Executive Summary
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The Obama Health Care Plan: More Power to Washington

Robert E. Moffit, Ph.D., and Nina Owcharenko

Senator Barack Obama (D–IL) has unveiled an ambitious health care plan that is comprehensive in scope, sparse in detail, and therefore uncertain in its cost and savings estimates. His proposals focus on three stated objectives: offering affordable, comprehensive, and portable coverage; containing spiraling health care costs and improving quality of care; and promoting and strengthening prevention and public health. These key goals would appeal to most Americans, but the coercive means to accomplish them will be far less attractive.

Very little in the Obama health plan is new or original. Many of its policy initiatives are recycled from the ill-fated Clinton health plan of 1993 and the Kerry health plan of 2004 and strongly resemble a detailed proposal by the Commonwealth Fund, a prominent liberal think tank. In general, the Obama plan would give the federal government even more control of health care dollars and decisions—accelerating the federal domination of the U.S. health care system.

Instead of using the federal government to change the health care system from the top down, policymakers should transfer direct control of health care dollars back to individuals and families. Such a system of personal ownership would allow Americans to exercise real personal choice of health plans and benefits by choosing those plans that best meet their needs. This would also make health plans and providers compete directly for their dollars. Personal ownership of health care would help to control costs and guarantee better quality.

The Obama Plan. The Obama plan proposes a comprehensive, standardized federal health benefits structure; a massive expansion of federal regulatory authority over health insurance; and an enlargement of federal regulatory power over health care delivery, including the defining of what constitutes "quality" care. Moreover, the plan would prop up the existing employer-based health insurance system and government health programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), to expand health insurance coverage.

Centralizing Control. The most significant change in the Obama plan is a proposal to consolidate even more control of health care dollars and decisions in Washington, D.C. This is a radical departure from the decentralized decision-making system that sets the United States apart from other developed countries. His plan includes several initiatives that would give the federal government extensive control of the financing, delivery, and management of health care. These government initiatives would likely precipitate a rapid

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evolution toward a federal monopoly over the health care sector. These initiatives include:

- **New federal provision and control of health care.** Obama's new government-run national health plan would compete directly with private health plans in a National Health Insurance Exchange. Federal officials would not only run the new government plan but also use the exchange as a "watchdog" over participating private health plans. The federal government would decide the level of health benefits that Americans would receive through the exchange. These rules would apply to the new national health plan and all participating private health plans.
- **Additional federal involvement in employer-based coverage.** The Obama plan would mandate that employers provide a federally approved level of health benefits to their workers or pay a tax to help finance the government's new health plan. The plan does not specify the level of the employer contribution, value of the required health benefits package, or size of the payroll tax. The federal government would also assume the high-end costs of employer-based coverage and provide a new taxpayer subsidy to small businesses to encourage them to offer coverage. In any case, the Obama prescription would end employer-based health insurance as millions of Americans know it.
- **Expansion of existing government health programs, restrictions on state experimentation, and mandated coverage for children.** The plan calls for unspecified expansions of Medicaid and SCHIP and would severely limited states' ability to develop health care reform proposals on their own. Additionally, it would require parents to ensure that their children have health care coverage.
- **Federal regulation of health care delivery.** The federal government would regulate the delivery of medical care through specific initiatives, such as those that would govern medical reimbursement and determine the "comparative effectiveness" of medical treatments and procedures. It would also increase the federal regulation of medical liability reform, prescription drugs, and health insurance.

Cost Implications. How much the Obama health plan would cost American taxpayers is unclear. Independent economists have attempted to offer some estimates, but the lack of concrete details makes the true costs uncertain.

A Better Way. Despite the Senator's rhetoric of "choice and competition," his plan is laden with new regulations and government authority that would leave ordinary Americans with even less control of their health care dollars than they exercise today.

Instead of using the massive power of the federal government to impose a top-down change on the health care system, Senator Obama and other policymakers would be wise to transfer direct control of health care dollars to individuals and families. This would enable Americans to exercise real personal choice of health plans and benefits while making health plans and providers compete directly for consumers' dollars by providing value to patients.

The next President and Congress should start to level the playing field through tax and regulatory changes designed to harness the power of free-market competition to improve access, promote portability, and restrain health care spending. Specifically, they should reform the tax treatment of health insurance, expand options for employers and individuals to purchase health insurance, and restructure poorly performing public programs to help those in need buy superior coverage through private health insurance.

Such policies would constitute real change. They would empower individuals to make informed choices and enable the marketplace to respond rapidly to their needs and wants rather than placing them at the mercy of government bureaucrats and politicians in Washington.

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If I were designing a system from scratch, I would probably go ahead with a single-payer system.

—Senator Barack Obama[1]

Senator Barack Obama (D–IL), the Democratic presidential nominee, has unveiled an ambitious health care plan that is comprehensive in scope, sparse in detail, and limited in its cost estimates. The Senator insists that his proposal would save the typical American family $2,500 in medical costs. These savings are implausible, and the costs are unknown.

The Senator's proposals are organized around three stated objectives: offering affordable, comprehensive, and portable coverage; containing spiraling health care costs and improving quality of care; and promoting and strengthening prevention and public health.[2] These key goals would appeal to most Americans, but the coercive means required to accomplish these goals will be far less attractive.

Very little in the Obama health plan is new or original. A number of its policy initiatives are recycled from the ill-fated Clinton health plan of 1994 and the Kerry health plan of 2004 and bear a stark resemblance to a more detailed proposal by the Commonwealth Fund, a prominent liberal think tank. In general, the Obama plan would give the federal government even more control of health care dollars and decisions—a radical departure from the decentralized decision-making system that characterizes employer-based insurance and state-based insurance regulation.

Talking Points

- Senator Barack Obama's health plan is comprehensive in scope, but its costs are unknown and its savings implausible.
- The plan would centralize decision-making in Washington, with the federal government running a new government health plan, and existing government-run health programs expanded. According to the Lewin Group, over 48.3 million Americans would be in government coverage.
- The plan would move more Americans out of employer-based coverage and into government care by imposing a new payroll tax on employers. The Lewin Group estimates over 22.5 million workers and their families to lose employer-based coverage.
- The plan's delivery reforms could become regulatory tools that limit access to care and services.
- Policymakers should transfer direct control of health care dollars to individuals and families so that the health care system can respond rapidly to their needs and wants rather than placing them at the mercy of Washington bureaucrats and politicians.

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Instead of using the federal government to change the health care system from the top down, policymakers should transfer direct control of health care dollars back to individuals and families—the people with a personal interest in obtaining the best care at lower cost. Such a system of personal ownership would allow Americans to exercise real personal choice of health plans and benefits in choosing those plans that best meet their needs. This would also make health plans and providers compete directly for their dollars by providing value to consumers and patients. Personal ownership of health care would help to control costs and guarantee better quality, eliminating the need to depend on the government or third-party payers.

The Obama Health Care Plan

Similar to the Clinton health plan of 1994, the Kerry health plan of 2004, and the Commonwealth Fund's "The Building Blocks of Health Reform,"[3] the Obama plan proposes a comprehensive, standardized federal health benefits structure; a massive expansion of federal regulatory authority over health insurance; and an enlargement of federal regulatory power over health care delivery, including defining and determining what constitutes "quality" health care.

Moreover, the plan would prop up the existing employer-based health insurance system and existing government health programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), in an effort to expand health insurance coverage.

Centralizing Control. The most significant change in the Obama plan is a proposal to consolidate even more control of health care dollars and decisions in Washington, D.C. This is a radical departure from the existing system, which sets the United States apart from other developed countries.[4]

The Obama plan includes several initiatives that would give the federal government extensive control of the financing, delivery, and management of health care. These government initiatives would likely precipitate a rapid evolution toward a federal monopoly over the health care sector. These initiatives include:

- **New federal provision and control of health care.** Obama's new government-run national health plan would compete directly with private health plans in a National Health Insurance Exchange. Federal officials would not only run the new government plan but also use the exchange as a "watchdog" over private health plans "competing" in the exchange. The federal government would decide the level of health benefits that Americans would receive through the exchange. These benefit rules would apply to the new national health plan and all participating private health plans.
- **Additional federal involvement in employer-based coverage.** The Obama plan would mandate that employers either provide a federally

1. Amy Chozick, "Obama Touts Single Payer System for Health Care," *The Wall Street Journal*, August 19, 2008, at *http://blogs.wsj.com/washwire/2008/08/19/obama-touts-single-payer-system* (October 3, 2008).
2. Obama for America, "Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All," at *http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf* (October 3, 2008). See also Barack Obama, "Promising All Americans Good Value and Good Health," *Contingencies*, September/October 2008, pp. 33–35.
3. See Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993, at *http://www.heritage.org/research/healthcare/tp00.cfm*; Robert E. Moffit, Nina Owcharenko, and Edmund F. Haislmaier, "Details Matter: A Closer Look at Senator Kerry's Health Care Plan," Heritage Foundation *Backgrounder* No. 1805, October 12, 2004, at *http://www.heritage.org/research/healthcare/bg1805.cfm*; and Karen Davis, Cathy Schoen, and Sara R. Collins, "The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings," Commonwealth Fund *Issue Brief*, May 2008, at *http://www.commonwealthfund.org/usr_doc/Davis_buildingblocks_1135_ib.pdf* (October 3, 2008).
4. "The U.S. healthcare system provides a conspicuous contrast to the healthcare systems of other developed countries. It is not centrally controlled and has a very complex structure of financing, insurance, delivery, and payment mechanisms." Leiyu Shi, Lydie A. Lebrun, and Jenna Tsai, "Reforming U.S. Healthcare Delivery," *Harvard Health Policy Review*, Vol. 9, No. 1 (Spring 2008), p. 69.

approved level of health benefits to their workers or pay a tax to help finance the government's new national health plan. The plan does not specify the level of the employer contribution, the value of the required health benefits package, or the size of the payroll tax. The federal government would also assume the high-end costs of employer-based coverage and provide a new taxpayer subsidy to small businesses to encourage them to offer coverage. In any case, the Obama prescription would end employer-based health insurance as Americans know it.

- **Expansion of existing government health programs, restrictions on state experimentation, and mandated coverage for children.** The plan calls for unspecified expansions of Medicaid and SCHIP. In a significant shift from current practice, the plan would severely limited states' ability to develop health care proposals on their own. Additionally, it would require parents to ensure that their children have health care coverage.
- **Federal regulation of health care delivery.** The federal government would regulate the delivery of medical care through specific initiatives, such as those that would govern medical reimbursement and determine the "comparative effectiveness" of medical treatments and procedures. It would also increase the federal regulation of medical liability reform, prescription drugs, and health insurance.

Cost Implications. How much the Obama health plan would cost American taxpayers is unclear. Independent economists have attempted to offer some cost estimates, but the lack of concrete details makes the exact costs uncertain.

More Federal Control of Health Care

> *I will establish a new national health plan, similar to the plan available to federal employees and Members of Congress, that gives every American the opportunity to buy affordable health coverage.*[5]

Senator Obama says he would create another government health care plan in addition to Medicare, Medicaid, and SCHIP. It would be available to individuals who cannot access employer-based coverage or do not qualify for existing public programs, such as Medicaid and SCHIP. The new government plan would also be available to the self-employed and small businesses.

The plan would have benefits similar to those in the Federal Employees Health Benefits Program (FEHBP), which serves Members of Congress, federal workers, and federal retirees. Benefits must also include prevention, maternity care, mental health care, disease management, self-management training, and care coordination.

According to Senator Obama's description of the new plan, no one could be denied access based on health status. Premiums would be "fair," with only "minimal" cost sharing for deductibles and preventive care. The federal government would provide income-based subsidies to needy individuals and families to enable them to buy health coverage. These subsidies could be used to purchase the new government plan or private insurance. Only federally approved private health plans would be eligible to participate alongside the government plan in the new National Health Insurance Exchange.

Doctors and hospitals that contract with the national health plan would be required to collect and report data to ensure that they comply with the federal standards for health quality, information technology, and administration as envisioned by an Obama Administration.[6] Yet even while imposing new reporting requirements for all of these items, Senator Obama promises to "simplify paperwork" for doctors and hospitals, which is expected to reduce costs throughout the system.[7]

Exactly how the plan would meet these seemingly incompatible goals of requiring additional reporting and reducing paperwork is not clear from the proposal. Perhaps it assumes that physician and

5. Obama, "Promising All Americans Good Value and Good Health," p. 33.
6. *Ibid.*
7. *Ibid.*

hospital compliance with the proposed information technology standards would yield these multiple benefits.

The new government plan, offered through a National Health Insurance Exchange, is the cornerstone of the Obama plan. In some respects, it resembles the Congressional Health Plan proposed by Senator John Kerry (D–MA) during the 2004 presidential campaign.[8]

Senator Obama's pointed reference to the popular and successful Federal Employees Health Benefits Program is obviously intended to make the new government-run national health plan politically attractive to ordinary Americans. However, Obama's new government plan would function very differently.

The FEHBP. There is much confusion about the FEHBP, its unique character, its structure, and how it actually works. Misinterpretations are common and sometimes deliberate. For one thing, the FEHBP simply does not have "a benefit package" or any type of standardized health benefits package. Furthermore, no single FEHBP plan covers all Members of Congress, federal workers, and federal retirees.

Within the FEHBP, competing health insurers offer a variety of premiums, cost-sharing options, and benefit packages across various types of health plans, ranging from fee-for-service options and preferred provider organizations (PPOs) to health maintenance organizations (HMOs) and health savings accounts. This year, 283 plans are available through the FEHBP at the national and local levels. The benefit packages change from year to year—sometimes dramatically—depending on prevailing market conditions, consumer demand, and insurers' willingness to compete and offer different packages through the FEHBP.

This wide range of personal choices and the intense competition among the various health plans are precisely what make the FEBHP both popular and successful. It is the closest thing that Americans—at least those Americans who work for the federal government—have to a functioning, consumer-driven national health insurance market.

Obama's New Government Plan Compared to the FEHBP. The principles and practice of the consumer-driven FEBHP contrast sharply with Obama's new national health plan.

First, in the regulatory spirit of the Clinton health plan of 1993,[9] the Kerry plan of 2004,[10] and the Commonwealth Fund proposals, the Obama plan would impose a standardized benefits structure on both the new government plan and every private health plan that participates in the proposed National Health Insurance Exchange. There is no comprehensive, standard benefit package in the FEHBP.

Second, the Obama proposal would have a government-run health plan in the National Health Insurance Exchange. No federal agency offers a government health plan through the FEHBP. Only private health insurance plans compete in that program, and even more important, they compete on a level playing field.

Third, Obama's proposal clearly envisions—but does not spell out—some type of price regulation. Although the language of his proposal is vague, enrollees are to be charged "fair" premiums and "minimal co-pays." Presumably, Congress or an

8. See Moffit *et al.*, "Details Matter," pp. 14–18. Similarly, the Commonwealth Fund proposed a Congressional Health Plan in 2003. See Karen Davis and Cathy Schoen, "Creating Consensus on Coverage Choices," *Health Affairs Web Exclusive*, April 23, 2003, at *http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.199v1/DC1* (October 3, 2008).
9. In its legislative form, the Clinton plan outlined which health benefits Americans would receive through federally approved private health plans. Under the plan, an enormously powerful National Health Board would have exercised ultimate authority over health care. A secondary layer of regulation would have governed a system of private managed-care plans offered through "regional health alliances." Senator Obama offers fewer details, but his proposed National Health Insurance Exchange, aside from being a "market organizer," would apparently execute regulatory functions broadly similar to the Clinton plan's National Health Board. Like the Clinton plan, the Obama plan would have the federal government develop and enforce quality standards. On Clinton's standardized benefit package and the specific powers of the National Health Board, see Moffit, "A Guide to the Clinton Health Plan," pp. 7–10 and 20–24.
10. See Moffit *et al.*, "Details Matter," p. 4.

authorized agent, such as the proposed National Health Insurance Exchange, would define these terms. This would put the federal government in the business of deciding what constitutes a fair price and a proper co-payment for benefits and services, leading to some type of centralized rate setting or standardization of payments for providers. In the FEHBP, prices are market-based. No price regulation is imposed on plans or services.

The challenge in creating a new government-run health plan is to balance promised benefits with costs. The subsidy envisioned in the Obama plan would probably need to be substantial, which would impose significant costs on taxpayers.[11] Concurrently, the plan would need to adopt tough regulatory mechanisms to control costs. For example, government officials could employ British-style "comparative effectiveness" standards to restrict use of medical services and procedures, or they could enforce strict pay-for-performance measures to discourage doctors from providing what government officials deem "wasteful" treatments. In either case, the plan would need mechanisms that ration care and medical services to contain potentially explosive health care costs.

The National Health Insurance Exchange

> *I will also create a National Health Insurance Exchange for individuals wishing to purchase private insurance. The exchange will act as a watchdog to help reform private insurance markets. It will create transparent standards and guidelines to increase fairness, affordability and accessibility throughout the industry. Through the exchange, all Americans will have the opportunity to enroll in an approved plan. The exchange will ensure that private plan premiums, co-pays and deductibles are fair and stable.*[12]

The exchange would oversee the new government health plan and participating plans offered through the exchange. The private plan options would be required to meet the same standards as the new government plan. Specifically, plans would be required to accept all eligible applicants, to justify premium and premium changes, and to adhere to federal quality and efficiency standards. The exchange would also evaluate participating plans on a variety of measures, including cost.

Government As Umpire and Player. The proposed National Health Insurance Exchange would clearly be a powerful regulatory agency, not simply a clearinghouse for a national health insurance market. Under the Obama plan, the federal government would both set the highly prescriptive rules and compete in the market.[13] To borrow a sports analogy, the government would be both the umpire and one of the teams playing on the field.

The government would also enjoy special advantages that would tilt the playing field in the government's direction in that employers and taxpayers would subsidize the new government plan and cover any related risks—a unique advantage unavailable to the private health plans in the exchange. Furthermore, political incentives, not just economic and medical incentives, would drive the exchange and its powerful board of directors. It is difficult to imagine how the government officials could take and maintain a neutral stance.[14]

This process would probably steadily erode participation by private plans because the government

11. The Federal Employees Health Benefits Program provides a generous (up to 75 percent) contribution to the premium as an employer.
12. Obama, "Promising All Americans Good Value and Good Health," p. 33. The 1993 Clinton health plan would have imposed caps on health insurance premiums to ensure their compatibility with global budget targets. See Moffit, "A Guide to the Clinton Health Plan," pp. 33–35.
13. For an account of the likely dynamics of such an arrangement, see Robert E. Moffit, "Government As 'Competitor': The Latest Prescription for Government Control of Health Care," Heritage Foundation *WebMemo* No. 2024, August 14, 2008, at *http://www.heritage.org/research/healthcare/wm2024.cfm*.
14. For a discussion of recent efforts to undermine private, competing Medicare Advantage plans in Medicare, see Robert E. Moffit, "Medicare Advantage: The Case for Protecting Patient Choice," Heritage Foundation *WebMemo* No. 1836, March 6, 2008, at *http://www.heritage.org/Research/HealthCare/wm1836.cfm*.

would set the rules and offer a subsidized plan. This could easily pave the way to a government monopoly over health care. At a minimum, the private plans could be reduced to operating simply as administrative agents of the federal plan. In either case, without any realistic market options, would-be consumers, patients, individuals, and families seeking value for their health care dollars would be the biggest losers.

The Obama plan takes a giant step toward centralizing America's health insurance markets by creating the exchange not simply as a market organizer, but as a new watchdog agency to regulate private plan options offered through the exchange. Whether directly or indirectly, the federal government would control the availability, design, and delivery of health care. Although its jurisdiction is apparently confined to private health plans offering coverage through the proposed exchange, the reach of this powerful regulatory authority would circumscribe state health reform options and undoubtedly affect the entire private market for health insurance.

Distorting the Exchange Concept. The concept of a health insurance exchange is not a new idea,[15] but it can mean different things to different analysts. Regrettably, inaccurate policy analysis often misses or overlooks these crucial distinctions.

An exchange can be defined by its structure and function. Heritage Foundation analysts have proposed it as a state institution, designed to permit personal choice and ownership of insurance policies. The state-based exchange allows individuals and families to take advantage of the features of personal choice that characterize the individual market while securing the generous federal tax advantages of group coverage.[16]

State legislative proposals to create health insurance exchanges are often designed to enable individuals and small-business owners to buy health insurance tax-free, to facilitate defined contributions from employers, and to promote the personal ownership and portability of private health insurance policies under existing federal tax rules. In such instances, a statewide health insurance exchange, sometimes called a "Connector," serves as a clearinghouse for transactions between various sources of contributions and for choosing from a variety of health insurance options.[17]

Senator Obama's proposal to create a National Health Insurance Exchange as a powerful regulatory agency has little in common with this state-based approach to consumer-driven health insurance reform.

More Federal Involvement in Employer-Based Coverage

> *I will require employers who do not offer meaningful health coverage or make a significant contribution towards their employees' coverage to contribute a portion of their payroll toward the costs of the national plan.*[18]

15. Professor Alain Enthoven of Stanford University was an original champion of the idea. See Sara J. Singer, Alan M. Garber and Alain C. Enthoven, "Near Universal Coverage Through Health Plan Competition: An Insurance Exchange Approach," in Jack A. Meyer and Elliot K. Wicks, eds., *Covering America: Real Remedies for the Uninsured*, Economic and Social Research Institute, June 2001, p. 153–171, at *http://www.esresearch.org/RWJ11PDF/singer.pdf* (October 10, 2008).
16. In 2007 alone, legislators in 15 states introduced bills to create some form of state-based health insurance exchange. See Robert E. Moffit, "Choice and Consequences: Transparent Alternatives to the Individual Insurance Mandate," *Harvard Health Policy Review*, Vol. 9, No. 1 (Spring 2008), p. 230.
17. "As generally conceived, a Connector would allow individuals and workers in small companies to take advantage of the economies of scale, both in terms of administration and risk pooling, which are currently enjoyed by large employers. Multiple employers would be able to pay into the Connector on behalf of a single employee. And, most importantly, a Connector would allow workers to use pre-tax dollars to purchase individual insurance. This would make insurance personal and portable, rather than tying it to an employer, all very desirable things." Michael Tanner, "Reforming Health Care in Kansas," testimony before the Committee on Insurance and Financial Institutions, Kansas House of Representatives, February 13, 2007, at *http://www.cato.org/testimony/ct-mt-02132007.html* (October 3, 2008). For more on the structure and functions of a state health insurance exchange, see Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at *http://www.heritage.org/Research/HealthCare/wm1230.cfm*.

This broad language is supplemented by slightly more detailed questions and answers about the plan in which the Senator indicates that "small employers" (i.e., small business, but the term is not defined) would be exempt from the proposed mandate.[19]

Analysis. The Senator's proposal resurrects the employer mandate—buy coverage or pay a tax—which is more commonly known as the pay-or-play model. However, unlike the Clinton health plan, the Obama plan is short on detail. Accurately calibrating how the plan would affect workers, businesses, and the employer-based health insurance markets would require much clearer definitions of "meaningful coverage," "meaningful contribution," and "small business" as well as the amount of the proposed tax penalty. However, such critical details are missing from the plan.

As a policy matter, however, a few things are certain. First, the pay-or-play model would add another layer of administrative compliance to those borne by already overburdened employers. Determining whether an employer meets the meaningful coverage and benefit threshold would require imposing a new reporting and certification process on affected businesses.

Another certainty is that while the Senator's employer mandate would be seen as another tax on business, it is in reality a new tax on labor. The broad economic consequences of employer mandates are not in dispute among economists, regardless of their political or philosophical orientation. Health insurance is part of workers' compensation, just as wages are, and any increase in health benefits routinely means a reduction in wages or other compensation.

As Professor Mark Pauly, a prominent economist at the University of Pennsylvania, has observed:

> The economic analysis of employment-based benefits is as clear in economic theory and empirical work as it is muddled in public debate: theory and econometric studies both say that workers pay for the majority of health insurance costs, through lower money wages as well as through explicit premiums.[20]

Likewise, any new payroll tax on employers would ultimately be borne by workers, either in reduced compensation or in job loss. While forcing employers to do "the right thing" is politically attractive rhetoric for politicians, such efforts would effectively lower wages and eliminate jobs. As Joseph Antos, Gail Wilensky, and Hanns Kuttner point out in their analysis of the Obama plan, "The pay-or-play mandate, which is meant to help workers who do not have insurance gain coverage, could instead undermine their chances of economic success."[21]

While the absence of any firm details makes empirical analysis of the Obama plan difficult, recent econometric analysis illustrates the potential impact of an employer mandate. The Lewin Group, a national, nonpartisan econometrics health care firm, assumes a 6 percent payroll tax and estimates that $226 billion in new taxes over 10 years would be imposed on employers with 25 or more workers who do not offer health insurance.[22]

18. Obama, "Promising All Americans Good Value and Good Health," p. 33. Under the Clinton plan, employers would have been required to contribute 80 percent to the average cost of a premium. See Moffit, "A Guide to the Clinton Plan," pp. 24–28.
19. Obama for America, "Background Questions and Answers on Health Care Plan," at *http://www.barackobama.com/pdf/Obama08_HealthcareFAQ.pdf* (October 6, 2008).
20. Mark W. Pauly, "Blending Better Ingredients for Health Reform," *Health Affairs Web Exclusive*, September 16, 2008, p. w484.
21. Joe Antos, Gail Wilensky, and Hanns Kuttner, "The Obama Plan: More Regulation, Unsustainable Spending," *Health Affairs Web Exclusive*, September 16, 2008, p. w467, at *http://content.healthaffairs.org/cgi/reprint/hlthaff.27.6.w462v2* (October 3, 2008). See also John C. Goodman, "The Barack Obama Health Plan," National Center for Policy Analysis *Brief Analysis* No. 628, September 5, 2008, at *http://www.ncpa.org/pub/ba/ba628* (October 3, 2008).
22. Lewin Group, *McCain and Obama Health Care Policies: Cost and Coverage Compared*, October 8, 2008, pp. 24 and 30, at *http://www.lewin.com/content/Files/The_Lewin_Group_McCain-Obama_Health_Reform_Report_and_Appendix.pdf* (October 10, 2008).

Combined with the new government health plan available through a National Health Insurance Exchange under the Obama plan, this new tax on business (and workers) would create economic incentives that would likely cause a massive shift from private coverage to public coverage. As John Goodman, economist and president of the National Center for Policy Analysis, states, "It will not take many people (perhaps a majority) long to discover that they will be better off if their employers drop their current health plan."[23] In its recent analysis of the Obama plan, the Lewin Group concludes that an estimated 22.5 million workers and dependents would lose their employer coverage.[24]

Thus, the mandate on employers proposed by Senator Obama would effectively end employment-based coverage as Americans know it. James Capretta, a fellow at the Ethics and Public Policy Center and former official with the Office of Management and Budget, warns that, "despite Obama's rhetoric and protestations, his plan would destroy employer-based insurance, not preserve it, by pricing it out of business and subsidizing government-run alternatives."[25]

Taxpayer Subsidies for Small Business

While Senator Obama would impose new taxes on businesses (and workers), he would also provide new taxpayer subsidies to certain small businesses to entice them to offer coverage. He would create a refundable tax credit worth up to 50 percent for small-business employers who secure a "quality" health plan for their employees and cover a "meaningful" share of premiums for their employees. However, the language does not define what constitutes a small business, a quality health plan, and a meaningful share of premiums.

Senator Obama, like so many before him, stubbornly insists on trying to make small businesses fit into the traditional mold of employer-based group coverage that characterizes large and mid-size firms. As many analysts have argued, a number of factors could explain why traditional employer-based health insurance may not be the best model for small business. Trying to force such a policy on these firms may not be either in their own best interests or in the best interests of their workers. These firms often operate on low profit margins, are burdened by high worker turnover, have small pools for spreading health risk, and face daunting administrative obstacles.[26] Offering these businesses a subsidy to encourage them to buy coverage for their workers would buttress an older corporate insurance model that is increasingly inappropriate for small-business owners and their employees.

The Lewin Group estimates that the Obama small-business tax credit would cost $77.9 billion over 10 years and assumes that the credit would apply only to businesses with fewer than 10 workers.[27] This would result in about 3.6 million workers and dependents benefiting from this new small-business tax credit.[28]

Reinforcing employment-based health insurance for firms with a large turnover in their workforce, in which a change or loss of employment often translates into a loss of coverage for the worker, runs counter to the goal of expanding portability in health insurance—a key stated goal of the Obama health plan.[29]

Real portability means that the insurance policy follows the worker, not the employer, meaning that workers can keep their health coverage regardless

23. Goodman, "The Barack Obama Health Plan."
24. Lewin Group, *McCain and Obama Health Care Policies*, p. 30.
25. James Capretta, "Dr. Obama's Prescription," *National Review*, September 1, 2008.
26. For further discussion of these issues, see Stuart M. Butler, "Evolving Beyond Traditional Employer-Sponsored Health Insurance," Brookings Institution *Discussion Paper* No. 2007-06, May 2007, at *http://www3.brookings.edu/es/hamilton/200705butler.pdf* (October 3, 2008).
27. These estimates also limited the credit to firms "with an average payroll of less than twice the minimum wage." Lewin Group, *McCain and Obama Health Care Policies*, pp. 24 and 31.
28. *Ibid.*, p. 31.
29. Obama for America, "Barack Obama and Joe Biden's Plan."

of their job or job status. This is best achieved through personal ownership of health insurance and would also improve continuity of coverage and care for the worker.

Taxpayer Reinsurance for Employers

> *Under my plan, employers will be reimbursed for a portion of the catastrophic costs they incur above a threshold if they promise to use those savings to reduce the costs of workers' premiums.*[30]

The Obama plan would have the taxpayers reimburse employers for the high-end health costs in their health plan. This proposal broadly resembles the 2004 proposal by Senator Kerry.[31]

The Lewin Group, basing its calculations on the government's assuming 75 percent of the cost in excess of $140,000 for each plan member, estimates that the Obama reinsurance proposal would cost $419.2 billion over the first 10 years.[32]

Beyond saddling taxpayers with employers' high health care costs, the reinsurance proposal would weaken incentives to control or manage health care costs.[33] Helen Darling, president of the National Business Coalition on Health, has noted that once a patient reaches the threshold at which the taxpayer funding kicks in, "there's no reason for anyone to pay attention to costs."[34] In other words, the premium rebate would drive up health care costs.

Merrill Matthews, executive director of the Council for Affordable Health Insurance, a health insurance trade association, argues:

> [Such a proposal] would undermine the innovative health insurance products currently being designed both by new health plans, third-party administrators and traditional insurers. The government likes uniformity, not diversity and competition, because it makes regulation simpler.[35]

Government reinsurance would not only stifle existing efforts by insurers, employers, and individuals to seek out value, but also likely replace those efforts with more regulation.

Expanding Existing Government Programs

> *I will expand Medicaid and the federal State Children's Health Insurance Program (SCHIP) eligibility and ensure that they continue to serve their critical safety net function. Finally, I will encourage states to continue to innovate and experiment with different methods of coverage expansion, as long as they meet the minimum federal standards established for the national plan.*[36]

Expanding Medicaid and SCHIP. These proposed expansions are nothing new. Given the dynamics of the status quo, including the steady decline of employer-based health insurance, public program expansions have been routine features of current policy.

Medicaid, the federal–state health program for the poor and indigent, is already a $350 billion program, and previous Medicaid expansions have unquestionably helped to "crowd out" private

30. Obama, "Promising All Americans Good Value and Good Health," p. 34.
31. In its analysis of the 2004 Kerry plan, which would have had the government assume 75 percent of costs in excess of $50,000, the Lewin Group estimated a cost of $725.7 billion over the first 10 years. See Lewin Group, *Bush and Kerry Health Care Proposals: Cost and Coverage Compared*, September 21, 2004, p. 21, at *http://www.lewin.com/content/publications/2983.pdf* (October 3, 2008).
32. Lewin Group, *McCain and Obama Health Care Policies*, p. 24.
33. Moffit *et al.*, "Details Matter," pp. 3–4.
34. *Ibid.*, p. 5.
35. Merrill Matthews, "What Everyone Should Know About Reinsurance," Council for Affordable Health Insurance *Issues and Answers* No. 138, February 2007, at *http://www.cahi.org/cahi_contents/resources/pdf/n138whateveryoneshouldknow.pdf* (October 4, 2008).
36. Obama, "Promising All Americans Good Value and Good Health," p. 33.

health insurance coverage for certain populations.[37] Nonetheless, during 2007–2008 alone, 36 states expanded Medicaid eligibility.[38] Contrary to the original intent of SCHIP to provide health coverage for poor children in working families ineligible for Medicaid, states have also steadily expanded SCHIP eligibility, reaching well into the middle class, with periodic bailouts from Congress.[39]

Compared to private coverage, these programs are conspicuously lacking in quality care, particularly in giving patients access to physicians for appropriate care at the appropriate time. Researchers at the Center for Health System Change found that 21 percent of physicians were not accepting any new Medicaid patients between 2004 and 2005.[40] Research also shows that Medicaid and SCHIP patients were more likely than the uninsured and private health plan enrollees to go to emergency rooms for non-emergency needs.[41]

Compounding the Entitlement Crisis. Meanwhile, America faces an entitlement crisis. Spending on Medicare, Medicaid, and Social Security is projected to rise rapidly, pushing up primary federal spending (excluding interest payments on the national debt) from 18.2 percent of gross domestic product in 2007 to 28.3 percent of GDP in 2050. According to the Congressional Budget Office (CBO), financing entitlement spending will require massive tax increases, including doubling individual and marginal tax rates in every bracket and doubling corporate tax rates.[42]

Expanding Medicaid and SCHIP would only deepen the entitlement crisis. Both programs are fiscally challenged and promise more than they deliver, undermining access and quality for those on these programs today. For example, it was projected that Medicaid and SCHIP, combined federal and state spending, would cost $717 billion by 2017.[43]

For states, the Medicaid and SCHIP crisis is apparent. Medicaid is already the largest item in state budgets, accounting for 22 percent of total state fiscal expenditures in 2006.[44] Senator Obama's unspecified expansions of these public programs would accelerate this process and significantly affect the remaining health care economy.

A Step Toward a Federal Takeover? Perhaps of greater concern, these expansions could serve as first steps in a more ambitious federal takeover of American health care. Although these expansions appear incremental and thus less radical, they could be highly consequential. Simply expanding eligibility for children up to 400 percent of the federal poverty level ($84,800 for a family of four) would qualify more than 70 percent of American children for a government health care program.[45]

37. For example, see David Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs*, Vol. 16, No.1 (January/February 1997), pp. 196–198.
38. Heather Jerbis, "Tracking State Health Reform Initiatives," *Contingencies*, September/October 2008, pp. 20–26.
39. Nina Owcharenko, "SCHIP: Congress Must Stop Another State Bailout," Heritage Foundation *WebMemo* No. 1732, December 11, 2007, at *http://www.heritage.org/Research/HealthCare/wm1732.cfm*.
40. Peter J. Cunningham and Jessica H. May, "Medicaid Patients Increasingly Concentrated Among Physicians," Center for Studying Health Systems Change *Tracking Report* No. 16, August 2006.
41. John O'Shea, "More Medicaid Means Less Quality Care," Heritage Foundation *WebMemo* No. 1402, March 21, 2007, at *http://www.heritage.org/Research/HealthCare/wm1402.cfm*.
42. Stuart M. Butler, "CBO's Warning on Raising Taxes to Pay for Medicare, Medicaid, and Social Security," Heritage Foundation *Backgrounder* No. 2153, June 27, 2008, at *http://www.heritage.org/research/budget/bg2153.cfm*.
43. Sean Keehan, Andrea Sisko, Christopher Truffer, Sheila Smith, Cathy Cowan, John Poisal, and M. Kent Clemens, "Health Spending Projections Through 2017: The Baby Boomer Generation Is Coming to Medicare," *Health Affairs Web Exclusive*, February 26, 2008, p. w151.
44. National Association of State Budget Officers, *State Expenditure Report, Fiscal Year 2006*, Fall 2007, p. 2, at *http://www.nasbo.org/Publications/PDFs/fy2006er.pdf* (October 4, 2008).
45. Michael Leavitt, remarks at the American Enterprise Institute, Washington, D.C., April 24, 2007, at *http://www.hhs.gov/news/speech/2007/sp20070424a.html* (October 4, 2008).

Inhibiting State Flexibility. The Obama proposal would severely restrict state variation and experimentation by requiring state innovations to meet the specific minimum standards of the proposed new government health plan.

This highly prescriptive approach would be a major step backward. One of the most promising developments during the past three years has been the willingness of state governors and legislators to experiment with different methods to expand their citizens' health care coverage. Not surprisingly, state legislatures have produced a flurry of state health reform legislation. However, confining state reform efforts to a narrow, single federal standard would effectively end any serious experimentation and discourage any outside-the-box innovation.

In this sense, the Obama health care plan would follow a path opposite from that of the successful welfare reform of the 1990s, which gave state officials broad goals and a high degree of flexibility in designing approaches to encourage work and reduce welfare dependence. There is serious bipartisan interest in replicating this success in health care policy.[46] State flexibility is not only desirable, but also necessary because the provision of health care varies widely across the states, reflecting differences in demographics, political culture, and insurance markets. Of course, this flexibility would be undesirable only if the real goal of the process is to centralize health care decision-making in Washington, D.C.

The Parents' Mandate

> *I will also require that all children have meaningful health coverage and will allow young people up to the age of 25 to continue coverage through their parents' plans.*[47]

Obama's proposed insurance mandate extends only to children, and "allow" appears to be a mandate on insurers to cover young adults on their parents' coverage until they reach age 25.

The Parents' Mandate. While the Obama plan does not recommend a universal individual mandate, as supported by Senator Hillary Clinton (D–NY), Obama does not appear to be philosophically opposed to an individual mandate. To the contrary, his endorsement of a mandate for children could be seen as an incremental step toward a full-blown universal mandate for health insurance. As Dr. Kavita Patel, an Obama adviser, explains, "[Obama] has voiced his disagreement with having [an individual mandate] be a part of his health-care plan last year. But he is not opposed to the idea itself."[48]

However, even with a mandate, universal compliance is rarely if ever achieved. If "near universal" coverage is an acceptable policy goal, it can be achieved using more benign means than a mandate.[49] In any case, mandates without penalties are meaningless. Much would depend on how Senator Obama would enforce his mandate on parents and what the penalties for noncompliance would be. The Senator has not specified any of them.

Given his proposed expansion of public programs, the Senator's mandate for children's health insurance coverage would likely result in millions of children becoming dependent on the government for their health care for their entire lifetimes. For example, it would be easy for these government health programs to serve as the default option, automatically enrolling children if their parents fail to act.

For families who obtain coverage for their children, federal bureaucrats would define what constitutes qualified coverage. The federal government would have significant control over the type of health insurance coverage that a child receives. In a number of highly sensitive areas, such as the provision of contraception to minors, parents may be

46. See Henry Aaron and Stuart Butler, "A Federalist Approach to Health Reform: The Worst Way, Except for All Others," *Health Affairs,* Vol. 27, No. 3 (May/June 2008), pp. 725–735.

47. Obama, "Promising All Americans Good Value and Good Health," p. 33.

48. ABC News, "Obama Health Plan Could Go in Clinton's Direction," June 27, 2008, at *http://blogs.abcnews.com/politicalradar/2008/06/obama-health-pl.html* (October 4, 2008).

49. For a discussion of these alternatives, see Moffit, "Choice and Consequences," pp. 223–233.

permitted little or no control.[50] Even if parents provide health coverage for a child, federal officials could deem that coverage inadequate, regardless of what the parents think. As with the proposed mandate on employers, parents would be required to obtain a plan that conforms to the federal standards or face a penalty.[51]

Senator Obama's proposal to raise the age at which a dependent may remain on a parent's health care plan is misguided and would further centralize regulatory control of health insurance in Washington. It is true, of course, that people ages 18 through 24 comprise the largest cohort of uninsured and have an uninsurance rate of 28 percent.[52] This population tends to be healthy, and many could obtain coverage, especially if state officials took steps to make health coverage more affordable. Insurance rules are predominately matters of state jurisdiction. In overregulated state health insurance markets, some states compel young persons to pay the same price as older persons even though they are a much lower risk and to buy coverage that includes mandated benefits and services that they may not want or need, pricing many young adults out of the market.[53]

Federal Regulation in the Delivery of Medical Care

> *As part of a comprehensive strategy to improve health outcomes and reduce waste, I will establish an independent institute to engage in comparative effectiveness research that helps doctors understand what therapies actually contribute to better patient outcomes.*
>
> *I will also ensure that all public programs implement disease management programs—systems that help patients with chronic illnesses better manage their conditions. My plan will improve care coordination and integration by supporting team-based approaches, such as medical homes. To promote transparency and provide Americans a greater role in health care decisions, I will require hospitals and providers to collect and publicly report quality and cost data, including rates of preventable medical errors and hospital acquired infections—and my plan will accelerate efforts to align reimbursement with the provision of high quality care…. My plan will reward providers in all public plans for achieving performance thresholds based on physician-validated outcomes.*[54]

This ambitious agenda focuses on using delivery reform to control costs and improve quality:[55]

- **Disease management programs,** particularly in all public insurance plans, such as the new national health plan, Medicare, Medicaid, SCHIP, TRICARE (the military health plan), the Department of Veterans Affairs, and even the Federal Employees Health Benefits Program;
- **Care coordination** in developing new reimbursement systems that focus on care coordination based on the "medical home" model;
- **Transparency,** including new requirements for health care providers to report to the government on cost and quality;
- **Pay for performance,** to be achieved by developing and applying best-practice models to

50. On this point, see Daniel Patrick Moloney, "Reforming Health Care to Protect Parents' Rights," Heritage Foundation *Backgrounder* No. 2181, September 15, 2008, at *http://www.heritage.org/Research/Family/bg2181.cfm*.
51. For example, new "minimum credible coverage" rules affected an estimated 200,000 Massachusetts residents whose coverage did not meet the state standard. See Robert E. Moffit, "The Massachusetts Health Plan: An Update and Lessons for Other States," Heritage Foundation *WebMemo* No. 1414, April 4, 2007, at *http://www.heritage.org/Research/HealthCare/wm1414.cfm*.
52. Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, "Income, Poverty and Health Insurance Coverage in the United States: 2007," U.S. Census Bureau, August 2008, p. 22, at *http://www.census.gov/prod/2008pubs/p60-235.pdf* (October 4, 2008).
53. Devon Herrick, "Crisis of the Uninsured: 2007," National Center for Policy Analysis *Brief Analysis* No. 595, September 28, 2007, at *http://www.ncpa.org/pub/ba/ba595* (October 4, 2008).
54. Obama, "Promising All Americans Good Value and Good Health," pp. 33–34.
55. Obama for America, "Barack Obama and Joe Biden's Plan."

realign reimbursements for providers participating in the new public health program, Medicare, and the FEHBP;

- **An independent institute to oversee research on comparative effectiveness,** with research focused on developing comparative information on drugs, devices, and procedures for use in diagnostic and treatment options;
- **Elimination of disparities** by diversifying the workforce to ensure "culturally effective" care, implementing and funding evidence-based interventions, and expanding safety-net institutions; and
- **Information technology,** which under the Obama plan would involve investing heavily in implementing a national health information technology system.

Analysis. The current structure of third-party payments—which Senator Obama wants to preserve—creates serious problems in the delivery of care. In this system, insurers and medical professionals have little direct accountability to individuals, either as consumers of insurance or as patients. The existing financial and insurance arrangements compromise both the interests of consumers who demand health insurance that meets their individual needs and the interests of patients who demand the best and highest value of medical services. Insurance may encourage either too much or too little of certain types of care. As many prominent economists have suggested, the best policy response to that problem is to restructure the market to align the incentives of insurers, doctors, hospitals, and patients to ensure the delivery of value to patients.[56]

When market forces are robust or employers are engaged to keep costs low, innovations emerge as private plans explore ways to keep their enrollees healthier and provide better, cost-effective services. If the plans compete directly for market share, as they would in a consumer-driven system, insurers will be compelled to develop approaches that keep their claim payments down and reduce costs for their enrollees. The healthier the enrollees are, the fewer claims insurers need to pay out, and the lower health care spending will be—all very desirable outcomes.

However, if the federal government mandated care tools on insurers, this would directly undercut flexibility, entrenching these government-approved delivery tools for current and future use, while politicizing the process. Moreover, it would further shift control of health care decisions to Washington.

The Obama plan avoids spelling out important details needed to understand the scope of these initiatives, both individually and as a whole. One danger of having the federal government coordinate these delivery reforms is that they could become regulatory tools for controlling costs by limiting access to care and services that fall into official disfavor. These measures would establish a federal infrastructure for such rationing, regardless of whether or not the Obama plan intends this outcome.

Medical Homes. Senator Obama wants to develop new reimbursement arrangements for care coordination based on the "medical home" model. The concept of a medical home dates back to the 1960s, but this idea can mean different things.

The American Academy of Pediatrics and the Maternal and Child Health Branch of the Health Resources and Services Administration (HRSA) have focused on the utility of the medical home in serving children with special needs. In 2004, HRSA awarded $2.2 million to promote medical homes that "include family members in decisions on treatment and seek to coordinate comprehensive, culturally competent care for [children with special health care needs] who have health and behavioral needs beyond those of most other children."[57]

More recently, medical homes have been authorized for seniors in Medicare demonstration

56. See Regina Herzlinger, *Who Killed Health Care? America's $2 Trillion Problem and the Consumer-Driven Cure* (New York: McGraw Hill, 2007), and Michael Porter and Elizabeth Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston: Harvard Business School Press, 2006).
57. Press release, "HRSA Awards $2.2 million to Provide Medical Homes for Children with Special Health Needs," U.S. Department of Health and Human Services, Health Resources and Services Administration, June 18, 2004, at *http://newsroom.hrsa.gov/releases/2004/CSHCN.htm* (October 4, 2008).

projects. This demonstration was established "to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high needs populations."[58]

The various definitions of "medical home" make it difficult to determine precisely what Senator Obama envisions. However, if the federal government, followed by states and third-party payers, is to use new payment systems to move segments of the population into medical homes, federal officials will need to define the term. This could significantly affect medical practices, which presumably would be required to comply with federal rules for the coordination of care. Federal rules would also be required to determine which institutions could be defined as medical homes, such as health plans, managed-care organizations, or group practices.

The better alternative is to create a consumer-driven health insurance market and allow medical homes and various other institutions to evolve as natural features of the health care sector, in which individuals can obtain the kind of care they want and need at competitive prices.

Transparency. For the vast majority of ordinary Americans, the health care sector is opaque and mysterious. Transparency, especially in terms of the price and performance of medical providers, is unquestionably a good thing. Senator Obama is to be applauded for promoting clarity of information with respect to the cost and quality of medical services. The Senator's proposal does not specify how the information will be made available and used.

The information could be organized and used in different ways. For example, the federal government could be the central depository of such information, in effect creating a monopoly over the data. In an alternative system based on personal freedom and choice, individuals and medical professionals could obtain information on price and quality from multiple sources, including government sources. Most important, such a system would focus on enabling consumers, not the government, to make informed health care decisions for themselves and their loved ones.

Pay for Performance. The Senator's pay-for-performance proposal is a variation of a Bush Administration initiative. President George W. Bush first introduced the pay-for-performance proposal in conjunction with reforming the Medicare payment system for physicians. The key idea is to base physician Medicare reimbursement on compliance with Medicare standards for best medical practices. Yet Senator Obama would go further than the Bush Administration's initiative by "accelerat[ing] efforts to develop and disseminate best practices" and by applying this new payments structure across all federal programs.[59]

This, like the original Bush Administration initiative, is an undesirable policy. Under the original Medicare statute, federal officials are specifically forbidden from interfering with the practice of medicine—a legal recognition of the profound need to protect the independence and integrity of the medical profession from government interference. The Obama proposal would breach that wall of separation between the financing of medicine and the practice of medicine. This should cause concern among both doctors and patients.

As Heritage Foundation research on its application to the Medicare program has shown, the pay-for-performance agenda rightly recognizes that patients are not receiving the best value from the health care system.[60] However, a federal pay-for-performance system would treat patients according to "cookbook medicine," undermining high-quality, personalized care and retarding innovation in care delivery. It would also encourage doctors to game the system at the expense of patients, further

58. Tax Relief and Health Care Act of 2006, Public Law 109–432, § 204. See U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Medical Home Demonstration Fact Sheet," September 2008, at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_FactSheet.pdf* (October 4, 2008).

59. Obama for America, "Barack Obama and Joe Biden's Plan."

60. Richard Dolinar and S. Luke Leininger, "Pay for Performance or Compliance: A Second Opinion on Medicare Reimbursement," Heritage Foundation *Backgrounder* No. 1882, October 5, 2005, at *http://www.heritage.org/Research/HealthCare/bg1882.cfm*.

weakening the already attenuated doctor–patient relationship.[61]

Comparative Effectiveness. In light of wide geographic variations in health care spending without any meaningful difference in health outcomes, various analysts want to reduce costs by improving the quality of care delivered. Endemic to the drive toward "evidence-based" medicine is the analysis of the comparative effectiveness of drugs, devices, and procedures. This is intended to shed light on which treatments work best for patients and on whether more effective but more expensive treatments are worth the additional financial costs.

In principle, researching the comparative effectiveness of different medical options is an excellent thing. Like pay for performance, the concept is attractive, but it is also potentially harmful, depending on how the quality-of-care strategy is designed and implemented. The Obama plan would create a new institute—another government-sponsored agency—to analyze the "comparative effectiveness" of medical treatments, procedures, drugs, and devices.

If the institute's findings were used to control costs by binding medical professionals through law, regulation, or reimbursement, they would compromise professional independence, intrude into the practice of medicine, and directly affect patients' access to the full range of care options. Without such harsh application, the investment is unlikely to yield any significant cost savings. The CBO notes:

> [T]o affect medical treatment and reduce health care spending in a meaningful way, the results of comparative effectiveness analyses would not only have to be persuasive but also would have to be used in ways that changed the behavior of doctors, other health professionals and patients.[62]

As Urban Institute scholars point out, "these cost-containment initiatives can only be successful if they are aggressively pursued."[63] Examples of aggressive application of comparative effectiveness emphasize the potential hazards. For example, in Great Britain, the National Institute on Clinical Effectiveness makes such decisions, including a controversial determination that certain cancer drugs are "too expensive."[64] In short, it serves as a sophisticated instrument for rationing care to British citizens.

Eliminating Disparities. Unquestionably, there are disparities in American health care. The issue is whether Congress or an authorized agency is capable of improving these outcomes without first addressing the health care system's underlying problems. Dr. Sally Satel, a resident scholar at the American Enterprise Institute and practicing physiatrist, has found that socioeconomic status is more likely than race to drive disparities.[65] Furthermore, she argues, continuity of care and better reimbursement are two critical components in leveling out these disparities.

Simply having coverage from Medicaid, for example, does not necessarily "correlate to having

61. *Ibid.*
62. Congressional Budget Office, "Research on the Comparative Effectiveness of Medical Treatments," December 2007, p. 3, at *http://www.cbo.gov/ftpdocs/88xx/doc8891/12-18-ComparativeEffectiveness.pdf* (October 6, 2008). America's Health Insurance Plans found that comparative effectiveness research would produce savings of only 0.3 percent savings in national health expenditures over 10 years. See America's Health Insurance Plans, Center for Policy and Research, "Technical Memo: Estimates of the Potential Reduction in Health Care Costs from AHIP's Affordability Proposals," June 2008, p. 3, Table 1, at *http://www.ahipresearch.org/PDFs/TechnicalMemo06.11.08.pdf* (October 6, 2008).
63. They go on to say that "several can be successful only if they reduce revenues of hospitals, physicians, or pharmaceutical and medical device manufacturers." See John Holahan and Linda J. Blumberg, "An Analysis of the Obama Health Care Proposal," Urban Institute, Health Policy Center, September 22, 2008, p. 5.
64. Jacob Goldstein, "U.K. Says Glaxo's Breast Cancer Drug Isn't Worth the Money," *The Wall Street Journal*, July 7, 2008, at *http://blogs.wsj.com/health/2008/07/07/uk-says-glaxos-breast-cancer-drug-isnt-worth-the-money* (October 10, 2008).
65. Sally Satel, "Addressing Disparities in Health and Health Care: Issues for Reform," testimony before the Committee on Ways and Means, U.S. House of Representatives, June 10, 2008, at *http://www.aei.org/publications/filter.all,pubID.28128/pub_detail.asp* (October 6, 2008).

a regular source of coverage."[66] Medicaid and employment-based health insurance are often unstable sources of coverage for individuals and families because the coverage is often determined by external factors over which individuals have little control, such as unemployment, legal eligibility for public assistance, or an employer's decision to offer or drop insurance.

Researchers at the American Cancer Society have found that individuals on Medicaid or without private health insurance are more likely than those with private insurance to be diagnosed with cancer.[67] This reinforces the point that attempting to address disparities in the abstract without first addressing the problems of the public programs or the unequal tax treatment of private health insurance would only scratch the surface of the problem.

Information Technology. Health information technology, which could significantly increase efficiency in the financing and delivery of medical services, has emerged as a kind of painless alternative to major structural reform of health insurance markets and financing. Like comparative effectiveness and pay for performance, increased use of information technology (IT) is expected to deliver major savings and superior medical outcomes. Yet the CBO has warned that "[b]y itself, the adoption of more health IT is generally not sufficient to produce significant cost savings."[68]

The achievements of the IT revolution can save time, money, and lives, but they would be far more promising in an open economic environment in which individuals personally control their health care dollars and choices. As consumers, individuals would purchase coverage based on what services they desire, such as a plan that offers a personal health record, and could demand that providers communicate with them using 21st century technology. Banks and credit card companies, in which the widespread reliance on information technology and fast transactions are simply taken for granted, are prime examples of how consumer demand and market competition can drive massive change without massive federal involvement.

Addressing the Medical Liability Crisis

Medical liability is an enormous problem for physicians and other medical professionals. The fear of lawsuits and their destructive impact on a doctor's professional reputation and medical practice encourages doctors to practice defensive medicine, which often leads to providing excessive, unnecessary, and inappropriate care to protect against lawsuits.

Senator Obama's approach to reforming medical malpractice would focus on preventing insurers from overcharging physicians by strengthening antitrust laws. He would also focus on new models for reducing medical errors and strengthening the doctor–patient relationship to lessen the need for medical malpractice suits.

Senator Obama is to be applauded for his concern about the burdens on doctors and other medical professionals and for seeking to reduce medical errors and restore the doctor–patient relationship, but his proposal sidesteps the major obstacle to serious medical malpractice reform: the incentives in the current system that encourage attorneys to pursue frivolous lawsuits, which have caused medical malpractice insurance premiums to skyrocket.

Tort law is an issue of state jurisdiction, and states should address the problem because high medical liability insurance is affecting access to critical services. States can choose from a variety of reforms, including adopting effective damage award caps.[69] Not only is this issue best addressed under state law, but the variation in remedies among the states provides an excellent opportunity

66. *Ibid.*

67. American Cancer Society, "Late-Stage Diagnosis More Likely Among Uninsured," February 18, 2008, at *http://www.cancer.org/docroot/NWS/content/NWS_1_1x_Uninsured_More_Likely_to_Be_Diagnosed_With_Late-Stage_Cancer.asp* (October 6, 2008).

68. Peter R. Orszag, "Evidence on the Cost and Benefits of Health Information Technology," statement before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, July 24, 2008, at *http://www.cbo.gov/ftpdocs/95xx/doc9572/07-24-HealthIT.pdf* (October 6, 2008).

for the states to learn from each others' successes and failures.[70]

Increased Regulation of Prescription Drugs and Insurers

Senator Obama proposes several initiatives that are focused specifically on influencing the pharmaceutical and insurance markets.

Senator Obama would permit the importation of pharmaceuticals provided that they are purchased from other developed countries, can meet a safety threshold, and are priced lower than in the United States. The proposal would also require increased use of generics in government plans and would prohibit keeping generics out of the market.

Senator Obama would also authorize Medicare to "negotiate" directly with pharmaceutical companies to set prices for Medicare drugs. In tandem with this price setting, the Senator would also cancel what he deems "excess" subsidies to the competing Medicare Advantage plans.

Insurers would also be required to allocate a "reasonable" share of collected premiums for care and to limit their allocations for administrative costs and profits.

Drug Importation. Senator Obama's prescription for drugs replicates policy proposals that have been routinely advanced but rejected.

Americans lead the world in pharmaceutical innovation, but the American people pay the largest portion of the costs for American research and development of new drugs. America's problem is that foreign consumers, such as those in Europe and Japan, directly benefit from these advances but do not bear the research and development costs in the prices they pay for drugs because foreign governments impose price controls on drugs, thus shifting additional costs to American consumers.[71]

Drug importation is, in effect, a policy response to this international cost shift. The basic idea is to take advantage of these artificially cheaper prices by importing price-controlled drugs into the United States. The concept seems simple in theory, but its consequences are many and complicated.[72]

First, by taking such an approach, the U.S. would be endorsing price controls and discouraging pharmaceutical companies from developing other life-saving drugs.

Second, importation raises basic safety and cost concerns. The U.S. Secretaries of Health and Human Services under Presidents Bill Clinton and George W. Bush could not guarantee the safety of imported drugs.[73] Even if the federal government could guarantee safety and was willing to allocate significant resources to address safety concerns, the potential cost savings are minimal. The Congressional Budget Office estimated that drug importation would save less than 1 percent of overall prescription drug spending in the U.S.[74]

Third, beyond these basic issues, conditions on the ground change the relevance of the earlier

69. For a discussion of the various state remedies, see Randolph W. Pate and Derek Hunter, "Code Blue: The Case for Serious State Medical Liability Reform," Heritage Foundation *Backgrounder* No. 1908, January 17, 2006, at *http://www.heritage.org/Research/HealthCare/bg1908.cfm*.

70. *Ibid.*

71. Merrill Matthews, "Riding the Coattails of U.S. Patents," Institute for Policy Innovation *Ideas* No. 27, June 4, 2004, at *http://www.ipi.org/ipi%5CIPIPublications.nsf/PublicationLookupFullText/E8C319D5BAF9DA2E86256ED6006CA1CD* (October 6, 2008).

72. See U.S. Department of Health and Human Services, Task Force on Drug Importation, *Report on Prescription Drug Importation*, December 2004, at *http://www.hhs.gov/importtaskforce/Report1220.pdf* (October 6, 2008); Panos Kanavos and Paul Holmes, "Pharmaceutical Parallel Trade in the UK," Civitas: Institute for the Study of Civil Society (London), April 2005, at *http://www.civitas.org.uk/pdf/ParallelTradeUK.pdf* (October 6, 2008); and Nina Owcharenko, "Debunking the Myths of Drug Importation," Heritage Foundation *WebMemo* No. 542, July 20, 2004, at *http://www.heritage.org/Research/HealthCare/wm542.cfm*.

73. See Tommy G. Thompson, U.S. Secretary of Health and Human Services, letter to Senator James Jeffords (I–VT), July 9, 2001, at *http://www.fda.gov/oc/po/thompson/medsact.html* (October 6, 2008).

debate.[75] The main rationale was the lack of a prescription drug benefit in the Medicare program. The Medicare Modernization Act of 2003 gives all Medicare beneficiaries access to a prescription drug benefit, including heavily subsidized coverage for low-income seniors. Therefore, pharmaceuticals are widely available and more affordable than ever before to seniors, the largest cohort of American drug consumers. As a result, demand for drug importation has diminished.

Finally, persons who are still unable to obtain needed drugs at affordable prices can receive help. For example, consumers can avail themselves of retail discounts[76] or private initiatives, such as the successful Partnership for Prescription Assistance,[77] which helps needy persons directly.

As for accelerating use and access to generic drugs, the Senator's plan offers no specifics. However, the use of generics has already increased significantly: 68 percent of all prescriptions are filled with generic drugs.[78]

In addition, any reexamination of patent laws should be conducted with great care to preserve the delicate balance between rewarding innovation and opening access to generics. Loosening drug patent protections could run the risk of undermining incentives for future pharmaceutical development.

Undermining Success. Whatever the overall merits of the Medicare drug entitlement may be, it has produced one development that has surprised supporters and critics alike: Private health plans have succeeded dramatically in delivering prescription drugs to seniors at affordable and transparent prices. Since the program's inception, the projected annual premium for drug coverage has declined by 40 percent.[79]

However, along with some other Members of Congress, Senator Obama proposes to break a feature of the Medicare drug program that is not broken by giving the Secretary of Health and Human Services the authority to intervene in the private negotiations between private health plans and pharmaceutical companies. This would essentially substitute Medicare-style pricing for prices that reflect the real conditions of supply and demand. Normally, the government price fixers set prices too high or too low, but rarely just right.

As the CBO has observed, such a drug pricing strategy cannot achieve measurable savings unless government officials also limit seniors' access to drugs.[80] Both the Veterans Administration program and Medicaid deliberately limit access to certain drugs to contain costs.[81]

Similarly, the Medicare Advantage program, a new system of competing private health plans in Medicare, has been a genuine policy success. More than one in five Medicare beneficiaries are enrolled in Medicare Advantage plans. These plans offer broader benefits, more health care options, and increasingly better value for seniors' dollars.[82]

74. Congressional Budget Office, "Would Prescription Drug Importation Reduce U.S. Drug Spending?" *Economic and Budget Issue Brief*, April 29, 2004, p. 1, at *http://www.cbo.gov/ftpdocs/54xx/doc5406/04-29-PrescriptionDrugs.pdf* (October 6, 2008).
75. Nina Owcharenko, "Missing the Point on Medicare Reform: Why Drug Importation Is Bad Policy," Heritage Foundation *WebMemo* No. 304, June 26, 2003, at *http://www.heritage.org/Research/HealthCare/wm304.cfm*.
76. For example, Wal-Mart, Sam's Club, and Target provide such discounts. See Levi J. Long, "Target Joins Move to $4 Generics," *Arizona Daily Star,* October 20, 2006, at *http://www.azstarnet.com/business/151991* (October 10, 2008).
77. See Partnership for Prescription Assistance, Web site, at *https://www.pparx.org* (October 6, 2008).
78. Pharmaceutical Research and Manufacturers of America, "Sharp Decline in Prescription Drug Spending Growth," April 2008, at *http://www.phrma.org/files/Drug%20Spending%20Brochure%20FINAL.pdf* (October 6, 2008).
79. Michael O. Leavitt, "Medicare: Drifting Toward Disaster," Heritage Foundation *Lecture*, No. 1088, June 11, 2008, at *http://www.heritage.org/research/healthcare/hl1088.cfm* (October 6, 2008).
80. See Greg D'Angelo," The Medicare Fair Prescription Drug Price Act of 2007: A Step Towards Government Interference," Heritage Foundation *WebMemo* No. 1426, April 17, 2007, at *http://www.heritage.org/research/healthcare/wm1426.cfm*.
81. On the rationing of prescription drugs in Medicaid, see Derek Hunter, "Government Controls on Access to Drugs: What Seniors Can Learn from Medicaid Drug Policies," Heritage Foundation *Backgrounder* No. 1655, May 27, 2003, at *http://www.heritage.org/Research/HealthCare/bg1655.cfm*.

Senator Obama's contention that Medicare Advantage plans are "overpaid" compared to traditional Medicare ignores the substantial benefit differences between traditional Medicare and Medicare Advantage. A better policy would be to build on Medicare Advantage's success and the success of competitive health plans in delivering Medicare drugs, extending these features of consumer choice and competition to the entire Medicare program.

Furthermore, Senator Obama's proposal to legislate the distribution of insurance premiums among patient care, administrative costs, and profits is shortsighted and undermines consumer choice. His proposal is similar to the failed attempts in California to set an 85 percent "minimal loss ratio."[83] Sometimes, higher administrative costs, such as those for better care management, are good, especially when they help to bring down overall costs. For example, one insurer might charge a $200 premium but meet the 85 percent loss ratio, while a second insurer might charge a $150 premium but have a 75 percent loss ratio.

From a consumer's standpoint, the premium cost is a more important consideration than the arbitrary minimum loss ratio. Instead of mandating a certain minimal loss ratio, the government should empower consumers with the information and allow them to decide whether the $200 plan is worth the extra $50 per month.

Encouraging Healthy Behavior

Senator Obama's plan includes prevention, public health initiatives, and measures to promote "shared responsibility" among employers, schools, workers, individuals, families, and government officials.[84]

For employers, the Obama plan would "expand and reward" efforts that incorporate preventive services in employer-based benefit packages and work-site interventions, such as offering nutritious foods in cafeterias and vending machines.[85]

For schools, the plan would help schools to create "healthier environments" for children by assisting with "contract policy development for local vendors, grant support for school-based health screening programs and clinical services, increased financial support for physical education, and educational programs for students."[86]

The Obama plan would "expand funding" for the health care workforce (doctors, nurses, and other medical professionals) through "loan repayments, adequate reimbursement, grants for training curricula, and infrastructure support to improve working conditions."[87]

For individuals and families, the Obama plan would require preventive services in all federally supported health programs, including Medicare, Medicaid, SCHIP, Obama's new government health plan, and (theoretically) the FEHBP. Senator Obama says that he would also pursue policies to develop "healthy environments," including "sidewalks, biking paths and walking trails; local grocery stores with fruit and vegetables; restricted advertising for tobacco and alcohol to children; and wellness and educational campaigns."[88]

Within the government, the plan would assess and make changes at all levels of government (federal, state, and local) to develop "a strategic plan" to improve coordination and realign government policies to support public health.[89]

82. For a description of the achievements of Medicare Advantage, see Robert E. Moffit, "The Success of Medicare Advantage Plans: What Seniors Should Know," Heritage Foundation *Backgrounder* No. 2142, June 13, 2008, at *http://www.heritage.org/research/healthcare/bg2142.cfm*.
83. Jordon Rau, "California Legislature Enacts No Major HealthCare Overhaul but OKs Some Key Changes," *Los Angeles Times*, September 4, 2008, at *http://www.latimes.com/news/local/valley/la-me-health4-2008sep04,0,5666112.story* (October 6, 2008).
84. Obama for America, "Barack Obama and Joe Biden's Plan."
85. *Ibid.*
86. *Ibid.*
87. *Ibid.*
88. *Ibid.*

To liberals in Congress and elsewhere, "shared responsibility" in health care financing means new mandates and more taxes. In the context of federally promoted prevention and public health, the precise meaning of "shared responsibility" is unclear. In public health, Senator Obama envisions the government adopting a strategic plan that would involve all levels of government in "realigning" government policies. This would likely mean new federal rules, or at least new federal guidance, combined with grants or other economic incentives permeating all areas of national life in America. If federal officials are to pursue policies that encompass "fruits and vegetables" sold in local grocery stores, it is hard to imagine what if any limits on the federal government's power an Obama Administration would recognize.

Focusing on personal responsibility rather than shared responsibility is a better way to promote health and well-being. For example, if government officials would allow individuals to take advantage of health insurance premium discounts for enrollment in prevention and wellness programs, the economic incentives would align with personal behavior. Similarly, health insurers should be permitted to charge higher premiums to persons who insist on smoking, drinking alcohol excessively, or engaging in other risky behaviors.

Such a health policy strategy would preserve personal freedom but would make personal choices transparent and consequential. This type of approach would comport with the ideals of a civil society based on personal freedom and responsibility, in sharp contrast to Senator Obama's collective undertaking based on a vague and coercive idea of shared responsibility.

Costs, Savings, and Coverage Under the Obama Plan

Estimating the exact costs, savings, or coverage of the Obama health plan is difficult without clearer, more specific policy details. Therefore, existing estimates depend heavily on assumptions. As James Capretta observes:

> Obama's plan is calculatedly short on detail. He will never admit that it would lead to rationing of care, and he won't make the same mistake the Clintons did when they issued their 1,300-plus-page legislative proposal.[90]

On overall costs, there is a broad range of cost estimates. The Lewin Group estimates that the Obama plan will cost $1.17 trillion over the first 10 years.[91] Other estimates range from $1.6 trillion[92] to $6 trillion over 10 years.[93]

On overall savings, the Lewin Group estimates that the Obama plan would reduce family spending by $426 in 2010,[94] an amount far less than the Obama plan's promised $2,500.

Finally, on coverage, the Lewin Group estimates that the Obama plan would reduce the number of uninsured by 26.6 million by 2010[95] and increase the number of people on public coverage by 48.3 million.[96]

Regressive Taxation of Health Insurance

Senator Obama has not proposed any changes in the one area of health care policy where a broad

89. *Ibid.*
90. Capretta, "Dr. Obama's Prescription."
91. Lewin Group, *McCain and Obama Health Care Policies*, p. ES-1.
92. Len Burman, Surachai Khitatrakun, Greg Leiserson, Jeff Rohaly, Eric Toder, and Bob Williams, "An Updated Analysis of the 2008 Presidential Candidates' Tax Plans," Urban Institute and Brookings Institution, Tax Policy Center, updated September 12, 2008, p. 53, at *http://www.taxpolicycenter.org/UploadedPDF/411749_updated_candidates.pdf* (October 10, 2008).
93. This assumes a 7 percent rate of medical inflation. Roger Feldman, Lisa Tomai, and Sally Duran, "Impact of Barack Obama 2008 Health Reform Proposal," Health Systems Innovations Network, August 21, 2008, p. 4, at *http://www.hsinetwork.com/Obama_HSI-Assess_08-21-2008.pdf* (October 10, 2008).
94. Lewin Group, *McCain and Obama Health Care Policies*, p. 42.
95. *Ibid.*, p. ES-1.
96. *Ibid.*, p. ES-3.

intellectual consensus argues for significant change: the inequity and inefficiency of the existing federal tax treatment of health insurance.[97] This is a profound mistake. He would retain one of the most regressive features of the federal tax code, thus propping up the largest component—and one of the most inefficient components—of the health care status quo.

Instead of pursuing a rational alignment of economic incentives through serious tax policy changes, the Senator resorts to an array of new mandates, taxes, and subsidies in an attempt to force an industrial-age insurance model to serve the needs of a highly mobile post-industrial workforce. The unreformed health care sector contrasts sharply with other economic sectors, in which individuals seek increasingly personalized services and receive higher quality service, which is routinely provided by competitive suppliers.

Meanwhile, the existing tax exclusion for employer-based health insurance encourages excess spending, discriminates against low-income workers and workers without employer-based coverage, and discourages consumer engagement in health care decisions.

Improvements in health care delivery are supremely important, and Senator Obama is right to focus on the need to make sure that Americans secure high-quality care from doctors and other medical professionals. Nonetheless, focusing on health care delivery without first reforming health care financing is a fundamental mistake.

Washington policymakers first need to fix the federal tax treatment of health insurance, the major force that shapes America's health care financing and its insurance markets. They could do this by replacing the existing tax exclusion on health benefits with universal tax relief for individuals and families, regardless of where they work.

This straightforward change would force insurers to compete for consumers' dollars and enable persons to buy and own their health policies. This would result in affordable and portable coverage and would start to align the economic incentives throughout the entire system in a rational way, making insurance plans both competitive and accountable and driving innovation and improvements in the delivery of health care. This is the way to secure the highest value for individuals and families who ultimately pay 100 percent of the nation's medical bills.

A Better Way

The broad goals of the Obama plan are laudable, but his proposed policies to achieve those goals are largely recycled proposals that would require a high degree of coercion. They include:

- Federal domination and control of health insurance,
- An employer mandate,
- A mandate on parents to cover their children,
- A comprehensive standardized benefits structure,
- Unspecified new taxpayer subsidies to business to cover their high-end health care costs, and
- Expanded federal involvement in the delivery of care by doctors and other medical professionals.

Despite Senator Obama's rhetoric of "choice and competition," his plan is a vehicle for new regulations and federal power that would leave ordinary Americans with even less control of their health care dollars than they exercise today.

Instead of using the massive power of the federal government to impose a top-down change on the health care system, Senator Obama and other policymakers would be wise to transfer direct control of health care dollars to individuals and families. This would enable Americans to exercise real personal choice of health plans and benefits while making health plans and providers compete directly for consumers' dollars by providing value to patients.[98]

The next President and Congress should start to level the playing field through tax and regulatory

97. Holahan and Blumberg note this deficiency in their analysis of the Obama health plan. See Holahan and Blumberg, "An Analysis of the Obama Health Care Proposal."

changes designed to harness the power of free-market competition to improve access, promote portability, and restrain health care spending. Specifically, they should reform the tax treatment of health insurance, expand options for employers to help their workers purchase health insurance, and restructure poorly performing public programs to help those in need buy superior coverage through private health insurance.

Such policies would constitute real change from the status quo. They would empower individuals to make informed choices and enable the marketplace to respond rapidly to their needs and wants rather than placing them at the mercy of government bureaucrats and politicians in Washington.

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98. For an overview of the elements of such a comprehensive change, see Edmund F. Haislmaier, "Health Care Reform: Design Principles for a Patient-Centered, Consumer-Based Market," Heritage Foundation *Backgrounder* No. 2128, April 23, 2008, at *http://www.heritage.org/research/healthcare/bg2128.cfm*.