DISCUSSION OUTLINE

THE AFFORDABLE CARE ACT ("OBAMACARE"): A HEALTH ECONOMICS PERSPECTIVE

PREPARED BY

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INTRODUCTION

On the eve of its implementation, the Patient Protection & Affordable Care Act (the ACA commonly referred to as "Obamacare") has come under fire for a variety of reasons, including that:

- U.S. healthcare expenditures are approaching 18 percent of Gross Domestic Product (GDP),
- The federal debt is approaching $17 trillion
- The law, as written, is extremely complex, and
- Congress is more divided and dysfunctional that any time in recent memory.

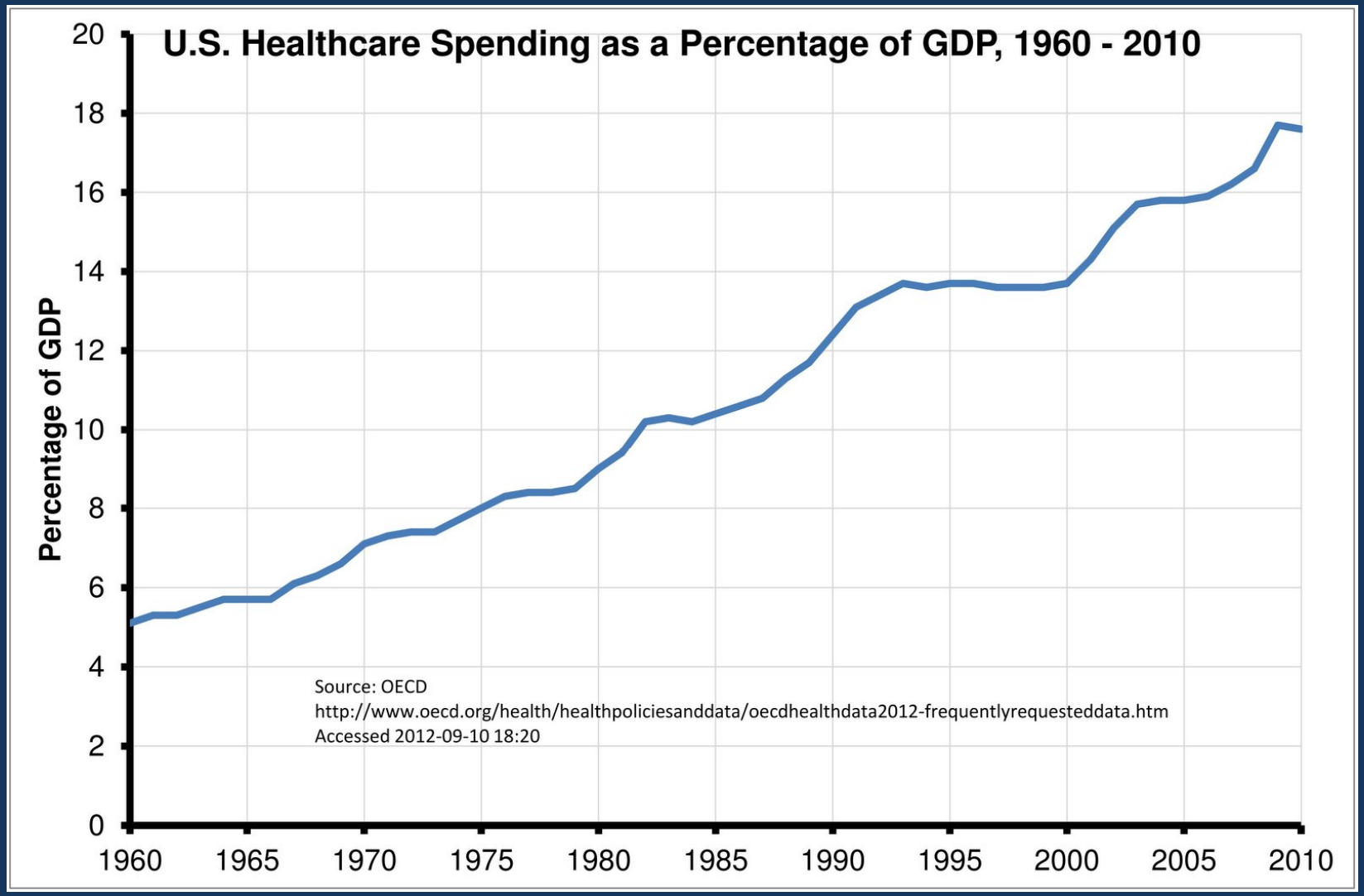
This document is intended to help put the ACA and U.S. healthcare economics in perspective and provoke fact-based discussion. It is a DISCUSSION OUTLINE rather than a final report and may be updated from time to time.

The report examines the healthcare economics and insurance arrangements of the United States and other developed nations. It draws on data and ideas contained in ***The Healing of America: A Global Quest for Better, Cheaper and Fairer Health Care*** written by T. R. Reid (2009), data from The Organisation for Economic Co-operation and Development (OECD), the American Association of Health Plans and other industry sources and on the author's 25 years of professional experience in healthcare finance, as an insurance executive, investment banker and strategic consultant. His clients have included some of the most advanced managed healthcare & technology organizations in this country and overseas.

EXECUTIVE SUMMARY

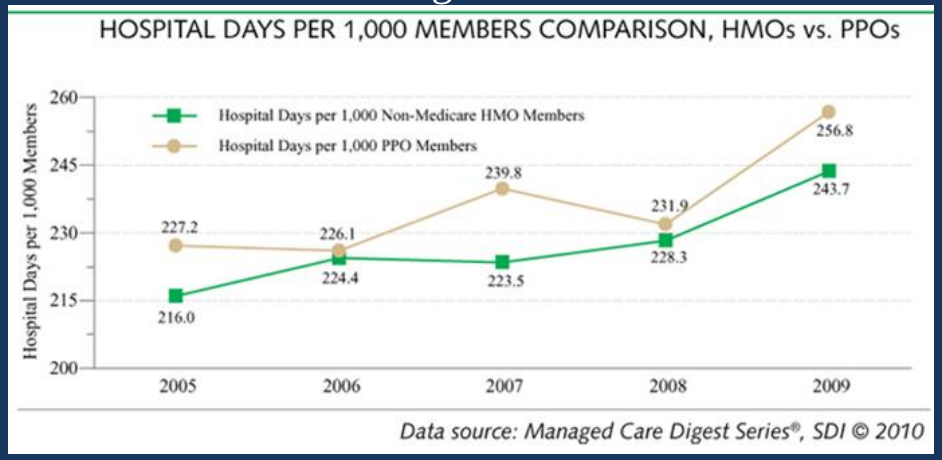
- Rising healthcare costs in the U.S. have been cause for concern since the 1960s.
- Competition is no longer the antidote and may actually be a cause of rising healthcare costs.
- The United States spends far more money (per capita and % of GDP) on healthcare than other developed countries, yet it ranks poorly on various measures of health quality.
- The U. S. is the only developed country that does not provide universal health coverage due, in part, to Americans' fear of "socialized medicine".
- Major causes of the United States' high healthcare costs and poor outcomes include:
  - An estimated 53 million people with no insurance coverage and many more with inadequate coverage.
  - The inefficiency, complexity and embedded profit motive of its healthcare "system"
  - Excess costs estimated at over $500 billion according to an affiliate of McKinsey & Company
- By 2023 the ACA will provide health insurance for 30 million uninsured people and improved coverage for millions more at no net cost according to the non-partisan Congressional Budget Office
- While the ACA is a significant leap forward, it falls short of true healthcare reform
- The United States could provide meaningful health coverage at significantly reduced cost and better quality for all if it could incorporate many aspects of other developed countries' systems.

RISING U.S. HEALTHCARE COSTS HAVE BEEN CAUSE FOR CONCERN SINCE THE 1960S.



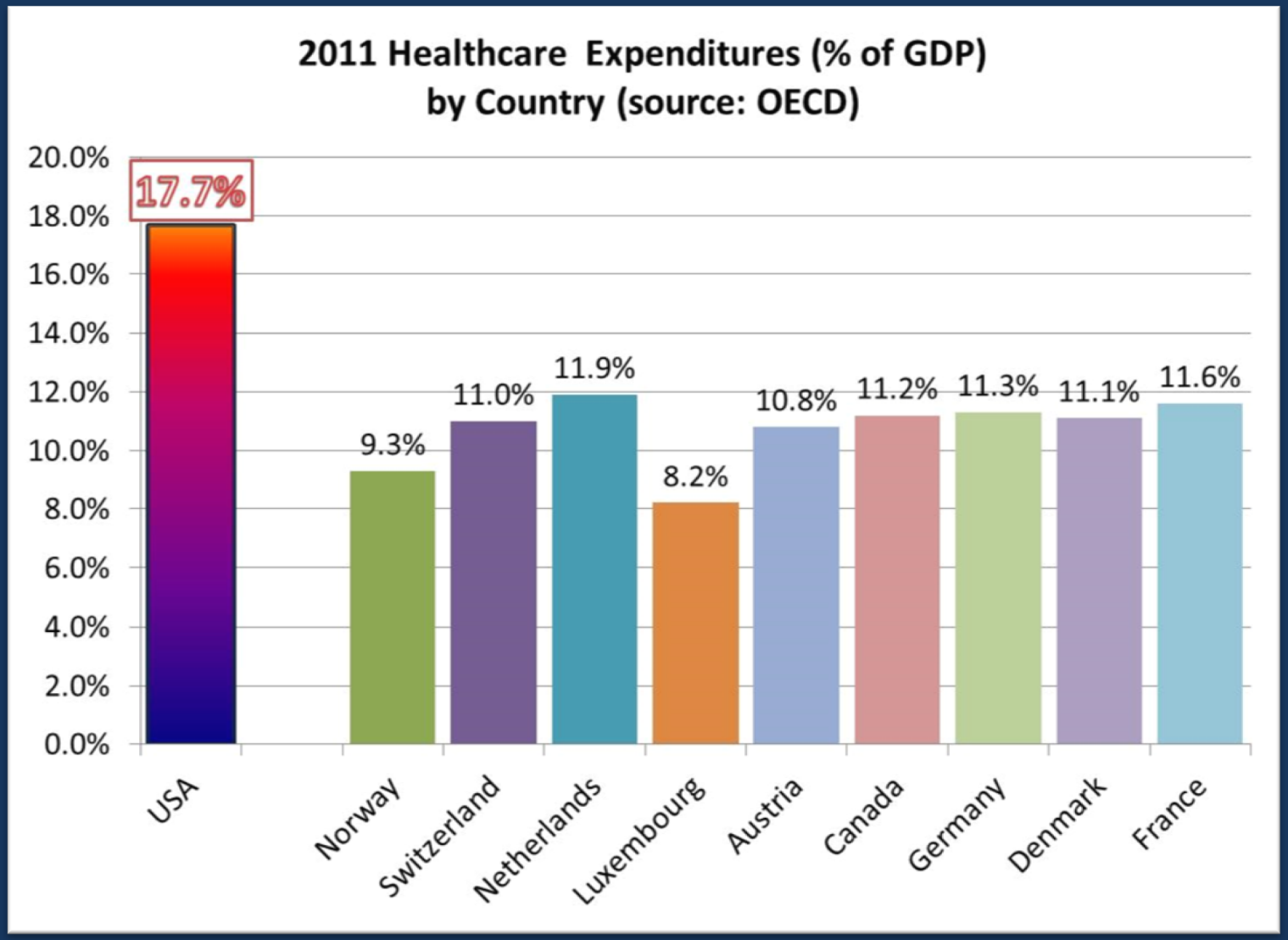
COMPETITION IS NO LONGER THE ANTIDOTE
BUT ACTUALLY CONTRIBUTES TO RISING HEALTHCARE COSTS

- The rapid growth of HMOs and other managed care organizations during the 1980s and '90s was spurred by their ability to price their coverage plans lower the traditional health insurers
  - HMO enrollment skyrocketed from 11 million in 1982 to 80 million in 2000
  - Other managed care organizations, e.g. Preferred Provider Organizations, grew even more rapidly
  - Resultant hospital utilization plunged from well over 700 days/1000 to below 300 days/1000
- But HMO enrollment peaked in 1999 and the number of HMOs and PPOs declined thereafter
  - The number of HMOs declined by 30% and PPOs by over 50% between 2000 and 2009
  - Large insurers like Aetna and CIGNA acquired or merged with HMOs
- Hospital utilization reversed course and began to rise after the millennium



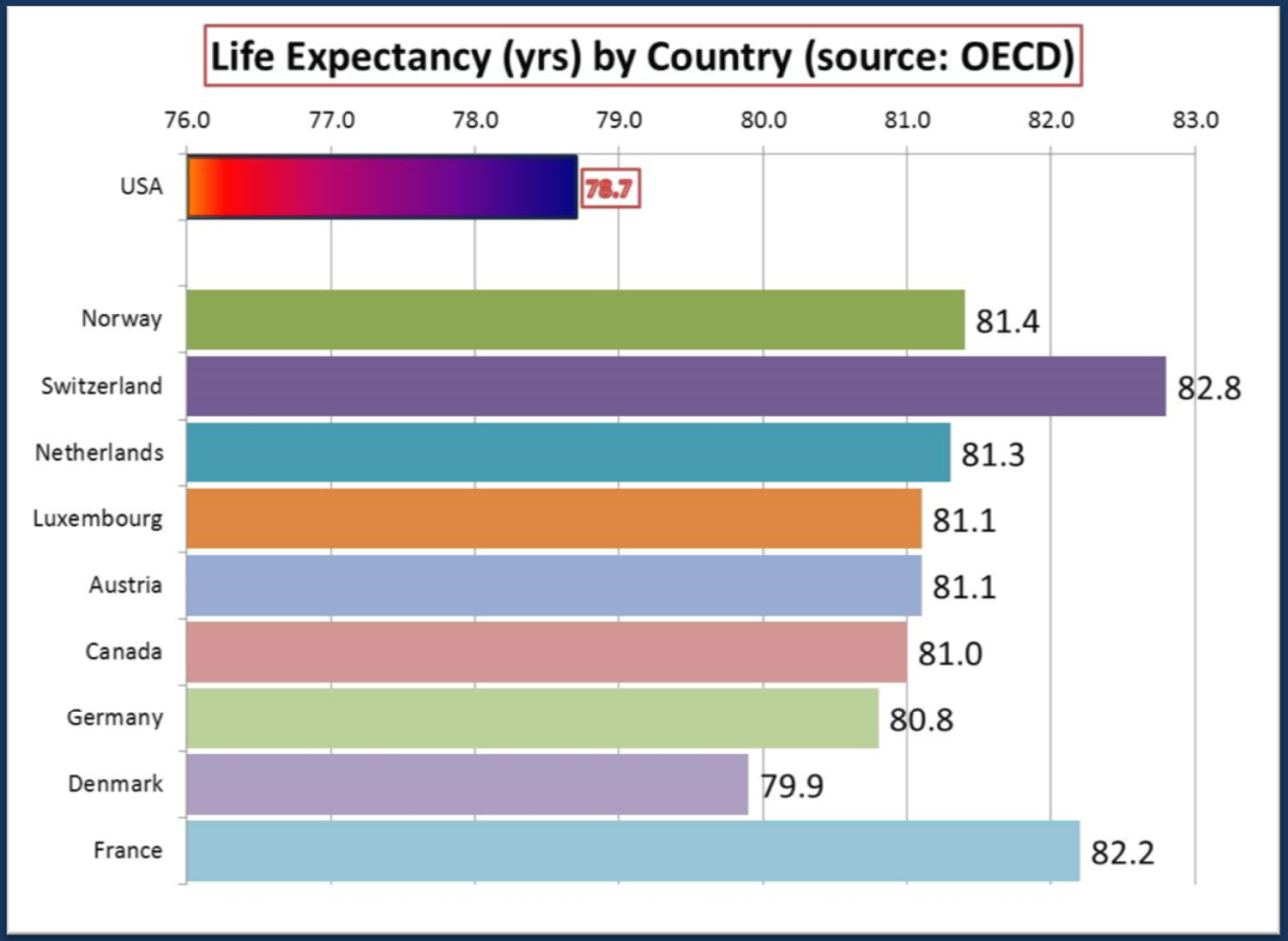
- In response to managed care, hospitals and physicians have been consolidating since the 1990s.
- Due in part to the proliferation of health plans, claims processing and collection is often cited as a significant component of the rising administrative cost of hospitals, physicians and other providers.

THE U. S. SPENDS 65% MORE RELATIVE TO GROSS DOMESTIC PRODUCT (GDP) THAN THE AVERAGE OF 9 OTHER DEVELOPED COUNTRIES



SOURCE: The Organisation for Economic Co-operation and Development (OECD)

YET AVERAGE LIFE EXPECTANCY IN THE UNITED STATES IS SIGNIFICANTLY LOWER THAN IN ANY OF THOSE 9 OTHER DEVELOPED COUNTRIES



SOURCE: The Organisation for Economic Co-operation and Development (OECD)

…AND THE U. S. RANKS POORLY IN MANY OTHER MEASURES OF HEALTHCARE QUALITY

- Life expectancy at age 65 - Females
  - US ranked out 18th out of 30 OECD countries
  - 20.3 years vs. 23.6 for Japan and 20.2 for all the OECD average.
- Mortality from heart disease and stroke
  - Ischemic Heart Disease – USA ranked 23rd out of 28 countries
  - Stroke Mortality Rates – USA ranked 4th out of 28 countries
- Mortality from cancer (OECD 2006)
  - Lung cancer – USA ranked 19th
  - Breast Cancer – USA ranked 14th
  - Prostate Cancer – USA ranked 5th
- "Deaths Before Age 75 … at least partially modifiable with Effective Medical Care" (Commonwealth Fund 2008)
  - US ranked 19th out of 19 developed countries
  - "almost twice as high in the US as in … France, Japan and Spain."
- Premature mortality, potential years of life lost for females (OECD 2006)
  - USA ranked 27th out of 30 countries
  - Japan 1.88 years/100,000 females; USA 2.633; OECD average 2.548
- Disability-Adjusted Life Expectancy (World Health Organization)
  - Japan ranked 1st at 74.5 years
  - USA ranked 24th at 70 years (72.6 for females and 67.5 for males)
- Life Expectancy at Birth (OECD Health at a Glance 2009 – 2007 stats)
  - US ranked out 21st out of 30 OECD countries[i]
  - 78.1 years vs 82.6 for Japan and 79.1 for all OECD countries.

CONTRARY TO POPULAR OPINION, MANY DEVELOPED COUNTRIES THAT PROVIDE UNIVERSAL COVERAGE DO NOT EMPLOY "SOCIALIZED MEDICINE"

- "Switzerland still has private health insurance companies; but [they] can't make a profit on the basic health insurance coverage, and … have to cover everybody…"[1]
- In Germany, Japan, France, Belgium, Switzerland "and, to a degree, Latin America both health care providers and payers are private."[2]
- In these countries health insurance companies don't make a profit and must insure everyone.
- Some of the countries that do have "socialized medicine", e.g. Great Britain, also have private physicians, hospitals and health plans for those who can afford it.

[1] ***The Healing of America: A Global Quest for Better, Cheaper and Fairer Health Care*** by T. R. Reid (2009)
[2] **IBID**

THE HIGH COST & POOR EFFECTIVENESS OF U. S. HEALTHCARE ARE CAUSED, IN PART, BY INADEQUATE COVERAGE, ADMINISTRATIVE COSTS & THE WRONG FINANCIAL INCENTIVES

- 53 million people in the U.S. lacked health insurance coverage of any kind prior to ACA
- Millions more have insurance policies that discourage access to healthcare when needed
  - lifetime caps, exclusions for pre-existing conditions, specific treatments, etc.
  - high deductibles and/or coinsurance for primary care that discourage early diagnosis and treatment.
- People with inadequate or no health insurance coverage end up costing more to treat
  - They often end up in emergency rooms (ERs) or hospitalized.
  - They tend to be sicker before they seek care
  - Hospitals stays and ER visits are intrinsically more expensive than office care
- McKinsey Global Institute estimated $477 billion per year (2003 dollars) in "excess spending"
  - US spent $477 billion more than might predicted by higher per capita income than other developed nations.[ii]
  - higher spending on hospital care ($224 billion), outpatient care ($178 billion) and on drugs ($57 billion).
- The plethora of health plans (competition) increases both providers' and payers' administrative costs
  - 13% of every healthcare dollar spent on administration, "consumer services" and profits, according to an affiliate of health insurers' trade association (American Health Insurance Plans).
  - 6% (vs. 13%) is the comparable number for Medicare
  - And "the additional [cost] of the multiple-payor structure and insurance products, which is accounted for under providers' operational costs."[iii]
- The U.S. has a higher proportion of highly paid physician specialists than other countries.

AUTHOR'S HYPOTHESES

Based on what has been presented so far and what follows, the author proposes the following hypothetical conclusions for further analysis and discussion.

- While its intentions are noble, the ACA is a needlessly complex "Rube Goldberg" approach to universal healthcare produced by a politically divided, dysfunctional Congress.
- If we could transplant the best of the European healthcare systems, we could reduce costs by as much as $1 trillion while providing coverage for all
  - The Netherland's national health plan, the most expensive European system (11.8% of GDP) could save the U.S. $869 billion while providing coverage to everyone, regardless of age, health status or citizenship.
  - The Swiss system, which retains private insurers & payors, would save the U.S. over a $1 trillion.
  - In either case, all Americans would be covered, be healthier and live longer.
- The ACA only gets us part way there – 28 out of 53 million uninsured - due, in part, to
  - Naked political opposition,
  - Vested interests among payors, providers and suppliers
  - An irrational attachment, by many Americans, to competition and private enterprise.
- While we will never achieve all of the potential savings of a European style system, their successes can help us set clear, realistic objectives instead of tinkering around the edges our own inefficient healthcare system.

TRUE HEALTHCARE REFORM SHOULD PROVIDE MEANINGFUL COVERAGE FOR ALL WHILE REDUCING COSTS AND IMPROVING OUTCOMES

- Provide health coverage for as many as 53 million people currently without health insurance
  - Includes people above and below the poverty line
  - They are currently served by hospital emergency rooms (ERs) and inpatient facilities
  - An estimated 40 million U.S. citizens are uninsured according to the CBO.
  - Coverage for 13 million undocumented residents will be debated for years to come
- Eliminate the holes in the current private insurance system
  - Excessively high premiums for individuals and families not belonging to groups
  - Lack of portability of coverage when employment ends
  - Exclusion for pre-existing conditions, lifetime and episode caps, rescissions, etc.
  - Insufficient coverage of dental and prescription needs
- Substantially reduce total healthcare costs per capita and as a percentage of GDP
  - Recapture the $417 billion (2003 dollars) per year documented by the McKinsey Global Institute
  - Simplify providers' claims submission and collections costs
  - Maximize private insurers' premium revenue spent on actual healthcare – currently 87%
  - Invest in outcomes research, best practices and cost-effectiveness
- Improve the effectiveness of healthcare as measured by life expectancy, disease and recovery rates
- Continue to offer the best healthcare in the world for those who can afford to pay for it.
  - Support teaching hospitals and medical education
  - Fund advances in medical technology, biotechnology, minimally invasive techniques, pharmaceuticals, etc.
- Ensure long term solvency of publicly funded health programs, such as Medicare, Children's Health Insurance Program (CHIP), Veterans Administration (VA) and Medicaid.

ACA, WHILE A SIGNIFICANT LEAP FORWARD, FALLS SHORT OF TRUE HEALTHCARE REFORM

While the ACA is a major step toward providing affordable health insurance for Americans, it falls short of nearly every other objective of healthcare reform, including results comparable to other developed nations.

- ACA's primary purpose is to provide adequate health insurance coverage for all Americans.
  - Fills holes in private insurance, e.g. exclusions, high deductibles, lifetime caps, rescissions, etc.
  - Expands coverage through private and public insurance
  - Should reduce national health care costs and improve quality through better coverage and resulting care
- But ACA will cover only half the currently uninsured by 2023 according to CBO estimates
  - CBO estimates approximately 28 million additional people under age 65 will be covered by 2023
  - CBO estimates 17 million citizens and 13 million illegals will be UNINSURED by 2023.
  - CBO estimates do not include the 26 states currently refusing to expand Medicaid eligibility
- Reliance on Medicaid, with low physician participation rates, may prove the ACA's Achilles heel
- ACA should improve the effectiveness of healthcare by making insurance coverage more available.
  - Still omits a significant number of uninsured people under age 65 (see above)
  - More research is on the relationship between health insurance coverage and health quality is needed
- ACA makes no structural changes to reduce healthcare costs for those in private insurance programs
  - Number and variety of insurance plans may actually proliferate
  - Nothing to recapture $417 billion (2003 dollars) per year of excess costs documented by MGI (see above)
- ACA continues to offer the best healthcare in the world for those who can afford it, but with a 40% tax on "gold-plated" insurance coverage.
- ACA is budget neutral according to the CBO
- ACA helps ensure long term solvency of Medicare by cutting $575 billion through reduced reimbursement and subsidies (NOT benefits), but more may be needed.

AND THE ACA IS CONTROVERSIAL FOR A NUMBER OF REASONS, SOME VALID

- Incremental Costs for Medicaid Expansion, Exchange Subsidies, Employer Tax Credits expected to add almost $1.7 trillion to government spending between 2012-2023 ($155 billion/year on average)
  - Estimated revenue offsets of $1.2 trillion from penalty payments & "Effects on Tax Revenues and Outlays"[3]
  - The net average annual cost between 2012-2023 would be $45 billion.
- Individual Mandate: controversial for obvious reasons but found constitutional by Supreme Court
- Employer Mandate: estimated to cost $117 billion between 2012-2023
  - $2000 per full-time employee not adequately covered
  - Applies to employers with at least 50 Full Time Equivalent (FTE) employees
  - FTE = (total number of full-time employees) + (total Part-time employee hours divided by 30).
  - Some contend that this will motivate many employers to terminate coverage
  - It will significantly increase employers' per hour costs for entry level jobs.
- Misunderstandings due to the ACA's complexity and entrenched Political Opposition
  - The ACA is 906 pages long, although some claim that it is much longer
  - "Death Panels", a term popularized by Sarah Palin, referring to "voluntary counseling to Medicare patients about living wills, advance directives, and end-of-life care options"[4]
  - Betsy McAughey's[5] scare tactics concerning $575 billion of Medicare cost-saving cuts
  - A 46% of a recent poll of Americans thought that "Obamacare" had already been repealed
  - Greatly exaggerated estimates of cost
- Mistrust of "socialized medicine", defined as anything so labeled by the opposition, and an irrational attachment to private enterprise and competition in medicine and healthcare.

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[3] Congressional Budget Office, July 2012
[4] http://en.wikipedia.org/wiki/Death_panel
[5] **Decoding the Obama Health Care Law: What You Need to Know**, Betsy McAughey (Paperless Publishing, LLC, 2012)

CONCLUSIONS : WHILE THE ACA IS A BIG LEAP FORWARD, MUCH MORE NEEDS TO BE DONE

- The Congressional Budget Office (CBO) estimates the net cost of ACA from $45 billion in 2014 to $159 billion by 2022 before offsetting savings – hardly enough to bankrupt the country.
- While the ACA represents a significant leap forward in terms of health insurance reform, an additional 17 to 30 million people (13 million illegals) will not be covered.
- The Medicaid program on which ACA relies in part has many problems that need attention
  - low physician participation due to very low reimbursement rates
  - inadequate participation by 26 states
  - significant fraud and abuse
- Universal coverage would obviate the need for the individual mandate (originally recommended by the Heritage Foundation, later adopted in Massachusetts) the most controversial aspect of the ACA.
- "Socialized medicine" is NOT REQUIRED to achieve universal coverage
- COMPETITION is NOT the solution to the country's healthcare problems and contributes to costs
  - Provider costs of processing claims for many different payors and coverages
  - Costs of marketing, profits, etc.
  - The profit motive contributes to inefficiency in many ways large and small
- Expansion of Medicare and the Federal Employees Health Benefits (FEHB) could reduce costs
  - Administrative costs are much lower than for the average private insurance plan
  - Buy-ins at appropriate age-adjusted rates could prove very popular
- Congress should empower a bi-partisan commission to improve quality & reduce cost of care
  - Compare U.S. healthcare outcomes with those of other developed nations
  - Recapture excess spending on hospital and outpatient care and drugs as per McKinsey Global Institute.

REFERENCES & RESOURCES

2011 HEALTH CARE EXPENDITURES FOR THE U. S. AND 9 OTHER DEVELOPED COUNTRIES

2011 Healthcare Expenditures (OECD)	Per Capita		% GDP		Life Expectancy	
	$$$s	% of US	% GDP	% of US	yrs.	% of US
France	$4,118	48%	11.6%	66%	82.2	104%
Germany	$4,495	53%	11.3%	64%	80.8	103%
Denmark	$4,495	53%	11.1%	63%	79.9	102%
Canada	$4,522	53%	11.2%	63%	81.0	103%
Austria	$4,546	53%	10.8%	61%	81.1	103%
Luxembourg	$4,755	56%	8.2%	46%	81.1	103%
Netherlands	$5,099	60%	11.9%	67%	81.3	103%
Switzerland	$5,643	66%	11.0%	62%	82.8	105%
Norway	$5,669	67%	9.3%	53%	81.4	103%
Average (ex USA)	**$4,816**	**57%**	**10.7%**	**61%**	**81.3**	**103%**
USA	**$8,508**	**100%**	**17.7%**	**100%**	**78.7**	**100%**

SOURCE: The Organisation for Economic Co-operation and Development (OECD)

The Healing of America:
A Global Quest for Better, Cheaper, and Fairer Health Care

"New York Times bestselling author T. R. Reid shows how all the other industrialized democracies have achieved something the United States can't seem to do: provide health care for everybody at a reasonable cost.

"… Reid visits wealthy, free market, industrialized democracies like our own-including France, Germany, Japan, the U.K., and Canada…. Reid shares evidence from doctors, government officials, health care experts, and patients the world over, finding that foreign health care systems give everybody quality care at an affordable cost.

"And that dreaded monster "socialized medicine" turns out to be a myth. Many developed countries provide universal coverage with private doctors, private hospitals, and private insurance. In addition to long-established systems, Reid also studies countries that have carried out major health care reform.

"*The first question facing these countries-and the United States, for that matter-is an ethical issue: Is health care a human right? Most countries have already answered with a resolute yes, leaving the United States in the murky moral backwater with nations we typically think of as far less just than our own..*

" *Reid sees problems elsewhere, too: He finds poorly paid doctors in Japan, endless lines in Canada, mistreated patients in Britain, spartan facilities in France. Still, all the other rich countries operate at a lower cost, produce better health statistics, and cover everybody. In the end, The Healing of America is a good news book: It finds models around the world that Americans can borrow to guarantee health care for everybody who needs it."*

- selections from longer book summary at Amazon.com (*emphasis added herein*)-

CONGRESSIONAL BUDGET OFFICE ESTIMATES OF ACA COSTS (BEFORE SAVINGS)

ACA Cost Estimates, excluding offsetting savings, range from $45 billion in 2014 to $159 billion in 2022, hardly enough to bankrupt the country (***The budgetary impact of other provisions of the ACA, which in the aggregate reduce budget deficits, not included***.)" [6]

($ billions except per Insured)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2014-2022 Average
Medicaid and CHIP Outlays	$26	$49	$62	$69	$77	$83	$86	$92	$99	$71
Exchange Subsidies & Related Spending	$25	$61	$97	$119	$129	$137	$141	$148	$155	$112
Small Employer Tax Credits	$3	$4	$2	$1	$2	$2	$2	$2	$2	$2
GROSS COST OF COVERAGE	**$53**	**$113**	**$161**	**$190**	**$208**	**$221**	**$229**	**$242**	**$256**	**$186**
LESS: PENALTY PAYMENTS										
Uninsured Individuals	$0	($3)	($6)	($7)	($7)	($7)	($8)	($9)	($9)	($6)
Employers	($4)	($9)	($11)	($12)	($14)	($15)	($16)	($17)	($18)	($13)
Tax on High-Premium Plans	$0	$0	$0	$0	($11)	($18)	($22)	($27)	($32)	($12)
Other	($4)	($7)	($16)	($25)	($31)	($36)	($38)	($37)	($37)	($26)
NET COST OF COVERAGE	**$45**	**$94**	**$129**	**$145**	**$145**	**$144**	**$145**	**$153**	**$159**	**$129**
Additional Insureds (MM)	14	20	26	28	29	29	29	30	30	26
NET COST PER ADDL. INSURED	**$3,214**	**$4,700**	**$4,962**	**$5,179**	**$5,000**	**$4,966**	**$5,000**	**$5,100**	**$5,300**	**$4,932**

[6] **Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision**, Congressional Budget Office (July, 2012)

CONGRESSIONAL BUDGET OFFICE ESTIMATES OF PEOPLE COVERED BY ACA

TABLE 3.

Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage, Updated for Supreme Court Decision

EFFECTS ON INSURANCE COVERAGE[a]		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
(Millions of nonelderly people, by calendar year)												
Prior-Law Coverage[b]	Medicaid and CHIP	34	34	35	34	32	32	31	32	32	32	32
	Employer	154	156	157	157	159	160	160	161	161	160	161
	Nongroup and Other[c]	25	25	25	27	28	28	31	30	30	31	31
	Uninsured[d]	55	56	56	56	56	57	58	57	59	60	60
	TOTAL	269	271	272	274	275	277	280	280	282	283	284
Change in Coverage under the ACA, Updated for Supreme Court Decision	Medicaid and CHIP	*	1	7	9	10	10	11	11	11	11	11
	Employer[e]	1	1	-1	-2	-5	-5	-5	-6	-5	-4	-4
	Nongroup and Other[c]	1	*	-1	-1	-2	-2	-3	-2	-2	-3	-3
	Exchanges	0	0	9	14	23	25	26	26	25	25	25
	Uninsured[d]	-2	-2	-14	-20	-26	-28	-29	-29	-29	-30	-30
Uninsured Population Given the Supreme Court Decision												
Number of Uninsured Nonelderly People[d]		53	53	41	36	30	29	29	29	29	30	30
Insured Share of the Nonelderly Population[a]												
Including All Residents		80%	80%	85%	87%	89%	90%	90%	90%	90%	89%	89%
Excluding Unauthorized Immigrants		82%	82%	87%	89%	91%	92%	92%	92%	92%	92%	92%
Memo: Exchange Enrollees and Subsidies												
Number with Unaffordable Offer from Employer[f]				*	*	1	1	1	1	1	1	1
Number of Unsubsidized Exchange Enrollees				1	2	4	4	4	4	4	5	5
Average Exchange Subsidy per Subsidized Enrollee				$5,320	$5,380	$5,490	$5,640	$6,080	$6,470	$6,750	$7,160	$7,510

Footnotes omitted to improve readability. Please consult the actual report (**Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision**, Congressional Budget Office , July, 2012) to view notes

DECODING THE OBAMA HEALTH CARE LAW: WHAT YOU NEED TO KNOW, BETSY MCAUGHEY

Critique by Peter A. Wadsworth

Betsy McCaughey, a frequent guest on Fox News and a historian by training, with a Ph.D. from Columbia University. was the 72nd Lieutenant Governor of New York from 1995 to 1998, She has, over the years, provided commentary on healthcare policy. Her 1993 attack on the Clinton healthcare plan was considered to be a major factor in the defeat of the bill In 2009, her criticisms of the healthcare plan then being debated in the 111th Congress inspired the slogans "death panel" and "pulling the plug on Grandma", which nearly defeated the legislation. She has been a fellow at the conservative Manhattan Institute and Hudson Institute think tanks, and has written numerous articles and op-eds. (cribbed from Wikipedia and edited)

An extensive and informative but biased analysis of “Obamacare”. The "Obama Health Law Timeline" (Chapter 2) cites three separate court rulings that find the ACA unconstitutional" but does not mention of several court rulings upholding its constitutionality including the Supreme Court ruling in an opinion written by Chief Justice Roberts.

By setting aside the author's strongly held opinions and carefully screening her conclusions, however, there is a lot can be learned about the law from this book, most notably the incremental costs to employers. Ms. McAughey makes a compelling case that millions who are now covered by employer-based health coverage will lose their benefits backed up by a study by my former employer, McKinsey & Co., which found that 50% of employers surveyed plan to stop offering health insurance to their employees. No mention, however, of how the employers are sampled, so there could be unintended bias there.

But the author equates increased benefit costs and loss of choices in health insurance plans of dubious value, e.g. mini-med plans, as compelling negatives. In fact it is the proliferation of health insurance coverage plans and the lack of adequate coverage that drives up the costs of the American healthcare system. For example, millions or people now receive "free" care in hospital emergency rooms and wards, the cost of which is passed along to everyone else's health insurance bill, not to mention the higher costs of treating patients in a hospital setting. Yet when the author discusses costs, she often fails to mention offsetting savings.

The author rails against the expansion of Medicaid, which she says will drive up enrollment by 57% in Texas, 49% in Oklahoma, 42% in Florida and 41% in Virginia, but fails to express moral outrage that these states fail to care for the needy. She does express moral outrage that the new Medicaid enrollees will be under-served because of the scarcity or participating physicians. All too often the author makes the dollars and cents argument against the ACA will omitting the moral argument for it.

THE AUTHOR

Peter A. Wadsworth specialized in healthcare and technology finance for over 25 years before founding AmoryAssociates.net as an insurance executive, investment banker and head of his own financial advisory firm. During that time he represented some of the most forward thinking and successful managed care and technology companies in the U.S. and overseas.

During his investment banking career, Mr. Wadsworth was recognized for his expertise in managed healthcare financing and was called upon to give a number of presentations and seminars and write articles on the subject.

In recent years Mr. Wadsworth has founded and directed several community based organizations and an international foundation. He earned an MBA and undergraduate degree in operations research and information technology from Cornell University.

For more information visit http://amoryassociates.net or

email the author at Amory47@optimum.net

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[i] The 30 OECD member countries: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, the Slovak Republic, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States.

[ii] "Accounting for the Cost of Health Care in the United States", McKinsey Global Institute, January 2007

[iii] IBID.