Live Talk from May 5: Michael D. Tanner

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1. What, if anything, is wrong with President Barack Obama's proposal for a "public option" being made available to purchasers of health 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.

2. In your view, what are the consequences of the U.S. ultimately going to a government-run single-payer health care system?

The one common characteristic of all single-payer health care systems is that they ration care. Sometimes they ration it explicitly, denying certain types of treatment altogether. More often, they ration it indirectly, imposing global budgets or other cost constraints that limit the availability of high-tech medical equipment or imposes long waits on patients seeking treatment. For example, at any given time, 750,000 Britons are waiting for admission to National Health Service hospitals and shortages force the NHS to cancel as many as 50,000 operations each year. Roughly 90,000 New Zealanders are facing similar waits. In Sweden, the wait for heart surgery can be as long as 25 weeks, while the average wait for hip replacement surgery is more than a year. In Canada more than 800,000 patients are currently on waiting lists for medical procedures. As the Canadian Supreme Court noted in striking down the part of Canada's single-payer law that prohibited private payment for health care, "Access to a waiting list is not access to health care." The court went on to note that "in some cases patients die as a result of waiting lists for public health care" and "many patients on non-urgent waiting lists are in pain and cannot fully enjoy any real quality of life."

3. Insurers, doctors and hospitals –- many of whom opposed "Hillary Care" in the early 1990s -- all seem to be coalescing behind the president's health-care plans. Why is this happening, in your judgment?

Most providers would rather be at the table than on the menu. They are attempting to shape health-care reform to their advantage. For example, insurers would be all to happy to have the government mandate that people be required to purchase their products. Of course, we should not fall into the trap of believing that what is good for providers is good for

patients.

4. What alternatives are the Republicans offering that you believe have merit?

There are two proposals that would go a long way towards lowering health-care cost and increasing access. We should change the tax treatment of health insurance so that individuals who purchase their own insurance receive the same tax break as those who receive employer-provided insurance. By breaking the link between employment and insurance we can ensure that insurance is personal and portable. That is, if people lose their jobs, they will no longer lose their insurance. At the same time, because people would be directly purchasing their insurance, and therefore directly confronting the cost, they would become much more cost-conscious in their health care spending. Second, one of the best health-care proposals of recent years is Rep. John Shadegg's proposal to allow Americans to buy insurance across state lines. State mandates and regulations drive up the cost of health insurance. Consumers should be allowed to shop for insurance in states with less costly regulatory regiemes. Finally, we can and should expand the use of health savings accounts.

5. Will the president's proposals actually lower health-care costs? If you don't believe they will, why not?

Sure, there are efficiency savings to be had here and there. But even Obama's budget director, Peter Orszag, just told Congress that savings from things like greater emphasis on preventive care are unlikely to be realized for years, if at all. In reality, any health-care reform will have to confront the fact that the biggest single reason costs keep rising is that the American people keep buying more and more health care. At its most basic, no one wants to die. If a treatment can save our lives, or increase quality of life, we want it. This problem becomes even more acute when someone else is paying. Right now, consumers pay only about 15 cents out of every dollar spent on health care in this country. The rest is paid by government (50 percent) or insurers (35 percent). One study by MIT's Amy Finkelstein suggests that the prevalence of insurance itself has roughly doubled the cost of health care. So, if Obama succeeds in expanding insurance coverage, it's very likely to increase the cost of care. Ultimately, controlling costs requires someone to say "no," whether the government (as in single-payer systems with global budgets), insurers (managed care) or health-care consumers themselves (by desire or ability to pay).

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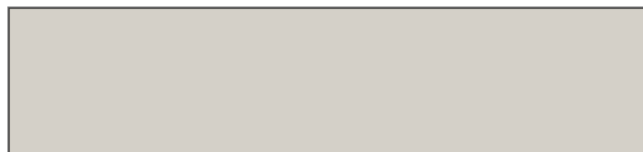

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