

# The Obama Health Plan: Rationing, Higher Taxes, and Lower Quality Care

By Peter Ferrara\*

## 1. Introduction

President Barack Obama and Congressional Democrats are rushing to enact legislation that would overhaul the way health care is financed and delivered in the United States. It would dramatically increase the role of government in virtually all aspects of health care. Such an initiative should be carefully studied to determine whether it actually solves problems in the health care arena or makes them worse.

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National health plans similar to what President Obama is proposing have been adopted in other countries. They always start out promising universal access and free or reduced-price health care. But they end up with massive institutional bureaucracies whose purpose and function are to deny health care and medical services. Often they fail to control spending despite resorting to withholding care to politically weak groups.

President Obama insists that his plan to fundamentally restructure health care is needed to reduce costs. He has touted a report from his Council of Economic Advisors<sup>2</sup> that specifies exactly how that would be done. That report, however, elaborates a policy of thorough government health

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<sup>2</sup> The President's Council of Economic Advisors, *The Economic Case for Health Reform*, June 2, 2009.

care rationing achieved through government control of the financing and delivery of care.

This study will explain how the health policy changes President Obama and Congressional Democrats support would cause millions of Americans to lose their choice of doctors and insurance coverage, require that access to care be strictly rationed, and cause the quality of care to deteriorate. Despite all this sacrifice, nationalizing health insurance in America would require major tax increases, slow economic growth, and increase the national debt.

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Part 2 of this study describes the Obama health plan as it is presented in legislation being debated in Congress. Part 3 explains how the Obama health plan would result in the loss of freedom of choice. In particular, it shows how you would not be free under President Obama's plan to keep your current health insurance because employers would "dump" millions of people into a one-size-

fits-all government-run program. Part 4 explains how the Obama plan would give government the power to ration health care, including the power to deny access to the elderly, who need it the most.

Part 5 explains how, despite rationing, the Obama health plan would increase health costs. Part 6 describes the intractable entitlement crisis America already faces based on the undeliverable promises made for Social Security, Medicare, and Medicaid. The Obama health plan would recklessly add yet another unfunded middle-class entitlement program, this one giving subsidies for families earning \$88,000 per year and more.

Part 7 discusses the health policy reforms America *should* adopt, based on expanding patient power and choice in a market-based health care system. These reforms would provide a true health care safety net that would ensure no one suffers without essential health care while reducing costs and preserving those parts of the current health care system that work. Part 8 presents a brief summary and concluding remarks.

Today, Americans enjoy the best health care and medical services in the world, an important part of our high standard of living. President Obama has said "my view is that health care reform should be guided by a simple principle: fix what's broken and build on what works."<sup>3</sup> But that is not what his plan would do. Instead, he would tear down what is good about the current system and replace it with old-fashioned and outdated socialized medicine policies adopted by other countries, reflecting their lower living standards. It would be a terrible mistake.

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<sup>3</sup> Barack Obama, address to the American Medical Association on June 15, 2009, quoted in "Obama: 'If You Like Your Doctor, You Can Keep Your Doctor,'" *Washington Wire*, June 25, 2009.

## 2. President Obama's Health Care Plan

President Obama's plan to restructure the nation's health care system would be implemented by legislation that is advancing, with his encouragement and approval, in the House and the Senate. The plan discussed below is based on those legislative proposals.

The Senate Health, Education, Labor and Pensions (HELP) Committee, chaired by Sen. Ted Kennedy (D-MA), has developed a bill called the Affordable Health Choices Act, while the Senate Finance Committee, under the chairmanship of Sen. Max Baucus (D-MT), is writing a separate bill. In the House, the three committees with jurisdiction – Ways and Means, Education and Labor, and Energy and Commerce – developed a joint bill, HR 3200, which each committee is amending separately. The House and Senate bills are quite similar and closely track President Obama's policy outline and campaign rhetoric.

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President Obama and Democratic leaders in Congress insist that health reform legislation must include a "public option" – a new government-run health insurance program that would compete with private insurers. Both bills provide for guaranteed issue of all health insurance plans, which means insurers must accept everyone who applies for coverage, regardless of their health condition. Insurers also would be prohibited from excluding coverage for pre-existing conditions.

The two bills would mandate community rating, which prohibits insurers from varying premiums based on the health condition of the individual applying for coverage. Premiums would be allowed to vary based only on the age of those covered, family size, the benefits covered, and costs in the applicable local community rating area. Some versions of the bills limit the age rating to as little as a 2-to-1 ratio of highest to lowest premiums.

Both bills provide for a government bureaucracy that would risk-adjust premium income to insurers by redistributing funds from insurers whose covered customers are healthier and lower-cost than average, to insurers whose covered customers are sicker and higher-cost than average, as determined by a new health care bureaucracy. The two bills also would establish a government bureaucracy to facilitate the sale of insurance, dubbed an "Exchange" by the House bill and a "Gateway" by the Senate HELP bill. These bureaucracies may be established at the state, regional, or national levels.

Both bills impose a pay-or-play mandate on *employers* requiring them to either provide health insurance to their employees with benefits, terms, and conditions specified by the government or pay a new payroll tax of up to 8 percent of all wages. This payroll tax would be in addition to the current Social Security and Medicare payroll tax rate of 7.7 percent paid by employers and 7.7 percent paid directly by employees.

The two bills also would impose an individual mandate on all *workers* to pay for health insurance, with qualifying policies once again meeting the benefits, terms, and conditions specified by the government. This would be enforced through a new section of the Internal Revenue Code imposing a tax penalty on individual taxpayers who do not maintain the government-specified coverage.

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The proposed legislation would extend Medicaid to all individuals with incomes up to 133 percent of poverty, including for the first time childless single adults. The House bill provides for additional subsidies, called affordability credits, for those who earn up to 400 percent of the federal poverty level. That would mean families earning up to \$88,000 a year would be eligible for new federal taxpayer subsidies that they could use to

purchase health insurance and to reduce cost-sharing through deductibles and co-payments. The Senate bill provides health insurance subsidies for those with incomes of up to 500 percent of the federal poverty level, which would provide health insurance subsidies for a family of four with an annual income of more than \$110,000 a year.

Both bills provide a tax credit for small businesses to help them purchase health insurance for their employees. The House bill defines a “small employer” as a business employing fewer than 25 employees, while the Senate bill sets the threshold at 50 employees. The maximum credit under the House bill is 50 percent of health insurance expenses for employees earning less than \$20,000 per year; the credit gradually falls to zero for employees earning \$125,000 per year. The maximum small business credit under the Senate bill is \$2,000 per year for family coverage and \$1,000 for single workers making up to \$50,000 per year. The credit available to small businesses under the Senate bill would last for only three years.

The Congressional Budget Office estimates the total cost of these bills would be about \$1.5 trillion over the next decade.<sup>4</sup> Members of Congress are trying to make changes that would bring the price tags to under \$1 trillion, but few of their amendments would amount to savings even close to the amounts needed to achieve this target. The government’s record for estimating the cost of new entitlements for health care is very poor. Private research analysts put the 10-year cost of the plans being considered at the time of this writing at close to \$4 trillion.<sup>5</sup>

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<sup>4</sup> Congressional Budget Office, *H.R. 3200, America’s Affordable Health Choices Act of 2009*, July 17, 2009, <http://www.cbo.gov/doc.cfm?index=10464>.

<sup>5</sup> HSI Network, LLC, *The Impact of the 2009 Affordable Health Choices Act*, June 13, 2009 (Senate bill); HSI Network, LLC, *The Impact of the 2009 Access to Quality Affordable Health Care for All Act*, June 24, 2009 (House bill).

### 3. Loss of Choice: The Public Option

President Obama has repeatedly said that under his plan, if you like the health insurance you have today, you would be able to keep it. For example, in his speech to the American Medical Association in June he said:

... no matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor. Period. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what.<sup>6</sup>

But in fact, if you currently have employer-provided health insurance, whether or not you get to keep it wouldn't be up to you. Your employer would decide.

President Obama and the Democratic leaders in Congress want to create a new "public option" health insurance program that the federal government would run in competition with private insurance. Your employer would have several incentives to stop paying for your private health insurance and instead enroll you in the public plan and pay an 8 percent payroll tax. If your employer's work force averages \$50,000 a year in wages, the employer would face a payroll tax of only \$4,000 per year per worker, which may be considerably less than what he is currently paying for your health insurance.

Even if your employer wants to preserve your current private insurance, the federal government's new Health Choices Commissioner may decide your employer's plan is not "qualified" because it doesn't cover all mandated treatments and procedures or requires too much cost-sharing by the employee. Your employer could be fined for every day the "violation" continues and even prohibited from enrolling new employees. This would further encourage your employer to drop your current health plan and "dump" you into the public option.

There would be a good chance that your insurer would be driven out of business by unfair competition from a government-subsidized program.

Finally, even if you currently purchase health insurance directly on your own, you won't necessarily be able to keep that insurance under the Obama plan. There would be a good chance your insurer would be driven out of business by unfair competition from a government-subsidized program that operates under rules different from those enforced on private insurance companies. The government-run plan could be the only "choice" you have left.

Some supporters of health reform would *prefer* that the public option destabilize the private insurance market because this would lead eventually to the "single payer" health system they

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<sup>6</sup> Barack Obama, address to the annual meeting of the American Medical Association on June 15, 2009, quoted in "Obama: 'If You Like Your Doctor, You Can Keep Your Doctor,'" *Washington Wire*, June 25, 2009.

desire, where taxpayers finance all health care and government agencies control all health care delivery.<sup>7</sup> Many of those Democrats openly seek “Medicare for all” as the ultimate result of health care reform, with everyone in a government health plan.

Private health plans would not be able to compete with a government plan that can lower costs simply by dictating lower payment rates to doctors and hospitals.

The principal reason a government health plan would drive private plans out of business is that the government would have the power to dictate what it would pay doctors and hospitals. The government has long underpaid doctors and hospitals under Medicaid and Medicare. Medicare now pays doctors almost 20 percent below market rates, and hospitals more than 30 percent

below market,<sup>8</sup> and Medicaid pays 30 to 40 percent less than Medicare.

The Senate and House health reform bills say the public option plan would pay doctors and hospitals Medicare rates to start. However, the bills expressly give government the power to change that over time and pay even lower rates, as it has under Medicaid. According to The Lewin Group, a health care consulting firm,

premiums for the public plan would be 20 percent to 25 percent less than for comparable private coverage. For some individuals and small employers, savings would be 30 percent or more. *These savings derive primarily from the fact that provider payment levels under Medicare are substantially lower than for private payers.*<sup>9</sup> (emphasis added)

Private health plans would not be able to compete with a government plan that can lower costs simply by dictating lower payment rates to doctors and hospitals. Medicaid and Medicare already drive up the cost of private health plans, as doctors and hospitals underpaid by the government plans try to recover their losses by charging more to privately insured patients. According to one recent study, higher prices due to cost-shifting cost privately insured patients nearly \$90 billion a year in 2006 and 2007.<sup>10</sup> The Lewin Group estimates about 40 percent of hospital payment shortfalls in public programs are passed on to private payers in the form of

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<sup>7</sup> See Jacob Hacker, “The Case for Public Plan Choice in National Health Reform: Key to Cost Control and Quality Coverage,” Institute for America’s Future, December 17, 2008; Robert E. Moffit, “How a Public Health Plan Will Erode Private Care,” Heritage Foundation, December 22, 2008.

<sup>8</sup> The Lewin Group, *Analysis of the July 15 draft of the American Affordable Health Choices Act of 2009*, July 17, 2009, p. 2.

<sup>9</sup> *Id.*, p. 13.

<sup>10</sup> Milliman, “Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid and Commercial Payers,” December 2008.

higher prices.<sup>11</sup>

The Lewin Group estimates that by 2011, when the House bill is fully implemented, “about 88.1 million workers would shift from private employer insurance to other options.”<sup>12</sup> Lewin analysts also estimate that almost half of those insured in the individual market would be covered by the new public option.<sup>13</sup> Combined, that means almost 60 percent of those who currently have private insurance coverage would lose their coverage and be enrolled in the public option plan.

Over time, private insurance plans would be put at an even greater competitive disadvantage because of political pressure to keep premiums for the public option as low as possible. Funds to subsidize the public option would start with the 8 percent payroll tax assessed on employers and could then expand to include general tax revenues, government deficit spending, and resources drawn from other government agencies. The House bill calls for an excise tax on private health insurance plans that clearly would disadvantage private plans.

The public option would get the capital it needs to conduct its operations, including the capital to meet all reserve requirements, from the government. The government could decide the public option plan doesn’t need to comply with the reserve requirements that apply to private plans, although supporters of the public option insist the same regulatory requirements would apply to the public option as to the private plans. Capital for the public option would come from taxes or from government borrowing through the Treasury Department, which is lower-cost than privately raised capital because it is guaranteed by taxpayers. All these options result in another competitive disadvantage for private plans.

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The public option would enjoy free marketing from the President of the United States and other government officials and agencies touting the plan across the country. The news media would promote the public option as well, with regular coverage of the government’s official statements. It is unlikely the public option would carry such marketing expenses – such as some share of the salaries of the president and Congressional Democrats promoting the plan – on its books. Nor is it likely that state and local governments would be permitted to burden the public option with the same regulatory requirements they impose on private health plans. These are further sources of unfair competitive disadvantages for the private plans.

All these unfair competitive advantages for the public option would likely produce the result

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<sup>11</sup> The Lewin Group, *supra* note 7, p. 18.

<sup>12</sup> *Id.*, p. 5.

<sup>13</sup> *Id.*, pp. 5-6.

most advocates of the government plan want: a government-run, single-payer monopoly, with all private plans driven out of business. That would mean not *more* choices, as President Obama's rhetoric emphasizes today, but *no* choice at all.

A government single-payer monopoly would mean not *more* choices, as President Obama's rhetoric emphasizes today, but *no* choice at all.

Even if that dire consequence did not come to pass, choice would be greatly restricted under President Obama's health reform proposal because the government would decide what kind of insurance you can buy to satisfy its individual and employer mandates. Current health insurance plans would be grandfathered

in, but if you have to or want to change health plans, or if your current plan goes out of business, you would have to buy the coverage the government requires you to have, not the coverage you once had or want. So much for "you will be able to keep your health care plan. Period. No one will take it away. No matter what."

The insurance plan you must have in order to comply with the government's mandates would reflect the lobbying of many special-interest groups insisting on coverage for the services or treatments they help to produce, or that may benefit them especially. You may have to pay for maternity coverage even though you cannot get pregnant, or for Viagra, hair pieces, acupuncture, bariatric surgery, marriage counseling, mental illness treatments, or for some other treatment or benefit you will never use and don't want to pay for.

President Obama likes to say he wants a government public option plan "to keep insurance companies honest."<sup>14</sup> But once the public option has driven those insurers out of business and becomes a government monopoly, who is going to keep bureaucrats, politicians, and lobbyists honest?

#### 4. Rationing and the Denial of Care

The combination of several elements of the Obama health plan would lead to government rationing of health care. The supply of health care would be sharply constricted and the government would decide who will, and who will not, receive the care they need, and when.

The first factor is the low reimbursements to doctors and hospitals that would prevail under the Obama health plan. We see this already in Medicare, which pays doctors and hospitals 20 to 30 percent less than market rates for the care and services they provide under the program. Doctors

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<sup>14</sup> Barack Obama, speech in Green Bay, Wisconsin on June 11, 2009, reported by Michael A. Fletcher, "Obama Touts Public Plan at Health Care Town Hall," 44: The Obama Presidency, WashingtonPost.com, June 11, 2009.

are dropping out of the Medicare program or refusing to accept more patients.<sup>15</sup> The situation is even worse under Medicaid, which pays doctors and hospitals 30 to 40 percent less than Medicare does. In 2008 over 33 percent of physicians had closed their practices to Medicaid patients and 12 percent had closed their practices to Medicare patients.<sup>16</sup> This restricts access to health care for the poor and elderly served by the programs, who must scramble for short and hurried appointments with available doctors or wait for emergency hospital care. The lower quality of care provided to Medicaid patients results in poorer health outcomes, including more and earlier deaths from heart disease and cancer compared to privately insured patients.<sup>17</sup>

There is every reason to believe the government-run public option plan would similarly restrict payments to doctors, hospitals, drug companies, and other health providers. The House and Senate bills explicitly say the public option would pay Medicare rates to start, and both bills give the government authority to change that reimbursement rate over time – meaning payment rates could fall to Medicaid levels or lower.

There is every reason to believe the government-run public option plan would sharply restrict payments to doctors, hospitals, drug companies, and other health providers.

The Lewin Group estimates that under the House bill doctors' net income would fall by \$13.4 billion in the first year alone, a decline of almost \$20,000 per physician, or 6.3 percent.<sup>18</sup> Hospital net income would fall by \$67 billion in the first year – an amount greater than the entire net income now expected by hospitals for the year.<sup>19</sup>

As discussed above, the government public option is likely to drive out of business most private insurance competitors over time, leaving the health care industry to survive on whatever the government chooses to pay. Any private plans that survive would do so by paying only what the government plan pays. So the government would end up dictating all payments to health providers.

This underpayment of doctors and hospitals begins the process of rationing. Doctors and hospitals would begin to restrict their care to fit what the government would pay. Doctors and specialists would cut back on the time they devote to each patient. They would stop offering

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<sup>15</sup> The Physicians' Foundation, "The Physicians' Perspective: Medical Practice in 2008," Survey Key Findings, November 18, 2008, [http://www.physiciansfoundations.org/news/news\\_show.htm?doc\\_id=728872](http://www.physiciansfoundations.org/news/news_show.htm?doc_id=728872).

<sup>16</sup> *Id.*

<sup>17</sup> Jeet Guram and John S. O'Shea, M.D., "How Washington Pushes Americans into Low-Quality Health Care," *Background* #2264, The Heritage Foundation, April 24, 2009.

<sup>18</sup> The Lewin Group, *supra* note 7, pp. 9-10.

<sup>19</sup> *Id.*, pp. 10-11.

more-expensive medical services and treatments that government payments would not sufficiently cover.

This underpayment would have a powerful effect on *investment* in the health care industry. Investors are not going to finance acquisition of the latest, most advanced equipment and technologies if the government slashes compensation for the services such technologies provide. Investors won't finance new or expanded hospital facilities or clinics, or even the full maintenance of existing ones. This is how the long waiting lines for diagnostics, surgery, and other referrals begin to develop in countries with socialized health care. It is why hospitals and other medical facilities in those countries are often old and deteriorating.

Low reimbursement levels would destroy incentives for investors to put their money into the next generation of advanced, high-tech medical care.

Development of the next generation of medical technology would be negatively affected as well. Low reimbursement levels would destroy incentives for investors to put their money into research and development to discover the next generation of advanced, high-tech medical care. Vast new opportunities for innovative health services

and care opened up by modern science would be unutilized. Drug companies would cut back on investment in cutting-edge, restorative, pain-relieving, or life-saving miracle drugs. Many people would suffer or die unnecessarily as a result.

Investment not only in physical capital, but also in *human* capital, would be negatively affected. Underpaid doctors, surgeons, and specialists would choose less-demanding and perhaps more-remunerative fields. Some would see fewer patients, devote more time to their families, and take more vacations. Others would simply retire earlier than planned. Survey evidence reveals that, thanks to underpayment under Medicaid and Medicare, this is already starting to happen.<sup>20</sup>

With less investment in technology and facilities and lower pay in the future, some of the bright young students who would have pursued careers in medicine and health care would choose other professions instead. A smaller supply of health professionals would exacerbate the problems of longer lines, waiting times, and less health care. Combined with the effects of greater demand for health care from millions of people wanting their "free" health care and the formerly uninsured, the severity of inadequate supply of health care would become even more acute.

President Obama is so anxious to get all of this underway that he and Congressional Democrats are talking about financing their health care reforms from the very start by cutting back on compensation for doctors and hospitals. The health care rationing that must result would mean tremendous sacrifices by doctors, surgeons, specialists, nurses, hospital administrators, and other health professionals. They would soon be joined by patients who must be denied access to care.

President Obama said "no matter how we reform health care, we will keep this promise: If you

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<sup>20</sup> The Physicians' Foundation, *supra* note 15.

like your doctor, you will be able to keep your doctor.” But would your doctor be willing to keep you?

## Obama’s CEA Spills the Beans

A recent report from President Obama’s Council of Economic Advisors (CEA),<sup>21</sup> which he has touted as showing how his plan would reduce health costs, describes explicit and comprehensive government rationing of health care. The CEA report alleges 30 percent of American health care spending is due to waste, which it claims a government bureaucracy would be capable of somehow identifying and then eliminating.

*Question:* What is the difference between waste and the health care you want?

*Answer:* A government bureaucrat.

The CEA explains exactly how this is going to work, saying that under President Obama’s health reforms the government is going to reduce health costs sharply by:

A health care bureaucracy in Washington, DC – not you and your doctor – would decide what health care works and what doesn’t, what is high-value care and what is low-value care.

**Looking systematically at what works and what doesn’t in order to provide more high value care and less care that is of low value.** For many types of medical conditions, a patient may have a choice of several methods or treatments, each having different benefits or risks. Systematic examinations of the merits of different treatments and dissemination of the results of these examinations to patients and providers is one mechanism for promoting high value health care.<sup>22</sup> (bold in the original)

In other words, a health care bureaucracy in Washington, DC – not you and your doctor – would decide what health care works and what doesn’t, what is high-value care and what is low-value care. Of course, this bureaucracy would not know you or anything about your illness, as your doctor does. But like all good central planners, the CEA and President Obama assume the government is omniscient.

President Obama and Congressional Democrats already have begun to implement this policy of determining what health care you are to be allowed to receive. The American Recovery and Reinvestment Act – the “stimulus bill” signed by the president in February 2009 – established and financed a federal Coordinating Council for Comparative Effectiveness Research. The

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<sup>21</sup> The President’s Council of Economic Advisors, *The Economic Case for Health Reform*, June 2, 2009.

<sup>22</sup> *Id.*

council is tasked with determining which health care services are the most “cost-effective.” The sponsors of that provision explained,

By knowing what works best and presenting this information more broadly to patients and healthcare professionals, those items, procedures, and interventions that are most effective to prevent, control, and treat health conditions will be utilized, while those that are found to be less effective and in some cases, more expensive, *will no longer be prescribed.*<sup>23</sup> (emphasis added)

Cost-effectiveness decided by a government bureaucracy in the context of a national health insurance plan where the government is paying much or most of the costs is a dangerous policy for the health care of ordinary citizens. It means the government would decide what costs *to the government* are worth the benefits *to you*. The government’s own agendas and priorities are substituted for your own. The CEA goes on to explain in its report how the government would enforce its decisions:

**Reorienting the financial incentives of providers toward value rather than volume.** Payment ... [s]ystems should reward providers who deliver care that adheres to evidence based guidelines and should not pay for preventable medical errors.<sup>24</sup> (bold in the original)

But a bureaucracy in Washington doesn’t, can’t, and won’t know, out of all the health care services in the economy, what works and what doesn’t, for every patient in the country.

In other words, the government would enforce its decisions through the payment system for doctors and hospitals. Those who follow the government’s decisions get paid well, and those who don’t may not be paid at all.

But a bureaucracy in Washington doesn’t, can’t, and won’t know what works and what doesn’t for every patient in the country. It won’t know what are the right prices that would provide the

right incentives to eliminate the so-called “waste” and yet preserve the health care services you need and want. This “knowledge problem,” as economists call it, confounds and undermines the Obama plan even before politics gets involved. Politics then ensures that government payments to doctors and hospitals get redirected to those in the districts with the most powerful Congressmen or Senators.

Despite the government’s severe lack of knowledge as to what it is doing, those doctors and

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<sup>23</sup> Report, *The American Recovery and Reinvestment Act of 2009*, Committee on Appropriations, House of Representatives, January, 2009, p. 52.

<sup>24</sup> Council of Economic Advisors, *supra* note 20.

hospitals who don't follow the government's decisions as to what is quality care would get formally labeled as "lower quality," losing out to those who win high-quality provider labels by slavishly following the health care diktats of the bureaucrats. This is explained in another CEA cost control measure:

**Expanding performance measurement and provider feedbacks.** Performance measurements include collecting and summarizing information about clinical quality, consumer satisfaction, and resource use of provider practices. ... One potential way to increase efficiency is to facilitate the development of a set of performance measures that all providers would adopt and report. ... Additionally, new efforts could be made to generate risk-adjusted provider performance profiles to encourage quality improvement and to inform consumer decision-making around quality.<sup>25</sup> (bold in the original)

Somehow, the government bureaucracy would know exactly how to measure the performance of every doctor and every hospital in the country for every health care service, and there won't be any politics in that either.

Somehow, the government bureaucracy would know exactly how to measure the performance of every doctor and every hospital in the country for every health care service, and there won't be any politics in that either.

Obama's budget czar, Peter Orszag, clearly spilled the beans when he said, "Future increases in spending could be moderated if costly new medical services were adopted more selectively in the future than they have been in the past, and if the diffusion of existing costly services was slowed."<sup>26</sup> In other words, the government is going to use its power over reimbursements to doctors and hospitals to delay implementation of new technological innovations and discourage investment in new technology development. This is a prescription for discouraging investment in advanced medical technologies and drugs and leaving patients in long waiting lines.

## What Tom Daschle Wanted

These CEA health rationing policies reflect the thinking of Democrat Tom Daschle, former Senate Majority Leader, as outlined in his book, *Critical: What We Can Do About the Health*

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<sup>25</sup> *Id.*

<sup>26</sup> Congressional testimony quoted in "Obama's Health Cost Illusion," *The Wall Street Journal*, editorial, June 8, 2009.

*Care Crisis*.<sup>27</sup> Daschle was President Obama’s first choice for Secretary of Health and Human Services, forced to withdraw when it was revealed he had failed to pay all of his federal income taxes. The president picked Daschle for that post because he liked the health care reform policies Daschle proposed.

In his book, Daschle explicitly advances the British model of extreme government health care rationing for the U.S.

In his book, Daschle explicitly advances the British model of extreme government health care rationing for the U.S., saying,

In our fragmented health-care system, only the federal government is in a position to develop national quality standards that everyone would follow –

and it would cost relatively little for it to do so. In Great Britain, the National Institute on Clinical Excellence (NICE), which develops guidelines for the National Health Service (NHS), spends less than 1 percent a year of its total national health spending.<sup>28</sup>

Daschle adds,

In other countries, national health boards have helped ensure quality and rein in costs in the face of these challenges. In Great Britain, ... NICE ... is the single entity responsible for providing guidance on the use of new and existing drugs, treatments, and procedures. ... NICE also weighs what it calls “economic evidence,” or how well the medicine or treatment works in relation to how much it costs.<sup>29</sup>

The Orwellian-named NICE is the national health care rationing board used in Great Britain. In 2006, it ruled that elderly patients with macular degeneration could not get a costly new drug to save their sight until they went blind in one eye.<sup>30</sup> To decide who gets what health care services, NICE uses a formula that divides the cost of the treatment by the number of years the patient would likely live and receive the benefits of that treatment.<sup>31</sup> This greatly disadvantages senior

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<sup>27</sup> Tom Daschle, *Critical: What We Can Do About the Health Care Crisis* (New York: St. Martin’s Press, 2008).

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> Betsy McCaughey, “Ruin Your Health with the Obama Stimulus Plan,” Bloomberg.com, February 9, 2009.

<sup>31</sup> *Id.*

citizens in getting health care, as compared to younger people who on average have longer to live.

Daschle advocates a Federal Health Board for the U.S. explicitly modeled on NICE, saying,

The Federal Health Board would promote “high value” medical care by recommending coverage of those drugs and procedures backed by solid evidence. It would exert influence by ranking services and therapies by their health cost impacts. ... We won’t be able to make a significant dent in health care spending without getting into the nitty-gritty of which treatments are the most clinically valuable and cost effective. That means taking a harder look at the real costs and benefits of new drugs and procedures. In Great Britain, NICE ... uses cost effectiveness information in deciding whether to cover a new drug or procedure. ... The challenge ... is creating an entity with the credibility and the clout to make those tough decisions.<sup>32</sup>

In other words, the government would decide what health care is the most effective considering the costs, and impose that decision on all patients and doctors across the country. Daschle advocates an enforcement mechanism for doing this that is very similar to what is advocated in the CEA report:

Former Clinton advisor Dick Morris contends the Obama health plan effectively would repeal Medicare.

The federal government could exert tremendous leverage with its decisions on covered benefits and payment incentives. In choosing what it will cover and how much it will pay, it could steer providers to the services that are the most clinically valuable and cost-effective, and dissuade them from wasting time and money on those that are neither.<sup>33</sup>

### **The Elderly Are Most Vulnerable**

Former Clinton advisor Dick Morris and attorney Eileen McGann, in a new book titled *Catastrophe*, contends the Obama health plan effectively would repeal Medicare, with negative consequences for the elderly. On Morris’s Web site he writes:

Obama’s health care proposal is, in effect, the repeal of the Medicare program as we know it. The elderly will go from being the group with the most access to free medical care to the one with the least access. Indeed, the principal impact of the

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<sup>32</sup> Daschle, pp. 171-172.

<sup>33</sup> *Id.*

Obama health care program will be to reduce sharply the medical services the elderly can use. No longer will their every medical need be met, their every medication prescribed, their every need to improve their quality of life answered.

“It’s time for the elderly to wake up before it is too late!

“In our new book, *Catastrophe*, we explain the consequences the elderly of Canada are feeling from just this kind of program. Limited colonoscopies have led to a 25 percent higher rate of colon cancer. ... Overall, the death rate from cancer in Canada is 16 percent higher than in the United States and the heart disease mortality rate is 6 percent above ours.

“Today, 800,000 doctors struggle to treat adequately the 250 million Americans who have insurance. Obama will add 50 million more to their caseload with no expansion in the number of doctors or nurses. Indeed, his plan will likely reduce their number by lowering reimbursement rates and imposing bureaucrats above them who will force medical decisions down their throats. Fewer doctors to treat more patients. The inevitable result will be rationing.

“And it is the elderly who rationing will most affect. ... It is high time that the elderly of America realized what the stakes are in this vital fight to preserve Medicare as we know it. ... It is truly a battle for their very lives.”<sup>34</sup>

The dramatic decline in the quality of care the elderly are likely to receive would mean a sharp decline in the quality of life for many families in America.

The elderly clearly have the most to lose from Obama’s health care plan. The dramatic decline in the quality of care the elderly are likely to receive would mean a sharp decline in the quality of life for many families in America.

## Health Care Rationing In Practice

We can see some real-world examples of health care rationing in other countries with policies similar to what President Obama is proposing. Nadeem Esmail, director of health system performance studies at the Fraser Institute in Canada, provides some examples of experience under the Canadian system She writes:

In Ontario, Lindsay McCreith was suffering from headaches and seizures yet faced a four and a half month wait for an MRI scan. ... [H]e went south, and paid for an MRI scan across the border in Buffalo [New York]. The MRI revealed a malignant brain tumor. Ontario’s government system still refused to provide

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<sup>34</sup> Dick Morris and Eileen McGann, “Obama Will Repeal Medicare,” July 9, 2009, [www.DickMorris.com](http://www.DickMorris.com).

timely treatment, offering instead a months-long wait for surgery. In the end, McCreith returned to Buffalo and paid for surgery that may have saved his life.<sup>35</sup>

Esmail offers another example,

In March of 2005, [Ontario resident Shona] Holmes began losing her vision and experienced headaches, anxiety attacks, extreme fatigue, and weight gain. Despite an MRI scan showing a brain tumor, Ms. Holmes was told she would have to wait months to see a specialist. In June, her vision deteriorating rapidly, Ms. Holmes went to the Mayo Clinic in Arizona, where she found that immediate surgery was required to prevent permanent vision loss and potentially death. Again, the government system in Ontario required more appointments and more tests, along with more wait times. Ms. Holmes returned to the Mayo Clinic and paid for her surgery.<sup>36</sup>

And another example,

[Alberta resident] Bill Murray waited in pain for more than a year to see a specialist for his arthritic hip. The specialist recommended a ‘Birmingham’ hip resurfacing surgery [a state-of-the-art procedure that gives better results than basic hip replacement]. But government bureaucrats determined that Mr. Murray, who was 57, was ‘too old’ to enjoy the benefits of this procedure and said no. In the end, he was also denied the opportunity to pay for the procedure himself. He’s heading to court claiming a violation of constitutional rights.<sup>37</sup>

While Tom Daschle and Obama’s CEA tout European health care rationing as a model for the U.S., long queues and limited access to specialists and the latest medical equipment in those countries result in health outcomes that are inferior to those of the U.S. For example, one-quarter of those diagnosed with breast cancer in the U.S. die of it, while the comparable figure is 35 percent in France and

Long queues and limited access to specialists and the latest medical equipment in other countries result in health outcomes that are inferior to those of the U.S.

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<sup>35</sup> Nadeem Esmail, “‘Too Old’ for Hip Surgery,” Fraser Forum, [www.fraserinstitute.org](http://www.fraserinstitute.org), June 6, 2009.

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

46 percent in Britain and New Zealand.<sup>38</sup> About 19 percent of American men die from prostate cancer once diagnosed. The figures are 30 percent and 35 percent in New Zealand and Australia, respectively, and 49 percent and 57 percent in France and Britain, respectively.<sup>39</sup>

In Canada, the median average wait for treatment after referral to a specialist was 18.3 weeks in 2007.<sup>40</sup> Patients in Saskatchewan waited the longest – 27.2 weeks – followed by New Brunswick (25.2 weeks) and Nova Scotia (24.8 weeks). Britain’s National Health Service (NHS) has more than one million people on waiting lists for care. The cumulative waiting time expected by all Britons already in the queue for medical treatment exceeds *one million years*.<sup>41</sup>

The number of physicians per capita is nearly 50 percent higher in the U.S. than in Britain and Canada.

The number of physicians per capita is nearly 50 percent higher in the U.S. than in Britain and Canada.<sup>42</sup> Moreover, out of these available doctors, only 11 percent in the U.S. are general practitioners, while in Canada and Great Britain nearly half are, which means

American patients have much greater access to specialists.<sup>43</sup>

American patients also have much greater access to the latest medical technology. American patients receive 83.2 MRI exams per 1,000 people versus 25.5 for Canadian patients and 19.0 for British patients.<sup>44</sup> American patients also receive 172.5 CT scans per 1,000 people versus 87.3 for Canadian patients and 43.0 for British patients.<sup>45</sup>

These restrictions on access to medical care have real-world consequences for patients. The Council for Affordable Health Insurance reports,

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<sup>38</sup> John C. Goodman, Gerald L. Musgrave, and Devon M. Herrick, *Lives at Risk: Single Payer National Health Insurance Around the World* (Lanham, MD: Rowman & Littlefield, 2004). A 2007 study published in *Lancet Oncology* found U.S. patients fare better for 13 of 16 types of cancer studied. See David Gratzer, “American Cancer Care Beats the Rest,” *The Wall Street Journal*, July 22, 2008.

<sup>39</sup> *Id.*

<sup>40</sup> N. Esmail, E. Walker, and D. Wrona, *Waiting Your Turn: Hospital Waiting Lists in Canada*, 17th Edition (Vancouver: Fraser Institute, 2007).

<sup>41</sup> M. Young and E. Butler, “Britain’s Million-Year Wait,” *Health Care News*, June 2002.

<sup>42</sup> Gerald Anderson, *et al.*, “It’s the Prices, Stupid: Why the United States Is So Different from Other Countries,” *Health Affairs*, May/June 2002.

<sup>43</sup> John C. Goodman, Gerald L. Musgrave, and Devon M. Herrick, *supra* note 37.

<sup>44</sup> Nadeem Esmail and Dominika Wrona, “Medical Technology in Canada,” *Studies in Health Care Policy*, Fraser Institute, August 2008, Table 10, p. 25.

<sup>45</sup> *Id.*

In Great Britain's National Health Service, breast cancer patients have been denied access to widely used cancer drugs, and lack of access to dentists has led patients to pulling out their own teeth. In Canada, 12 percent of the Ontario population can't get a family physician, and Nova Scotia resorted to a lottery so people could get a doctor's appointment.<sup>46</sup>

## Some Closing Thoughts on Rationing

The Obama health care plan would allow, and even require, the government to take over and run every aspect of the American health care system. The detailed blueprints for this take-over appear in the CEA report and were endorsed by Tom Daschle in his book and President Obama in speeches delivered before

President Obama's cost control plans involve government rationing of your health care, as in every other country that has adopted socialized medicine.

and since his election. The language of the House and Senate bills opens the door to this kind of government control. And the president's rhetoric notwithstanding, the legislation he supports would make this level of micromanagement unavoidable.

Remote government bureaucrats in Washington would decide what health care works and what doesn't, and what health care you get and when. They would decide what health care technologies and advances would be adopted and when. All of this involves pervasive and detailed central economic planning, which experience in many other fields teaches us would not work.<sup>47</sup> In other words, President Obama's cost control plans involve government rationing of your health care, as in every other country that has adopted socialized medicine.

For doctors, surgeons, and specialists, this also involves a substantial loss of control over their practice of medicine. Their clinical judgment would be increasingly displaced by the dictates of faraway government bureaucrats who don't even know their patients. This would likely accelerate the departure of health professionals from medicine and slow the entry of young professionals, exacerbating even further the problem of reduced health care supply under the Obama health care plan.

Liberal supporters of President Obama's health care takeover argue that insurance companies are already rationing and denying care. But insurance companies have nowhere near the power the government would have under the Obama health plan. Under the traditional health insurance model, if your doctor prescribes specific care or treatment, and the terms of your insurance policy cover it, the insurer has no power to deny the care or payment for it. If you choose an

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<sup>46</sup> Council for Affordable Health Insurance, *America's Affordable Health Reform Plan: A Common-Sense Solution*, 2009.

<sup>47</sup> A good review of that experience appears in Don Lavoie, *National Economic Planning: What Is Left?* Cato Institute, 1985.

HMO or other insurance that requires service or treatment from a specified network of providers, then you have agreed to give up some control over your health care in return for lower costs. But even in such cases, if you don't like how your insurer handles that control and power, you can switch to another insurance company.

Once the government controls your health care, "choice" means getting to vote for a different candidate every two or four years, hoping he or she wins, and hoping public policy will change as a result. This is all the "hope" the Obama health care plan would deliver.

## 5. Why Spending Will Increase

President Obama insists his national health plan would reduce costs. At a press conference on July 23, 2009, he said:

If we do not control these costs, we will not be able to control our deficit. If we do not reform health care, your premiums and out-of-pocket costs will continue to skyrocket. If we do not act, 14,000 Americans will continue to lose their health insurance every single day.<sup>48</sup>

But if his plan is going to reduce costs, why must taxes be increased to pay for it? If it were really reducing costs, the plan would allow taxes to be reduced, not increased.

President Obama insists his national health plan would reduce costs. But if it is going to reduce costs, why must taxes be increased to pay for it?

Taxes must go up under President Obama's plan because even with health care rationing, total costs under the Obama plan – for the government, for everyone who buys private health insurance, and for working people and their employers – would go up, not down.

One reason is that the Obama health plan provides subsidies to buy health insurance not just for the poor, but also for middle-income families earning up to \$88,000 per year and possibly more than \$100,000. This results from the proposed expansion of Medicaid and from the "affordability credits" discussed earlier.

With the government paying for health care, or for insurance that pays for health care, everyone would have new incentives to demand more health care. Over-reliance on third-party insurers already has insulated most of the population from most of the costs of health care. This inflates the demand for health care services because we do not weigh the advantages of a medical treatment or test against the benefits that might be acquired from an alternative use of the same amount of money. The problem is greater when we have comprehensive, low-deductible,

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<sup>48</sup> Barack Obama speaking at July 22 press conference, quoted by Don Gonyea, "Obama: Health Overhaul 'Central' to Economic Fix," National Public Radio, July 23, 2009, <http://www.npr.org/templates/story/story.php?storyId=106913204>.

employer-paid health insurance. It is less when we pay for our own less-inclusive, higher-deductible insurance policies.

With government paying for comprehensive, low-deductible insurance, more people would have an incentive to use health care services even though the benefits are very small compared with the cost. We would feel entitled to “get our fair share” of the free health care services our tax dollars are financing. Economists call this “the tragedy of the commons,” where people tend to over-use a “free” public good. The result is over-use and under-investment; everyone ends up worse off.

While government-subsidized insurance works to expand demand for health care, caps on physician reimbursement and other tools of rationing in the Obama health plan would reduce the supply of health care. This combination of increased demand and reduced supply results in what Milton Friedman called “the black hole of socialized medicine,”<sup>49</sup> the tendency of government-run health care systems to cost more and more while producing an ever-lower standard of health care.

New regulatory burdens under the Obama health plan would sharply increase insurance premiums. Both the House and Senate bills require guaranteed issue, which means the insurer must issue a policy to all applicants regardless of how sick they are. Someone can show up at the insurer’s door with cancer or in need of heart surgery and the insurer must cover them starting on that day. Both bills also require community rating, which means the insurer cannot adjust premiums based on the health condition of the person applying for insurance. Guaranteed issue and community rating have dramatically increased insurance premiums in states that have imposed them on private insurers.<sup>50</sup>

Milton Friedman referred to “the black hole of socialized medicine,” the tendency of government-run health care systems to cost more and more while producing an ever-lower standard of health care.

Healthy workers, particularly young ones, would have every incentive to avoid paying for health coverage until they are sick. Despite the mandates, many people would evade coverage until they need it, just as millions of drivers avoid paying for car insurance even though it is mandated by all 50 states. Wherever they can, employers would minimize their direct employment and hire labor as independent contractors. Many young workers would pocket their wages and leave it to

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<sup>49</sup> Milton Friedman, “How to Reform Health Care,” *Hoover Digest*, 2001 #3.

<sup>50</sup> See Conrad Meier, *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States*, Council for Affordable Health Insurance and The Heartland Institute, 2005.

the government to catch up with them to enforce the mandate.<sup>51</sup>

The cost of private insurance would increase even more because the government would be mandating exactly what benefits must be covered by individual and employer-provided policies. Everyone would be forced to pay higher premiums to get coverage for the benefits government would require, regardless of whether they want or need those benefits. These unnecessary mandates, mostly adopted at the state level, already increase the cost of an average health insurance plan by 25 to 50 percent.<sup>52</sup> Under the Obama plan, mandate madness would become a national disease. Without even the moderate discipline of inter-state competition, the number and cost of mandates would increase. People who currently work for companies that self-insure currently benefit from lower premiums because their plans are exempt from state mandates under the Employee Retirement Income Security Act (ERISA). If they were “dumped” into the public option, they would be forced to pay for whatever mandates are part of the government’s plan, greatly increasing the number of people subject to insurance mandates.

HSI Network estimated the House bill would cost \$3.5 trillion, and the Senate bill \$4.1 trillion, over 10 years.

People with private insurance would pay higher premiums because of cost-shifting from the public plan, as discussed above. The Lewin Group estimates that premiums for privately insured people would increase by about \$460 per year due to shortfalls in

payments to providers under the public option, partially offset by the reduction in uncompensated care resulting from expanded coverage.<sup>53</sup>

The Congressional Budget Office estimates the Obama health plan would cost the federal government roughly \$1.5 trillion over the next 10 years.<sup>54</sup> But government estimates for the cost of new government health programs have been notoriously unreliable. When Medicare was adopted in 1965, the official government estimates projected the program would cost only \$12 billion by 1990. The actual costs of the program by that year were \$109.7 billion, nine times greater than the original estimate.

Independent cost estimates for the Obama health plan have been far higher than what CBO

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<sup>51</sup> Michael Tanner, “Individual Mandates for Health Insurance: Slippery Slope to National Health Care,” *Policy Analysis* #565, Cato Institute, April 2006.

<sup>52</sup> G.A. Jensen and M. Morrissey, “Mandated Benefit Laws and Employer-Sponsored Health Insurance,” Health Insurance Association of America, 1999; Victoria Craig Bunce and J.P. Wieske, *Health Insurance Mandates in the States 2009*, Council for Affordable Health Insurance, March 2009.

<sup>53</sup> The Lewin Group, *supra* note 7, p. 18.

<sup>54</sup> Congressional Budget Office, *supra* note 3.

projects. Using its proprietary ARCOLA simulation model,<sup>55</sup> HSI Network estimated the House bill would require \$3.5 trillion in additional federal spending alone over 10 years.<sup>56</sup> The firm estimated the Senate bill would cost \$4.1 trillion over 10 years.

Even CBO, now completely run by the Democrat Congressional majorities, has concluded the Obama plan won't reduce health care spending. CBO Director Doug Elmendorf testified to the Senate Finance Committee in July,

Even CBO, now completely run by the Democrat Congressional majorities, has concluded the Obama plan won't reduce health care spending.

In the legislation that has been reported we don't see the sort of fundamental changes that would be necessary to reduce the trajectory of federal spending by a significant amount. And on the contrary, the legislation significantly expands the federal responsibility for health costs. ... [The government public option for health insurance] raises the amount of [spending] that is growing at this unsustainable rate.<sup>57</sup>

President Obama's rhetoric about how his health plan would reduce costs is false. Because the cost of health care under the Obama plan would go up, not down, the House Ways and Means Committee has passed a raft of new tax increases to pay for the increase. These include:

- An income tax increase on workers who do not purchase the government-required health insurance. The amount of the tax would be 2.5 percent of adjusted gross income or the average individual premium amount for such insurance for the year, whichever is less;
- A new payroll tax, equal to 8 percent of payroll, on employers who do not provide health insurance;
- A new excise tax on private health insurance plans;
- A new income tax surcharge on small business and others that would raise total income taxes paid. For families earning between \$350,000 and \$500,000 per year, the new tax surcharge would start at 1 percent in 2011 and rise to 2 percent in 2013. For families earning between \$500,000 and \$1,000,000, the tax would start at 1.5 percent in 2011 and rise to 3 percent in 2013. Families earning more than \$1,000,000 a year would pay a tax surcharge of 5.4 percent

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<sup>55</sup> This model is specified in detail in R. Feldman, S.T. Parente, *et al.*, "Health Savings Accounts: Early Evidence of National Take Up from the 2003 Medicare Modernization Act and Future Policy Proposals," *Health Affairs*, 24:6 (November/December 2005), pp. 1582-1591.

<sup>56</sup> HSI Network, June 13, 2009.

<sup>57</sup> Quoted by James Rowley and Kristin Jensen in "Health Care Plans Fail to Curtail Spending, CBO Says (Update 1)," Bloomberg.com, last updated July 24, 2009.

in 2011. Single taxpayers earning \$280,000 or more also would pay a surcharge.

These tax increases are all on top of other tax increases in the Obama budget that would go into effect in 2011. Together, these income tax increase proposals would raise the top marginal federal tax rate to almost 48 percent, up from 35 percent today.<sup>58</sup> Counting state income taxes, the average top income tax rate in America would climb to about 52 percent.<sup>59</sup>

Among the 30 Western countries ranked by the OECD, only three – Belgium, Denmark, and Sweden – would suffer under higher top marginal tax rates.

Such tax rates would be among the highest in the world: higher than in socialist Europe, formerly socialist India, and Communist China. Among the 30 Western countries ranked by the Organization for Economic Cooperation and Development (OECD), only three – Belgium, Denmark, and Sweden – would suffer under higher top marginal tax rates.<sup>60</sup>

If you are a blue-collar worker with a job in manufacturing, say good bye to that job as it moves to South Korea, where the total top marginal tax rate is 38.5 percent.<sup>61</sup> The U.S. rate would be more than 35 percent higher, making us uncompetitive. The U.S. rate also would be higher than the top marginal tax rates of Canada, France, Germany, and Poland, among 22 others in the OECD.

In five states politically dominated by liberal Democrats – California, Hawaii, New Jersey, New York, and Oregon – the total top tax rate would be higher than in socialist Sweden.<sup>62</sup> The nonpartisan Tax Foundation reports that 10 states would suffer total top tax rates above 54 percent, higher than in socialist Belgium at 53.7 percent.<sup>63</sup> According to the Tax Foundation, 39 states would suffer total top income tax rates over 50 percent.<sup>64</sup>

The federal capital gains tax rate – which economists know to have a significant effect on

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<sup>58</sup> Brian M. Riedl and Curtis S. Dubay, "Income Tax Surtax Should Not Fund Government Health Care Expansion," *WebMemo #2544*, July 15, 2009.

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> "If Health Surtax is 5.4%, Taxpayers in 39 States Would Pay a Top Tax Rate Over 50%" Tax Foundation, *Fiscal Fact No. 178*, July 14, 2009.

<sup>64</sup> *Id.*

economic growth rates – would be almost doubled, from 15 percent today to 26.5 percent.<sup>65</sup> The tax on corporate dividends would be more than tripled from 15 percent today to 46 percent.<sup>66</sup>

President Obama has been telling the public that his health plan would reduce federal deficits over the long run. But the Democrat-controlled Congressional Budget Office says just the opposite. Even with the many tax increases, CBO says the House bill would add another \$239 billion to the federal deficit over the next 10 years – a federal deficit that is now approaching a record-shattering \$2 trillion for this year alone, almost 10 times as large as President Ronald Reagan’s largest deficit, and more than four times President George W. Bush’s largest.

No one, not even CBO, is taking into account the economic cost of these tax increases, which is in addition to the estimated direct costs for the Obama health plans. These tax increases would result in higher unemployment, fewer jobs, lower wages, and slower economic growth. The new employer mandate payroll tax would raise employment costs for small businesses, which traditionally have been the source of most of the country’s new jobs, an economic driver that is all the more important in the current economic recession.

The federal deficit is approaching a record-shattering \$2 trillion for this year alone, almost 10 times as large as President Ronald Reagan’s largest deficit, and more than four times President George W. Bush’s largest.

The tax surcharge on high income earners also would have ripple effects throughout the economy. According to the latest data from the CBO, the top 1 percent of income earners already pay 39 percent of all federal income taxes.<sup>67</sup> The top 5 percent pay 61 percent, and the top 10 percent pay 73 percent. These high income earners have a great deal of flexibility and control over their incomes, investments, hours worked, and the form of their incomes. They would not sit still for even higher taxes.

The tax hikes needed to fund the Obama health plan would cause capital flight from the U.S. as domestic and foreign capital seek more friendly tax jurisdictions in emerging markets in Brazil, China, India, South Korea, and even in Eastern European countries with favorable flat-tax policies. Even most of Western Europe would have more competitive tax policies. The stagnating effect of these tax increases means they would not raise nearly as much revenue as currently projected, leaving still higher budget deficits and sharply higher national debt – already projected to triple over the next 10 years.

There is no rule of reality that says America must have the highest standard of living in the world. Under the Obama health care plan, it soon would not.

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<sup>65</sup> American Shareholders Association, July 15, 2009; Americans for Tax Reform, July 15, 2009.

<sup>66</sup> *Id.*

<sup>67</sup> Congressional Budget Office, *Historical Effective Federal Tax Rates: 1979 to 2006*, April 2009.

## 6. America Already Suffers an Intractable Entitlements Crisis

America can't finance all the long-term entitlement promises it already has made to Social Security, Medicare, and Medicaid beneficiaries. But President Obama and Congressional Democrats ignore this fact and insist instead on adopting still another entitlement with subsidies for health insurance for families making \$100,000 a year or more, and Medicaid expanded even further.

The latest Trustees' Reports show the unfunded liability for Medicare alone is \$89 trillion.<sup>68</sup> Social Security adds another \$15.1 trillion in unfunded liabilities, for a total of \$104 trillion.<sup>69</sup> And that doesn't even count Medicaid. The entire American economy right now produces only about \$14 trillion a year.

Since World War II, going back 60 years, total federal spending as a share of Gross Domestic Product has been stable, hovering around 20 percent. But the cost of the three big entitlement programs alone, Social Security, Medicare, and Medicaid, is now projected to eventually reach 20.5 percent of GDP.

In the face of this long-term entitlement crisis, it could not be more fiscally reckless and irresponsible to propose a new middle-class entitlement for health insurance.

Counting burgeoning interest on the national debt, on our current course federal spending would skyrocket towards 40 percent of GDP by 2040. Counting state and local spending, total government in America would consume more than 50 percent of GDP. GDP would collapse under the weight of all that spending and the resulting taxation and debt. America, quite simply, would no longer be a free

country in terms of the freedom of people to enjoy the fruits of their own labor.

This doubling of federal spending as a share of GDP implies a doubling of federal tax rates. The Heritage Foundation reports that trying to pay all of the promised benefits of Social Security, Medicare, and Medicaid by raising income taxes would require raising the top 35 percent tax bracket to 77 percent and the 25 percent tax bracket paid by middle-income earners to

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<sup>68</sup> The 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 12, 2009; p. 69, Table III.B10; p. 112, Table III.C16; p. 127, Table III.C23.

<sup>69</sup> The 2009 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, May 12, 2009, pp. 62, 63, Table IV.B6. Measuring the unfunded liability as under a private pension plan that cannot count on forced contributions from others not presently participating in the system would yield an unfunded liability of \$16.3 trillion for Social Security. *Id.*, pp. 63, 64, Table IV.B7. This assumes in addition another \$2.4 trillion in federal borrowing to make good on the Social Security bonds held by the Social Security trust funds.

55 percent.<sup>70</sup> All income tax brackets, in fact, would have to be doubled.

By 2018, less than 10 years from now, Medicare Part A will be running a deficit of close to \$100 billion. General revenue contributions for Medicare Parts B and D that year are now projected to be \$364 billion. Consequently, the deficit for Medicare alone that year will be close to \$500 billion, and that assumes a scheduled reduction, which Congress will surely reverse, in doctor and hospital reimbursements of more than 20 percent.

President Obama's runaway tax-and-spend economic policies are making all of this much worse. CBO projects the national debt would soar under his budget, from 40 percent of GDP today to 82 percent by 2019, almost as big as our entire economy.<sup>71</sup> And this 10-year period includes only the very beginnings of the exploding entitlement crisis. The national debt at the end of World War II was 113 percent of GDP. Throwing President Obama's economic policies on top of the entitlement crisis would shoot the national debt well past that record. House GOP budget chief Paul Ryan projects the national debt would reach 200 percent of GDP by 2035 and continue rocketing upwards.

And this is *before* adoption of a new national health care entitlement. In the face of this long-term entitlement crisis, it could not be more fiscally reckless and irresponsible to propose a new middle-class entitlement for health insurance.

The Obama government takeover of health care is unnecessary. Policies can be adopted that provide a true safety net for the uninsured, so no one would suffer without essential health care.

## 7. The Patient Power Alternative

The Obama government takeover of health care is unnecessary. Policies can be adopted that provide a true safety net for the uninsured so no one would suffer without essential health care. Other policies can be adopted that would provide true and effective incentives to control costs. Removing costly and unnecessary regulatory burdens on health insurance would further reduce costs.

These policies can be adopted while expanding patients' control over their own health care, so that health care choices are made by patients and their doctors, not by third-party bureaucrats. All of this can be accomplished without the government taking over the health care system and making everything worse in the process.

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<sup>70</sup> Brian M. Riedl and Alison Acosta Fraser, "How to Reform Entitlement Spending: A Memo to President Elect Obama," *Special Report #43*, The Heritage Foundation, Washington, DC, January 13, 2009, p. 2.

<sup>71</sup> Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2010*, June, 2009, p. 4, Table 1-3.

## Focusing on the Truly Needy

President Obama and the Democrats talk about many things that could be wrong with the American health care system and therefore might justify government intervention, but the one fault that gets the most emphasis and attention is the number of uninsured. The claim that 47 million Americans are without insurance is endlessly repeated by administration spokespersons and reported uncritically by the press. But this estimate is wildly exaggerated.

Twelve million people who are uninsured in America are eligible for public programs like Medicaid, SCHIP, or Medicare, but are not enrolled.<sup>72</sup> They immediately become insured when they enter a hospital and ask for care. Another 16.2 million earn over 250 percent of the poverty level<sup>73</sup> (about \$50,000 for a family of four and about \$25,000 for childless singles). With some exceptions involving people with pre-existing conditions who have allowed their insurance coverage to lapse, they could afford to purchase insurance but choose not to. That leaves closer to 18.8 million uninsured who may actually be unable to purchase health insurance. But even this number overstates the size of the problem.

About 10 million of the uninsured overall are non-citizens, whether here legally or illegally. Right or wrong, many American taxpayers doubt whether their taxes should be used to subsidize or buy health insurance for members of this group.

At least half of the low-income uninsured are young adults, ages 18-34,<sup>74</sup> many of whom do not want to spend the money for health insurance, and the great majority of whom do not incur substantial medical expenses. Health insurance is simply a bad deal for these people, and so long as care is available on a cash or credit basis, or via the safety net of free care for the indigent, they will continue to choose not to buy health insurance.

About 10 million of the uninsured overall are non-citizens,<sup>75</sup> whether here legally or illegally. Right or wrong, many American taxpayers doubt whether their taxes should be used to subsidize or buy health insurance for members of this group.

Finally, many of the people who are uninsured lack insurance for only short periods of time.

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<sup>72</sup> National Institute for Health Care Management, *Understanding the Uninsured: Tailoring Policy Solutions for Different Subpopulations*, NIHCM Foundation Issue Brief, April 2008; March 2007 Current Population Survey, U.S. Bureau of the Census.

<sup>73</sup> June E. O'Neill and Dave M. O'Neill, *Who Are the Uninsured: An Analysis of America's Uninsured Population, Their Characteristics, and Their Health*, Employment Policies Institute, June, 2009, p. 8, Table 2.

<sup>74</sup> *Id.*, p. 14, Table 7.

<sup>75</sup> NIHCM Foundation Issue Brief, *supra* note 71, p. 2; March 2007 Current Population Survey, U.S. Bureau of the Census.

Three quarters of the uninsured regain coverage within 12 months.<sup>76</sup> Being without insurance for several weeks or months is not the same as lacking access to care: Care can be purchased with cash or credit, people with low incomes can receive free or subsidized care, and some kinds of care and treatment can be delayed or scheduled for when insurance is recovered.

All these numbers and explanations for being uninsured don't mean there is no "uninsured problem." There is ... too many people who would benefit from having health insurance currently are uninsured. What these numbers and explanations mean is that the uninsured population is heterogeneous: Not everyone who is uninsured lacks access to care or deserves taxpayer assistance. Most don't need the government to come to the rescue with free or subsidized insurance. Yet the fiction that "47 million people are uninsured" drives much of the urgency of the present debate.

Understanding that the true size of the problem is much smaller than 47 million people, and more complicated than simply "let's insure everyone," opens the door to a series of reforms that target aid to the people who genuinely need it and remove barriers to affordable health care that really matter. The reforms described below would provide a true health care safety net for all uninsured Americans.

## Reform Medicaid

We already have a program that is supposed to provide a safety net for health care: Medicaid. Yet that program is just another example of the black hole of socialized medicine. It already costs more than \$400 billion a year and its costs are projected to explode in future years. It is projected to cost almost \$5 trillion over the next 10 years alone, reaching an annual cost of \$674 billion in 2017 alone.

Medicaid reform should be based on the enormously successful 1996 reform of the old Aid to Families with Dependent Children (AFDC) welfare program.

Remarkably, given all that spending, Medicaid payments to doctors and hospitals are already so low – 30 to 40 percent less than under Medicare – that a growing number of doctors and hospitals do not accept Medicaid patients. Medicaid clearly needs to be reformed, but how?

Medicaid reform should be based on the enormously successful 1996 reform of the old Aid to Families with Dependent Children (AFDC) welfare program.<sup>77</sup> That reform sent the federal share

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<sup>76</sup> Census Bureau, *Health Insurance Coverage: 2005*, Housing and Household Economic Statistics Division, 2007.

<sup>77</sup> See Gary MacDougal, Kate Campaigne, and Dane Wendell, *Welfare Reform After Ten Years: A State-by-State Analysis*, Chicago, IL: The Heartland Institute, 2009.

of spending for the program back to each state in a finite block grant, with each state then to create a new welfare program focused on getting recipients back to work.

Under the old program's matching-funds formula, the federal government sent states more money the more they spent, which encouraged states to enroll people in AFDC welfare. In 1996, the matching-funds formula was replaced with a fixed federal block grant to each state which did not vary with the amount of state spending. If costs for the program rose in a state, the state would have to pay for the added costs itself. If the state saved money through innovation and finding work for those on the welfare rolls, the state could keep the savings.

This reform transformed the incentives for the state bureaucrats running the programs, with spectacular results. Welfare rolls dropped from 12.2 million in 1996 to 4.1 million in 2006, a national decline of 67 percent.<sup>78</sup>

Armed with vouchers, poor families would be free to choose the health insurance coverage they prefer, including health savings accounts.

Medicaid reform should follow that model. The current matching-funds formula should be replaced with finite block grants, adjusted each year for health care inflation, to be used for a completely redesigned Medicaid program in each state. Under such a reform, states could better serve the poor by using the

program to provide vouchers for the purchase of private health insurance, enabling the poor to enjoy the same health coverage as middle-income earners. Armed with vouchers, poor families would be free to choose the health insurance coverage they prefer, including the health savings accounts discussed below. This would enable them to escape the low-quality coverage and care of the current Medicaid ghetto. Like the modernized AFDC, Medicaid vouchers should be subject to a work requirement for the able-bodied.

Each state's voters would be free to decide how much assistance for the purchase of health insurance they wanted to provide at what income levels. Reforms that would increase the quality of care while lowering costs, which state lawmakers and bureaucrats currently have little incentive to consider, could finally get the attention they deserve.<sup>79</sup> The poor would be assured of enough assistance to purchase at least basic, essential, health insurance, so no one would have to go uninsured because they didn't have enough money to buy health insurance.

## State High-Risk Pools

States and the federal government also could do more to help fund high-risk health insurance

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<sup>78</sup> *Id.*

<sup>79</sup> For example, see John C. Goodman, "Ten Steps to Reforming Medicaid," *Health Care News*, July 2008, and John C. Goodman *et al.*, *Handbook on State Health Care Reform*, National Center for Policy Analysis, 2008.

pools for those who do not qualify for Medicaid but who cannot afford to buy private health coverage. The majority of states already have such risk pools, and they work quite well.<sup>80</sup> Those who cannot obtain health insurance because of their health condition are typically eligible for coverage through the state's risk pool and are charged premiums that are subsidized by a tax on insurance companies or by general tax revenues.

Few people become truly uninsurable because of a health condition. But trying to force those who do into the same insurance market as everyone else, through such regulations as guaranteed issue and community rating, just ruins health insurance for the general public, making it too expensive and sharply increasing the number of people who choose to go without insurance as a result. Providing for the uninsurable separately through their own pool is a much better policy.

High-risk pools would address the problem of pre-existing conditions as well. Most insurers limit coverage for pre-existing conditions for only a few months. Each state's high-risk pool could provide coverage for pre-existing conditions during those excluded months.

High-risk pools are not without their critics.<sup>81</sup> Most of the criticism focuses on the lack of financing for the pools, which forces fund managers to enforce tight restrictions and caps on enrollments, raise cost-sharing, and minimize marketing outreach to the uninsured. The cost of expanding high-risk pools to address these concerns, while still limiting access to the truly needy, would be tiny compared to the costs of the Obama health plan.

The cost of expanding high-risk pools to address these concerns, while still providing access to the truly needy, would be tiny compared to the costs of the Obama health plan.

Expanding high-risk pools, along with Medicaid vouchers for insurance coverage, would provide a true health care safety net for everyone, ensuring no one would have to suffer without essential medical care.

## Guaranteed Renewability

Federal and state laws should be changed to provide for guaranteed renewability of all health insurance.<sup>82</sup> This is supposed to be the law in all 50 states, but it does not seem to be the case in

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<sup>80</sup> J.P. Wieske and Merrill Matthews, *Understanding the Uninsured and What to Do about Them*, Council for Affordable Health Insurance, 2007; NASCHIP, *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 22nd Edition, 2008-2009*, Denver, 2008.

<sup>81</sup> See L. Achman and D. Chollet, "Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools," The Commonwealth Fund, August 2001.

<sup>82</sup> Vip Patel and Mark Pauly, "Guaranteed Renewability and the Problem of Risk Variation in Individual Health Insurance Markets," *Health Affairs*, August 2002; Bradley Herring and Mark V. Pauly, "Incentive-Compatible Guaranteed Renewable Health Insurance Premiums," *Journal of Health Economics*,

reality, at least not in all states.

An insurance company should not be permitted to cancel a health insurance policy after the beneficiary becomes sick, so long as premiums are paid. Allowing insurers to do otherwise would be like allowing an insurer to cancel a fire insurance policy once the house catches on fire. Such a policy would provide no real protection against the costs of fire, just as health insurance that is not renewable provides no protection against serious illnesses. Guaranteed renewability should include prohibiting the insurer from raising the premiums for someone who becomes sick beyond the normal increase for his entire rate class.

Guaranteed renewability ensures that everyone who has health insurance can keep it, so long as they continue to pay for it. It is *not* unworkable or counterintuitive, as guaranteed issue and community rating are. While guaranteed renewability encourages people to become insured and maintain their policies *before* they need insurance, guaranteed issue and community rating *discourage* people from becoming insured ... until after the house catches fire or they become sick.

## Reducing Health Insurance Costs

With Medicaid reform, high-risk pools, and guaranteed renewability in place, state and federal governments could adopt policies to reduce the costs of health insurance, enabling more people to buy such insurance and reducing the number of uninsured.

State and federal governments should adopt policies to reduce the costs of health insurance, enabling more people to buy such insurance and reducing the number of uninsured.

This could start with repealing all requirements for guaranteed issue and community rating, which experience has shown raise the costs of health insurance sharply and increase the number of uninsured.<sup>83</sup> With Medicaid vouchers and state uninsurable risk pools, guaranteed issue and community rating would be unnecessary and counterproductive.

Another factor dramatically increasing the cost of health insurance is special-interest state mandates that require insurance to cover particular health care providers and services that patients should be free to choose – or not choose – on their own. States have imposed more than 2,000 such mandates nationwide, raising the costs of health insurance by 25 to 50 percent, increasing the number of uninsured as a result.<sup>84</sup> Each state should make available to all

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May 2006, pp. 395-417.

<sup>83</sup> See Conrad Meier, *supra* note 49.

<sup>84</sup> Victoria Craig Bunce and JP Wieske, *supra* note 51.

consumers a basic insurance option without these unnecessary special-interest mandates.

To further reduce the costs of health insurance, federal law should be changed to allow insurers to sell health insurance nationwide across state lines. Each insurer would be subject to the regulation of its home state. This would create a competition among the states to allow basic insurance without unnecessary mandates, leading to sharply reduced costs.

The Medicaid reforms proposed earlier also would reduce the cost of health insurance by transferring Medicaid patients to the private insurance market, ending the cost-shifting to private insurance that currently results from the steep underpayment of doctors and hospitals under Medicaid.

### **Medical Malpractice Reform**

Unnecessary, wasteful, costly lawsuits add to the costs of health care and health insurance in America.<sup>85</sup> Some doctors and specialists pay astronomical malpractice insurance fees as a result. Sensible liability reforms would reduce such costs.

Unnecessary, wasteful, costly lawsuits add to the costs of health care and health insurance in America.
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Non-economic damages, such as compensation for pain and suffering, should be sharply limited. Punitive damages should apply only in criminal proceedings, not in civil trials. Traditional tort standards for medical liability should be strictly enforced. Doctors and hospitals should be responsible only for damages for which they were the proximate cause.

### **Health Savings Accounts**

The most important innovation for reducing health costs is health savings accounts (HSAs). Individuals with HSAs keep most of their money for health care in a savings account, earning tax-free interest, with the rest going to purchase a high-deductible catastrophic insurance policy. The premium cost for such catastrophic coverage, with deductibles generally ranging from \$2,000 to \$6,000 a year, is much lower than for standard, low-deductible health insurance, allowing the savings in the account to grow quickly to cover the entire deductible.

Patients with HSAs are free to use the money in their accounts for any health care, including preventive care, check-ups, prescriptions, dental care, eye care, and the full range of alternative medicine. Nothing can do more to put patients in control of their own health care. All

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<sup>85</sup> J.P. Wieske, *2007 State Legislators Guide to Health Insurance Solutions*, Council for Affordable Health Insurance, January 2007, pp. 29-30; American Medical Association, "Medical Liability Reform – NOW!" July 19, 2006; U.S. Department of Health and Human Services, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System*, July 2002.

non-catastrophic health care is completely under patients' control.

At the same time, HSAs restore powerful market incentives to control costs. Money kept in HSAs can be used for health care in later years, or for anything in retirement. Patients are using *their own money* for non-catastrophic care. That means they will avoid overly costly or unnecessary care and look for doctors and hospitals that can provide them quality care at lower cost, creating real market competition to reduce costs.

To strengthen the incentives for being a careful health care consumer, employees with HSAs should be permitted to take some money out of the account at the end of the year for any use, as a reward for saving on health costs. Such incentives have proven highly effective and are the only morally sound means of reducing health care costs across the board.

Similar to HSAs are the health reimbursement arrangements (HRAs) offered by some employers. The employer contributes all of the money to an HRA and retains control over it, but the employee is free to use the money in the account for the health care he or she wants. About 20 percent of the privately insured population in the U.S. is now covered by HSAs, HRAs, or similar high-deductible coverage.<sup>86</sup>

Almost 12 million Americans now enjoy high-deductible health insurance coverage, with \$9.2 billion in health savings account deposits, projected to grow to \$16 billion in 2010.

Participation in such high-deductible coverage plans has been soaring in recent years. The number of Americans with an HSA or similar high-deductible plan increased by 40.6 percent from 2006 to 2007, and then again 35.5 percent from 2007 to 2008, and another 31 percent from 2008 to 2009.<sup>87</sup> In 2008, 20 percent of employers with 500 or more employees offered such

plans, up from 14 percent in 2007.<sup>88</sup> Also in 2008, HSAs or similar high-deductible plans represented 31 percent of new coverage issued in the small group market.<sup>89</sup> Overall, almost 12 million Americans now enjoy such coverage, with \$9.2 billion in HSA deposits, projected to grow to \$16 billion in 2010.<sup>90</sup> Enrollment in such plans may well exceed HMO enrollment this year.

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<sup>86</sup> Robin Cohen, *et al.*, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January – March 2008," Centers for Disease Control, <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200809.htm>.

<sup>87</sup> America's Health Insurance Plans (AHIP), "January 2009 Census Shows 8 Million People Covered by HAS/High Deductible Plans," May 2009.

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> Interpro Publications, Consumer Driven Market Report, 2009 Issue #2.

Health insurance premiums paid by companies with at least half of their workforce enrolled in HSAs and other high-deductible plans rose about 50 percent less over the past two years than the average for other companies.<sup>91</sup> Similar results were reported by federal employees choosing HSAs over standard coverage.<sup>92</sup> WellPoint and Cigna report no increase in costs for such plans from 2007 to 2008, and similar programs offered by the Postal Workers Union and the Government Employees Health Association experienced no increase in premiums for four years running.<sup>93</sup>

Health savings accounts are a prime example of something that is working to improve America's health care system. The Obama health plan abandons this promising reform and in fact moves in the opposite direction, taking power away from millions of people by forcing them into a one-size-fits-all government insurance plan.

True reform of the nation's health care system is within reach. Many of the tactics and ideas have been debated for years, and more than a few (such as high-risk pools) have been implemented by progressive states. The key is to empower health care consumers to make the right decisions with their health care dollars.

## 8. Conclusion

This study has explained how the Obama health plan would result in comprehensive government rationing of your health care, with the government, not you and your doctor, deciding what health care you would get and when. For many Americans, especially senior citizens, this means the government would deny you access to the quality of health care you enjoy today.

Rationing is exactly what President Obama is talking about when he says, repeatedly, that his health plan would reduce health costs.

Such rationing is exactly what President Obama is talking about when he says, repeatedly, that his health plan would reduce health costs. His own Council of Economic Advisors specifies a system of rationing to achieve such cost savings. This should not come as a surprise: Rationing has occurred in every country that has adopted a government-run health care system.

Even with such rationing, the Obama health plan would result in higher, not lower, health care costs. This is because it expands comprehensive, low-deductible health insurance coverage, increases subsidies through Medicaid and for the middle-class and beyond, and increases

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<sup>91</sup> *Id.*

<sup>92</sup> Greg Scandlen, "Ten Ways Consumer Driven Health Care is a Proven Success," *CHCC Report*, May 2009, [http://www.heartland.org/custom/semod\\_policybot/pdf/25244.pdf](http://www.heartland.org/custom/semod_policybot/pdf/25244.pdf), p. 2.

<sup>93</sup> *Id.*

demand for health care services while at the same time reducing the supply of those services.

This is why the Obama health plan requires higher, not lower, taxes. The tax increases supported by President Obama and the Democrat Congressional majorities would leave America uncompetitive in the world marketplace, with investors finding far more friendly tax climates in Brazil, Communist China, India, South Korea, and European countries

The Obama health plan is the wrong approach to health care reform, offered at the wrong time.

Despite these tax increases, the Congressional Budget Office projects the Obama health plan would further increase our already record-shattering deficits and soaring national debt. The tax increases would result in higher unemployment, fewer jobs, lower wages, and

slower economic growth. The employer mandate payroll tax would impose a heavy new burden on small businesses at just the time we need them to lead the economic recovery.

America can't finance all the promises it already has made to Social Security, Medicare, and Medicaid beneficiaries. President Obama and Congressional Democrats are acting in a fiscally reckless and irresponsible way in the face of this long-term entitlement crisis.

The Obama government takeover of health care is unnecessary. Real, long-lasting reform can be accomplished without the government taking over the health care system. Key reforms are focusing on the truly needy, Medicaid reform, high-risk pools, repealing mandates and regulations that inflate insurance costs, and expanding health savings accounts.

The Obama health plan is the wrong approach to health care reform, offered at the wrong time.

## About the Author

Peter Ferrara is director of entitlement and budget policy for the Institute for Policy Innovation and general counsel of the American Civil Rights Union, among other posts. He served as a senior staff member in the White House Office of Policy Development under President Ronald Reagan and as associate deputy attorney general under President George H.W. Bush. He is a graduate of Harvard College and Harvard Law School and has practiced law with firms on Wall Street and in Washington, DC. He wrote the first book for the Cato Institute providing a comprehensive intellectual foundation for a personal account option for Social Security, *Social Security: The Inherent Contradiction* (1980), and has continued to write on that concept in further books, studies, and articles for Cato, The Heritage Foundation, National Center for Policy Analysis, Family Research Council, U.S. Chamber of Commerce, and a wide range of other institutions and publications.

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