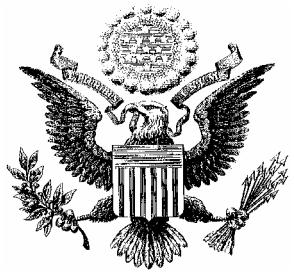
AN ANALYSIS OF SENATOR KERRY'S HEALTH PLAN

A JOINT ECONOMIC COMMITTEE STUDY



Vice Chairman Jim Saxton (R-NJ)

Joint Economic Committee
United States Congress

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Executive Summary

Senator John Kerry has proposed a significant expansion of the federal government's role in paying for and managing health care, extending the reach of government into new areas and affecting a great many families. This study examines his proposal and finds:

- Two separate, independent analyses estimate that gross new spending in the Kerry health plan totals $1.6 trillion over ten years. Cost savings are estimated to be less than one-quarter that size.
- The Kerry health plan moves the U.S. toward a single-payer, government-financed health care system by increasing the number of people dependent on the government for health coverage while simultaneously crowding out private sector coverage.
- The Kerry health plan would entail many mandates and regulations, and add to the administrative burdens of the current system.
- The Kerry health plan fails to propose serious medical liability reform or to address the third-party system of health care financing, key causes behind the escalating cost of health insurance.

Joint Economic Committee
433 Cannon House Office Building
Washington, DC 20515
Phone: 202-226-3234
Fax: 202-226-3950

Internet Address:
http://www.house.gov/jec/

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I. Introduction

In May 2004, Senator John Kerry (D-MA) proposed a significant expansion of the federal government's role in providing and paying for health care. The goal of the plan is to directly or indirectly provide health coverage for a range of people through a series of new spending proposals and tax credits. This study reviews the key elements of the plan as they have been detailed thus far and discusses the potential impact such a plan would have.

The proposals to expand health coverage in the Kerry health plan would have a total cost exceeding $1.6 trillion over the next ten years, according to two separate, independent analyses. These analyses also estimate that the plan would realize cost savings of between $116 and $415 billion, indicating a net total cost of between $1.2 trillion and $1.5 trillion. The available evidence suggests that the key cost saving provisions in the Kerry health plan are unlikely to cover even one-quarter the expected costs.

The Kerry health plan would effect other changes beyond an increase in federal outlays. First, the plan would greatly increase the role of the federal government as the payer and manager of health care, moving the U.S. closer to a single-payer health care system. Second, as currently crafted, the plan creates enormous liabilities for the federal government in terms of commitments to pay, directly or indirectly, for health care. Third, the plan does not address key drivers of health care costs, such as medical liability or the third-party payer system of financing health care. Finally, the Kerry health plan's expansion of public health insurance would crowd out health coverage currently provided by the private sector.

II. Elements of the Kerry Health Plan

The Kerry health plan aims to expand the number of Americans with health insurance. The plan consists of an expansion of existing government programs, new government programs, tax incentives and regulatory mandates. The Kerry health plan is quite large in scope, vague about numerous aspects and lacking many details. Such vagueness and lack of specificity makes description, much less analysis, of the plan difficult. The remainder of this section describes the major components in greater detail.[1]

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[1] The details of the Kerry plan are drawn from John Kerry for President, "John Kerry's Plan to Make Health Care Affordable to Every American," http://www.johnkerry.com/issues/health_care/health_care.html [October 2004]. Additional details are taken from the analyses of the Kerry health plan by Antos et al., Sheils and Haught and Thorpe, see *infra* notes 15, 16 and 17.

Medicaid/SCHIP Expansion

The Kerry health plan would use the existing framework of Medicaid and SCHIP (state child health insurance program) to provide coverage to persons with lower-incomes.[2] Specifically, all children in families under 300 percent of the poverty line would be covered.[3] In fact, the plan requires children to have health insurance and would enforce this requirement by automatically enrolling all eligible children when they come to school. All parents in families with incomes up to 200 percent of the poverty line would be covered, as would all single individuals with incomes below the poverty line.[4] Additionally, the Kerry health plan would make program participation immediately available to certain legal immigrants (pregnant women and children), eliminating the current five-year waiting period. States could opt not to participate in the Medicaid/SCHIP expansion, but in that event they would not be eligible for the extra federal funding provided to cover the new populations.

Congressional Health Plan

The second main component of the Kerry health plan is a substantial expansion of the Federal Employees Health Benefit plan (FEHBP), through the creation of the Congressional Health Plan (CHP). The FEHBP currently provides health coverage to federal employees. Under the Kerry health plan, all Americans would be eligible to purchase insurance through the newly-created CHP, with varying degrees of subsidization by the government. For small businesses, the federal government would match employer contributions up to one-half the cost of health insurance through a refundable tax credit. However, such firms must pay for at least one-half of their employees' health premiums and would be subject to a 10 percent surcharge. For unemployed workers, the federal government would pay 75 percent of health insurance costs, also via a refundable tax credit.[5] Large employers could participate as well, so long as they maintain the same level of premium contribution that they currently offer.[6] Finally, individuals between the ages of 55 and 64 could participate in the CHP with a 25 percent subsidy.[7] Other persons could also insure through the CHP, but without a subsidy.

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[2] For a general overview of these programs, see Elicia J. Herz, Evelyne Baumrucker and Peter Kraut, "A State-by-State Compilation of Key State Children's Health Insurance Program (SCHIP) Characteristics," Congressional Research Service, Report RL32389 (May 19, 2004); and U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Medicaid: A Brief Summary," http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp (September 16, 2004).

[3] The poverty line varies by size of family and number of dependent children (though not by geography). In 2003, the poverty line for a family of four with two children was $18,660. U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2003* (Washington, DC: Government Printing Office, 2004), 39.

[4] This part of the Kerry plan is achieved through a "swap" with state governments, which manage their own Medicaid and SCHIP plans. Under the Kerry health plan, the federal government would assume all costs for providing health coverage to all children in Medicaid. In return, states would assume the added costs of expanding SCHIP coverage to include the other populations described in the text.

[5] The Kerry health plan does not appear to attach any income, coverage or time limits to this subsidy. In theory, then, a high-income individual between jobs could receive this 75 percent subsidy indefinitely for an extremely generous health plan.

[6] Business participation in the CHP would be an all or nothing proposition: either firms must offer CHP coverage to all of their employees or to none of them.

[7] This subsidy also does not appear to have any income, coverage or time limits, or even to be contingent on employer-provided coverage. In theory, then, persons in this age group could turn down employer-provided coverage in favor of taxpayer-subsidized health insurance with more generous benefits.

The Kerry health plan claims that the CHP would "allow every American access to the same health plan members of Congress get today."[8] In truth, however, the CHP merely allows people to participate in the same *type* of program as federal employees. The Kerry health plan itself states that it would create a new "separate pool."[9] There is no stated requirement that CHP plans must match FEHB plans in terms of coverage levels or pricing. The health insurance available through the CHP will be priced differently than the plans in the FEHBP because it will cover a different pool of insureds.[10]

Stop-Loss Program (Premium Rebate)

A major feature of the Kerry health plan is creation of a federal "stop-loss" program through which the federal government would pay most catastrophic health care costs for enrollees in employer-based health plans.[11] Specifically, the federal government would assume the cost of 75 percent of all health care expenses exceeding a certain "catastrophic" threshold. The threshold would vary by year, but would initially start out at as low as $30,000 in 2006 and eventually rise to $50,000.[12] The government would reimburse 75 percent of such costs incurred by employers by providing a premium rebate. The Kerry health plan would impose a number of conditions that businesses would have to meet in order to participate in this premium rebate plan. For example, the Kerry health plan states that businesses would be required to "provide affordable coverage to all their employees" and must demonstrate that the savings realized from this plan are passed on to the employees.[13]

Income Cap

The Kerry health plan offers a subsidy to parents and single individuals with incomes between 100 percent and 300 percent of the poverty line. For such persons, the Kerry health plan would cap health insurance costs at 6 percent of income. The government would pay for any such costs over 6 percent. The cap would phase out as income rises, increasing to a cap of 12 percent of income. The federal government would presumably pay for such costs through a refundable tax credit, although the specifics are not clearly spelled out in the proposal.

Cost Saving Provisions

The Kerry health plan makes several proposals that would attempt to partially offset the costs of the new or expanded health insurance programs. The Kerry health plan promises, among other things, the reimportation of prescription drugs from foreign countries and more

[8] John Kerry for President.
[9] *Ibid*.
[10] For a general discussion of the CHP and FEHBP, see Robert E. Moffit, Nina Owcharenko and Edmund F. Haislmaier, "Details Matter: A Closer Look at Senator Kerry's Health Care Plan," Heritage Foundation, Report 1805 (October 12, 2004), 14-19.
[11] Some observers have called this proposal a reinsurance pool. However, the proposal does not operate like reinsurance at all, since participants pay no premiums and there is no adjustment for risk. The program simply consists of the federal government transferring money to businesses that meet certain conditions.
[12] The threshold would be set at a level that would reduce benefit costs by 10 percent. Initial estimates place this level to be between $30,000 and $36,000 in 2006.
[13] John Kerry for President.

affordable medical malpractice insurance. There are three chief savings proposals. First, the Kerry health plan supports improved disease management. The premise of cost savings from disease management is that the cost of additional health services for chronic conditions in the short run would be offset by reduced spending later on. Second, the Kerry health plan seeks faster implementation of cost-saving information technologies. The Kerry health plan would accelerate use of electronic medical records, update the technology used by the federal government, and require private insurers to use cost-saving information technology.

Finally, the Kerry health plan also includes spending cuts to Medicare and Medicaid. These reductions derive from three sources. First, according to Thorpe, the Kerry health plan would reduce funding for Medicare Advantage plans. Created in 2003, Medicare Advantage plans offer Medicare recipients the option of participating in a variety of health coverage plans, such as regional plans that function similarly to Preferred Provider Organizations (PPOs).[14] Second, Thorpe reports that the Kerry health plan would reduce Medicare and Medicaid outlays on disproportionate share payments. Medicare and Medicaid both make payments to hospitals that serve a high proportion of low-income patients. If the Kerry health plan works as advertised, fewer low-income individuals would lack health insurance. As a result, the amount of uncompensated care provided by such hospitals would drop, thus allowing spending reductions. It is unclear whether such spending reductions would be implemented through legislation regardless of the Kerry health plan's effectiveness, or if such savings occur as a by-product of the Kerry health plan. Finally, as part of the disease management proposal, the Kerry health plan would cut Medicare's fee-for-service payments for heart disease and diabetes by 10 percent.

III. Impact of the Kerry Health Plan on the Federal Budget

Two independent analyses have arrived at remarkably similar estimates of the gross impact of the Kerry health plan on the federal budget. The non-partisan think tank American Enterprise Institute (AEI) released a study showing that new and expanded programs in the Kerry health plan would cost $1.636 trillion over the first ten years (2006 to 2015).[15] A second study, by the health care consulting firm The Lewin Group, estimated the same proposals to have a gross cost of $1.664 trillion over the same

Table 1. New Spending in the Kerry Health Plan, 2006-2015

	AEI	Lewin	Thorpe*
Medicaid/SCHIP Expansion	$881.1	$553.1	$518.0
Premium Limitation	$49.6	$204.1	$44.4
Tax Credits	$132.0	$180.8	$132.7
Stop-Loss Program	$573.4	$725.7	$256.7
Total	**$1,636.1**	**$1,663.7**	**$951.8**

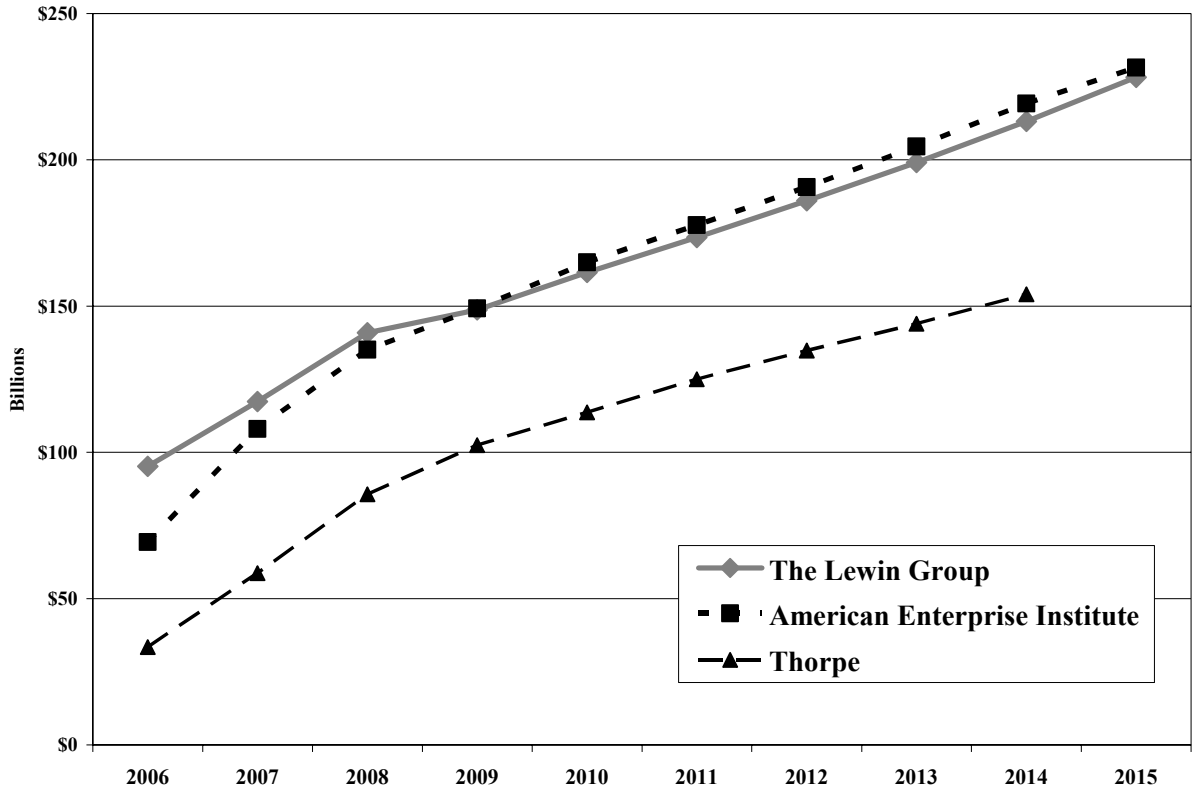
All amounts in billions.
* Thorpe's estimates only cover nine years (2006-2014).
Source: Antos et al., Sheils and Haught, and Thorpe.

[14] Hinda Ripps Chaikind and Paulette C. Morgan, "Medicare Advantage Payments," Congressional Research Service, Report RL32618 (September 29, 2004).
[15] Joseph Antos, Roland (Guy) King, Donald Muse, Tom Wildsmith and Judy Xanthopoulos, "Analyzing the Kerry and Bush Health Proposals: Estimates of Cost and Impact," American Enterprise Institute (September 13, 2004), 4.

time period.[16] The aggregate difference between the studies' estimates of gross spending is less than 2 percent (though their net cost estimates differ to a larger degree).

A third cost analysis of the Kerry health plan comes from Kenneth E. Thorpe, a former Clinton Administration health analyst who is currently a professor at Emory University's Rollins School of Public Health.[17] Thorpe estimates that the portions of the Kerry health plan that would expand health coverage would have deficit cost of $951.8 billion over just nine years (2006 to 2014).[18] Thorpe's year-by-year estimates suggest that over the ten-year window, new program costs would exceed $1.1 trillion. Table 1 summarizes the different studies' cost estimates of new spending in the Kerry health plan. As can be seen, some variance exists over the cost of specific proposals. Figure 1 displays the gross cost estimates from the studies on an annual basis.

Figure 1. Cost of New Spending in the Kerry Health Plan, 2006-2015



Source: Antos et al., Sheils and Haught, and Thorpe.

[16] John Sheils and Randall Haught, "Bush and Kerry Health Care Proposals: Cost and Coverage Compared," The Lewin Group (September 21, 2004), 8.

[17] Thorpe's analysis actually consists of four separate reports: Kenneth E. Thorpe, "A Note on the Lewin Analysis of Senator Kerry's and President Bush's Health Care Plans" (October 3, 2004); Kenneth E. Thorpe, "Comparison of Thorpe and American Enterprise Institute Estimates of the Kerry Health Care Plan" (September 15, 2004); Kenneth E. Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Care Plan" (August 2, 2004); Kenneth E. Thorpe, "The Impact of Sen. John Kerry's Health Care Proposal on Health Care Costs" (June 2004).

[18] Thorpe uses the ten-year budget window of 2005-2014. However, any legislation to enact the Kerry health plan would be scored over the 2006-2015 budget window.

One obstacle to analyzing the cost of the Kerry health plan is the lack of detail and specificity in the plan. The Kerry health plan outlines the general scope and structure of proposals, but omits the exact method of implementation. Thus, each of the three analyses of the Kerry health plan varies to some degree on the plan itself. Each analysis must make its own assumptions about plan details, causing differences to arise in estimating the cost of the Kerry health plan. Both the American Enterprise Institute and the Lewin studies provide detailed descriptions of the plan they analyze, the assumptions they make and the methodology they use. One shortcoming with the Thorpe analysis is lack of clear documentation, making it difficult to asses the plan, methodology and assumptions he uses.

Cost Savings

A great deal of uncertainty exists over the magnitude of cost savings in the Kerry health plan. The American Enterprise Institute study estimates the offsetting provisions in Kerry's health plan would yield savings of $116 billion over ten years, while The Lewin Group places the figure much higher at $415 billion. The net ten-year costs according to these two studies are $1.5 trillion and $1.2 trillion, respectively. Thorpe's analysis puts cost savings at $299 billion, putting his nine-year net cost at $653 billion. Table 2 summarizes the different studies' estimates of the cost saving provisions in the Kerry health plan. As in Table 1 above, sizeable differences exist in the estimated savings of each provision.

Table 2. Cost Savings in the Kerry Health Plan, 2006-2015

	AEI	Lewin	Thorpe*
Disease Management	**	$22.3	$116.5
Information Technology	**	$8.8	$79.9
Addition Tax Revenue	NA	$238.0	NA
Disproportionate Share Payments	$100.2	$100.2	$88.0
Other	$16.2	$45.4	$14.4
Total	**$116.4**	**$414.7**	**$298.8**

All amounts in billions.
* Thorpe's estimates only cover nine years (2006-2014).
** Less than $100 million.
Source: Antos et al., Sheils and Haught, and Thorpe.

In addition to the cost saving measures specifically included in the health plan, the Kerry campaign has proposed raising taxes in order to finance the health plan. In particular, Senator Kerry would raise taxes on high-income taxpayers in help finance his health plan. However, those tax increases are often mentioned in the context of Senator Kerry's other tax and spending proposals.[19] An assessment of the net deficit impact of all of Senator Kerry's budgetary proposals should for these other proposals, an analysis beyond the scope of this paper.

One key discrepancy in the cost savings is that the Lewin analysis assumes that an extra $238 billion in tax revenue would result from employers passing on lower health care costs to workers in the form of higher taxable wages. Another major difference in the cost estimates relates to improved disease management and increased utilization of more efficient information technologies. The American Enterprise Institute estimates little or no savings from these

[19] Calvin Woodward, "Where Bush and Kerry Stand on the Issues," *Associated Press*, October 16, 2004.

proposals, while the Lewin study indicates ten-year savings of $31.2 billion. In sharp contrast, Thorpe argues for savings from disease management and information technology of $196 billion.

Another means of cost savings featured in the Kerry plan is to allow the reimportation of prescription drugs from foreign countries. The Kerry health plan would also restrict the use of patents on pharmaceuticals; encourage more favorable contracting by the government; and target pharmacy benefit managers for savings. Neither the American Enterprise Institute study nor Thorpe estimate any savings from such proposals and the Lewin study estimates savings of about $1 billion a year.

A significant portion of the savings in the Kerry health plan would come from spending cuts in Medicare and Medicaid. According to Thorpe's analysis, the Kerry health plan would reduce funding for Medicare Advantage plans, saving $14 billion by 2014. Additional spending reductions would come by lowering disproportionate share payments for Medicare and Medicaid. The Thorpe analysis puts the disproportionate share payments savings at $88 billion over nine years.

IV. Impact of the Kerry Health Plan

The Kerry health plan is broad in scope and would undoubtedly engender major changes in the U.S. health care system. While the details of the plan have yet to be fully articulated, several general impacts of the plan are apparent. This section analyzes the likely effects the Kerry health plan would have on the provision of health insurance in this country. Based on the elements of the plan thus proposed, the evidence supports several conclusions.

Impact 1: The Kerry Health Plan Would Greatly Expand the Government's Role in Health Care

The Kerry health plan represents a substantial expansion of the role of the federal government in providing and financing health care. According to the plan's goals, the cost of health insurance for millions of Americans would become the responsibility of the federal government. The plan also offers to pay for between 50 percent and 75 percent of the health insurance premium for millions of others who work at small businesses, are unemployed, or are approaching retirement (ages 55 to 64). Additionally, the Kerry health plan would drive employers into a health care system that is more taxpayer-funded and government-directed than is the current system.

Even seemingly innocuous proposals would extend the reach of government into new areas and could affect a great many families. For example, the proposal for expanded coverage of children would function "by automatically enrolling kids when they come to school, requiring continuous 12 months of eligibility."[20] Every family in America with school age kids would presumably be forced to enroll their kids in a government health program or provide proof of insurance or income. Although perhaps not a major imposition, such a requirement would add yet another layer of bureaucratic regulation on families. Likewise, employers would have to satisfy numerous requirements in order to participate in the new government programs. Even the

[20] John Kerry for President.

sensible goal of accelerated adoption of information technologies would be achieved through government mandate.

Impact 2: The Kerry Health Plan Would Move Health Care toward a Single-Payer System

The Kerry health plan would shift the U.S. health care system away from the private sector and toward a single-payer system. Today, health insurance is primarily provided through the private sector. Health insurance through an employer is the most common source of insurance. Government health insurance programs such as Medicare, Medicaid and the military currently provide coverage to approximately 27 percent of the population.[21]

The Kerry health plan claims that its health program would extend insurance to 27 million people.[22] Since the bulk of the proposals rely on government financing, the vast majority of those receiving health insurance from the Kerry health plan would do so at least partially at government expense.[23] In addition, the subsidies in the Kerry health plan would shift funding for millions of currently insured individuals to the federal government. If the Kerry health plan's projection of 27 million new insureds turns out to be accurate, the number of Americans directly dependent, to one degree or another, on the federal government for health care would exceed 100 million people, accounting for more than one in three Americans.[24]

Many additional individuals who are currently insured would be subsidized by the Kerry health plan. For the stop-loss program alone, both the American Enterprise Institute and Lewin studies estimate that approximately 80 percent of firms, covering 130 million people, would participate in the new program.[25] Similarly, the tax credit for purchase of non-group health insurance would affect 2.8 million currently-insured persons in 2006, according to the Lewin analysis.[26]

Not only would the Kerry health plan emphasize government funding for health coverage, but the plan would also diminish the role of private sector coverage. The expansion of Medicaid would crowd out private insurance. For example, some employers would discontinue or scale back their health benefit since their workers would be eligible for coverage under the Medicaid expansion in Kerry health plan. This effect would be most pronounced for firms that have a predominantly low-wage workforce.

The academic literature on the crowding-out effect strongly supports the contention that as the availability of government health care increases, there is a contraction in private health

[21] U.S. Census Bureau, 16.
[22] John Kerry for President.
[23] The Lewin analysis estimates that 86 percent of the newly insured would be covered by Medicaid. Sheils and Haught, 6.
[24] An estimated 76.8 million people received health coverage from the government in 2003. U.S. Census Bureau, 14.
[25] The American Enterprise Institute study estimates the participation rate at 77 percent, while the Lewin estimate is 83 percent. Antos et al., 24; and Sheils and Haught, 41.
[26] Sheils and Haught, 55.

coverage.[27] Multiple studies have estimated that the crowding-out effect could be as large as 50 percent.[28] In other words, for every two people who are added to Medicaid, one person loses private health insurance. Even the Thorpe analysis, which the Kerry health plan cites, concedes that public crowd out equals 30 percent of newly covered people.[29] Thus, the Kerry health plan's own projection of insuring 18 million people through the Medicaid/SCHIP expansion implies that approximately 5.4 million people would lose private coverage. The Lewin Group estimates that the crowding-out effect would result in 3.9 million currently-insured people losing their health insurance coverage.[30]

An increase in persons covered by government health programs, combined with a decrease in persons insured in the private sector, would represent a step toward a single-payer government health care system. The net impact of the various provisions of the Kerry health plan would be a greatly increased role for the federal government in financing health care.

Impact 3: The Kerry Health Plan Would Lead to Increased Homogenization in Health Care

A natural consequence of greater federal financing of and involvement in health insurance is increased uniformity in health care. Homogenization in health care means that consumers and patients would have fewer choices in terms of the type, cost and benefit levels of their health insurance coverage. Although a decrease in choices might not result immediately from a government expansion in health care, such an outcome would likely result in the long run.

Greater government involvement in health care often means fewer choices for the patient. This effect is already evident in the current Medicaid program, which the Kerry health plan seeks to greatly enlarge. Participants in Medicaid currently have limited choices in health care because many doctors choose, for a variety of reasons, not to participate in the program.[31] Also, patients in Medicaid do not get to choose the parameters of their coverage, as recipients must accept the benefit coverage set by the government. By comparison, a great many types of plans are available in the private sector, allowing each individual or family to choose the plan that best suits their budget and coverage requirements.

Even though the Kerry health plan professes to simply subsidize an expansion of employer-based coverage and the FEHBP, the promised benefits and savings come with strings

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[27] A survey of the literature on the subject concluded that "All of the studies find evidence of crowdout, although the magnitude of the crowdout varies." David M. Cutler, "Health Care and the Public Sector," National Bureau of Economic Research, Working Paper 8802 (February 2002), 77.

[28] Anthony T. LoSasso and Thomas C. Buchmueller, "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," National Bureau of Economic Research, Working Paper 9405 (December 2002); Lara Shore-Sheppard, Thomas C. Buchmueller and Gail A. Jensen, "Medicaid and Crowding Out of Private Insurance: A Re-examination Using Firm Level Data," *Journal of Health Economics* 19, no. 1 (January 2000): 61-91; and David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics* 111, no. 2 (May 1996): 391-430.

[29] E-mail correspondence from Thorpe, as cited in John C. Goodman and Devon M. Herrick, "The Case against John Kerry's Health Plan," National Center for Policy Analysis, Report No. 269 (September 2004), at note 10.

[30] Sheils and Haught, 43.

[31] Joel B. Finkelstein, "Low Pay Hurts Medicaid Access to Specialist," *AM News*, http://www.ama-assn.org/amednews/2004/07/26/gvl20726.htm, July 26, 2004. See also *infra* notes 69 and 71 and accompanying text.

attached. For instance, any employer that wishes to participate in the stop-loss program would be subject to requirements set forth by the federal government, such as providing "affordable coverage" to all employees.[32] Similarly, in order for large businesses to participate in the CHP, they would be required to "maintain the same employer-based contribution they currently offer."[33] Insurers who seek to offer coverage through the FEHBP would also be required to participate in the CHP, opening the door to bureaucratic or even political control. While there would not be a constriction of choices in the short term, long term cost pressures could threaten to transform government involvement into government control.

While expanding health insurance coverage may be a laudable goal, the danger of homogenization stems from the lack of effective restraints on health care spending. Because of this omission, future cost increases would be increasingly shouldered by the federal government (and ultimately, taxpayers). As the cost to the federal government rises, there would be a concomitant increase in the pressure to control costs. Indeed, government financing could be used to justify imposition of controls and limits on benefit levels. Future policymakers might attempt to rein in fiscal liabilities by imposing greater regulatory and administrative measures, limiting reimbursement rates for health care providers, and circumscribing benefit levels, all of which lead to fewer choices for consumers. In fact, a recent survey of state Medicaid programs found reliance on such measures to be commonplace.[34]

One implicit risk of the Kerry health plan is that increased single-payer financing would open the door to greater price controls in health care. Once the government becomes the primary financer of health coverage, it is a small step for the government to implement price controls. Since the Kerry health plan does not address the long-term causes of increased health care spending, future policymakers would be faced with ever-rising costs. Price controls would be one possible policy response. Even if policymakers refrain from explicit price controls, the mere presence of such a dominant payer could lead to monopsony-like *de facto* price controls. The government already exerts some influence over prices for health care through the reimbursement rates set in Medicare and Medicaid. Price controls would mean fewer health care choices for consumers, as hospitals and doctors would find it increasingly difficult to prescribe a unique treatment path for each individual patient.[35] Moreover, price controls would add inefficiency to the health care system by preventing prices from reaching a market-determined level, and could lead to shortages and rationing of health care.[36]

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[32] The Kerry health plan further states that participants must "guarantee such savings are used to reduce the cost of workers' premiums," yet does not provide any clarification of how this "guarantee" would be fulfilled. John Kerry for President.

[33] *Ibid*.

[34] Vernon Smith, Rekha Ramesh, Kathleen Gifford, Eileen Ellis, Robin Rudowitz and Molly O'Malley, "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005 – Results from a 50-State Survey," Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/medicaid/7190.cfm (October 2004).

[35] For a review, see Hugh Rockoff, "Price Controls," The Concise Encyclopedia of Economics, http://www.econlib.org/library/Enc/PriceControls.html [October 2004].

[36] Fiona M. Scott Morton, "The Problems of Price Controls," *Regulation* 24, no. 1 (Spring 2001): 50-54.

Impact 4: The Kerry Health Plan Would Exacerbate Existing Problems in Health Care

One of the problems in the current health care system is the persistence of waste, fraud and abuse. The Kerry health plan would greatly expand the number of people on Medicaid or SCHIP, by 18 million according to the Kerry campaign.[37] Any Medicaid expansion would also increase the amount of resources lost through fraud, waste and abuse. The General Accounting Office (now called the Government Accountability Office) has documented how the Medicaid program is susceptible to fraud and abuse.[38] In fiscal year 2002 alone, the federal government secured $1.8 billion in judgments, settlements and fines in fraud cases, a figure that just represents the fraud that was caught and legally prosecuted.[39]

The central vehicle to expand health coverage in the Kerry health plan is the expansion of Medicaid and SCHIP. Yet these programs already have limited effectiveness in reaching the targeted populations. Ironically, even as Kerry proposes to greatly expand SCHIP, total enrollment in that program actually declined in the second half of 2003, and many states have responded to fiscal pressures by implementing changes in eligibility requirements or benefits.[40] Likewise, the effectiveness of enlarging Medicaid is circumscribed by the fact that millions of persons are already eligible for Medicaid, yet do not participate. According to a 2004 report from the Kaiser Commission on Medicaid and the Uninsured, nearly half (46 percent) of all eligible adults without health insurance are not enrolled in Medicaid.[41] If Medicaid and SCHIP do not currently enroll all eligible persons, an expansion of these programs would seem to be a less than efficacious means of expanding health coverage.

The new stop-loss program comes with its own problems. The concern with the Kerry proposal for a stop-loss program is that it does nothing to fundamentally alter the real risk that occurs. Rather, the Kerry health plan tries to brush over the problem by shifting such costs onto the federal government. As such, the plan could actually exacerbate catastrophic claims costs. If the federal government simply pays for 75 percent of all such expenses, private markets have little reason to control costs. Patients and insurers would have few incentives to maximize efficiency, since every dollar saved in the management of catastrophic costs really only yields savings of 25 cents to the patient or insurer. Moreover, it is not difficult to imagine that this catastrophic threshold would become a target for some persons or insurers. Participants could choose to run up medical expenses above the threshold in order to take advantage of the 75 percent subsidy from the government.[42]

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[37] John Kerry for President.

[38] U.S. General Accounting Office, *Medicaid Fraud and Abuse: Stronger Action Needed to Remove Excluded Providers from Federal Health Programs* (Washington, DC: U.S. General Accounting Office, 1997).

[39] U.S. Department of Health and Human Services, Office of Inspector General, *Annual Report: State Medicaid Fraud Control Units, Fiscal Year 2002* (Washington, DC: Office of Inspector General, 2003), 18.

[40] Vernon K. Smith, David M. Rousseau and Molly O'Malley, "SCHIP Program Enrollment: December 2003 Update," Kaiser Commission on Medicaid and the Uninsured (July 2004).

[41] Amy Davidoff, Anna S. Sommers, Jennifer Lesko and Alshadye Yemane, "Medicaid and State-Funded Coverage for Adults: Estimates of Eligibility and Enrollment," Kaiser Commission on Medicaid and the Uninsured (April 2004).

[42] Such thresholds have been known to function this way. See, for example, Sarah S. Marter and Herbert I. Weisberg, "Medical Expenses and the Massachusetts Automobile Tort Reform Law: A First Review of 1989 Bodily Injury Liability Claims," *Journal of Insurance Regulation* 10, no. 4 (Summer 1992): 462-514.

V. Cost Containment in the Kerry Health Plan

One of the reasons health care has become unaffordable for some people is the long-term rise of health care costs. Over the last three decades, total expenditures on health care have grown at annual average real rate of 4.5 percent, reaching $1.6 trillion in 2002. Such spending has outpaced economic growth, climbing from 7.0 percent of gross domestic product in 1970 to 14.9 percent in 2002.[43] The Kerry health plan proposes an additional $1.6 trillion in new spending over the next ten years. Despite this new spending, the Kerry health plan proposes cost saving measures of debatable effectiveness, lacks a substantive response to medical liability costs, would exacerbate the third-party financing system, and would add new layers of administrative and compliance costs. This section examines these issues and evaluates the cost savings proposed in the Kerry health plan.

The Cost Savings Projected by the Kerry Health Plan May Not Fully Materialize

As noted above, the Kerry health plan proposes a number of measures to reduce health care costs. One proposal relates to improved disease management by insurers. Thorpe estimates that the disease management proposal would save $117 billion over nine years. By comparison, the American Enterprise Institute estimates little or no savings and the Lewin study indicates ten-year savings of just $22 billion. The available evidence does not support Thorpe's projection of large savings. In a comprehensive review of the potential savings from disease management, a recent Congressional Budget Office (CBO) study sheds some light on the debate:

> On the basis of its examination of peer-reviewed studies of disease management programs for congestive heart failure (CHF), coronary artery disease (CAD), and diabetes and the conclusions reached by other reviews of the relevant literature published in major medical journals, **CBO finds that to date there is insufficient evidence to conclude that disease management programs can generally reduce the overall cost of health care services.**[44] (emphasis added)

In fact, disease management programs could actually result in higher levels of health care spending. The premise of cost savings from disease management is that the cost of additional health services in the short run would be offset in the longer term by less spending on acute care. However, it is not clear that this trade-off makes economic sense. As CBO itself concluded, such "programs could even raise costs."[45]

Moreover, future savings from disease management are likely to be small for the obvious reason that private markets have already moved aggressively to implement such changes without government mandate. Even Medicaid programs have begun to put disease management

[43] Douglas Holtz-Eakin Congressional Budget Office, "Health Care Spending and the Uninsured," Prepared Testimony to the Committee on Health, Education, Labor, and Pensions, United States Senate (January 28, 2004).
[44] U.S. Congress, Congressional Budget Office, "An Analysis of the Literature on Disease Management Programs" (October 2004), 1.
[45] *Ibid*, 1.

programs in place.[46] A new program in disease management is unlikely to squeeze out any additional savings. The Lewin study summarizes the current situation:

> The available evidence indicates that much of the savings from disease management and advance billing systems already is occurring. One survey of health plans showed that 97% of all health plans have a disease management program for at least one health condition, and over half have disease management programs for four or more health conditions. … Thus, **most of these savings will occur over the next 10 years, regardless of whether either candidates' plans are implemented**.[47] (emphasis added)

The same facts undercut the claimed savings from accelerated adoption of advanced health information technology. While Thorpe estimates the IT proposal to save $80 billion, the American Enterprise Institute and The Lewin Group estimate ten-year savings of less than $100 million and $8.8 billion, respectively. The use of electronic billing and payment systems is already common and becoming more widespread. The IT mandates in the Kerry health plan would not seem to offer much additional savings beyond what is already in place or being implemented. The Lewin Group presents some statistics confirming the trend.

> Also, virtually all health plans have automated billing systems, and up to 80% of plans have automated remittance (i.e., provider payment and explanation of benefits) systems. Provider use of these systems also is growing at a rapid rate. Thus, most of these savings will occur over the next 10 years, regardless of whether either candidates' plans are implemented.[48]

A third area for savings in the Kerry health plan is prescription drugs. It is unlikely, however, that reimporting drugs from foreign countries would yield substantial savings. A 2004 report from the Congressional Budget Office found that such legislation would reduce total spending on prescription drugs by just 1 percent.[49] In addition, drug reimportation could result in adverse consequences for patients, such as fewer new drug introductions and counterfeit drugs. The potential for savings from the other drug provisions, such patent limitation and financial regulation, is uncertain.

One additional risk about the fiscal impact of the Kerry health plan relates to the Medicaid/SCHIP swap. Since the Kerry health plan promises 100 percent federal funding for all children in Medicaid, states would have an incentive to restructure their Medicaid programs in order to shift children out of SCHIP and into Medicaid. Although the Kerry plan does not explicitly address this point, such a maneuver could raise costs for the federal government.

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[46] Claudia Williams, "Medicaid Disease Management: Issues and Promises," Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/medicaid/7170.cfm (September 2004).
[47] Sheils and Haught, 14.
[48] *Ibid*.
[49] U.S. Congress, Congressional Budget Office, "Would Prescription Drug Importation Reduce U.S. Drug Spending?" (April 2004), 5.

The Kerry Health Plans Lacks Substantive Medical Liability Reform

The Kerry health plan does not include a serious medical liability reform proposal. To its credit, the Kerry health plan recognizes medical liability as a cost driver in health care, despite the omission of substantive reform. For example, the plan states that "improvements can and should be made to our medical liability system."[50] Unfortunately, the Kerry health plan's response to medical liability problems is watered-down and lacks the components necessary to effect meaningful results.

The Kerry health plan includes a requirement for a "qualified specialist" to affirm that the plaintiffs' claim is "reasonable."[51] Additionally, the Kerry health plan would mandate that states must make nonbinding mediation available, supports sanctions for "improper" cases, and favors more restrictive language for the award of punitive damages. These provisions would likely have little, if any, significant impact on medical liability costs. First, these proposals are all exceptionally vague. For instance, it is unclear what would constitute an "improper" claim. Second, 25 states already have some form of pre-trial screening process,[52] and these processes have not proven effective in reducing litigation. Third, these provisions are largely discretionary or interpretative in nature. That is, much of the Kerry health plan's medical liability reform consists of measures that are non-binding, suggesting that they would be ineffective as limitations on medical liability. Fourth, the proposal on punitive damages is virtually meaningless, as it simply restates the existing standard for punitive damages that exists in many cases.[53] The punitive damages proposal also misses the point, as the main source of rising liability costs is pain and suffering damage awards. Finally, the plan does not include a cap on pain and suffering damages, a policy that has proven effective in reducing liability costs. Overall, this tort reform proposal would likely not reduce the costs or other adverse effects of the medical liability system.

The high and increasing cost of medical liability insurance is a "crisis" in 20 states, while serious problems afflict another 24 states.[54] The consequences of these problems are widespread, affecting both the availability and cost of health care.[55] In terms of availability, anecdotal evidence repeatedly appears indicating that high medical liability premiums are forcing limitation and outright reductions in availability. In Las Vegas, Nevada, for instance, the state's only Level 1 trauma center was forced to close for 10 days due to the inability of emergency room doctors to obtain liability insurance.[56] Trauma centers around the country have

[50] John Kerry for President.
[51] *Ibid*.
[52] State law summaries available from American Tort Reform Association, "State Laws on Medical Liability," http://www.atra.org/show/7338 [October 2004]; and McCullough, Campbell & Lane, "Summary of Medical Malpractice Law," http://www.mcandl.com/states.html [October 2004].
[53] For general information on punitive damages, see Dan B. Dobbs, *The Law of Torts* (St. Paul, MN: West Group, 2000), 1062-1066.
[54] American Medical Association, "Medical Liability Crisis Map," http://www.ama-assn.org/ama/noindex/category/11871.html [October 11, 2004].
[55] For a review of these issues, see U.S. Congress, Joint Economic Committee, *Liability for Medical Malpractice: Issues and Evidence*, by Dan Miller (May 2003).
[56] Tony Batt, "UMC Official Says Crisis Is far from Over," *Las Vegas Review-Journal*, October 12, 2002.

also closed or been threatened with closure due to high malpractice rates.[57] The obstetrics field has been particularly hard hit, with many doctors simply unable to afford the liability coverage needed to deliver babies.[58] The American College of Obstetricians and Gynecologists has reported that 14 percent of its membership has stopped practicing obstetrics due to liability issues.[59]

In terms of the cost of health care, medical liability insurance impacts health care costs in two ways. The direct impact of such costs is the high cost of medical liability insurance. With premiums frequently exceeding $100,000 per year per physician, some of these costs are passed on to consumers. Nationally, malpractice costs totaled $24.6 billion in 2002.[60] Not only are such costs high, but they are increasing rapidly, with a 44 percent rise over the last five years (1998-2002). In some parts of the country, premiums are growing at annual rates of 20 percent to 40 percent.[61] The indirect costs of medical liability are much larger. These indirect costs manifest as defensive medicine, defined as treatment decisions motivated to avoid litigation rather than to benefit the patient. Surveys of doctors reveal that two-thirds to three-quarters admit to practicing defensive medicine.[62] This survey evidence is corroborated by numerous studies documenting the existence and cost of defensive medicine.[63] One study by Stanford University researchers found that defensive medicine accounted for 5 percent to 9 percent of health care expenditures.[64]

The available evidence and research on medical liability reform strongly supports the contention that effective reform includes caps on pain and suffering damage awards. Perhaps the

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[57] See Jeff Miller, "Rendell: Jury Award Caps Fall Short," *Morning Call* (Allentown, PA), February 11, 2003; Margaret Ann Mille, "Manatee Doctors, Nurses Rally for Cap on Malpractice Suits," *Sarasota Herald-Tribune*, March 1, 2003; and Frances X. Clines, "Insurance-Squeezed Doctors Folding Tents in West Virginia," *New York Times*, June 13, 2002.

[58] See, for example, OB/GYN Crisis Coalition, "Survey Reveals Women's Healthcare in Illinois in Major Crisis," http://www.obgyncrisis.org/ (April 14, 2004); Roger A. Rosenblatt et al., "Tort Reform and the Obstetrics Crisis: The Case of the WAMI States: Washington, Alaska, Montana, and Idaho," *Western Journal of Medicine* 154, no. 6 (June 1991): 693-699; and Daniel Yee, "Study: Insurance Rates Affect Ga. Care," *The Washington Post*, January 26, 2003.

[59] American College of Obstetricians and Gynecologists, "Medical Liability Survey Reaffirms More Ob-Gyns Are Quitting Obstetrics," ACOG News Release, July 16, 2004.

[60] Tillinghast-Towers Perrin, *U.S. Tort Costs: 2003 Update* (New York, NY: Tillinghast-Towers Perrin, 2003), 13.

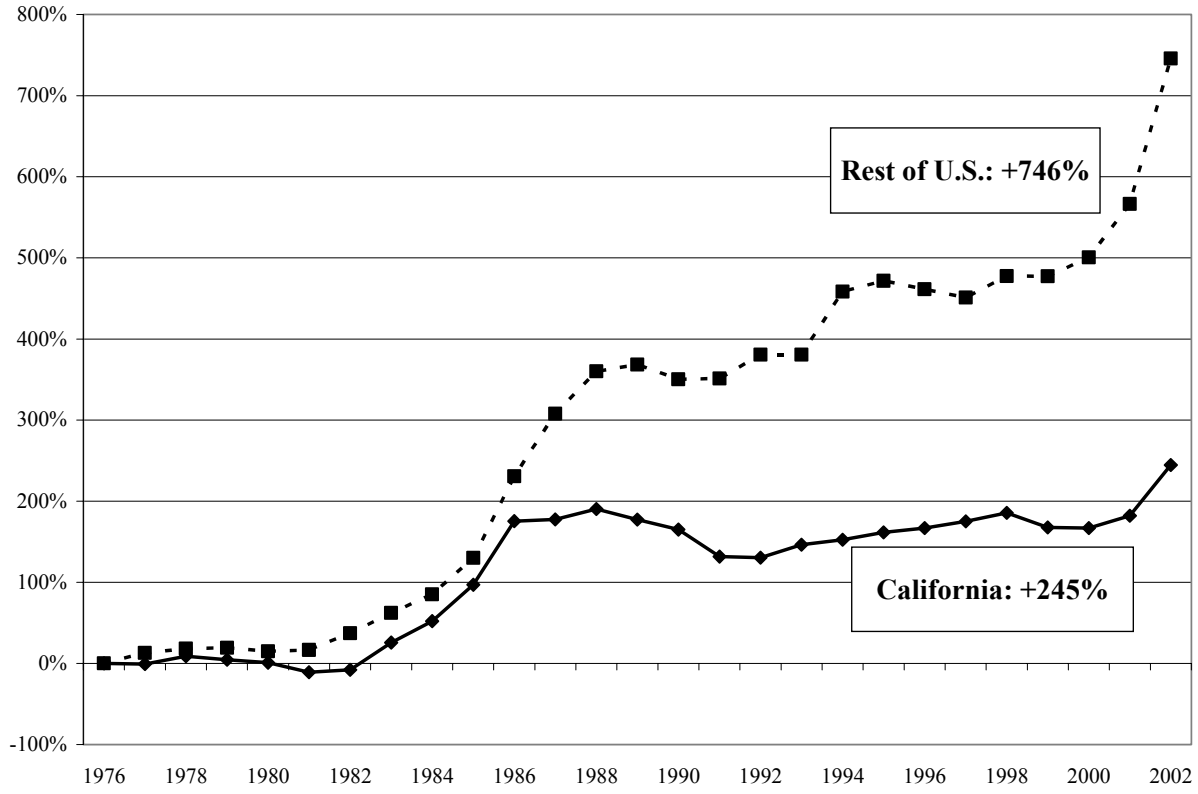
[61] Sarah Dore, "2003 Rate Survey Shows Rates Still on the Rise, Underwriting Tougher, No End in Sight," *Medical Liability Monitor* (October 2003).

[62] See *Medical Economics*, "Once Burned, Twice Defensive," v. 76, no. 14 (July 26, 1999); Humphrey Taylor, "Most Doctors Report Fear of Malpractice Liability Has Harmed Their Ability to Provide Quality Care," The Harris Poll #22 (May 8, 2002); and Berkeley Rice, "Medical Errors: Is Honesty Ever Optional," *Medical Economics* 79, no. 19 (October 11, 2002).

[63] Robert J. Rubin and Daniel N. Mendelson, "How Much Does Defensive Medicine Cost?" *Journal of American Health Policy* (July/August 1994): 7-15; A. Russell Localio et al., "Relationship between Malpractice Claims and Cesarean Delivery," *Journal of the American Medical Association* 269, no. 3 (January 20, 1993): 366-273; U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H-602 (Washington, DC: Government Printing Office, 1994); Daniel P. Kessler and Mark B. McClellan, "Medical Liability, Managed Care, and Defensive Medicine," National Bureau of Economic Research, Working Paper 7537 (February 2000); and Lisa Dubay, Robert Kaestner and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics* 18 (1999): 491-522.

[64] Daniel P. Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" National Bureau of Economic Analysis Working Paper 5466 (February 1996), 2.

Figure 2. Effect of Medical Liability Reform on Premiums in California



Source: National Association of Insurance Commissioners.

clearest example of this fact is California's experience with medical liability reform. In the early 1970s, California suffered from rapidly escalating malpractice premiums that affected the cost and availability of care in the state. In response, California adopted the Medical Injury Compensation Reform Act (MICRA) in 1975. MICRA contained several provisions, including a $250,000 cap on non-economic damages. The effects of the reform are evident in Figure 2. Over the period 1976-2002, medical malpractice premiums in California increased by 245 percent, while premiums for the rest of the nation rose by 746 percent.[65]

Statistical analyses confirm the finding that limits on pain and suffering awards are a crucial component of medical liability reform.[66] Different studies on medical liability reform

[65] Author's calculations using data on direct premiums from National Association of Insurance Commissioners, *Report on Profitability by Line and by State* (Kansas City, MO: National Association of Insurance Commissioners, various years).

[66] See W. Kip Viscusi and Patricia H. Born, "Damages Caps, Insurability, and the Performance of Medical Malpractice Insurance," Harvard Law School, John M. Olin Center for Law, Economics, and Business, Discussion Paper 467 (March 2004); Patricia M. Danzon, *New Evidence on the Frequency and Severity of Medical Malpractice Claims* (Santa Monica, CA: RAND Institute for Civil Justice, 1986); Kenneth E. Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms," *Health Affairs* (January 21, 2004); American Academy of Actuaries, *Medical Malpractice Tort Reform: Lessons from the States* (Washington, DC: American Academy of Actuaries, 1996); U.S. General Accounting Office, *Medical Malpractice: Implications of Rising*

reach different conclusions regarding other components of reform (such as those dealing with collateral sources offset, lawyers' fees and punitive damages). However, all the studies cited here affirm the importance of caps on pain and suffering as an effective means to reduce medical liability costs.

The omission of substantive medical liability reform means that the Kerry health plan fails to seriously address one of the most important deficiencies in the health care system. Under the Kerry health plan, the problems in medical liability would continue to drive up the costs of and reduce the availability of health care.

The Kerry Health Plan Would Reinforce the Third-Party Financing of Health Care

An important driver of health care costs is the third-party system of paying for health care, in which a third party (such as the government or an employer) pays a significant portion of health care costs. The consumer, in contrast, bears only a portion of health care expenses and therefore lacks incentives to spend health care money wisely or efficiently. The third-party financing system is widely regarded as a key cause of the long-term increase in health care spending.[67]

In fact, the Kerry health plan would exacerbate the existing problems associated with the third-party payer system. Medicaid and SCHIP, which the Kerry health plan would greatly expand, provide government-funded medical care. Similarly, the proposal for the federal government to pay for three-quarters of all costs over $30,000 would weaken private incentives for spending restraint in high-cost cases. The reason such proposals would accelerate cost increases is straightforward: when the payers of health care pay for one-quarter or less of the costs, there is a natural tendency to increase consumption. Ultimately, such incentives would lead to further increases in the cost to the federal government.

The Kerry Health Plan Would Increase Regulation and Impose Substantial Administrative Costs

The current health care system in the U.S. suffers from high levels of regulation and administrative costs. The Kerry health plan would add both new layers of regulation and impose additional administrative costs. Such costs result from requirements attached to the Medicaid expansion, the stop-loss program, the Congressional Health Plan and tax credits for businesses.

With respect to Medicaid, the Kerry health plan would automatically enroll kids in government health programs when they come to school. The plan would further require "12 months of eligibility" and promises to have "eligibility workers" at community health centers.[68] Such requirements obviously require some degree of government oversight to ensure compliance.

Premiums on Access to Health Care, GAO-03-836 (August, 2003), 30-34; and Kessler and McClellan, "Do Doctors Practice Defensive Medicine?"

[67] See Paul J. Feldstein, *Health Care Economics* (Albany, NY: Delmar Publishers, 1993), 91-105; U.S. Congress, Joint Economic Committee, *Medical Spending Growth and the Level of Insurance Coverage*, by Tom Miller (February 2004); and Edgar A. Peden and Mark S. Freeland, "A Historical Analysis of Medical Spending Growth, 1960-1993," *Health Affairs* 14, no. 2 (Summer 1995): 235-247.

[68] John Kerry for President.

More importantly, the regulatory and administrative burden on physicians who participate in Medicaid is already high, discouraging physician participation in Medicaid. The Kerry health plan would only increase that burden. A 2000 survey by the American Academy of Pediatricians found that "paperwork concerns" was the second most common reason that pediatricians cited for limiting participation in Medicaid, behind only low reimbursement rates.[69] Other reasons identified by pediatricians included unpredictable payments, payment delays and "Medicaid program too complex."[70] A report from the General Accounting Office found similar effects among dentists:

> Dentists also report that their dissatisfaction with the administrative requirements of state Medicaid programs keeps them from seeing more Medicaid patients. Research has found that dentists fault unique Medicaid claim forms and codes, difficulties with claims handling, preauthorization requirements, slow Medicaid payments, and what they consider to be arbitrary denials of submitted claims. They also cite complicated rules and eligibility-verification processes for patients and provider enrollment. One survey of New Mexico dentists found that about one in three dentists cited excessive paperwork and about one in five dentists cited slow payment as reasons for not accepting Medicaid patients.[71]

The federal stop-loss program also carries conditions for participation. First, businesses would have to offer health coverage to all their employees. In other words, participating businesses would face the administrative burden of proving to the federal government that 100 percent of their workforce has a health insurance benefit. Second, businesses would be required to "guarantee" that "they pass along savings to their employees."[72] The vagueness of the savings makes this condition difficult to prove. For example, if businesses simultaneously implement another cost saving measure or change the type of health coverage they offer, then it becomes extremely difficult to isolate the savings that result solely from the stop-loss program.

The Kerry health plan includes a proposal to accelerate the use of newer information technologies (IT) to reduce overhead and transaction costs. The implementation of more advanced IT is desirable and non-controversial. Not only can IT lower costs, it can improve health outcomes by reducing medical errors and ensure health care providers have the necessary information to diagnose and treat patients.

Although increased use of new IT is widely accepted as a positive development, there remains debate as to the best way to implement such changes. One option is to allow the private sector to determine the most efficient and effective means of adopting new IT. However, the Kerry health plan elects to mandate new technology standards on the private sector. The plan would "require private sector insurers to use advanced systems."[73] Historically, the private

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[69] Beth K. Yudkowsky, Suk-Fong S. Tang and Alicia M. Siston, "Pediatrician Participation in Medicaid/SCHIP: Survey of Fellows of the American Academy of Pediatrics, 2000," http://www.aap.org/statelegislation/med-schip/ped_part.htm (October 2000).
[70] *Ibid*.
[71] U.S. General Accounting Office, *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*, Report HEHS-00-149 (September 2000), 14.
[72] John Kerry for President.
[73] *Ibid*.

sector has been quick (and typically quicker than the federal government) to adopt new technologies. The federal government has also traditionally allowed the market to set new technology standards. It seems ill-advised, then, for the Kerry health plan to make the federal government the final arbiter of technology standards in health care. In fact, advances in IT generally occur so rapidly that the federal government is often unable to keep pace with the private sector. In light of that fact, relying on the federal government to set technology mandates and standards would likely result in slower, inflexible and suboptimal adoption of IT in health care. Firms would focus on satisfying government mandates and standards rather than adopting the most efficient and effective information technology.

A recent study by the Center for Regulatory Effectiveness examined the Kerry health plan to assess its regulatory impact on businesses. Although the Kerry health plan is largely vague about many of the details that would accompany actual legislation and reform, the CRE study estimated the regulatory mandates that would be required in order to implement the plan. The report concluded that the Kerry health plan "would, conservatively, impose at least 225 regulatory mandates on businesses that participated in the plan. These mandates would be in addition to the uncounted number of additional regulatory mandates inherent in other aspects of the [Kerry health plan.]."[74]

VI. Conclusion

Senator John Kerry has proposed a significant expansion of government-financed health care. Two separate, independent analyses estimate that gross new spending in the Kerry health plan totals $1.6 trillion over ten years. Estimated cost savings indicate that offsetting provisions are likely to be less than one-quarter that size. The Kerry health plan would greatly enlarge the government's role in the management and provision of health care. Not only does the plan diminish the role of the private sector by crowding out private sector insurance, but would add to the regulatory and administrative burdens of the current system. The ultimate result of the Kerry health plan would be fewer choices in health care and a significant shift toward a single-payer health care system.

Despite its substantial size, the Kerry health plan would fall short of truly universal coverage, as its own projections show that 18 million people would still lack health insurance. The Kerry health plan also fails to put forth substantive remedies for two of the key cost drivers in health care spending. The plan pays only nominal attention to medical liability reform and does not address the third-party financing of health care. On balance, the Kerry health plan proposes a remarkable expansion of government health care programs at tremendous cost to the taxpayer, with long-run consequences that undercut the ability of the private sector to provide coverage, adopt new innovations and control costs.

Dan Miller
Senior Economist

[74] Bruce Scott Levinson and Jim J. Tozi, "The Business-Specific Elements of the Proposed Kerry-Edwards Health Plan: Endangering Workers' Jobs And Benefits," Center for Regulatory Effectiveness (October 2004).

Appendix: The Number of Uninsured

A central question when discussing efforts to increase health insurance availability is determining the actual number of Americans that lack health insurance. The most widely-cited figure of uninsured individuals is the U.S. Census Bureau's Annual Social and Economic Survey (ASEC). According to ASEC data, 44.96 million persons were uninsured in 2003, representing 15.6 percent of the population.[75]

However, the validity of this estimate is subject to debate.[76] The Census Bureau itself recognizes that the ASEC data overstate the extent of the problem:

> Health insurance coverage is likely to be underreported on the CPS. While underreporting affects most, if not all, surveys, underreporting of health insurance coverage on the ASEC appears to be a larger problem than in other national surveys that ask about insurance.[77]

The most glaring shortcoming of the Census Bureau's data is the apparent failure to accurately count people in Medicaid. According to the government agency that runs Medicaid, that program provided health coverage to 53.3 million people in 2003.[78] However, the Census Bureau's ASEC data show only 35.6 million people covered by Medicaid, a difference of nearly 18 million people.[79] A discrepancy of this magnitude signals serious deficiencies in the Census Bureau's figures.

The Congressional Budget Office states flatly that the Census Bureau's "estimate overstates the number of people who are uninsured all year and more closely approximates the number who are uninsured at a point in time during the year."[80] A more accurate count of the year-round uninsured is between 22 percent and 48 percent lower than the Census Bureau estimate.[81]

In that 2003 report, the CBO further concluded that since 1998, "the number who are uninsured all year probably has not changed substantially, given historical trends. The uninsured population is fluid, with many people gaining and losing coverage."[82] In fact, the CBO estimates the duration of uninsured spells to vary significantly. The large majority (71 percent) of the people without insurance regain coverage within one year, with close to 45 percent of uninsured spells lasting four months or less.[83]

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[75] U.S. Census Bureau, 15.
[76] See Derek Hunter, "Counting the Uninsured: Why Congress Should Look beyond the Census Figures," Heritage Foundation, Web Memo #555, http://www.heritage.org/Research/HealthCare/wm555.cfm (August 2004).
[77] U.S. Census Bureau, 52.
[78] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Medicaid Enrollment and Beneficiaries; Selected Fiscal Years," http://www.cms.hhs.gov/researchers/pubs/datacompendium/2003/03pg34.pdf [October 2004].
[79] U.S. Census Bureau, 53.
[80] U.S. Congress, Congressional Budget Office, "How Many People Lack Health Insurance and For How Long?" (May 2003), vii.
[81] *Ibid*, 3.
[82] *Ibid*, 2.
[83] Percentages are for the nonelderly population. *Ibid*, 9.

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