

# Policy Analysis

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## *Halfway to Where? Answering the Key Questions of Health Care Reform*

by Michael Tanner

### Executive Summary

Although neither the House nor the Senate passed a health care bill by President Obama's August deadline, various pieces of legislation have made it through committee, and they provide a concrete basis for analyzing what the proposed health care reform would and would not do. Looking at the various bills that are moving on Capitol Hill, we can determine the following:

- Contrary to the Obama administration's repeated assurances, millions of Americans who are happy with their current health insurance will not be able to keep it. As many as 89.5 million people may be dumped into a government-run plan.
- Some Americans may find themselves forced into a new insurance plan that no longer includes their current doctor.
- Americans will pay more than \$820 billion in additional taxes over the next 10 years, and could see their insurance premiums rise as much as 95 percent.

- The current health care bills will increase the budget deficit by at least \$239 billion over the next 10 years, and far more in the years beyond that. If the new health care entitlement were subject to the same 75-year actuarial standards as Social Security or Medicare, its unfunded liabilities would exceed \$9.2 trillion.
- While the bills contain no direct provisions for rationing care, they nonetheless increase the likelihood of government rationing and interference with how doctors practice medicine.
- Contrary to assertions of some opponents, the bills contain no provision for euthanasia or mandatory end-of-life counseling. The bills' provisions on abortion coverage are far murkier.

In short, Americans will pay more and get less. Whatever the variation, however these bills are merged or compromised, this would be bad news for Americans.

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## **Introduction**

Contrary to President Obama's wishes, neither the House nor the Senate passed health care reform before adjourning for the annual August recess. Still, after months of debating concepts and abstractions, there now is actual legislation to consider. To be more accurate, there are at least three very different bills to consider. In the House, a bill drafted by the Democratic leadership, HR 3200, has cleared three important committees, with slightly different variations. Those three variations will eventually have to be combined into a single bill before the House finally votes. And even though the differences are not large, splits in the Democratic caucus will make it difficult to find agreement on those differences.

Meanwhile in the Senate, the Health, Education, Labor, and Pensions (HELP) Committee has passed a bill that, while structurally similar to the House bill, differs in many important details.<sup>1</sup> A third bill, being drafted by the Senate Finance Committee, is considered the best candidate to receive some bipartisan support. However, that bill is still being negotiated by a small group of senators, and has not even been put in final form, let alone come to a vote (although its basic shape has been leaked to the media).

The basics of the bills have been known for some time.<sup>2</sup> Coverage would be mandated, both for employers and individuals. Exchanges would be established to both regulate the insurance markets and facilitate consumer access to those markets. Most versions would set up a government-run plan to compete with private insurers. Theoretically, people could choose either private insurance or the public plan. The government would undertake comparative-effectiveness and cost-effectiveness research on medical treatments and would use the results of that research to impose practice guidelines on providers, initially in government programs such as Medicare and Medicaid, but possibly eventually extending such rationing to private insurance plans as well. Private insurance would face a host of new reg-

ulations, including a requirement to insure all applicants and strict limits on pricing premiums on the basis of risk. Subsidies would be available to help low- and middle-income people purchase insurance.

But having actual legislative language allows us to move beyond the above generalities.

For example, we have long suspected but now know that all three bills would be hugely expensive. Although final Congressional Budget Office scoring has not been released on any of them, it is generally estimated that the House bill will cost roughly \$1.3 trillion over the next 10 years, while the Senate HELP bill would cost in excess of \$1 trillion.<sup>3</sup> Senators negotiating the Finance Committee bill are hoping that its final price tag will be about \$900 billion.<sup>4</sup>

We also know that, while all of the bills would significantly expand the number of Americans with health insurance, none of them actually achieves universal coverage. The House bill,<sup>5</sup> for instance, would leave 16-17 million Americans uninsured.<sup>6</sup> The Senate HELP bill would fall even shorter, leaving 37 million uninsured.<sup>7</sup>

Additionally, the answers to several other important questions are now becoming clearer.

## **Will You Be Able to Keep Your Current Coverage?**

Roughly 85 percent of Americans currently have health insurance, and 81 percent of those are satisfied with their current coverage.<sup>8</sup> As a result, President Obama has gone to great pains to reassure people, "If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what."<sup>9</sup>

White House spokesmen backpedaled from the claim, noting that the president's remarks were not meant to be taken literally.<sup>10</sup> That is a good thing because, under all three proposed bills, millions of Americans would not be able to keep their current coverage.

## Mandates and Mandated Benefits

First, all three bills contain an individual mandate, a legal requirement that every American obtain adequate health insurance coverage. Those who do not receive such coverage through government programs, their employer, or some other group would be required to purchase individual coverage on their own. Those who fail to do so would be subject to fines or other penalties. Under the House bill, the penalty would be a tax of 2.5 percent of the individual's income (up to a maximum of the average national insurance premium).<sup>11</sup> The Senate HELP bill would impose a flat penalty of \$750.<sup>12</sup>

Simply having insurance, however, is not necessarily enough to satisfy the mandate. To qualify, insurance would have to meet certain government-defined standards. For example, under the House bill, all plans would be required to cover hospitalization; outpatient hospital and clinic services; services by physicians and other health professionals, as well as supplies and equipment incidental to their services; prescription drugs, rehabilitation, and habitative services; mental health and substance abuse treatment; preventive services (to be determined by the Centers for Disease Control and Prevention and the United States Preventive Services Task Force); and maternity, well-baby, and well-child care, as well as dental, vision, and hearing services for children under the age of 21.<sup>13</sup> But that is not all. The bill also establishes a federal Health Benefits Advisory Committee, headed by the U.S. surgeon general, which will have the power to develop additional minimum benefit requirements (subject to final approval by the secretary of Health and Human Services).<sup>14</sup> There is no limit to how extensive those future required benefits may be.

In addition to the mandated benefits, there are also limits on consumer cost-sharing. For example, co-payments and deductibles cannot apply to preventive services, maximum out-of-pocket expenses cannot exceed \$5,000 for an individual or \$10,000 for a family, and the plan must be designed to provide benefits equal to at least 70 percent of the actuarial value of the plan if there was no cost-sharing.<sup>15</sup> The

Benefits Advisory Committee can change these limits.<sup>16</sup>

The minimum benefit requirements in the Senate bills are equally generous. The Senate HELP bill gives the secretary of HHS responsibility for designing the minimum benefits package but says that at a minimum it must include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services, and pediatric services.<sup>17</sup> The HELP bill also prohibits any annual or lifetime limits for coverage and prohibits more than "minimal" cost-sharing for preventive services.<sup>18</sup>

What does that mean to people who have health insurance today but whose policies do not satisfy the government's benefit requirements? Under the Senate HELP bill, they would be allowed to continue that coverage and even add family members to that coverage.<sup>19</sup> However, this grandfather clause may not be as solid as advertised because the new minimum benefit standards will kick in "if significant changes are made to the existing health insurance plan."<sup>20</sup>

Furthermore, the Senate HELP bill is vague about whether the grandfathered plans will have to meet the individual mandate requirements once those requirements are fully phased in after five years.<sup>21</sup> The sections of the bill containing the mandate language make no reference to grandfathered plans, a conspicuous omission. Thus, it appears that although people would be technically free to remain enrolled in their current noncomplying plan, they would still be subject to the tax penalty for failing to comply with the mandate. The House bill, in contrast, explicitly allows grandfathered individual policies to qualify in meeting the individual mandate requirement.<sup>22</sup> However, there is a question of whether grandfathered plans will continue to remain viable if they are not allowed to enroll new members.

And, if you currently receive insurance through work?

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**As with the individual mandate, employer-provided policies must meet the government's designated minimum benefit requirements.**

The House and Senate HELP bills include a similar mandate for businesses. The House version is particularly punitive, requiring employers with payrolls of more than \$250,000 (\$400,000 in the Energy and Commerce Committee's version) to pay 72.5 percent of the premium for individual coverage and 65 percent for family coverage, or pay a tax equal to 8 percent of their payroll.<sup>23</sup> The Senate HELP bill requires employers with more than 25 employees to pay at least 60 percent of the cost of workers' coverage or face a penalty of \$750 per full-time employee and \$375 per part-time worker.<sup>24</sup>

The Senate Finance Committee is reportedly discussing a somewhat milder, but ironically more regressive employer mandate. Employers who failed to provide workers with health insurance would have to pay the cost of all subsidies that the government provides to the employer's workers to help them pay for insurance on their own.

As with the individual mandate, employer-provided policies must meet the government's designated minimum benefit requirements. Current plans would be grandfathered, but for only five years under the House bill.<sup>25</sup> The Senate bill exempts plans negotiated under a collective bargaining agreement (that is, union plans) from the minimum benefit requirements for one year beyond the expiration of the current contract.<sup>26</sup> Other employer-provided plans are required to immediately come into compliance.<sup>27</sup>

It appears, therefore, that people with health insurance today will not immediately be forced to change policies in order to comply with the individual or employer mandates. However, over the long run, more and more Americans are likely to have to change policies to one that meets government specifications, even if the government-designed plan is more expensive or contains benefits that individuals do not want or may even be morally opposed to.<sup>28</sup>

#### **Dumped into the Public Option**

Both the House bill and the Senate HELP bill would establish a government-run insur-

ance plan that would compete with private insurance.<sup>29</sup> The danger of such a government-run plan is that it would encourage employers to dump workers from their current employer-provided plan into the government plan. The degree to which that would occur depends on how premiums, benefits, reimbursement rates, and subsidies are structured within the government plan.

For example, to the extent that the government plan is not required to be self-sustaining (that is, the degree to which it is subsidized by the taxpayers) it can keep its premiums artificially low. Both the House and HELP bills say that after its initial establishment (financed by a \$2 billion interest-free loan from taxpayers), the program would have to cover administrative and benefit costs entirely out of premium revenues.<sup>30</sup> The government program would also be required to maintain a reserve or "contingency margin," although the size of that reserve is not specified.<sup>31</sup>

However, there is ample reason to be skeptical about just how "self-sustaining" such a program will be. After all, Medicare Part B (physician services) was originally supposed to support 50 percent of its costs through premiums. That has shrunk to the point where premiums pay for less than 25 percent of the program's cost.

The government has myriad ways to prevent the true cost of the program from showing up in premium prices.<sup>32</sup> For example, the government-run plan will not have to pay state or federal taxes. Also, unlike private insurance plans that can be sued in state courts, the government-run plan could only be sued in federal court.<sup>33</sup> An amendment by Rep. George Radanovich (R-CA) to subject the government health plan to the same legal rules and standards as private health plans was defeated.<sup>34</sup>

At the very least, the program carries with it an implicit guarantee against future losses. Would a Congress that has bailed out banks and automobile companies because they are "too big to fail" resist subsidizing the government's insurance plan if it began to lose money? Even without an actual bailout, such an implicit guarantee has value—consider the

implicit guarantees behind Fannie Mae and Freddie Mac that were estimated to have saved those institutions \$6 billion per year.<sup>35</sup> Such savings would show up in premium prices, allowing the public plan to undercut private insurance pricing.

Second, there is the question of who would be eligible to participate in the government plan. Obviously, if the plan were open to everyone, the shift from private to public insurance would be far greater than if only small businesses or the currently uninsured could join.

Under the House bill, the government-run program would initially be open to workers who were currently uninsured and businesses with 20 or fewer workers. However, officials overseeing the health insurance exchanges would have the option of allowing larger firms to participate. The Senate bill opens the public option to everyone.

Finally, and perhaps most important, the way in which the public plan determines reimbursement rates for providers will be a key determinant of how it competes with private insurance. Government plans such as Medicare and Medicaid traditionally reimburse providers at rates considerably lower than those of private insurance. Providers recoup the lost income by shifting costs onto those with private insurance. Indeed, it is estimated that privately insured patients pay \$89 billion annually in additional insurance costs because of cost-shifting from government programs.<sup>36</sup> If one assumes that the new public option has similar reimbursement policies, it would both allow the public plan to keep its own premiums artificially low while simultaneously increasing costs and, therefore, premium prices for private insurance.

The Senate HELP bill allows the secretary of HHS to negotiate reimbursement rates but also requires that they be no higher in the aggregate than the average reimbursement rates for insurers who are selling policies through the national exchange.<sup>37</sup> The House bill requires reimbursement rates to be based on Medicare, plus 5 percent.<sup>38</sup> Assuming that Medicare reimbursements are on average

about 80 percent of provider costs, public plan reimbursements would still be below costs.

All of this means that the government-run plan would be significantly cheaper than private insurance, not because it would out-compete private insurance or because it was more efficient, but because it had unfair advantages. The lower cost means that businesses, in particular, would have every incentive to dump workers from their current health insurance plan into the government plan.

Estimates of how many people would ultimately be forced out of their current insurance and into the government plan vary widely. At the low end, the Congressional Budget Office suggests that about three million people would be involuntarily shifted to the government plan under the House bill. It bases this estimate on a premise that premiums in the government plan would be about 10 percent lower than private insurance and that the plan would be open only to employers with fewer than 50 employees.<sup>39</sup> On the other hand, the independent actuarial firm Lewin Associates assumes that the government plan premiums would be 20–25 percent below private insurance, and most importantly, that the government plan would be open to all employers. Under that scenario, they suggest, 89.5 million workers would be forced into the government plan.<sup>40</sup>

On the other hand, CBO estimates that premiums under the Senate HELP committee's government plan would not be appreciably lower than private insurance. As a result there would be a negligible shift from private to public insurance.<sup>41</sup> There have been no independent estimates of the impact of the government option under the HELP bill.

The Senate Finance Committee bill is not expected to contain a government-run plan. It will probably contain a proposal to establish a nationwide health care co-operative to compete with existing private insurance plans.<sup>42</sup> These aren't likely to be true co-ops. The members would not choose its officers—the president would. Plus, the secretary of HHS would have to approve its business plan, and thus could force it to offer whatever benefits, premiums,

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**Since the rules for HSAs require that they be accompanied by a high deductible plan, the result would be to end HSAs.**

and reimbursement schedules Washington wants. Finally, the federal government would provide start-up, and possibly ongoing, subsidies.<sup>43</sup> A “co-op” run by the federal government, under rules imposed by the federal government and with federal funding, is simply government-run health insurance by another name. Or, as Senate Majority Leader Harry Reid put it, “We’re going to have some type of public option, call it ‘co-op,’ call it what you want.”<sup>44</sup>

Thus an assessment of the co-op proposal’s impact on people’s ability to keep their current health insurance awaits final legislative language. If the Finance Committee brings forth something close to a true co-op, it will probably not have a significant impact on people keeping their coverage. But the more the co-op proposal resembles the type of public option called for in the House and HELP bills, the more Americans will be forced out of their existing plan and into the government-plan.

#### **Health Savings Accounts**

Roughly eight million Americans currently have a health savings account.<sup>45</sup> However, it seems unlikely that such plans could continue under any of the bills currently being considered.

Under the Senate HELP bill, insurance payouts must cover at least 76 percent of the plan’s benefits.<sup>46</sup> The House bill mandates that the insurance payout cover 70 percent.<sup>47</sup> The bills also require that all insurance cover preventive care, including annual physicals, prenatal and well-child, immunizations, smoking cessation, weight loss programs, and early screening services, on a first-dollar basis.

In theory, a high deductible plan designed to work with health savings accounts could meet those requirements if it had (a) a deductible no higher than the current high-deductible plan minimum (\$1,150 for an individual, \$2,300 for a family), (b) an out of pocket limit of exactly the same amount, and (c) first-dollar coverage of all mandated preventive care services. But, no current high-deductible plan would qualify under such a standard.<sup>48</sup> Moreover, a plan designed to those specifications would offer few if any advan-

tages over traditional insurance and would not be competitive in today’s markets. As a result, insurers warn they would stop offering high-deductible policies.<sup>49</sup> And since the rules for HSAs require that they be accompanied by a high deductible plan, the result would be to end HSAs.<sup>50</sup>

Reps. Mike Rogers (R-MI) and Phil Gingrey (R-GA) offered an amendment in the House Energy and Commerce committee that would have included high-deductible plans with HSAs in the bill’s definition of a “qualified health benefits plan.” It was defeated.<sup>51</sup>

#### **Medicare**

Approximately 10.2 million seniors, 22 percent of all Medicare recipients, are currently enrolled in the Medicare Advantage program, which allows Medicare recipients to receive their coverage through private insurance plans.<sup>52</sup> President Obama and many congressional Democrats have long been hostile to this program, and all three health care bills make significant changes in the program that could affect the ability of seniors to retain their current coverage.

In particular, the bills would change the way payments are calculated for Medicare Advantage. Currently Medicare Advantage programs receive payments that average 14 percent more than traditional fee-for-service Medicare,<sup>53</sup> something that Democrats have derided as wasteful.<sup>54</sup> However, the program also offers benefits not included in traditional Medicare, including preventive-care services, coordinated care for chronic conditions, routine physical examinations, additional hospitalization, skilled nursing facility stays, routine eye and hearing examinations, glasses and hearing aids, and more extensive prescription drug coverage than offered under Medicare Part D.<sup>55</sup>

All three bills essentially eliminate this differential in payments, cutting payments to Medicare Advantage programs to the level of traditional Medicare, a reduction in payments to Medicare Advantage payments of roughly \$156.3 billion over 10 years.<sup>56</sup> In response, many insurers are expected to stop participat-

ing in the program, while others increase the premiums they charge seniors. Analysis of similar proposals in the past have suggested that 1.5 to 3 million seniors could be forced out of their current insurance plan and back into traditional Medicare.<sup>57</sup>

Particularly hard hit would be minorities and seniors living in underserved areas. For example, nearly 40 percent of African-American and 54 percent of Latino seniors participate in Medicare Advantage, in part because lower-income seniors see it as a low-cost alternative to Medigap insurance for benefits not included under traditional Medicare.<sup>58</sup>

Thus, the president and Democratic leaders in Congress are clearly not telling the truth when they claim that you will be able to keep your current insurance. Any way you look at it, under the bills currently before Congress, millions of Americans will be forced out of their current health insurance plans, even if they are happy with them.

## **Will You Be Able to Keep Your Doctor?**

Those Americans forced to change insurance plans, and especially those who are forced into the government-run plan, may also not be able to keep their current doctor. As employers try to bring their health plans into compliance with the minimum benefits package over the next five years (see above), they may well shift insurance carriers. As a result, Dallas Salisbury, of the Employee Benefits Research Institute, warns, “Your doctor may no longer accept your insurance.”<sup>59</sup>

The risk for those pushed into the government plan is even greater. There is no requirement that physicians participate in the government plan. Whether they will choose to do so will depend in large part on reimbursement rates. Low reimbursement rates are already driving physicians out of the Medicare and Medicaid programs. In 2008, for instance, over 33 percent of physicians had closed their practices to Medicaid patients and 12 percent had closed their practices to Medicare patients.<sup>60</sup>

As noted above, the House bill requires reimbursement rates to be based on Medicare, plus 5 percent, while the Senate HELP bill allows the secretary of HHS to negotiate reimbursement rates.<sup>61</sup> As a result, we should expect physician nonparticipation in the government-run plan to be at least as high as it is for Medicare. Therefore, those Americans forced into the government plan may find that their doctor is not available under that plan.

Similarly, seniors forced out of Medicare Advantage plans and back into traditional Medicare may encounter problems if their doctor does not participate in traditional Medicare. This problem may be particularly acute in states such as Texas, where as many as 42 percent of physicians do not accept new Medicare patients.<sup>62</sup>

All of this could be made still worse if Congress adopts some of the Medicare reimbursement cuts being considered as a way to pay for the reforms. In a survey looking at previous proposals for reductions in Medicare reimbursements, 39 percent of physicians said they would limit how many Medicare beneficiaries they treat, and 19 percent said they would not accept new patients on Medicare.<sup>63</sup>

Both the Senate HELP and House bills envision roughly \$500 billion over 10 years in Medicare reductions.<sup>64</sup> While much of these savings are supposed to be generated through increased efficiencies, it also envisions lower reimbursements for at least some Medicare services. For example, the House bill calls for \$196 billion in savings through a permanent reduction in reimbursement rates.<sup>65</sup> Most if not all of those reductions may be offset by the elimination of a 21 percent reimbursement reduction currently scheduled under the program’s “sustainable growth rate” (SGR) formula.<sup>66</sup> However, Congress likely would prevent those cuts (as they have in each of the past several years) even in the absence of health reform. Indeed, President Obama’s proposed 2010 budget made just such an assumption.<sup>67</sup> Therefore any discussion of the impact of reform on physician income should be based on a baseline that assumes an SGR correction.

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And, whereas you may be able to keep your doctor, you may have more difficulty in getting in to see him. Lewin Associates estimates that under the House bill physician income would decline by \$13.4 billion in the first year alone, a decline of 6.3 percent or almost \$20,000 per physician.<sup>68</sup> This could result in doctors devoting less time to individual patients.

The Massachusetts health reform plan enacted in 2006 is in many ways similar to the current congressional proposals, and provides a useful warning of how attempts to limit physician income can reduce physician availability.<sup>69</sup> Reports suggest that as the state responds to the rising cost of its health care reform by ratcheting down on reimbursements, a number of physicians are limiting their practice or refusing to accept new patients.<sup>70</sup> The inevitable result of increased demand chasing a finite supply has been shortages. In Massachusetts, the impact has been small so far. In 2007, 4.8 percent of state residents reported forgoing care because they could not find a doctor or get an appointment, an increase of 1.3 percentage points since the legislation was signed. For low-income residents, the problem was slightly worse: 6.9 percent could not find a doctor or get an appointment, a 2.7 percentage point hike since 2006.<sup>71</sup> Waiting times were a somewhat bigger problem, with the wait for seeing an internist, for example, increasing from 33 days to 52 days during the program's first year.<sup>72</sup> In the future, the problems are expected to grow worse.

President Obama has repeatedly pledged that “if you like your doctor, you can keep your doctor.”<sup>73</sup> The reality, however, is not quite that simple. At the very least, many Americans are apt to find themselves with a longer wait to see their doctor, and some may be dropped by their doctor altogether. Others may find that they have been forced into a health care plan that does not include their doctor.

## **Will You Pay More?**

The president has promised that health care reform would save the average American

money.<sup>74</sup> However, the evidence suggests that many, if not most, Americans will end up paying more, both in higher taxes and higher insurance premiums.

### **Taxes**

Final CBO scoring is not yet available for any of the bills, which means Congress is voting on bills without knowing how much they will cost. However, preliminary scoring suggests that the House bill would cost \$1.3 trillion over the next 10 years, while the Senate HELP bill would cost at least \$1 trillion over the same period.<sup>75</sup> The fiscally conservative “Blue Dog” Democrats on the House Energy and Commerce Committee added amendments that they claim will reduce the bill's cost by approximately \$100 billion, although those changes have not yet been incorporated in other versions of the House bill.<sup>76</sup> The Senate Finance Committee negotiators claim that their bill will only cost some \$900 billion over 10 years, but that is impossible to verify since there is no bill yet.<sup>77</sup>

The House bill finances most of the cost through a \$583 billion tax increase on individuals earning more than the “floor level” of \$280,000 per year and families with incomes above \$350,000. A progressive income tax surtax would begin at 1 percent for incomes above the floor level, rising to 1.5 percent for incomes between \$500,000 and \$1 million, and jumping to 5.4 percent for incomes over \$1 million.<sup>78</sup> However, the legislation also contains a trigger so that if some of the anticipated savings in other areas of the bill fail to materialize, the surtax would automatically rise to 2 percent for incomes above the floor, and 3 percent for incomes between \$500,000 and \$1 million. The tax would remain at 5.4 percent for incomes over \$1 million.<sup>79</sup>

Combined with President Obama's plan to allow President Bush's tax cuts to expire, the surtax would push the top marginal tax rate in 39 states to more than 50 percent.<sup>80</sup> (See Table 1.)

The top marginal tax rate in the United States would be higher than in notoriously high-tax countries like France, Italy, Spain,



**Table 1**  
**Marginal Tax Rate by State from HR 3200**

|             |        |           |        |               |        |                |        |               |        |
|-------------|--------|-----------|--------|---------------|--------|----------------|--------|---------------|--------|
| Alabama     | 49.67% | Hawaii    | 57.22% | Massachusetts | 52.05% | New Mexico     | 51.69% | South Dakota  | 47.25% |
| Alaska      | 47.25% | Idaho     | 54.32% | Michigan      | 51.59% | New York       | 56.92% | Tennessee     | 47.25% |
| Arizona     | 51.36% | Illinois  | 49.97% | Minnesota     | 54.36% | North Carolina | 54.27% | Texas         | 47.25% |
| Arkansas    | 53.65% | Indiana   | 51.38% | Mississippi   | 51.78% | North Dakota   | 51.65% | Utah          | 51.78% |
| California  | 56.58% | Iowa      | 51.61% | Missouri      | 52.79% | Ohio           | 54.27% | Vermont       | 55.36% |
| Colorado    | 51.44% | Kansas    | 53.09% | Montana       | 50.48% | Oklahoma       | 52.23% | Virginia      | 52.46% |
| Connecticut | 51.78% | Kentucky  | 53.37% | Nebraska      | 53.45% | Oregon         | 57.54% | Washington    | 47.25% |
| Delaware    | 53.69% | Louisiana | 50.05% | Nevada        | 47.25% | Pennsylvania   | 51.16% | West Virginia | 53.14% |
| Florida     | 47.25% | Maine     | 53.46% | New Hampshire | 47.25% | Rhode Island   | 56.22% | Wisconsin     | 54.27% |
| Georgia     | 52.69% | Maryland  | 55.61% | New Jersey    | 55.46% | South Carolina | 53.59% | Wyoming       | 47.25% |

Source: Tax Foundation, Fiscal Facts no. 178, July 14, 2009.

and Germany. In fact, only three economically developed countries would have a higher rate. Taxpayers in the six highest taxed U.S. states would pay higher rates than every industrialized country except Denmark.<sup>81</sup>

If that were not bad enough, many of those forced to pay the new surtax would not be wealthy individuals but small businesses that file as sole proprietorships and subchapter S corporations whose owners pay the individual rate. In fact, nearly 60 percent of those affected by the surtax have at least some small business income.<sup>82</sup>

In addition, as mentioned above, the House bill would impose an 8 percent payroll tax on businesses that fail to provide their workers with health insurance, and a 2.5 percent income tax penalty on individuals who fail to obtain insurance. The CBO says the business tax penalty will yield \$163 billion in revenue over 10 years, while the individual penalty will provide another \$29 billion.<sup>83</sup> The House bill imposes a number of additional business taxes, mostly dealing with income that U.S. corporations earn from overseas operations.<sup>84</sup>

All of these tax increases together total more than \$800 billion, making this bill the largest tax increase in U.S. history in inflation-adjusted dollar terms.<sup>85</sup> As a percentage of GDP, it would be the fifth largest tax increase since 1968.<sup>86</sup>

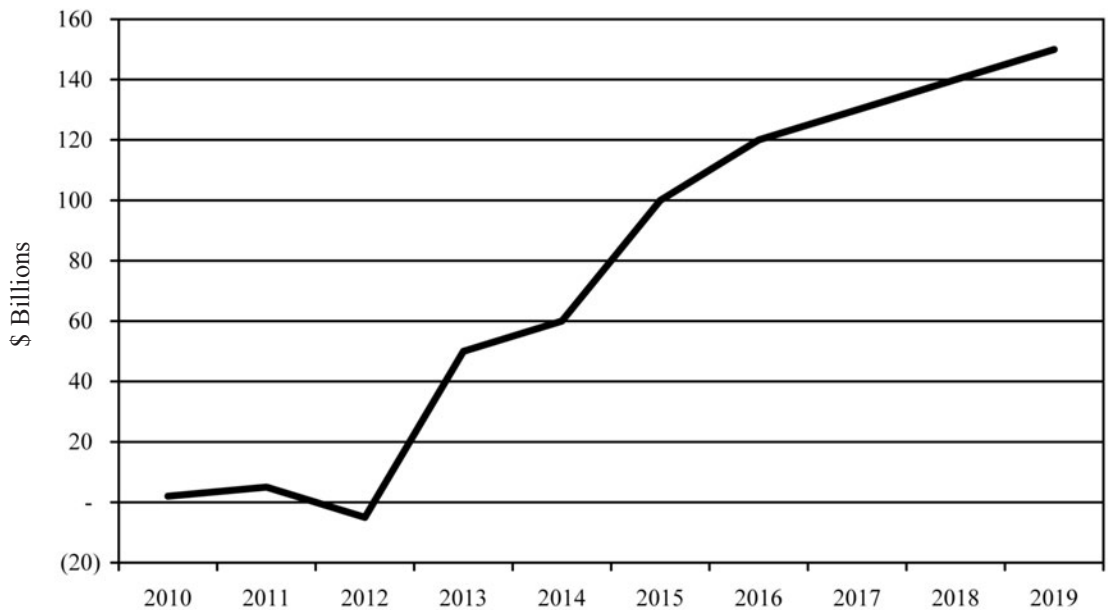
The Senate HELP bill does not include any financing mechanisms, and the Senate Finance

Committee has not released any language on financing. However, news reports suggest that they are looking at a variety of new taxes, including taxes on soft drinks and beer, taxes on employer-provided health benefits, restricting or eliminating flexible spending accounts and health savings accounts, and eliminating the deductibility of health expenses above 7.5 percent of adjusted gross income. At one point, White House budget director Peter Orszag and members of the Finance Committee reportedly “flipped through the tax code looking for ideas.”<sup>87</sup>

As large as the projected tax increases are, they likely understate both the actual cost of the final bill and the amount of taxes required to fund it. CBO scores cover a 10-year period, in this case 2010–2019. However, most provisions of health care reform will not take effect until 2013. As a result, what is commonly reported as a 10-year cost for the bills actually includes only seven years of cost. In fact, only \$8 billion of cost is in the first three years and only \$77 billion in the first four years, leaving more than 90 percent of the cost over the last six years. (See Figure 1.)

The CBO does not provide formal budget analysis beyond the 10-year window. However, since program costs will be on an upward trajectory through 2019 (Figure 2), it expects the cost of the program to continue growing rapidly after 2019. But even if program costs were miraculously flat after 2019, the legisla-

**Figure 1**  
**Spending in HR 3200**



Source: Congressional Budget Office.

tion would cost roughly \$2 trillion during its second 10 years of operation, roughly double the cost of its first decade.

It is unrealistic to believe that these growing costs can be paid for only through taxes on the “rich.” According to calculations by Jagadeesh Gokhale of the Cato Institute and Kent Smetters of the Wharton School, funding health care reform solely through taxes on households making \$200,000 or more per year would require permanently increasing their annual total tax payments by about 50 percent. That would be nearly impossible even if it were the only future obligation the country faced. But we are also facing growing budget debts and obligations aside from health care, not to mention the looming insolvency of Social Security and Medicare. Paying for all those obligations with taxes on only those earning more than \$200,000 per year (as President Obama has promised) would require a 328 percent increase in taxes on them. For many families earning between \$200,000 and \$500,000 per year, that tax increase would consume every penny they earned.<sup>88</sup>

The bottom line is that, despite promises being made today, taxes will eventually have to be raised for the middle class.

### **Premiums**

During the 2008 presidential campaign, then-candidate Obama promised that his health care reform plan would reduce premiums by up to \$2,500 per year.<sup>89</sup> That promise has long since been abandoned. However, without putting a dollar amount to it, the president continues to promise that health care reform will reduce insurance costs. While that may be true for those Americans receiving subsidies or those who are currently in poor health, millions of others will likely end up paying higher premiums.

First, as mentioned above, if the government-run plan reimburses providers at rates comparable to Medicare or Medicaid, there will be a significant cost-shift to private insurance. Lewin Associates estimates that such cost-shifting would add \$460 to the average annual insurance premium.<sup>90</sup>

More significant would be the impact of insurance regulatory changes imposed under

**Despite promises being made today, taxes will eventually have to be raised for the middle class.**

all three bills. Among these are requirements that insurers accept all applicants regardless of their health (guaranteed issue)<sup>91</sup> and that restrict the ability of insurers to base premiums on risk factors such as health or age (community rating).<sup>92</sup> For example, under both the House and Senate HELP bills, a 64 year old with a serious illness could be charged no more than twice the premium of a healthy 18 year old.

Although these regulatory changes may make health insurance more available and affordable for those with preexisting conditions and will reduce premiums for older and sicker individuals, it will also increase premiums for younger and healthier individuals. In fact, a study by the Council for Affordable Health Insurance suggests that premiums for some individuals could increase by 75 to 95 percent in states that do not now have guaranteed issue or community rating requirements.<sup>93</sup>

Finally, the additional benefits required under the standard minimum benefits package would add to the cost of policies that do not currently include those benefits. There is no way to know how much those requirements will increase premiums, since we do not know what those benefits will be. (As noted above, the legislation gives the federal Health Benefits Advisory Committee the power to determine the final benefits package.) However, experience at the state level suggests that the cost of mandating additional benefits ranges from 3 to 5 percent for dental care, to 10 percent or more for mental health or drug and alcohol treatment.<sup>94</sup>

For low- and some middle-income Americans, any increase in premiums will be offset by government subsidies. But individuals whose income falls in the range where subsidies begin to phase out and those not receiving subsidy will likely see significant premium hikes.

## Will It Increase the Deficit?

President Obama has repeatedly said that he would not sign a health care reform bill

that increases the federal deficit. However, both the House and Senate HELP bills add significantly to the deficit, both within the 10-year budget window, and far more significantly in the years beyond.

The Congressional Budget Office estimates that the House bill would increase the budget deficit by \$239 billion by 2019.<sup>95</sup> Beyond 2019, neither the offsets nor revenues contained in the bill would keep pace with the growing costs.<sup>96</sup> In fact, the CBO warns that “the proposal would probably generate substantial increases in federal budget deficits during the decade beyond the current 10-year budget window.”<sup>97</sup>

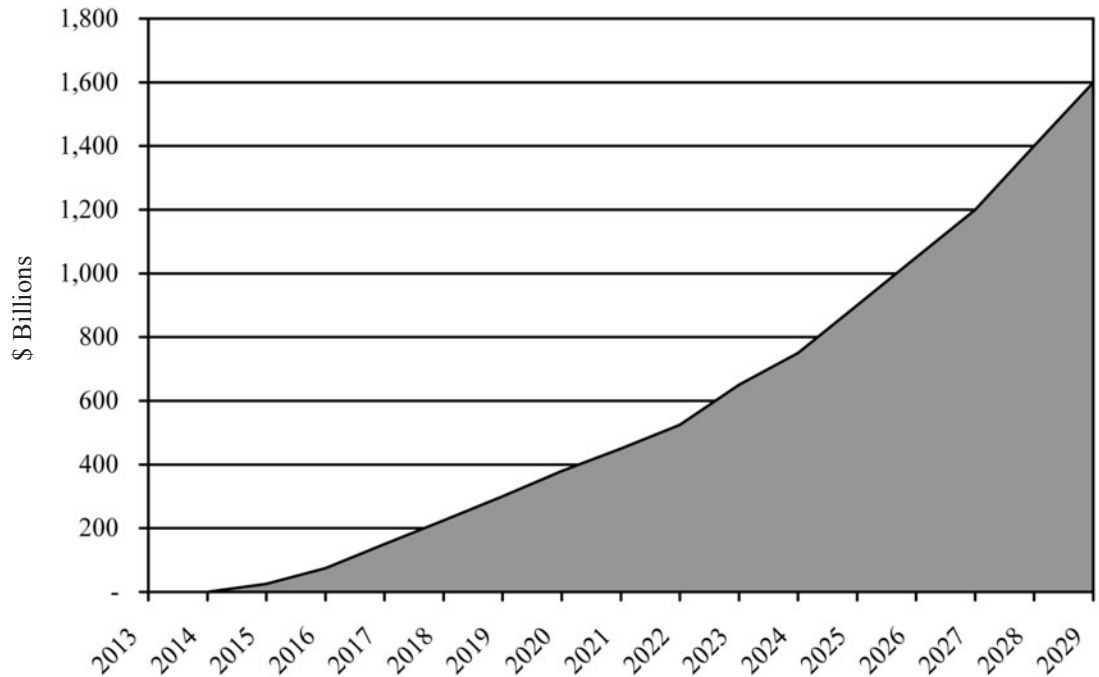
According to an analysis by minority staff of the House Ways and Means Committee, the deficit from the House bill would top \$760 billion by 2024, and reach an astonishing \$1.6 trillion by the end of the 2020s. (See Figure 2.)

Using the same 75-year actuarial period that the government applies to other entitlement programs such as Social Security and Medicare, the net present value of the program’s unfunded liabilities would exceed \$9.2 trillion. That would be on top of the cumulative \$51.3 trillion (discounted present value) unfunded liabilities in Social Security and Medicare.<sup>98</sup>

Of course, it is also worth noting that cost estimates for government programs have been wildly optimistic over the years, especially for health care programs. For example, when Medicare was instituted in 1965, it was estimated that the cost of Medicare Part A would be \$9 billion by 1990. In actuality, it was seven times higher—\$67 billion.<sup>99</sup> Similarly, in 1987, Medicaid’s special hospitals subsidy was projected to cost \$100 million annually by 1992, just five years later; it actually cost \$11 billion, more than 100 times as much.<sup>100</sup> In 1988, when Medicare’s home care benefit was established, the projected cost for 1993 was \$4 billion, but the actual cost in 1993 was \$10 billion.<sup>101</sup> If the current estimates for the cost of Obamacare are off by similar orders of magnitude, future deficits will be even larger.

**Using the 75-year actuarial period that the government applies to other entitlement programs . . . the net present value of the program’s unfunded liabilities would exceed \$9.2 trillion.**

**Figure 2**  
**Cumulative Increase in Deficit from HR 3200**



Source: House Ways and Means Committee minority staff.

### **Will Government Ration Care?**

There is no language in any of the bills that would directly ration care or allow the government to dictate how doctors practice medicine. There is no “death board” as Sarah Palin wrote about in her Facebook posting.<sup>102</sup> However, the legislation does set the stage for government interference in medical decisions and raises several reasons for concern.

Advocates for reform continue to speak of the need to reduce health care spending or to “bend the cost curve down.”<sup>103</sup> And it is true that the current trajectory of U.S. health care spending is unsustainable. We currently spend \$2.5 trillion per year for health care, or 17.5 percent of GDP.<sup>104</sup> Under current trends, that will increase to 48 percent of GDP by 2050.<sup>105</sup> Indeed, at that point, government health care programs like Medicare and Medicaid alone will consume 20 percent of GDP.<sup>106</sup>

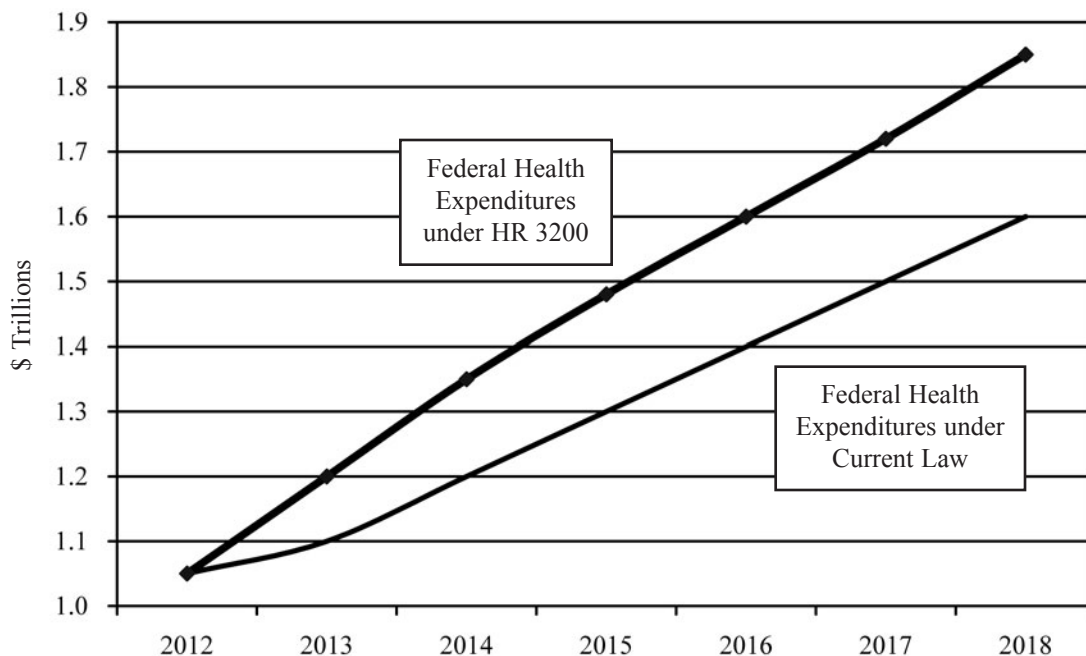
But, as noted above, the bills in Congress actually bend the curve in the opposite direction—upward. They increase spending. (See Figure 3.)

In the long run, the only way to spend less on health care is to consume less health care. And, since the current trajectory for health care spending is unsustainable, there is nothing inherently wrong with refusing to pay for some services or procedures, particularly with programs like Medicare and Medicaid. Indeed, there has been a certain amount of hypocrisy—or perhaps *schadenfreude*, given how often Republican health care reformers have been criticized for wanting to “slash Grandma’s Medicare”—in conservative complaints about Medicare cuts. Almost certainly any free market reform effort would also seek to reduce Medicare (and Medicaid) spending.<sup>107</sup>

The real health care debate, therefore, is not about whether we should ration care, but about who should ration it. Thus, while free-

**There is no “death board” as Sarah Palin wrote about in her Facebook posting.**

**Figure 3**  
**Raising the Cost Curve**



Source: Testimony of Douglas Elmendorf, director of Congressional Budget Office, on HR3200, before the Senate Budget Committee, July 14, 2009.

market health care reformers want to shift more of the decisions (and therefore the financial responsibility) back to the individual, there is reason to believe that the current reform legislation would ultimately put the government in charge of those decisions, if for no other reason than the fact that if most Americans are ultimately pushed into the government-run plan, that plan plus existing government programs such as Medicare and Medicaid will account for nearly all health care spending.

Indeed, this trend is already playing out in Massachusetts. With the cost of the state's reform becoming unsustainable, the legislature established a special commission to investigate the health payment system in a search for ways to control costs.<sup>108</sup> In March 2009, the commission released a list of options that it was considering, including "exclud[ing] coverage of services of low priority/low value" under insurance plans offered through Commonwealth Care. Along the same lines, it has also suggested that Commonwealth Care plans

"limit coverage to services that produce the highest value when *considering both clinical effectiveness and cost.*"<sup>109</sup>

This latter recommendation is particularly significant, since much of the debate about whether the government will ration care or interfere in the doctor-patient relationship revolves around the concepts of "comparative effectiveness" and "cost-effectiveness" research.

The House bill establishes a Center for Comparative Effectiveness Research within the existing Agency for Healthcare Research and Quality.<sup>110</sup> (That agency had previously been given \$1.1 billion to conduct comparative effectiveness research as part of the stimulus bill passed in February 2009.<sup>111</sup>)

Many health care reform advocates believe that much of U.S. health care spending is wasteful or unnecessary. Certainly it is impossible to draw any sort of direct correlation between the amount of health care spending and outcomes.<sup>112</sup> In fact, by some estimates as much as 30 percent of all U.S. health spending

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

produces no discernable value.<sup>113</sup> Medicare spending, for instance, varies wildly from region to region, without any evidence that the variation is reflected in the health of patients or procedural outcomes.<sup>114</sup> The Congressional Budget Office suggests that we could save as much as \$700 billion annually if we could avoid treatments that do not result in the best outcomes.<sup>115</sup> It makes sense, therefore, to test and develop information on the effectiveness of various treatments and technology.

The fear, however, is that comparative effectiveness research will not simply be used to provide information but to impose a government-dictated way of practicing medicine. The House bill prohibits the Center from “mandating coverage, reimbursement, or other policies of any public or private player.”<sup>116</sup> The research would initially be informative only. Still, there is no doubt that many reformers hope to ultimately use the information to restrict the provision of “unnecessary” care.

As the CBO notes, “To affect medical treatment and reduce health care spending in a meaningful way, the results of comparative effectiveness analyses would not only have to be persuasive but also would have to be used in ways that changed the behavior of doctors, other health professionals and patients.”<sup>117</sup> America’s Health Insurance Plans (AHIP) estimates that, if implemented on a purely voluntary basis, comparative effectiveness research would produce savings of only 0.3 percent in national health expenditures over 10 years.<sup>118</sup> The CBO estimates that voluntary implementation of comparative effectiveness research would reduce federal health spending by a mere “one one-hundredth of one percent” over the next 10 years.<sup>119</sup>

Therefore, if there is to be any significant cost savings, the results of the effectiveness research would have to be imposed on a mandatory basis in a way that proscribes treatments deemed not cost-effective. And many, including Obama health care adviser and former senator Tom Daschle, have suggested that Congress should “link the tax exclusion for health insurance to insurance that complies with [comparative effectiveness] recommendations.”<sup>120</sup>

National health care systems in other countries use comparative effectiveness research as the basis for rationing. For example, in Great Britain, the National Institute on Clinical Effectiveness makes such decisions, including the determination that certain cancer drugs are “too expensive.”<sup>121</sup>

During committee debates, several amendments were offered to prohibit the use of comparative effectiveness research to ration or deny care. All were rejected.<sup>122</sup>

Adding to the case that health care reform will lead to rationing, President Obama has called for the creation of a new Independent Medical Advisory Committee that would have sweeping power to recommend changes to Medicare, to the procedures that Medicare will cover and the criteria to determine when those services would be covered, provided its recommendations “improve the quality of care” or “improve the efficiency of the Medicare program’s operation.”<sup>123</sup> Once IMAC makes its recommendations, Congress would have 30 days to vote to overrule them. If Congress does not act, the secretary of Health and Human Services would have the authority to implement those recommendations “notwithstanding any provisions of this Act or any other provisions governing the Medicare program.”<sup>124</sup>

Whatever the merits of the proposal, it has not yet been incorporated in any of the bills before Congress. And, interestingly, the CBO does not believe that IMAC would actually be effective in reducing costs:

The probability is high that no savings would be realized . . . but there is also a chance that substantial savings might be realized. Looking beyond the 10-year budget window, CBO expects that this proposal would generate larger but still modest savings on the same probabilistic basis.<sup>125</sup>

CBO goes on to recommend that, if cost savings are truly the goal, the commission should be given even greater authority to impose reimbursement limitations and restrictions on care.<sup>126</sup>

In the end, however, the big question is not whether there will be rationing. Rationing exists under any system. Health care is a commodity, after all, and a finite one at that. There are only so many doctors, so many hospitals, and, most importantly, so much money to go around. The real health care debate, therefore, is not about whether we should ration care, but about *who* should ration it, and whether people will still be able to purchase a procedure even if the government denies coverage for it. In many government-run health care systems around the world, private contracting outside the government system is restricted or even prohibited.

The concern, therefore, is that once people are forced into the government-run plan, they will not be able to purchase services that are denied under that plan—or that the government would punish private insurers for going beyond government guidelines.

Responding to that concern, the House Education and Labor Committee approved an amendment by Rep. Tom Price (R-GA) that would ensure that patients could contract privately with doctors and other health-care providers, even if such procedures fell outside of the guidelines for health plans in the newly created national health-insurance exchange or the public-insurance option.<sup>127</sup> However, similar language has not been adopted for other versions of the bill.

In addition, even without direct rationing, health care reform could reduce the availability of some types of care. As mentioned above, both House and Senate HELP bills anticipate significant reductions in provider reimbursements. Hospital payments could fall by as much as \$67 billion per year.<sup>128</sup> There are also specific reductions in reimbursement for some services such as diagnostic imaging, which the administration believes are overused.<sup>129</sup> This would dry up investment capital for new medical technology. In the short term that means fewer MRI units or CT scanners available, leading to the type of waits seen in countries such as Canada. In the longer-term it means less investment in medical research, with significant implications for innovation.

## What's the True Story about Euthanasia and Abortion?

Not every criticism of the congressional health care reform bills has been on target.

For example, some have claimed that the bill encourages euthanasia for the elderly. At its most hysterical, these claims can be found in internet rumors and pamphlets claiming that the congressional bills would “pull the plug and decide a 24-year-old’s life was important and that an 85-year-old’s wasn’t.”<sup>130</sup> More mildly, former New York lieutenant governor Betsy McCaughey wrote in the *Wall Street Journal* that the House bill would require “end-of-life” counseling for seniors. The counseling, she wrote, “would be focused on telling seniors how to end their lives sooner.”<sup>131</sup>

Neither of these claims is credible. The provision in question actually requires Medicare to reimburse for advanced care counseling for seniors once every five years, or more frequently if the patient has a life-threatening disease. This counseling would include “an explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.”<sup>132</sup> In plain language, the bill is talking about assistance for seniors in completing living wills, medical powers of attorney, and end-of-life directives.

The counseling would not be mandatory; seniors are perfectly free to refuse it. On the other hand, it might well benefit seniors to put their desires about end-of-life care in writing. This includes both those who do and those who do not wish extraordinary measures to be taken. In fact, in 1990, Congress passed the Patient Self-Determination Act, which requires hospitals and long-term care facilities to provide patients with information on advance directives such as a living will. It also requires health care facilities to ask patients whether they have an advance directive and to follow what it says.<sup>133</sup> There has long been bipartisan support for this policy. And, in 2003, the Bush administration expanded on

**Not every criticism of the congressional health care reform bills has been on target.**

**The question of how the bills handle abortion is much murkier.**

the law, issuing “a 20-page report outlining a five-part process for physicians to discuss end-of-life care with their patients.”<sup>134</sup>

Some critics do worry that there is no direct prohibition on counseling about physician-assisted suicide. House Minority Leader John Boehner (R-OH) is concerned that the counseling could “create a slippery slope for a more permissive environment for euthanasia, mercy-killing and physician-assisted suicide.”<sup>135</sup> However, physician-assisted suicide is illegal in 48 states.<sup>136</sup> Nothing in any of the bills currently before Congress would change that in any way.

Regardless of the merits, the issue seems dead. Sen. Charles Grassley (R-IA) has announced that end-of-life counseling will not be included in the Senate Finance bill.<sup>137</sup>

The question of how the bills handle abortion is much murkier. The word “abortion” does not actually appear anywhere in the legislation. Despite this, there are three issues in question.

First, will abortion services be among the benefits mandated as part of the standard minimum benefit package required to comply with the individual mandate? Most insurance policies today *do* cover abortion services (87 percent according to the Guttmacher Institute), but it is possible to purchase insurance that excludes such coverage. If abortion were included as an essential service under the legislation, individuals who are morally opposed to abortion will nonetheless be required to have and pay for such services as part of their insurance.

The Senate HELP bill is silent on the issue, as was the original House bill. However, anti-abortion groups have expressed concern that federal courts have ruled that in the absence of a specific prohibition, abortion services are considered to be included within the definition of such terms as “inpatient services” or “outpatient services,” which are mandated as part of the minimum benefits package.<sup>138</sup> Other legal experts dispute this interpretation. Of course, whatever services are directly mandated by the bill itself, it is always possible that the Benefits Advisory Committee could add abortion to the package at a later date. When

White House spokesman Robert Gibbs was asked about an abortion coverage requirement, he responded that “a benefit package is better left to experts in the medical field to determine how best and what procedures to cover.”<sup>139</sup>

In response to these concerns, the House Energy and Commerce Committee passed an amendment that would exclude abortion from the minimum benefit package. On the other hand, the House Ways and Means Committee rejected a similar amendment.<sup>140</sup> Finally, the HELP Committee passed an amendment by Sen. Barbara Mikulski (D-MD) that requires insurers to include “essential community providers” in their networks, including providers like Planned Parenthood.<sup>141</sup>

It remains an open question, therefore, how the issue will be treated in the final bill.

On a related issue, there is the question of whether providers, such as Catholic hospitals, would be required to provide abortion services. One in eight U.S. hospitals is affiliated with the Catholic Church. Catholic hospitals employ more than 750,000 people and treat 16 percent of all hospital patients.<sup>142</sup> It is the policy of those hospitals not to perform abortions or make abortion referrals. Federal law has recognized this policy for decades, and the Weldon Amendment, passed in 2004, specifically forbids any federal agency or program (or state or local government receiving federal funds under the act) to discriminate against individual or institutional health care providers or insurers because they decline to provide, pay for, provide coverage of, or refer for abortion.<sup>143</sup> However, the U.S. Council of Bishops and organizations representing Catholic hospitals have expressed concern that if abortion services are labeled an “essential benefit,” they would be prohibited from refusing to provide such services.

A similar case developed in Massachusetts as a result of its health reform. A Catholic health care system, Caritas Christi, which operated six hospitals in Massachusetts, entered into a for-profit joint venture to offer a state-subsidized Commonwealth Care health plan to low-income patients. All plans offered



through the Commonwealth Care program in Massachusetts are required to provide coverage for abortions. The state has therefore ordered hospitals operated by Caritas Christi to offer abortion and other family planning services. In response, Caritas Christi withdrew from the joint venture and will not offer care through the Commonwealth Care program.<sup>144</sup>

This could have severe consequences for health care. The Catholic bishops have made it clear that “If Catholic hospitals were required by federal law to perform abortions, we’d have to close our hospitals.”<sup>145</sup> An amendment by Rep. Lois Capps (D-CA), approved by the House Energy and Commerce Committee, allows for plans that do not pay for abortion to be sold through the exchange, which would appear to create a safe harbor for Catholic hospitals.<sup>146</sup> The Senate HELP Committee approved an amendment with a similar provision.<sup>147</sup> However, the House Ways and Means Committee voted down such a change.

Finally, there is the question of whether taxpayer funding would be used to pay for abortion. Currently, the Hyde Amendment, passed in 1976, prohibits the use of federal Medicaid funding to pay for abortions except in certain rare circumstances.<sup>148</sup> Separate laws apply the restrictions to the federal employee health plan and military and other programs.

However, the health care reform legislation would create new methods of abortion funding that would not be subject to these restrictions. First, the government-run plan would offer abortion among its covered benefits. Second, federal subsidies for low- and middle-income people would assist them in buying coverage through the new exchange, including plans that cover abortion.

The Energy and Commerce Committee approved a compromise amendment by Rep. Capps that would prohibit direct federal funding of abortion but allow indirect funding. Specifically, it would allow the government-run plan to cover abortion, but require that such services be paid for out of premiums, without using any government funds. It would also allow government subsidies to be used to purchase insurance plans that cover

abortions, but the subsidies could not pay for the part of the premium related to abortion services.<sup>149</sup> A stronger amendment offered by Rep. Bart Stupak (D-MI) that would have prohibited any use of government funds for abortion offered by Rep. Bart Stupak (D-MI) was rejected.<sup>150</sup> The Ways and Means Committee also rejected an amendment that would have banned abortion funding.

The Senate HELP Committee rejected an amendment that would have prohibited the use of taxpayer subsidies to purchase coverage that included abortion services. At the same time, however, the HELP Committee approved an amendment that prohibits states from banning abortion coverage in plans sold through their exchanges.<sup>151</sup>

## Conclusion

There has been a great deal of misinformation in the debate over health care reform. Opponents have sometimes been hyperbolic in describing death panels and forced euthanasia. At the same time, supporters have been disingenuous in promising that people will be able to keep their doctors and current insurance plans.

The confusion has been magnified by the lack of a single health care bill. At least three different versions are currently making their way slowly toward the House floor. A fourth version has passed the Senate HELP Committee, and a fifth still-inchoate version is being negotiated behind closed doors by six members of the Senate Finance Committee. This makes it hard to pin down specific details and easy for representatives to duck questions on the issue.

However, if one reads through the different bills and proposals, it becomes clear that under all the current versions of health reform, Americans will end up paying more and getting less. In fact, Americans will pay more than \$820 billion in higher taxes over the next 10 years and could see their insurance premiums rise as much as 95 percent.

Health care reform will increase the budget deficit by at least \$239 billion over the next 10

**Under all the current versions of health reform, Americans will end up paying more and getting less.**

**While the bills contain no direct provisions for rationing care, they nonetheless set the stage for government rationing and interference with how doctors practice medicine.**

years and far more in the years beyond that. If the new health care entitlement were subject to the same 75-year actuarial standards as Social Security or Medicare, its unfunded liabilities would exceed \$9.2 trillion.

At the same time, while the bills contain no direct provisions for rationing care, they nonetheless set the stage for government rationing and interference with how doctors practice medicine. Millions of Americans who are happy with their current health insurance will not be able to keep it, while at least some Americans may find it more difficult to see their current doctor.

Perhaps the best summation, comes from Rep. John Adler (D-NJ): “The bill that’s coming through the House, with or without the public option, isn’t good for America.”<sup>152</sup>

## Notes

1. However, a final version of the bill’s language has not been released despite repeated requests from the committee’s Republican members. Sen. Mike Enzi, “So Much for Transparency” (press release, July 30, 2009). Throughout this study, references to the HELP bill refer to the chairman’s markup unless otherwise noted.
2. See, for example, Michael Tanner, “Obamacare to Come: Seven Bad Ideas for Health Care Reform,” Cato Institute Policy Analysis no. 638, May 21, 2009.
3. Congressional Budget Office (letter to Sen. Edward Kennedy, July 2, 2009).
4. Gregg Hitt, “Baucus says CBO Prices Health Bill Below \$900 Billion,” *Wall Street Journal*, July 29, 2009.
5. Unless otherwise noted, the House bill refers to the version that passed the Ways and Means Committee.
6. Congressional Budget Office (letter to Rep. Charles Rangel, July 14, 2009).
7. Congressional Budget Office (letter to Sen. Edward Kennedy, July 2, 2009).
8. “Current Satisfaction vs. Future Worry Defines the Battle on Health Reform,” ABC News/Washington Post Poll, June 24, 2009, <http://abcnews.go.com/images/PollingUnit/1091a2HealthCareReform.pdf>.
9. White House, “Remarks by the President at the Annual Conference of the American Medical Association” (press release, June 15, 2009), [http://www.whitehouse.gov/the\\_press\\_office/Remarks-by-the-President-to-the-Annual-Conference-of-the-American-Medical-Association/](http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-the-Annual-Conference-of-the-American-Medical-Association/).
10. Ricardo Alonso-Zaldivar, “Obama Making Health Care Promises He Can’t Keep,” Associated Press, June 19, 2009.
11. HR 3200, [AQ: Can you provide Congress, session, and publication info?] Secs. 59(B)(a) and (C)(1).
12. HELP bill, Sec. 151 and Sec. 59(b).
13. HR 3200, Sec. 122(b)(1–10).
14. HR 3200, Sec. 123(b)(1).
15. HR 3200, Sec. 122(c)(1–3).
16. HR 3200, Sec. 123(b)(5).
17. HELP bill, Sec. 3103.
18. HELP bill, Secs. 2708 and 2710.
19. HELP bill, Secs. 131(a) and 131(b).
20. HELP bill, Sec. 131(e). The determination of whether a change to your current insurance is “significant” is left to the discretion of the secretary of HHS. “[T]he Secretary shall by regulation establish criteria to determine whether a plan or health insurance coverage has been modified to a significant extent under the preceding sentence.”
21. HELP bill, Sec. 161.
22. HR 3200, Sec. 401.
23. HR 3200, Sec. 313.
24. HELP bill, Sec. 3115. The House mandate includes companies that self-insure, effectively repealing the Employment Retirement Income Security (ERISA) exemption from state insurance regulation. HR 3200, Sec. 100(c)19.
25. HR 3200, Sec. 102(b).
26. HELP bill, Sec. 132(b).
27. HELP bill, Sec. 161.
28. For example, one continuing controversy is whether the minimum benefits package will include abortion coverage. See discussion later in this paper.

29. HELP bill, Sec. 3105; HR 3200, Sec. 221.
30. HR 3200, Secs. 222(A)(1)((b)(1) and (2).
31. HR 3200, Sec. 222(A)(2).
32. See Michael Cannon, "Fannie Med: Why a 'Public Option' Is Bad for Your Health," Cato Institute Policy Analysis no. 642, August 6, 2009.
33. HR 3200, Sec. 221(g).
34. HR 3200, Energy and Commerce Committee, Radanovich, Amendment no. 22.
35. U.S. Department of the Treasury, "Government Sponsorship of the Federal National Mortgage Association and Federal Home Loan Mortgage Corporation," July 11, 1996.
36. Ronald Williams, CEO, Aetna Insurance Company (testimony before the Senate Committee on Health, Education, Labor, and Pensions, March 24, 2009).
37. HELP bill, Secs. 3106(6)(A) and (B).
38. HR 3200, Sec. 223.
39. Congressional Budget Office (letter to Rep. David Camp [R-MI], July 26, 2009).
40. John Sheils and Randy Haught, "Analysis of the July 15 Draft of the American Affordable Health Choices Act of 2009," Lewin Associates, July 23, 2009.
41. Congressional Budget Office (letter to Sen. Edward Kennedy, July 2, 2009).
42. A "co-op" can be defined as a business owned and controlled by its workers and the people who use its services, in this case presumably the people whom it insures. In that sense, government provision of some sort of legal framework or seed money to help establish health insurance co-ops seems relatively harmless but also relatively pointless. States already have the power to charter co-ops, including health insurance co-ops. In fact, health care co-ops already exist. Health Partners, Inc., in Minneapolis has 660,000 members and provides health care, health insurance, and HMO coverage. The Group Health Cooperative in Seattle provides health coverage for 10 percent of Washington State residents. PacAdvantage, a California co-op, covers 147,000 people. By all accounts the people insured through these co-ops are happy with their choice, but there is no evidence that they are significantly less expensive or more efficient than other insurers.
43. "Conrad Moves Closer to Public Plan after Negotiations," *Huffington Post*, July 23, 2009, [http://www.huffingtonpost.com/2009/06/22/conrad-moves-closer-to-pu\\_n\\_219266.html](http://www.huffingtonpost.com/2009/06/22/conrad-moves-closer-to-pu_n_219266.html).
44. "Reid Says Co-ops Might Be Public Option," *Foxnews.com*, July 9, 2009, <http://congress.blogs.foxnews.com/2009/07/09/reid-says-co-ops-might-be-public-option/>.
45. "Health Savings Account Enrollment Reaches Eight Million," America's Health Insurance Plans (press release, May 13, 2009). A health savings account (HSA) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a High Deductible Health Plan. The funds contributed to the account are not subject to federal income tax at the time of deposit.
46. HELP bill, Sec. 311(a)(1)(A)(i).
47. HR 3200, Sec. 122(c)(3)(A).
48. John Fund, "Health Reform's Hidden Victims," *Wall Street Journal*, July 24, 2009.
49. Ibid.
50. This should not be surprising. President Obama has always been hostile to HSAs. In his book, *The Audacity of Hope*, he dismisses health savings accounts as being based on the idea that people have "an irrational desire to purchase more than they need." Barack Obama, *The Audacity of Hope: Thoughts on Reclaiming the American Dream* (New York: Three Rivers Press, 2006), p. 179.
51. HR 3200, Energy and Commerce Committee, Rogers and Gingrey, Amendment no. 10.
52. "Medicare Advantage Fact Sheet," Kaiser Family Foundation, April 2009.
53. Peter R. Orszag, director, Congressional Budget Office, "The Medicare Advantage Program" (testimony before the Committee on the Budget, U.S. House of Representatives, June 28, 2007).
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124. Ibid. Many observers believe that Medicare already has statutory authority to use both comparative-effectiveness and cost-effectiveness research to deny reimbursement for procedures it deems ineffective or too costly. As Sean Tunis, founder of the Center for Medical Technology Policy, writes in the *New England Journal of Medicine*, "For the nearly four decades since Medicare was created in 1965, coverage decisions have been based on Section 1862(a)(1)(A) of the statute that enacted the program: 'Notwithstanding any other provision of this title, no payment may be made . . . for any expenses incurred for items or services which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury.' No additional language from Congress explaining 'reasonable and necessary' accompanied the 1965 law." Congress, however, has generally intervened to block any attempts to implement any reductions in services. The Independent Medical Advisory Committee (IMAC) is therefore designed to deal with the political roadblocks to Medicare changes, not statutory hurdles.
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