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WHY AMERICA STILL NEEDS HEALTH CARE REFORM

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IN MARCH 2010, PRESIDENT OBAMA signed into law the Patient Protection and Affordable Care Act (PPACA), the nation's latest effort to reshape its health care industry. Under the new law, which critics often call "Obamacare," most Americans will be fined if they lack medical coverage with minimum standards set by government regulators, and many employers will be fined if they do not provide that coverage to employees working at least 30 hours a week. Lower- and some middle-income households and very small employers can receive federal subsidies to purchase coverage. Health insurers will be required to offer coverage to any eligible applicant regardless of medical condition and at capped premium prices. And in some states, income qualifications for Medicaid will be relaxed so that more households will receive benefits.

PPACA's supporters claim the new law will improve Americans' health while lowering medical prices and spending. Those are laudable goals. However, the legislation does little to solve most of the serious problems with the U.S. health care system, and it may worsen some of those problems. Despite PPACA's noble intentions, the need for health care reform is as pressing today as it was when the legislation became law.

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A PROBLEM-PLAGUED SYSTEM

Many of the problems with U.S. health care are well-known. Care and insurance prices are high and rising rapidly. Care providers and insurers seem inhospitable, inflexible, and inscrutable. Many medical procedures seem wasteful. And many Americans are uninsured or fear they will lose coverage when they most need it and incur heavy medical debt.

Other problems are not so well-known. Chief among them is the alarming frequency of iatrogenesis: injury or illness caused by medical providers. Iatrogenesis is one of the largest contributors to premature death in the United States. As many as 180,000 people die each year[1] following medical errors such as unnecessary surgeries,[2] adverse drug events,[3] and poor hygienic practices.[4] America's vigorous tort system is failing to combat those errors: relatively few instances of medical error result in a tort claim.[5] On the other hand, the majority of filed malpractice claims are found to have little merit.[6]

Still other health care problems are known but ignored. Medicare and Medicaid's fiscal woes are well-established: current tax and spending rates will underfund the programs by tens of trillions of dollars over the long term.[7] Yet few politicians and voters support policies that would make the programs solvent.

THIRD PARTIES

These diverse problems share a root cause: the weak economic connection between health care consumers and providers. That weakness reduces incentives and disincentives that should encourage providers to improve the quality and efficiency of care.

This connection is weak in part because people struggle with viewing health care in economic terms, and some refer to health care as a "right." Health care is a need according to this viewpoint, and no one wants a need to be constrained by scarcity and economic tradeoffs. But health care is produced from limited resources that are used to produce many other valued goods, and various medical goods are of greater or lesser benefit (and can even be harmful) in different circumstances. Therefore, health care should be approached economically to maximize the benefit from medical spending and avoid low-value, wasteful, and counterproductive consumption. Tradeoffs should be made between care and cost, and some of those tradeoffs can be difficult. The best people to decide those tradeoffs are the affected consumers and providers. Therefore, it is important to harness the virtuous incentives and disincentives that result from a strong economic relationship between consumers and providers.

Consumers pay out of pocket for less than 12 percent of U.S. health care spending,[8] while most of the rest is paid by government (45 percent), private employers and their insurers (21 percent), and other private insurers (11 percent).[9] Though consumers do ultimately fund those third parties through taxes (for Medicare), forgone wages (for employer-provided coverage), and insurance premiums, third-party involvement distorts the relationship between providers and consumers. Consumers have less incentive to demand that suppliers provide care efficiently and fewer disincentives to pursue costly treatments of questionable value.[10] At the same time, the third parties have economic incentives to skimp on financing consumers' health care, even if available treatments are worthwhile.

Those perverse incentives influence medical decisions in ways that produce suboptimal outcomes for consumers.[11] Consider two examples:

- Government is trying to control Medicare and Medicaid expenditures by limiting how much the programs pay to health care providers. As a result, many providers limit the number of Medicare and Medicaid beneficiaries they see, so the providers can devote more time to higher-paying customers with private insurance. This reduces Medicare and Medicaid beneficiaries' choice of providers—and likely harms provider quality.
- Insurers often require health care providers to provide extensive documentation showing that the care they provide is justified. As a result, providers devote considerable resources to processing insurance paperwork—resources that could be used to improve patients' care.

Documentation and spending controls are neither irrational nor nefarious. However, they place additional demands and limits on the health care system beyond the demands of patients.

Many conservative policy analysts claim that if these third-party distortions were reduced, health care prices would fall dramatically. As evidence, they point to health care services that usually are not covered by third parties. For instance, the inflation-adjusted price of LASIK eye surgery fell 27 percent between 1999 and 2010, yet LASIK has one of the highest customer satisfaction rates of any

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surgery.[12] Similarly, the inflation-adjusted price of laser skin resurfacing (a type of cosmetic surgery) fell 18.5 percent between 2003 and 2010 despite a large increase in demand for the procedure.[13]

The conservative analysts' expectation of lower medical prices may be overly optimistic, however. Health insurers and government both have strong incentives to hold down expenditures, and it is unclear how much success consumers would have in further reducing spending. However, it is likely that a stronger economic connection between health

care consumers and providers would increase the incentive for providers to offer the types and quality of care that consumers value highly, and reduce practices that consumers value less. That dynamic would significantly ease the problems with American health care.

PPACA AND HEALTH INSURANCE

Instead of strengthening the economic relationship between providers and consumers, PPACA expands the role of third parties by mandating health insurance coverage for most Americans and requiring more employers to provide that coverage. Some PPACA supporters claim this will yield a healthier America, but the evidence for that result is unconvincing, as explained in *Does Universal Coverage Make People Healthier?* (below). A more reasonable justification is that broader insurance coverage will reduce the number of Americans at risk of high medical debt as a result of a severe illness or injury. That is a worthwhile goal.

In theory, insurance would be a good tool for achieving that goal. Properly understood, insurance protects against low-probability, high-cost events. A person does not purchase insurance to, say, cover the routine costs of homeownership—e.g., utilities, lawn care, and routine maintenance—because the price of such insurance would be little different from the cost of paying for those expenses out of pocket. Rather, homeowners purchase insurance to cover the cost of low-probability, high-cost losses to their homes from fire, flooding, burglary, etc. Because the cost of such losses is large, homeowners are willing to pay a relatively small price—the insurance premium—in order to be protected.

For insurance companies, providing such coverage is largely an exercise in research and mathematics. They assess the risks that a customer ("insured") faces, the probability that those risks will be realized, and the cost of rectifying the potential loss. They then charge a premium that covers the risk-adjusted cost. For a very simple example, assume that all of the catastrophic risks my home faces sum to a one-in-1,000 chance that I will experience a $100,000 loss. My insurance premium should thus be $100. Insurance companies repeat this exercise for many insureds with similar risk profiles, creating large "risk pools" of similar insureds that diversify away those insureds' particular risks. In essence, insurance is the private socialization of the cost of catastrophic losses among a pool of insureds.

PPACA expands the role of third parties by mandating health insurance coverage for most Americans and requiring more employers to provide that coverage.

DOES UNIVERSAL COVERAGE MAKE PEOPLE HEALTHIER?

PPACA supporters often claim that the new law will improve Americans' health. If PPACA expands medical coverage, then, the reasoning goes, previously uninsured people will be more likely to access medical care and do so early-on when they are sick or injured, thus improving the likelihood and speed of their recovery.

However, social science has had difficulty demonstrating a statistical link between coverage and improved physical health.[19] In fact, earlier this year, a team of prominent policy researchers made national headlines when they publicly conceded that the latest attempt to reveal such a link had yielded disappointing results.

The research effort, known as the Oregon Health Insurance Experiment, resulted from that state's 2008 decision to expand its Medicaid coverage for low-income, non-elderly adults. When Oregon received far more applicants than it could finance, the state used a series of lotteries to select who could enroll. The random selection gave researchers an ideal opportunity to study the benefits of medical coverage: they followed the health and financial condition of lottery entrants and looked for differences between the winners and losers.

After two years, there appears to be little difference between the two groups' physical health.[20] Lottery winners did receive more care, were diagnosed with more illnesses, and consumed more medication, but there was no statistical difference between the groups' blood pressure, cholesterol level, or blood sugar level—health measures the researchers expected would respond to medical coverage over the two-year period. Likewise, there was no statistical difference between the groups' self-reported feeling of physical well-being, pain level, or sense of happiness.

How can that be? The explanation may lie in an oft-overlooked fact: people without medical coverage still receive medical care. Since 1996, the typical uninsured person below age 65 (the Medicare-eligible age) received only 30 percent less care (measured in dollars) than the typical under-65 person with public coverage like Medicaid or Medicare.[21] (It should be noted that the typical person with private coverage received twice as much care as the uninsured person.) Couple that fact with the common belief among health care experts that at least a third of the money spent on health care yields no health benefit, and the Oregon results begin to make sense. If the uninsured make more efficient use of their medical dollars, then it should not surprise us that their physical health is little different from people with Medicaid.

With that said, the Oregon experiment did show some important benefits from coverage. Lottery winners were significantly less likely to experience depression. They also were far less likely to be burdened with heavy medical debt. Better mental health and lower debt are good things, though they likely could be achieved without all the taxes, fees, fines, mandates, complexities, and unintended consequences of PPACA.

However, contemporary American medical coverage has two features that separate it from traditional insurance. First, medical coverage often covers routine, predictable, and small costs (e.g., doctor's visits, treatments for minor illnesses and injuries, preventive care) along with catastrophic losses. Second, for people under age 65, coverage is usually obtained through employers as part of the compensation given to workers. Those features seem virtuous, but they contribute to the problems with American health care that were described above. How did those features arise?

For much of U.S. history, health insurance did employ the traditional "low-probability/high-cost" insurance

WILL IPAB LOWER HEALTH CARE COSTS?

According to both proponents and critics of PPACA, one provision of the new law has the potential to significantly lower U.S. health care spending. The provision empowers a federal panel known as the Independent Payment Advisory Board (IPAB) to "recommend policies to Congress to help Medicare provide better care at lower costs."[22] Despite the word "recommend," IPAB plays a powerful role: it is supposed to review medical procedures covered by Medicare and judge whether those procedures are effective and worth the cost. IPAB will then "recommend" eliminating Medicare funding for procedures it decides do not meet these requirements. Congress can overrule the recommendations, but it will require a supermajority vote. IPAB's judgments will affect Medicare and are also expected to affect insurance coverage as insurers copy Medicare's decisions.

PPACA supporters say IPAB will eliminate many inefficient but costly medical procedures, which will reduce Medicare and health care spending. PPACA critics claim IPAB will ration medical care. Contrary to those opinions, IPAB will more likely have no effect on spending at all or perhaps even increase it. To understand why, consider the recent experience of a separate federal health care panel known as the U.S. Preventive Services Task Force.

In fall 2011, the task force released a much-anticipated report on prostate-specific antigen (PSA) screening, a common test for prostate cancer.[23] The report generated newspaper headlines and intense controversy because the task force recommended that men not undergo routine PSA testing. According to the task force, the benefits of such screening appear to be outweighed by unintended negative consequences.

The problem with PSA screening is not simply that it can give false results, though that happens, as with other medical tests. The problem is that PSA screening and follow-up biopsy typically cannot determine if a detected cancer is dangerous. The conventional wisdom is that all cancer is dangerous, but some cancer can be so slow-growing that the patient will live a long life and pass away peacefully before it becomes a problem. Cancer can even be non-growing, existing neutrally in the body like wisdom teeth. And in some cases the body's own defenses can kill off cancer.[24] The vast majority of prostate cancer appears to be non-dangerous. Over half of men above age 50 have prostate cancer, as do over 80 percent of men over age 70. Yet just 3 percent of men die from the disease.[25] The rest of those men likely would live out their lives never experiencing a cancer symptom or knowing they have the disease unless they have a PSA test.

Another problem with PSA screening is that early detection from the test seems to provide little benefit for men who do have an aggressive form of the cancer. Despite the rise of PSA testing, the frequency of prostate removal surgery and radiation therapy, and the emergence of exotic treatments like hormone therapy, the annual U.S. death rate from prostate cancer has declined only slightly from 30 per 100,000 men in 1975 to 25 per 100,000 in 2005.[26]

Thus PSA tests cannot distinguish non-malevolent cancers from malevolent ones and are of small benefit in fending off aggressive cancers. Still, the test might seem worthwhile to gain that small benefit. But prostate cancer treatment is risky, regardless of whether the cancer is aggressive. About half of men who undergo prostate-removal surgery experience sexual dysfunction; a third have urination problems; and between one and two in a thousand die as a result of iatrogenesis from the surgery and aftercare. Men who undergo radiation treatment also risk impotency and urinary problems (at lower rates than surgery) and 15 percent suffer radiation damage to the rectum, resulting in "moderate or big problems."[27]

For men who actually exhibit symptoms of dangerous prostate cancer, the benefits of treatment likely outweigh the risks and side effects. But for asymptomatic men, the task force believes the anxiety and risk from undergoing unnecessary treatment outweigh the benefits of PSA screening. A number of empirical studies appearing in prominent health care journals had previously indicated the same conclusion.

It would thus seem that routine PSA screening would be exactly the sort of medical procedure that IPAB would identify and recommend that Medicare not fund. But consider that, even before the task force released its findings, Congress and the White House adopted a law mandating that Medicare ignore the findings and cover PSA screening. That is, they *require* Medicare to fund a procedure that, in general, is harmful to men's health.

The task force had run afoul of Congress and the White House once before. In 2009, the task force announced that it did not recommend routine breast cancer mammography screening for seemingly healthy women under age 50.[28] (The task force does recommend screening for women over 50.) Its reasons were similar, though less severe, to its PSA reasoning: the benefit to women as a group seems not to outweigh the harm of false alarms and unnecessary treatment. Just like the PSA announcement, Congress and the White House mandated that, regardless of the task force's findings, government programs continue to provide screening for women in their 40s.[29] More recently, the Obama administration has issued PPACA regulations requiring health insurers to cover mammograms for women in their 40s, with no deductible.[30] In other words, the Obama administration mandates health care spending for a procedure that provides no general benefit to women's health.

Given Congress and the Obama administration's responses to the task force's recommendations on PSA screening and mammography, it seems highly unlikely that politicians would accept IPAB recommendations to eliminate funding for procedures that are publicly perceived as beneficial. Instead, just as the Obama administration has done with mammograms and PSA tests, politicians will likely issue laws, orders, and regulations to increase health care spending for such procedures. Thus, IPAB will likely prove to be a paper tiger.

model. "Mutual aid societies" (groups of people who jointly self-insured) and early insurance companies followed that model in the 19th and early 20th centuries. However, the development of modern medicine and changes to U.S. law fostered the emergence of today's employer-driven "comprehensive coverage" model. The Revenue Act of 1954 was the biggest contributor to that transformation, allowing employers to deduct payments for worker medical coverage from their business taxes but affirming that workers do not have to pay taxes on the benefit.[14] This contrasts with tax law for individuals who purchase health insurance, because they must use after-tax dollars to pay their premiums.

Likewise, individuals who purchase medical goods and services typically must use after-tax dollars, but health care goods and services received through employer-provided comprehensive care are ultimately funded with tax-exempt dollars. Because of those tax breaks, employer-provided comprehensive coverage became the most common form of health insurance in the United States in the latter part of the 20th century. This is the form of coverage that PPACA strives to expand.

But this type of coverage has several long-term problems. Among them:

- Such coverage is part of employee compensation, so people who lose their jobs risk losing their coverage.[15]
- Few workers stay with a single employer for their whole career. Therefore, employers purchase coverage that provides benefits for illnesses and injuries occurring only when the worker is employed. This coverage is a poor fit for people with long-term, later-developing, and pre-existing health problems.
- The market for individual and small-business coverage is limited because it is regulated by the individual states, unlike larger employers, whose insurance is regulated by the federal government. Different states have different, sometimes peculiar regulations governing how health insurance should operate and what benefits it should provide. As a result, state markets are often dominated by a few firms under tepid competition.
- Health care costs have risen dramatically in recent decades, and by extension so have employers' labor costs. This has caused financial troubles for employers and stagnant wages for workers, and in some cases has led to employers dropping coverage.[16]

To its credit, PPACA tries to address the individual/small-group and pre-existing condition problems. Concerning the former, each state is to have a streamlined insurance market, called an "exchange," that PPACA authors hope will be more inviting to insurers and thus more competitive. In addition, insurance offerings will be tailored around specific product designs established by the federal government, which PPACA supporters hope will make it easier for purchasers to comparison-shop. And PPACA includes a number of subsidies, incentives, and mandates intended to push consumers into the exchanges, which PPACA supporters hope will make them robust marketplaces.

PROBLEMS WITH PPACA

Those features of PPACA exchanges sound appealing. Yet the resulting health insurance market likely will not differ much from the existing one, and will suffer many of the same problems. Third parties will continue to have considerable influence over the provider-consumer relationship; indeed, that influence probably will intensify once most Americans are required to have coverage. As a result, the third-party distortions will continue to hinder health care quality and responsiveness to patient needs. PPACA supporters often counter that the legislation will lower health care spending, but as the sidebar *Will IPAB Lower Health Care Costs?* (page 4) explains, the new law will more likely increase spending while realizing few health benefits.

Beyond those long-existing problems with American health care, PPACA may create a new one. It establishes a powerful incentive for employers to curtail workers' hours in order to avoid the employer mandate for employees working at least 30 hours a week. In many cases, it will also be cheaper for employers to pay PPACA fines rather than provide coverage to full-time workers. And some workers would support employer decisions to drop coverage—provided the workers get a share of the money employers save from ending coverage. PPACA may even go so far as to tempt some uncovered workers to violate the individual mandate and not purchase coverage, while other formerly covered workers would then qualify for federal subsidies to purchase coverage, burdening the subsidy program.

Third-party distortions will continue to hinder health care quality and responsiveness to patient needs.

University of Missouri law professor Thom Lambert first described this problem,[17] which arises as follows: One of PPACA's most-praised features is its requirement that insurers cover all applicants regardless of their health, at premiums that are price-capped. For currently uninsured people with a costly medical condition, this provision is a godsend, because it helps them to purchase comprehensive health insurance at discounted prices. Unlike other members of the insurer's risk pool, these insureds have a 100 percent probability of experiencing a high-cost illness or injury. Under the standard insurance model, those insureds should be assessed a premium equal to their high risk-adjusted cost, but PPACA's price caps prohibit that. To finance the new high-cost insureds' care, healthy members of the risk pool will be charged premiums that are higher than their risk-adjusted cost—and thus higher than what they were paying for coverage before PPACA.[18]

As Lambert explains, the higher premiums will encourage some employers to drop their medical coverage. Even though they would then be fined under PPACA, there would often be a net savings from this decision. Workers would likely accept their employer's decision provided that the employer shares some of the savings with the workers—and the workers would likely be eligible for PPACA subsidies to purchase individual coverage on their state exchanges. Some of those workers might even be tempted to forgo individual coverage despite the PPACA fine.

A vicious circle would thus emerge: the higher premiums cause some employers and healthy people to drop their coverage, which would raise the average risk-adjusted cost of the remaining members of the insurance pool, resulting in still-higher premiums, causing more employers and healthy people to drop coverage, and so on. All the while PPACA's cost of providing subsidies to the uncovered will mount, and people who go uncovered will still receive emergency medical care that will ultimately be subsidized by others.

If Lambert is right, PPACA could result in higher insurance costs, less employer coverage, increased government spending on health care, and increased volatility in insurance status: the opposite of what the legislation's architects intended. It is questionable whether that represents an improvement over the longstanding uninsurance problem.

CONCLUSION

PPACA was written and enacted with the highest of intentions: to expand health care coverage, improve Americans' health, and lower medical costs. However, the legislation is poorly constructed. It does nothing to address iatrogenesis or improve Americans' health, and its attempts to reduce health care spending—including Medicare spending—appear likely to backfire. Further, the one problem PPACA does try to address—the high number of uninsured Americans—may ultimately worsen under the legislation as people and employers elect to drop coverage and insurers' risk pools become overwhelmed with high-cost insureds.

Despite its noble intentions, PPACA appears destined to be a colossal, costly, complex failure. America still needs health care reform.

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1 Robert W. Dubois and Robert H. Brook, "Preventable Deaths: Who, How Often, and Why?" *Annals of Internal Medicine*, 109(7): pp. 582-589, http://www.rand.org/pubs/reprints/RP133.html.
2 Barbara Starfield, "Is U.S. Health Care Really the Best in the World?" *JAMA* 284(4): pp. 483-485, http://jama.jamanetwork.com/article.aspx?articleid=192908.
3 David C. Classen, et al, "Adverse Drug Events in Hospitalized Patients: Excess Length of Stay, Extra Costs, and Attributable Mortality," *JAMA* 277(4): pp. 301-306, http://www.ncbi.nlm.nih.gov/pubmed/9002492.
4 R. Monina Klevens, et al., "Estimating Health Care–Associated Infections and Deaths in U.S. Hospitals, 2002," *Public Health Reports* 122(2): pp. 160-166, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1820440/.
5 David A. Hyman and Charles Silver, "Speak Not of Error," *Regulation* 28(1): pp. 52-57, http://www.cato.org/sites/cato.org/files/serials/files/regulation/2012/8/v28n1-1.pdf.
6 Thomas A. Firey, "The Right Diagnosis: Addressing Maryland's Medical Malpractice Problem," in *Health Care in Maryland: A Diagnosis*, ed. Alison Lake. Rockville, Md.: Maryland Public Policy Institute. 2005, http://www.mdpolicy.org/mppi_press/detail/health-care-in-maryland-a-diagnosis.
7 For an accounting of Medicare's woes, see the annual reports produced by the Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/TrusteesReports.html.
8 Centers for Medicare and Medicaid Services, "National Health Expenditure Data, 2010: Historical," Table 4, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.
9 Ibid, Table 5. Though government is the largest source of health care spending, private health insurance covers the majority of Americans. The difference between coverage and spending is the result of the high cost of end-of-life care, which is primarily covered by Medicare.
10 Robert H. Brook, Emmett B. Keeler, Kathleen N. Lohr, et al., "A Classic RAND Study Speaks to the Current Health Care Reform Debate," *RAND Research Brief* no. 914. Santa Monica, CA: RAND Corporation. 2006, http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf.
11 Though I use the term "consumer" to refer to recipients of health care services, it is unclear who the true health care consumer is when third parties are involved. It could be the care recipient, the insurer or the government agency that pays for the treatment, or the employer or taxpayers who provide the coverage. This ambiguity raises the question of whose demands health care providers are most intent on satisfying and how those demands affect the care received.
12 Matt Palumbo, "How the Free Market Can Cure Health Care," *American Thinker,* December 17, 2011, http://www.americanthinker.com/2011/12/how_the_free_market_can_cure_health_care.html.
13 Ibid.
14 Employee Benefits Research Institute, "History of Health Insurance Benefits." Washington, D.C.: EBRI. March 2002, http://www.ebri.org/publications/facts/index.cfm?fa=0302fact.
15 Under a federal law known as COBRA, a recently unemployed person can purchase coverage from his former employer for a period of time. However, COBRA is costly and is purchased with after-tax dollars. As a result, many financially strapped unemployed people choose to go uncovered.
16 Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," *Journal of Labor Economics* 24(3): pp. 609-634, http://www.nber.org/papers/w11160. See also Michael A. Morrissey and John Cawley, "Health Economists' Views of Health Policy," *Journal of Health Politics, Policy, and Law* 33(4): pp. 707-724, http://jhppl.dukejournals.org/content/33/4/707.full.pdf+html.
17 Thomas A. Lambert, "How the Supreme Court Doomed the ACA to Failure," *Regulation* 35(4): pp. 32-38, Winter 2012-2013.
18 The insureds who will provide this subsidy will likely be young workers. That is significant because individual wealth correlates strongly with age. Younger workers typically have low incomes and heavy expenses as they pay off college loans, purchase housing, and start families. For this reason, some commentators have correctly criticized PPACA's premium price caps as being regressive.
19 For a quick survey of the literature and its limitations, see Linda Gorman, "Does Lack of Health Insurance Kill?" *John Goodman's Health Policy Blog,* May 13, 2013, http://healthblog.ncpa.org/does-lack-of-health-insurance-kill/.
20 Katherine Baicker, Sarah L. Taubman, Heidi L. Allen, et al,. "The Oregon Experiment: Effects of Medicaid on Clinical Outcomes," *New England Journal of Medicine* 368, 18 (May 2, 2013): pp. 1713-22.
21 Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey: Total Health Services: Mean and Median Expenses per Person," Table 1.1, Years 1996-2010, http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=1&subcomponent=0&year=2009&tableSeries=1&tableSubSeries=&searchText=&searchMethod=1.
22 Nancy-Ann DeParle, "The Facts about the Independent Payment Advisory Board," *White House Blog.* April 20, 2011, http://www.whitehouse.gov/blog/2011/04/20/facts-about-independent-payment-advisory-board.
23 Gardiner Harris, "U.S. Panel Says No to Prostate Screening for Healthy Men." *New York Times.* October 6, 2011, http://www.nytimes.com/2011/10/07/health/07prostate.html.
24 See H. Gilbert Welch, Lisa M. Schwartz, and Steven Woloshin, *Overdiagnosed: Making People Sick in the Pursuit of Health*. Boston: Beacon Press, 2011, pp. 53-55.
25 Ibid, pp. 47-48.
26 Ibid, Figure 4.8, p. 57.
27 Side-effects data are from Welch, Schwartz, and Woloshin 2011, p. 58.
28 Welch, Schwartz, and Woloshin 2011, pp. 76-77.
29 Harris 2011.
30 U.S. Department of Health and Human Services, "Preventive Services Covered under the Affordable Care Act," HealthCare.gov, July 2010, http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforWomenIncludingPregnantWomen.