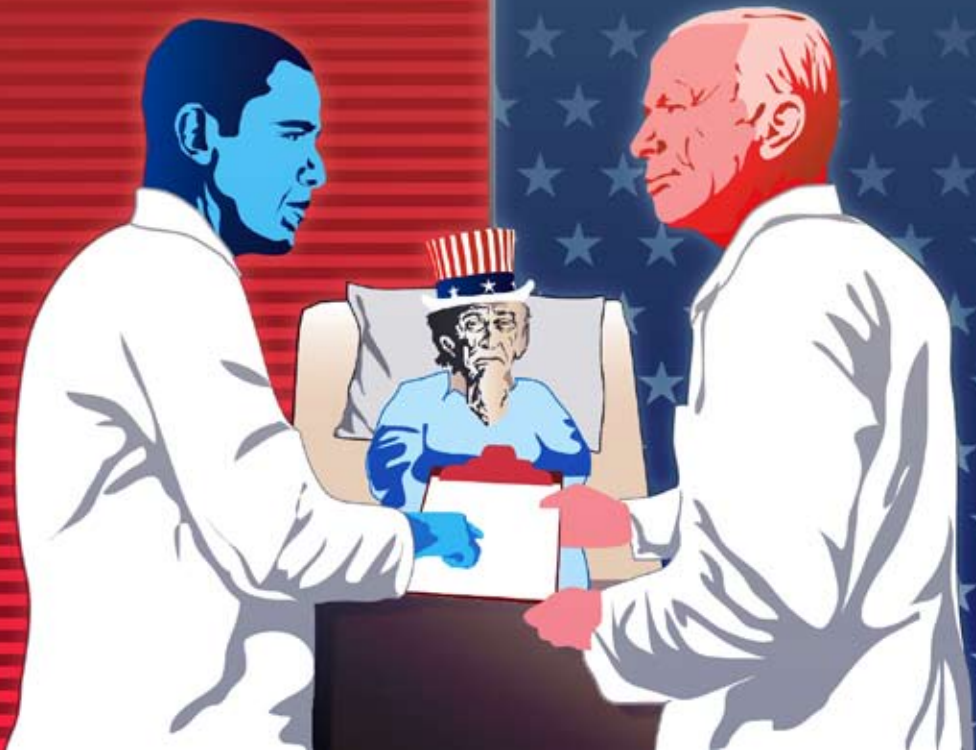


PRESIDENTIAL PRESCRIPTIONS

Diagnosing the Candidates' Health Reforms

By John R. Graham



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In health there is freedom. Health is the
first of all liberties.

— **Henri-Frédéric Amiel**

(Swiss philosopher, 1828–1881)

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Key Points

There are important differences on health reform between the two presidential candidates, especially in two areas: *health insurance* and *medical-malpractice reform*.

Senator John McCain proposes dramatic, positive change that will give American families control of their health care dollars, while Senator Barack Obama proposes to continue the trend of the past four decades: delivering command of health care into government hands.

Senator McCain's proposals to change how we buy health insurance will improve Americans' ability to access health care:

- His tax reform will result in a raise of about \$9,000 for every working American family.
- While this raise will be taxable, it will be supplemented by a universal, refundable tax credit of \$5,000 per family or \$2,500 per single person that will eliminate the “job lock” caused by employer-based health benefits and significantly reduce the Medicaid poverty trap that holds back many Americans.
- Combined with his plan to allow a national market in health insurance, these reforms will result in about six million currently uninsured Americans buying health insurance voluntarily, within an estimated range of two million to 12 million.
- If people choose not to buy health insurance, their unused tax credits can go into a fund that states use to finance their uncompensated care and “safety nets.”
- Because Americans will control their health care dollars, Americans—rather than the government or employers—will decide how to spend them, thereby reducing healthcare costs and increasing quality.
- Senator McCain has made a commitment to protect those with pre-existing conditions during the transition, so they retain coverage as Americans find new ways to organize themselves to share the financial risks of health care.

Senator Obama's proposals will have significant, negative consequences to America's health:

- His National Health Insurance Exchange (NHIE), which promises ordinary Americans the same gold-plated benefits that Congress receives, will deteriorate into another dysfunctional and expensive government program.
- He proposes to fund his NHIE with taxes on business, which will cost thousands of jobs.
- His health insurance reforms, specifically guaranteed issue and community rating of health insurance premiums, will cause about one million to lose their individually purchased health insurance in the short term, instead of fixing the real problems of private health insurance today.
- His expansions of Medicaid and State Children's Health Insurance Program will make more American families dependent on government health care, trapping them in poverty and limiting their choices.
- Senator Obama will spend an extra \$100 billion a year of your health dollars on health goods and services that serve his priorities, not your family's needs.
- Combined, these reforms are likely to lead to a "death spiral" for privately chosen health insurance.
- His medical-malpractice insurance reform threatens to make it impossible for physicians to pay for liability insurance, threatening patients' access to care and their legal rights.

Introduction

A politician (who shall remain unnamed) once said that “an election is no time to talk about policy.” Certainly, much of the media coverage of the current presidential campaign confirms that judgment. Yet, there are real policy differences between Senator McCain and Senator Obama on health care, and the goal of this briefing paper is to alert voters to the consequences of each approach.

Certainly, there are similarities. Both promise greater investments in health information technology, an increased focus on prevention and wellness—always a popular theme—and a commitment to cut out “waste.” However, these are staples of any politician’s health care platform: easy to talk about, but exceedingly difficult to execute.

The fundamental differences between the candidates center on health insurance and medical-malpractice reform. In both cases, Senator McCain has grasped the nature of the problems we face, while Senator Obama has completely misunderstood them. As a result, Senator McCain’s proposal will be far more likely to improve Americans’ access to affordable, high quality health care that American families can control.

Senator Obama’s proposal, on the other hand, will drag us further down the same path of fragmented, dysfunctional, bureaucratic, government-run, and employer-run health care that we have been traveling for four decades as increasingly passive patients. This briefing paper addresses these two areas, health insurance and medical malpractice, where there is clear blue water separating the two candidates’ positions.

Health Insurance

Background: Despite What You Think, Employer-Based Health Insurance Is a *Liability*, Not a “Benefit”

There is one very clear difference between how the candidates want you to get health insurance. Put simply: Senator McCain proposes to *free* you to buy the health insurance that you choose. Senator Obama proposes to *trap* you deeper in the *status quo*—one paycheck away from losing both your job and your health care, and more likely to become dependent on the state when that happens.

This bold allegation demands some background.

You probably get your health insurance from your employer. Why? There are a number of wrong answers and one correct one. The first wrong answer is that *your employer has “purchasing power,”* leveraging the dollars of his entire workforce to get the best price for group-health benefits. A moment’s reflection reveals the fallacy.

If your employer was such a great “bulk buyer,” he’d buy your clothes, groceries, and home for you, too. At the extreme, you would receive no cash wages, but all of your goods and services “in kind.” This does not happen because you and your family prefer different clothing, groceries, and housing than your colleague in the next cubicle, and there is no way that your employer can figure out and buy the right collection of clothing, groceries, and homes that would satisfy all his workers and their families.

A second wrong answer is that *you are just too dumb* to figure out how to buy health care for your family. According to a leading business group: “Health insurance contracts—their language and the underlying technology—are extremely complex. There are too many possible future events. Few consumers really understand their policies or actually read them. Even the ‘simplified’ presenta-

tions of employee benefit packages usually take 40–50 lines just to describe the services covered or excluded, the limitations, and the co-payments or coinsurance rates.

Medical care is even more complex. It generally takes seven or eight years of post-graduate education and training to be considered a qualified physician, plus continuing education thereafter. Although some people can become sufficiently informed to contribute to strategic choices in particular cases, the vast majority must rely on the advice of their doctors, which makes them less than equal participants in a competitive market.”¹

That’s all true, but only *because* of wrong answer number one: your employer is negotiating and executing a purchase on your behalf, despite his almost total ignorance of your preferences for health care. Of course, people do not like to admit ignorance, so everyone involved in purchasing your health care tramples you (and each other) in a cavalcade of complexity. Remarkably, for all this unnecessary complexity, you end up with extremely limited choices.

Half of workers work for firms that offer only one type of plan (such as Health Maintenance Organization, Preferred Provider Organization, Point of Service, or High-Deductible Health Plan), and even firms that offer more than one type may not offer full choice to all employees.² On the other hand, you are free to engage your own lawyer, accountant, car mechanic, or feng shui consultant without your employer’s “expert” input. And those professionals all know more than you do about the matter at hand. In fact, that’s exactly the reason *why* you choose to engage them! In an environment of individual choice, providers have to “race to the top” to provide you with goods and services of increasing quality at decreasing cost, no matter the complexity.

The third wrong reason is that *your employer pools risk*. After all, the whole point of “insurance” is to spread risk across a group so

nobody suffers an unbearable financial loss when they succumb to a catastrophically expensive illness or accident. Once again, ordinary experience shows us that this reason does not hold water.

Auto insurance, homeowners' insurance, long-term care insurance, and life insurance all pool risk, and yet we buy those policies as individuals or families. As discussed below, health insurance is not quite as simple as these other examples, but there is compelling evidence that individually purchased health insurance pools risk very well. There is also contrary evidence that employer-sponsored health benefits do not pool risks as advertised.

It's not the case that the young and healthy subsidize the older and sicker.³ Research has shown that obese workers with health benefits pay for their extra health care costs through lower wages, whereas obese workers at jobs without health benefits do not experience reduced wages.⁴ Older workers at firms with health benefits earn less, relative to younger colleagues, than older workers at firms without health benefits.⁵ When states began to mandate that health plans provide maternity benefits, the costs of pregnancy were not distributed across the workforce. Rather, women of childbearing age and their spouses bore *all* the cost of mandatory maternity benefits, through wage reductions of about 5 percent.⁶

The *correct* reason for employer-based health benefits is that *the government took almost \$9,000 of your money* and gave it to your boss to buy a health plan for you.⁷ The government did this through the tax code, whereby health benefits that your employer buys in your name are excluded from your taxable income. The exclusion of health benefits from taxable income “cost” the government \$246.1 billion in 2007, of which \$145.3 billion was foregone income taxes and \$100.7 billion foregone payroll taxes.⁸

This tax treatment also explains why your doctor is working for a health insurer—and suffering the paperwork thereof—instead

of working for you. Unless you have a Health Savings Account or similar tax-advantaged arrangement to pay the doctor, you will likely be over-insured. Say an employer-based plan covers a \$100 consultation with a doctor. Including administrative fees, the premium would be about \$105, but the average employee is only paying about \$71 for the benefit, considering the tax avoidance. That's a major reason why our health policies have such high premiums, but deductibles and co-pays too low to motivate us to search for low-cost, high-quality health care.⁹

Indeed, despite rapidly rising health spending, Americans are paying directly for a *smaller share* of total health costs than they ever have (and paying for more indirectly). In the mid-1990s, out-of-pocket spending accounted for 30 percent of health care spending among privately insured people. It was down to 26 percent by 2005. By 2007, workers were paying 16 percent of the premium, down from 20 percent in 1993, for single coverage. For family coverage, it dropped from 32 percent to 28 percent.¹⁰

For the typical worker, with a 15-percent marginal tax rate, 5-percent state tax, and 15.3-percent payroll tax, the price of getting health benefits from his employer is only two-thirds what he would pay with after-tax dollars.¹¹ However, that's only for the typical worker. Because of America's progressive income tax, this tax exclusion makes health care relatively cheaper for high-income Americans than for low-income Americans.

The Kaiser Family Foundation demonstrated this by calculating the tax benefit of employer-based health benefits for a California family in 2006.¹² The Foundation figured that an employer-based policy for a California worker and his dependents cost \$11,500, of which the employer paid \$10,000 and the employee paid \$1,500 through a pre-tax payroll deduction.¹³ Table 1 shows the real cost of the policy to such a family, according to its income.

**Table 1: Tax Avoidance from Employer-Based Health Benefits
for a California Family, 2006**

Household Taxable Income	\$40,000	\$80,000	\$120,000	\$150,000
Federal Income Tax Avoided	\$1,720	\$2,245	\$2,875	\$3,220
California Income Tax Avoided	\$215	\$920	\$1,070	\$1,070
Social Security & Medicare Taxes Avoided	\$1,760	\$1,760	\$1,760	\$1,760
Total Taxes Avoided	\$3,695	\$4,925	\$5,705	\$6,050

Family of two waged spouses and two dependents.

Source: Kaiser Family Foundation.¹⁴

This tax treatment of health benefits is clearly unjust: the household with taxable income of \$150,000 avoids \$2,355 more taxes than does the family earning \$40,000. It’s a reverse Robin Hood caper with a perverse counter-Marxist twist: “From each according to his labor, to each according to his tax bracket,” according to one scholar.¹⁵ This exclusion of employer-sponsored health benefits from taxable income leads to high-income people getting more health benefits than they would otherwise use, and low-income people getting less—a bizarre and surely unacceptable welfare policy. And it gets worse.

Higher-income workers in a firm will demand a richer health benefit than the lower-income workers would prefer, but they all likely have to pay for the same plan.¹⁶ To rub more salt in the wound, high-income people don’t actually need that extra subsidy to get health care. They will always use more health services than low-income people, due to a greater willingness to pay out-of-pocket, higher valuation of health and health care, and skill in navigating the system.¹⁷

Of course, we do have programs such as Medicaid and the State Children’s Health Insurance Program (SCHIP), but they make things *worse* because of the “poverty trap.” Someone who earns too much to qualify for Medicaid or SCHIP but not enough to have employer-based health care is out of luck.¹⁸ The media are full of these examples, such as Susanna Espinoza of San Diego.

Ms. Espinoza has two children, earns \$39,000, and has employer-sponsored health benefits for herself, but not her children. And she earns too much to qualify her kids for Medi-Cal or Healthy Families, (California's Medicaid or SCHIP programs.)¹⁹ She might be better off taking a lower-paying job! A decade ago, economists reckoned that the marginal tax rate of Medicaid beneficiaries was between 70 percent and 100 percent.²⁰

The perverse nature of the *status quo* was recently illustrated by a *New York Times* article on how health benefits actually drive decisions to marry or divorce. Here's the story of Brandy Brady and Ricky Huggins. Ms Brady, "finds much to admire in Mr. Huggins," perhaps above all, said Ms. Brady, who received a kidney transplant last year, "He's got great insurance." An officiant at a wedding chapel in Covington, Kentucky, is no longer shocked to learn that one-tenth of the couples that come to him for marriage cites health insurance as the reason.²¹

In recent congressional testimony addressing the tax treatment of health benefits, professor Jonathan Gruber of MIT emphasized that, "As a result of these limitations, *no expert today* would ever set up a health system with such an enormous tax subsidy to a particular form of insurance coverage.... Both economic theory and a large body of economic evidence show that *there are no employer dollars*: the money that employers spend on insurance would otherwise just be spent on worker wages."²² (emphasis original)

Despite the utter absurdity of the situation, Americans are discouraged and demoralized about their ability to take back control of their health care dollars. In a poll last June, registered voters with employer-based health insurance were asked: "If you were to buy health insurance on your own, do you think it would make each of the following easier, harder, or it wouldn't make much difference compared to your current situation?" A full 63 percent thought that it would be harder to find a plan that matched their needs,

64 percent thought that it would be harder to administer, 80 percent thought that it would be harder to find or keep health insurance if they were sick, and 81 percent thought that it would be harder to get a good price for health insurance.²³



Basics: Employer-Based Health Insurance Increases the Number of Uninsured

There is evidence that employer-based health insurance actually causes more people to become uninsured, especially for relatively short periods when they are between jobs. This is not surprising.

The average person born between 1957 and 1964 held 10.8 jobs between the ages of 18 and 42. Although the duration of each job lengthened as the workers aged, two-thirds of the jobs they had between ages 38 and 42 lasted less than five years, and almost one-third lasted less than a year.²⁴ When the government makes you get health insurance through your job, it's no wonder you fall through the cracks once in a while. Without a robust market for individually purchased health insurance, this will always be the case.

The most commonly cited estimate of the uninsured is 45.7 million in 2007, an estimate that is published annually from the U.S. Census Bureau's *Current Population Survey* (CPS).²⁵ However, this number is questionable. First, immigrants grew from 8.8 percent to 12.8 percent of the non-elderly population between 1994 and 2006, but the survey does not know how many of them are legal and how many are illegal. They are concentrated in low-wage jobs in California, Texas, Florida, and New York. It's highly unlikely that these are all legal immigrants. In 2006, 10 million of these non-citizen immigrants were uninsured according to the CPS, more than one-fifth of the total uninsured.²⁶

Furthermore, although the CPS purports to estimate the number of people uninsured for an entire year, it is unlikely that this is the case.²⁷ A less widely reported survey conducted by the Centers for Disease Control and Prevention’s National Center for Health Statistics draws the picture more clearly. In 2007, 43.1 million Americans were uninsured *at the time of the survey*, but 53.9 had been uninsured *at least some of the time over the past year* and 30.6 million had been uninsured for *at least an entire year*.²⁸

There is also a huge “cycling” of people through health insurance. For example, if we look only at people who were uninsured *for the month* of March, 1998, according to the Current Population Survey, 8 percent were uninsured for four months or less, 14 percent were uninsured for five to 12 months, and 78 percent were uninsured for more than 12 months. However, if you look at people uninsured for some time *during the whole 12 months* of July 1996 through June 1997, 45 percent were uninsured for four months or less.²⁹

If you draw the period out to two full years, 2006 and 2007, 89.6 million Americans were uninsured *at some point* in the two years. However, even for the two years, half of them were uninsured for eight months or less.³⁰ Ironically, the group that produced this latter study, Families USA, actually supports our current state of servitude to employer-based health care—the very system that caused many of these people to be uninsured!³¹

In 2006, 26 percent of the non-elderly population, which had a head of household in a full-year, full-time job, was either uninsured or on a government program like Medicaid, but *two-and-a-half times* as many, or 65 percent, of those in part-time or no job were in those situations.³²

However, many of the short-term uninsured are freshly employed full-time workers waiting to get on their employers’ health plans. In 2002, 19 percent of uninsured workers were ineligible for their

employers' plans (which is greater than the 14 percent who "chose" not to be covered, mostly because their share of premiums was too expensive). However, 42 percent of those uninsured workers who were ineligible for employer-sponsored health benefits had just not completed their waiting period for coverage.³³ In 2006, 27.6 million workers (including part-timers) had no health insurance, according to the CPS.³⁴ If the 2002 proportions are consistent, 2.2 million workers are uninsured simply because of the waiting period.

Clearly, the employment-based nature of American health insurance causes a lot of friction and short-term loss of health insurance. The flip side of this is "job lock," that is, not leaving a job for fear of falling through the cracks. The media are full of stories of people who cannot leave a job for fear of losing health insurance.³⁵ Over the years, there have been scholarly attempts to measure the degree of job lock. Two recent reviews of the literature conclude that job lock is worse for women than men, worse for singles than married people, and reduces job mobility by 15 percent to 60 percent. The shorter end of the range results from laws such as COBRA, HIPAA, and related state legislation dating back to the early 1990s that try to "fix" the lack of portability by mandating continuation of coverage after separation from the employer, with only partial (if any) success.³⁶

There is a "halfway house" of quasi-portability already, but it only exists for unionized employees. Multi-employer benefit plans, for both pensions and health, were established by the Taft-Hartley Act of 1947, which forbade employers to give money to a union pension plan, but allowed unions and multiple employers to establish a plan with a board of trustees comprising representatives of unions and participating employers. Although the decline of unionization in the private sector has caused this arrangement to recede into the background somewhat, it is still an effective model because a unionized worker can transfer employers and stay in the same Taft-Hartley plan.³⁷ In 2003, more than 80 percent of union workers in

firms with 25 or fewer employees had employment-based health benefits in their own name, versus only 36 percent of non-union workers in firms of similar size. The difference is even more eye-popping when considering part-time unionized workers, of whom 59 percent have health benefits from their own jobs, versus only 22 percent of non-union workers.³⁸

Unfortunately, non-unionized Americans don't have this option, and they suffer lack of portability of health benefits. The candidates have very different approaches to dealing with these problems.



Obama's Plan: Fragmentation, Frustration, and Fiscal Ruin

Senator Obama's proposal is so vague that it is not really possible to aggregate the costs and benefits, although some have tried. Friendly academics made a "best guess" that the massive increase in central planning would save businesses money, but would also increase federal spending by \$50 billion to \$65 billion annually.³⁹ A less friendly National Taxpayers Union Foundation priced out Senator Obama's plan at more than \$100 billion a year.⁴⁰

Whatever the numbers turn out to be, it is clear that, as far as fundamental, pro-patient health reform goes, Senator Obama's proposal misses the mark widely. Curiously, or perhaps bending to political reality, he has also put forward a "plan" that falls short of his own, true vision, which is government-monopoly health care, like Canada's.⁴¹ Although he refrains from going that far this year, four of Senator Obama's campaign commitments will do serious damage to Americans' ability to choose health plans that they prefer and, if executed as he describes, are highly likely to send health care into a death spiral toward government monopoly.⁴² The commitments are:

1. **Scaling out the Federal Employees Health Benefits Program (FEHBP) to all Americans, through a National Health Insurance Exchange**
2. **Taxing employers to pay for health care (but not requiring it for individuals)**
3. **Imposing guaranteed issue and community rating on health plans nationwide**
4. **Increasing government dependency through expanding Medicaid and SCHIP, including mandatory coverage of children**

Scaling out FEHBP nationwide

If you've always wanted to join the Post Office, you don't need to apply; Senator Obama will enroll you in the mailmen's health plan automatically, through the National Health Insurance Exchange. Actually, of all four of Senator Obama's points addressed in this briefing, this is the least worst, because it comes painted with a thin coat of individual choice. It is true that congressmen, federal public servants, and retirees are spoiled for choice.

When I went to the FEHBP website and posed as a federal public servant in San Francisco, I could pretend to select from about 14 different plans. As noted above, most private-sector workers are lucky to have a choice of one plan. But that is not surprising; federal workers are organized into powerful unions that have negotiated forcefully with the government for decades to get more and better benefits from taxpayers. In fact, if the government was the powerful negotiator that it claims it could be (with respect to pharmaceutical manufacturers and private health plans in Medicare), FEHBP would be spare, not generous.

Scaling FEHBP out as a national entitlement would result in the deterioration of the quality of the FEHBP, not an improvement in the quality of American health care overall. There is simply no way that you and I, as ordinary citizens, can exercise the same sway over the government as the public-sector unions can. Senator Obama might as well promise that he will give every American the same gourmet meals, paid for by lobbyists, which his congressional colleagues enjoy.

Of course, the FEHBP/National Health Insurance Exchange will *start out* very attractive, attracting more and more applicants because it will likely cost less than traditional employer-sponsored health benefits. However, the argument that government programs cost less to administer than private ones is mythological. Government programs appear to cost less to administer for a number of illusory reasons. For example, they force costs of tax collection onto businesses as employers or vendors, ignore the deadweight cost of taxation on people's incentives, pay no rent or cost of capital for their buildings and equipment, and are unconcerned with monitoring fraud.⁴³

Taxing Employers to Pay for Health Care

Senator Obama proposes a tax credit for small firms to buy health insurance for their employees; his advisors have suggested that this credit would go to businesses with a maximum of 15 employees.⁴⁴ All other businesses will come under a “pay-or-play mandate.” That is, Senator Obama will also tax employers to fund his FEHBP/National Health Insurance Exchange if they do not make a “meaningful contribution” (to be defined) to their employees' health benefits.

In a contradiction that is not possible to untangle, Senator Obama claims that this will allow individuals to move from job to job without changing or jeopardizing their health coverage. However, as discussed above, the actual employer contribution to our health benefits is zero; every penny of health benefits that is “paid for” by our employers comes out of our wages (whether we see it or not). If Senator Obama does not plan to return our health care dollars back to us, but to continue to funnel them through our employers, with a layer of government added on, this cannot result in “portability,” because our employer and the government will decide what plan we're enrolled in.

Further, although traditional employer-based health insurance has huge drawbacks, at least it allows the employer and the workers to negotiate and mutually accept the proportion of remuneration that will be paid in cash wages, versus the proportion paid in health benefits. Senator Obama's proposal removes even that limited freedom. It is this loss of choice that imposes the real costs. Economists have modeled similar, previously proposed "pay-or-play" mandates. Although the results of their models differ, they are uniformly negative.

Ellen Meara of Harvard University and two colleagues designed an econometric model to analyze the effects of an employer mandate on firms that employ at least 25 full-time workers, at the prevailing level of health benefits. They concluded that the employer mandate would reduce wages of higher-income workers by about 2 percent. Because workers near the minimum wage cannot adjust their wages in response to a mandate, 950,000 would lose their jobs and 1.6 million would be forced to go into part-time work, decreasing annual wages by \$71 billion.⁴⁵ Of course, some of these workers would likely go "underground," taking work where the minimum wage is hard to enforce.⁴⁶

Professors Katherine Baicker of Harvard University and Helen Levy of the University of Michigan estimate that a nationwide pay-or-play mandate that imposed a tax of \$3 per hour would immediately cost 225,000 jobs among low earners, assuming that a 10-percent increase in labor costs reduces employment by 1 percent.⁴⁷ Professors Richard Burkhauser and Kosali Simon of Cornell University use a similar dataset but a more detailed analysis and conclude that job losses would total 325,000, even if firms employing fewer than 25 workers were exempt. If jobs are even more sensitive to artificially high labor costs than these researchers believe, then the numbers quickly become worse. If a 10-percent increase in labor costs reduces employment by 2 percent, 750,178 jobs disappear nationwide; more than a million jobs disappear if a 10-percent increase reduces employment by 3 percent.⁴⁸

Imposing Guaranteed Issue and Community Rating Nationwide

When a politician says something like: “No American will be turned away from any insurance plan because of illness or pre-existing conditions,” what he means, quite simply, is that people can wait until they become sick before they buy health insurance. No real insurance can function like that. Imagine if you could buy car insurance after you’d crashed your car. Premiums would go sky-high, until only the most reckless drivers even sought out car insurance.

The phenomenon is called “death spiral,” and there is no doubt that imposing these regulations nationwide will cause one. This death spiral drives health plans out of the market, which is a strange policy for one who claims that health plans are a monopoly, with “two companies dominating a third of the national market.” In fact, there is not really a “national market,” but state markets. And these regulations tend to drive state markets into monopolies, as the experience of several states indicates.

In the early 1990s, eight states imposed guaranteed issue and community rating in the individual market. All have experienced this death spiral. Fortunately, some have begun to deregulate individual health insurance. It’s easy to see why:

- In New Jersey, monthly premiums for the state’s standard “Plan D” policy, offered by Aetna, rose 683 percent between 1994 and 2005, and New Jersey Blue Cross/Blue Shield’s increase was similar. These were the only two of 14 carriers operating in 1994 that continued to offer Plan D in 2005.
- In Vermont, the regulations drove out most carriers, resulting in Blue Cross/Blue Shield controlling 56 percent of the market by 2004. Many individuals who lost coverage became dependent on government health care, which was Governor Dean’s thinly disguised objective.

- In New York, premiums for a 30-year-old single male rocketed up 170 percent just *one month* after the regulations came into effect.
- In Kentucky, 45 insurers had pulled out of the individual insurance market two years after the regulations came into force.
- In Washington, 40,000 individual policyholders dropped their policies in 1996 and 14,000 in 1997. By 1999, individually purchased health insurance was *unavailable* in 32 of the state's 39 counties.
- In Massachusetts, 20 carriers withdrew from the individual market within two years of the regulations.
- In New Hampshire, the number of carriers serving the individual market shrunk from 12 to five within two years.
- In Maine, these regulations resulted in a virtual monopoly for one carrier, Anthem, which had 97.3 percent of the market by 2001.⁴⁹

Other states are also learning the tragic lesson of guaranteed issue and community rating. Perhaps the most dramatic rebound is in South Dakota. There, the *repeal* of guaranteed issue brought the individual insurance market back to life, only a few years after 20 health insurers abandoned the state. In 1990, 30 carriers wrote individual policies in South Dakota. The guaranteed-issue law passed in 1996, and the number of carriers collapsed to seven by 2003. Guaranteed issue was repealed that year, and the number of carriers writing policies has almost doubled since, to at least 12 by 2007.⁵⁰

Nor do these regulations have a big effect on high-risk patients, whom they are supposed to benefit. Guaranteed issue and community rating in the few states that vigorously imposed these regulations increased the likelihood of high-risk individuals being insured by only about eight percent.⁵¹ However, analysis of national data for consumer-directed plans in 2003 indicated that guaranteed issue in a state increases premiums by 227 percent, and community rating increases them by 10.2 percent.⁵² Earlier analyses were less dramatic.

A study of policies from two national databases covering 1996–2004 shows that community rating reduced the number of insured by 6.0 to 7.4 percent, by increasing premiums 12.0 percent to 14.8 percent.⁵³ Yet another econometric study of data from 1989 through 1994 did not find the net reduction in insured persons statistically significant, but did find that the regulations had definitely tilted the composition of health coverage: older people took up coverage and younger ones dropped it.⁵⁴

A final point is that community rating encourages high-risk behavior, because everybody pays the same premium.⁵⁵ The smoker, obese person, and reckless person pay the same premiums as the abstainer, athlete, and cautious person. Such regulations contradict any stated goal of wellness or prevention.

About 15 million Americans owned individually purchased health insurance in 2006, mostly in states that do not have guaranteed issue and community rating.⁵⁶ Clearly, millions of these citizens are at risk of losing their health insurance if Senator Obama’s plan goes forward, because these destructive regulations punish people who undertake the responsibility of buying health insurance before they get sick or injured.

Increasing Government Dependency through Medicaid and SCHIP

Senator Obama has pledged to increase Medicaid and SCHIP enrollment. However he has not stated by how much. A couple of recent analyses indicate how much certain “benchmarks” would cost. Professor Jonathan Gruber of MIT figures that an expansion of Medicaid to all individuals under 100 percent of the Federal Poverty Level (FPL)—which would rope in many more single adults and parents than today—would move 6.2 million onto Medicaid, but only reduce the number of uninsured by 5.1 million. This is because of “crowd out”: more than 17 percent

of the newly covered would drop private coverage in favor of government dependency. Gruber reckons that this would cost the taxpayers \$27 billion. To cover everyone up to 185 percent of the FPL, he estimates a cost of \$47 billion.⁵⁷

Another analysis of a Medicaid expansion up to 300 percent of the FPL included a small positive effect, as employers take on low-wage workers, who are happy to become employed since they won't lose Medicaid. Almost 230,000 new jobs would be created. However, the authors note that this merely moves the jaws of the poverty trap up, but it does not eliminate it. That's because higher-income workers will now be tempted to reduce their work in order to qualify for Medicaid. Furthermore, 5 million more people would enroll in Medicaid, with a crowd out from private coverage of 2.7 million. Also, they estimated a marginal deadweight cost of taxation to fund the expansion of \$4.9 billion in 2005.⁵⁸

Medicaid and SCHIP's experience insuring kids serves as a warning that Senator Obama's ability to execute a mandate to cover all children is unrealistic. The director of the Congressional Budget Office recently reported that we have already reached the point where 60 percent to 75 percent of uninsured children are eligible for SCHIP or Medicaid, and that for every 100 children enrolled in SCHIP, 25–50 have abandoned private coverage.⁵⁹ The government cannot even cover all the kids who are already entitled to it, and Senator Obama wants to impose a mandate.

Another, "hidden tax" of Medicaid or SCHIP growth is the cost shift to privately insured patients caused by underpayment by government payers. The cost shift that hospitals execute from government programs to private insurers is significant. Table 2 shows payment-to-cost ratios for in-patient care by payer in California in 2005. Private insurers pay \$129 for every \$100 of hospital costs. On the other hand, traditional Medi-Cal (California's Medicaid

program) pays only \$56, and other government payers also fail to cover the cost of treatment. Obviously, hospitals could not deliver the care they do if they relied fully on government payers.

Table 2: Net Hospital Revenue as Percentage of Average Cost per Adjusted Patient Day, 2005

Private	Medicare Managed Care	Medicare Traditional	Medi-Cal Managed Care	Medi-Cal Traditional	County/Other Indigent
129%	99%	74%	65%	56%	42%

Source: California HealthCare Foundation.⁶⁰

An analysis by Professor Daniel Kessler of Stanford University compared California hospitals’ cost shift from government payers to the insured. Medicare and Medi-Cal’s failure to pay the full costs of their patients’ hospital care causes premiums for private payers to go up by about one-eighth.⁶¹ Obviously, any expansion of Medicaid amplifies this effect, increasing “hidden taxes” on private patients.



McCain's Plan: Give American Health Care Dollars Back to American Families

Senator McCain's proposal is dramatically different: a universal tax credit that is breathtakingly simple to understand and can be executed at minimal cost. In one fell swoop, it eliminates the ability of the tax code to interfere with our choice of health plan, correcting half a century of injustice. And it does it for virtually nothing.

The National Taxpayers Union puts the net price of the McCain tax credit at a little under \$3 billion a year.⁶² However, by eliminating the bias that favors employer-based health insurance, Senator McCain's proposal gives rise to an understandable fear in anyone who has a history of poor health: that they will be thrown out of their group-health plan and into the "wild west" marketplace of individual health insurance, where they will not be able to find an affordable policy. This was Elizabeth Edwards' challenge to Senator McCain, and it is very answerable. But first, let's tackle the easy part.

A Universal Tax Credit for Every American

Basically, Senator McCain's tax credit of \$5,000 per family or \$2,500 per individual will give ownership of your family's health care to you.⁶³ The tax credit does not abolish an employer's right to offer health benefits. Employers and workers will still be free to participate in a group plan if they mutually agree to do so, in which case the worker will simply pay the premium (including the tax credit) back to his employer.

It is certainly possible that large employers, especially, will try to maintain the *status quo*. Indeed, when health insurance began in the 1930s, it was originally offered through employers, before the tax treatment was recognized. It may well be the case that employers have administrative advantages to offer in buying employees' health care.⁶⁴ More power to them: they'll just have to do it on a level playing field.

Table 3 is an amended version of Table 1, with the McCain tax credit implemented in place of the *status quo*.

Household	\$40,000+\$11,500 =\$51,500	\$80,000+\$11,500 =\$91,000	\$120,000+\$11,500 =\$131,500	\$150,000+\$11,500 =\$161,500
Marginal Federal Income Tax Due	\$1,720	\$2,245	\$2,875	\$3,220
Marginal California Income Tax Due	\$215	\$920	\$1,070	\$1,070
Marginal Social Security & Medicare Taxes	\$1,760	\$1,760	\$1,760	\$1,760
Total Taxes Due	\$3,695	\$4,925	\$5,705	\$6,050
Tax Credit	\$5,000	\$5,000	\$5,000	\$5,000
Net Benefit to California Family	\$1,305	\$75	(\$705)	(\$1,050)
Net Benefit for a Family in a No-Income Tax State	\$1,520	\$995	\$365	\$20

Family of two waged spouses and two dependents.
Source: Author's calculations based on Kaiser Family Foundation.⁶⁵

Each household increases its taxable income by \$11,500 and decreases its taxes payable by \$5,000. Clearly, the lower the household income, the better it does with the McCain tax credit. Nevertheless, none of the households is doing that well. Indeed, the household that earned \$80,000 is just a whisker away from the break-even point. However, this is not the fault of the McCain tax credit, but of the California income tax. Table 3 also shows the effect of the McCain tax credit on the same households in a state with no income tax. It's uniformly positive: everybody wins.

These hypothetical families are raising children. The McCain tax credit's real leverage kicks in with young adults, because if one buys a policy for less than the value of the tax credit, he gets to put the difference in a Health Savings Account (HSA), a tax-advantaged bank account that allows him to build up savings when he's young and healthy so he has health care dollars available when he needs them.

For example, a quick search for individual health insurance on eHealthinsurance.com for a non-smoking, 25-year old male in California resulted in three high-deductible plans charging premiums between \$60 and \$100 a month, or \$720 to \$1,200 annually. So, if he bought one of these policies with his \$2,500 McCain tax credit, he would have between \$1,300 and \$1,780 to deposit in his HSA.

Note that this is a *universal tax credit, giving universal choice* to Americans. It does *not* promise *universal coverage*. As long as the government is prepared to help people financially to buy health insurance, but not compel people to do so, it is highly unlikely that every last person will choose to buy health insurance. Nevertheless, there is little doubt that many will opt to become insured given the incentives of McCain's plan.

Professor Ken Thorpe, a leading health economist at Emory University, stated that the McCain plan would cause five million to seven million people who are currently uninsured to choose to buy health insurance.⁶⁶ President Bush has also proposed to eliminate the preference for employer-sponsored health insurance, by bringing the premium back into taxable income. However, he proposed to offset it with a *deduction* of \$15,000 per family or \$7,500 per individual, rather than a *credit*. The Congressional Budget Office concluded that this reform would result in the number of uninsured going down by seven million in 2010, and that seven million would leave employer-based health care, for a total increase in the individual market of 14 million.⁶⁷

An even more optimistic estimate takes account of Senator McCain's proposal that Americans should have internal "free trade" in health insurance (although it refers to a bill in Congress, not to the McCain presidential platform). If Americans were free to buy health insurance in any state, many would buy in lightly regulated Alabama. Professor Parente and colleagues estimated that this freedom to buy across state lines would result in an estimated midpoint of 12 million more insured people, with a wide range of two million to 16 million newly insured, who could choose from a portfolio of consumer-directed, traditional PPO, and traditional HMO plans.⁶⁸

There have been multiple estimates of the effect of tax credits on the number of insured Americans. However, the tax credits have not been universal like Senator McCain's. Rather, they have been targeted at low-income households, and phased out with increasing wages. Of course, such a means-tested credit is more progressive than the McCain tax credit and much more difficult to administer, because the IRS doesn't just send the same amount to everyone.⁶⁹

Professor Ellen Meara and colleagues from Harvard University modeled a smaller credit of \$1,000 per individual, plus \$556 per child for up to two kids, or \$3,000 per family, which phases out completely at an individual income of \$30,000 and a family income of \$60,000. This was the tax credit that President Bush proposed in his 2006 budget, which they concluded would have taken only about 1.6 million people off the uninsured count, while moving 12 million previously insured persons into the individual market.⁷⁰ Other estimates show a larger effect.

Professors Mark Pauly of Wharton Business School and Bradley Herring, now of Johns Hopkins University, modeled tax credits of various fractions of premiums in 2001. A 25-percent subsidy reduced the uninsured by 13 percent, largely among the self-employed.⁷¹ This is about the same as the current value of the McCain tax credit, but Pauly and Herring's tax credit goes only to low-income earners:

it is not universal. If the model held true for today, it would imply about six million uninsured becoming insured.

Another study of the individual market in California from 1996 to 2002 found a similar effect. It concluded that a 20-percent discount would increase the number of uninsured people buying individual insurance by 12 percent, or about 5.5 million people.⁷²

In 2005, professors John Cogan, Glenn Hubbard, and Daniel Kessler of the Hoover Institution and Stanford University advocated a tax credit of 25 percent of the premium of health insurance, up to \$1,000 for a family, to be phased out between 100 percent and 300 percent of the FPL. They estimated that this would induce between two million and seven million uninsured to get coverage.⁷³

Professor Jonathan Gruber examined a similar, progressive tax credit, phased out once a single earned \$30,000 or a family earned \$60,000. However, Gruber figured that it would cost between \$22.6 billion and \$29.3 billion to cover five million people and \$61.5 billion to \$79.1 billion to cover 10 million.⁷⁴ While this sounds expensive, recall that this is not a universal tax credit traded off against an increase in taxable income (which increases government revenues), like the McCain tax credit is, but a targeted subsidy.

There are definitely some implementation costs for the McCain tax credit. It is not “free,” like the current tax exclusion is. The exclusion of health-insurance premiums from taxable income requires no IRS action, whereas refundable tax credits will require some bureaucratic engagement and are vulnerable to fraud.⁷⁵

In the longer term, a refundable tax credit also presents risks to taxpayers, while a tax deduction (like President Bush has proposed) does not. A tax deduction can only be claimed by taxpayers, whereas a refundable tax credit also goes to those who pay no taxes, thus making them dependent on the state. So, while a tax deduction has

a natural stopping point, a tax credit does not. Indeed, the model for this sort of tax credit is the Earned Income Tax Credit (EITC), which has grown far bigger than its original goal of covering payroll taxes for low-income workers.⁷⁶

However, the tax credit also provides one outstanding advantage that is seldom recognized. It will allow the government to figure out, once and for all, whether the insured subsidize the uninsured or vice versa. Calls for so-called “universal” health care and mandatory coverage are often driven by the notion that uninsured hordes crowd into hospital emergency rooms, get treated, and don’t pay their bills. I have previously suggested that there are enough high-income uninsured that the extra, voluntary taxes that they pay as a class is more than enough to cover the costs of uncompensated care.⁷⁷ However, because of the tax exclusion, the IRS cannot fully know how much money the high-income uninsured have “left on the table.”

With the McCain tax credit, it will be relatively easy for the IRS to know which tax-filers have not bought health insurance and, therefore, not claimed the credit. These amounts can be added up, deposited in a “bucket,” and given to the states for their uncompensated costs of care and to various safety-net providers.⁷⁸

So, the McCain tax credit, which will allow Americans to shop for the health plan they prefer, free of their employer, looks very good. Except for one thing...

Elizabeth Edwards’ Challenge: Can Individual Health Insurance Take Care of the Sick?

Last April, Elizabeth Edwards, wife of then–Democratic presidential candidate John Edwards, pointed out the obvious challenge: that neither she nor Senator McCain would be able to buy health insurance after the reform that he intends to execute. Both had a

history of cancer, a pre-existing condition that would have made them too risky for a private insurer to underwrite for individual health insurance, at any reasonable rate.⁷⁹ Mr. McCain responded with a “Guaranteed Access Plan” to prevent people from falling through the cracks, promising more details pending discussions with governors. Since then, the commentariat has resonated with the fact that, for his entire life, Senator McCain has actually been a beneficiary of government-run health care. This is somewhat of a red herring.

As noted, there is nothing preventing the McCain tax credit from being used for employer-based health care, and the U.S. Navy and U.S. Congress will surely persist in providing benefits for their people. Econometric models do not show a complete collapse of employer-based health care.⁸⁰ Further, Senator McCain’s plan will allow you to take your tax credit to another group, if you prefer. Churches or professional associations could serve as groups, providing their members with benefits.⁸¹ Nevertheless, many of us will likely change jobs every few years, and we might not have an affinity group to join. We definitely do not want to fall through the cracks in the sidewalk on the way from one office to the next. And we do not want our policy to be abruptly cancelled or revoked when we get sick. So, we need to make sure that the individual market works.

In fact, if we look at real data, instead of newspaper stories, we will see that the market for individual health insurance does exceedingly well at pooling risk, perhaps because there are a lot of people who stay enrolled in individual policies for a long time. This is surprising, because employer-based health care draws so many people from the individual market that one could reasonably expect individual risk-pools to be small and unstable, increasing the likelihood of premium increases.⁸² However, some scholars now attribute this successful pooling to “guaranteed renewability,” which basically means that once you have passed initial underwriting your premiums will go up at the same rate as other beneficiaries.’

Scholars at the RAND Corporation analyzed California data from 1996 through 2002, showing that 43 percent of new enrollees continued in individual policies for more than one year, 31 percent for more than two years, and 24 percent for more than four years. Scholars found not only that the individual market pooled risk, but that the pooling *increased* over time. New enrollees with a family member suffering from a chronic condition paid actuarially adjusted premiums 12 percent greater than those with no chronically ill family member, but this premium shrunk to 7 percent for those with three or four years in their policies.⁸³ Indeed, individually insured families with a member suffering a chronic illness were somewhat *more* likely to switch plans than were the healthy.⁸⁴

In a series of articles, professor Mark Pauly and colleagues have demonstrated that the market for individually purchased health insurance does pool risk well. Looking at data from 1987, they found that the only characteristics that affect premiums are a person's age, gender, and location (*not* chronic illness), and insurers only adjust premiums by 30 or 40 cents for each expected dollar of risk. Nor did Pauly and colleagues find that higher risks had been excluded from the market.⁸⁵ Further research on data from 1996 and 1997 confirmed these results: "Somehow, high-risk individuals in the individual market pay premiums not very different from those charged to average risks."⁸⁶

They theorized that individual health policies are front-end loaded; that is, that they might be "too expensive" for young people in order to be "too cheap" for older people, thus keeping the pool stable. Empirical data tracked the model pretty closely. Low-risk people don't drop out for lower, competing rates as long as their current premiums equal the low-risk premium plus the expected value of all future costs if they become expensive in the next year. Nor are high-risk people persistently expensive: the median high-cost period is four years, after which a person either dies or gets better.⁸⁷

The same researchers examined three overlapping national data sets covering 1996–2004. Seeking evidence of “cherry picking” (accepting low risks and rejecting high ones), they discovered that privately insured people (in either group *or* individual markets) did *not* have a significantly lower risk profile than uninsured Americans. Although an individual’s premium increased with his age, it varied very little because of chronic conditions. Indeed, when controlling for the demographic factors (age and sex), which explained 33 percent to 48 percent of premium variation, health conditions explained 11.5 percent to 15.5 percent, meaning that 84.5 percent to 88.5 percent of the risk was pooled. They also found that, even in states where the individual market was unregulated, high-risk applicants for individual insurance were about 92 percent as likely as average-risk applicants to buy policies.⁸⁸

For people with very good health status, becoming uninsured is most likely for those with individual health insurance. But for people in only fair or poor health, those with small-group coverage are far *more* likely to lose it than those with individual coverage, examining data from 2000 to 2004. Once again, this is job-related risk.

A young, high-risk male who has small-group coverage faced a 44-percent risk of becoming uninsured, a risk *nearly twice as great* as if he had individual insurance. The authors note: “Somewhat ironically, the usual blame for such a person lacking coverage will be laid at the door of the medically underwriting individual insurer which quotes a high premium, rather than referred to the group insurance system that plunged this person into such a vulnerable situation in the first place.”⁸⁹

In another detailed survey of 70,000 Americans over seven consecutive two-year periods (seven panels), of all those with individual health insurance, 65 percent still had individual insurance two years later. As expected, high-risk people (measured according to fifteen conditions, from asthma to skin cancer) were more likely to be

insured in the group market. It looks like those with the most severe diseases were likely not to be individually insured. Being high risk, however, did *not* have an effect on *losing* coverage (although it had an effect on gaining coverage in the large-group market: sick people want to get jobs with big firms). Surprisingly, becoming high risk *increased* the chances of getting insurance in both the individual and large-group market, but also increased the likelihood of becoming *uninsured* in the large-group market (perhaps because these folks lost their jobs).

When it came to developing a new, high-risk condition during the period, results were similar. People newly diagnosed were slightly *more* likely to maintain their individual insurance (while results for group coverage were statistically insignificant), and those who began uninsured were slightly *more* likely to get either individual or small-group coverage (while the results for large groups were statistically insignificant). Researchers found no statistically significant increase in premiums in the individual market for patients *after* they had suffered an illness. On the other hand, the larger the group the more generous the coverage, likely a result of higher loading (non-medical) costs for smaller groups.⁹⁰

These thorough articles tell a consistent story: individual health insurance pools risk quite successfully, with *no job lock!* And this is in a residual market. If the individual market were on an equal footing with the group market, the risk pooling would be even more robust.⁹¹ So, a few years after the McCain health reform has been implemented, we could expect to see such a robust individual market develop, which enrolls people before they get sick. After all, there's a point in almost everyone's life when he or she did not have a pre-existing condition.⁹²

However, there will also be a transition period of a few years, when the tax reform could well result in people losing group coverage who are unable to get it elsewhere, due to pre-existing conditions. The

Guaranteed Access Plan, which Senator McCain proposes to manage this transition, is not yet well defined. Nor should it be, because he will discuss its terms with the governors, which is appropriate.

Coincidentally (or perhaps not) Guaranteed Access Plan is also the term used by America's Health Insurance Plans (AHIP), the trade association, to support and build upon states' high-risk pools. High-risk pools have a mixed record. Current high-risk pools impose waiting periods for previously uninsured people and sometimes rely on funding from tobacco taxes or provider taxes.⁹³ Furthermore, casting sick people into high-risk pools continues the "fragmentation" of American health care that the tax reform is supposed to eliminate. And, of course, the federal government gives them grants, as Senator McCain has proposed, so the taxpayer is also on the hook.

AHIP's Guaranteed Access Plan does not give total confidence. It proposes to help states set up expanded high-risk pools in which all carriers would participate, with funding from a "broad base of sources, so that coverage remains affordable for those who are currently insured."⁹⁴ It's not too hard to read between the lines of that previous sentence: "privatize the profits, socialize the costs." To the degree that these state-based, high-risk pools are necessary, states (and the future president) must be vigilant so that taxpayers are not on the hook. As a trade-off, they should also immunize the pool from political interference.⁹⁵ During the transition period, especially, they will be necessary to the degree that the population experiences risk segmentation.

Medical Malpractice

Neither candidate has a fully flushed out program for medical-malpractice reform, but both have described approaches to deal with the high costs of medical-malpractice litigation. Senator McCain invites legislation to eliminate “endless, frivolous lawsuits.” Many states have moved forward on this, and his platform does not explain why he thinks the federal government also needs liability reform.⁹⁶ Nevertheless, he has the right idea.

On the other hand, Senator Obama’s proposal for medical-malpractice reform would actually make the crisis *worse*, by making liability insurance less available. According to Senator Obama, “Increasing medical malpractice insurance rates are making it harder for doctors to practice medicine and raising the costs of health care for everyone.”⁹⁷ True enough, but instead of going after frivolous lawsuits, his proposal recommends strengthening anti-trust laws to prevent liability insurers from “overcharging” doctors.

Senator Obama does not name the legislation that concerns him, but there is little doubt that he is referring to the McCarran-Ferguson Act, which gives a very limited exemption from anti-trust laws to insurers (in any line of business) for one purpose only: to pool claims data so that each carrier can understand the whole universe of experience. There is a very strong argument that this ability to pool claims data leads to lower premiums, because carriers operate with more complete information.⁹⁸

With respect to medical-malpractice insurance specifically, there is also good evidence that the market is competitive. Before any liability insurers go bankrupt as a result of Senator Obama preventing them from “overcharging,” let’s clarify what drives medical-malpractice premiums. It is medical-malpractice *payouts*, not a conspiracy of liability insurers.

Despite positive reforms in many states, long-term trends show a harmful, perhaps unsustainable, growth in American medical-malpractice liability, according to analysis by James R. Copland of the Manhattan Institute.⁹⁹ Copland points out that the public suffers from a great deal of misunderstanding about the causes of escalating medical-malpractice insurance premiums, and argues that much of this misunderstanding is generated by the plaintiffs' bar and its allied, self-styled "consumer groups." We can now include Senator Obama with those sufferers. Medical-malpractice insurance premiums, in both the long run and the short run, are principally a function of tort awards. Premiums' considerable variation across states is largely explained by states' different tort payouts.

It should not be too hard to understand that high jury verdicts and settlements tend to lead to high premiums for insurance against such jury verdicts and settlements. Nevertheless, advocacy groups allied with the trial bar argue that rising malpractice premiums are a result of both insurance underwriting cycle and insurers' "price gouging."¹⁰⁰

Such claims have been debunked.¹⁰¹ Average medical-malpractice jury verdicts rose from \$1.9 million to \$4.7 million from 1997 to 2003, an increase of 147 percent. Of course, most cases settle and do not go to trial, but there is also a connection between verdicts and settlements. Average settlements in medical-malpractice cases rose from \$1 million to \$1.9 million over the same period, a 90-percent jump.¹⁰²

It would be remarkable if these outcomes did not influence liability-insurance premiums. Alexander Tabarrok and Amanda Agan, economists at George Mason University, have found a very strong relationship between medical-malpractice tort payouts and medical-malpractice insurance premiums. Using a statistical cointegration test, Tabarrok shows not only that tort awards and premiums are closely linked in the long run, but that malpractice premiums track changes in tort awards in the short run.¹⁰³

Certainly, premiums do vacillate around claims, somewhat cyclically. However, today's premiums must cover future awards or settlements, which are unknown. So, liability insurers set today's premiums based upon their forecast of future payouts. Tabarrock and Agan's test showed that past awards are not very useful for predicting future awards, leaving insurers with a very difficult job: they must forecast future awards under great uncertainty. Short-term departures of premiums from awards, therefore, are not remarkable, and we should expect that insurance premiums will tend to "overshoot" changes in underlying tort awards, without mooting conspiracy.¹⁰⁴

Also, tort payouts vary significantly across states, ranging in 1999–2001 from a high of \$10,025 per doctor in Pennsylvania to a low of \$1,658 in Wisconsin. It is highly unlikely that doctors are six times more likely to make errors in Pennsylvania than in Wisconsin, or that doctors in Nevada, where the average doctor's tort payout was \$7,880, are really three times worse than those in neighboring California, where awards per doctor are only \$2,589, according to Copland.¹⁰⁵

And now, to connect the dots: Medical-malpractice premiums also vary substantially from state to state. A state's average medical-malpractice tort payout per doctor has a significant and large predictive association with the state's malpractice premium per doctor. This relationship holds when controlling a number of variables, including concentration (market shares) of liability insurers, according to Tabarrock and Agan.¹⁰⁶

Their analysis also drives a stake through Senator Obama's current suggestion about a conspiracy of insurers, finding that the degree of concentration in a state has a *negative*, although weak, correlation with the state's medical-malpractice insurance premiums. In other words, when a few big carriers have more market share in a state, the state tends to have lower insurance premiums. According to Tabarrock and Agan, this makes sense if "efficient firms lower prices and increase their market shares. Wal-Mart, for example, dominates

many markets because of its lower prices.”¹⁰⁷ These efficient returns to scale are larger than any pricing power they might gain through their market share. Tabarrok and Agan’s finding that states with more concentrated insurance markets actually have lower med-mal premiums strongly supports the common-sense notion that price-gouging cannot explain malpractice premiums.

Copland also points out that close to half of doctors are insured through mutual (i.e., doctor-owned) insurance companies, so the “price-gouging” argument implies that doctors are price-gouging themselves! He also notes that insurers left the medical-malpractice underwriting business in droves, after racking up \$3 billion in industry losses in 2001. The St. Paul Companies, previously the nation’s largest med-mal insurer, was part of the exodus.¹⁰⁸ Surely, a move by Senator Obama to toughen up anti-trust rules against improper (and actually non-existent) pricing power by liability insurers would simply cause more of them to stop writing policies again. This would hardly be good for either America’s patients or doctors.

Conclusion: Two Different Visions

The two presidential candidates in the 2008 election represent two very different visions of health care. On the one hand, Senator Barack Obama promises to continue the failed approach of decades past: more control by government and less by patients, more taxes and more decisions about your family's health care made in Washington, D.C. Specifically:

- His health insurance reforms, namely guaranteed issue and community rating, will cause about one million to lose their individually purchased health insurance over the short term.
- His expansions of Medicaid and SCHIP will make more American families dependent on government health care.
- He will spend an extra \$100 billion a year of your health dollars on health goods and services that serve his priorities, not your family's needs.
- Combined, these three reforms are likely to lead to a "death spiral" for privately chosen health insurance.
- His medical-malpractice insurance reform threatens to make it impossible for physicians to pay for liability insurance, threatening patients' access to care and legal rights.

On the other hand, Senator John McCain proposes to give your health care dollars back to you, to spend on the health care that your family needs. Specifically:

- His tax reform will result in a raise of about \$9,000 for every working American family.
- While this raise will be taxable, it will be supplemented by a universal, refundable tax credit of \$5,000 per family or \$2,500 per single person that will eliminate the "job lock" caused by employer-based health benefits, and significantly reduce the Medicaid poverty trap that holds back many Americans.
- Combined with his plan to allow a national market in health insurance, these reforms will result in about six million currently uninsured Americans buying health insurance voluntarily, within an estimated range of two million to 12 million.

- If people choose not to buy health insurance, their unused tax credits can go into a fund that states use to finance their uncompensated care and “safety nets.”
- Because Americans will control their health care dollars, Americans—rather than the government or employers—will decide how to spend them.
- He has made a commitment to protect those with pre-existing conditions during the transition, so they retain coverage as Americans find new ways to organize themselves to share the financial risks of health care.

About the Author

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Mr. Graham speaks frequently on health care reform on radio and television, and at conferences in the United States, Canada, and Europe. He has also worked as a management consultant and investment banker in Canada and Europe and has previously served as an infantry officer in the Canadian Army in Canada, Germany, and Cyprus.

He received his M.B.A. from the London Business School (England) and his B.A. (with Honors) in economics and commerce from the Royal Military College of Canada.

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