

CURVES: THE RISE AND FALL OF A HEALTH CARE COVER STORY

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He used twenty-two pens to sign the Patient Protection and Affordable Care Act (PPACA)¹ into law.² On March 23, 2010, President Obama finally put the ink on the legislative drive that had stretched for more than a year, and had burned brightly in the imagination and dreams of Democrats since the demise of President Clinton's efforts in 1994.

The journey to the East Room signing ceremony had been long and hard. Not surprisingly, then, the ceremony itself seemed unusually festive. With the final pen stroke, he commented: "We are a nation that faces its challenges and accepts its responsibilities. We are a nation that does what is hard. What is necessary. What is right. Here, in this country, we shape our destiny."³

The rhetoric may have been tall, but the legislation was sweeping. Analysts would compare it in scope and importance to the mid-1960s creation of the Great Society programs of Medicare and Medicaid.⁴ In many ways, the legislation rivaled the creation of Social Security seventy-five years earlier.

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 25 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.) [hereinafter PPACA]. For ease of reference, PPACA as used here also includes amendments made to it by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

2. See Claire Suddath, *Why Did Obama Use So Many Pens to Sign the Health Care Bill?*, TIME (Mar. 23, 2010), <http://www.time.com/time/politics/article/0,8599,1974490,00.html>.

3. President Barack Obama, Remarks at the Signing of the Patient Protection and Affordable Care Act (Mar. 23, 2010), available at <http://www.whitehouse.gov/the-press-office/remarks-president-and-vice-president-signing-health-insurance-reform-bill>.

4. See, e.g., Jonathan Oberlander, *Long Time Coming: Why Health Reform Finally Passed*, 29 HEALTH AFF. 1112, 1112 (2010).

It was a political victory. It was also a policy victory with the goal of refurbishing a sixth of the national economy.⁵ And, in rhetoric and tone, it seemed at least partly a conservative victory. President Obama had not emphasized the plight of the uninsured in his many speeches and press conferences, as the Clintons had a decade and a half earlier. Rather, he focused on something more concrete: our pocketbooks. The President and his staff focused on the need to bend the curve of future health costs.

Today, a year later, the future of PPACA seems less clear. Republicans, after big wins in the 2010 midterm elections, promise to undermine implementation with defunding.⁶ Court challenges move forward.⁷ Some states balk at their role in implementation.⁸

More significantly, the core promise of fiscal restraint appears shattered. Even Democrats now have moved away from the rhetoric of deficit reduction and a slowing of health spending. What then to make of the original talking points? Do we need to bend the curve? What impact is PPACA likely to have? Is the Washington approach of subsidies, regulations, and a Medicare panel—an attempt to divorce health care from health—even the right one? In this Essay, I attempt to answer these questions. I also advise Republicans and moderate Democrats seeking an alternative that the best way to reduce future health costs

5. See *Health Care's Share of U.S. Economy Rose at Record Rate*, N.Y. TIMES PRESCRIPTIONS BLOG (Feb. 4, 2010, 12:05 AM), <http://prescriptions.blogs.nytimes.com/2010/02/04/us-health-care-spending-rose-at-record-rate-in-2009>.

6. See David M. Herszenhorn & Robert Pear, *House Votes for Repeal of Health Law in Symbolic Act*, N.Y. TIMES, Jan. 20, 2010, at A1.

7. See, e.g., *Fla. ex rel. Bondi v. U.S. Dep't of Health & Human Serv.*, No. 3:10-cv-91-RV/EMT, 2011 WL 285683, at *29 (N.D. Fla. Jan. 31, 2011) (holding individual mandate unconstitutional use of the Commerce Clause power); *Va. ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 782 (E.D. Va. 2010) (same); *Liberty Univ., Inc. v. Geithner*, No. 6:10-cv-00015-nkm, 2010 WL 4860299, at *14 (W.D. Va. Nov. 30, 2010) (“[T]here is a rational basis for Congress to conclude that individuals’ decisions about how and when to pay for health care are activities that in the aggregate substantially affect the interstate health care market.”); *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 893–94 (E.D. Mich. 2010) (holding same).

8. The most obvious evidence of state resistance was a lawsuit by twenty-six states seeking to declare some or all of the law unconstitutional. See *Fla. ex rel. Bondi*, 2011 WL 285683. On January 7, 2011, Republican governors from thirty-three states wrote to the President asking him to ease Medicaid provisions in the law. See William Selway, *Republican Governors Threaten to Leave Health Exchanges to U.S.*, BLOOMBERG (Feb. 7, 2011, 4:57 PM), <http://www.bloomberg.com/news/2011-01-07/republican-governors-ask-obama-to-allow-deeper-cuts-in-health-care-costs.html>.

will be to keep people out of the health care system in the first place.

I. BENDING THE CURVE

President Obama's message could not have been plainer. When he launched his campaign for sweeping health reforms, he put health care costs at the top of his list of priorities. In a February 2009 budget message, the Administration listed eight principles to guide reform. The first, second, and last principles directly addressed health care costs.⁹ On March 5, the President called rising health costs "the biggest threat to our nation's balance sheet."¹⁰ Later, in a summer press conference, President Obama said:

If we do not control . . . [health care] costs, we will not be able to control our deficit. If we do not reform health care, your premiums and out-of-pocket costs will continue to skyrocket. If we do not act, 14,000 Americans will continue to lose their health insurance every single day. These are the consequences of inaction. These are the stakes of the debate we're having right now.¹¹

Months later, in his September 2009 address to Congress, costs were still center-stage. The President referred to the cost of care eighteen times in his speech,¹² and when he spoke of health care outcomes, it was only in relation to the price paid to obtain those outcomes.

Throughout the health reform debate, the President's key health reform spokespersons maintained this fiscal focus. Few did it as consistently as the Administration's unlikely point man for the initiative, Peter Orszag. In his previous job as director of the Congressional Budget Office (CBO), Orszag personally crafted his own "bend the cost curve" message.¹³ As President

9. See *Obama-Care 101: The President's 8 Principles*, POLITICO (Feb. 26, 2009, 11:26 AM), <http://www.politico.com/news/stories/0209/19362.html>.

10. *At Summit, Obama Warns Health Care Costs Pose "Biggest Threat" to Economy*, FOX NEWS (Mar. 5, 2009), <http://www.foxnews.com/politics/2009/03/05/summit-obama-warns-health-care-costs-pose-biggest-threat-economy>.

11. President Barack Obama, Remarks at the Presidential News Conference (July 22, 2009), *available at* <http://www.whitehouse.gov/the-press-office/news-conference-president-july-22-2009>.

12. President Barack Obama, Remarks to a Joint Session of Congress on Health Care (Sept. 9, 2009), *available at* www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/.

13. For example, Orszag actually used the phrase "bending the cost curve" in reference to health spending in a CBO press conference in September 9, 2008 while Mr. Obama was still a senator and presidential candidate. Peter Orszag, Remarks at Congressional Budget Office News Conference (Sept.

Obama's budget director, Orszag often repeated his bold claim that "health care reform is deficit reduction."¹⁴

To make his austerity message stick, President Obama threatened to veto any health bill that did not reduce the ten year projected deficits¹⁵—a threat he never voiced to protect other stated goals of health reform, such as universal coverage or coverage for patients with pre-existing conditions.

Taken at face value, the President's goal was not to make America measurably healthier, or extend the average American life, or conquer a particular disease. Health reform was not about improving access to life-saving drugs as it is in Britain,¹⁶ or shortening wait times for care as Canadian reformers promise.¹⁷ Instead, it was a simple matter of price. Health care messaging fit snugly into the American wallet: insurance premiums, out-of-pocket costs, and deficits.

Historians and policymakers alike face a troubling question. In its final, 2010 incarnation, "ObamaCare" seemed to parody the business cliché that one must "spend money to make money." Americans were told they had to spend almost one trillion dollars more over the next ten years if they hoped to save less than two hundred billion dollars over the same period. It was the most unlikely formula for cost containment in American history.

9, 2008), available at <http://www.cbo.gov/ftpdocs/97xx/doc9706/transcript.htm>.

14. Ryan Lizza, *Can Peter Orszag Keep the President's Political Goals Economically Viable?*, NEW YORKER, May 4, 2009, at 50.

15. Throughout 2009, the threat was often phrased a threat "not to sign," as if it was a threat to use the pocket veto. For example, at a forum on July 23, 2009, at Shaker Heights, Ohio, the President said, "And that's why I pledged that I will not sign health insurance reform—as badly as I think it's necessary, I won't sign it if that reform adds even one dime to our deficit over the next decade . . ." President Barack Obama, Remarks at Shaker Heights Town Hall Meeting (July 23, 2009), available at http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-at-Health-Care-Reform-Town-Hall.

16. The first and only significant proposal to change the British health care system in the general election of 2010 was on the first day of the campaign, when Conservative leader David Cameron called for an expansion in the National Health Service funding for orphan drugs to treat rare disorders.

17. See *First Minister's Meeting of the Future of Health Care 2004*, HEALTH CAN. (Sept. 16, 2004), <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php> (explaining that Canada's last Liberal government focused resources on "timely access to care" in the 2004 First Minister's Meeting); Paul Wells, *Political Promises: Martin Says His Promises Beat Harper's. Problem is No One Believes Any Politician Will Actually Deliver*, MACLEANS (Jan. 11, 2006), http://www.macleans.ca/article.jsp?content=20060116_119667_119667 (reinforcing the consensus by stating that both major political parties promised wait times guarantees during the 2006 election).

Was this emphasis on deficits, taxes, and fiscal benefits sincere? Or was it simply a tactical attempt to sugarcoat new public health entitlements in the face of rising deficits and a national recession?

II. THERE IS A CURVE

Whatever the Administration's true motives, the rising cost of American health care is a legitimate cause for alarm.

The pressure on taxpayers is cause enough to act: Medicare and Medicaid costs have consistently outpaced estimates for their entire history.¹⁸ Taken together, federal health programs edged out Social Security and Defense in 2010 to become the single largest spending category in the federal budget.¹⁹ In 2009, the public sector's share of health costs grew disproportionately higher as America's unemployment rate forced millions to abandon employer-based coverage. Refugees from the private system now rely on transitional "COBRA" subsidies or Medicaid programs instead—if they are eligible for either.²⁰ As a result, America's public health costs exceed private care expenditures; the system is more than half socialized.

The President also sought to lower cost inflation for private insurance plans—with a good reason: premium increases for workers and employers outpaced core inflation for almost two decades.²¹ Rising premiums repeatedly cancelled out the benefits of higher worker productivity in the American economy. For example, in 2009, private sector health costs grew 4.4%, but

18. Then-Senator Sam Brownback (R-Kansas, now the State's governor) released a good—if partisan—summary of historic estimates prepared by minority staff of the Joint Economic Committee in June 2009. See SAM BROWNBACK, JOINT ECON. COMM., ARE HEALTH CARE REFORM COST ESTIMATES RELIABLE? (2009), available at http://jec.senate.gov/republicans/public/?a=Files.Serve&File_id=5802c84c-e821-4ab3-baeb-793f3ae2e036.

19. See FIN. MGMT. SERV., CITIZEN'S GUIDE TO THE 2010 FINANCIAL REPORT OF THE UNITED STATES GOVERNMENT 40 (2010), <http://www.fms.treas.gov/frsummary/frsummary2010.pdf>.

20. The Consolidated Omnibus Budget Reconciliation Act of 1986 created a transitional health insurance regime for unemployed workers. Aon Consulting tracked the increased use of COBRA coverage through the recession in its annual benefits study. See Press Release, Aon Consulting, Unemployed See COBRA Costs Increase in 2010, While Current Workers Brace for More Health Care Cost Shifting in 2011 (Aug. 25, 2010), available at <http://aon.mediaroom.com/index.php?s=43&item=1998>.

21. See John Commins, *Healthcare Costs Soar Above Overall Inflation*, HEALTH LEADERS MEDIA (Oct. 22, 2010), <http://www.healthleadersmedia.com/content/FIN-258088/Healthcare-Costs-Soar-Well-Above-Overall-Inflation>.

wages grew only 1.5%.²² While careless regulation is partly to blame (in the form of state mandates requiring Cadillac coverage²³), patients and consumers only see the costs, not the causes.

President Obama's "cost curve" is certainly worth fearing. But did his tough talk on cost control survive the legislative process?

Almost a year after PPACA became law, "bending the cost curve" seems more a matter of optics than policy. Americans will soon depend on—and pay for—a complex new system of insurance subsidy entitlements. Yet there is no guarantee they will see any relief from higher health-care costs.

III. TWISTING THE CURVE

How would Americans judge the President's success in "bending the curve?" Throughout the 2009–2010 debate, Democrats relied on estimates from the non-partisan CBO to demonstrate each proposal's fiscal probity. The CBO's scoring of each legislative proposal took on an almost divine quality, as supporters and reporters floated CBO estimates as fact without regard for uncertainties, risks, or nuances. To ensure estimates were as positive as possible, legislative drafters carefully crafted certain policies to avoid triggering unfavorable CBO rules.

In the short term, the CBO's scoring served as the crutch the Administration clearly hoped it could be. Every financial adjustment in the eight-month debate left new subsidies and entitlements intact, while incrementally maintaining a modest savings projection in keeping with the President's core message of net restraint.

22. See *Wage and Benefits Grow Slower Than Inflation*, WALL ST. JOURNAL REAL TIME ECONS. (Jan. 29, 2010, 1:32 PM), <http://blogs.wsj.com/economics/2010/01/29/wage-and-benefits-grow-slower-than-inflation>.

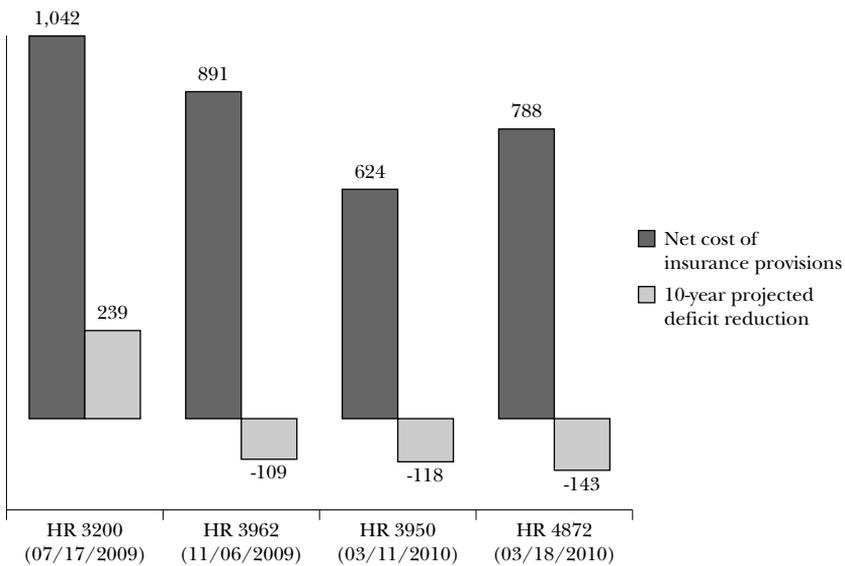
23. See, e.g., David Grutzer, *Regulation, Not Size, Is Health Care's Biggest Problem*, WASH. EXAMINER (July 22, 2009), <http://washingtonexaminer.com/op-eds/2009/07/manhattan-moment-regulation-not-size-health-cares-biggest-problem>; David Grutzer, *Less Is More: In Maryland, Deregulation Is the Bold New Idea*, NAT'L REVIEW ONLINE (May 27, 2004), <http://www.nationalreview.com/articles/210818/less-more/david-grutzer>.

CBO SCORING OF SELECTED HEALTH CARE REFORM PLANS,
2009–2010

	HR 3200 (07/17/09)	HR 3962 (11/06/09)	HR 3590 (03/11/10)	HR 4872 (03/18/10)
Net impact of insurance provisions only	1042	891	624	788
10 year deficit reduction estimate	239	-109	-118	-143

(Figures in billions of dollars, 10 year projections; costs included are insurance-only)

CBO SCORING, SELECTED HEALTH CARE PLANS
(IN BILLIONS)



However, supporters used these estimates with total disregard for the President’s stated objectives. For example, the final enabling legislation was scored as “saving” \$143 billion, as noted in the above table. But the reconciliation bill included unrelated provisions to save billions from the federal student loan program, so attributing \$143 billion in savings to the health plan was mis-

leading.²⁴ In fact, the PPACA'S "health-only" provisions scored just \$124 billion in net projected savings by 2019.²⁵

If that result seems promising, consider a few of the warnings the CBO added to its estimates throughout the debate:

- Despite projected savings within both ten and twenty-year windows, "[t]hose estimates are all subject to substantial uncertainty."²⁶
- Reviewing the proposed new Community Living insurance plan, "[t]hese estimated effects of the CLASS proposals are subject to considerable uncertainty The CLASS program could be subject to considerable financial risk in the future if it were unable to attract a sufficiently healthy group of enrollees."²⁷
- Assumptions of longer term deficit benefits after the tenth year "reflect an assumption that the provisions of the reconciliation proposal and H.R. 3590 are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation."²⁸

If projecting taxpayer costs for 2,000 plus pages of legislation was not trouble enough, the CBO was also told to project the impact of health reform on private insurance prices across America. In December 2009, the CBO answered with a study suggesting that while prices should drop for many Americans, new mandates in the bill should also add costs for over 32 million Americans covered by individual insurance plans.²⁹ Planned subsidies would assist *just over* half of those affected.³⁰

To counter fears that private insurance costs might rise after health care reform, in February 2010, White House officials insisted their final legislative plan would authorize the federal

24. CONG. BUDGET OFFICE, SELECTED CBO PUBLICATIONS RELATED TO HEALTH CARE LEGISLATION, 2009–2010 (2010), <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>.

25. *Id.*

26. Letter from Douglas Elmendorf, Director, Cong. Budget Office, to John D. Dingell, U.S. House of Representatives (Nov. 6, 2009), *available at* http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf.

27. Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Tom Harkin, Chairman, Comm. on Health, Educ., Labors, & Pensions, U. S. Senate, (Nov. 25, 2009), *available at* http://www.cbo.gov/ftpdocs/108xx/doc10823/CLASS_Additional_Information_Harkin_Letter.pdf.

28. Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Nancy Pelosi, Speaker of the House, U.S. House of Representatives (Mar. 20, 2010), *available at* <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

29. CONG. BUDGET OFFICE, *supra* note 24, at 197–98.

30. *Id.*

government to regulate insurance premium increases directly. The proposal received major media play.³¹ But the tabled plan merely created an advisory role for the federal government, as many states already regulate insurance prices.³²

Despite these caveats and setbacks, PPACA supporters still insisted the bill was about cost containment above all else. For example, in an interview with PBS' Charlie Rose on February 24, Orszag stuck doggedly to his view that the savings measures were transformative. Rose asked whether "the goal always has been coverage, or cost containment?"³³ In reply, Orszag maintained that improving insurance coverage was political cover for cuts to health care, and not the other way around. He said:

I think it is highly unlikely that we would have gotten anywhere nearly as much in Medicare savings were they not linked to other things that were desirable . . . [a]nd there's certainly no way that a Medicare commission would have been passed on the floor of the United States Senate . . . except if it was part of a comprehensive package.³⁴

It would be remarkable if Orszag actually believed the words he spoke. Roughly half of the plan's costs are funded with new taxes or other revenue measures.³⁵ Orszag's own proposal for a tough new Medicare Commission had already been gutted and its ten-year savings target set at a paltry \$15.5 billion.³⁶ Almost three-quarters of the final \$455 billion in Medicare savings targets were to come from crude—and easily reversed—cuts to Medicare fee-for-service payments.³⁷ The Administration had floated a "public option" to hold down private sector premiums through competition, but the idea was dropped.³⁸ The Presi-

31. Michael Shear & Dan Balz, *Obama Proposal Targets Insurance Rate Increases*, WASH. POST, Feb. 22, 2010, at M2.

32. GOV'T ACCOUNTING OFFICE, HEALTH INSURANCE REGULATION: VARYING STATE REQUIREMENTS AFFECT COST OF INSURANCE (1996), <http://www.gao.gov/archive/1996/he96161.pdf>.

33. *Charlie Rose* (PBS television broadcast Feb. 24, 2010), available at <http://www.charlierose.com/view/interview/10878> (comment available at the 9:28 mark).

34. *Id.* (comment available at the 10:25 mark).

35. CONG. BUDGET OFFICE, *supra* note 24, at 20–21.

36. See Roger Collier, *The Pitfalls of PPACA #5—The Effectiveness of IPAB—Maybe?*, HEALTHCARE FIN. NEWS (June 21, 2010), <http://www.healthcarefinance.com/blog/pitfalls-ppaca-5-effectiveness-ipab-maybe>.

37. CONG. BUDGET OFFICE, *supra* note 24, at 20.

38. Jordan Fabian, *Pelosi: Public Option Will Not Be in Health Bill Despite Liberal Efforts to Revive It*, THE HILL (Mar. 12, 2010, 6:00 PM), <http://thehill.com/blogs/blog-briefing-room/news/86447-pelosi-public-option-will-not-be-in-health-bill>.

dent's proposal for a competitive national insurance exchange was replaced with a far weaker plan for fifty separate state markets.³⁹

Effective July 30, 2010, Mr. Orszag left the White House—one of the first senior officials to do so after the Inauguration.⁴⁰ As he left, the cost containment story began to unravel.

In May 2010, the CBO reported that an additional \$115 billion would be needed to implement the bill.⁴¹ White House officials deflected the issue to Congress, challenging members to find other offsets.⁴²

Throughout 2009, Orszag and other Administration officials insisted that wasteful spending was rampant in American hospitals, and cutting that waste could easily pay for the President's plan. Administration officials held up a Dartmouth Institute study of American health care costs to "prove" their case on waste.⁴³ But in June 2010, the *New York Times* reported on widespread health sector criticisms of the report's comparative assumptions. For instance, while Administration officials used the study to claim Texas hospitals were inefficient, critics countered that the cost difference

between, say, Houston and Bismarck, N.D., may result less from how doctors work than from how patients live. Houstonians may simply be sicker and poorer than their Bismarck counterparts. Also, nurses in Houston tend to be

39. See Peter Grier, *Health Care Reform Bill 101: What's a Health 'Exchange'?*, CHRISTIAN SCI. MONITOR, Mar. 20, 2010, at 6.

40. See Richard Adams, *Peter Orszag to Resign: First Big Name to Quit Obama's White House*, THE GUARDIAN (June 22, 2010, 5:21 PM), <http://www.guardian.co.uk/world/richard-adams-blog/2010/jun/22/peter-orszag-resignation-obama-white-house>.

41. See Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Jerry Lewis, Comm. on Appropriations, U.S. House of Representatives (May 11, 2010), available at http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr_HR3590.pdf; see also Jake Tapper, *CBO: Health Care Bill Will Cost \$115 Billion More Than Previously Assessed*, ABC NEWS (May 12, 2010, 9:08 AM), <http://blogs.abcnews.com/politicalpunch/2010/05/cbo-health-care-bill-will-cost-115-billion-more-than-previously-assessed.html>.

42. Julian Pecquet, *Republicans Jump on New CBO Score to Blast Health Reform Bill*, THE HILL (May 11, 2010, 4:34 PM), <http://thehill.com/blogs/blog-briefing-room/news/97283-republicans-jump-on-new-cbo-score-to-blast-health-reform-bill> ("If these authorizations are funded, they must be offset somewhere else in the discretionary budget" (quoting Kenneth Baer, Office of Mgmt. & Budget, Remarks on Cong. Budget Office Report (May 11, 2010))).

43. Ryan Lizza described Orszag as "obsessed" with the Dartmouth findings. See Lizza, *supra* note 14.

paid more than those in North Dakota because the cost of living is higher in Houston.⁴⁴

The article noted that “[n]either patients’ health nor differences in prices are fully considered” in the study.⁴⁵

In a final blow in August, Trustees for America’s Medicare insurance funds released their 2010 report on the future of the program. They praised the PPACA for adding twelve years to the life of the Hospital Insurance Trust Fund, according to their own projections.⁴⁶ Cheerleaders for the plan claimed victory. The liberal Center on Budget and Policy Priorities found the report “clearly demonstrates that the Affordable Care Act . . . has greatly improved the financial status of the Medicare program.”⁴⁷

How clearly, exactly? The Trustees themselves noted “substantial uncertainty in the various projection factors.”⁴⁸ Worse, the Trustees’ own actuaries filed an alarming dissent, arguing the report understates how tenuous the savings claims are. Center for Medicare and Medicaid Services Chief Actuary Richard S. Foster wrote:

While the Part B projections in this report are reasonable in their portrayal of future costs under current law, they are not reasonable as an indication of actual future costs. Current law would require physician fee reductions totaling an estimated 30 percent over the next 3 years [to achieve the projected savings]—an implausible result.⁴⁹

With insight that seems to have escaped others in Washington, Foster described the trap facing Congress. Delivering on the promised fee-for-service cuts would push care providers out of public practice. The federal government would be forced to restore higher fees, wiping out projected savings. If they did not do so, Medicare’s capacity to deliver quality care would rapidly erode. Finally, echoing eighteen months of similar warnings,

44. Reed Abelson & Gardiner Harris, *Critics Question Study Cited in Health Debate*, N.Y. TIMES, June 3, 2010, at A1.

45. *Id.*

46. See THE BD. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, ANNUAL REPORT 25 (2010), <https://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf>.

47. PAUL N. VAN DE WATER, CTR. ON BUDGET & POLICY PRIORITIES, 2010 MEDICARE TRUSTEES’ REPORT SHOWS BENEFITS OF HEALTH REFORM AND NEED FOR ITS SUCCESSFUL IMPLEMENTATION (Aug. 16, 2010), <http://www.cbpp.org/files/8-16-10health2.pdf>.

48. THE BD. OF TRS., *supra* note 46, at 26.

49. *Id.* at 281.

Foster closed by noting that economic conditions were “unusually uncertain.”⁵⁰

The Obama White House has been uncharacteristically quiet in response. Just one year after the President told Congress that high health-care costs were a lethal threat to the national economy, the tight deficit reduction margins prescribed by his own plan have largely vanished.

Yet there has been no urgent presidential call to find new savings. The \$115 billion in new costs have been pushed aside for a future Congress to manage, despite the President’s pre-inaugural promise to stop “kicking the can down the road.”⁵¹ The Presidential threat to veto legislation if it failed to reduce the national deficit is long forgotten.

IV. IN WASHINGTON, THE CURVE BENDS YOU

In May 2010, CBO Director Douglas Elmendorf gave a post-partum presentation on health reform to the Institute of Medicine. Reviewing CBO data, Elmendorf felt the President’s plan should reduce “the growth rate of Medicare spending (per beneficiary, adjusting for overall inflation) from about 4 percent per year for the past two decades to about 2 percent per year for the next two decades,”⁵² assuming all targets are reached. Was this enough to “bend the curve?” Apparently not:

Rising health costs will put tremendous pressure on the federal budget during the next few decades and beyond. *In CBO’s judgment, the health legislation enacted earlier this year does not substantially diminish that pressure.*⁵³

In case listeners missed his point, Elmendorf concluded this way:

Putting the federal budget on a sustainable path would almost certainly require a significant reduction in the growth of federal health spending relative to current law (*including this year’s health legislation*).⁵⁴

So even if PPACA is law, the threat the President identified remains unaddressed.

50. *Id.* at 281–83.

51. For an example of the President’s fondness for the phrase, see *He Told Them So: A Conversation with David Walker, Deficit Hawk*, WASH. POST (Aug. 30, 2009), <http://www.washingtonpost.com/wp-dyn/content/article/2009/08/28/AR2009082802112.html>.

52. DOUGLAS W. ELMENDORF, CONG. BUDGET OFFICE, HEALTH COSTS AND THE FEDERAL BUDGET (2010), <http://www.cbo.gov/ftpdocs/115xx/doc11544/Presentation5-26-10.pdf>.

53. *Id.* (emphasis added).

54. *Id.* (emphasis added).

Congressional leaders faced elections at the end of 2010. Democrats appeared to abandon cost control claims in their own campaigns during the fall. Politico.com released a leaked presentation dated August 19.⁵⁵ The notes were purportedly written to help the President's supporters defend the reforms. Citing voter research, Lake Research and others advised Democrats to focus on one of the most popular—and one of the cheapest—provisions of the bill, offering coverage for Americans with pre-existing health conditions. The presentation explicitly advised PPACA supporters *not* to claim the “law will reduce costs and deficit [sic],”⁵⁶ a complete reversal from the President's own stated goals for reform.

Clearly, Democrats are eager to defend the plan rather than improve it. Democrat-sponsored changes are unlikely until at least 2014, when the key elements of the plan could be implemented. But if the plan is unaffordable, 2014 may be too late as families begin to rely on new entitlements. So the most likely agent of responsible change on the horizon is the Republican caucus in Congress, with strengthened numbers in the Senate and a majority in the House.

Can Republicans bend the curve? If prior history is a guide, the answer is likely “no.” After all, prior Republican caucuses also used cost-containment and optimistic CBO estimates as a cover story for new health entitlements—most notably in the creation of Medicare Part D.⁵⁷

In their search for an alternative plan, responsible policymakers should remember why the White House forwarded pocketbook arguments in the first place. Yes, there is a cost curve. True, the cost curve is consistent with cost inflation in other

55. Ben Smith, *New Dem Message: Improve Health Care, Don't Talk Cost*, POLITICO (Aug. 19, 2010, 4:36 PM), http://www.politico.com/blogs/bensmith/0810/The_new_message_Improve_health_care_dont_talk_cost.html.

56. *Id.*

57. *See generally* Letter from Douglas Holtz-Eakin, Director, Cong. Budget Office, to William M. Thomas, Chairman, Comm. on Ways & Means, U.S. House of Representatives (Nov. 20, 2003), *available at* <http://www.cbo.gov/ftpdocs/48xx/doc4808/11-20-MedicareLetter.pdf>. The CBO priced Medicare Part 'D' and related programs at approximately \$390 billion, including offsetting revenues. *Id.* However, that pricing reflected the CBO's mandate to cost the program over the next ten years, rather than the full ten-year cost of the program itself—masking costs deemed since to be almost three times higher. *See also* Bobby Scott says Republicans Created \$1 Trillion Prescription Drug Plan, RICHMOND TIMES-DISPATCH (Dec. 7, 2010), <http://politifact.com/virginia/statements/2010/dec/07/bobby-scott/bobby-scott-says-republicans-created-1-trillion-pr/> (noting that PPACA proponents used a similar approach to obtain favorable scoring by backloading costs and frontloading revenues in their bill).

countries,⁵⁸ but that does not change the fact that it poses a real threat to the United States—both to taxpayers and to families and employers in the private market. The fact that PPACA will not change that trend does not change the fact that the public sees rising health care costs as a legitimate target for public policy.

Whether critics of ObamaCare call their response “repeal” or not, an alternative approach should promote competition and cost reduction. It should offer federal help to states (or even market regions) to build truly competitive health insurance exchanges. It should attack the cost of basic private insurance by rolling back costly state mandates.

But most of all, true reformers can fight rising costs with a concerted effort to improve national health—attacking rising health care *demand* that is the root cause of the cost curve in the first place.

V. THE RIGHT CURVE

ObamaCare’s focus on insurance prices, costs, and subsidies is hardly unique. For half a century, American healthcare analysts have seen health care as an insurance problem, not a health problem. Regulations were written one after another and have only reinforced that bias; now one’s familiarity with insurance policy is the primary qualification for health policy expertise. To pick two recent examples: Mr. Orszag’s interest in health policy has been exclusively financial, and the Secretary of Health and Human Services, Kathleen Sebelius, served as a state insurance commissioner before her election as Governor of Kansas.⁵⁹

The result is that leaders from both parties fixate on budget measures, supplier penalties, rationing committees, and other micromanagement techniques to try to suppress a supply curve. But managing health supply has proven to be an impossible task.

Across the Western World, governments that broadened public insurance coverage or spent more public dollars on health care have faced the same dilemma: more supply only begets more demand, leading to health inflation increases in excess of core inflation.⁶⁰ Just as traffic planners insist wider highways sim-

58. See David Gratzer, ‘Cost’: Health Care’s Four-Letter Word, *FORBES* (Aug. 24, 2009, 2:45 PM), <http://www.forbes.com/2009/07/24/obama-administration-health-care-costs-opinions-contributors-david-gratzer.html>.

59. *Biography: Secretary Kathleen Sebelius*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/secretary/about/biography/index.html> (last visited Mar. 31, 2011).

60. See Gratzer, *supra* note 58.

ply attract more cars to fill them,⁶¹ growth in health insurance has only encouraged Westerners (especially Americans) to behave more recklessly and make full use of the new “sick care” benefits.

Why are health care consumers using so much more care? Because they can: only thirteen cents of every dollar Americans spend on care comes directly from individuals themselves, thanks to the subsidized structure of American public and private insurance models.⁶² That figure should drop further thanks to PPACA. As their direct share of costs drops, Americans have less of a direct financial stake in their own health outcomes. The insurance bias in American health care policy has literally created a culture of sick care dependency, redistributing the costs of unhealthy behavior to the healthy—even if the unhealthy behavior is *entirely* voluntary.

Tellingly, national data on health demand is still anecdotal at best. Yet even the arbitrary patchwork of studies on preventable disease costs paints a frightening fiscal (and physical) picture. Take just two examples of preventable disease: smoking and obesity.

The Centers for Disease Control and Prevention (CDC) estimates in 2004 placed the (rising) cost of smoking-related illnesses at \$98 billion, and the cost of treating second-hand smoking ailments at \$10 billion annually.⁶³ As obesity threatens to overtake smoking as America’s number one preventable killer, researchers have shifted focus to the fat epidemic. In 2009, a CDC study estimated that \$147 billion in national health expenditures were directly attributable to obesity—almost one in every ten dollars spent on health care.⁶⁴

Americans have a McVictim attitude toward preventable diseases, assuming that unacceptable social sacrifices are necessary to prevent them. Former FDA Commissioner Dr. David Kessler even claims unhealthy foods are now physiologically addictive, so

61. See, e.g., Kelly Thayer, *The Road More Traveled: Recent Studies Concur: New Roads Cause Congestion*, GREAT LAKES BULLETIN, Summer/Fall 1999, at 17.

62. See DAVID GRATZER, *THE CURE: HOW CAPITALISM CAN SAVE AMERICAN HEALTH CARE* 36–37 (2006) (in 2006, consumers’ out-of-pocket share was fourteen cents of every health care dollar; this reflects the updated figure.).

63. *Economic Facts About U.S. Tobacco Production and Use*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/tobacco/data_statistics/fact_sheets/economics/econ_facts/index.htm (last visited May 31, 2011).

64. Press Release, Ctrs. for Disease Control & Prevention, *Study Estimates Medical Cost of Obesity May Be as High as \$147 Billion Annually* (July 27, 2009), available at <http://www.cdc.gov/media/pressrel/2009/r090727.htm>.

much so that he began his recent book with a story about his inability to resist the temptations of a single cookie.⁶⁵

Yet simply turning back the clock a quarter-century to more traditional American diets and lifestyles could radically improve national (and personal) health outcomes, saving billions in the process. Suppose America slashed its rate of obesity-related illness by 20% in the next five years—a tough but hardly implausible goal. Achieve that, and America's care system could save \$30 billion or more annually, forever.⁶⁶ Or Congress could save \$20 billion annually simply by ending subsidies for unhealthy food ingredients.⁶⁷ *Either* step would save more in ten years than the best projected savings for ObamaCare.

Reforming insurance models to reduce demand has also shown promising results. Safeway, North America's third largest grocery chain, is leading the way, experimenting with incentivized health insurance. While critics dispute the actual figures, Safeway insists it has brought per capita health costs under control by creating incentives for wellness instead of simply redistributing the cost of poor health:

According to company statistics, the proportion of employees classified as obese declined by five percentage points, while the proportion who were overweight declined by one percentage point. Meanwhile, 40 percent of workers and spouses who failed the blood pressure test in 2008 passed in 2009, 30 percent of former smokers registered as tobacco-free, and 17 percent who failed the cholesterol test in 2008 passed in 2009.⁶⁸

Proposed new mandates in early PPACA drafts nearly outlawed this promising approach. Only an amendment co-sponsored by Senators John Ensign (R-Nev.) and Thomas Carper (D-Del.) kept the experiment legal.⁶⁹

65. DAVID A. KESSLER, *THE END OF OVEREATING: TAKING CONTROL OF THE INSATIABLE NORTH AMERICAN APPETITE* x–xi (2009). It was an orange-chocolate confection that pushed him over the edge. *Id.*

66. Or approximately one-fifth of the CDC's lowest recent estimate of the annual cost of obesity to the American health care system. See Ctrs. for Disease Control & Prevention Press Release, *supra* note 64.

67. For a detailed review of these programs and their historic annual costs, see *Harvesting Cash: A Yearlong Investigation* by *The Washington Post*, WASH. POST, <http://www.washingtonpost.com/wp-srv/nation/interactives/farmaid/> (last visited May 28, 2011) (showing that actual food subsidy totals vary annually because many are based on price-support systems).

68. David S. Hilzenrath, *Misleading Claims About Safeway Wellness Programs Shape Health-Care Bill*, WASH. POST, Jan. 17, 2010, at G1, G4.

69. Michelle Andrews, *If Your Waistline Grows, Should Your Premiums, Too?*, N.Y. TIMES PRESCRIPTIONS BLOG (Oct. 8, 2009, 3:23 PM), <http://prescriptions.>

In an ironic turn, the White House has a plan to attack health demand. However, as if to prove it to be an afterthought, the initiative is led by the East Wing, not the West Wing. Attacking health care *demand* is the First Lady's job, delivered through a program called "Let's Move"—a modest effort to improve inner city food choices and promote childhood exercise in cooperation with state governors.⁷⁰

Americans are spending too much for the health care outcomes they get. But if policymakers in Washington attacked the health curve instead of the health insurance curve, they would see that challenge in a different light. In the words of one of ObamaCare's liberal critics:

The only sure way to bend the curve and curb the rate of increase in health care costs is to keep people out of the sick care system, to put as much profit in prevention as there is in acute care, and to put financial gain and pain into how individuals take (or don't take) care of themselves.⁷¹

The speaker? Joseph Califano—who served as President Lyndon Johnson's domestic policy advisor during the introduction of Medicare. Later, Califano was President Jimmy Carter's Health, Education, and Welfare Secretary. He now serves as Chairman of the National Center on Addiction and Substance Abuse.⁷²

If one of the founding fathers of Medicare can reach those conclusions, it's time for those tinkering with Medicare to at least consider them. The lesson from the rise and fall of President Obama's cost curve cover story is that America must stop trying to bend the curve, and instead seek to prevent the curve outright.

blogs.nytimes.com/2009/10/08/if-your-waistline-grows-should-your-premiums-too/.

70. LET'S MOVE, <http://www.letsmove.gov/> (last visited May 31, 2011).

71. Joseph Califano, *Bending the Curve Requires Health Care Reform, Not Just Sick Care Reform: A History Lesson*, KAISER HEALTH NEWS (Aug. 10, 2009), <http://www.kaiserhealthnews.org/Columns/2009/August/081009Califano.aspx>.

72. *About the Chairman*, THE CHAIRMAN'S CORNER, http://chairman.scorner.casacolumbia.org/?page_id=7 (last visited May 31, 2011).

