May 21, 2009, 4:00 a.m.

The Obamacare to Come

Dems' health-care plans do not provide the reform most Americans seek.

By Michael Tanner

Drip by painful drip, the details of the Democratic health-care-reform plan have been leaking out. And from what we can see so far, it looks like bad news for American taxpayers, health-care providers, and, most important, patients.

The plan would not initially create a government-run, single-payer system such as those in Canada and Britain. Private insurance would still exist, at least for a time. But it would be reduced to little more than a public utility, operating much like the electric company, with the government regulating every aspect of its operation.

It would be mandated both that employers offer coverage and that individuals buy it. A government-run plan, similar to Medicare, would be set up to compete with private insurers. The government would undertake comparative-effectiveness and cost-effectiveness research, and use the results to impose practice guidelines on providers. Private insurance would face a host of new regulations, including a requirement to insure all applicants and a prohibition on pricing premiums on the basis of risk. Subsidies would be extended to help middle earners purchase insurance. And the government would subsidize and manage the development of a national system of electronic medical records.

The net result would be an unprecedented level of government control over one-sixth of the U.S. economy, and over some of the most important, personal, and private decisions in Americans' lives.

Let's look at some of the most troubling ideas in detail.

An employer mandate. Employers would be required to insure their workers through a "pay or play" mandate. Those who did not provide "meaningful coverage" for their workers would pay a penalty, equal to some percentage of their payroll, into a national fund that would provide insurance to uncovered workers. Such a mandate is, of course, simply a disguised tax on employment. As Princeton University professor Uwe Reinhardt, the dean of health-care economists, points out, "[That] the fiscal flows triggered by mandate would not flow directly through the public budgets does not detract from the measure's status of a bona fide tax." Estimates suggest that an employer mandate could cost 1.6 million jobs over the first five years.

An individual mandate. As is the case with an employer mandate, an individual mandate is essentially a disguised tax. It is also the first in a series of dominoes that will lead to greater government control of the health-care system.

To implement an insurance mandate, the government will have to define what sort of insurance fulfills it. As the CBO puts it, "an individual mandate . . . would require people to purchase a specific service that would have to be heavily regulated by the federal government." At the very least, deductible levels and lifetime caps will have to be specified, and a minimum-benefits package will likely be spelled out. This means the oft-repeated promise that "if you are happy with your current insurance, you can keep it" is untrue. Millions of Americans who are currently satisfied with their coverage will have to give it up and purchase the insurance the government wants them to have, even if the new insurance is more expensive or covers benefits the buyer does not want.

A "public option." The government would establish a new universal-health-care program, similar to Medicare, that would compete with private insurance. Regardless of how it is structured or administered, such a plan would have an inherent advantage in the marketplace because it would ultimately be subsidized by taxpayers. It could, for instance, keep its premiums artificially low or offer extra benefits, then turn to the U.S. Treasury to cover any shortfalls. Consumers would naturally be attracted to the lower-cost, higher-benefit government program.

A government program would also have an advantage because its tremendous market presence would allow it to impose much lower reimbursement rates on doctors and hospitals. Government plans such as Medicare and Medicaid traditionally reimburse providers at rates considerably below those of private insurance. Providers recoup the lost income by raising prices for those with private insurance. It is estimated that privately insured patients pay $89 billion annually in additional insurance costs because of cost-shifting from government programs. If the new public option would have similar reimbursement policies, it would result in additional cost-shifting of as much as $36.4 billion annually. Such cost-shifting would force insurers to raise their premiums, making them even less competitive with the taxpayer-subsidized public plan. Lewin Associates estimates that as many as 118.5 million Americans, nearly two out of every three people with insurance, would shift to the government program. The result would be a death spiral for private insurance.

Given that many of the most outspoken advocates of the "public option" have, in the past, supported a government-run single-payer system, it is reasonable to suspect they support a public option precisely because it would squeeze out private insurance and eventually lead to such a system. President Obama himself has said that if he were designing a health-care system from scratch, his preference would be a single-payer system "managed like Canada's." He has also said that, while his proposal is a less radical approach, "it may be that we end up transitioning to such a system."

Comparative- and cost-effectiveness research. In an attempt to control health-care costs, the government would undertake research to determine which health-care procedures and technologies are most effective and, more ominously, cost-effective. Of course, there is a great deal of waste in the U.S. health-care system, and if the government's goal were simply to provide better information there would be little cause for concern. But there is every reason to believe such research would be used to impose restrictions on how medicine is practiced. For example, some reform advocates have said that when an insurance company fails to comply with government practice guidelines, workers should no longer be able to exempt the value of that company's plans from their taxable income.

There is no doubt that other countries use comparative-effectiveness research as the basis for rationing. For example, in Great Britain, the National Institute on Clinical Effectiveness makes such decisions, including a controversial determination that certain cancer drugs are "too expensive." The U.K. government effectively puts a price tag on each citizen's life — about $44,305 (£30,000) per year, to

be exact, under NICE's guidelines. That's just a baseline, of course, and, as NICE chairman Michael Rawlins points out, the agency has sometimes approved treatments costing as much as $70,887 (£48,000) per year of extended life. But such treatments are approved only if it can be shown they extend life by at least three months and are used for illnesses that affect fewer than 7,000 new patients per year.

The final health-care-reform bill is likely to include a number of other bad ideas: a host of new insurance regulations that will drive up costs and limit consumer choice (under one leaked proposal, Americans would be limited to a choice of four standardized insurance plans); subsidies for middle-class families (a family of four earning as much as $83,000 per year would receive subsidized care under one proposal); and government preemption of private investment and research into health IT. All of this would come at a cost to taxpayers of at least $1.5 trillion over the next ten years.

The American people are right to demand health-care reform. The current system is broken. But taken individually, most of the ideas currently being considered by Congress would make the problems we face even worse. Taken together, they amount to a complete government takeover of the American health-care system. That is not the type of reform most Americans seek.

— *Michael Tanner is a senior fellow at the Cato Institute, author of* Leviathan on the Right: How Big Government Conservatism Brought down the Republican Revolution*, and co-author of* Healthy Competition: What's Holding back Health care and How to Free It.
