PRESIDENT OBAMA'S FIRST FOUR YEARS

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The following 23 commentaries on President Obama's first term as president are drawn from a larger set of comments written at different times in those first four years. They relate mainly to two principal events during his presidency: the Great Recession and the Affordable Care Act.

If, as the old cliché says "the past is prologue," these commentaries may tell us where we are headed in Obama's second term.

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BIG GOVERNMENT IS BACK

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Thirteen years ago in his State of the Union address President Clinton pronounced that "the era of big government is over." To drive that point home, he used it three times in his address, and to further reinforce that message repeated it in his radio address four days later. This was no spontaneous, ill-conceived outburst on his part. He had tested the waters with it in October and November 1995 and found it to his liking.

In his address to the American public before Congress last night President Obama put supporters of limited government on notice that he intends to restore big government in order to assure jobs, housing, education, health care, and clean renewable energy for all Americans. This is Obama's vision: *only* big government can put America back on the right track.

Bringing back big government includes 3.5 million jobs created or saved in two years, mortgage relief, more money for early childhood education, access to quality education for every child followed by affordable college education, and quality health care affordable and accessible for all. He said there would be a major cleanup of bank balance sheets, a "new lending fund" which he did not describe further, and pledged to cut the deficit in half by the end of his first term in the Oval Office.

Jobs would be created building wind turbines and solar panels, broadband access, plug-in hybrid cars, lithium batteries. He urged everyone to get at least one year of college to improve their prospects for finding work and set down the goal of having the highest percentage of college graduates in the world by 2020. He specifically urged passage of the Kennedy-Hatch sponsored *Serve America Act* which would amend earlier legislation and create a Clean Energy Service Corps, Education Corps, Healthy Futures Corps, Opportunity Corps, National Service Reserve Corps, along with a Commission on Cross-Sector Solutions to America's Problems and a Community Solutions Funds Pilot program.

There will be more and better health care for all veterans, a cure for cancer, and more preventive care. He lauded the new SCHIP legislation offering expanded health care coverage to American children. He endorsed regulatory reform and cap-and-trade legislation to limit greenhouse gas emissions.

There were several no-no's in Obama's address openly expressed or between the lines. No torture. No Guantanamo, no fancy drapes and private jets for bank executives. Absolutely no earmarks. No mention of school vouchers, or energy produced from methane or nuclear power. expanded offshore drilling, or ANWR. No mention of the moral hazard associated with government rescue plans which undermine personal responsibility by assuring everyone that when they stumble they will be saved.

He trumpeted passage of the stimulus package which would avert ten years of sputtering along had he taken no action at all and which will bring tax relief to 95 percent of working families starting in April.

Budgetary cost savings will come from rooting out waste and fraud in government programs, cutting out subsidies to agribusiness giants, setting up electronic medical records which will reduce redundant costs in the delivery of health care, and axing expenditures on new military weapons systems. Only those with incomes above $250,000 -- about two percent of all taxpayers -- would have their taxes increased.

Several nagging questions remain. How does expanded government assurance for jobs, housing, education, health care, and clear renewable energy promote greater personal responsibility? Who pays for the continued deficit spending in the years ahead which adds to the public debt and the cost of servicing that debt? Other than make-work jobs, when jobs are created, aren't other jobs lost through the process of creative destruction? Why is it ok for Canada to despoil its environment processing oil from oil sands and not for the United States to tap the oil reserves in ANWR? How do we justify calling on Americans to become more responsible when already 41 percent pay no federal income taxes, with even more becoming exempt under new refundable tax credits? Is an earmark an earmark when it is inserted in a bill at the last minute but not an earmark when it was there from the very beginning?

How will we know that 3.5 million jobs have been created or saved when official employment estimates do not count the jobs created or saved? Do we simply attribute any and all of the increase in employment to the stimulus package? How do we reconcile electronic medical records which are shared with the 1996 Health Insurance Portability and Accountability Act (HIPAA) which protects the confidentiality of individually identifiable health information? Who sets the cap on cap-and-trade? Why not just tax the sources of emissions and use the revenues to reduce the budget deficit? Why isn't there a built-in trigger to shut down the flow of stimulus funds when the crisis is over? What incentives remain for physicians, many of whom earn more than $250,000 a year (a pittance compared to the incomes of many hedge fund managers, bank executives, and professional athletes), to work long, exhausting hours performing risky procedures delivering health care to the increasing numbers of persons covered by government health programs which routinely slash reimbursement to half or less of their charges for services rendered?

Over and over in his speech, President Obama underscored transparency, accountability, and responsibility. Keeping in mind his admonition that we dare not "pass on to [our children] a debt they cannot pay," one wonders if in being faithful to his own accountability and responsibility as president he would not seek a second term if he fails to achieve his goal of cutting the deficit in half

After barely more than 30 days in office, President Obama has made it clear that he intends to sweep aside the Reagan/Clinton endorsed limits on government intrusion into our lives. Big government is back.

EXPECTATIONS FOR THE NEW PRESIDENT

March 3, 2009

UNDENIABLE FACTS:

- **Huge deficits and enormous debt.**
- **Debt service on $10 trillion to approximate $300-$400 billion per year.**
- **Disagreement among economists as to how best to stimulate the economy.**
- **Troubled Medicaid and Medicare programs.**
- **Ever-present threats to homeland security.**
- **Broken financial system.**
- **Mortgage defaults**
- **Serious breakdown in housing sales, construction, and prices.**
- **Possible return of much higher oil, natural gas, and fuel prices.**
- **Failure on regulatory bodies including Congressional committees with oversight.**

The public discourse on the high and rising cost of health care at times triggers an attack on profit-making enterprises especially pharmaceutical companies. Critics assert that if we could only get profits out of the system, costs would be much lower. A review of U.S. health care expenditures may shed light on the part that profits play in health care costs.

National health expenditures in 2005 amounted to $1.988 trillion.[1] Roughly 45 percent of those expenditures are funded from public sources principally Medicare and Medicaid. The largest single category of expense is hospital care at $612 billion. Data for 2004 indicate that only 15 percent of all U.S. hospitals operate as for-profit institutions and taken together they account for just nine percent of all hospital care expenditures.

The nursing home business is largely in the hands of for-profit organizations but the number of homes has been declining since 1999. Though their numbers are quite large alongside the number of hospitals, on average they have fewer beds than hospitals and therefore expenditures at nursing homes – $122 billion in 2005 – represent only six percent of national

[1] **Throughout we employ the most recently available data.**

health expenditures. Monthly charges at for-profit nursing homes are lower than at other types of nursing homes.

The second largest category of health expenditures is physician and clinical services – $421 billion in 2005. Mayo Research Institute found no national data on the extent to which physician and clinical service enterprises operate as for-profit businesses. However, two comments are relevant though presented without statistical support.

First, many physicians establish their practices as business enterprises in a way that allows them to draw a regular monthly salary and, after meeting their other financial obligations, to divide any surplus at the end of the year among the practice partners. Physicians who are employed in the practice but are not partners do not share in this distribution. This surplus does not represent profit in that it originates in the services provided by the physicians. It and their regular salaries are properly considered compensation for services rendered.

Second, due to severe problems with reimbursement from private and public health insurers physicians – many are paid 50 percent or less of what they charge for their services – increasingly are closing their office-based practices and are finding paid employment with hospitals where they are designated "hospitalists."

After hospital care and physician/clinical services, the third largest category is prescription drugs that added $201 billion (10.1 percent) to national health expenditures in 2005. Most of these funds no doubt went to for-profit pharmaceutical companies, and critics assert that caps imposed on prescription drug prices would do much to reduce the cost of health care. The opportunities for earning profits are considerable. So are the risks and the cost of developing new drugs. Tufts University Center for the Study of Drug Development stated in late 2006 that it takes eight years for the typical biotechnology product to move from the development stage through the regulatory phase and costs $1.2 billion, with the cost about evenly split between the preclinical stage and the clinical stage. Sales that fall short of $1.2 billion mean that the company takes a loss on a product even if it proves to be clinically safe and effective.

Further, many of the large pharmaceutical firms are investor owned. Market valuation toward the end of November 2007 for Johnson and Johnson, for instance, was $191 billion, for Pfizer $157 billion, and for Merck $125 billion. Who will buy out the current stockholders if price caps also lead to a call for transforming these companies into nonprofit enterprises? As nonprofits would they be more successful in developing new products? Would they be more efficient and able to reduce the cost of product development below what it would have been had they remained profit-making companies? What would the public do if pharmaceuticals decided to halt the development of new drugs and switch to other product lines?

Critics also assert that it is unethical to profit from human suffering. Quite true. However, is there anything unethical in making a profit producing products and services that help relieve human suffering? Should we condemn Bayer for producing at a profit its hugely successful over-the-counter drug aspirin? Is General Electric to be condemned for the profits it makes in selling high-tech diagnostic equipment? Is for-profit IASIS Healthcare to be condemned for

rescuing community-owned Glenwood Regional Medical Center in West Monroe, Louisiana that for years had been hemorrhaging cash to the point of almost forcing it to close its doors permanently?

Students of economics 101 learn that for any transaction to take place both parties must experience gain: what is gotten is more highly valued than what is given up. Remove that gain and the exchange collapses even for a nonprofit business unless it is subsidized to the point where its income (what is gotten) at least covers the cost of production (what is given up).

How, then, do we tackle the problem of rising health care expenditures which climbed from 5.2 percent of GDP in 1960 to 16 percent in 2004? Surely not by cutting reimbursement because over the long term cuts in reimbursement drive providers out of the health-care system: what is gotten is less highly valued than what is given up. Cutting reimbursement leads to cost shifting where paying patients are charged inflated prices to cover the cost of providing services to nonpaying patients. It also leads to a narrowing of access to physician care. In the extreme, cuts in reimbursement leave nothing in compensation for providers who take seriously their duty to pay in full their own financial obligations to their employees, suppliers, and others. Certainly not by eliminating for-profit companies, especially in pharmaceuticals, though curbing *excess* profits – profits above what are necessary to retain them in the health care system – likely would bring down the cost of health care.

Since U.S. health care is governed by market forces, there are in general two options: the demand-side option and the supply-side option. On the demand side we have heard for years that more must be done to prevent the onset of disease and injury such as wearing seat belts, exercising, eating healthy foods, and cutting out cigarettes. The growing problems of obesity and sexually transmitted diseases, to name just two serious health disorders, indicate that the demand option is not working, at least not well enough to cut health expenditures. That leaves the supply side option. One possibility is to deny access to certain very expensive procedures. Insurers are doing that already and are facing great resistance from the persons they insure. Another possibility is to concentrate research and development on those products and clinical modalities that reduce the cost of treatment today without compromising quality of care or outcomes. We've done it successfully with cheaper and better computer hardware, with more fuel efficient and safer automobiles and aircraft, with lower-cost telecommunications, with inexpensive and lightning-fast online systems for selling equities, buying books, and trading second-hand goods, with energy-saving appliances and insulating materials, with wider use of reprocessed materials in new products such as flooring and counter tops. And many more.

It's time to try this alternative with renewed vigor in health care especially hospital care. Nanotechnology for one might contribute that kind of creative energy if it can transition from a basic to an applied science and then profitably to commercial products. It simply does not make sense to banish for-profit companies from health care when it has been firmly established for many years that the profit motive is one of the principal forces driving innovation.

Sources: U.S. Centers for Medicare/Medicaid Services http://www.cms.hhs.gov/NationalHealthExpendData; U.S. Census Bureau, *2007 Statistical Abstract of the United States;* Centers for Disease Control and Prevention, *The National Nursing Home Survey:1999 Summary*; *2004 National Nursing Home Survey; Health, United States*, 2006.

CRAM-DOWN IS CRIPPLING HEALTH CARE

March 5, 2009

Cram-down is the expression used today to describe the forced easing of mortgage terms in order to rescue a homeowner from default and foreclosure. In brief, cram-down is a court-ordered reduction of the balance owed on a home mortgage allowing the homeowner who has filed for personal bankruptcy to reduce his/her monthly payment and forcing the mortgage holder to write off a portion of the unpaid balance.

Cram-down is a fundamentally unjust practice because it forces the mortgage holder to accept less from the homeowner than they both agreed to originally and voluntarily and to which they committed themselves in a written contract. The principle of equivalence states that the parties to any exchange agreement are ethically required to exchange things of equal value and impose equal burdens on one another. With cram-down the mortgage holder is forced to accept a new contract where the benefits and burdens shift in favor of the homeowner. It's the coercion that offends our sense of justice.

On the other hand, cram-down is defended as necessary to protect the homeowner who presumably has been making a good-faith effort to keep up with his/her monthly payments but simply is overwhelmed financially. In the end, cram-down is doubly unjust when the loss to the mortgage holder is greater than gain to the homeowner. At best cram-down is an act of mercy which silently and coercively redistributes income from mortgage holders to homeowners.

Cram-down has been a regular practice in health care financing for years. There are three basic types of cram-down in health care. The first type involves third-party payers, including private health insurance companies and public insurers such as Medicare, along with public welfare programs such as Medicaid and SCHIP (State Children's Health Insurance Program), which often do not fully reimburse health care providers including hospitals, physicians, and others for services rendered. To illustrate, it is not unusual for a third-party payer to force the provider to accept one-half or even less of the charges submitted for services rendered to a specific patient.

The second type involves patients who present at a hospital emergency room and must be treated under the provisions of a 1986 federal law which fines a federally-funded hospital and physician up to $50,000 for refusing to admit a person in need of emergency care even if that person has no way of paying for the services rendered or refuses to pay. In some cases, the hospital may stabilize and transfer such a patient -- a "no-pay"-- to another facility in a practice known as "dumping."

The third type closely resembles mortgage cram-down in that the patient who cannot pay seeks relief through bankruptcy.

In addition to dumping, there are at least four other responses to cram-down from health care providers. First, they refuse to accept or consult on patients whose third-party payers are well known for cram-down. Second, they run large numbers of patients through their office-based practice to compensate for cram-down thereby in effect running a "Medicare/Medicaid mill." Third, they close their office-based practice and retire or in some instances become hospitalists hired and paid by a hospital to render care to patients in their area of specialization. Fourth, they reduce their work effort by quietly walking away from parts of their overall practice to which for years they volunteered their support or accepted as a part of their duty even when the reimbursement did not cover their costs.

One of the first bills passed by Congress and signed by President Obama was H.R. 2 which extends health coverage to an additional 4.1 million children who previously were not covered by SCHIP. Obama is reported to have said that this expansion is "a down payment on my commitment to cover every single American." In other words, it is a big step toward universal health care.

The added cost of SCHIP which allows states to get full access to federal matching funds to cover children in families with incomes up to three-times the poverty threshold ($63,000 for a family of four) is to be paid from a 62 cents increase in the federal tax on cigarettes and similar increases on other tobacco products. Even before H.R.2 was passed, SCHIP was known for cram-down. It likely will retain that reputation among providers under the expanded coverage.

The increase in the tax paid by smokers and users of other kinds of tobacco products may not yield the estimated $30 billion in additional revenues over the next five years because the cigarette business for years has been plagued by counterfeit cigarettes and counterfeit federal tax stamps which are sold to merchants attracted by the wider profit margins available selling counterfeit products to an unsuspecting public. The increase in the tax makes counterfeiting even more lucrative. Actual federal revenues from this source which fall short of the expected $30 billion could intensify cram-down.

To cope with cram-down some providers are transforming their practices so that their patients are seen by a nurse-practitioner rather than a physician without necessarily changing their fee structure. Access to care is provided though it may not be the same quality of care available from a physician. This option is attractive because hiring and paying a nurse-practitioner instead of a physician, at the same time maintaining the same fee structure, reduces the financial impact of cram-down.

Cram-down is a form of forced income redistribution. Private insurers do it to hold down their expenses and thereby offer coverage at lower premiums. Public payers, both state and federal, do it to hold down budget deficits and to avoid having to raise taxes to cover the additional cost of expanded coverage. Universal health coverage, as promised by the Obama administration, will lead to more cram-down, more restricted access to quality health care, and more income redistribution unless steps are taken to provide the necessary revenues to cover the costs of

that care. Without the funds to arrest cram-down, universal health coverage does not fix a financially broken health care system. Quite the contrary, it violates the first principle of health care: do no harm.

OBAMA'S $1.8 TRILLION HEALTH CARE GAMBLE

April 1, 2009

To grasp what universal health coverage under President Obama means for access to quality health care we begin by noting the critical but often misunderstood difference between costs and expenditures and the ways in which the two are reduced. Simply put, health care costs relate to the cost of acquiring the resources to provide health care services. Health care expenditures relate to the payments made for services rendered.

For the health-care provider, payments are really revenues and as anyone in a for-profit business knows there must be some gain -- revenues > costs – for the business to survive. Absent subsidies, grants, or donations, a non-profit organization cannot survive if revenues < costs.

There are two ways to reduce expenditures: (a) do not use health care services and (b) do not pay for services rendered. Option (a) makes sense if a person has no need for the available services. It makes no sense if a person simply postpones needed health care and his/her health condition deteriorates to the point where more costly intervention is required. Thus the emphasis on regular checkups, preventive care, and a sensible lifestyle.

Option (b) covers bankruptcy, no pays, and third-party payers who do not reimburse the full cost of the care provided. This option makes sense for the patient and the payer. It makes no sense for a provider unless the care is given freely.

No pays and below-cost third-party reimbursement can be reversed through vigorous collection efforts. In the end, however, unpaid balances must be written off as bad debts. Third-party payers including Medicare, Medicaid, and private insurers are adept at not fully reimbursing providers for the care rendered. This practice reduces their expenditures but does not reduce the cost of providing that care. If in the short-run reimbursement < cost, providers may render care selectively or silently shift the cost to others who seek care from those providers. If this condition persists, the provider may no longer provide health care to anyone. That harsh reality may turn away capable and eager young men and women from entering the health-care professions and together with the loss of older professionals may reduce the quality of care available. Or it may channel the young into those subspecialties where the gains make worthwhile the sacrifices made to prepare themselves professionally.

Costs can be reduced in two ways: (a) replace more expensive resources with less expensive ones and (b) improve efficiency in delivering care. Under option (a) a hospital may for example substitute a licensed practical nurse for a registered nurse or purchase supplies in bulk through a purchasing consortium. A physician in an office-based practice might for instance employ a nurse-practitioner instead of a physician partner or relocate to a building with lower

heating and air-conditioning costs. Driven by the need to re-align costs and reimbursement and by the cold logic of option (a) the U.S. health-care system depends more and more on walk-in clinics staffed by nurse-practitioners to deliver primary care.

Under option (b) rendering care more efficiently is more complicated than improving productivity in manufacturing washing machines or soft drinks in a capital-intensive assembly-line process. Anyone familiar with fine furniture, for example, knows that hand-crafted furniture is more expensive than mass-produced furniture precisely because it is more labor intensive Health care is labor-intensive because literally every patient is different. The economies of scale available in mass-production manufacturing simply do not apply.

Even so, waste is ever-present in every process, whether capital-intensive or labor-intensive. Because health care is labor intensive, waste originates largely in labor utilization. Wherever found, wasted labor resources means labor is not producing what it was employed to produce -- a nurse who momentarily is idle because a patient is late in keeping an appointment or is a no show, a physician waiting while a lab completes vital tests or a technician repairs a piece of equipment. This problem is difficult to manage because it involves complex human interactions and rests primarily in the hands of supervisory staff to monitor the process, re-arranging schedules and assignments as the situation unfolds without interfering with the care.

The Obama plan promises to extend coverage to everyone without increasing health-care expenditures by reducing the cost of care through efficiencies in the ways care is delivered. Central to this plan is the adoption of an electronic system to share medical records across the entire health-care system. A system like that means every provider must be linked together electronically in ways similar to the internet wherein there is no central depository and every user bears the full cost of maintaining records on every patient served in a standard format that makes the information accessible to any authorized person in need of that information.

Such an electronic system reduces the cost of health care only if the cost of maintaining and sharing medical records is less than the cost of replicating whatever information is needed at the moment. Savings are possible but problematical. Does it make sense to wait on retrieving information when the patient suddenly presents in need of immediate emergency care, if the information retrieved is dated, the information is inaccurate, when the system shuts down due to a virus or power outage? Protocols will have to be developed that uniquely identify every patient, prevent access to all but those authorized to use that information, protect information suppliers from malpractice suits involving providers who misuse shared information, and comply with Health Insurance Portability and Accountability Act.

Massive systems are both a blessing and a curse. When they work well they offer substantial benefits. When they fail they impose large costs. Before a final decision is made to provide universal health care coverage, Obama and the Congress should spend one week observing how hospital care is provided and at least one day on how patient and billing records are maintained and processed.

Health care spending contributes $1.8 trillion to total GDP of $14.3 trillion. Ignorance is no

excuse for re-structuring health care without first-hand information on how much is spent on it, how much it costs to provide that care, and the complex process by which the care is delivered.

PUBLIC HEALTH INSURANCE LEADS TO FEDERAL CONTROL OF HEALTH CARE

June 15, 2009

The White House's public health insurance option will lead inevitably to a single-payer system. For years both Medicare and Medicaid have "crammed down" reimbursement rates for services rendered by hospitals and health care providers including pharmacies such that they have been forced to shift unreimbursed costs to other payers notably private insurance companies. Thus, private health insurance rates are higher today in part because Medicare and Medicaid do not reimburse adequately for services provided. In some cases, reimbursement is below the actual cost to the provider for services rendered.

The Louisiana Hospital Association states that in FY2008 Medicaid "cram down" exceeded $150 million. The Louisiana legislature is proposing to cap reimbursement for neonatal care at roughly 50 percent of the average cost of care in a neonatal intensive care unit. Any hospital with an intensive care unit for newborns will have to figure out how to handle expenses above that cap. The reason for setting this limit is the State's current budget crisis forcing deep cuts in Medicaid reimbursement.

The problem is not limited to Louisiana. The Henry Kaiser Family Foundation reported earlier this year that the "economic downturn is affecting *every state budget and Medicaid program,* in some cases causing severe distress." It follows that Medicaid "cram-down" will become even worse, leading to more cost shifting where private insurers are forced to pay a portion of cost of care for indigent patients which Medicaid does not reimburse resulting in higher private health insurance premiums.

With the Obama administration's public health insurance option the same "cram down" practice will continue in order to bring down federal expenditures on health care. This practice will force providers to shift unreimbursed costs to private insurers, forcing them to raise premiums, and enticing persons and companies with private coverage to switch to the less expensive public insurance program. Inevitably, the only remaining insurance program will be public health insurance – a single-payer system.

Bright university students who in the past were willing to undertake the costs and rigors of a pre-med program and medical school followed by years of specialized training and often long hours under the threat of a malpractice lawsuit will think twice about a career in "cram-down" medicine.

President Obama claims that the public health insurance option does not amount to socialized health care because under his plan the federal government does not assume *ownership* of health care facilities and therefore does not transform those who work in the system into

public employees. True enough, but a single-payer system is one in which the government *controls* health care. Private ownership with federal control is a fine distinction without a real difference.

Twenty-five years ago Canada adopted a single-payer health care system that many would like to see adopted in the United States. Even now, however, the Minister of Health reports that the system's most prominent concerns are patient charges and queue jumping, practices which restrict access to care. Queue jumping involves private-pay patients who are moved ahead of others for medically necessary health services. Patient charges involve private physicians ("extra-billing") and facilities ("user charges") charging patients for those services. The provincial governments are required to report those practices to the federal government and are penalized accordingly.

Senator Kennedy has introduced a health reform bill which runs 615 pages in length and would greatly expand the role of government in the health care system. Mayo Research Institute will review and comment on Kennedy's bill in a future report. Virtually any student of economics will tell you that whenever a product or service is offered free of charge, it is overused. With greater federal involvement in health care, expansion and overuse are predictable, imposing heavy demands on the federal Treasury and intensifying "cram down." Some providers will be driven out of the system; others will walk away. Some will take only private-pay patients or as in Canada allow private-pay patients to jump the queue ahead of others covered by the single-payer plan. The health services which the market no longer allocates will be allocated by politicians and government bureaucrats.

What is being sold to Americans today as access to quality, affordable health care is unattainable for one compelling reason. Americans want the best care available, but as the record shows are not willing to pay for it. "Cram-down" reduces what Medicare and Medicaid pay providers for *rendering* health care services. It does not reduce the cost of *providing* those services. Unless and until the American public learns that lesson, there is no fixing a system which is financially broken.

ACCESS DELAYED IS HEALTH CARE DENIED

July 21, 2009

Everyone familiar with health care knows that the guiding principle is *first do no harm*. The principle derives from the sacred dignity of every human being and the conviction that there is no place in medicine for tinkering with anyone's health as one might do repairing an truck engine or fitting a piece into a jigsaw puzzle.

Do the health reform proposals of the Obama administration conform to that principle? We focus on the one question which reflects Obama's central argument for reform. Do his proposals provide access to quality, affordable care? In raising that question it is necessary to address two others. Do the proposals protect freedom of choice? Do they respect freedom of conscience?

The question of access to quality, affordable care divides into three parts. Does access actually improve? Will the system be able to maintain the current standard of care? Will the cost of care become more affordable? How one answers those questions depends very much on who is covered.

Yes -- access to care improves for those currently denied access for the simple reason that any access is better than none at all. Does access deteriorate for those being served by the system in place? Perhaps -- much depends on how providers react. Serving more persons in need of care means that the current providers will have to work longer hours. Will they? Possibly -- depending on whether they are paid sufficiently for that work. If reimbursement is not sufficient, as has been a complaint against Medicare and Medicaid for years, the supply of health care services will decline forcing patients to wait for care.

This is one of the principal criticisms of the Canadian system. The Canadian Institute for Health Information stated in 2008 that 30 percent of Canadians, versus 20 percent of Americans, reported waiting six days or more to see their doctor. In Canada 22 percent have same-day access to care compared to 30 percent of Americans. The Minister of Health for Canada stated recently that private-pay patients are being seen ahead of others – are queue jumping -- for medically necessary health services. Since free and universal access to publicly insured health care was established in Canada in 1984, total health expenditures not adjusted for inflation have climbed from $36.7 billion to $171.9 billion in 2008.

Following the familiar adage that "justice delayed is justice denied" we conclude tentatively that under the Obama reforms *access delayed is health care denied.*

If reimbursement is not reduced, the supply of health care services presumably is preserved but the cost of care increases making it less affordable, unless that cost is subsidized. If the

supply of services is maintained by using providers with less professional training, such as nurse practitioners in place of board-certified physicians, quality of care suffers.

So how do we provide access to quality, affordable care? By maintaining reimbursement so as not to lose some of the health care providers and by supporting the system through higher income taxes which at present apply to fewer than 60 percent of all income tax filers and thus are a painless remedy for millions of Americans. Or by imposing new or higher taxes on products used by consumers. To illustrate, in order to expand health insurance coverage for children, the administration earlier this year imposed a higher tax on tobacco products. Mayo Research Institute predicts that the administration will impose a similar tax on other products precisely because it is difficult for the typical consumer to know how much of the purchase price is tax, how much is the cost of production, and how much is profits. Then one can always blame the tobacco companies for the high price of cigarettes. By raising the current federal tax on gasoline at the pump the oil companies can be blamed for charging higher prices. Most recently using rhetoric like "boondoggle" and "windfall profits, " President Obama spearheaded an attack on private health insurers for their bureaucratic waste and excessive pay of their senior executives. He also blames pharmaceutical companies for running up the cost of health care.

We turn now to the questions regarding freedom of choice and freedom of conscience. If a public insurance plan is included in the Obama reforms and becomes the law of the land, private health insurers will have to decide whether to continue offering health insurance or drop it entirely. If they decide to continue they will be competing on an uneven playing field because by making use of subsidies the public plan will be able to offer lower premiums than the private plans. Will employers who currently provide private health insurance switch to the less expensive public plan? In the end, a subsidized public plan will crowd out private insurance companies resulting over time in a single-payer plan. The long-standing problems with Medicare and Medicaid financing should give us pause about putting in place a public insurance option which likely will morph into a single-payer plan.

Will the Obama reform package assure freedom of conscience for health care providers? Not if birth control and abortion services are mandated as required under the public insurance plan especially if public funding is withheld from any provider such as a hospital, physician, or pharmacist who for reasons of conscience refuses to provide those services. Down the road, will the public option mandate coverage of assisted suicide as a health-care right? Will it selectively deny coverage of health-care services such as hip-replacement for the elderly because they have less upside potential or brain surgery for cyclists injured while not wearing a helmet because they acted irresponsibly or treatment of the chronic lung disease of persons addicted to cigarettes?

The Obama health care reforms are a two-edge sword which in the end could cut the heart out of the principle *first do no harm*.

HR 3200: IS THE DEVIL IN THE INTENT?

August 5, 2009

HR 3200 -- America's Affordable Health Choices Act of 2009 – has stirred the American public like nothing else has in years. Most visible have been the town hall meetings scheduled by members of Congress to explain what's in the bill. But HR 3200 is more than 1000 pages long and some in Congress have admitted to not having read it. Congressional staffers and insiders may understand how the bill would reform health care but for anyone else who wants to be informed the bill presents a serious challenge.

We call attention in the following to just nine sections of HR 3200 which are especially problematical. No doubt there are others which may be even more convoluted. These problems call for careful study before any legislation finally emerges from Congress for President Obama's signature. We refer to the official July 14 version of the bill. The problem begins with the bill's objective.

● Objective. "To provide affordable, quality health care for all Americans and reduce the growth of health care spending, *and other purposes."* Question: Why are the sponsors of HR 3200 not limiting the bill to health care affordability, access, quality, and spending?

● Advance Care Planning Consultation (§1233). "The level of treatment … may range from an indication for full treatment to an indication to limit some or all or specified interventions [including] … *the use of antibiotics; and … artificially administered nutrition and hydration*." Question: Before antibiotics, wasn't pneumonia called "the old man's friend" and weren't artificially administered nutrition and hydration at the heart of the Terri Schiavo case?

"… the Secretary [of Health and Human Services, Kathleen Sebelius] shall include quality measures on end of life care and advanced care planning that have been adopted or endorsed by a consensus-based organization, if appropriate. Such measures shall measure *both the creation of and adherence to orders for life-sustaining treatment*." Question: To measure adherence to end of life care doesn't HHS need access to patient records?

" … the Secretary … shall update the online version of the Medicare and You Handbook *to include … any additional information as determined by the Secretary*." Question: What special expertise does the Secretary have which warrants giving her a free hand in deciding the advance care planning information to be made available to Medicare recipients?

● Comparative Effectiveness Research (§1401). "The Secretary shall establish … a Center for Comparative Effectiveness Research … to conduct, support, synthesize research … with respect to outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can

most effectively and appropriately be prevented, diagnosed, treated, *and managed clinically*." Question: Will this research produce protocols to be strictly followed in patient care?

"The Center shall … assist the users of health information technology focused on clinical decision support *to promote the timely incorporation of such findings into clinical practices and promote the ease of use of such incorporation*." Question: Will this technology be used to track the compliance of health-care providers with the protocols to be followed in patient care?

• Reduction in Medicaid DSH (§1704). "No hospital may be defined or deemed as a disproportionate share hospital, or as an essential access hospital … unless the hospital provides services … without discrimination on the ground of race, color, national origin, creed, source of payment, status as a beneficiary … *or any other ground unrelated to such beneficiary's need for the services or the availability of the needed services in the hospital …"* Note: A disproportionate share hospital treats significant populations of indigent patients; an essential access hospital provides local access to inpatient services to Medicare enrollees. Question: Will a hospital be denied reimbursement for patient care because it does not provide services which it regards as ethically objectionable?

• Required Coverage for Preventive Services (§1711). "The term 'nurse home visitation services' means home visits by trained nurses to families with a first-time pregnant woman, or a child (under 2 years of age), who is eligible for assistance under this title, *but only, to the extent determined by the Secretary* based upon evidence, that such services are effective in one or more of the following … improving maternal or child health and pregnancy outcomes or increasing birth intervals between pregnancies." Question: Will the Secretary decide what methods, including abortion, are to be used to assure the birth intervals between pregnancies which she decides are appropriate?

• Public Health Investment Fund (§2002). "There is established a … 'Public Health Investment Fund' … [where] amounts deposited into the Fund shall be derived from general revenues of the Treasury [and] … *amounts in the Fund are authorized to be appropriated by the Committees on Appropriations of the House of Representatives and the Senate for carrying out activities under designated public health provisions*." Note: $88.7 billion is to be deposited in the fund between 2010 and 2019. Question: Will this Fund let members of Congress funnel monies to favored constituents?

"Amounts appropriated under this section, and outlays flowing from such appropriations, *shall not be taken into account for purposes of any budget enforcement procedures including allocations under section 302 (a) and (b) of the Balanced Budget and Emergency Deficit Control Action and budget resolutions for fiscal years during which appropriations are made from the Fund."* Question: Are Fund expenditures excluded from an accounting of the federal deficit?

In addition to pro-choice Kathleen Sebelius, two other Obama appointees are major health care reform architects. Nancy-Ann DeParle, most recently managing director of the private equity firm CCMP Capital, heads the White House Office of Health Reform. Ezekiel Emanuel, brother of White House chief of staff Rahm Emanuel and bioethicist on loan from the National

Institutes of Health, is senior adviser on health policy in the Office of Management and Budget. Emanuel has authored *The Ends of Human Life: Medical Ethics in a Liberal Polity,* published by Harvard University Press, and book chapters "Ethics of Treatment: Palliative and Terminal Care" and "Why Not? Regulating How We Die."

Question: In the end do the "other purposes" of HR 3200 include introducing "death with dignity" into health care reform?

PRESIDENT OBAMA'S STEALTH PLAN TO ESTABLISH UNIVERSAL HEALTH INSURANCE

February 23, 2010

President Obama's health care proposals openly target the health insurance industry and seek to establish universal health insurance by stealthy means. Four of the five goals in his opening statement point directly to private health insurance companies, calling on them for affordable and accessible health care, financial accountability, and doing away with denial of coverage on grounds of pre-existing conditions. The fifth claims that his proposals will put "our budget and economy on a more stable path."

Though nothing of the sort is stated in his proposals, two broad features of Obama's plan likely lead to the establishment of health insurance for all through the public sector. The first is the establishment of a new federal agency to rein in health insurance premiums. The second imposes new costs on private insurance companies or other segments of the health care system which inevitably are passed along to insurance companies through the billing/reimbursement process.

Obama's Health Insurance Rate Authority would order any health insurance company which proposes an "unreasonable and unjustified" premium hike to lower that premium, provide a rebate, or take other actions to make that premium affordable. This provision is a throwback to the scuttled efforts of the Clinton administration in 1994 to reform health care by putting a "cap" on health insurance premiums. Experience with regulation of rates charged by public utilities tells us how rate review in health insurance would work. There are three scenarios.

A ceiling is set at or above the proposed increase allowing the insurance company to operate unimpeded. This scenario results in an ineffective ceiling but gives the appearance that the government is serious about making premiums affordable.

A ceiling is set below the proposed increase forcing the insurer to operate at a lower premium. The company then proposes a smaller increase which HIRA approves. This scenario protects insurance companies and shields the public from even greater increases.

A ceiling is set so far below the proposed increase that the insurance company stops offering coverage. The ensuing shortage of insurance is taken up by a public insurance program made necessary by the shortage. This scenario is the stealth plan for universal coverage. Of the three, this scenario appears to be most likely.

The fundamental problem with HIRA is that it addresses the symptoms of rising health care costs without treating the causes -- the cost of the resources used to provide health care services. Under pressure from HIRA insurance companies will drive reimbursement to

hospitals and other health-care providers even lower forcing some out of health care entirely and leading to wider utilization of cheaper health resources such as substituting nurse practitioners for primary-care physicians. This chain reaction has the effect of narrowing access to quality care and subjecting providers to the greater risks and attendant costs of defending against charges of malpractice.

There is a second factor behind the argument that the Obama proposals represent a stealth plan to establish universal public health insurance coverage. Specifically, his proposals impose significant new costs on health insurance companies thereby squeezing their profits and making it even more difficult for them to continue offering insurance coverage.

As Obama has insisted on numerous occasions, the public will be free to keep their current coverage. However, "grandfathered" plans must be modified to insure coverage for adult dependents up to age 26, set aside all annual and lifetime limits, ban exclusions for pre-existing conditions, prohibit discrimination in favor of highly compensated individuals, and provide preventive services with no cost sharing. The cost to insurance companies necessarily will increase and if HIRA denies premium increases, insurance company profits will be hammered.

Further, the Obama plan imposes a $33 billion assessment over 10 years on the pharmaceutical industry for the additional revenue "as more Americans gain health insurance …. [and are] able to pay for prescription drugs." This assessment no doubt will be passed on to health insurance companies through the higher charges of hospitals and other health care providers for the pharmaceuticals prescribed in the treatment of patients.

The president's plan also calls for a $20 billion excise tax on medical device manufacturers over 10 years justified by the gains "from expanding health insurance coverage." As with the pharmaceuticals assessment this tax will be shifted to hospitals and other health care providers who in turn will seek additional reimbursement from health insurance companies.

Most damaging of all, the president proposes a $67 billion assessment on health insurance companies over 10 years due to the gains insurers will experience as "more Americans get coverage." This assessment directly impacts their cost of conducting business and pushes them away from providing coverage to the public.

HIRA coupled with additional provisions imposed on current health insurance plans, a $20 billion excise tax, and $100 billion in additional assessments portend the end of private health insurance and the commencement of health insurance coverage for all through the public sector. This outcome should come as no surprise. It's been a central part of Obama's inaugural pledge to remake America. It's the stealth part that is alarming.

OBAMACARE TRAMPLES ON THE CONSENT OF THE GOVERNED

March 20, 2010

More than 150 years ago President Lincoln asserted a vital principle of good governance in a democracy: "government should do for the people only what the people are unable to do for themselves." President Obama wants to change that to: "government should do for the people what he, as the winner in 2008, decides is right." Lincoln's formulation respects the consent of the governed. With opinion polls consistently showing that Americans do not want OBAMACARE, the president by ramming through what he has decided is right for America tramples on the consent of the governed.

Obama promises that his way makes quality health care affordable and accessible for nearly all Americans without increasing the public debt. This from a man who attacked pediatricians for performing unnecessary tonsillectomies when those procedures are done by ear-nose-throat specialists. This from a man who assailed surgeons for the $50,000 fee they charge for removing a diabetic foot when the actual reimbursement is much, much lower.

Obama promises that he can accomplish his lofty purpose by removing waste, fraud, and abuse in Medicare and Medicaid, by squeezing the profits of private health insurance companies which have run "amuck" and by taxing investors, the rich, and medical device manufacturers and importers. The transformative Obama sidesteps the issue of malpractice lawsuits that make physicians fearful of the lawsuit waiting behind every exam room door and does nothing to restrain the cramming down of reimbursement to doctors and hospitals for services rendered.

Obama misleads the public by referring to health care *costs* when he really means health care *spending*. In a market economy the cost of producing an item is more or less the same as the money spent on that item. Notice, however, that OBAMACARE depends critically on cutting $500 billion in Medicare *spending*. He is able to do that by further cramming down Medicare reimbursement such that what is spent on health care is less than the cost of producing that care. Physicians and hospitals have been coping with Medicare cram down for years by shifting the unreimbursed cost to other patients who pay cash or are covered by private insurance. To cut health care costs it is necessary to find more efficient ways to produce health care. OBAMACARE cram down doesn't do it.

A first principle of economics is that whenever a good or service is offered free to the public, it is overused. Because it promises access to millions more who won't be charged for their care, OBAMACARE will be overused because Medicaid imposes no limit on access such as a nominal fee for an office/clinic visit or a somewhat higher fee for an emergency room visit.

Since OBAMACARE rejects price as a means for rationing care, bureaucrats will ration care by fiat. Instead of private insurance company bureaucrats whom he has demonized on numerous occasions, Obama puts his trust in bureaucrats in the Department of Health and Human Services. The same bureaucrats who are responsible for Medicare, which is headed toward bankruptcy by 2017. His solution to this impending bankruptcy is to impose a new 3.8 percent tax on the rich and investors which the Treasury is instructed to transfer to the Medicare trust fund in order to keep it from running out of money.

Obama's 2.9 percent tax on medical devices will be passed along to the health care providers who buy and use those devices thereby adding to the cost of health care.

It's not clear how the already cash-strapped states are to pay their share of Medicaid as that share increases in the years ahead with more persons becoming eligible for Medicaid.

Access to care is not assured as long as physicians are free to not accept patients covered by third-party payers such as Medicare and Medicaid known for low reimbursement. Further, low reimbursement forces primary-care physicians to close their practice and accept direct employment as hospitalists.

More and more walk-in clinics will open because they keep the cost of care in line with reimbursement by replacing physicians with nurse practitioners. Unless nurse practitioners are as competent in patient care as physicians, quality of care is compromised.

To protect their incomes from the new 3.8 percent tax on joint returns above $250,000, physicians understandably will increase their fees thereby adding to the cost of care.

Obama's methods often are traced to his ties to Chicago's Democratic machine, which promises to pick up the garbage on time, provide clean drinking water, plow the streets after a snowstorm, and fill in the potholes in the spring. For all its muscle, the machine hasn't been able to deal effectively with gang violence, failing public schools, corruption in public office, to cite just three thorny issues. The machine maintains itself through a system of patronage at the ward level, which secures the necessary votes for the boss. To illustrate, the men who operate the city's garbage trucks double as Democratic precinct captains who are held accountable for getting out the vote.

With OBAMACARE the White House is operating the same way as the Chicago machine. Acting like ward committee men in Chicago, Democratic Congressional leaders are cutting backroom deals with the elected representatives of the people to secure their votes. If you don't like what the boss decides is right for Chicago, you can flee to the suburbs. If you don't like what the president decides is right for America, where do you go? Switzerland?

WILL A SPOONFUL OF OBAMACARE SUGAR MAKE THE MEDICINE GO DOWN?

March 23, 2010

Remember Julie Andrews as the quintessential English nanny Mary Poppins whose remedy for a child's minor aches and pains was rendered so cheerfully in "A Spoonful of Sugar Makes the Medicine Go Down"? As nanny-in-chief of the New American Welfare State, President Obama has prescribed the same remedy for all 301 million of his American children which he promises will relieve all their aches and pains. First, and leaving aside the backroom deals, the sugar of OBAMACARE. Then the medicine.

The Sugar.

Expand eligibility for Medicaid coverage.

Cover dependent children on their parents' health insurance plan until age 27.

Deny no one coverage for a pre-existing condition and drop coverage on no one with insurance when they get sick.

Eliminate lifetime limits on insurance benefits.

Subsidize families with incomes up to 400 percent of poverty to purchase insurance through a health insurance exchange.

Give tax credits to small businesses that offer insurance coverage to their employees.

Impose no patient fees, not even nominal ones, for Medicaid services.

Close the donut hole in Medicare prescription drug coverage.

Make preventive health care available through insurance.

The Medicine.

Impose a new 3.8 percent tax on the rich.

Levy a 2.9 percent tax on medical device (no such tax on pharmaceutical companies).

Require everyone to have health insurance coverage subject to an IRS-imposed penalty for not being covered.

Tax employer-provided "Cadillac" insurance plans (for a family plan, an annual premium greater than $27,500).

Force employers with 50 or more employees to offer insurance or face penalties.

Reduce subsidies to private health insurance companies offering Medicare Advantage health plans.

Cut Medicare spending by $500 billion.

The Side Effects.

More stress on state budgets from increased enrollment in Medicaid, forcing state legislators to make tough decisions about financial support for higher education.

Additional borrowing by the federal government to cover added health care expenditures due to expanded Medicaid and Medicare coverage, growing the public debt even bigger.

Further cramming down Medicare and Medicaid reimbursement for physicians and hospitals to cope with mounting federal budget deficits.

Reimbursement cramdown forces physicians and hospitals to continue to shift unreimbursed costs to other patients, driving up private health insurance premiums.

Quality of care compromised as hospitals refer patients in need of primary care from the emergency room to the hospital's own outpatient clinic staffed by nurse practitioners.

With more persons covered by insurance, more eligible for free health care, and health care considered a right to which all Americans are entitled, there will be more opportunities for attorneys to file malpractice suits.

Notwithstanding Obama's promise to sign an executive order banning the use of federal funds for abortion, the over-the-counter morning-after pill already is available without charge when prescribed by a Medicaid physician or at a reduced price if a private physician prescribes it for a woman covered by a federally subsidized private health insurance plan.

No incentive for patients to limit their demand for care because they are entitled to that care through free government insurance or subsidized private insurance.

No improvement in efficiency or reduction in the cost of the resources used to produce health care services because OBAMACARE addresses the demand for health care services but not the supply.

Mary Poppins is a sweet fictional character loved by everyone. Except for the nanny connection, Obama is no Mary Poppins. He is a real, strong-willed person who was handpicked and groomed by the Chicago Democratic machine, is convinced that he knows what is right, and uses the power of the presidency to impose his will on everyone.

Will the sugar of OBAMACARE be sufficient to make the medicine go down? The answer may come with the mid-term Congressional elections in November.

Or it may come from the judicial system if a constitutional challenge is raised against OBAMACARE, and if as Chicago newspaperman Finley Peter Dunne's fictional Irishman Mr. Dooley who held forth in a pub on the South Side of Chicago asserted years ago "… th' supreme coort follows th' iliction returns."

OBAMA'S STIMULUS PACKAGE ONE YEAR LATER

May 13, 2010

The Obama White House, Congressional Democrats, and the media are feeling affirmed and encouraged by the recent increase in jobs as reported in the payroll survey (CES) and employment as detailed in the household survey (CPS). Between March and April, payroll jobs increased by 290,000 and the number of persons employed grew by 550,000. The 255,000 increase in unemployment is explained away by the re-entry of workers who exited the work force some time in the past, and for that reason the unemployment rate that climbed from 9.7 percent to 9.9 percent can be dismissed.

This account, however, does not square with the March-April increase of 203,000 in the number of discouraged workers. And it draws attention away from labor force developments since the stimulus package was approved shortly after Obama was inaugurated in January 2009 and from a possible glitch in the CES and CPS data regarding illegal aliens.

Compared to April 2009 employment according to the CPS is down (-1,447,000) nearly across the board for adult women, teenagers, whether white or African American, and white adult men. For adult African American men employment over the year was up by 55,000. At the same time, unemployment is up (+1,444,000) for adult men and women whether white or African American, and white teens. The one exception is African American teens where joblessness is down by an estimated 16,000. Further, there has been a 457,000 increase in the number of discouraged workers.

Oddly, and quite unexpectedly, year-to-year employment was *not* down for persons 25 years of age or older with less than a high school diploma and their unemployment was *not* up.

The Obama administration argues that the stimulus package is working because without it employment would have fallen further and unemployment would have risen even higher. For the record, the White House website *Recovery.gov* reports that as of the end April 2010 a total of $205.2 billion had been approved mostly for state and local governments, universities and other research institutions, nonprofit organizations, and private companies. The same website claims that the stimulus package created or saved a total of 682,779 jobs. In a worst case scenario where all those with jobs linked to the stimulus package instead were unemployed it follows that there would have been 15.943 million out of work in April not 15.260 million. The April unemployment rate would have been 10.3 percent not 9.9 percent.

The problem with the stimulus package, which comes as no surprise to anyone familiar with government spending to stimulate the economy, is that it takes time to approve proposals in order to assure that they are well conceived and consistent with the goal of putting people back to work. Though 81,636 awards had been approved by the end of April 2010, only $61.6 billion

had been funded and transferred to the recipient parties. Compared to the entire U.S. economy as measured by current-dollar GDP, the $61.6 billion represents less than one-half percent. The stimulus funds passing through the fiscal pipeline even for "shovel-ready" projects hardly qualifies as a flow. At best they are no more than a trickle. This is no way to fight a recession that began more than two years ago.

If one accepts Obama's own promise that the jobless rate would not exceed 8 percent if Congress approved the stimulus package, the centerpiece of his economic policy has fallen short of its primary goal. Based on the last time unemployment hit 9.5 percent (September 1983 after it had peaked at 10.8 percent in the preceding December), it took until March 1989 for the jobless rate to fall to 5.0 percent. It did not drop to 4.0 percent until December 1999.

The lesson is simple enough: in a deep recession unemployment rises quickly and falls slowly. In December 2007 unemployment stood at 5.0 percent; it rose to 10.1 percent in less than two years. It could take 10 years or more for joblessness to decline to 4.0 percent.

There appears to be a serious glitch in the CES and CPS data that might misrepresent economic performance and mislead policymakers. To explain, with more than 10 million illegal aliens in the United States, it's problematical that they are being accurately counted in either data series. Every month the CPS randomly selects housing units across the United States and then interviews the persons living in those units. To assure that respondents do not get bored answering the same questions month after month, some units are rotated out of the sample each month and others are rotated in.

Are the housing units in which illegal aliens are living actually included in the CPS sample? Aren't illegals taking steps to hide where they live in order to avoid detection by immigration authorities? If such a "hiding place" is included in the sample, is it reasonable that the household respondent would truthfully answer questions regarding any illegals living there put by a CPS enumerator who is an official agent of the federal government? Regarding the CES, are employers honestly reporting their payrolls when they have been employing illegal aliens?

Three years ago Mayo Research Institute inquired of the BLS about the counting of illegal aliens in the CPS and the CES. Here is the Bureau's reply:

> **Neither the establishment [CES] nor household [CPS] survey is designed to identify the legal status of workers. Thus, while it is likely that both surveys include at least some undocumented immigrants, *it is not possible to determine how many are counted in either survey*.**
>
> **…** ***it is not possible to estimate their number*** **and, therefore, we do not make any adjustments to [the CES] data.**
>
> **Your question talks about adjustments [to the CPS estimates] if any for undocumented aliens who deliberately misrepresent their labor force status.**

> **Since no questions are asked about their legal status, *there is no way of knowing if there are any misrepresentations and who the illegal aliens are*.**

At least two problems arise with the CPS and CES data when immigration status is unknown. First, to be counted as employed in the CPS a person has to hold a paid job for one hour or more during the reference week. With day labor, detailed records are not kept making it especially attractive for employers and households who hire illegal aliens and for illegal aliens who therefore may be undercounted in both surveys. Second, illegal aliens may be taking jobs that American citizens and immigrants who are here legally might otherwise hold. In other words, they may be boosting the CPS count of the number of persons classified as unemployed.

Until there is some resolution of the status of immigrants living illegally in the United States, we should not feel confident that the monthly employment and unemployment data are truly accurate indicators of economic performance especially in the southwest border states and sanctuary cities where many illegal immigrants live and are likely to work.

PRESIDENT OBAMA'S STIMULUS PACKAGE: WHAT WENT WRONG

September 10, 2010

Two principal factors account for the anemic performance of the roughly $800 billion stimulus package that was sold to the American public as necessary to re-energize the dismal U.S. economy and was signed into law by President Obama in February 2009. First, it was not a real stimulus package. Second, the president and his economic advisers did not expect U.S. consumers to tighten their belts.

Regarding the first, consider where the monies went according to *Recovery.gov*. The following five not-for-profit organizations are representative of the many others funded by the stimulus package:

> **Roman Catholic Archbishop of Portland (Oregon): $35,362**
> **American Federation of State, County, & Municipal Employees (Kansas): $1,522,384**
> **Columbia Urban League Inc (South Carolina): $55,000**
> **Miami County Young Men's Christian Association (Indiana): $1,594,284**
> **Thelonius Monk Institute of Jazz (Louisiana): $50,000**

All of these expenditures can be rationalized under the official language of the American Recovery and Investment Act.

> **An act making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and state and local fiscal stabilization, for the fiscal year ending September 30, 2009, *and for other purposes*. (emphasis added).**

Thus stimulus monies were allocated even to prestigious institutions such as ten Ivy League universities that have received more than $750 million. The University of Michigan alone has taken $223 million. More than $715 million was paid out to the University of California system. An equal amount was paid out to the California State University system.

Though "shovel-ready" has been used on numerous occasions to characterize the intent of the Act, nowhere on *Recovery.gov* does one find the total amount of national expenditures on infrastructure projects. The curious researcher has to go state by state for that information and even then the state totals are not listed. Included as *infrastructure* projects, for example, are:

> **Metropolitan Organization to Counter Sexual Assault (Missouri): $92,203**
> **Northeast Kingdom Community Action Inc (Vermont): $411,464**

Lewis-Clark Early Childhood Program Inc (Idaho): $83,848
Northeast Service Cooperative (Minnesota): $124,008
Presbyterian Medical Services Inc (New Mexico): $1,293,945

It seems that in following Rahm Emanuel's dogmatic principle "never let a serious crisis go to waste" the architects of the stimulus package intended it primarily to line up and solidify support among friendly and otherwise sympathetic constituencies across the nation for the White House's aggressive agenda to change America and only secondarily to re-start the economy. Their mistake was to presume that simply spreading the wealth around would be sufficient to accomplish the second task. Crudely paraphrasing Lord Acton: *money buys favors and bundles of it buys lots of favors.*

Regarding the second reason, the architects of the Act assumed that consumption expenditures would be boosted by the $144 billion in entitlements and $223 billion in tax benefits paid out to date. Apparently, they did not anticipate that consumers would use those monies to pay down debt. According to the Federal Reserve, on an annual basis consumer credit outstanding began to decline in IVQ 2008 (-3.2 percent) and continued to decline in every quarter in 2009 including fourth quarter (-6.1 percent). The latest information indicates a second quarter 2010 decline of -3.2 percent. Further, by filing for bankruptcy, 1.4 million consumers and businesses last year were able to unload or restructure their debts.

On top of that, 2.8 million properties were foreclosed in 2009 removing the mainstay asset of millions of Americans, and from second quarter 2009 to second quarter 2010 the inflation adjusted price of homes dropped by 4.4 percent. Expecting consumers to step up spending when their net worth is eroding gets a beginning student in economics a grade of F. Buying favors rather than putting America back to work gets the White House the same failing grade.

Had President Obama focused stimulus funding more intensely on *physical* infrastructure projects like highways, water and sewage systems, levees, airports, rail systems, bridges, and harbors in February 2009 when the jobless rate for construction workers stood at 21.4 percent, the construction industry would have been able to supply the labor necessary to carry those projects forward. That kind of sharpened focus would have directly stimulated the demand for material supplies, design and engineering services, and heavy equipment, and indirectly the demand for consumer goods and services. It's safe to say that the jobless rate in construction would have been considerably lower than the current 17.0 percent and for that reason the national jobless rate today would be lower than 9.6 percent.

Obama let a serious crisis go to waste.

OBAMA DEALS WITH U.S. DEBT NOT AS PRESIDENT BUT AS HEAD OF DEMOCRATIC PARTY

August 3, 2011

Two lessons from the blistering discourse just concluded on the debt ceiling. Language matters. Social Security and Medicare are untouchable.

The Social Security retirement trust fund, according to the 2011 report of the program's trustees, will be exhausted in 2038. At that time current benefits will be paid from current tax contributions. However, the trust fund *already* is encountering serious financial problems. Benefits paid in 2010 amounted to $577 billion while net payroll tax contributions totaled $545 billion. The cash deficit was covered mainly by interest payments from the fund's holdings of Treasury securities purchased in the past with the fund's excess cash. With no changes in this program, anyone born after 1972 will not receive the full retirement benefits currently promised.

The Medicare Hospital Insurance trust fund will be exhausted in 2024. The current plan is to deal with this financial crisis by further cutting reimbursement to hospitals. Inevitably access to care will be restricted or possibly denied entirely or the quality of care will diminish. These outcomes will immediately impact anyone Medicare-eligible who was born before 1959 including many baby boomers.

The falling birth rate in the United States means not only fewer workers to support the retiring baby boomers but also fewer adult children to assist their baby boomer parents in times of need. The boomers increasingly will be dependent on the public safety net for assistance. Baby boomers with children have a legitimate worry that their children and grandchildren will be saddled with the burgeoning cost of the public debt, Medicare, and Social Security retirement. Childless baby boomers have no skin in the Social Security retirement game unless they live beyond 2038. Add to them the millions who pay no income taxes and there is little support for addressing the public debt and Social Security retirement. With or without children, boomers do have skin in the Medicare game.

These entitlement programs are untouchable for another reason. The discourse in Congress fosters disagreement. Watching Congressional speeches on C-SPAN, especially the debate in the House of Representatives, reveals a terrible lack of civility that divides rather than unifies. Consider the language used most recently in Congress: "they are acting like terrorists," "he has moved to the dark side," "the deal is a Satan sandwich," "fat cats," "they're taking us back to the 19th century," "they've been holding Congress hostage." Not to mention the harsh and destructive language in the media, especially cable TV, where "strategists" from the

Republican and Democratic camps routinely batter one another.

So what's happened to the civility that President Obama called for immediately following the deadly shootings earlier this year in Tucson, Arizona? Language matters: it can heal and it can hurt. Congress will not soon set aside the hurt inflicted this summer.

Presidential leadership on volatile issues such as the debt ceiling, the public debt, and entitlements where the various interested parties are deeply divided is not a matter of setting down a detailed plan that those parties buy into. Rather, leadership involves bringing the parties together and helping them find common ground amid their differences in order to reach agreement. The president must set aside his role as head of his political party and focus on agreement and not his personal "big deal" agenda. The president must become a mediator or step aside and appoint someone else. Someone who is widely known and respected for an ability to forge agreement in especially difficult circumstances. Someone who sides with none of the parties at the table.

The president should have been striving to get an *agreed bill* that he would have signed whatever its provisions even if it did not reflect his own preferences. He should have taken this position well before the discourse degenerated into rival talking points expressed in uncivil language, scapegoating, posturing, scare tactics, and demonizing. In a time of crisis, the American people deserve better than in-your-face language.

Don't expect the Super Committee to reach agreement. The deep divisions in Congress persist and there is no one clearly able and willing to mediate differences. Instead, expect the same outcome as with last year's Bowles-Simpson report that Obama disowned before the ink was dry. Cuts projected into the future are meaningless whenever they require future Congresses to approve those cuts. The only cuts that truly matter are the ones that are linked to permanent changes in the entitlement programs. And because they have been untouchable in 2011 those programs very likely will remain untouchable in the elections next year.

Pity the president who in little more than 12 years, possibly sooner, has to deal with the American people who have become outraged that Medicare is broken and the president who in roughly 27 years has to admit that the promised retirement benefits cannot be delivered.

Just as the cost of repairing a leaky roof increases the longer one puts off those repairs, the longer that Medicare and Social Security reforms are put off the more costly the reforms become with every passing year.

In the end, will reform require the kind of rebellion Thomas Jefferson spoke of nearly 225 years ago?

HOW MANY MORE JOBS NEEDED TO GET OBAMA RE-ELECTED?

November 7, 2011

Even his staunchest allies acknowledge that President Obama's re-election in 2012 turns critically on improvements on the jobs front. They know that without substantial improvement there will be no re-election.

Thus the essential question facing President Obama re-election team is how many more jobs are needed to reduce the jobless rate to a politically acceptable level?

Oddly enough, Ronald Reagan encountered strikingly similar economic conditions: a failing economy inherited from his predecessor that produced double-digit joblessness early in his first term. Further, in September 1983 -- one year prior to the 1984 re-election cycle -- the unemployment rate stood at 9.2 percent. One month later it had dropped to 8.8 percent. For Obama the September-October 2011 numbers are roughly the same: 9.1 and 9.0 percent.

In January 1984 the rate of unemployment fell to 8.0 percent, and by the following July it dropped to 7.5 percent. One month before the 1984 elections, it stood at 7.4 percent slipping to 7.2 percent in November.

The historical record and Reagan's re-election suggest that it is possible for Obama to repeat, but here's the kicker: during the 12-month period ending in November 1984 the number of employed persons increased by 3.2 million. In addition, given the increased size of U.S. population, the improvement in employment necessary to drive the jobless rate below 7.5 percent by November 2012 would have to be even greater than 3.2 million. How much greater depends in part on the number of persons presently not in the labor force who would enter the labor force if and when economic conditions improve.

Based on data from the Bureau of Labor Statistics, the following table shows the actual change in the jobless rate, the number of months to effect that change, and the corresponding increase in employment beginning in September-October 1983 when the rate of unemployment hovered around 9 percent.

Change in jobless rate	*Number of months to effect change*	*Corresponding increase in employment*
9.0 to 8.5	**1-2**	**917,000**
8.5 to 8.0	**2**	**472,000**
8.0 to 7.5	**6**	**2,234,000**
7.5. to 7.0	**16**	**2,372,000**
7.0 to 6.5	**16-17**	**3,594,000**
6.5. to 6.0	**4**	**1,456,000**
6.0 to 5.5	**12-13**	**2,262,000**
5.5 to 5.0	**6-7**	**1,703,000**
TOTAL: Sep/Oct 1983 to Mar 1989		**15,210,000**
< 5.0	**88**	**12,800,000**

At the end of Reagan's second term in 1988, the jobless rate stood at 5.5 percent, which at that time economists regarded as somewhat above the full-employment mark. Finally, by March 1989 with employment having risen by 15.2 million since 1983 the rate of unemployment dropped to a more politically acceptable 5.0 percent. With another recession intervening in the early 1990s, it took an additional 88 months and a 12.8 million increase in the number of persons employed to push the jobless rate below 5 percent.

While it is possible for Barack Obama to repeat in 2012, the harsh political reality is that he is no Ronald Reagan. President Reagan was notably business-friendly. Solyndra aside, President Obama is not.

OBAMA MANGLES LINCOLN ON THE ROLE OF GOVERNMENT

January 25, 2012

In his 2012 *State of the Union* address President Obama defends his personal convictions regarding the role of the government by twisting Lincoln's own words on this matter. Lincoln did not say, "government should do for the people only what they cannot do better for themselves." Rather, he said "in all that the people can individually do as well for themselves, the government ought not to interfere." See Ralph Y. McGinnis, *Quotations from Abraham Lincoln,* Chicago: Nelson-Hall, 1977, p. 41.

This mangling of Lincoln is doubly unfortunate coming from the former U.S. senator from the State of Illinois that proudly and officially proclaims itself the "Land of Lincoln."

This twisting of Lincoln's convictions is much more than unfortunate. Obama's version enables government action. Lincoln's version limits government action. Obama empowers the federal government. Lincoln empowers the people. Obama sets aside the Tenth Amendment of the Constitution. Lincoln embraces it. "The powers not delegated to the United States by the Constitution nor prohibited to the States, are reserved to the States respectively, *or to the people*."

Societies are constructed and re-constructed around functional elements of different size and strength. The largest and strongest functional element of American society is the federal government. The smallest and weakest is the individual. Between those two are four other functional elements: state governments, local governments, private organizations (such as firms, unions, trade associations), and families. Within these four, state governments in general are larger and stronger, families are smaller and weaker.

Obama believes in a re-construction that makes the federal government even bigger and stronger. Lincoln rejects any re-construction that makes the people smaller and weaker. By widening opportunities for smaller, less powerful functional elements to participate directly in economic decision-making processes that bear upon their well-being, Lincoln reinforces the democratic principle. Obama weakens it.

By affirming a strong preference for private enterprise, those who are faithful to Lincoln's vision decentralize ownership and control of economic activities that in turn (1) leads to a greater diversity of goods and services produced because entrepreneurs have a freer hand; (2) a smaller risk that large-scale mistakes will be made because in general private enterprises are smaller than public enterprises; and (3) private enterprises will be more responsive to their customers because they are driven by the need to turn a profit. Those who are faithful to

Obama's vision are convinced that private enterprises have to be controlled lest they run amuck. They put their trust in the government, not the people. Big banks are bad. Big government is good.

In his *State of the Union* address Obama spoke often and approvingly of the entrepreneur. He sees the entrepreneur as a partner with the federal government in energizing economic affairs. In his vision, the taxpayer is the one who stands to win or lose when the federal government chooses to invest in a specific company such as Solyndra. And when the taxpayer loses why isn't this the equivalent of taxation without representation?

What Obama does not accept is that whenever an individual or firm is truly empowered and becomes successful in an entrepreneurial venture, the need for public intervention and the scope of any public-private partnership are reduced. The key issues for the empowered entrepreneur are freedom *from* excessive government control and freedom *to* risk investing in new ideas. Those freedoms are nurtured more in a social order where preference is given to private control of decision-making, where private investors win or lose based on their own decision-making, and the taxpayer is not on the hook for business decisions made by public officials and Washington bureaucrats.

Americans have a special genius for strengthening private enterprise without turning to the government to solve their problems. From time to time private firms that otherwise compete form alliances to address issues that cannot be handled by those firms operating independently. These alliances are positive-sum agreements that seek to achieve gains for all of the parties involved whether they are directly represented in the alliance or not. Four examples help make this point, reflect the great diversity of such alliances, and drive home the lesson that whenever private enterprise acting alone cannot manage certain problems it is not necessary to turn immediately to government for assistance.

Advanced Book Exchange (Abebooks) is the world's largest online marketplace for used, rare, and out-of-print books. The exchange brings together thousands of independent booksellers worldwide. Each seller decides which books to list, their general condition, price, and other information. Buyers can browse the books through a convenient search function. The on-line exchange allows buyers to comparison shop and sellers to reach a much wider market.

Louisiana Offshore Oil Port (LOOP) is a limited liability company that offloads and stores foreign crude oil from tankers for eventual transport by pipeline to refineries throughout the Gulf Coast and Midwest. LOOP has three owners: Marathon Pipe Line LLC, Murphy Oil Corporation, and Shell Oil Company. To assure the safe handling of oil from deep draft supertankers the offloading is done at a terminal located 18 miles off the Louisiana coast in 110 feet of water. A pipeline transports the oil to onshore storage facilities and from there to the participating owners' refineries. LOOP was built and continues to operate only because the three owners understand that they can reduce the risks in offloading and transporting crude oil more effectively by working together than by operating independently.

The Business Software Alliance was established to combat piracy of software products. BSA members include among others Adobe, Apple, Intel, Microsoft, and Symantec. To help reduce the unauthorized installation of proprietary software products without a license BSA has issued an annual report on the extent of piracy and dollar losses by country every year since1992. Unrestrained piracy takes away the economic gain (profit) necessary for private enterprise to survive and thereby destroys the very means by which new and better products and services are brought to the marketplace.

PRIDE of St. Louis is the first voluntary labor-management organization in the construction industry in the United States. Under the direction of a seven-person leadership team, PRIDE meets monthly with representatives from area architectural, engineering, and construction firms, the building trades, and the buyers of construction services to identify stress points in the St. Louis construction industry in order to forge agreement on how best to improve productivity, cost-effectiveness, and work force training. PRIDE's ultimate objective is to ensure the continued growth and development of the construction industry in St. Louis for the benefit of all parties involved.

Ceding control of economic decision-making to Washington over time has weakened the resolve and ability of many smaller, weaker functional elements in America to reclaim control of those decisions that directly impact their economic well-being. Lincoln's vision that empowers the people is being cast aside by Obama who then misquotes Lincoln to make it seem that empowering government was Lincoln's intention. Lincoln did not say that government should intervene. He emphasized that it "ought not to interfere."

These two substantially different visions of the role of government are at the very core of the 2012 presidential election campaign and likely will determine if Obama will serve a second term.

REPLACING MONOLITHIC OBAMACARE WITH CHOICE AND FLEXIBILITY

April 1, 2012

If the Supreme Court rules that Obamacare is unconstitutional, Congress will have to decide whether to attempt another federal overall or put in place entirely different reform legislation. To replace a monolith like Obamacare, which brings down the whole house when it fails, Mayo Research Institute strongly recommends ten *bare* essentials of a more flexible and freedom-protecting reform that puts control of health care largely in the hands of the states.

Reform along these lines -- though clearly imperfect because health care is a uniquely personal, one-on-one practice subject at times to human error -- is better than a federal, universal-care system because if and when one state program collapses other state programs are not brought down. In addition, charging the states with the main responsibility for health care moves the system closer to those in need and thereby helps make the system more responsive to their needs.

● Based on the 10th amendment that reserves all un-enumerated powers in the Constitution to the states, each state is instructed to reconstruct its own health care system according to the specific health care needs, resources, values, and principles of its citizens.

● Guided by the principle of subsidiarity, the federal government would provide financial support for any state that is unable to meet the basic health care needs of its citizens with its own resources. To assure that any such state continues to function as the principal party in its health care system, federal assistance would contain no mandates and would be limited to no more than 49 percent of that state's public expenditures on basic health care services.

● Founded on the principle that health care is a universal human need, each state would decide the minimum health care it requires of insurance companies offering coverage to its citizens. The minimums would be recommended by an advisory group constituted of representatives from throughout the state's health care system. Whenever that advisory group reaches agreement its recommendations would be passed without revision by the legislature and signed into law by the governor. Whenever that advisory group is unable to reach agreement the legislature would define those minimums. The advisory group would revisit those minimums as circumstances change. .

● Based on the long-standing practice of private employers offering insurance coverage to their employees, employers would be encouraged but not required to offer health care coverage to their employees with the state reimbursing up to 50 percent of the cost of the state minimums. Substantial co-payments would be a necessary part of any insurance policy in order to limit abuse. Any employer who wants to provide coverage beyond the minimum

would have to pay in full the additional expense of providing that protection. An employer with such coverage thereby would be at a competitive advantage in attracting and retaining workers.

● Grounded on the principle that individuals have a fundamental responsibility to provide for their own needs as far as possible, any individual without employer-backed insurance would be encouraged but not required to purchase coverage with the state reimbursing up to 50 percent of the cost of the state minimum coverage. Co-pays would be a necessary part of any insurance policy. Anyone who wants coverage above the minimum would have to pay in full the additional cost for that protection.

● Taking account of the special health care needs of certain persons, catastrophic coverage policies would be required of any insurance company doing business in the state. Anyone electing that added protection but not able to afford it would get a state tax credit to cover up to 50 percent of the cost.

● Relying on the principle that no one of means has a right to impose the cost of their health care on others, anyone of means who decides not to have insurance coverage and subsequently requires health care services would be restricted to the minimum coverage as defined by the state. That person would be eligible for health care beyond the minimum only if he/she is willing to pay in full the additional expense of providing that care.

● Based on the fundamental dignity of all humankind, persons too poor to afford their own health care would have access to the minimum coverage as defined by the state at the state's expense. To help eliminate abuse, a nominal co-pay would be required of anyone in financial distress.

● Backed by the principle of the fundamental freedom of every individual as confirmed in the Declaration of Independence and the Constitution, citizens and employers unhappy with their state program are free to relocate to a different state with a program better aligned with their needs, resources, values, and principles.

● Guided by the principle that the federal government should do for the people only what the people, private organizations, and state governments are unable or unwilling to do for themselves, any state that does not want to reconstruct its own health care system must accept whatever reforms are developed in Washington.

In the mid 1930s, states were offered the option of designing and managing their own unemployment insurance programs or having one imposed by the federal government. Without exception every state opted for its own program.

Given the similarity between the need of unemployed and the need of the sick -- both needs are largely outside the control of the individual -- the states' nearly 80-year track record of providing for the need of their jobless workers encourages us to think that they are able to do as well for their citizens in need of health care, though it won't be easy.

In the end, reform that originates in each state, though less than perfect, provides the kind of choice and flexibility that monolithic federal reform does not and cannot.

OBAMACARE'S AAA RATING: ACCESSIBLE, ACCEPTABLE, AFFORDABLE

June 29, 2012

In a 5-4 decision, the Supreme Court has ruled that the Affordable Care Act is constitutional with apparently the exception of the mandated expansion of state Medicaid rolls under penalty of loss of federal Medicaid funding.

Anyone who labored through last March's oral arguments in this case on C-SPAN witnessed the justices continually interrupting one another with other questions or comments, sometimes extraneous, in which the discussion shifted back and forth at times with one party talking about the health insurance market and the counterparty talking about the health care market. And parsing the difference between a fee, a tax, and a penalty.

Nowhere in those arguments was the issue of the supply of health care addressed, the overall cost of care, and who eventually pays for that care, with the exception that anyone who does not have insurance and uses health care is imposing an additional cost on those who do have insurance. Explicit in that argument was the premise that those who are young and healthy today and do not need health care have an obligation to buy insurance so that later on they will have access to care when they need it. This argument falls flat because the young and healthy are forced to buy health insurance not to assure that their healthcare will be paid in the future but to pay the cost of providing care to those who need it today.

One comes away from listening to those arguments wondering if this is the best the Court can do on this crucial issue that shoves America further down the road of greater federal government control of health care.

The supply of health care reduces to three stark realities: the cost of medical school, reimbursement, and the risk of practicing medicine. First, medical school increasingly is an expensive investment for which the return may not be worth it. To illustrate, tuition today at one private medical school in the Midwest that traces its origins to 1818 is $47,440 per year. Assuming living expenses of $1500 per month pushes the annual financial burden to well over $65,000. Add to that the cost of three to five years of specialty training or more.

Second, health insurers including Medicare and Medicare reduce their costs and the premiums they charge the persons they insure by routinely gutting reimbursement payments to physicians and hospitals. One example among thousands makes this point: a physician in the South this June was paid $19.27 by a private insurer on a $445 bill submitted for a woman's health care services.

Third, years ago one primary-care physician in private practice said in exasperation: "there's a lawsuit waiting behind every examining room door." Obamacare does absolutely nothing about these realities.

Let's take a closer look at the AAA promises made by Obamacare: accessibility, acceptability, and affordability.

Accessible. **Today hospitals are not free to deny care to anyone who presents in the emergency room, but physicians are turning away patients whenever a Medicare, Medicaid, or private insurance card is presented because experience has demonstrated that too often reimbursement doesn't cover the cost of care, even when they take no compensation for providing that care. Thus, a two-tiered system is evolving in health care. The first-tier is for those who are able and willing to pay. The second, in which the quality of care may be compromised, is for those whose insurance company does not pay.**

Acceptable. **Producers typically address rising costs and the squeeze on their bottom line in one of two ways: by improving productivity and by substituting cheaper resources for more expensive ones. Improving productivity is especially challenging in health care because unlike manufacturing where the product is the same and the process is repetitive each patient is different and presents unique problems of care. Outsourcing is one method for reducing the cost of resources. Hospitals and clinics pursue the outsourcing logic by replacing physicians with nurse practitioners. Intending no disrespect to nurse practitioners, even when fully trained are they capable of performing quadruple bypass surgery, or removing a bullet from the cranial cavity, or reconstructing a woman's breast following cancer surgery, or intubating a premature newborn who needs respirator care, or removing a ruptured appendix or herniated disc?**

Affordable**. With the cost of educating and training physicians on the rise, and reimbursement problems telling medical students that it will take years to pay back the cost of their education and training, the supply of such critical subspecialties as neurosurgery, neonatology, and cardio-vascular surgery will contract reducing access to quality care. Hospitals that want to continue offering those kinds of services will have to pay more. Others may decide to drop those services entirely.**

Once rising health care costs and insurance premiums collide with falling reimbursement rates, higher taxes, more public debt, and rationing become the only options. With the Court's decision, there is no apparent limit on the federal government taxing power. It follows that many public officials in Washington will push for higher taxes, mainly income taxes, to feed the health care system. If resistance to higher taxes cannot be overcome, the government may find it easier to simply add to the current budget deficit and the public debt.

Future generations will pay for the cost of health care that the current generation is unwilling to pay for because, after all, it's an entitlement. Under the rationing option decisions regarding who gets what will be made in Washington by bureaucrats who do not have to tell patients that their access to care has been denied. Conceivably, the obese may be forced into a strict dietary

and exercise program or be taxed, or the elderly may be compelled to take certain medications or face the same consequences.

Writing more than 60 years ago an apolitical Bernard Dempsey offered the following. Just as democracy is in a precarious state when those who vote the taxes and those who pay the taxes are not the same people, so too, when economic decisions are made by persons who do not bear the economic consequences, good or evil, of their decisions, inevitably, those who do bear the consequences of the decisions will exhaust every resource to influence them. When this occurs, as it has in all industrial countries, the state has lost its impartiality and authority.

Is there no adult left in Washington who remembers the well-intentioned AAA promises made in the 1950s and known as urban renewal and high-rise public housing?

OBAMANOMICS:
NOT WORKING FOR HIS KEY CONSTITUENCIES

July 7, 2012

From the very start of his presidency Barrack Obama has blamed the economy's poor performance on the "failed" policies of his predecessor George Bush. His insistence on shifting the blame is reinforced virtually every day by various Democrat pollsters, strategists, spokespersons, party loyalists, public officials, and assorted other allies.

If their claims had any validity at all, one would expect to find some improvement of late especially for Obama's base: African-Americans, Hispanics, young Americans, and labor. It's here, however, that his supporters' claims collide with data published by Obama's own Departments of Labor and Commerce on unemployment, inflation, GDP, labor productivity, real compensation, and labor's share of the economic pie.

Consider the following data on the jobless rate for June 2012 vs. January 2012.

	Jun 2012	Jan 2012
Seasonally adjusted		
All persons	8.2	8.3
Black men 20 yrs +	14.2	12.7
Black women 20 yrs +	12.7	12.6
Not seasonally adjusted		
Whites 16-24 yr olds	16.0	15.2
Blacks 16-24 yr olds	30.2	26.3
Hispanics 20 yrs +	9.9	11.0

The record is clear: double-digit unemployment for Obama's core constituencies that with the exception of Hispanics has gotten *worse* in 2012.

Consider five other measures of economic performance since Obama was inaugurated: GDP, productivity, prices, compensation, and labor's share.

	Percentage Change			
	2009	**2010**	**2011**	**I qtr 2012**
Real GDP	**-3.5**	**+3.0**	**+1.7**	**+1.9**
Lbr productivity	**+2.5**	**+4.0**	**+0.2**	**+0.4**
Consumer prices	**-0.4**	**+1.6**	**+3.2**	**+0.9**
Real comp @ hr	**+2.0**	**+0.3**	**-0.9**	**-1.5**
Labor's share	**-1.5**	**-3.2**	**-0.4**	**-0.9**

Here, too, the record is clear: anemic improvement in real GDP and labor productivity, steady increases in consumer prices, and most recently deteriorating real hourly compensation.

The 0.2 percent gain in labor productivity in 2011 was the lowest annual increase since 1995. Improving labor productivity is important because workforce gains in efficiency in general allow producers to increase compensation without raising prices.

Perhaps most significant of all, and very telling with regard to Obama's labor constituency, are the data on labor's share – compensation paid to labor as a share of national output – that show a decline every year of his presidency, continuing into the first quarter 2012.

President Obama and his surrogates no doubt will continue to ballyhoo large increases in private-sector payrolls over the past 2-3 years. At the same time, they will be largely silent as to why those improvements have failed to reduce the jobless rate for key constituent groups below the double-digit level, and why labor's share of the national economic pie throughout his entire term of office has been shrinking.

According to the National Bureau of Economic Research, which officially dates the start and the end of economic contractions, the Bush recession ended in June 2009. For all intents and purposes, and in spite of his best efforts to turn the U.S. economy around over the last three years, the Great Recession has not ended for many of Obama's most loyal constituents.

OBAMA SELLS HIS LATEST MIDDLE-CLASS TAX CUTS ON MISLEADING CLAIMS

July 12, 2012

On July 9 President Obama proposed extending the Bush middle-class tax cuts for one more year, at the same time allowing the cuts to expire for anyone making more than $250,000 a year, thereby boosting their taxes. In the past, he has argued that the wealthy ought to pay more in taxes because under the Bush tax regime, which is set to expire on January 1, they have not been paying their fair share. This time, however, his argument is different: "top-down" economics hasn't worked.

Obama asserted that over the last decade the Bush tax cuts promised "more jobs and higher income for everybody, and that prosperity would start at the top but then trickle down." In addition, he asserted that the United States had the "slowest job growth in half a century."

In January 2001, when George Bush was sworn in a president, total employment according to the BLS household survey was 137.8 million. When Bush's second term ended eight years later in January 2009, total employment had climbed to 142.2 million. That's an increase of 4,400,000 or 3.2 percent. Drop the data for 2008, and the increase amounted to 8,619,000 or 6.3 percent. Based on the BLS payroll survey, on the other hand, the increase in the number of jobs for Bush's full eight years in office was just 1,095,000.

The household survey counts persons, the payroll survey counts jobs. One important difference is that a dual jobholder is counted once in the household survey but twice in the payroll survey.

Since Obama was inaugurated as president, the number of persons employed has increased by 228,000. At the same time, however, the number of payroll jobs has *decreased* by 473,000. A reminder: the Great Recession ended officially in June 2009. It's Obama's own employment record that is the weakest in the last 50 years, and his payroll record is even worse.

In December2008, the last full month of Bush's presidency, the jobless rate stood at 7.3 percent – higher than at any time in his eight years in the White House. In none of the following 41 full months that Obama has served as president has unemployment dropped below 8.1 percent. The last time joblessness stayed at 8 percent or higher for an extended period of time was the 27 consecutive weeks from November 1981 through January 1984 after the Federal Reserve cranked up the prime rate of interest to 21.5 percent in December 1980 to rein in inflation. In sharp contrast, Obama's dismal jobless record occurred in spite of historic lows in interest rates, bailouts, and a massive stimulus package.

Regarding income, Obama is fond of citing figures on household or family income that can be

misleading because over time household and family composition has changed. Household and family size has been getting smaller due to fewer babies being born, and more households and families breaking up. For those reasons, Mayo Research Institute examined instead real hourly compensation for workers in the business sector because that metric is not subject to those changes. With the exception of 2008, real compensation improved in every one of the Bush years. Even including 2008, it climbed by a total of 6.6 percent. During Obama's years in office, real compensation dropped in 2011 and again in the first quarter of 2012.

Obama wants a return to the Clinton era tax regime because, as he claims, under Clinton nearly 23 million additional jobs were created and we had the "the biggest budget surplus in history." The first part of that claim is accurate; the second is not. In every one of Clinton's eight years the federal budget closed with a deficit raising the public debt from $4.411 trillion at the end of FY 1993 to $5.807 trillion at the end of FY 2001, an increase of $1.4 trillion. The budget surpluses Obama is talking about are the surpluses in the budgets Clinton submitted to Congress, surpluses based on rosy projections of tax revenues before the start of the fiscal year, and not on the actual revenues and expenditures as recorded at the end of the fiscal year.

Real hourly compensation during the Clinton years actually fell in each of the first three years of his tenure in office, and then rose in the last five years. The overall increase for his eight years in office was 14 percent.

There are two lessons to be drawn from the kinds of claims made by Obama on July 9. First, because they are ambitious human beings politicians tend to pick and choose the numbers that best serve their purposes at the moment, and as it often turns out the data pickings are as rich and varied as the offerings on the buffet line at a swanky casino. Second, because they can be devious human beings politicians may call attention to a certain data point, leaving out important details about its reliability, relevance, statistical significance, and historical context, and hoping that no one will take the time to unpack their claims.

In all of this we are reminded of the warning of founding father Ben Franklin: "it is in the religion of ignorance that tyranny begins."

OBAMA ATTACKS ROMNEY'S CORPORATE TAX PLAN FOR CREATING JOBS OVERSEAS

July 19, 2012

Several days ago President Obama attacked Mitt Romney's corporate tax plan that would exempt from U.S. taxation all profits earned by U.S. multinational corporations from activities in foreign countries. This so-called pure territorial tax system would, according to Obama, increase employment overseas by 800,000.

Unlike Romney, Obama does not propose a pure territorial tax system. Obama's offers instead a minimum tax on foreign earnings thus subjecting those earnings to double taxation: once by the country in which they were earned and again by the United States. The purpose of this double taxation is to penalize U.S. corporations for investing and creating jobs abroad.

The largest share of these 800,000 jobs – an estimated 189,000 – would go to Canada and Mexico with whom the United States has a free trade agreement. Obama's truth team, speaking on his behalf at www.barackobama.com, warns that Romney's plan could displace American workers for Chinese workers but says nothing about the much bigger estimated impact on the America's NAFTA trading partners. This tip of Obama's attack on Romney could be called "playing the China card."

Obama's numbers come from a June 2012 study by Kimberly Clausing of Reed College in which she assumes that the effective tax rate on corporate profits in the United States is 27.1 percent. The effective tax rate is lower than the current 35 percent statutory rate due to loopholes in the U.S. tax code. Portions of the data she employs in making her estimates come from U.S. multinational operations over the 1982-2004 period.

In citing her study, Obama referred to Clausing as a "nonpartisan economist" even though the Center for Responsive Politics reports that she contributed $242 on September 14, 2011 and $250 on May 18, 2012 to Obama's re-election campaign.

Most of the countries benefiting from the 800,000 increase in jobs, according to Clausing, are not tax havens. They have lower effective tax rates than the United States.

Nowhere in her study does Clausing indicate how much of the 800,000 jobs increase overseas is attributable (1) to a displacement of American workers that derives from differences in the cost of production, lower effective tax rates on earnings in other countries, or both, or (2) to attractive opportunities in countries where demand for goods and services is growing. The first involves *relocating* U.S. operations in foreign countries. The second involves *starting up* or *expanding* operations in foreign countries.

Thus, consider her language: "a pure territorial tax … *would* increase employment in low-tax countries by about 800,000 jobs" and "these new low-tax country jobs *could* displace jobs at home." Obama's website, where the Clausing study appears under the heading "Mitt Romney's guide to creating 800,000 jobs overseas," makes no mention whatever of the startup/expansion effect, leaving the impression that Romney's territorial tax scheme would in fact displace hundreds of thousands of American workers.

Romney would reduce the statutory tax rate to 25 percent. Thus, the effective tax rate would be lower than 27.1 percent. As Clausing says "If the U.S. effective tax rate were to fall [below 27.1 percent] due to changes in the tax code, the calculated job responses would be lower." Lower than 800,000. Obama makes no mention of this in his public remarks condemning Romney's proposal.

Further, he makes no mention of the effect of current unemployment rates in the United States that, according to Clausing, "could displace jobs at home." In other words, the failure of the Obama administration to achieve a much lower jobless rate raises the chances that the 800,000 jobs created abroad would actually displace jobs in the United States.

Thus, the very study that Obama cites in attacking Romney's proposed tax plan also in effect takes to task Obama's own failed economic policies. Understandably in a presidential election year with so much at stake for the winners, one can hardly blame a candidate for picking the data points that put him at some advantage. Even so, with his vast army of partisan data miners shouldn't Obama be able to find just one who has done his homework and could warn him that the Clausing study can be turned against not only his own economic policies but the performance of the U.S. economy on his watch?

BUSH RECESSION, OBAMA RECOVERY

September 14, 2012

President Obama and his supporters have not yet tired of blaming the economic mess that he faced when he first took office in January 2009 on President Bush and asserting that the Great Recession – the Bush Recession -- is the worst since the Great Depression. Let's look at the historical record.

Phase I of the Great Depression ran from September 1929 to March 1933. Phase II ran from May 1937 to June 1938. Total number of months in economic contraction: 56. It was not the New Deal that brought an end to the Great Depression. It was World War II.

The Great Recession ran from December 2007 to June 2009. Number of months in contraction: 18. Thus, measuring the severity of the contraction in terms of months, the Great Depression was three times longer than the Great Recession. Comparisons in terms of joblessness are not possible because the Bureau of Labor Statistics, which provides that information, did not begin collecting it until the early 1940s. Prior to that time there are only guestimates of the extent of joblessness.

The current recovery has lasted 38 months. If the contraction can be called the Bush Recession it follows that the recovery should be called the Obama Recovery. Let's take a look at the performance record of that recovery. In the following, ten data points are reported covering activities in the labor, financial, real-estate, and product markets.

First, there were 7 million persons in August 2012 who were classified as not in the labor force but who want a job now. This is the largest number of persons so classified in any month since this information was first made available to the public in January 1994. It is more than eight times greater than the number of discouraged workers. If those 7 million are added to the jobless total, the labor underutilization rate jumps from 8.1 percent to 12.1 percent. The BLS regularly reports 6 measures of labor underutilization. This one, developed by Mayo Research Institute, is not one of them.

Second, since June 2009 there have been 393 FDIC-insured bank failures.

Third, for all black persons poverty climbed from 25.9 percent in 2009, to 27.4 percent in the following year, to 27.5 percent last year.

Fourth, annual percent improvement in labor productivity – 3 percent is the norm – dropped from 3.1 percent in 2009 to 0.4 percent in 2011. Productivity improvements are important because they help reduce the cost of production and make America more competitive globally.

Fifth, the Federal Reserve holdings of U.S. Treasury securities climbed from $606 billion in June 2009 to $1.652 trillion in September 2012. At the same time, its holdings of mortgage-backed securities increased from $427.6 billion to $843.7 billion. Most recently the Fed announced that it will purchase $40 billion of mortgage-backed securities on a monthly basis in order to further stimulate economic growth.

Sixth, in the first half of 2012 there was a total of 1.046 million properties with foreclosure filings.

Seventh, the U.S. merchandise trade deficit, essentially exports minus imports, rose from $218 billion in June 2009 YTD to $359 billion in June 2012 YTD. This deficit represents the amount that U.S. producers and consumers must borrow in order to pay for the imports that earnings from U.S. exports do not cover. National income accounting reports this deficit as a drag on GDP.

Eighth, the 75-year estimated unfunded obligation of Medicare Part A increased from $3 trillion in 2011to $5.3 trillion in 2012. Direct comparisons to 2009 are misleading because the Affordable Care Act changed the benefits allowed through Medicare Part A.

Ninth, in 2009 the federal government's multi-billion dollar bailout of General Motors included the purchase of 500 million shares of stock – a 26 percent ownership stake. Sales of the Chevrolet Volt, the electric vehicle so attractive to the Obama administration for reducing toxic emissions, amounted to 8,817 for the first six months of 2012. The base price of the Volt is approximately $40,000 but the buyer gets a $7500 federal income tax credit. The Ford Motor Company, which got no federal bailout monies, has set a 2013 base price for its hugely popular Ford 150 pickup truck at $23,000.

Tenth, in the 81-page report of the National Economic Council, "Moving America's Small Businesses and Entrepreneurs Forward," which was released to the public last May, President Obama is mentioned 75 times.

Bush owns the recession. Obama owns the recovery.

OBAMA PRESIDENCY AND JOBS: MYOPIC, EMBELLISHING, DISMISSIVE

November 3, 2012

The latest BLS jobs report that focuses on the 171,000 new payroll jobs and the 7.9 percent unemployment rate diverts our attention from the performance of the Obama presidency that is myopic, embellishing, and dismissive.

The myopic side of the presidency begins with those parts of the report that command little attention: joblessness among black Americans that rose to 14.3 percent in October; the typical unemployed worker who has been out of work for 40.2 weeks; the 8.3 percent of full-time workers who are unemployed; and the 325,000 additional women who compared to one year ago are not in the labor force but want a job now.

Consider as well these instances of myopia. The current unemployment rate is above 8 percent for all workers in production occupations, above 9 percent for all transportation and material moving occupations and all service occupations, and above 12 percent for all construction and extraction occupations.

What also matters for the Obama presidency is how well the economy has performed since he was sworn into office. How well has it performed especially in terms of the stimulus package, auto bailout, financial reform, and Obamacare?

Payroll jobs. **Since January 2009, total nonfarm payroll employment has inched upward from 133.6 million to 133.8 million.**

Stimulus package. **Consider the White House's embellished claims about job creation. Since the start of the recovery program in 2009, a total of $777.8 billion has been paid out, creating in third quarter 2012 a total of 135,455 jobs. The impact of removing these 135,455 jobholders from the pool of the unemployed in October is a reduction in the jobless rate of less than 0.1 percentage point.**

Auto bailout. **And this embellished claim. Employment in U.S. motor vehicle and parts manufacturing – some partisan strategists and bloggers claim that it has climbed by 2 million -- increased by only 83,500 since January 2009.**
In the battleground state of Ohio, employment in this sector increased by only 2,100 since January 2009. Of the 5.2 million jobs in Ohio today, roughly 1.5 percent are in motor vehicle and parts manufacturing.

Financial reform. **Reflect on this instance of Obama myopia. The number of jobs at all U.S. commercial banking, savings institutions, credit unions, and other depository institutions has declined by 34,800 since Obama's inauguration.**

Obamacare. **Think about this grand instance of dismissiveness. The Association of American Medical Colleges reports that the combination of the Affordable Care Act and physician retirements will balloon the shortage from 7,400 physicians in 2008 to 62,900 in 2015 and 91,500 in 2020. The shortfall will be especially critical for surgeons where it will reach 35,000 in 2020. Who will care for the additional 32 million Americans with coverage under Obamacare?**

Myopia, embellishment, and dismissiveness are not the stuff of sound economic, financial, and health care policies for the American people. They are instead indicators of very costly, failed economic, financial, and health care initiatives pushed through by the Obama presidency.

A HOUSE DIVIDED AGAINST ITSELF CANNOT STAND

November 9, 2012

With roughly 370,000 more votes in Florida, Iowa, Ohio, and Virginia, Romney would have been elected president. Put differently, if only 185,000 voters who in the end voted for Obama had cast their ballots for Romney, Obama would not be getting ready for a second term in the White House.

A total of 9,614,484 votes were cast for Obama in Florida and the other three states. Thus a switch to Romney of fewer than 2 percent of the votes cast for Obama in those four states and Romney is preparing to take the oath of office.

This presidential election demonstrates clearly that America is almost evenly divided between a land of opportunity and a land of entitlements. America is a land of opportunity as long as there is an incentive to work hard. It is a land of entitlements whenever politicians can persuade enough voters to cast their votes for them on the promise that they (the voters) will be taken care of. Land of opportunity rests on America the economic system. Land of entitlements is grounded in America the political system.

There is one legal limit on America the land of opportunity: taxes and regulation (another form of taxation). There is one legal limit on America the land of entitlements: the debt ceiling. In both cases, the limit is determined in Washington.

The debt ceiling represents no effective limit on America the land of entitlements because it is raised by Congress almost always without any real objection. The problem is with the limit based on taxes because the Democratic Party is seriously committed to raising taxes on the rich and they can succeed in imposing this limit if enough Republicans can be persuaded to approve higher taxes by promising to deliver cuts in spending in the future. The problem with Democratic promises is that too often they have been empty promises.

The only way out of this divided house is by growing the economic pie. A larger pie makes possible both a land of opportunity and a land of entitlements. But as we have seen higher taxes – no one knows for sure how much higher – impose a limit on America the land of opportunity. Why work harder, or at all, if much of one's income is taxed away? Take the case of American doctors for whom higher taxes take the form of lower reimbursement for services rendered under Medicaid and Medicare. The doctor shortage is expected to rise to 91500 by 2020, thereby restricting access to care and undermining America the land of entitlements. Curbing opportunity effectively restricts entitlements.

High taxes reinforce two behaviors: tax avoidance and tax evasion Tax avoidance can be addressed by closing loopholes in the tax code. Tax evasion – a kind of silent secession -- can be

reduced by IRS audits but cannot be eliminated. More and more taxpayers will find cash transactions attractive because with no receipts and no bank records the IRS cannot find a money trail to follow. But the more that it "lost" in the underground economy, the less that is available to support America the land of entitlements.

Where does that leave the Great American Experiment? At considerable risk because the land of entitlements has been drawing on more tax revenues while the land of opportunity can starve the land of entitlements by not paying taxes. As America learned most painfully more than 150 years ago, a house divided against itself cannot stand.

In the short term, this problem can be addressed by raising the debt ceiling, borrowing more money to support the land of entitlements without imposing higher taxes on the land of opportunity. However, this is not a long-term solution because the interest on the public debt -- $480 billion every year on a $16 trillion public debt at an interest rate of 3 percent – has to be paid by the land of opportunity. Borrowing more means paying more and taxing more.

In the long run, there is no other way to deal with this problem without public figures in Washington who have the *courage* to do what is necessary to keep the house from imploding even if it means they must sacrifice their constituents' approval and personal political ambitions. The options are obvious to everyone in public office: reduce entitlements by resorting to a strict means test; raise taxes and vigorously audit tax returns; grow the economy in a sustainable way.

What isn't self-evident, because rhetoric has replaced reason as the pathway to political success, is that there is no way to maintain America the land of entitlements without preserving America the land of opportunity. History and current events elsewhere in the world show clearly that it is not and cannot be the other way around.

A house divided against itself -- the land of entitlements at odds with the land of opportunity -- cannot stand.

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