

*Killing Jobs through
National Health Care
Reform*

David G. Tuerck, PhD

Paul Bachman, MSIE

Michael Head, MSEP

Alfonso Sanchez-Penalver, MSF

THE BEACON HILL INSTITUTE AT SUFFOLK UNIVERSITY

8 Ashburton Place

Boston, MA 02108

Tel 617-573-8750, Fax 617-994-4279

E-mail: bhi@beaconhill.org, Web: www.beaconhill.org

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Executive Summary

Nancy Pelosi, the Speaker of the House of Representatives, has urged passage of the massive health reform plan moving through Congress as a way to create up to 400,000 jobs.¹ Speaker Pelosi bases her claim on a report by the Center for American Progress (CAP) in which the Center estimates that the Patient Protection and Affordable Care Act (PPACA) would create 250,000 to 400,000 jobs per year over 10 years.²

This estimate by CAP amounts to a hurried effort to add academic heft to the claim that national health care reform offers a collateral benefit in the form of an economic “stimulus.” It turns out, however, that its methodology, stripped of unsupportable claims about savings in health care costs, shows just the opposite of what CAP intended. PPACA is a job killer, not a job creator.

Using the CAP methodology, we find that the bill would destroy a total of 120,000 to 700,000 jobs by 2019, a far cry from the number suggested by leading advocates.

CAP’s claim about job creation rests on its assumption that various developments ensuing from passage of the bill – upgrades in medical technology, the promotion of preventive care and the reduction in administrative costs – would save \$683 billion over ten-years and thus set in motion new incentives for firms to create jobs. The trouble is that the claimed costs savings are at odds with estimates from both Congress and the Executive Branch, which, together, are responsible for considering and ultimately implementing the legislation.

There is no evidence that the projected savings proposed by the Obama administration, particularly in areas such as preventive care, would ever materialize. The literature cited by proponents is speculative at best. Also, there is no guarantee that the administration would be successful in lowering insurance premiums while expanding coverage, without limiting access to health care.

¹ “Pelosi: Health Reform Will Create 400,000 Jobs ‘Almost Immediately,’” *Real Clear Politics*, February 25, 2010,

http://www.realclearpolitics.com/video/2010/02/25/pelosi_health_reform_will_create_400000_jobs_almost_immediately.html (accessed March 12, 2010).

² David M. Cutler, Karen Davis and Kristoff Stremikis, Center for American Progress Action Fund, “Why Health Reform Will Bend the Cost Curve,” *Commonwealth Fund Issue Brief* 72 (December 2009):3.

<http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/Dec/Why-Health-Reform-Will-Bend-the-Cost-Curve.aspx> (accessed March 12, 2010).

Data provided by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS) show that rosy estimates about cost savings are, to say the least, of dubious validity. The Chief Actuary of CMS states that “all such estimates are uncertain and that actual future impacts could differ significantly from the estimates of any given organization.”³ Prominent health care experts such as Dr. Delos Cosgrove of the Cleveland Clinic and Dr. Jeffrey Flier, Dean of the Harvard Medical School, echo this sentiment.

In particular, the CMS report points out that Congress is not likely to allow the roughly \$500 billion in Medicare cuts, which are essential to the CAP argument, to take place. The unlikelihood that these savings would ever see the light of day is predictable in the light of the “doctor fix,” under which Congress or the President have suspended scheduled cuts (now at 21% for 2010) in the physician’s Medicare reimbursement rate under the Sustainable Growth Rate (SGR) program every year since 2002.

Once we dismiss purported cost savings such as the proposed Medicare cuts, the job gains produced by the CAP methodology become job losses. We utilized the same econometric model used by the CAP authors to derive employment effects of PPACA, but with the unsupportable costs savings stripped from the model. We provide two estimates:

1. The first estimate applies the CAP methodology to the CMS estimate that the PPACA would increase national health expenditures by \$24.8 billion over the baseline case by 2019. This estimate shows that PPACA would kill 120,000 jobs by 2019.
2. The second estimate applies the CAP methodology to a scenario in which we begin with the CMS estimate but in addition eliminate the \$437 billion in Medicare cuts assumed by CAP and then factor in an additional \$70 billion in discretionary spending that the CBO indicated would take place under the Bill. The addition of these figures would increase national health expenditures by \$148.8 billion in 2019 and thus kill 700,000 jobs by 2019.

It turns out that the CAP methodology, when revised to incorporate realistic assumptions about the cost effects of PPACA, shows the bill to be a job killer rather than a job creator. If Speaker Pelosi wants to transform national health care, that is one

³ Richard S. Foster, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act’ Passed by the Senate on December 24, 2009,” (January 8, 2010) http://www.cms.hhs.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf (accessed March 12, 2010).

thing. To pass PPACA as a stimulus measure is, however, to engage in wishful thinking.

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) would expand health insurance coverage to 34 million Americans by, among other measures, mandating insurance coverage for both individuals and businesses and expanding Medicaid and the Children’s Health Insurance Program (CHIP). To meet the goal of universal coverage, PPACA would enact new taxes (e.g. a 3.8 percent Medicare payroll tax rate on annual wage and self-employment income which exceeds \$250,000 for families and \$200,000 for singles) and cut costs by upwards of \$500 billion in Medicare. It would include certain measures to promote prevention and to remove inefficiencies from the current health care system.

Current Estimates

The Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS) have estimated the cost of implementing PPACA.⁴ An independent research entity, the Center for American Progress (CAP) has also produced cost estimates. Table 1 contains a summary of the estimates by all three entities for the period 2010 to 2019.

Table 1: Cost Estimates of PPACA from CBO, CMS, CAP

Senate Bill	CBO	CMS	CAP
		(\$ billions)	
Coverage Expansion	836	883	402
Medicare/Medicaid CHIP cuts	-404	-568	-393
CLASS & Other	-51	-33	Na
New Taxes/Fees	-473	Na	Na
Transforming the Healthcare Delivery System	-26	-2	-692
Cumulative Total (2010-2019)	-118	280	-683

Both CBO and CMS estimate that expanding insurance coverage will cost over \$800 billion, while the CAP estimates that it will cost only \$402 billion. CAP reports lower Medicare and

⁴ Ibid. See also U.S. Congressional Budget Office, “Letter to Honorable Harry Reid,” (March 11, 2010) <http://www.scribd.com/doc/28208128/CBO-Reid-Letter-HR3590> (accessed March 12, 2010).

Medicaid cuts than the others because it accounts for some of the cuts under the coverage expansion category.⁵ Neither the CAP nor the CMS report account for new taxes and fees.

The last category “Transforming the Health Care Delivery System,” which is intended to account for various cost-saving measures, shows the largest differences between the estimates from CBO, CMS and CAP. CBO estimates that these measures will save the government \$26 billion over 10 years. These include \$11.4 billion under Title 1, Subtitle B, 1104 – Administrative Simplification and \$14.1 billion under Title III, subtitle A – Transforming the Health Delivery System.⁶ CMS excludes the effect on administrative costs, but estimates that the comparative effective research initiative will save \$2 billion over the period. On the other hand, CAP estimates that reductions in administrative spending will save \$162 billion and that modernizing the health care system will save another \$530 billion, for a total of \$692 billion.

The CBO and the CMS reviews of the proposed PPACA arrive at similar conclusions on the subject of cost savings resulting from modernization: the opportunities are minimal. CAP itself casts doubts on its estimates when it says that CBO and CMS “rely largely on peer-reviewed studies utilizing carefully controlled comparison groups (either randomized trials or the natural equivalent) for their evidence.”

Finding these checks overly restrictive, CAP predicates its assumption on the “less formal, but no less important, literature that sees the world very differently.”⁷ Unlike CBO and CMS, CAP is comfortable with anecdotal evidence about experience at the state and local levels, as with Denver Health and/or Partners Health in Minnesota, and with evidence from current practices in cardiac care and the treatment of diabetes. No need for any bothersome peer review process, in CAP’s view of things. Just find a few cheery examples and charge full speed ahead.⁸

Policy recommendations based on cherry-picked references that avoid the peer-review process, are, however, of little value to policy makers. While anecdotes have their place in policy analysis, it is not helpful merely to pick the anecdotes that support a preconceived point of view.

In reviewing such “no less important” sources, BHI found conclusions that call into question several CAP claims. Dr. Delos Cosgrove of the Cleveland Clinic, praised by

⁵ Ibid.

⁶ Ibid., Table 4.

⁷ Ibid.

⁸ Cutler et al. “Why Health Reform Will Bend the Cost Curve.”

President Obama for its efficiency, says that under the current bill, “individual costs may come down in terms of what people pay for insurance, but they're going to pay for it in a different way -- in taxes, one way or another.”⁹

He adds, “I do not see anything in this that will keep the total cost for health care - not necessarily the government’s bill for health care, but the total bill for the country for health care, I don’t see anything in this that’s going to keep that from escalating.”¹⁰

Dr. Jeffrey Flier, Dean of the Harvard Medical School gives current health care reforms a failing grade, due in large part to the fact that “the final legislation that will emerge from Congress will markedly accelerate national health-care spending rather than restrain it.”¹¹ Moreover, in his discussions with leading health-care and economic leaders, “nearly all agree that the legislation would do little or nothing to improve quality or change health-care's dysfunctional delivery system.”¹²

The Lewin Group, the renowned health care consultancy, also cast doubts on cost-saving measures in PPACA. The group estimates that total spending will increase by between \$305 and \$425 billion between 2010 and 2019. The main cost driver will be “new utilization” resulting from adding 34 million people to health insurance rolls. Subsidies for health care tend to increase the use of health care. Moreover, the Lewin Group estimates that the bill, as measured by CAP, would fail to curb “administration costs.” It finds that PPACA will increase administration spending by \$87 billion over the ten-year period.¹³

Part of CAP’s health system modernization includes “increased emphasis on wellness and prevention,” but, by subsidizing health insurance and removing enrollment limits on preexisting conditions, this is bound to fail. Prevention is the Holy Grail of health care reform; it is long sought-after but rarely achieved. While the CAP authors do not

⁹ Geoff Colvin, “Cleveland Clinic Chief on the Business of Health,” *CNNMoney*, February 18, 2010, http://money.cnn.com/2010/02/17/news/companies/cleveland_clinic_cosgrove.fortune/ (accessed March 15, 2010).

¹⁰ Bill Rice, “Clinic’s Cosgrove: Little Cost Control in Health Care Bill,” *WCPN Interview*, November 10, 2009, <http://www.wcpn.org/WCPN/news/28548/> (accessed March 15, 2010).

¹¹ Jeffrey S. Flier, “Health ‘Reform’ Gets a Failing Grade,” *Wall Street Journal*, November 17, 2009, <http://online.wsj.com/article/SB10001424052748704431804574539581994054014.html> (accessed March 15, 2010).

¹² *Ibid.*

¹³ John Shiels and Randy Haught, “Comparing the Cost and Coverage Impacts of the House and Senate Leadership Health Reform Bills: Long Term Costs for Government, Employers, Families and Providers,” The Lewin Group. December 9, 2009 http://www.lewin.com/content/publications/Lewin_Senate_and_House_Bill_Compared.pdf (accessed March 12, 2010).

put specific cost savings on individual prevention policies, past experiences provide a cautionary tale.

Obesity has far-ranging negative effects on health, but the rate of obesity for adults in the United States has increased almost as fast as the research showing its negative effects. In 1962, 13.4% of American adults were obese, while in 2006 the number had almost tripled to 35.1%. Over the same time period, the fraction of extremely obese adults increased almost seven-fold, from 0.9% to 6.2%. To assume that increasing education on wellness and prevention will decrease the cost of insurance and thus lead to cost savings is naive at best.

There is no consensus as to what the potential savings from the PPACA will be, or if they will even materialize. In the absence of this consensus, relying on studies other than the most-thoroughly reviewed estimates such as the CBO and CMS can lead to mistaken policy conclusions. For this reason, we use the CMS calculations as the baseline for our calculations.

The BHI Estimates

CMS estimates that PPACA will increase national health expenditures by \$24.8 billion or 0.6% in 2019.¹⁴ However, it has to be a minimum estimate. Congress has a history of reversing spending cuts and tax increases after enacting them. The Alternative Minimum Tax, which was geared toward capturing revenue from a handful of millionaires who escaped taxation, provides an example. Since its early days, the AMT has come in for several fixes to provide relief for an increasing number of middle class taxpayers who are trapped by the tax code.

The so-called “doctor fix” provides the most telling example in the health care field. In 1998, Congress replaced Volume Performance Standard (VPS), which was based on the historical trend in volume, with the current Sustainable Growth Rate (SGR) method to calculate Medicare physician reimbursement rates. The SGR mechanism aimed to control spending on physicians’ services provided under Part B of Medicare. It set an overall target amount of spending on goods and services provided under Part B. Payment rates were supposed to be adjusted annually to reflect differences between actual spending and the spending target. Payment rates were to be adjusted up if spending was below the target and down if spending was above the target.¹⁵

¹⁴ Foster, Table 5.

¹⁵ Donald B. Marron, Congressional Budget Office, “Medicare’s Physician Payment Rates and the Sustainable Growth Rate, Testimony before the Subcommittee on Health Committee on Energy and

Until 2001, actual spending under SGR was below the target, and thus payment rates were adjusted up. Starting in 2002, actual spending was above the target and payment cuts were scheduled to be implemented. However, in each year since 2002, the SGR mechanism has been modified (either by Congress or administrative action) to avoid reductions in those payments.¹⁶

The history of the “doctor fix” provides evidence that the cuts to Medicare and Medicaid prescribed in the PPACA will not be implemented. CMS echoes similar concerns. The CMS report states the following:

- “Many of the provisions, particularly the coverage proposals, are unprecedented or have been implemented only on a smaller scale (for example, at the State level). Consequently, little historical experience is available with which to estimate the potential impacts.”¹⁷
- “In the section on Medicare estimates, reduction in payment updates to health care providers...are unlikely sustainable on a permanent basis...actual Medicare savings from these provisions would be less...”¹⁸
- “In the section on the CLASS program, we believe that there is a very serious risk that the program, as currently specified, would not be sustainable due to adverse selection.”¹⁹
- “We assumed that the increased demand for health care services could be met without market disruptions. In practice, supply constraints might initially interfere with providing the services desired by the additional 34 million insured persons. Price reactions—that is, providers successfully negotiating higher fees in response to the greater demand—could result in higher total expenditures or in some of this demand being unsatisfied.”²⁰
- “Differences in results from one estimating entity to another may tend to cause confusion among policy makers. These differences, however, provide a useful reminder that all such estimates are uncertain and that actual future impacts could differ significantly from the estimates of any given organization.”²¹

Commerce,” U.S. House of Representatives (July 25, 2006): 2, under <http://www.cbo.gov/ftpdocs/74xx/doc7425/07-25-SGR.pdf> (accessed March 12, 2010).

¹⁶ Ibid., 3.

¹⁷ Foster, CMS, 16.

¹⁸ Ibid., 19.

¹⁹ Ibid.

²⁰ Ibid.

²¹ Ibid., 16.

Table 2: Cuts to Federal Programs Unlikely to be Implemented

Unlikely Medicare & Medicaid Cuts	2010- 2019	2019
	(\$ billions)	
Part III – 3133 Improvement to Medicare DSH Payments	46	7
Part III (B) - 3112 Improvement Fund (A & B)	28	28
Part III (C) - 3139 Biological Products (B & D)	5	2
Part III (C) - 3201 Medicare Advantage (A & B)	88	15
Part III - 3131 Home Health Care(A & B)	28	7
Part III (E) - 3402 Temporary Adjustment Part B Premiums	8	2
Part III (E) - 3401 Market Basket Revisions and Productivity Adjustments	193	49
Part II (G) - 2551 Disproportionate Share Hospital Payments (Medicaid)	33	5
Part III (D) - 3308 Reducing Premium Subsidy for High Income Beneficiaries	8	2
CBO Additional Discretionary Expenditures	70	7
Total	507	124

In order to capture the effect of the portions of PPACA that are unlikely to be implemented, BHI calculated an alternative to the CMS estimate of the Bill’s impact on national health expenditures. Table 2 lists each item, its cumulative cost from 2010 through 2019 and the cost for 2019, as calculated by CMS.²²

These items total \$507 billion in federal expenditures that would likely take place under PPACA, which, according to CMS, would equal \$124 billion in 2019. We add the \$124 billion to the \$24.8 billion from CMS to arrive at our estimate that the Bill would be likely to raise national health expenditures by \$148.8 billion, or 3.3% in 2019.

The Results

In order to estimate the changes in employment caused by the changes in health care costs, we used the results from the model by Sood and his co-authors (Sood, Arkadipta and Escarce, 2009), in the same manner that the CAP authors (Cutler and Sood, 2010) used it. See the methodology section for details of the model.

Table 3 presents our results. We observe that the increased costs in health care by 2019 would reduce jobs by 120,000 in the low cost scenario and by 700,000 in the high cost scenario. The most sensitive sector is the professional and business services which will suffer losses of 23,000 jobs and 133,000 jobs in the respective scenarios. The least sensitive sector is the utilities sector that would suffer losses of 900 and 5,000 jobs in the low cost and high cost scenarios, respectively.

²² CBO, “Letter to Honorable Harry Reid,” 5.

Table 3: Employment Effects under Health Care Reform (2019)

Sector	ESI %	Jobs	
		Low	High
Agriculture, mining and construction			
Agriculture, forestry, fishing and hunting	20	-923	-5,441
Mining	68	-939	-5,478
Construction	37	-7,374	-43,316
Manufacturing	65	-18,022	-105,229
Trade			
Wholesale trade	57	-8,149	-47,663
Retail trade	39	-14,364	-84,339
Transportation and communication			
Transportation and warehousing	55	-6,290	-36,806
Utilities	80	-906	-5,271
Services			
Information	63	-4,510	-26,342
Financial Activities	66	-13,236	-77,269
Professional and business services	44	-22,606	-132,596
Educational services	61	-5,493	-32,102
Leisure and hospitality	25	-8,436	-49,682
Other services	48	-7,946	-46,564
Totals		-119,194	-698,098

Conclusion

The optimistic jobs outlook provided by CAP overestimates the ability of government to manage costs. There is no assurance that the federal government can cover more people by simply squeezing inefficiencies or by curbing unnecessary medical tests or revising doctor reimbursement rates. History shows otherwise. The fact that Medicare, based on a single-payer model, can theoretically deliver medical services more efficiently misses the point that the system itself is not sustainable in the long term given the demographic challenges of a graying population.

Moreover, the CAP model asks the wrong questions. By focusing on “excess cost growth” in industries where employees are already covered by employer-provided insurance, the authors fail to take into account how firms respond to higher taxes and mandates. Instead of absorbing the costs for the workers they already cover, firms will

instead, under the new system, be induced to fire or lay off workers. In other words, the jobs will not be created in the first place.

By inputting more realistic cost estimates from the Centers for Medicare and Medicaid Services into the same model used by the CAP authors, BHI estimates that PPACA will, in fact, destroy between 120,000 to 700,000 jobs by 2019.

Methodology

In order to estimate the changes in employment caused by the changes in health care costs, we used the results from the model by Sood and his co-authors, in the same manner that Cutler and Sood used it. Letting i represent the industry and t the time period, the change in health care costs affects employment through the interaction of the lagged percentage of workers with employer sponsored insurance (ESI) and the natural logarithm of health care costs as a share of GDP:

$$\alpha_{it} = ESI\%_{it-1} \ln\left(\frac{HC_t}{GDP_t}\right).$$

Since the change in the independent variable comes from a change in health care costs, letting Δ represent 'change in':

$$\begin{aligned} \Delta\alpha_{it} &= ESI\%_{it-1} \left[\ln\left(\frac{HC_t^1}{GDP_t^1}\right) - \ln\left(\frac{HC_t}{GDP_t}\right) \right]; \\ \Delta\alpha_{it} &= ESI\%_{it-1} \ln\left(\frac{HC_t^1}{HC_t}\right). \end{aligned} \tag{1}$$

Following the model, where y represents employment:

$$\begin{aligned} \Delta\ln(y_{it}) &= -0.016 \Delta\alpha_{it}; \\ \ln\left(\frac{y_{it}^1}{y_{it}}\right) &= -0.016 \Delta\alpha_{it}; \\ y_{it}^1 &= y_{it} e^{-0.016 \Delta\alpha_{it}}; \\ \Delta y_{it} &= y_{it} (e^{-0.016 \Delta\alpha_{it}} - 1). \end{aligned} \tag{2}$$

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About the Authors

David G. Tuerck, PhD, is Executive Director of the Beacon Hill Institute for Public Policy Research at Suffolk University where he also serves as Chairman and Professor of Economics. He holds a Ph.D. in economics from the University of Virginia and has written extensively on issues of taxation and public economics.

Paul Bachman, MSEP, is Director of Research at BHI. He manages the Institute's research projects, including its STAMP model and other projects. He has published studies on state and national tax policy and on state labor policy. He also produces the institute's state revenue forecasts for the Massachusetts legislature. He holds a Master of Science in International Economics from Suffolk University.

Michael Head, MSEP, is an Economist at the BHI. He holds a Master of Science in Economic Policy from Suffolk University.

Alfonso Sanchez-Penalver, MSF, is a Research Economist at BHI. He has career experience in web programming and project management, as well as in accounting and financial analysis. He holds a Master of Science degree in Finance from Boston College, and a BSBA in Finance from Suffolk University, where he is also a PhD candidate.

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**THE BEACON HILL INSTITUTE
FOR PUBLIC POLICY RESEARCH**

Suffolk University

8 Ashburton Place

Boston, MA 02108

Phone: 617-573-8750 Fax: 617-994-4279

bhi@beaconhill.org

<http://www.beaconhill.org>