Backgrounder

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Note to Congress: Expanding Health Care Entitlements Is Bad Policy

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Many Americans who have private health insurance will lose their coverage if major health care policy proposals advanced by President Barack Obama and congressional leaders, including Senator Max Baucus (D–MT), chairman of the Senate Finance Committee, become law.

These proposals have common themes. President Obama, in particular, has repeatedly made assurances that those enrolled in private insurance will be able to keep it and has touted the benefits of marketplace competition, but he, along with Senator Baucus and others, has coupled these assurances with a counterproductive proposal for a new public health plan to compete directly with private-sector plans in a national health insurance exchange. Based on independent analysis, such a provision would displace the private health coverage of millions of Americans.[1]

Beyond the proposed public health care plan, however, the President and Senator Baucus would also undertake a major expansion of existing government health care programs and entitlements, including Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Given the inevitable dynamics of such program expansions, assurances to Americans that they would be able to keep their private health coverage are meaningless. Their employers would have powerful incentives to dump them into public coverage.

The insurance system would, in fact, become even more fragmented than it is today. President Obama's promise of access to the "same kind" of private health

Talking Points

- Congress should not expand Medicare and Medicaid, because expansion of federal health care entitlements undermines private health insurance solutions.
- Many Americans who have private health insurance will lose their coverage if the policy proposals advanced by President Barack Obama and Senator Max Baucus, chairman of the Senate Finance Committee, become law.
- A Medicare "buy-in," far from being a "cheaper" alternative, will be too expensive for many Americans. Totaling up the real costs of Medicare Parts A, B, and D, as well as supplemental coverage, it would be even more expensive than current private insurance.
- Expanding Medicaid discriminates against low-income families and provides limited access to health care.
- Medicaid is already unsustainable for states and is already threatening state budgets.

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insurance that is available to Members of Congress would not apply, for example, to an adult or a child living below the poverty level. That option would be very different. President Obama and Senator Baucus both propose expansions of Medicaid, a fundamentally flawed welfare program in which a disproportionate number of enrollees end up in hospital emergency rooms for routine care, and SCHIP, which in many states is simply Medicaid.

Fresh from his election as chairman of the House Committee on Energy and Commerce, which has jurisdiction over Medicaid, SCHIP, and part of Medicare, Representative Henry Waxman (D–CA) has also been a champion of Medicaid expansion. At the very least, expansion of Medicaid, SCHIP, and Medicare will be the "default" plan for Congress and the Obama Administration.

Expansion of Medicaid under H.R. 1, the American Recovery and Reinvestment Act of 2009 (the "economic stimulus" legislation) and expansion of SCHIP under H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009, may well become an excuse not to pursue genuine health care reform. True reform would entail structural changes not only in health insurance markets, but also in existing public programs, as well as expanded personal choice and genuine market competition. Using the tremendous leverage of Medicare and Medicaid and new authorities under H.R. 1 and H.R. 2, the federal bureaucracy will be able to do much of the handiwork without subjecting Members of Congress to controversial votes, leaving ordinary Americans unaware of the dangers to their private health insurance coverage that lurk beneath the surface.

Health reform should revitalize, not undermine, private health insurance. Policymakers should expand personal choice and get as many healthy people into private insurance pools as possible. Taking healthy children out of the private pools and putting them into government programs like Medicaid and SCHIP is exactly the opposite of what should be done. SCHIP expansion splits up health insurance coverage for families. Children go into SCHIP (many states run at least part of their SCHIP programs as Medicaid) while their parents remain in private coverage.

Medicare expansion also incurs its own costs. Those who are ages 55 to 64 would be better off in a pool with a younger population in a newly reformed health insurance market, with a robust set of affordable options, than in traditional Medicare, which routinely covers only part of retirees' health care costs, requires enrollees to buy supplemental private coverage to cover needed benefits and catastrophic care, and is routinely subject to confusing and often inconsistent rules and reimbursement cuts.

The Deepening Entitlement Crisis

Expanding Medicaid and Medicare and incurring new liabilities is, to put it mildly, fiscally unwise. After all, Congress, in launching a recent series of massive bailouts, an unprecedented splurge in federal spending, has just created a record deficit of $1.6 trillion.[2] At the same time, Congress has avoided the tough but vital decisions about how to pay for the massive entitlement obligations that have already been incurred in Medicare and Social Security, let alone how to finance new ones.

Independent analysts, as well as the Government Accountability Office (GAO), the watchdog of Congress, have repeatedly warned Congress and state officials that their budgets and taxpayers are already on a collision course with the rapidly rising costs of entitlement programs. Medicare and Medicaid, cheap at the point of service, are in fact not cheap at all—nor do they provide the affordable coverage politicians have promised and Americans seek. Medicare alone has long-term obligations that amount to $36 trillion, and rising long-term care costs in Medicaid, particularly costs incurred by the massive baby-boom generation, will add to the enormous pressure on state and federal taxpayers to meet the needs of retirees.

1. On the provision of a public health plan, see Robert E. Moffit, "How a Public Health Plan Will Erode Private Care," Heritage Foundation *Backgrounder* No. 2224, December 22, 2008, at *http://www.heritage.org/research/healthcare/bg2224.cfm*.
2. See Brian M. Riedl, "CBO Budget Baseline Shows Historic Surge in Spending and Debt," Heritage Foundation *WebMemo* No. 2193, January 7, 2009, at *http://www.heritage.org/research/budget/wm2193.cfm*.

The Office of the Actuary (OACT) at the Centers for Medicare and Medicaid Services (CMS) has estimated that Medicaid will grow about 7.9 percent annually between 2008 and 2017, reaching $673.7 billion in 2017.[3] Cumulative spending over the next 10 years will amount to about $5 trillion.

As Medicaid is close to Medicare in size and grows at approximately the same rate, the long-term cost of Medicaid is roughly equal to that of Medicare. Medicaid's long-term unfunded liability will be even greater than Medicare's because Medicaid is funded entirely through general funds on a pay-as-you go basis, with no trust funds or dedicated payroll tax available for its use. Given the unsustainable cost of the current programs and the utter failure of Congress to address these issues, it is hard to imagine how Congress would plan to finance additional entitlement costs. The current approach on Capitol Hill is to avoid such accountability.

Medicaid: Limited Access and Choices

Expanding Medicaid is an old idea. There is nothing innovative about it. Medicaid has been expanded incrementally over the past 40 years, both through federal mandates and through state initiatives, and enrollment in the program has climbed to more than 60 million people.

Medicaid is a convenient method for hiding the true cost of ever-expanding government programs because the federal government pays only 57 percent of the cost, with state and local governments responsible for the balance. Proponents of new federal expansion ignore the reality that states already have the authority to expand Medicaid to more individuals below the federal poverty level ($20,200 for a family of four in 2008) who are parents or caretaker relatives of children eligible for Medicaid. But the states have chosen not to do so.

Under the Obama and Baucus proposals, Congress would undertake such an expansion. While the Obama proposal is silent on the extent of expansion, the Baucus proposal would expand the existing Medicaid population and include childless adults as well. While a few wealthier states might benefit from expansion as new federal dollars replaced state and local dollars that currently fund health care for indigent populations, most states would experience new, unbudgeted costs. The consequence of Medicaid expansion for states is that they would be forced to accept this expansion as a higher priority than education, transportation, or other important issues for which they are responsible.

Under the Baucus plan, more than 7 million Americans would head into Medicaid.[4] Medicaid recipients would not have the choices and benefits that are available to federal employees. While the Baucus plan promises "access to recommended preventive care, including services like a health risk assessment, physical exam, immunizations, and age and gender-appropriate cancer screenings,"[5] millions consigned to Medicaid would not have access to such benefits.

With limited access to providers, too many Medicaid patients do not get the care they need. Once enrolled in Medicaid, many find that their access to doctors, particularly specialists, is limited, so they have to get care in the most expensive place on the planet: the hospital emergency room. In 2006, more than one-third of all ambulatory visits for people on Medicaid were to a hospital emergency room or outpatient department, compared to just 14 percent of visits by people with private insurance.[6] Nearly 36 percent of ambulatory care visits by privately insured people were to medical or surgical specialty offices.[7] For Americans on Medicaid, the percentage of visits to specialists was just 16 percent.[8]

3. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, *2008 Actuarial Report on the Financial Outlook for Medicaid*, October 17, 2008, p. 25.
4. Max Baucus, Chairman, Senate Finance Committee, "Call to Action: Health Reform 2009," November 12, 2008, p. 23, at *http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf* (February 6, 2009).
5. *Ibid.*, p. v.
6. Susan Schappert and Elizabeth Rechtsteiner, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, "National Health Statistics Reports: Ambulatory Medical Care Utilization Estimates for 2006," No. 8, August 6, 2008, p. 11, Table 1.

Medicaid directors themselves acknowledge the access difficulty, which is due in part to low rates of provider reimbursement through Medicaid. In a survey of the 51 Medicaid directors conducted for the Kaiser Commission on Medicaid and the Uninsured, 17 reported some or significant problems with access to primary care, and 36 reported some or significant problems with access to specialty care.[9]

Expansion of public programs will only make the access problem worse. According to the Lewin Group, hospitals and physicians could lose from $2.8 billion to $36.4 billion annually through different public payment scenarios created with the enactment of a new public health plan.[10] This would be even worse under a Medicaid expansion:

> Medicaid typically pays less than Medicare or commercial insurance and providers often cite low reimbursement rates as their primary reason for not participating in the program. These issues were exacerbated during the last economic downturn when all states reduced or froze provider rates to help curb Medicaid growth, sometimes for multiple years.[11]

President Obama and Senator Baucus, as well as liberals in Congress and the state legislatures, routinely press for an expansion of Medicaid, despite the fact that such expansion contradicts other key health care reform goals that they claim they want to achieve. In the description of his plan, Senator Baucus notes that:

> [T]he costs of care for the uninsured are largely borne by those with insurance; providers charge higher prices to patients with private coverage to make up for uncompensated care, and these costs are passed on to consumers in the form of increased premiums. Requiring all Americans to have health insurance will help end the shifting of costs from the uninsured to the insured.[12]

But Medicaid is also a major cause of cost-shifting. It pays lower reimbursement rates to doctors and hospitals and other medical professionals than are paid by Medicare and the private sector. Medicaid pays doctors only 56 percent of private coverage; hospitals, 67 percent.[13] Medicare pays hospitals 71 percent of private payments and pays doctors 81 percent of private payments.[14]

Faced with lower reimbursement levels from public plans, providers pass their losses on to those who are covered by private plans—which show up in higher private-sector premiums. "According to a recent report by Milliman, Inc., a prominent actuarial consulting firm," writes Robert E. Moffit, "this 'hidden tax' of lower reimbursement levels of Medicare and Medicaid amounts to $88.8 billion a year, or an additional annual cost of $1,788 in insurance for a family of four."[15] Thus, expanding Medicaid would not "help end the shifting of costs" as promised. Instead, it would probably make cost-shifting even worse.

Expansion of Medicare and Medicaid ranks last in Americans' preferences for insurance coverage. The Commonwealth Fund 2002 Workplace Health Insurance Survey found that 43 percent of adults favored employer-based coverage, 22 percent favored individually purchased insurance, 15 percent favored a new government program for the uninsured, and only 10 percent favored Medicare or

7. *Ibid.*
8. *Ibid.*
9. Kaiser Commission on Medicaid and the Uninsured, *Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn—Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009*, Henry J. Kaiser Family Foundation, September 2008, p. 55, Figure 29, at *http://www.kff.org/medicaid/upload/7815.pdf* (February 6, 2009).
10. Moffit, "How a Public Health Plan Will Erode Private Care," p. 3.
11. Kaiser Commission on Medicaid and the Uninsured, *Headed for a Crunch*, p. 30.
12. Baucus, "Call to Action," p. iii.
13. Moffit, "How a Public Health Plan Will Erode Private Care," p. 8.
14. *Ibid.*
15. *Ibid.*

Medicaid. Even among low-income adults, Medicare and Medicaid finished last: 27 percent preferred employer-based coverage, 21 percent favored a new government program, and 19 percent favored Medicare or Medicaid.[16]

Denying Lower-Income Families a Choice

Under the health insurance program available to President Obama and Members of Congress, a federal employee typically has the choice of a number of plans. Under the Obama and Baucus proposals, which claim to provide that same choice to Americans, such a choice would be denied to millions on the basis of their income. They would instead be required to accept whatever is offered by their state through Medicaid.

Under a reformed health care system, the option of choosing one's health insurance should not be based on one's income. If a person has an annual income of $10,829 or lower, which makes him eligible for Medicaid, it does not logically follow that he is therefore less capable of making decisions about his health care than someone with a higher income. It would be more equitable for people to have access, through a system of income-based premium support, to the kind of coverage they want rather than what government officials pick for them.

Instead of putting more people into Medicaid, authentic reform should reverse course and aim to expand private health insurance pools, including the healthy current Medicaid recipients, thereby freeing the public dollars that support them.

Medicare Expansion

Just as Medicaid expansion up the income scale has been routine health policy ever since the Clinton Administration proposed the idea in the late 1990s, Medicare expansion down the age scale has also been fashionable. As part of his health care initiative, Senator Baucus has proposed making coverage "immediately available" to Americans ages 55 to 64 through a "Medicare buy-in."[17] In the Baucus proposal, "[t]he premium amount would be calculated so that the total costs for the buy-in population would be budget neutral. Thus, this option would not create new costs for the Medicare program or for taxpayers."[18]

But singling out this age group in terms of the number of people who are uninsured misses the mark. According to the latest data from the U.S. Census Bureau, 4 million Americans between ages 55 and 64—12 percent of the 33.3 million individuals in this age range—are uninsured.[19] By comparison, 10.3 million people (25.7 percent) of the 40 million ages 24 to 34 are uninsured;[20] 7.7 million people (18.3 percent) of the 42 million ages 35 to 44 are uninsured;[21] and 6.8 million people (15.4 percent) of 44 million ages 45 to 54 years are uninsured.[22] In terms of making the greatest impact on increasing the sheer number of Americans with health insurance, starting with this age group makes little sense unless the real intent is to expand government, not insurance coverage.

The Baucus argument for the Medicare "buy-in" is that the individual insurance market for people in the target age group is not affordable. Senator Baucus points out that from 2006 to 2007, the "average annual premium" in the individual market for those ages 60 to 64 was more than $5,000 for single coverage and $9,200 for family coverage.[23]

It cannot be overlooked, however, that a person who buys individual insurance, as opposed to

16. Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care," Commonwealth Fund, August 2002, p. 5.
17. Baucus, "Call to Action," p. 21.
18. *Ibid.*, p. 22.
19. U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," August 2008, p. 69, Table C-3.
20. *Ibid.*, p. 67.
21. *Ibid.*, p. 68.
22. *Ibid.*, p. 69.
23. Baucus, "Call to Action," p. 21.

group health insurance through an employer, is deprived of the enormously generous tax subsidy for the purchase of health insurance. This is a crucial point that Senator Baucus himself has acknowledged as a major inequity in the insurance system.

The question of whether a health insurance premium is or is not "affordable" depends, of course, on what is meant by "affordability." It is a slippery concept in much of the conventional health policy discussion. "Affordability" is a result of a number of variables, such as the income of the person, the competitiveness of the health insurance market in his state or locality, the prevailing patterns of medical practice and cost of hospital care in his area, and the level of underwriting for coverage, among other things.

This also means that access for this group or any other group can be resolved by such measures as equally generous individual tax or premium subsidies for health insurance; reform of the health insurance market (including the combination of individual and small-group insurance markets in a single, statewide health insurance market exchange); risk-transfer pools for higher-risk individuals; regulatory reform of the state health insurance market and reduction of benefit mandates to allow people to buy cheaper coverage; or a restriction on health insurance underwriting.

The fact is that there is a wide variety of available remedies for high-cost individuals (senior citizens or those with chronic illnesses, for instance) that can make health insurance affordable through the private markets without expanding entitlements.

In Medicare, of course, no beneficiaries are excluded from coverage, and premiums are "community rated," lowering costs for high-risk individuals while driving up the cost for everyone else. But on the narrow issue of cost, the situation is more complex. It is simply not true that Medicare coverage is, on average, cheaper than private coverage. Medicare beneficiaries are heavily subsidized by virtue of their entitlement, but Medicare coverage is not usually affordable for an individual to purchase without such subsidies. If the real issue is ultimately a matter of government subsidies for the purchase of health insurance, those subsidies could be applied to private health insurance as easily as they are to Medicare.

Leaving aside the program's real and growing cost to taxpayers, the notion that Medicare is "cheaper" deserves closer examination. If private coverage on the individual market costs $5,000 a year and is not affordable without tax breaks or premium support, then the same applies to the cost of buying into Medicare without public subsidies.

In 2007, the standard monthly premium for Medicare Part A was $410. The standard monthly premium for Part B, which covers physician services, was $93.50. However, the Part B premium is mostly subsidized, and the ordinary Medicare beneficiary, at least age 65 or disabled, pays only 25 percent of the Part B cost. If an individual were charged just 80 percent of the true Part B premium, the cost would have been $161.40 per month. In 2009, the Part B premium jumps dramatically, and to pay 80 percent of the premium would cost $308.30 per month.

Beyond that, the cost of the prescription-drug benefit under Part D should be added, based on the reasonable assumption that a person in the 55–64 age group would need prescription drug coverage. In 2007, the base beneficiary premium was $27.35 per month. The total annual cost of these premiums would be $7,185 in 2007, as shown in Table 1, which is substantially higher than the individual coverage that Senator Baucus cited in his report for the same period.

Medicare Premiums, 2007

	Monthly	Annual
Part A Hospitalization and nursing homes	$410.00	$4,920.00
Part B Physicians and others	$161.40 *(80% of cost)*	$1,936.80
Part D Drugs	$27.35	$328.20
Total	**$598.75**	**$7,185.00**

Source: 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Table 1 • B 2240 heritage.org

But that is not all. Beyond the Medicare Parts A, B, and D premiums, the vast majority of Medicare beneficiaries find it necessary to secure catastrophic coverage or other private supplemental coverage to cover gaps in Medicare. In addition to the $7,185 in Medicare premiums in 2007, an individual under the Baucus plan would also have faced $992 for the inpatient hospital deductible in 2007 and even more costs for deductibles and coinsurance for Part B services, typically 20 percent of the cost of the service. Part D also carries another set of deductibles and coinsurance.

It would not be unreasonable for persons in the 55–64 age group also to secure such private supplemental coverage, knowing that Medicare does not cover some necessary and desirable benefits and, used alone, would incur high routine out-of-pocket costs for the average Medicare beneficiary. Most Medicare beneficiaries receive additional assistance with the cost of their care through their employers, through Medicaid, or, as noted, through supplemental "Medigap" coverage that the government requires them to purchase. Because of its high costs and gaps in coverage, only 17 percent of Medicare beneficiaries depend solely on Medicare coverage.[24]

Today, Medicare beneficiaries can choose from among 12 different Medigap policies with wide variation in cost based on age, geography, and out-of-pocket costs. In 2007 and 2008, a Medicare beneficiary with a Medigap policy in Northern Virginia typically paid an annual cost ranging from $3,800 to $4,450 (including the Medigap premium plus residual out-of-pocket costs).[25] Allowing a person to "buy into Medicare" and be faced with the typical additional costs associated with the gaps in Medicare coverage and cost-sharing is not likely to be a bargain.

The Fiscal Nightmare

The official projections for current entitlements show that the American people will be confronted with a series of unpleasant options: savage benefit cuts, massive tax increases, or a combination of both. Heritage Foundation analysts, among many others, have amply documented the long-term economic catastrophe that lies ahead without comprehensive entitlement reform.[26]

By 2052, the combined cost of Social Security, Medicare, and Medicaid will leap from 8.4 percent to 18.4 percent of gross domestic product. Unless these programs are reformed, they will crowd out all other federal spending by 2052.

In buttressing the findings of independent analysts, the GAO recently released two reports, *The Nation's Long-Term Fiscal Outlook: September 2008 Update*, and *State and Local Fiscal Challenges: Rising Health Care Costs Drive Long-Term and Immediate Pressures*. These reports are must reading for Members of the 111th Congress.[27] Any notion that Medicaid and Medicare can be expanded without aggravating the current fiscal crisis is quickly dispelled by the work of these highly respected GAO analysts.

The GAO candidly tells Congress:

> Just ten years from now in this simulation that is based on historical trends and recent policy preferences, 76 percent of every dollar of federal revenue will be spent on retirees and their health care providers, health care providers for the poor, and our bond holders. This leaves little room for other priorities, such as national defense and investment in infrastructure and alternative energy

24. America's Health Insurance Plans, "Low-Income and Rural Beneficiaries with MediGap Coverage: 2004," February 2007, p. 2.
25. See U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Find and Compare Medicare Health Plans" at *http://www.medicare.gov/MPPF/Include/DataSection/Questions/SearchOptions.asp* (February 6, 2009).
26. See, for example, Heritage entitlement spending charts, "Entitlement Spending Will More than Double by 2050," "Entitlements Alone Will Eclipse Historical Tax Levels by 2052," and "Mandatory Spending Consumes Growing Share of Total Spending," at *http://www.heritage.org*.
27. U.S. Government Accountability Office, *The Nation's Long-Term Fiscal Outlook: September 2008 Update*, GAO-09-94R, at *http://www.gao.gov/new.items/d0994r.pdf* (February 6, 2009), and *State and Local Fiscal Challenges: Rising Health Care Costs Drive Long-Term and Immediate Pressures*, GAO-09-21-OT, November 19, 2008, at *http://www.gao.gov/new.items/d09210t.pdf* (February 9, 2008).

> sources, and threatens the government's fiscal ability to respond to emergencies, both natural and manmade.[28]

The GAO estimates that it would take a 39 percent increase in revenue, or a 37 percent decrease in non-interest spending, to close the federal fiscal gap.[29] Further, the GAO points directly to health care spending as the major cause of the fiscal gap: "Rapidly rising health care costs are not simply a federal budget problem; they are our nation's number-one long-term fiscal challenge."[30]

Health care costs, principally Medicaid costs, even at current levels will force states to raise revenue or reduce spending by 7.6 percent every year in order to close the fiscal gap faced by state and local governments.[31] It is ironic that just as Senator Baucus and others propose to add millions of additional beneficiaries to the fiscally troubled Medicaid program, Congress is on the threshold of passing a temporary increase in the Medicaid Federal Medical Assistance Percentage (FMAP), the federal Medicaid match, in order to provide urgent economic relief to states.

Adding more people to Medicaid when states cannot even afford their current programs makes no sense—unless the real object is to crash the program in order to force the states to support a single-payer system, under which the federal government would take over the entire health care system. Congress's own analysts have demonstrated that the current path for Medicare and Medicaid is "unsustainable."

Conclusion

Based on the promises and proposals advanced by President Obama and Senator Baucus, the individual pieces of the dominant congressional agenda for health care reform do not fit neatly together. Expansion of government programs undermines existing private health insurance coverage for millions of Americans—a development directly contrary to President Obama's campaign promises—and aborts any salutary effort to mainstream millions of Americans who are trapped in poorly performing public plans into the private health insurance system in which most of their fellow citizens participate.

The Obama and Baucus proposals also directly undermine the historic accomplishments of the 1990s welfare reform, which was designed to get Americans off of dependence on government programs. Indeed, expanding the private health insurance pool and spreading risk over a larger population would help to stabilize health insurance premiums and slow the growth in health care costs.

Expansion of government programs will divert more resources into federal and state bureaucracies and force states to divert more funds away from other public priorities into Medicaid and SCHIP. Likewise, the Medicare "buy-in" as a "cheaper" alternative is an illusion. Totaling up the real costs of Medicare Parts A, B, and D, as well as supplemental coverage, it would be even more expensive than current private insurance.

Entitlement reform, lowering the cost of both public and private health insurance, and expanding private insurance coverage should be accomplished simultaneously, allowing for a smooth interaction among the various parts. Expanding government entitlement programs will thwart the ability to harness market forces to control costs—while depriving more and more Americans of the opportunity to secure the private coverage of their choice.

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28. U.S. Government Accountability Office, *The Nation's Long-Term Fiscal Outlook: September 2008 Update*, p. 2.
29. *Ibid.*, p. 10.
30. *Ibid.*, p. 8.
31. *Ibid.*, p. 5.