.

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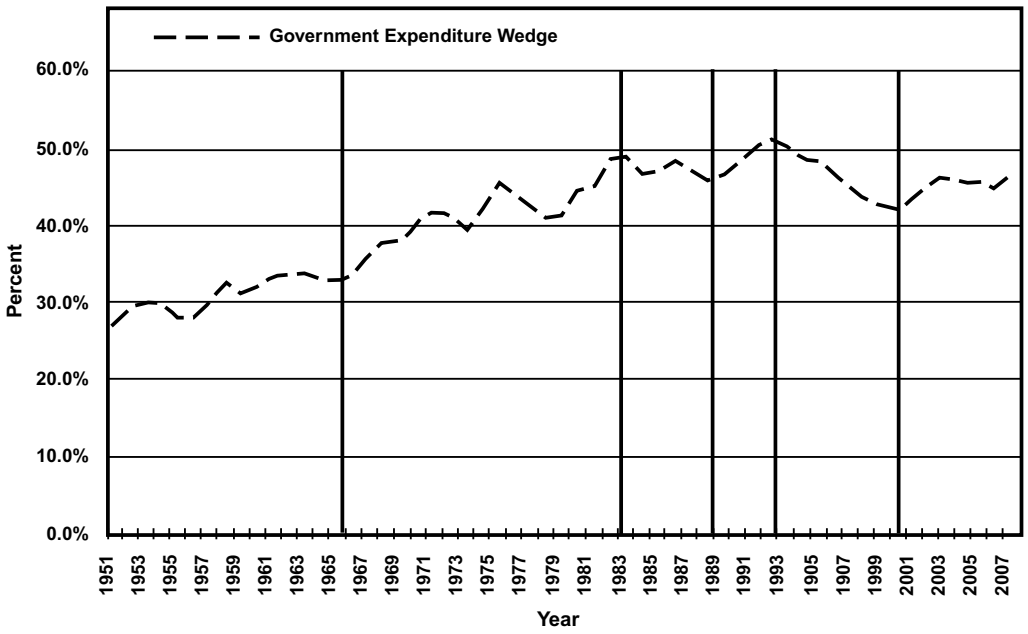
Economic wedges inevitably change economic incentives, often leading to undesirable outcomes. The burden of government on the growth of the private sector economy illustrates the costs associated with such wedges.

Figure 1
Total Federal, State and Local Government Expenditure Wedge
1951–2007[10]



One of the most basic axioms of economics examines changes in behavior after prices change. When the price of a product increases, consumers have an incentive to purchase less, while suppliers simultaneously have an incentive to produce more. When prices are obscured by government interference in the marketplace, however, neither consumers nor suppliers have the necessary knowledge to properly allocate society's scarce resources. Economic wedges inevitably change economic incentives, often leading to undesirable outcomes. The burden of government on the growth of the private sector economy illustrates the costs associated with such 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 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 depreciation) for 2007 was $9.5 trillion. The resulting government expenditure wedge for 2007 was 46.1 percent.

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

Table 1
Negative Relationship Between
Expenditure Wedge and Private Sector Growth
1950–2007[11]

YEAR	% 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%

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 that the overall government wedge has on total economic growth. By separating effort from reward, a large or growing government wedge diminishes the incentive to work, save, and produce. Consequently, there is less work, less saving, and less production of goods and services. Such basic fundamentals of economics are not repealed at the health care industry's doorstep.

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care industry, one must first understand the incentives driving the people and organizations participating in the health care market. Understanding the incentives pinpoints the current weaknesses of the U.S. health care industry, and provides the basis for developing a methodology to assess the impacts that would result from proposed reforms on specific health care problems in particular and on the 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 perverse incentives. Many of the problems with our current health care system stem from the perverse incentives created by the wedge between consumers and suppliers.

On the consumer side of the market, this wedge diminishes consumers' incentives to monitor costs; after all, consumers bear only a fraction of the costs from any additional health care service (see below). On the supplier side, doctors and other medical providers have no incentive to provide higher quality services for a lower cost. No positive 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 rising tort liability costs added $99 billion to $179 billion in additional costs in 2005 alone.[12]

As a result, the current health care system blinds both patients and doctors to the 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 that prompt implementation of the type of best practices programs that would help eliminate waste, fraud, and abuse. Whether the payer is government or an insurance company, the current process diminishes the competition and 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. health care system — a complaint not without merit — concerns the lack of effective comparative effectiveness research.

Michael F. Cannon of the Cato Institute illustrated in a 2009 study that removing government-created obstructions is a more effective policy reform than is the creation of a new government agency for creating comparative effectiveness research — an important goal supported by President Obama.

The president's has called for comparative effectiveness research to be provided by a government agency, claiming the market has failed in its provision. According to this theory, once comparative effectiveness research is known, it is difficult to keep out of the public domain. Organizations' incentives

to invest in this research are diminished by the prospect that their competitors will benefit from their private research at no cost to themselves. Consequently, according to this theory, organizations will naturally under-invest in comparative effectiveness research.

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 paid by consumers reduces their demand for comparative effectiveness research. Because consumers do not bear the costs or reap the benefit of ensuring the most cost-effective practices, their incentives to seek those benefits are accordingly lessened. Taken together, government interventions have deadened 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 produce this valuable research, the best way to create comparative effectiveness research isn't to commission it from government, but, rather, to remove the government obstructions that discourage its private 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 a dual set of 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, or monthly) payments to an insurance company, that company will pay a predetermined amount of money to the income earner should an unfortunate accident or disabling illness occur.

Unfortunately, most existing health insurance does not work this way. As opposed to covering only true health risks (the costs associated with broken arms or major surgeries), insurance pays the costs for routine health events that are not risks in the true sense of the word. An

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.

Imagine if another form of insurance, for automobiles, worked like health insurance. As opposed to covering only the costs from major automobile accidents, the insurance policy would also cover costs of routine maintenance, such as oil changes and tune-ups.

analogous situation would be if a disability insurance plan paid an individual's disability claims filed after missing work because of a cold. The basic principles of risk and insurance have been distorted. This type of distortion directly leads to diminished quality and increased prices.

Imagine if another form of insurance, for automobiles, worked like health insurance. As opposed to covering only the costs from major automobile accidents, the insurance policy would also cover costs of routine maintenance, such as oil changes and tune-ups. Additionally, in order 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 their policies in order to subsidize the costs caused by 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 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 increase as well.

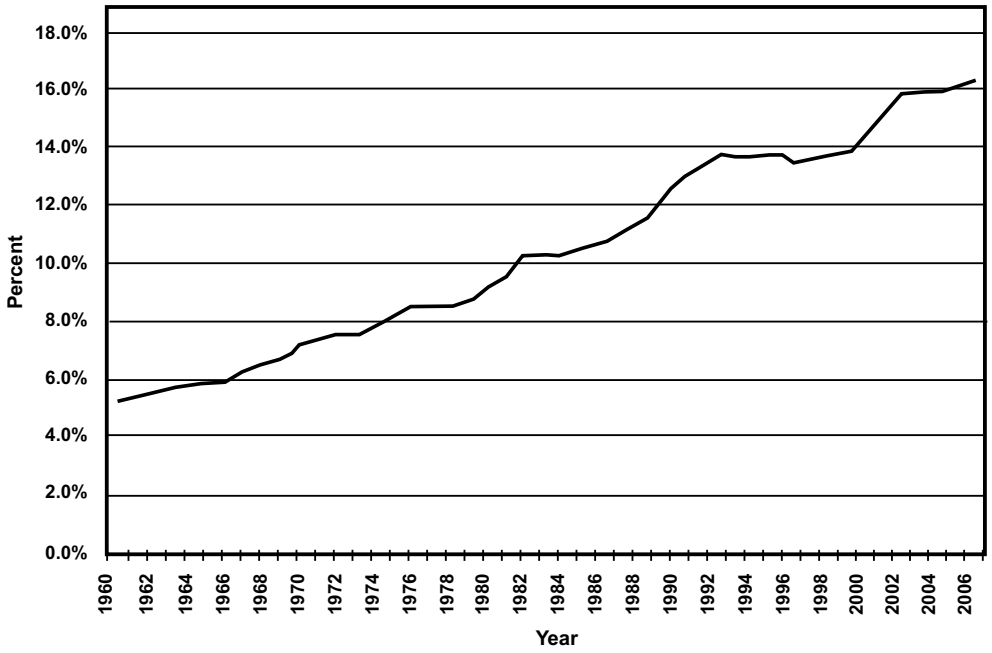
Automobile insurance companies, trying to arrest the rising costs of car repairs and car maintenance, would begin to increase the amount of rules and regulations. This would result in significant distortions in the automobile insurance market, skyrocketing repair costs, and an increase in the quantity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

THE EMPIRICAL EXISTENCE OF THE WEDGE

The empirical data confirm the outcomes we would expect to result from the wedge in the health care market: Health care expenditures and costs are rising faster than our economy's output. 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). Such expenditures are expected to be about 18 percent of GDP in 2009.[14]

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

Figure 2
National Health Expenditures as a Percentage of GDP
1960–2007[15]



Beneficial health care reform must begin with an understanding of the trends and drivers of health care expenditures.

Gross Domestic Product (GDP) is one 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 forever consistently outpace people's ability to pay. The same is true for health care. The consistent excessive growth of health care expenditures, in comparison to the economy's ability to pay for them, is the major weakness of the current health care system. All other problems (e.g., lack of insurance coverage and medical bankruptcy) find their genesis in the uncontrolled rise in health care expenditures. Consequently, beneficial health care reform must begin with an understanding of the trends and drivers of health care expenditures.

Part of the health care 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 also resulted in a reduction in private spending in the health care market. In 1960, over 75 percent of total health expenditures in the U.S. were funded privately. Beginning in 1966, with the passage of Medicare, the private sector's role in the health care market began to change. In 1965, the private sector still funded more than 75 percent of total national health expenditures. This fell to 70 percent in 1966, and 63 percent in 1967, after which the private sector slowly began funding less and less of the total national health expenditures. As of 2007, less than 54 percent of total national health care expenditures were paid for by the private sector.

Public expenditures at the federal and state levels now fund more than 45 percent of the total health care expenditures in the United States.

Figure 3
National, Private, and Public Health Expenditures as a Percentage of GDP
1960–2007[16]

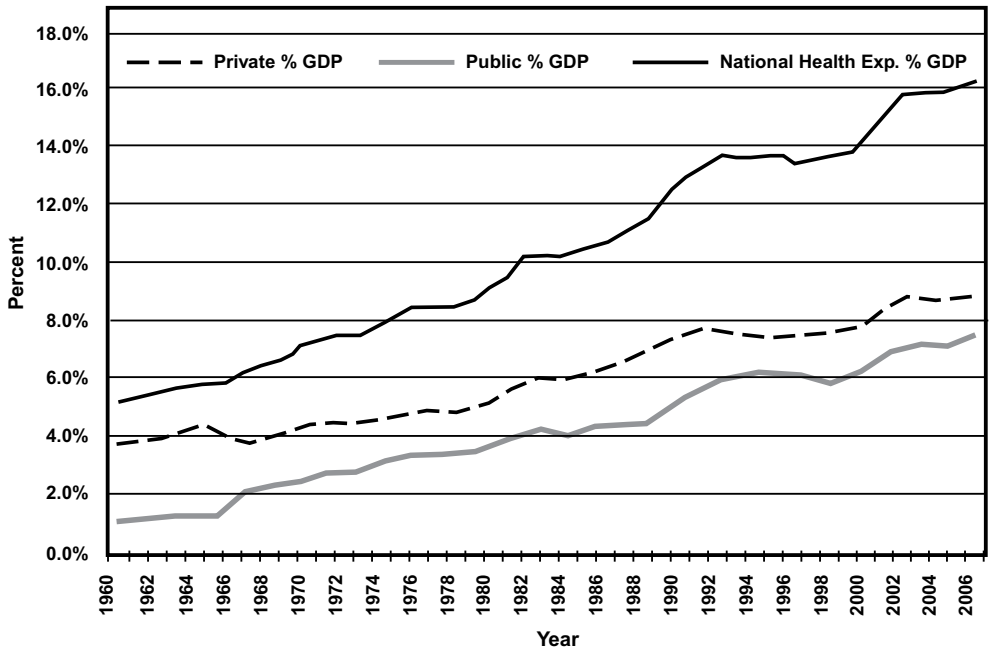


Figure 4
Out-of-Pocket Expenditures as a Percentage of Total National Health Expenditures
1960–2007[17]

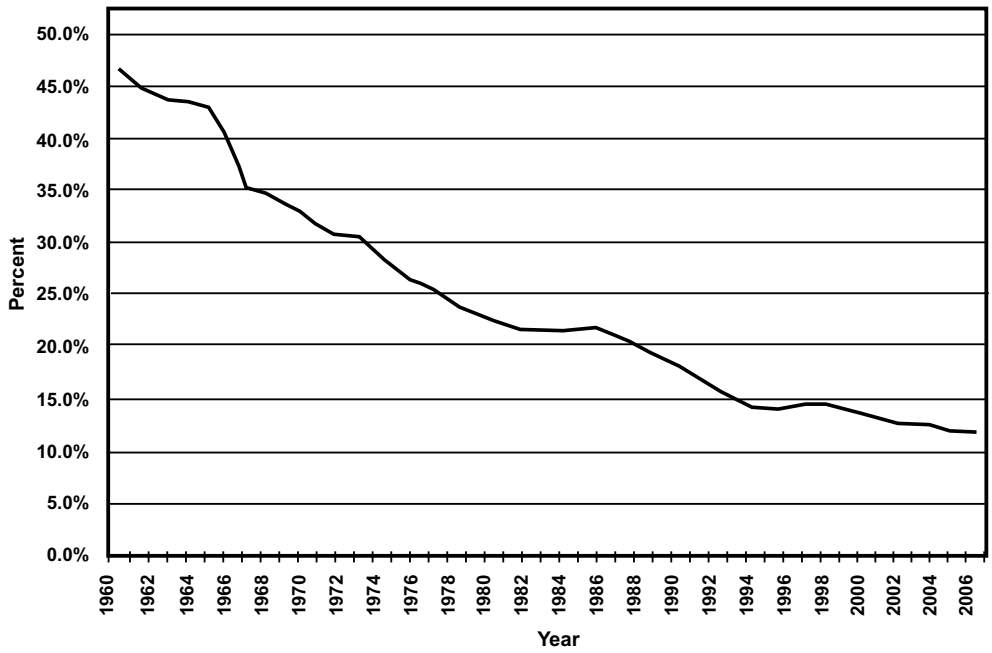
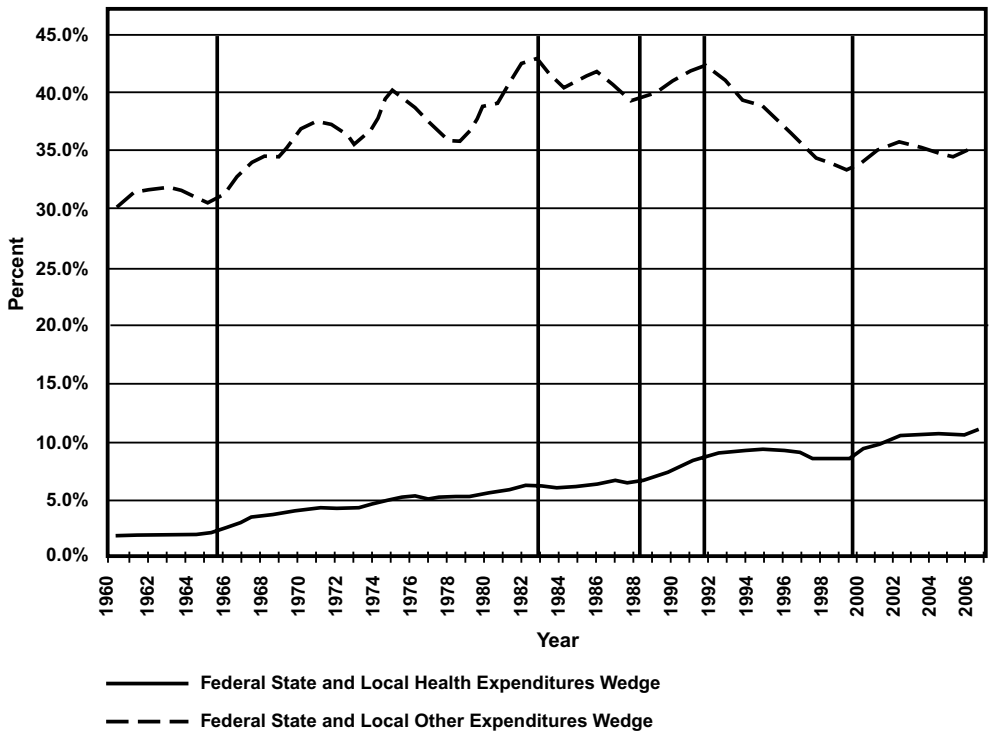


Figure 5
Total Federal, State, and Local Government Health Care Expenditure Wedge Compared to All Other Government Expenditures 1960–2007[18]



Public expenditures at the federal and state levels now fund more than 45 percent of the total health care expenditures in the United States. Along with these trends, total out-of-pocket expenditures have plummeted 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 the fact that government has covered an increasingly larger share of total health care 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 United States. In 1960, the private sector funded more than three quarters of national health care 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 health care expenditures and all other government expenditures. Figure 5 shows two important trends. First, the government expenditure wedge outside of health care, although volatile, is currently

In 1960, the private sector funded more than three quarters of national health care expenditures. Today, the private sector funds just a bit more than one half of these expenditures

Health care reforms based on President Obama's priorities would lead to large increases in government expenditures on health care without eliminating the negative consumer and supplier incentives.

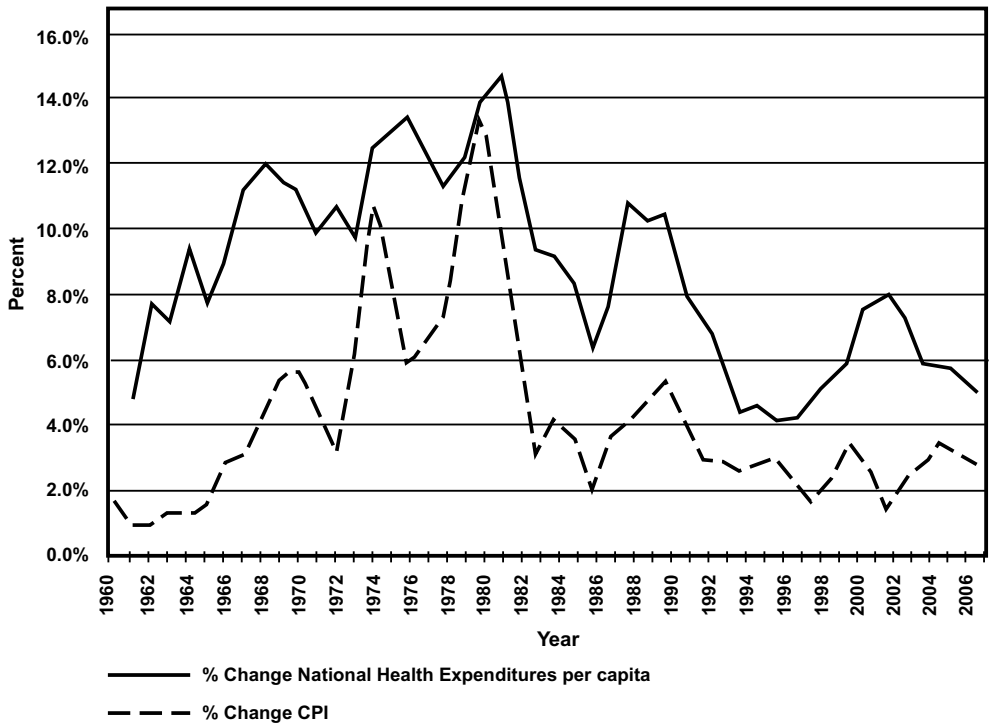
only 5 percentage points higher than the 1960 wedge (35.3 percent compared to 30.1 percent).

Second, health care 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 attributable to rising health care expenditures. Table 1 identified three main periods of a rising government expenditure wedge: 1965–1983, 1988–1992, and 2000–2007. Health care expenditures drove the rising government expenditure wedge during each one of these periods, the importance of which has been growing over time:

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

Government health care 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

Figure 6
Percent Change in Per-Capita National Health Expenditures Compared to Percentage Increase in Consumer Prices 1960–2007[19]



implications with respect to beneficial health care reforms. Health care reforms based on President Obama's priorities would lead to large increases in government expenditures on health care without eliminating the negative consumer and supplier incentives. Consequently, they would bring significant increases in government expenditures and subsequent decreases in economic growth.

The perverse incentives created by the growing separation between consumers and suppliers are manifested most prominently through skyrocketing health care costs. The relatively larger growth in health care expenditures is outpacing growth in overall consumer prices in the economy. Figure 6 shows that the rate of increase in the dollar level of health care expenditures per person has exceeded the rate of inflation in the economy each year for nearly the past 50 years.

The burden of health care costs to individuals in the economy goes beyond simply the current dollar outlays that individuals must pay. The individual cost of health care includes both 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 public health expenditures.

Health insurance expenditures have been rising as a share of disposable personal income, with premiums being "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 both as a share of total business costs and in government budgets. The Bureau of Economic Analysis tracks total costs for health care in a category called "supplements to wages." These costs incorporate all of the expenses, other than wages, that firms pay to employees — health insurance being a major component.

In 1960, most of an employee's compensation took 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 to 54.5 percent by 2007, while wage supplements rose steadily to 12.5 percent.

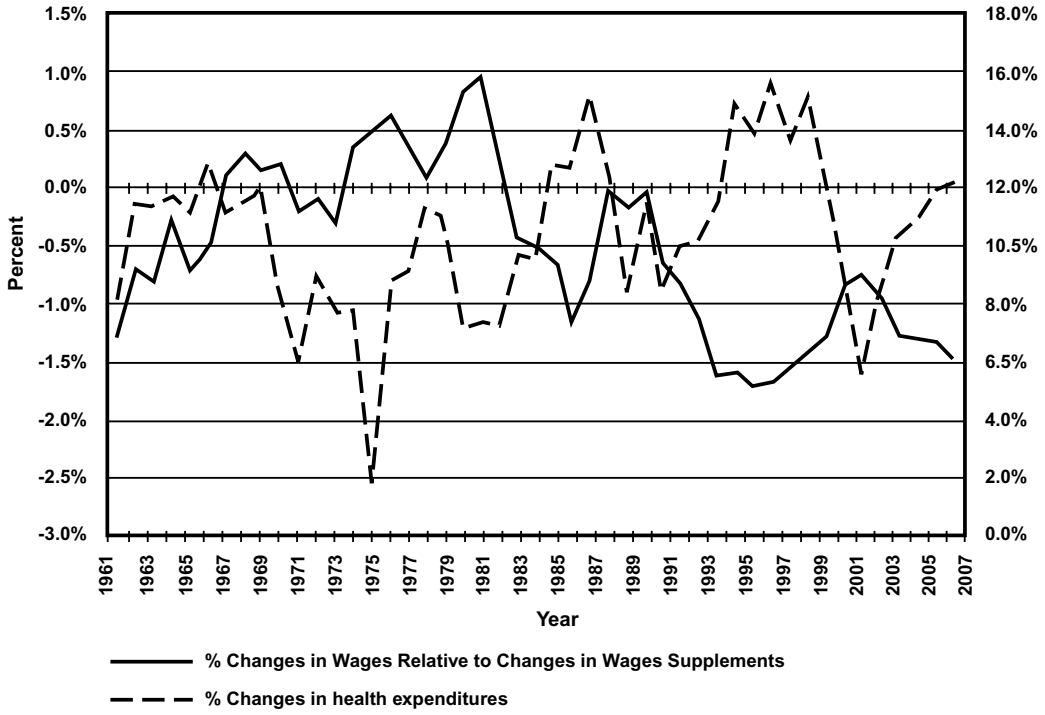
More important, perhaps, the decline in wages as a share of personal income increases when the growth in health expenditures accelerates, and moderates when the growth in health expenditures moderates. Supplements to wages (e.g., health insurance) move in the opposite direction as do wages. When growth 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. The red solid line in Figure 7 represents the percentage change in health care

The individual cost of health care includes both 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 public health expenditures.

Growing health care expenditure happens at the expense of growth in monetary wages, limiting workers' welfare by reducing their expenditure power outside of health care services.

Figure 7
Percentage 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
1961–2007[22]



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

Figure 7 clearly shows that when health care expenditure growth accelerates, supplements to wages grow faster than wages. The reverse happens when health care expenditure growth slows. This pattern illustrates the dampening impact that out-of-control health expenditures have had on monetary wages for American workers. Growing health care expenditure happens at the expense of growth in monetary wages, limiting workers' welfare by reducing their expenditure power outside of health care services.

The same can be true of the federal and state governments. Figure 8 traces the growth in health care expenditures as a share of federal, state, and local expenditures since 1960. Whereas health expenditures made up only 4.5 percent of total government expenditures (or less than $1 in $20) in 1960, by 2007 they constituted 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 health care expenditures have led to:

- *rising tax burdens to fund the government portion of health care 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, health care burden for individuals.

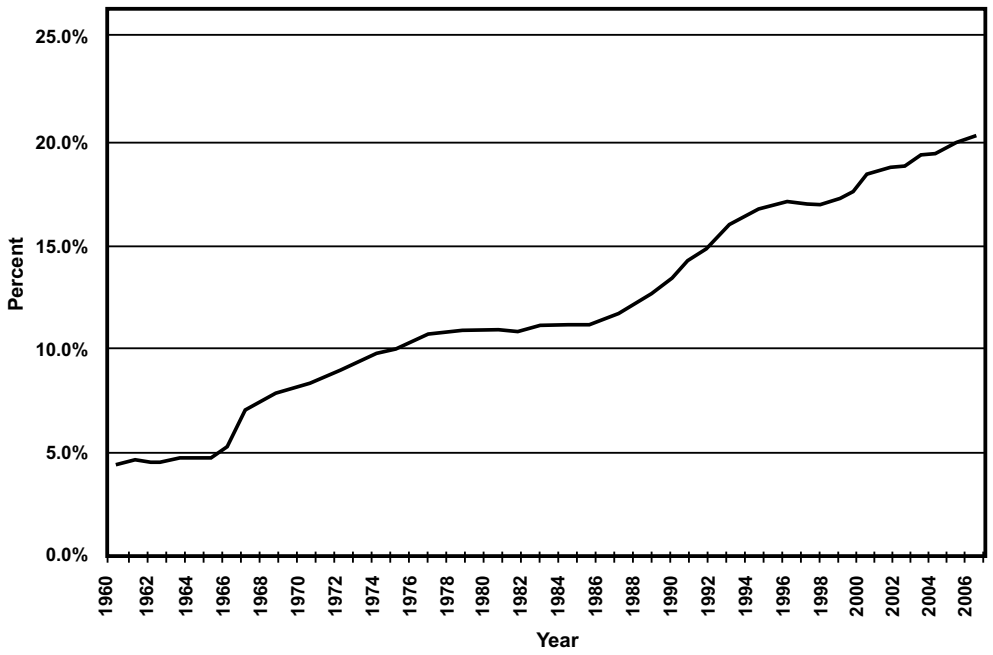
STUDIES DEMONSTRATE THAT GOVERNMENT POLICIES ARE THE PROBLEM

Research into the causes of excessive health care price increases finds that government policies are the primary reason why prices are growing excessively and coverage is so distorted. Consequently, the most effective method of controlling the excessive price increases would be to rescind those policies that are causing the excessive price increases in the first place.

The real alternative to today's health care system doesn't entail the intrusion of federal power into the process, as presently proposed in Washington, D.C. The real alternative would involve a reduction

Research into the causes of excessive health care price increases finds that government policies are the primary reason why prices are growing excessively and coverage is so distorted.

Figure 8
Total Federal, State, and Local Health Expenditures as a Percentage of Total Government Expenditures
1960–2007[23]



It is necessary to change the perverse incentives that consumers face so that they become price-sensitive when purchasing health care — and thus help, by their individual decisions, to contain out-of-control health care costs.

in government regulation and the consequent encouragement of robust competition among health care service and insurance providers.

The impact from government policies on the health care market is of two kinds — direct and indirect. The first comes from government medical spending policies that direct increase health care costs. The indirect impact results from government interference that eliminates incentives for individuals and medical professionals to engage in economizing behavior that would increase quality and decrease costs in providing health care.

MIT economics professor Amy Finkelstein in a 2007 study, and University of Illinois economics professor Jeffrey Brown along with Finkelstein in a 2008 study, established a direct link between government Medicare and Medicaid expenditures and rising health care prices or other distortions that limit the efficiency of the health care market.[24]

Finkelstein (2007) illustrates that of the six-fold increase in per-capita health care 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 growing government involvement in the health care industry has helped drive up health care expenditures.

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

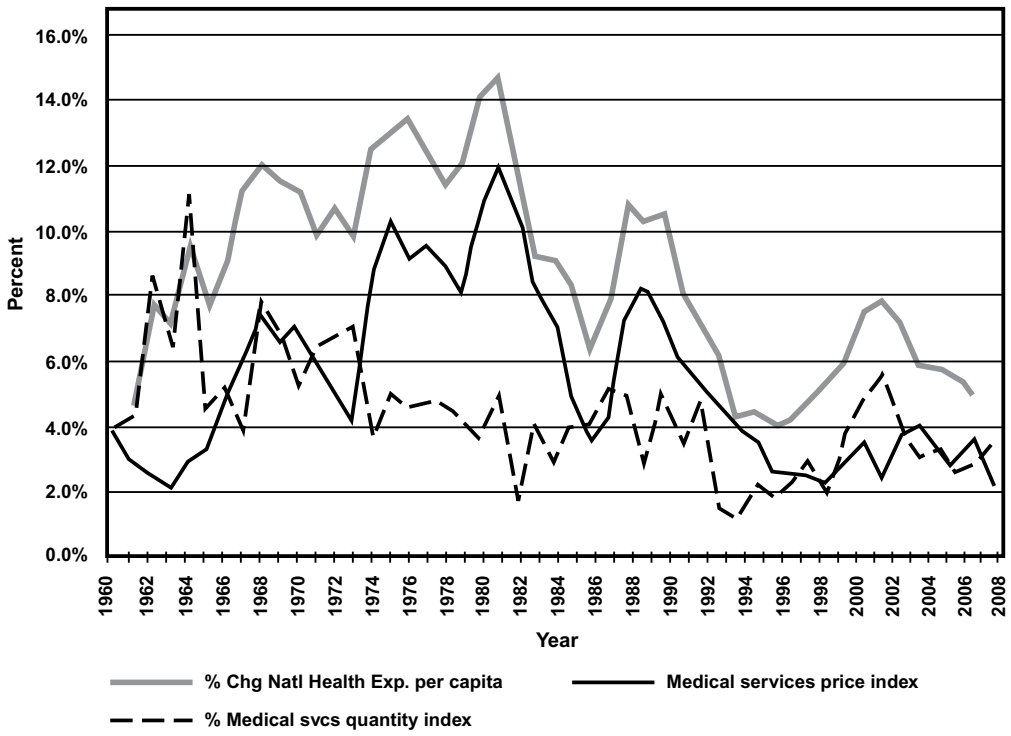
> *While health insurance provides valuable financial protection against high costs associated with medical treatment, current benefit designs often blunt consumer sensitivity with respect to prices, quality, and choice of care setting. There is well documented evidence that individuals respond to lower 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 perverse incentives that consumers face so that they become price-sensitive when purchasing health care — and thus help, by their individual decisions, to contain out-of-control health care costs. The same logic holds for the perverse incentives that the current system places on insurance companies, doctors, and other health providers.

THE CONSEQUENCES OF RISING HEALTH CARE COSTS

Higher expenditure growth can arise for three reasons. Either the price of

Figure 9
Percentage Change in Per-Capita National Health Expenditures Compared to Percentage Increase in Medical Service Prices and the Quantity of Medical Services Consumed 1960–2008[27]



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 because of rising prices. Specifically, the total quantity of goods in the U.S. economy increased by 377 percent between 1960 and 2008. The total quantity of medical services increased 712 percent — more than twice as much. However, while prices in the U.S. economy increased 490 percent, prices of medical services soared 1,239 percent — nearly two and a half times as much.

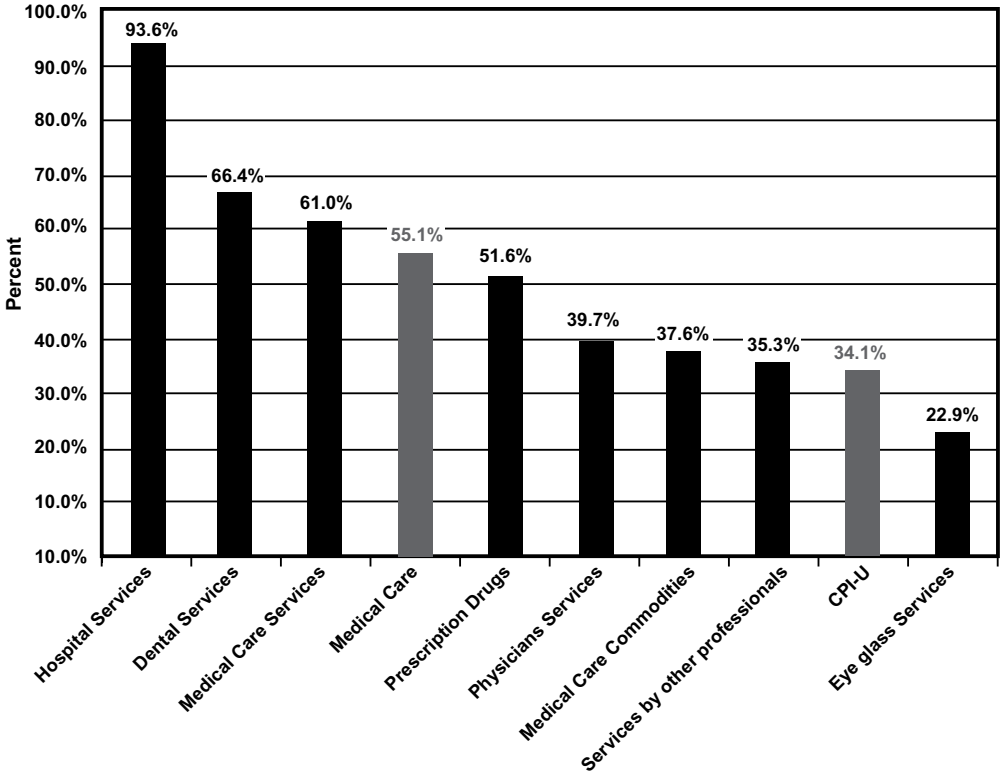
Figure 9 compares rising medical prices and medical consumption to total national medical expenditures. The phenomenon of rising national medical expenditures is clearly a combination of both rising costs and rising consumption, but rising costs are clearly the major driver.

Figure 10 illustrates the excessive growth in health care costs compared to general price inflation since 1998. The fact that the costs of medical and hospital services are driving price increases for medical care should not be surprising. These are the sectors most burdened by regulations and affected most 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

The fact that the costs of medical and hospital services are driving price increases for medical care should not be surprising. These are the sectors most burdened by regulations and affected most by the insurance market.

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.

Figure 10
Cumulative Growth in Health Care Prices by Category 1998–2008[28]



to eye glasses — are precisely the health care costs exhibiting the least amount of price pressures.

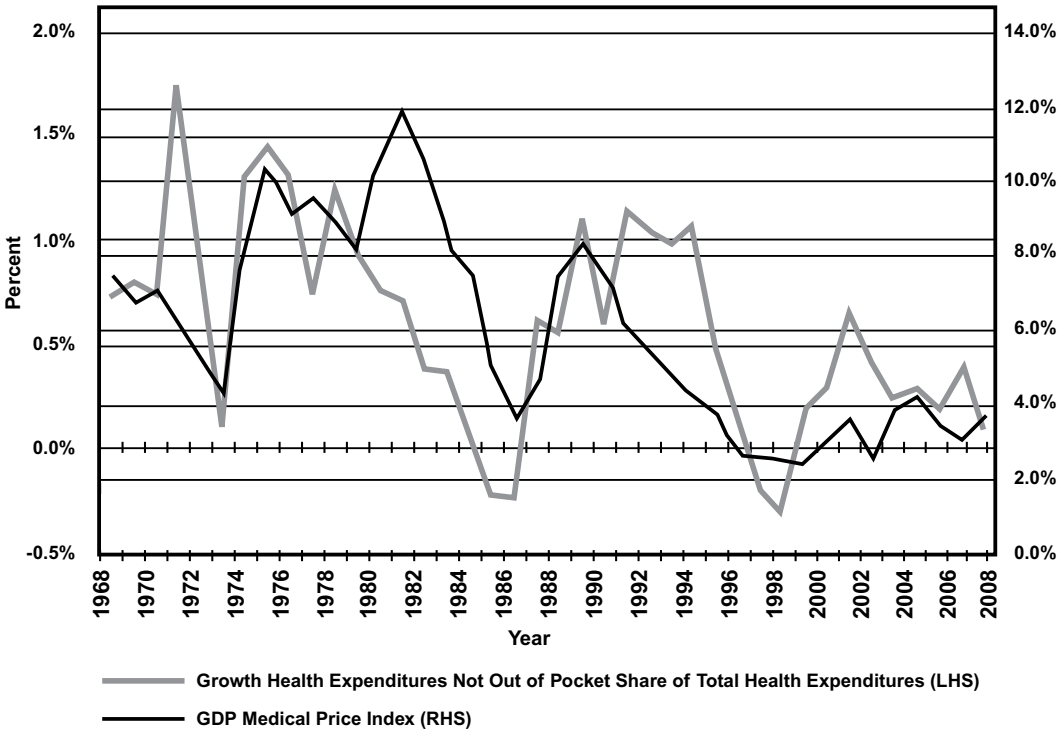
Figure 11 relates the medical price inflation back to the wedge and the perverse incentives created by the current system. When expenditures that are covered by either the insurance company or the government increase relative to national health expenditures, medical price inflation accelerates. When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

It is important to note that the distribution of total health care spending is not even. According to the Agency for Healthcare Research and Quality (AHRQ):

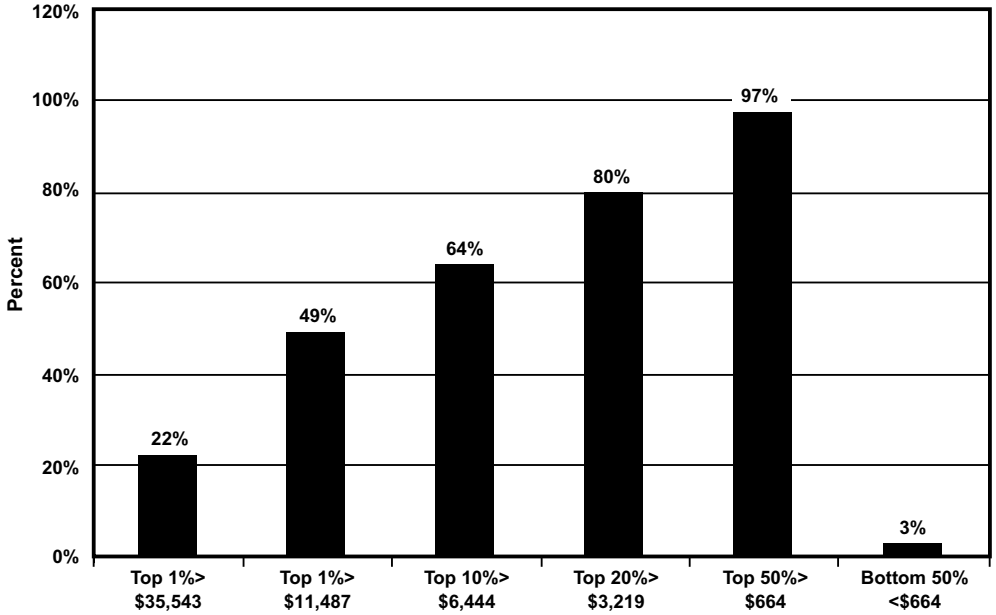
… actual spending [on health care] is distributed unevenly across individuals, different segments of the population, specific diseases, and payers. For example, analysis of health care spending shows that:

Figure 11
Growth in Health Expenditures Not Out of Pocket as a Share of National Health Expenditures Compared to Medical Price Inflation
1968–2007[29]



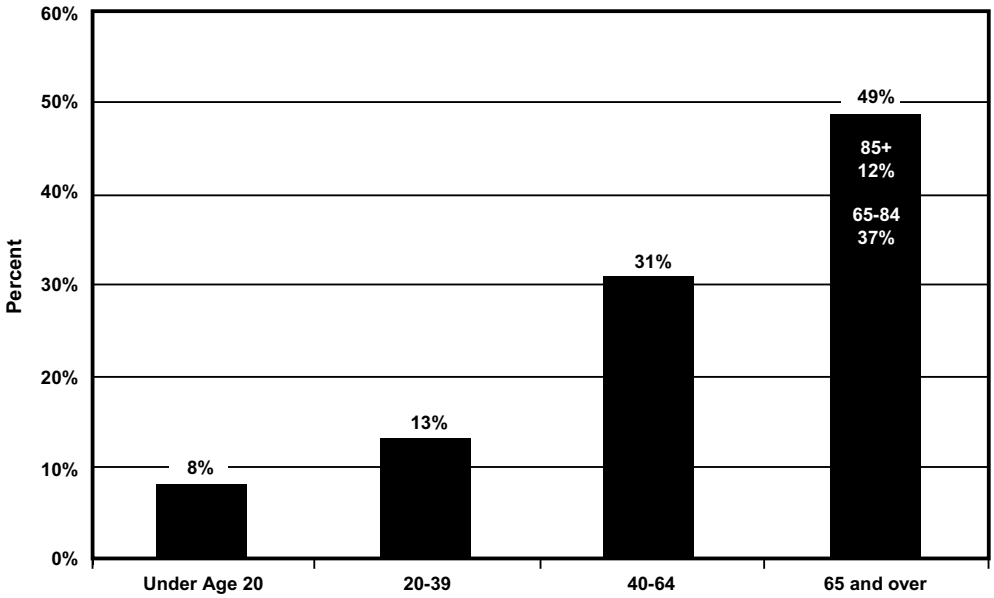
Accelerating medical inflation is strongly correlated with a growing separation (wedge) in the medical market between doctors and patients. Reform policies that increase this separation can be expected to increase pressures on medical price inflation.

Figure 12
Percentage of Total Health Care Expenditures by Percentage of the Population
2002[32]



Controlling spending requires limiting the spending of the 5 percent of the population that spends one half of all health care expenditures.

Figure 13
Percentage of Total Health Care Expenditures by Age
2002[33]



- *Five percent of the population accounts for almost half (49 percent) of total health care expenses.*
- *The 15 most expensive health conditions account for 44 percent of total health care expenses.*
- *Patients with multiple chronic conditions cost up to seven times as much as patients with only one chronic condition.*[30]

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 total health care spending (that is, spending on the consumers of health care services) is created by a small percentage of the U.S. population. Controlling spending, therefore, requires limiting the spending of the 5 percent of the population that spends one half of all health care 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, 8 percent of health care expenses:

> *… occurred 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 causes. 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. health care spending in 1996"; heart disease, cancer, trauma, mental disorders, and pulmonary conditions are the five most expensive diseases to manage.[36] Chronic conditions, such as asthma, are the other main causes of major medical expense.

Individuals 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 health care 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 an important context from which to interpret the rising expenditure trends — especially with respect to how perverse incentives are driving the excessive cost increases. Given the current demographic trends, the perverse incentives created by Medicare — as identified by Finkelstein (2007) — and especially the new Medicare prescription drug benefit are key focus areas for any effective health care reform effort.

OBAMA'S REFORMS DO NOT ADDRESS THE ROOT CAUSES OF THE PROBLEM

The facts presented above establish that rising health care 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 total health care spending in 2007:

The distribution of health expenditures provides an important context from which to interpret the rising expenditure trends — especially with respect to how perverse incentives are driving the excessive cost increases.

Rising costs and a distorted health insurance market are limiting insurance opportunities for millions of Americans. Implementing reforms true to the principles of the president's health care priorities would negatively impact the economy in excess of those negative impacts created by the current system.

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 health care bill of $700 billion in 2007. On a per-capita basis, $700 billion in waste, fraud, and abuse imposes a debt of more than $2,300 per legal resident in the United States. The possibility that 30 percent of total health care 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 government policies that have diminished the incentives and 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 health care costs higher. In reality, rising costs and a distorted health insurance market are limiting insurance opportunities for millions of Americans. Implementing reforms true to the principles of the president's health care priorities would negatively impact the economy in excess of those negative impacts created by the current system.

As of this writing, neither the president nor his allies in Congress have settled on a specific detailed health reform plan. Several general concepts guide their approaches, however, including:

- A public health insurance option intended to compete with the private sector.
- An individual or employer mandate requiring coverage.
- The establishment of health care exchanges in which 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 an administrative body that disseminates comparative effectiveness information or electronic medical records) 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 proposed creation of a public health insurance option that supposedly would ensure that private insurance companies provide a fair product at a reasonable price. Advancing such an idea as a solution is predicated

on the notion that the problems with our current health care system arise from health insurance companies offering ineffective pricing and services. As shown above, however, this is not the source of 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 industry 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 forced to close up shop.

Florida's experience with storm (e.g., hurricane) insurance exemplifies the likely fate of health care insurance under the federal plan as currently proposed. As everyone knows, hurricanes frequently batter Florida. Sometimes, a given hurricane is particularly severe. Storm insurance provides protection for residents against significant or catastrophic wind damage caused by the occasional strong hurricane.

Originally, storm insurance plans were offered by both private insurers and the state government. Under Gov. Charlie Crist, the state lowered its storm insurance rates to an actuarially unsound level. Under any reasonable scenario, the costs from storm insurance claims following the next large storm would overwhelm the insurance premiums collected and bankrupt any insurance fund that extended these rates. When combined with other market restrictions, the state has all but ensured that insurance companies operating in Florida would lose money in the wake of a large storm. In order to avoid bankruptcy, these companies already have been leaving Florida. As a result, the state government is becoming the primary storm insurer. The state of Florida is now insuring millions of people, and will face a financial crisis when the next major hurricane comes ashore.

The end result of the president's plan for the health insurance market would be essentially the same as in Florida's storm insurance market. The federal 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 health care system.

The Federal National Mortgage Association (Fannie Mae) and the Federal Home Loan Mortgage Corp. (Freddie Mac) provide additional examples of how federal influence over public companies can distort the market and reduce its allocative 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. This is a wildly unpopular response in the political realm, however.

The end result of the president's plan for the health insurance market would be essentially the same as in Florida's storm insurance market. The federal insurance program would drive out the private sector and become the primary health insurer in the United States.

Creating another government insurance plan would not address the problem of rising health care costs. It would instead exacerbate other problems, by further diminishing consumer incentives to monitor health care costs.

Representatives 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 is another real-world example of how public corporations, subject to the whims of politicians, distort the markets in which they operate.

Similarly, congressmen and senators will have an incentive to pressure the CEO of some future public health insurance company whenever premium price 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 health care costs. It would instead exacerbate other problems, by further diminishing consumer incentives to monitor health care costs. Brown and Finkelstein's research (2008) suggests that the likely impact from a public insurance option would be 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 health care reform priorities would create public health insurance exchanges. In theory, such exchanges provide people with the resources and information they need to make efficient insurance purchases. When combined with guaranteed issue 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 that contains these policies — the Affordable Health Choices Act. The CBO's reply dispels the myths that health insurance exchanges combined with an individual mandate constitute effective health care 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.*[40]

Given that the U.S. Census currently estimates that 45.7 million people did not have insurance in 2007, the net $1.0

trillion in estimated additional spending ($1.6 trillion gross spending) that the current federal health care reform proposal would bring would reduce the number of uninsured by only 35 percent. The initiative would therefore leave more than 30 million people uninsured.[41] The cost to reduce the number of uninsured by 16 million people would be $62,500 per each additional person insured.

That assessment is consistent with experience in Massachusetts following the state's recent health care reforms. The Massachusetts reform embodied the same main principles promoted by the Obama administration — the health exchange, individual mandate, and generous subsidies. That 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.
- The creation of the Massachusetts Health Connector, which is an exchange designed 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 polices on the open market. Many more obtained employer-sponsored coverage, particularly among lower-income workers.[42]

However, the same report also documents that these reforms are bankrupting the state and creating many unintended and unwanted consequences. These include:

… 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 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,

The current federal health care reform proposal would reduce the number of uninsured by only 35 percent. The initiative would therefore leave more than 30 million people uninsured.

The benefits from expanding insurance coverage are 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.

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.[43]

The benefits from expanding insurance coverage are 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.[44] "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."[45]

The resultant pressure isn't on taxpayers and state budget architects alone. Supporters claimed, however:

… 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.[46]

The Massachusetts experiment is a case study that demonstrates the negative economic impact of health reform rooted in the president's stated priorities for expanding coverage. Such an approach not only fails to address the perverse incentives driving up costs, it makes these incentives worse. The impact from these worsened economic incentives creates additional adverse economic outcomes that would result wherever the president's reform goals are implemented.

The last health care reform priority supported by President Obama addresses the outcomes of existing perverse incentives (the symptoms) and not those actual perverse incentives themselves (the disease). The president has discussed the need for best practices (such as an administrative body that disseminates comparative effectiveness information or electronic medical records) 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 health care providers to use electronic medical records, and $1.1 billion for comparative effectiveness research.

As Cannon (2009) illustrated, the medical profession lacks adequate comparative effective research and other best-practice-sharing initiatives because government programs and price insensitive consumers have eliminated the incentive for such programs to exist at all, let alone flourish. Throwing money at this problem will not appreciably change the incentive. What it will do instead is create

Figure 14
Projected Reduction in Uninsured From $1 Trillion in Federal Subsidies
2012–2019[47]

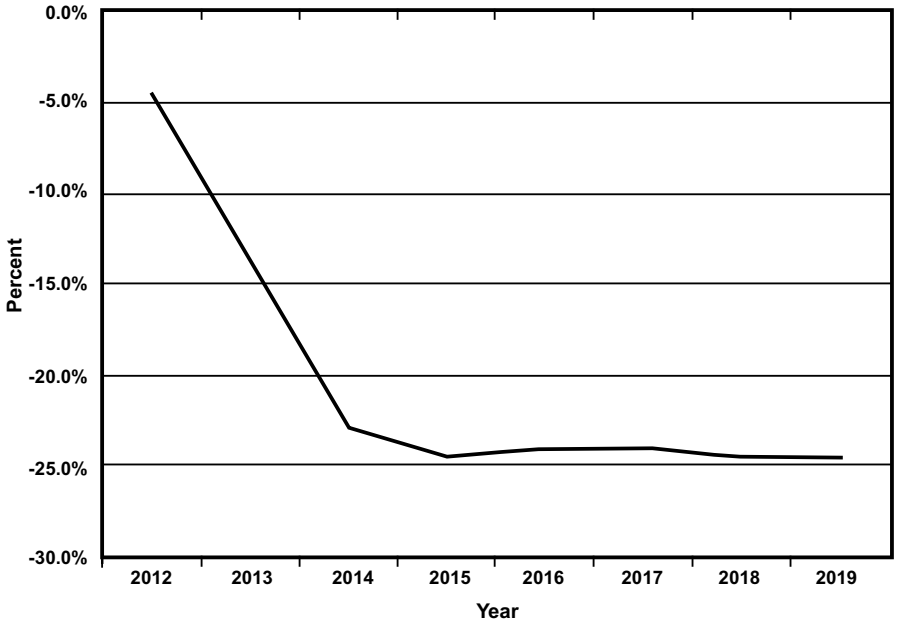
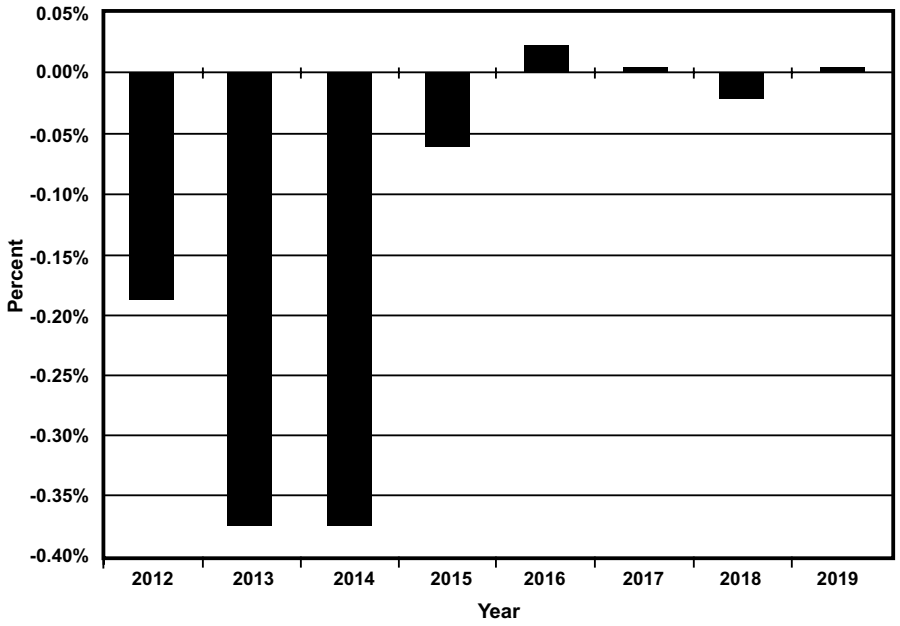


Figure 15
Annual Percentage Change in Connection Rate
Stemming From Increased Health Care Subsidies
2012–2019[48]



The medical profession lacks adequate comparative effective research and other best-practice-sharing initiatives because government programs and price insensitive consumers have eliminated the incentive for such programs to exist at all, let alone flourish.

Because the priorities behind the presidential administration's health care reform plans do not address perverse incentives in the current health care system — indeed, they often worsen these incentives — health reforms based on these concepts would have a significant negative economic impact.

new problems, such as the possibility that the term "best practices" will come to indicate practices that are politically, rather than medically, best. The more effective policy, which should be apparent by now, would be to address the problem directly by correcting the perverse incentives that are causing the inefficient result.

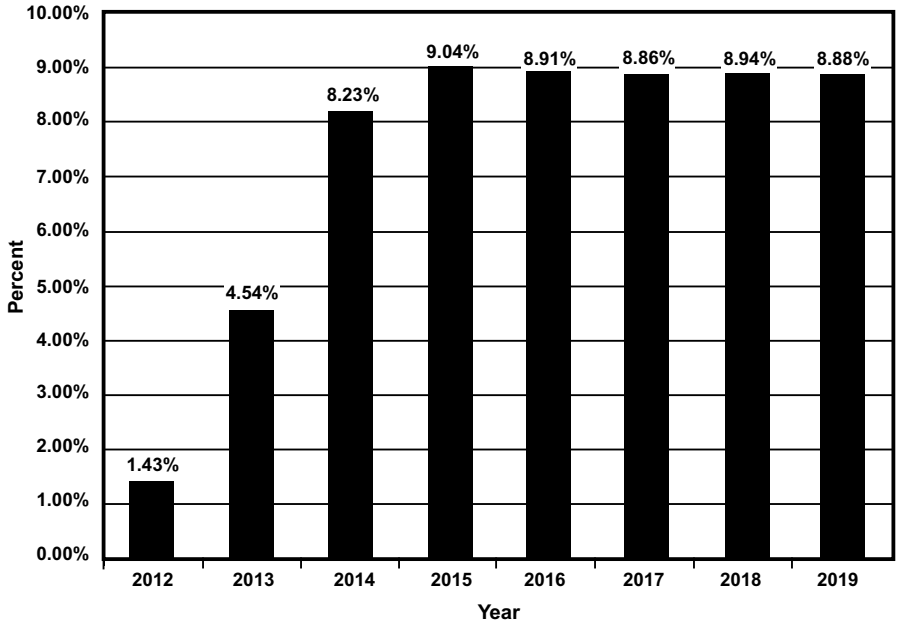
QUANTIFYING THE POTENTIAL ECONOMIC IMPACTS

Because the priorities behind the presidential administration's health care reform plans do not address perverse incentives in the current health care system — indeed, they often worsen these incentives — health reforms based on these concepts would have a significant negative economic impact. To quantify these impacts, we focus on each of these aspects of the reform proposal:

- It would create another public health care option that will directly compete with private health insurers.
- It would establish a mandate requiring all individuals to obtain health insurance coverage.
- It would create a health care exchange.

We base our analysis on the CBO's assessment of the Kennedy health care plan mentioned above. Because it is unlikely that the Kennedy plan as currently written will be the final health care reform bill, we modify the CBO's analysis to reflect the impact on the health care reform market from a cumulative $1.0 trillion in health care subsidies spent over the next 10 years. We assume that this

Figure 16
Additional Increase in Health Care Expenditures Stemming From Increased Health Care Subsidies 2012–2019[49]



$1.0 trillion figure will be spent in a similar manner, with similar timing, and with 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. (See Figure 14.) 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 perverse incentives driving health care cost inflation. Consequently, reforms based on the president's priorities would not only prove costly and ineffective at achieving his goals, they would actually aggravate current problems with the health care system. Expanding coverage in this manner would worsen existing incentives by increasing the number of dollars spent that are insensitive to costs.

Finkelstein (2007) demonstrated that, historically, health care expenditures increase rapidly when medical consumers are insulated from the financial costs of using the medical system (connection rate).[50] We estimate that increased government subsidies would reduce the expected connection rate by approximately

Expanding health insurance coverage fails to address the fundamental perverse incentives driving health care cost inflation.

Figure 17
Additional Increase in Medical Inflation
Stemming From Increased Health Care Subsidies
2012–2019[51]

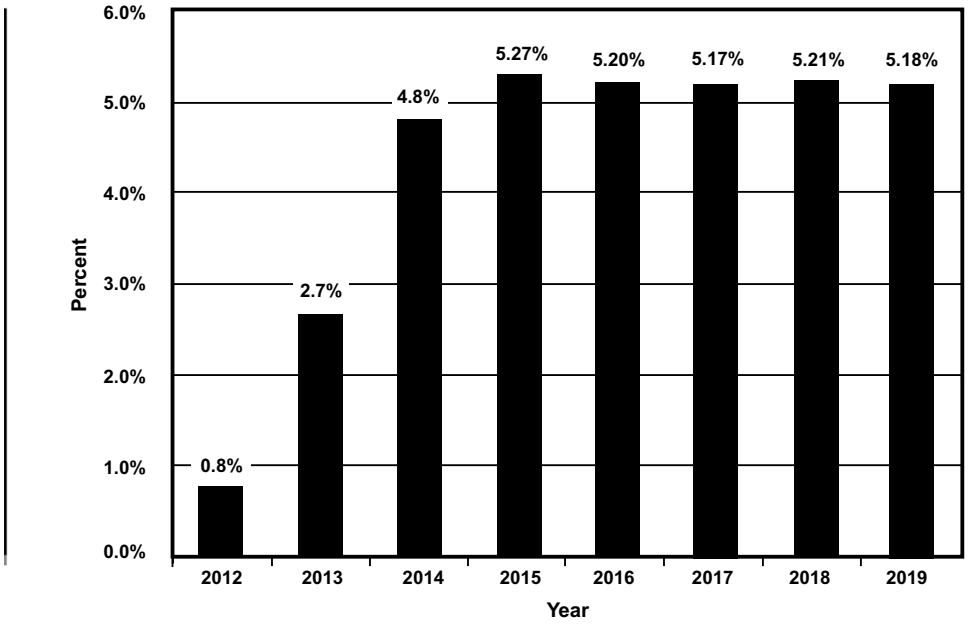
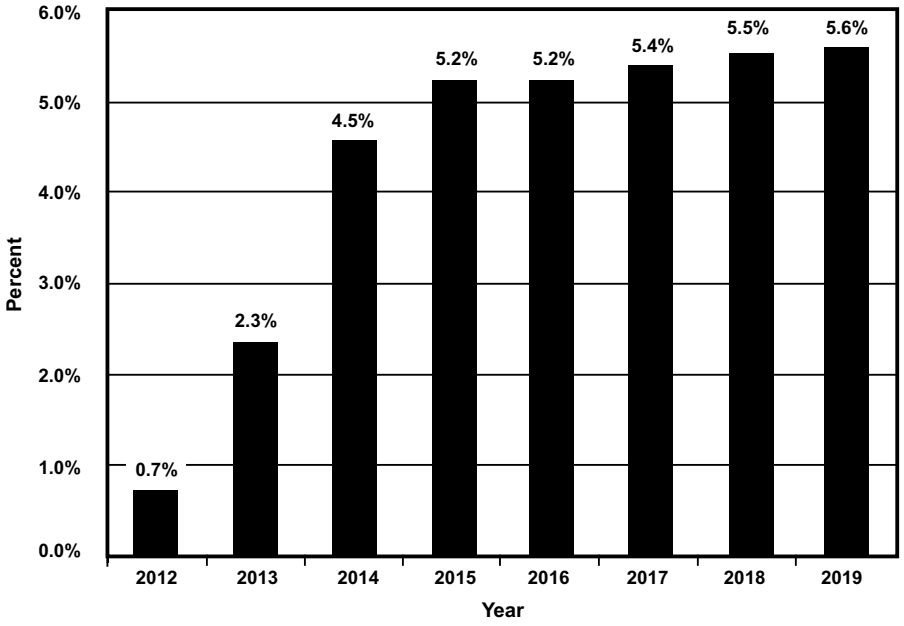


Figure 18
Increase in Federal Government Expenditures as a Percentage of Total Estimated Government Expenditures Stemming From Increased Health Care Subsidies 2012 – 2019[52]



Health care reform that does not directly address the perverse incentives of the health care system will merely trade one set of bad alternatives for another.

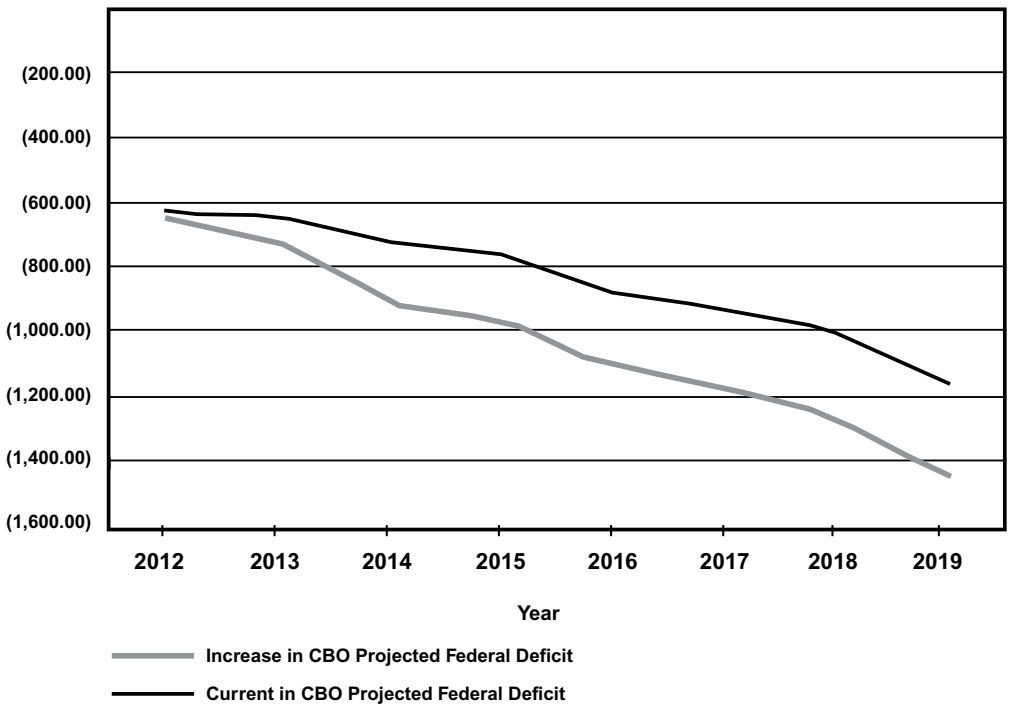
one percentage point. Figure 15 illustrates a year-by-year breakdown of changes in the connection rate stemming from the new government subsidies.

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), total medical expenditures would actually accelerate because of the reduced connection rates (and the additional perverse incentives created by the lower connection rates). 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 when compared to the baseline expenditures if Obama-style health care reforms were implemented. Note that such increases are the exact opposite of that predicted by the proponents of the president's health care priorities.

This impact illustrates how health care reform that does not directly address the perverse incentives of the health care system will merely trade one set of bad alternatives for another.

In this case, if we assume $1.0 trillion in government subsidies, an additional 13.3 million individuals would have health insurance who otherwise would not have had it — albeit at a high cost. It would accelerate health care expenditures that further inflate health care prices, increase pressure on federal and state budgets, reduce workers' wage growth, and lower overall economic growth.

Figure 19
Increase in Federal Government Deficit with Increased Health Care Subsidies Compared to Current Expected Federal Government Deficit 2012–2019 (billions $)[53]



A more fruitful approach would address the root cause of the problem first — the perverse incentives that currently drive excessive growth in health care expenditures. Only when this problem is addressed can the larger insurance problem be solved without transferring the costs from one group to another.

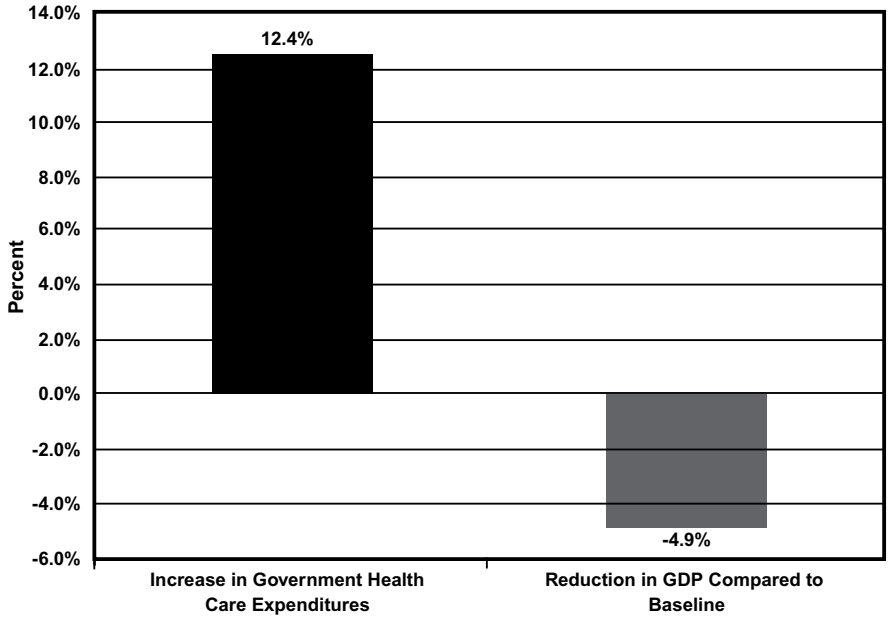
The increase in health care expenditures represents a shift out in the demand for medical services, but does not change any incentives that would simultaneously increase the supply of medical services. Rising demand in the face of stable supply leads to increasing prices. The historic relationship between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

Higher health care expenditures would also have disagreeable effects on federal and state budgets. Figure 18 shows total federal government expenditures increasing by more than 5.5 percent of total federal expenditures, including direct expenditures for the new subsidies, plus the higher Medicare, Medicaid, and SCHIP expenditures that would accompany higher medical costs.

The additional government expenditures would need to be financed either through higher taxes or through higher federal government deficits. Based on the CBO's expectation that the government deficit would increase

The increase in health care 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.

Figure 20
Reduction in GDP and Increase in Government Health Care Expenditures by 2019 Stemming From Cumulative Impact of Increased Health Care Subsidies, Compared to Baseline Scenario[54]



By 2019, Obama-style health care would shrink economic activity (GDP) by 4.9 percent compared to the baseline scenario.

over this period, we assume that these additional expenditures will simply increase the deficit dollar for dollar. As illustrated in Figure 19, this implies that by 2019, the federal budget deficit would be $285.6 billion larger (24.6 percent greater than it would have been without the health care reform). The present value of the total additional federal spending that would occur based on the president's health care 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 that would result from increased government intervention in the health care market. It compares the cumulative increase in government health care expenditures following reforms based on the president's health care reform priorities to the total reduction in economic output these reforms would cause.

Meanwhile, the proposed reform would crowd out private economic activity from the higher taxes and larger federal deficit that would be 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. 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 MISSOURI

Health care reforms based on the president's expressed priorities would affect each state differently. Missouri,

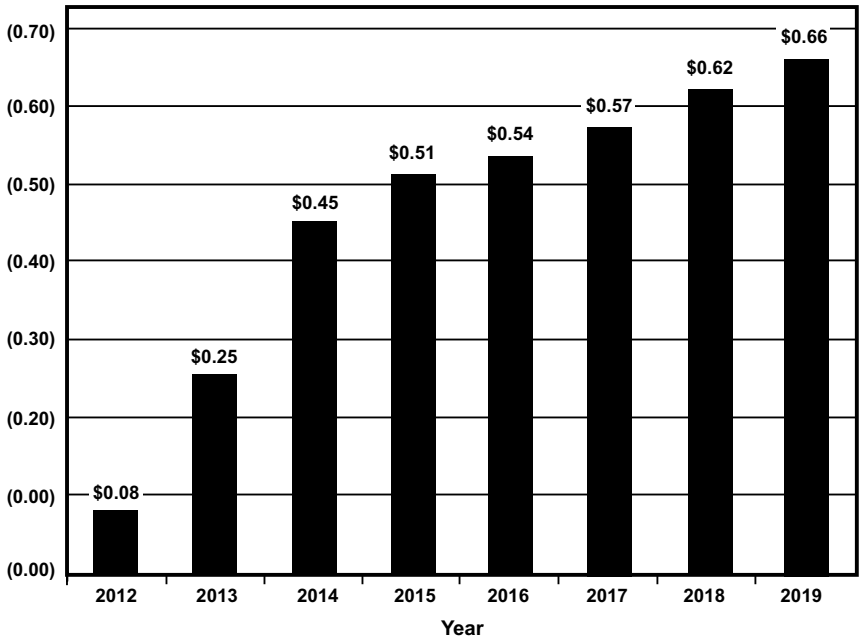
specifically, would experience lower overall economic activity, as well as increased fiscal pressures on the state budget. In assessing the impact of Sen. Kennedy's proposed health care reform, the CBO declares that:

… although the proposal would not change federal laws regarding Medicaid and CHIP, it would affect outlays for those programs. CBO assumes that states that had expanded eligibility for Medicaid and CHIP 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 Missouri'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 $1.0 trillion range.

The Senate HELP plan would currently force states to expand Medicaid eligibility to 150 percent of the poverty level, as well — without compensating them for the increased expenditures. Should that proposal pass, the CBO

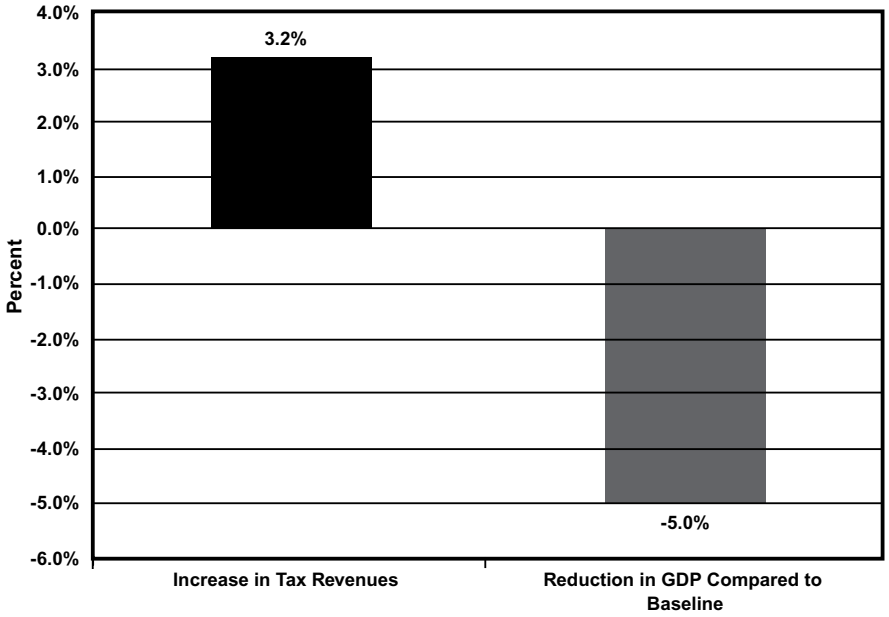
Figure 21
Additional Non-Federally-Funded Missouri State Government Expenditures Stemming From Increased Health Care Subsidies 2012–2019 (in billions)[55]



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 Missouri's ability to manage its growing Medicaid costs.

The present value of the nonfederally-funded additional health care expenditures that the Missouri state government would have to pay, if a health care reform based on the president's health care reform priorities were passed, is $2.8 billion — or $481 for every resident in Missouri.

Figure 22
Reduction in Missouri GDP and Increase in Missouri Health Care Expenditures by 2019 Stemming From Cumulative Impact of Increased Health Care Subsidies, Compared to Baseline Scenario[56]



estimate of total national Medicaid costs suggests that Missouri could be forced to spend an additional $9 billion based on current spending patterns, assuming that 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 Missouri 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 health care expenditures that the Missouri state government would have to pay, if a health care reform based on the president's health care reform priorities were passed, is $2.8 billion — or $481 for every resident in Missouri. Figure 21 illustrates the annual increased medical expenditures that Missouri would have to pay. These additional expenditures would need to be paid for through either higher taxes or spending cuts elsewhere in the budget.

All told, combining per-person federal costs with per-person Missouri costs, the present value of new government expenditures would cost every resident in Missouri $4,382.

While this figure would hold true regardless of which level of government — federal or state — picks up the costs for expanding Medicaid, the source of funding for Medicaid expansion will have a major impact on the Missouri state budget.

Regardless of the funding mechanism, Missouri taxpayers and the Missouri economy would suffer from the heavy costs imposed under these health care proposals. The economic impact on Missouri illustrated in Figure 22 is similar to the national impact in Figure 20. Missouri's economy would shrink by 5.0 percent. This is slightly more than the expected impact on the national economy.

Additionally, because Missouri does not have the option of running trillion-dollar deficits, Figure 22 illustrates the cost of the additional $0.66 billion in health care expenditures as a percentage of total tax revenues. Missouri's tax collections would have to be 3.2 percent larger in order to cover the additional $0.66 billion in health care expenditures in 2019. Again, this number does not include the additional cost to Missouri of expanding Medicaid if the federal government were to fail to pick up the tab.

CONCLUDING THOUGHTS

The core problem behind the current crisis in the U.S. health care system entails poor incentives for patients and medical providers to increase health care quality and decrease its costs. In fact, consumers and medical providers have the opposite incentives, because of issues such as defensive medicine or burdensome government regulations that thwart the development of comparative effectiveness research.

This results in skyrocketing health care 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. economy and underscore the importance of truly effective health care reform.

An effective approach to reforming the health care system would begin by addressing the perverse incentives that have driven the unsustainable rise in health care expenditures. Reforms based on President Obama's stated priorities fail to do this. Instead, those goals, if adopted, would exacerbate existing problems with the health care system, causing total national health care expenditures and health care inflation to increase. Lower economic growth and increased government deficits would result.

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

Reforming the problems with the current U.S. health care system is too important to do incorrectly. The guiding principle of beneficial health care reform should be that the current third-party/government-driven health care 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 health care providers and patients, but also adds to the overall cost of providing health care. This complexity is also responsible for much of the

Reform undertaken in the Obama manner would render Missourians poorer and their state government (along with the federal government) sorely pressed for needed revenues to fund the reforms.

Health care reform based on the president's priorities would exacerbate the current inefficiencies in the health care system. If implemented, they would significantly harm U.S. health care provision, patient welfare, and the economy overall.

waste in the system, which amounts to an estimated 30 percent of health care spending.

Rather than expanding the role of government in the health care market, Congress should reform health care by implementing a patient-centered approach that focuses on the patient-doctor relationship and empowers both the patient and the doctor to make effective and economical health policy choices. A patient-centered health care reform model 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 empower individuals to monitor their health care 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 health care 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.

Health care reform based on the president's priorities would exacerbate the current inefficiencies in the health care system. If implemented, they would significantly harm U.S. health care provision, patient welfare, and the economy overall.

By empowering patients and doctors to manage health care decisions, patient-centered health care reform not only would directly address the distortions weakening our current health care system, but it would simultaneously control costs, increase heath outcomes, and improve overall health care efficiency .

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[53] ALME calculations based on CBO estimates of federal budget between 2012 and 2019, based on President Obama's 2010 budget submission.

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About the Show-Me Institute

The Show-Me Institute is a research and educational institute dedicated to improving the quality of life for all citizens of Missouri.

The institute's scholars study public policy problems and develop proposals to increase opportunity for ordinary Missourians. The Institute then promotes those solutions by publishing studies, briefing papers, and other educational materials. It also forms constructive relationships with policymakers and the media to ensure that its research reaches a wide audience and has a major impact on public policy.

The work of the institute is rooted in the American tradition of free markets and individual liberty. The institute's scholars seek to move beyond the 20th-century mindset that every problem has a government solution. Instead, they develop policies that respect the rights of the individual, encourage creativity and hard work, and nurture independence and social cooperation.

By applying those principles to the problems facing the state, the Show-Me Institute is building a Missouri with a thriving economy and a vibrant civil society — a Missouri that leads the nation in wealth, freedom, and opportunity for all.

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