

## REVIEW & OUTLOOK

JULY 29, 2009, 9:05 P.M. ET

Fannie Med

The bipartisan Senate negotiators are leaning toward proposing a health-care Fannie Mae.

The details of the Senate Finance Committee's hush-hush health talks aren't fully known, but leaks suggest that one all-but-certain highlight will be new federally created health "cooperatives" to compete against private insurers. The onus is on Republican negotiators Chuck Grassley and Mike Enzi to explain why this isn't merely the House "public option" in a better suit.

North Dakota Democrat Kent Conrad floated the co-op concept last month, to attract Republicans who oppose President Obama's state-run plan.

According to Mr. Conrad, these nonprofits—modeled on local electricity or rural farm co-ops—fulfill the liberal goal of competing against private insurers, yet avoid "government control," since they will be member-owned. Presto, a Beltway splitting of the political baby.

And in theory, health-care co-ops needn't be destructive. Blue Cross and Blue Shield began as nonprofit health insurers, and some state Blues still are. Organizations like the Group Health Cooperative of Puget Sound are consumer-owned and compete with private plans.

But the Senate is talking about government-sponsored co-ops, and that means multiple devils are in the details. Mr. Conrad confirmed this week that the current plan is to have the feds provide \$6 billion in start-up cash, then appoint an "interim" national board to set policies for a network of state or regional co-ops. Mr. Conrad said this new network could attract 12 million people, making it the third-largest health insurer in the country.

Here's where the trouble starts. At least with the public option, Washington acknowledges that taxpayers are subsidizing public plans.

With co-ops, the government role is more subtle, if nearly as corrosive.

Start with Mr. Conrad's \$6 billion in "seed money," which is more than the total annual revenue of all but 20 of the nation's private plans.

This would provide a lower cost of capital than private firms and an implicit claim on any other money the co-ops need. The feds may also exempt co-ops from the taxes that private insurers pay, which average about 1.2% of premiums. This would let co-ops offer lower prices and poach customers with government-subsidized premiums.

The Senators may also exempt co-ops from the state mandates that now drive up the cost of private policies. We've long wanted the feds to let individuals or groups (such as the National Federation of Independent

Business) form risk pools and buy insurance across state lines free of these costly requirements. But liberals have killed attempts at such Association Health Plans, which suggests their goal in

exempting these “government-sponsored health enterprises” from state mandates is merely to give them another pricing edge.

Mr. Conrad suggests the federal board overseeing this network would be temporary, meaning at some point government appointees would be replaced by elected private directors. Mr. Grassley is said to be resisting federal control, but even if he succeeds for now, neither he nor Mr.

Conrad can bind a future Congress. When was the last time government supervision became less onerous over time, especially in health care?

All of which makes these co-ops sound a lot like a health-care Fannie Mae and Freddie Mac, which Congress created because there was supposedly no secondary mortgage market. The duo proceeded to use their government subsidy to dominate the market and drive out private competitors.


And all of this is before Congressional liberals get their hands on these co-ops. “We’re going to have some type of public option, call it ‘co-op,’ call it what you want,” Senate Majority Leader Harry Reid said earlier this month. New York’s Chuck Schumer wants \$10 billion to seed a single, nationwide co-op that will be governed by a federal board and have the authority to impose price controls. At the very least, liberals will demand to load up co-ops with the minimum-coverage mandates they’ve already included in the House and rival Senate legislation—from maternity care to government-funded abortion.

Messrs. Grassley and Enzi and Maine’s Olympia Snowe are under great pressure to agree to a deal, as Democrats grow more desperate to get political cover for reform that is sinking fast in the polls. The co-op idea might have begun as a benign proposal, but it is likely to become a mini-me public option. Senate Republicans can best serve the cause of bipartisan reform and fiscal sanity by opposing any form of new government health care, and urging Mr. Baucus to turn to the Plan B of helping the uninsured with tax credits.

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Heritage Foundation

### [Medicare Payment Rules: Looking Behind the Curtain](#)

-  Posted August 6th, 2009 at 10.01am in [Health Care](#).

As public relations campaigns over health care legislation are ramped up over the next few weeks, Americans will do well to remember the storybook classic, *The Wizard of Oz*. The power of the Wizard was based on mystery, fear, and intimidation. Only after the intrepid travelers pulled back the curtain did they realize the Wizard was a mere mortal turning the cranks of a great smoke belching machine. They were no longer afraid.

Congressional advocates of a single payer system would like Americans to believe that a government Wizard will be superior to our current decentralized network of health care. The logic of the single payer is that health care is too complicated for individuals to make their own choices and decisions. Decisions should be left to the Wizard.

Because paying for the promises is more difficult than anticipated, some in Congress want to make the Wizard even more powerful. To control costs, the House Majority Leader, Steny Hoyer, asked the Congressional Budget Office (CBO) to analyze the Obama Administration's proposal to create an Independent Medicare Advisory Council (IMAC) that would give the Executive Branch the power to change Medicare payments to providers (hospitals, doctors, etc.). Those changes would go into effect unless a super-majority in Congress voted to block them. In essence, give more power to the Wizard (technically, under the Obama proposal, there would be five Wizards).

Is the greater concentration of power into the hands of a few political appointees really a good idea? By coincidence, just as the House left town for the August recess, the Centers for Medicare and Medicaid Services (CMS) announced the final FY 2010 payment rates for about 3,500 acute care hospitals, 400 long-term care hospitals, 200 freestanding Inpatient Rehabilitation Facilities, about 1,000 rehabilitation units in hospitals, and more than 15,000 skilled nursing facilities. The three final rules covering four payment systems put on public display on July 31 total a mere 2,314 pages.

The final rules made changes from the proposed rules that have important financial impact on our hospitals, nursing homes, etc. For example, under the proposed rule, inpatient rates for inpatient hospital services would have resulted in a decline in payments. The final rule provides a \$1.9 billion increase in payments.

The rules also are abundantly clear that CMS is not some rogue agency operating on its own. The rules implement the laws Congress has passed and follow the decisions made by the political leadership provided by the Office of the Secretary, the Office of Management and Budget, and the White House.

In reality, it is highly doubtful that Congress would seriously consider such a dramatic shift in the balance of power between the Legislative and Executive Branches. If all the decisions are left to the Executive Branch, the hundreds of millions of dollars spent by hospitals, physicians, pharmaceutical companies, and health plans to influence Congress would dry up. Congress is not about to let that happen. Under the House bill, CBO estimates that Medicare payments to health plans, hospitals, nursing homes, home health agencies, and other providers will be reduced by more than \$500 billion over the next ten years. Every health care lobbyist in Washington knows such decisions will be revisited many times over that period. This instability will be multiplied if the federal government were to expand its role over payment systems and regulatory structure as envisioned by the House bill.

In an essay, "How to Attract Capital," from the 1960s, Walter Wriston wrote, "[t]he second basic requirement for the attraction of capital is some reasonable expectation that the rules of the game will not be changed with any great frequency. Private capital can adapt itself to most rules, provided always that the expectation exists that the game will be played by those rules over a period of time. It is for this same reason that private capital is frightened away by direct economic controls. While the private investor willingly accepts the risks of the free market place, he almost inevitably shies away from situations where arbitrary decisions can make or break his business."

Political interference in the health care market may be good for refilling campaign coffers and employment of high priced lawyers looking for loopholes, but it is no way to run 16 percent of our entire economy. Congress has already messed up Medicare and Medicaid. It should keep its hands off of the rest of the health care system. The American people should not put their faith in a Wizard.

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How CEOs can fix health care

WSJ – July 28, 2009

By **CLAYTON CHRISTENSEN** and **JASON HWANG**

It's time for American companies to turn health care costs from a weakness into a strength.

#### **About the Authors**

Clayton Christensen and Jason Hwang are co-authors of "The Innovator's Prescription: A Disruptive Solution for Health Care." Mr. Christensen is co-founder of Innosight Institute, a not-for-profit think tank for which Mr. Hwang is Executive Director of Healthcare. A former CEO of MinuteClinic, a retail health clinic, is a distinguished fellow there. Mr. Hwang is also a former physician at Kaiser Permanente.

High health care costs are one reason many of America's once-venerable corporations -- like General Motors and Chrysler -- are struggling to compete globally.

Foreign firms rely on their governments to shoulder the burden of providing health care to employees; in the U.S., tough decisions about funding and managing healthcare has always fallen upon business leaders. However, rather than simply being a historical and cultural burden, this responsibility also creates the opportunity for remarkable innovation.

We recommend executives make one or more of three innovative changes: 1) encourage employees to use nurse-staffed in-store health clinics for common ailments, 2) partner with integrated health systems like Kaiser Permanente, and 3) set up company-run clinics at corporate offices and plants.

Retail clinics are basic health clinics staffed by nurses and located inside pharmacies and stores such as [Wal-Mart](#), CVS and Walgreens. There are about 1,000 such sites in 37 states, according to a September 2008 article in the journal Health Affairs. Nurses deliver routine medical care for common ailments like a sore throat or ear infection. A typical visit costs one-third less than an urgent care clinic visit and three-quarters less than a visit to an emergency department, according to another article in Health Affairs that analyzed the costs to the insurance carrier.

Ninety percent of retail clinic visits are for 10 common complaints that constitute 18% of all visits to primary care doctors and 12% of visits to emergency rooms. So, the more employees visit retail clinics for these common problems, the more money companies will save.

Plus, retail clinics would help reduce the absenteeism related to the time it normally takes to schedule an appointment, see a doctor and fill a prescription. Retail clinics have made convenience a key part of their sales pitch by offering walk-in, no-wait visits in places where people already shop.

How to encourage employees to visit these clinics? Companies should demand coverage of retail clinic visits from their health plans and offer discounts to employees. In states where regulations bar nurses from operating health clinics without doctors, companies should lobby to reverse these restrictions.

Next, employers must take aim at the fee-for-service reimbursement system, which is the most common method by which health insurance companies pay for medical services and which has fueled much of our skyrocketing healthcare costs. Fee-for-service rewards providers who are able to squeeze in more patient visits and perform more procedures. It encourages providers to profit from treating sickness, but not from maintaining the wellness of their patients.

Employers can help fix this flawed incentive structure by moving their employees away from health plans that offer little more than a telephone directory of independent contractors. The alternative is to partner with prepaid, integrated health systems like Kaiser Permanente, which serve as both insurer and care provider. These organizations are much more likely to deliver cost-effective care that keeps their members well because these organizations are involved in both delivery and financing of care.

Finally, there is a vanguard of employers who have taken dramatic steps to involve themselves much more deeply in their employees' health. Moving far beyond reimbursement for gym memberships and implementation of disease management programs, companies like Perdue Farms have set up their own clinics and contract directly with healthcare providers instead of negotiating through insurers. Perdue's on-site wellness centers offer services similar to a typical family practice clinic, and patients can make appointments during company time. The company's goal is to return employees to normal health as quickly as possible and to keep them healthy year-round.

Quad/Graphics, a printing company based in Wisconsin, is another firm that operates its own on-site clinics. It was so successful that its subsidiary QuadMed now operates clinics for Briggs & Stratton and Miller Brewing. If employer-managed clinics prove to be a superior business model, similar spin-offs may eventually open their doors to the public.

Instead of continuing to outsource employee health to an utterly dysfunctional supplier, the best hope for rebuilding this nation's healthcare system is for our companies and business leaders to take a more proactive role.

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#### OPINION

AUGUST 7, 2009, 12:10 A.M. ET

#### Health Reform and the Polls

Obama's biggest obstacle is the 68% of voters who rate their health coverage as good or excellent.

By SCOTT RASMUSSEN

For all the back and forth about the "public option," Congressional Budget Office estimates and proposed tax hikes, the fundamentals are really what make health-care reform a hard sell to American voters. As members of Congress head home for the August recess, they should take a close look at some poll numbers before they attempt to pass any new legislation.

The most important fundamental is that 68% of American voters have health-insurance coverage they rate good or excellent. That number comes from polling conducted this past weekend of 1,000 likely voters. Most of these voters approach the health-care reform debate fearing that they have more to lose than to gain.

Adding to President Barack Obama's challenge as he sells health-care reform to the public is the fact that most voters are skeptical about the government's ability to do anything well. While the president says his plan will reduce costs, 53% believe it will have the opposite effect.

There's also the reality that 74% of voters rate the quality of care they now receive as good or excellent. And 50% fear that if Congress passes health-care reform, it will lead to a decline in the quality of that care.

Advocates of health-care reform on Capitol Hill are up against something bigger than voters' reactions to a variety of specific proposals. Our polling in February found that by a 2-1 margin, voters believe that no matter how bad things are Congress can always make matters worse. That's one reason 78% believe passage of the current congressional health-care proposals is likely to mean higher taxes for the middle class.

However, there are some numbers congressional Democrats can celebrate.

Specifically, 63% of voters agreed with the president earlier this year when he said, “We must make it a priority to give every single American quality affordable health care.” Yet while they agree in theory, only 28% are currently willing to pay higher taxes to achieve that goal.

Another point in the reformers’ favor is that a significant number of the voters we polled in May had experienced financial hardship brought on by health issues. One in four Americans—26%—say that health-care costs have at some point caused them to miss credit-card, rent or mortgage payments. That figure includes 21% of those who have health insurance coverage.

Finally, voters strongly believe that medical care should be provided when needed, regardless of insurance coverage. In May, Rasmussen Reports found that just 31% of voters believe young and healthy adults who choose not to buy health insurance should be forced to do so. But a follow-up question asked: “What if those who chose not to buy health insurance end up needing emergency room care?” Only 16% said treatment should be denied; 74% said they should be treated even if they did not have insurance.

Taken together, the data shows that at this point voters are pretty evenly divided. Last week’s polling showed that 47% at least somewhat favored the plan while 49% are somewhat opposed.

Though voters are torn about reform, there is intensity among the opposition. Just 25% strongly favor the reform effort, while 41% are strongly opposed. And that gets back to the very first point: 68% currently have good or excellent coverage. It’s going to be hard to generate passionate support for change among this group of voters.

Those opposed to Mr. Obama’s reform appear to have momentum on their side. Polling last weekend showed that 48% of voters rate the U.S. health-care system as good or excellent. That’s up from 35% in May and up from 29% a year ago. Only 19% now rate the system as poor, down from 37% a year ago. It appears that the prospect of changing health care has made the existing system look better to a lot of people.

Beyond the intensity of the opposition and its momentum, there is also a huge partisan gap that puts congressional Democrats in a very difficult position. Currently, 76% of Democratic voters favor the health-care reform plan proposed by Mr. Obama and the congressional Democrats, and they are counting on their representatives to deliver.

But delivering for the Democratic base has the potential to hurt the party’s standing among independents. Among the unaffiliated, 35% are in favor of the Democrats’ health-care reform initiative, and 60% are opposed. Notably, just 16% of unaffiliated voters strongly favor the legislative effort; 47% strongly oppose it.

As the Democrats scramble to pass a health-care reform bill by the fall, they appear to have two choices. One is to stick with the broad outlines of the plan that has been laid out by various congressional committees.

Those proposals would be well received within the party, but will cause some angst beyond it.

The other option would be to pass smaller scale reform and declare victory. That approach would probably be well received by voters in the middle, but create turmoil within the party.

In political terms, the most important reality will be how the reform affects the 68% who say they have good or excellent health-insurance coverage. If they end up having to change their coverage, pay significantly higher taxes, or encounter some other unpleasant reality, congressional Democrats will look back on this August as a time when they should have listened more closely to the folks back home.

Mr. Rasmussen is the founder and president of Rasmussen Reports. All polling data referred to in this article can be found at [RasmussenReports.com](http://RasmussenReports.com).

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## OPINION

AUGUST 11, 2009, 7:30 P.M. ET

The Whole Foods Alternative to ObamaCare Eight things we can do to improve health care without adding to the deficit.

By JOHN MACKEY

"The problem with socialism is that eventually you run out of other people's money."

—Margaret Thatcher

With a projected \$1.8 trillion deficit for 2009, several trillions more in deficits projected over the next decade, and with both Medicare and Social Security entitlement spending about to ratchet up several notches over the next 15 years as Baby Boomers become eligible for both, we are rapidly running out of other people's money. These deficits are simply not sustainable. They are either going to result in unprecedented new taxes and inflation, or they will bankrupt us.

While we clearly need health-care reform, the last thing our country needs is a massive new health-care entitlement that will create hundreds of billions of dollars of new unfunded deficits and move us much closer to a government takeover of our health-care system. Instead, we should be trying to achieve reforms by moving in the opposite direction—toward less government control and more individual empowerment. Here are eight reforms that would greatly lower the cost of health care for everyone:

- Remove the legal obstacles that slow the creation of high-deductible health insurance plans and health savings accounts (HSAs). The combination of high-deductible health insurance and HSAs is one solution that could solve many of our health-care problems. For example, Whole

Foods Market pays 100% of the premiums for all our team members who work 30 hours or more per week (about 89% of all team members) for our high-deductible health-insurance plan. We also provide up to \$1,800 per year in additional health-care dollars through deposits into employees'

Personal Wellness Accounts to spend as they choose on their own health and wellness.

Money not spent in one year rolls over to the next and grows over time.

Our team members therefore spend their own health-care dollars until the annual deductible is covered (about \$2,500) and the insurance plan kicks in. This creates incentives to spend the first \$2,500 more carefully.

Our plan's costs are much lower than typical health insurance, while providing a very high degree of worker satisfaction.

- Equalize the tax laws so that employer-provided health insurance and individually owned health insurance have the same tax benefits. Now employer health insurance benefits are fully tax deductible, but individual health insurance is not. This is unfair.
- Repeal all state laws which prevent insurance companies from competing across state lines. We should all have the legal right to purchase health insurance from any insurance company in any state and we should be able use that insurance wherever we live. Health insurance should be portable.
- Repeal government mandates regarding what insurance companies must cover. These mandates have increased the cost of health insurance by billions of dollars. What is insured and what is not insured should be determined by individual customer preferences and not through special-interest lobbying.
- Enact tort reform to end the ruinous lawsuits that force doctors to pay insurance costs of hundreds of thousands of dollars per year. These costs are passed back to us through much higher prices for health care.
- Make costs transparent so that consumers understand what health-care treatments cost. How many people know the total cost of their last doctor's visit and how that total breaks down? What other goods or services do we buy without knowing how much they will cost us?
- Enact Medicare reform. We need to face up to the actuarial fact that Medicare is heading towards bankruptcy and enact reforms that create greater patient empowerment, choice and responsibility.
- Finally, revise tax forms to make it easier for individuals to make a voluntary, tax-deductible donation to help the millions of people who have no insurance and aren't covered by Medicare, Medicaid or the State Children's Health Insurance Program.

Many promoters of health-care reform believe that people have an intrinsic ethical right to health care—to equal access to doctors, medicines and hospitals. While all of us empathize with those who are sick, how can we say that all people have more of an intrinsic right to health care than they have to food or shelter?

Health care is a service that we all need, but just like food and shelter it is best provided through voluntary and mutually beneficial market exchanges. A careful reading of both the Declaration of Independence and the Constitution will not reveal any intrinsic right to health care, food or shelter. That's because there isn't any. This "right" has never existed in America

Even in countries like Canada and the U.K., there is no intrinsic right to health care. Rather, citizens in these countries are told by government bureaucrats what health-care treatments they are eligible to receive and when they can receive them. All countries with socialized medicine ration health care by forcing their citizens to wait in lines to receive scarce treatments.

Although Canada has a population smaller than California, 830,000 Canadians are currently waiting to be admitted to a hospital or to get treatment, according to a report last month in Investor's Business Daily. In England, the waiting list is 1.8 million.

At Whole Foods we allow our team members to vote on what benefits they most want the company to fund. Our Canadian and British employees express their benefit preferences very clearly—they want supplemental health-care dollars that they can control and spend themselves without permission from their governments. Why would they want such additional health-care benefit dollars if they already have an "intrinsic right to health care"? The answer is clear—no such right truly exists in either Canada or the U.K.—or in any other country.

Rather than increase government spending and control, we need to address the root causes of poor health. This begins with the realization that every American adult is responsible for his or her own health.

Unfortunately many of our health-care problems are self-inflicted: two-thirds of Americans are now overweight and one-third are obese. Most of the diseases that kill us and account for about 70% of all health-care spending—heart disease, cancer, stroke, diabetes and obesity—are mostly preventable through proper diet, exercise, not smoking, minimal alcohol consumption and other healthy lifestyle choices.

Recent scientific and medical evidence shows that a diet consisting of foods that are plant-based, nutrient dense and low-fat will help prevent and often reverse most degenerative diseases that kill us and are expensive to treat. We should be able to live largely disease-free lives until we are well into our 90s and even past 100 years of age.

Health-care reform is very important. Whatever reforms are enacted it is essential that they be financially responsible, and that we have the freedom to choose doctors and the health-care

services that best suit our own unique set of lifestyle choices. We are all responsible for our own lives and our own health. We should take that responsibility very seriously and use our freedom to make wise lifestyle choices that will protect our health. Doing so will enrich our lives and will help create a vibrant and sustainable American society.

Mr. Mackey is co-founder and CEO of Whole Foods Market Inc.

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Watching A Bad Idea Implode

By INVESTOR'S BUSINESS DAILY | Posted Monday, August 17, 2009 4:20 PM PT

Health Care: As the White House apparently retreats on its "public option," the unconvincing reality at the heart of its plans becomes clear: Spend and regulate.

Over the weekend, as the president combined sightseeing with his health care tour, he began to hedge on his government-run public option. In answer to a plucky question from a Colorado college student arguing for more private competition, President Obama answered: "The public option, whether we have it or we don't have it, is not the entirety of health care reform."

According to the president, "this is just one sliver of it, one aspect of it." He complained that "it's both the right and the left that have become so fixated on this that they forget everything else."

HHS Secretary Kathleen Sebelius told CNN on Sunday that government-sponsored nonprofit cooperatives, an idea recently cooked up by the Senate Finance Committee, might take the place of a government option as "a competitor to private insurers."

But according to Senate Majority Leader Harry Reid, co-ops would be the same as a public option. They too would apparently have a federal government board dictating policies.

Sounds like a public option in disguise. And if so, it could still suck tens of millions of Americans away from their current plans, destroying the private health care industry in the process.

Howard Dean, former Democratic Party chairman, told NBC's "Meet the Press" on Sunday that "you can't really do health reform without" instituting a public option. For many such liberals, no public option means no deal.

So it looks like the task the president may face in the "post-town hells" political environment is a tough one indeed: convince millions of ObamaCare skeptics that co-ops are an innocuous innovation, while also assuring his pro-single payer base that co-ops are the same as the public option.

The public's concerns center, of course, on fears that the real destination of "reform" is socialized medicine — and with good reason. But a government-run option is not the only vehicle that would take us there.

Even during last year's campaign, independent health care experts, such as Robert Laszewski, president of Health Policy and Strategy Associates, were warning of where reform was really going. A year ago, he wrote that spending a fortune covering added tens of millions of people "would actually increase the rate of health care inflation and ultimately create an imperative for more draconian government intervention in the health care markets Obama would preserve."

Laszewski, who has flayed pro-free market health care commentators, now calls co-ops "the single dumbest idea I have heard in the health care debate in 20 years." Among his unanswered questions: "Will co-ops have an unlimited access to government capital without accountability?"

And where will ObamaCare be without either a public option or co-ops? Actually, still on the road to socialized medicine. In Montana on Friday, the president remarked that "we might see some expansion of Medicaid, in fact, under the reforms that have been proposed in some of the legislation."

The Medicaid and Medicare entitlement programs, with their massive annual automatic spending increases, are ever-expanding monsters that politicians never find the guts to rein in. Obviously, President Obama is no exception.

Along with more spending comes lots more regulation of health insurers. The president was promising crowds in New Hampshire, Montana and Colorado an end to insurer practices such as lifetime benefit caps and coverage denial due to medical history.

These pledges to meddle were followed with applause lines like: "If you like your health care plan, you keep your health care plan . . . I don't want government bureaucrats meddling in your health care."

The multitude of new rules will disfigure and make significantly more expensive that health coverage you "like" and will be allowed to "keep." They will mean massive new costs and thus higher premiums — the kind of "health care inflation" Laszewski warns will lead to a second wave of "draconian government intervention."

If President Obama and the Democratic Congress are still in power, they will get a second chance to impose socialized medicine on America — in a panicky environment of exploding medical costs of which they were the cause.

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OPINION

AUGUST 19, 2009, 7:12 P.M. ET

Health Co-ops: Slow Road to Government Care The potential benefits are nil; the potential costs are large.

By SCOTT HARRINGTON

There are hints that the Obama administration and Democratic congressional leadership might be willing to negotiate on the inclusion of a government health insurer as part of health-care reform. The most likely alternative proposal, which has been discussed by the Senate Finance Committee, is to establish some system of consumer cooperatives or "co-ops."

While details are sketchy, the basic idea is to subsidize the creation of nonprofit health insurers on a state or regional basis. These supposedly would be run independent of the government and compete with traditional private health-insurance plans.

These government-authorized co-ops would serve no useful purpose. And they would risk the same adverse consequences as a public plan.

Democrats' health insurance proposals already require private insurers to accept all applicants with no pre-existing condition exclusions, at premium rates that do not reflect health status and vary only within a narrow range based on age. These changes guarantee people access to health insurance at rates that would not price the ill or near-elderly out of the market—without creating government-authorized co-ops.

Democrats' proposals expand eligibility for Medicaid and provide significant premium subsidies to buyers with incomes up to 300% or even 400% of the poverty level. These provisions would make insurance substantially more affordable for people with low-to-moderate income—without creating government-authorized co-ops.

Government-authorized co-ops also are not necessary to provide consumers with nonprofit alternatives. Nonprofit mutual insurance companies, most notably many Blue Cross and Blue Shield plans, already offer health insurance in many states. They are dominant players in some states.

Absent taxpayer subsidies or special rules, co-ops would not have any inherent advantage over private health insurers in establishing provider networks, negotiating with providers, and monitoring health-care utilization and fraud. Proposed co-ops instead would require billions of dollars of "start-up" subsidies.

More important, the creation of government-authorized co-ops would entail significant risk of ongoing subsidies by taxpayers (if not by private health-insurance buyers), of substantial private insurance crowd-out, and of eventual conversion to a government-run plan. Like a proposed

public plan, government-authorized co-ops would be backed implicitly if not explicitly by taxpayers.

They would not have to hold the amounts of capital that private health insurers hold to back their promises. Government-authorized co-ops would almost certainly not have to pay income or premium taxes that private for-profit and nonprofit insurers must pay.

Although co-ops might initially be required to negotiate their own reimbursement rates with hospitals and doctors, substantial pressure would arise over time for centralized negotiations, with eventual benchmarking off Medicare reimbursement rates.

Compared with a public plan, government-authorized co-ops could simply be a slower road to government health care. The potential benefits are nil; the potential costs are large.

Mr. Harrington, professor of health-care management and insurance and risk management at the Wharton School of the University of Pennsylvania, is an adjunct scholar at the American Enterprise Institute.

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## REVIEW & OUTLOOK

AUGUST 21, 2009

### No Maine Miracle Cure

Another state 'public option' that failed.

Want a preview of ObamaCare in action? Sneak a look at what has happened in Maine. In 2003, the state to great fanfare enacted its own version of universal health care. Democratic Governor John Baldacci signed the plan into law with a bevy of familiar promises. By 2009, it would cover all of Maine's approximately 128,000 uninsured citizens. System-wide controls on hospital and physician costs would hold down insurance premiums. There would be no tax increases. The program was going to provide insurance for everyone and save businesses and patients money at the same time.

After five years, fiscal realities as brutal as the waves that crash along Maine's famous coastline have hit the insurance plan. The system that was supposed to save money has cost taxpayers \$155 million and is still rising.

Here's how the program was supposed to work. Two government programs would cover the uninsured. First the legislature greatly expanded MaineCare, the state's Medicaid program. Today Maine families with incomes of up to \$44,000 a year are eligible; 22% of the population is now in Medicaid, roughly twice the national average.

Then the state created a "public option" known as DirigoChoice. (Dirigo is the state motto, meaning "I Lead.") This plan would compete with private plans such as Blue Cross. To entice

lower income Mainers to enroll, it offered taxpayer-subsidized premiums. The plan's original funding source was \$50 million of federal stimulus money the state got in 2003. Over time, the plan was to be "paid for by savings in the health-care system." This is precisely the promise of ObamaCare. Maine saved by squeezing payments to hospitals and physicians.

The program flew off track fast. At its peak in 2006, only about 15,000 people had enrolled in the DirigoChoice program. That number has dropped to below 10,000, according to the state's own reporting. About two-thirds of those who enrolled already had insurance, which they dropped in favor of the public option and its subsidies. Instead of 128,000 uninsured in the program today, the actual number is just 3,400.

Despite the giant expansions in Maine's Medicaid program and the new, subsidized public choice option, the number of uninsured in the state today is only slightly lower than in 2004 when the program began.

Why did this happen? Among the biggest reasons is a severe adverse selection problem: The sickest, most expensive patients crowded into DirigoChoice, unbalancing its insurance pool and raising costs. That made it unattractive for healthier and lower-risk enrollees. And as a result, few low-income Mainers have been able to afford the premiums, even at subsidized rates.

This problem was exacerbated because since the early 1990s Maine has required insurers to adhere to community rating and guaranteed issue, which requires that insurers cover anyone who applies, regardless of their health condition and at a uniform premium. These rules—which are in the Obama plan—have relentlessly driven up insurance costs in Maine, especially for healthy people.

The Maine Heritage Policy Center, which has tracked the plan closely, points out that largely because of these insurance rules, a healthy male in Maine who is 30 and single pays a monthly premium of \$762 in the individual market; next door in New Hampshire he pays \$222 a month. The Granite State doesn't have community rating and guaranteed issue.

One proposal to get people into the DirigoChoice system is to reduce the premiums, presumably to give the uninsured a larger incentive to join. But that would explode the program's costs when it already can't pay its bills. A program that was supposed to save money by reducing health-care waste and inefficiencies has seen a 74% increase in premiums. But even those inflated payments can't keep the program out of the red.

Last year, DirigoCare was so desperate for cash that the legislature broke its original promise of no tax hikes and proposed an infusion of funds through a beer, wine and soda tax, similar to what has been floated to pay for the Obama plan. Maine voters rejected these taxes by two to one. Then this year the legislature passed a 2% tax on paid health insurance claims. Taxing paid insurance claims sounds a tad churlish, but the previous funding formula was so complicated that it was costing the state \$1 million a year in lawsuits.

Unlike the federal government, Maine has a balanced budget requirement.

So out of fiscal necessity, the state has now capped the enrollment in the program and allowed no new entrants. Now there is a waiting list.

DirigoChoice has become yet another expensive, failed experiment in government-run health care, alongside similar fiascoes in Massachusetts and Tennessee.

Not everyone sees it this way. Noting the similarities between the Maine program and the Congressional initiative, Karynlee Harrington, the executive director of the Dirigo Health Agency, boasted recently:

"DirigoChoice is consistent with what we think the definition of a public health option is." It certainly is.

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## OPINION

SEPTEMBER 1, 2009, 7:40 P.M. ET

### What I Learned From the 'Mob'

Voters don't believe the White House claim that we'll save money by spending more.

By TOM COBURN

I spoke with thousands of voters at town-hall meetings this summer. What I gathered from them is that it's not just the proposed overhaul of health care that has them upset. Many also expressed a sense of betrayal. In spite of their hope for change, it still appears that the government in Washington is run for its own benefit and the benefit of special interests—not for the benefit of the American people. The folks I met with also don't trust politicians in Washington to address mounting long-term challenges to our economy.

It's not just the attendees of town-halls meetings in Oklahoma. Voters across the country are telling Washington what's on their mind, if only more people inside the Beltway would listen. A Rasmussen poll released last month showed that 40% of voters said that cutting the deficit in half by 2012 should be President Barack Obama's top priority. Only 21% said health-care reform should be his No. 1 priority.

Notwithstanding these polling results, the administration and Congress have responded by trying to win public support on the strength of an argument that's too clever to be true. They say that the key to saving money is spending money, a lot of money. And they've done just that with a \$787 billion stimulus program as well as billions in bailouts and proposals to spend vast sums on health-care reform and other things.

Their belief seems to be that every government expenditure grows the economy or can be counterbalanced with cost savings.

It's a confusing argument, and it's flat wrong, particularly with regard to health care. The Congressional Budget Office has said as much when it stated a few weeks ago that the health-

care legislation before Congress fails to restrain costs and instead "significantly expands the federal responsibility for health-care costs."

A more convincing argument would be this: Let's save money by spending less. This argument doesn't require a clever explanation, but it does require putting the government in the position where it has to set realistic priorities. Most families realize that they can't live indefinitely on borrowed money and would be delighted if the government joined them in the real world of tough spending choices.

However, Congress has shown no sign of departing from the status quo. Spending bills continue to grow faster than the rate of inflation as members still earmark funds for special projects for parochial interests. The most recent appropriations bill to pass the Senate, the Agriculture Department bill, included a 15% spending increase over the previous year's bill, which itself was a 21% spending increase over the preceding year. In today's economy, such spending increases make Americans realize that the political class isn't even close to getting it.

Last week, White House Director of the Office of Management and Budget Peter Orszag released a review of the budget that adjusted our long-term deficit up by \$2 trillion—more than double the cost of the wars of Iraq and Afghanistan since 2001. In his 750 word report, Mr. Orszag cast blame on "previous administrations"—the Bush administration—five times and didn't once take aim at today's Congress or the annual orgy of wasteful, duplicative and special-interest spending in which it is now engaging.

Voters understand that our economic challenges hardly started with George W. Bush, and that at some point the administration has to stop blaming the last guy in the Oval Office and start providing real solutions. America is facing an economic reckoning because the cornerstone programs of the welfare state—Medicare, Medicaid and Social Security—will soon be bankrupt and will likely require massive tax increases to stay afloat.

The message the appropriators took from Mr. Orszag's finger-pointing is that it's OK to continue business as usual. I believe Mr. Obama is open to a different course. I was one of the few Republicans who applauded his modest call for specific spending cuts earlier this year. If he overrides the dogmatic wing of his party that believes spending money during a recession is always helpful—however wasteful it may be—he'll find an army of allies among the American people.

Congressional leaders have been using apocalyptic rhetoric about angry "mobs," "un-American" protestors and "evil-mongers" at town halls because they know that voter concerns about spending may not only derail the "public option" in health-care reform but could turn into a referendum on our real problems—our crushing burden of government and the politicians who defend the status quo. For the sake of future generations, such a referendum couldn't come soon enough.

Dr. Coburn, a family practice physician, is a Republican senator from Oklahoma.

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**Letter: On behalf of fewer than 47 million**

Published Friday, September 4, 2009

The Sept. 3 column, "On behalf of 47 million ...," cites a figure of 47 million uninsured Americans. This oft-quoted statistic is actually a gross overestimation of the problem, as recent research suggests the number of Americans who cannot currently afford health insurance is much lower.

A new study by Dr. June O'Neill, who served as director of the Congressional Budget Office from 1995-'99, shows that nearly half of those uninsured Americans could likely afford to purchase health coverage. These individuals have incomes at least 2.5 times the poverty level, with the average "voluntarily uninsured" household making \$65,000 per year.

We should not rush into the creation of a new, expensive healthcare system without a better understanding of the uninsured population. As long as we continue basing our arguments on inaccurate numbers, it's hard to see how we can make effective policy decisions.

Kristen Lopez Eastlick

Washington, D.C.

Sept. 3

The writer is a senior economic analyst at the Employment Policies Institute.

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**OPINION**

SEPTEMBER 7, 2009, 7:07 P.M. ET

**ObamaCare's Crippling Deficits**

The higher taxes, debt payments and interest rates needed to pay for health reform mean lower living standards.

By MARTIN FELDSTEIN

While the deficits caused by the fiscal stimulus package will end in

2011 and will help to sustain a fragile recovery in 2010, the deficits projected for the longer term are a threat to our economic future. The starting point for controlling those future deficits is for Congress to abandon the administration's health-care plan—a plan that will cost more than \$1 trillion.

The deficits projected for the next decade and beyond are unprecedented.

According to an assessment released in March by the Congressional Budget Office (CBO), the president's budget implies that deficits will average 5.2% of GDP over the next decade and will be 5.5% of GDP in 2019.

Without the president's proposals, the budget office forecasts a 2019 deficit of only 2% of GDP.

The CBO's deficit projections are based on the optimistic assumptions that the economy will grow at a healthy 3% pace with no recessions during the next decade; that there will be no new spending programs after this year's budget; and that the rising national debt will increase the rate of interest on government bonds by less than 1%. More realistic assumptions would imply a 2019 deficit of more than 8% of GDP and a government debt of more than 100% of GDP.

Such enormous deficits would crowd out productivity-enhancing investments in new equipment and software as the government borrows funds otherwise available to private investors. The result would be slower economic growth and a lower standard of living.

In the nearer term, the projected deficits could cause interest rates on bonds and mortgages to rise sharply if bond investors fear that the government will not prevent inflation. This is a greater risk now that more than half of the U.S. government debt is held by the Chinese and other foreign investors. Such an interest rate rise could kill a recovery in 2010 or 2011 and depress growth in the years that follow.

Dropping the Obama health plan would significantly reduce fiscal deficits over the next decade and help restore public confidence in the ability of Congress to control spending. The CBO estimates that the House committee versions of the Obama health plan would add more than \$1 trillion to federal deficits over the next decade. But the actual costs would be much higher.

For starters, \$1 trillion of extra debt-financed spending would cause the government to pay about \$300 billion of extra interest in the next decade. Moreover, the CBO's method of estimating the cost of such a program doesn't recognize the incentives it creates for households and firms to change their behavior.

The House health-care bill gives a large subsidy to millions of families with incomes up to three times the poverty level (i.e., up to \$66,000 now for a family of four) if they buy their insurance through one of the newly created "insurance exchanges," but not if they get their insurance from their employer. The CBO's cost estimate understates the number who would receive the subsidy because it ignores the incentive for many firms to drop employer-provided coverage. It also ignores the strong incentive that individuals would have to reduce reportable cash incomes

to qualify for higher subsidy rates. The total cost of ObamaCare over the next decade likely would be closer to \$2 trillion than to \$1 trillion.

The administration's claim that the health-care plan would be "self-financing" is both false and irrelevant. It is false because it would only be self-financing if one counts a variety of President Obama's proposed tax increases—and even those would produce much less revenue than is assumed in the budget calculations. The claim is irrelevant because those tax increases have nothing to do with health care and could be used instead to reduce other projected deficits.

For example, the administration and the congressional designers of ObamaCare say they would finance a substantial part of health reform with the revenue from new taxes on corporate foreign profits and on high-income individuals. The likely revenue from these tax changes would be much less than the official estimates because of the induced changes in taxpayer behavior that the estimators ignore.

Previous experience with changes in the marginal tax rates of high-income individuals implies that the current proposal to raise the marginal tax rate to about 50% from today's 40% would produce only about half of the official revenue estimates. No one knows how much of the estimated extra tax revenue on foreign profits would be lost as the resulting fall in international competitiveness reduces profits, and as businesses sell their overseas subsidiaries or shift their profits in other ways.

While abandoning health reform would be an important step, it would not be enough to limit the exploding level of future deficits and debt. That requires substantial reductions in existing spending programs, if large tax increases are to be avoided. Since Medicare is the largest contributor to the explosive growth in government spending, a good way to start shrinking government outlays would be by restructuring Medicare to shift more of its costs to supplementary private insurance, perhaps on an income-related basis.

Given the perceived need for significant additional tax revenue to shrink future fiscal deficits, there is now talk in Washington of introducing a value-added tax (VAT), the kind of national sales tax that European governments use to finance their welfare states. That would be a triply bad idea. Although it is a tax on spending, a VAT effectively raises marginal tax rates. Like the income tax, it reduces the reward for work and entrepreneurship by adding a tax to the prices of all goods and services. A VAT would also be grossly unfair to those whose lifetime savings would now be subject to a new tax when they start to spend those savings.

A VAT would open the door to an explosion of new spending programs. That's because, no matter how low the initial rate, the tax rate would be drawn inevitably to European rates of more than 15%—on top of existing income and payroll taxes.

The key to raising revenue without raising marginal tax rates or creating a new tax is to reduce or eliminate some of the "tax expenditures" that now lower tax revenue by special deductions and exclusions. Ending the current exclusion from taxable income of employer payments for

health insurance would increase income tax revenue by more than \$1 trillion over the next five years and nearly \$3 trillion over the next decade. Eliminating this subsidy would also lead to a restructuring of private health insurance that would give patients the incentive to seek more cost-effective care and thereby bring down the overall cost of health care.

Restructuring Medicare and reforming tax rules would be politically difficult. But a failure by Congress to address the exploding path of fiscal deficits would be morally irresponsible.

Mr. Feldstein, chairman of the Council of Economic Advisers under President Ronald Reagan, is a professor at Harvard and a member of The Wall Street Journal's board of contributors.

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REVIEW & OUTLOOK  
SEPTEMBER 8, 2009

Whoa, Trigger

The latest gimmick to disguise a health-care 'public option.'

President Obama has decided that another oration will rejuvenate his health-care agenda—despite having given 27 speeches entirely on health care, and another 92 in which it figured prominently. We'll see how tomorrow night's Congressional appeal works out, but the important maneuvers are taking place in the cloak rooms, as the White House tries to staple together a majority.

The latest political gimmick is the notion of a "trigger" for the public option: A new government program for the middle class would only come on line if private insurance companies fail to meet certain benchmarks, such as lowering overall health spending or shrinking the number of the uninsured. This is supposed to appeal to Maine Republican Olympia Snowe, who could end up as ObamaCare's 60th Senator, while still appeasing the single-payer left.

Liberals should love the idea because a trigger isn't a substantive concession; it merely ensures that the public option will arrive eventually, instead of immediately. Democrats will goose the tests so that private insurers can't possibly meet them, mainly by imposing new regulations and other costly burdens.

Keep in mind that every version of ObamaCare now under consideration essentially turns all private insurers into subsidiaries of Congress.

All coverage will be strictly regulated down to the fine print, and politics will dictate the level of benefits as well as premiums, deductibles and copays. Under the House bill, a "health choices commissioner" will have the final say, no doubt with Democrats Henry Waxman and Pete Stark at his elbow, if not another part of his anatomy.

The same bill also rewrites the 1974 federal law known as Erisa that lets large and mid-sized employers offer insurance with little regulation. Many businesses—including Safeway, General Mills and Marriott—are finding innovative ways to drive down spending, largely with worker incentives to live healthier and be more sensitive to the costs of care. Many Democrats call this discriminatory.

In the individual insurance market, Democrats intend to outlaw medical underwriting: Everyone must be charged the same rate or close to it for the same policies, regardless of health status or history. But this "community rating" tends to price younger and low-risk consumers out of the market. In a 2006 NBER paper, Bradley Herring of John Hopkins and Mark Pauly of the University of Pennsylvania found that community rating results in an overall increase in the uninsured in the individual market, maybe as high as 7.4%. For that reason, 35 states have no community rating at all, and another six allow very wide variations.

The larger reality is that private insurance won't be less expensive until overall health-care costs go down. Democrats may be confused on this point because government, which paid nearly 47 cents of every medical dollar in 2007, simply sets lower prices when Congress feels like it. On average, doctors and hospitals are forced to accept 20% to 30% less for their services in Medicare. That's another reason insurers wouldn't meet a trigger's thresholds, given that providers shift costs onto private under-65 patients to make up government shortfalls.

Conceivably insurers could make their products more affordable by cracking down on treatments and refusing payment more often, much as HMOs held down spending in the 1990s. But both patients and doctors hated this "managed care"—and in any case, Democrats would find a new rationale for the public option in the inevitable voter outcry about private "rationing."

It's true that there was a trigger in the Medicare prescription drug benefit and the world didn't end. But recall the dynamics in 2003: The GOP decided that private stand-alone or Medicare Advantage plans should manage the benefit. As a concession to Democrats, they agreed to trigger a "public option" for drugs—in which the government would have bought them directly, with its typical "negotiating" tactics—if seniors didn't have more than two plans in a given region.

Today, there are 1,689 stand-alone and 2,099 Advantage plans, and on average seniors have 50 to choose from—and costs in 2007 were \$26 billion lower than expected. For all its problems, the Medicare drug plan created more choice for seniors and more competition among providers to offer packages that they found most attractive, holding down costs. In short, it created the incentives for multiple "private options."

ObamaCare doesn't bother with incentives, instead merely increasing government command and control of private insurance while making it more expensive in the process. That's why a trigger will inevitably lead to the public option, and also why ObamaCare will make all of our current health problems worse.

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OPINION: BUSINESS WORLD

SEPTEMBER 8, 2009, 7:28 P.M. ET

A Bipartisan Plan to Wreck the System

The health-care address President Obama should really give to Congress.

By HOLMAN W. JENKINS, JR.

What follows is a leaked first draft of President Obama's speech on health care tonight, complete with instructions for Democrats in the audience.

Members of Congress, Ladies and Gentlemen, Children of the Obama Youth Corps—I come to you tonight to speak frankly about our nation's health-care crisis and how we in Washington can make it worse.

Salami tactics on health care have long involved slicing the salami from both ends.

On one hand, we enlarge the government's role in providing health care, making more and more voters dependent on Washington.

On the other, we enact regulations and restrictions to keep driving the private insurance system off a cliff.

To the American people I promise tonight, whatever compromises lay ahead, whatever the arduous negotiations, Democrats and Republicans will work together to continue to drive the current system off a cliff.  
(Applause from Democrats in the audience; Nancy Pelosi beams.)

Even if we cannot enact my administration's "public option," we will extend the great work of previous generations, making sure private health care continues to be unaffordable to more and more Americans, and piling up fresh mandates on employers so fewer and fewer of our citizens will have either jobs or health insurance.

At the same time, with tax dollars, we will continue to subsidize ever more consumption of that which everyone agrees we already consume too much.

We may not get there right away. But by taking these steps, we will bring closer the day when the only form of health care for most Americans will be government-provided health care, and the dream will never die. (Pandemonium among Democrats. Nancy Pelosi daubs her eye.)

I want to give a shout-out to our Republican friends, who have been with us every step of the way, who have been an important part of our salami progress so far—by pushing various "patient's bills of rights," defending the tax giveaways that encourage spending regardless of cost or benefit; by expanding Medicare, Medicaid, Veterans benefits and subsidized health care for middle-class children.

I say tonight, without Republican help, we could never have brought the system to its current dysfunction and I thank you.

Now, much has been said about our "public option" that's been confusing and misinformed. It's in that spirit that I speak to you tonight.

Critics wonder: How can a new "public option" bring meaningful competition to the health-insurance marketplace and drive down costs?

They miss the point. The great work done so far has tended to squash competition, and we would continue this work—by restricting the ability of insurance companies to design and market their policies; by regulating what coverage they can offer; by using tax distortions to keep consumers in the dark about what their health care really costs, so they will continue to treat it as a "free lunch" when it actually gobbles up more and more of their disposable incomes.

People, this is why insurance rates keep going up and up, and why a competitive marketplace, in which consumers reward those who provide high-quality care at low cost, hardly exists. And I say again, with all humility, this is a great bipartisan achievement.

So the purpose of our public option is not to change any of this, but merely to scoop up the growing number of Americans who won't be able to get private coverage because we've made private coverage so expensive and uneconomic.

Some say the public plan would be unfairly subsidized with tax dollars. No, no, no—the public option would be self-sustaining, just like the Post Office, just like Medicare, just like the federal government, which carefully lives within the tax revenues it receives each year.\*

Now, my administration is not wedded to the "public option." I know my Republican friends say families should not have health care. They believe we can save money by lying down before rapacious insurance CEOs. They say the indigent should be encouraged to practice self-surgery (I'm sure some Republican somewhere thinks this is a good idea).

But let's put aside our differences and recognize how much we have already accomplished together. I say to Republicans and Democrats alike, if we can just keep working together to inflate the burden of public and private health-care spending as we have the past 30 years, we will push the system to the breaking point. Yes, we can. Yes, we can. (Democrats chant, "Yes we can." Nancy Pelosi levitates above the audience, flies around the chamber three times and bursts into flame. . . .)

. . . Together we can push our current health-care system over a cliff, and then—well, then [STRONG ENDING HERE]

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\*Certain factual statements subject to OMB review.