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Placebo - Why the Democrats' proposals will not work

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The key congressional committees have yet to introduce the legislation that will carry Democrats' hopes for "universal coverage" -- i.e., a government guarantee that all Americans will have health insurance, if not access to actual medical care. But the leading Democratic reform proposals -- the plan on which Pres. Barack Obama campaigned, the "Call to Action" white paper by Senate Finance Committee chairman Max Baucus of Montana, and the "Healthy Americans Act" proposed by Sen. Ron Wyden (Oregon) -- bear enough similarities that we can predict the shape that legislation will take. Indeed, they all bear a striking resemblance to the reforms that Republican governor Mitt Romney signed into law in Massachusetts in 2006.

That failing Massachusetts experiment, like the failed Clinton health plan of 1994, relies on coercion, mandates, price controls, and government rationing. If comprehensive health-care reform happens in 2009, it will follow suit -- and perhaps go even farther, by creating a new socialized health-insurance program as an option for Americans under age 65. Tens of millions of Americans would lose their current health insurance and could also lose their current doctors, President Obama's reassurances notwithstanding. Since there aren't enough Americans earning more than $250,000 to finance the estimated $1.7 trillion price tag, reform would mean higher taxes for the middle class, violating another promise Obama made during the presidential campaign. Worst of all, these reforms would -- through government rationing and the sclerosis that government brings to health-care delivery -- reduce the quality of medical care and cost many lives.

Universal coverage is impossible without coercion; that's why the leading Democratic proposals would force Americans to obtain health insurance, either on their own or through an employer. Those who do not obtain the prescribed level of coverage would pay a fine. Those who do not pay the fine would go to jail. During the 2008 primaries, Hillary Clinton attacked Obama's plan for not being coercive enough: She proposed to compel all Americans to purchase coverage with a so-called individual mandate. Obama criticized this mandate, claiming that Clinton would "have the government force uninsured people to buy insurance, even if they can't afford it" -- but in reality, his plan was scarcely less coercive. He proposed an individual mandate for children's coverage -- don't worry, only the parents would face jail time -- and an employer mandate that would compel employers to provide "meaningful" coverage to their workers.

Whatever coercive power an employer mandate lacks because it exempts small businesses, part-time workers, and the unemployed, it more than makes up for in other ways. Obama's National Economic Council chairman, Larry Summers, once wrote that employer mandates "are like public programs financed by benefit taxes": They can increase unemployment, work against the very people they purport to help (i.e., low-wage workers and the sick), and "fuel the growth of government because their costs are relatively invisible." Economists Kate Baicker of Harvard and Helen Levy of Michigan estimate that, by effectively increasing the minimum wage, an employer mandate could kill 315,000 low-wage jobs. Unlike the hundreds of thousands of jobs lost to the current recession, those jobs would not return: The mandate would continue to eliminate jobs as long as the growth of health-insurance costs outpaces that of low-wage workers' productivity.

Since employers finance health benefits by reducing wages, it is practically irrelevant whether a government enacts an individual mandate, an employer mandate, or both. One way or another, the cost of any mandate comes out of the worker's hide. Politicians such as Obama tend to prefer an employer mandate, however, for the reason Summers suggests: Employer mandates hide the implicit "mandate tax" in the form of reduced wages, where workers are less likely to notice it.

During the campaign, Obama vaguely defined "meaningful" coverage as being at least as good as what members of Congress get. That standard could end up forcing half of all those with private health insurance (roughly 100 million people) and all of the uninsured (an estimated 46 million) to get a more comprehensive plan, whether they value the added coverage or not. Whatever the meaning of "meaningful" is, the mandate tax would grow over time as a result of "mandate creep." As they have done at the state level, patient advocates and providers will demand that Congress mandate lower deductibles and coinsurance, as well as coverage of particular services. Since the 1970s, states have gradually enacted nearly 2,000 laws requiring consumers to purchase specific types of coverage. The Congressional Budget Office (CBO) estimates that such laws increase premiums by an average of about 3 percent: less in states with few mandated benefits (such as Idaho: 13 mandated benefits) and more in states with many (Maryland: 63).

Massachusetts already had 40 such laws by the time Mitt Romney enacted an individual and employer mandate in 2006. After that, mandate creep accelerated. Bureaucrats and lobbyists imposed coverage for prescription drugs, preventive care, orthotics, prosthetics, dependent students, and domestic partners. They imposed other costly restrictions, including limits on cost-sharing such as maximum deductibles (no higher than $2,000 for individuals and $4,000 for families), a ban on per-illness or per-year caps on total benefits, and a ban on coverage providing a "fixed dollar amount per day or stay in the hospital."

The result is absurd: There's zero evidence that anything beyond a basic health plan actually improves health outcomes, yet the individual and employer mandates gradually make coverage less affordable by outlawing the leaner, less expensive plans. (If Congress enacts these mandates, we can say goodbye to health savings accounts as we know them.)

As a result, insurance premiums are rising rapidly in Massachusetts, as are the subsidies required to help residents -- including families of four earning up to $66,000 -- comply. Government spending has far outpaced projections, with the total cost of reform reaching $1.9 billion last year. Tax increases on tobacco, hospitals, insurers, and employers have failed to stanch the bleeding. Combined public and private health spending has grown an estimated 66 percent faster than it would have without the reforms. The true believers in universal coverage are so committed to this disaster that they spin the cost overruns as evidence of success. Of course, cost overruns are a success if your goal is simply to boost health-care spending. That's why the health-insurance lobby and physicians' groups such as the American Medical Association support an individual mandate, which opens the spigot by forcing more people to purchase more of their services. One insurer-funded study practically celebrates how the Massachusetts reforms hide the runaway spending by dispersing the burden across higher premiums, higher taxes, and lower wages.

The biggest sticking point among Democrats has been whether to create a new socialized health-insurance program. While many Democrats fear that a new government program would jeopardize health reform's chances for passage, Obama and Baucus want such a program to be an "option" for those under age 65, within the context of a new federally regulated market that Obama calls a "National Health Insurance Exchange." House Speaker Nancy Pelosi and four House caucuses representing more than 100 Democrats have stated that a "public-plan choice," modeled on Medicare, is the sine qua non of reform. Sixteen Democratic senators have signed a letter signaling their support.

Not even the 1993 Clinton reforms envisioned so radical a step. One analysis by the Lewin Group, a prominent health-care-policy firm, estimated that Obama's campaign plan would move 48 million Americans into a new government-run plan -- essentially doubling the Medicare rolls. Lewin subsequently estimated that if Congress used Medicare's payment rates and opened the new program to everyone, it could pull 120 million Americans out of private insurance -- more than half of the private market -- and boost the government rolls by an even larger number. Two-thirds of Americans would depend on government for their health care, compared with just over one-quarter today.

That would strike a historic blow against even the possibility of limited government. Medicare and Medicaid are the reason that the size of the federal budget will double from 20 percent to 40 percent of GDP within 80 years. Medicare's unfunded liabilities are in the neighborhood of $80 trillion. The CBO estimates that all income-tax rates would have nearly to double by mid-century (top rate: 66 percent)

estimates that all income-tax rates would have nearly to double by mid-century (top rate: 66 percent), and increase by nearly 150 percent by 2082 (top rate: 88 percent), just to pay for existing federal programs. If Congress creates a new government health program instead of reforming the ones we've got, tax increases will be inevitable and painful: The CBO estimates that by 2050, economic output could be 20 percent lower than if government remained at its current share of GDP. And tax cuts will be a pipe dream: In 1995 and 1996, Bill Clinton showed that the most effective strategy for defeating tax cuts is to paint them as a threat to voters' health care. If two-thirds of Americans come to depend on government for their health care, whether through a new program or through subsidized "private" coverage, we can forget about limiting government within our lifetimes.

Despite Medicare and Medicaid's failure to contain health-care costs, the Left claims that one more government program ought to do the trick. Their main strategy, which they seldom admit, is explicit government rationing. Thus the $1 billion in the stimulus bill for "comparative effectiveness" research -- which would help government bureaucrats decide, e.g., whether Mom's next round of chemo (in the words of a draft committee report on the stimulus bill) "will no longer be prescribed." Massachusetts has created a commission to help the government develop a "common payment methodology across all public and private payers," including the use of "evidence-based purchasing strategies" -- code for explicit government rationing.

Unlike Britons, though, Americans won't allow government bureaucrats to make their medical decisions. Neither will doctors, drugmakers, and device manufacturers, who don't like federal agencies questioning the value of their services. That's why Congress, at the behest of the industries, has repeatedly defunded agencies that produce industry-offending research. Even if a new comparative-effectiveness effort were to survive, the CBO estimates that after ten years it would reduce federal health spending by "less than one one-hundredth of 1 percent." When explicit rationing fails, the government will turn to its old standby: implicit rationing, typically via price controls.

Government already controls the prices for roughly half of all health-care spending. Medicare sets somewhere close to a million different prices. In Medicaid, the states do the same. The leading Democratic proposals would vastly expand government's role as price setter, primarily by moving tens of millions of patients into price-controlling government programs. Indeed, many reformers want a new government program to use the very prices Medicare does. Obama, Baucus, Wyden, and others seek to control private health-insurance premiums as well.

A government-controlled price is almost never right. Price controls are responsible for both the current surplus of specialists (because prices are too high) and the shortage of primary-care physicians (because prices are too low). Medicare and Medicaid price controls are generally not binding on private payers, though they do influence overall supply. That's one reason, for example, many Massachusetts residents -- particularly those newly insured under the Romney plan -- are facing long waits for primary care.

Price controls enable a veiled form of government rationing: If government sets the prices low enough, many doctors won't participate, which creates non-price barriers to access. States set Medicaid's prices so low that nearly half of all doctors limit the number of Medicaid patients they will accept. Some 20 to 30 percent refuse all Medicaid patients. Medicaid patients often travel hours to find a participating provider.

That is not to say that price controls are an effective tool for reducing spending. When government sets prices too high -- as with specialty care, agricultural price supports, and 20th-century airline regulation -- spending may rise. Government can ratchet prices downward, yet providers know more than regulators about their actual costs and are difficult to monitor. Northwestern University economist Leemore Dafny thus finds that hospitals are "quite sophisticated" in their "strategies" for gaming Medicare's price controls. Physicians likewise push back by increasing quantity and substituting higher-priced services (e.g., CT scans rather than X-rays). Even setting prices too low can sometimes cause spending to rise: In 2007, Maryland's low Medicaid price controls kept Deamonte Driver from seeing a dentist for his toothache. (Only one in six Maryland dentists accepts Medicaid patients.) The infection in Driver's abscessed tooth, which could have been treated with a simple extraction, spread to his brain. That led to $250,000 of medical services, including two unsuccessful brain surgeries. Price controls do not contain costs so much as pretend that certain costs don't exist -- like the loss of Deamonte Driver, who died at age 12, as the Washington Post put it, "for want of a dentist."

If anything, Medicare errs on the side of providing too much access to care. One-third of Medicare patients looking for a new primary-care physician have difficulty finding one, but that amounts to just 2 percent of enrollees. That cannot last, particularly if Congress creates a new government program. Given the cost pressures facing these programs, Medicare and any new program will start to look more like Medicaid. There will be more Deamonte Drivers.

Price controls even allow politicians to rob producers. Wharton professor Mark Pauly notes that the government's "raw bargaining power . . . can permit [it] to be inefficient . . . and actually incur higher true costs than other competitors, and to cover up those inefficiencies by the transfers extracted from providers." The Lewin Group estimates that if Congress moves 130 million Americans into a new government program, physicians and hospitals would see their net incomes fall by roughly $70 billion in 2010. That pay cut, which works out to about $47,000 per physician, may just correct existing overpayments. But what about the next $47,000 cut?

Price controls on insurance premiums create another form of implicit rationing. Premium caps, which Massachusetts governor Deval Patrick is currently threatening to impose, force private insurers to manage care more tightly -- i.e., to deny coverage for more services. Rating restrictions prevent insurers from pricing health insurance according to a purchaser's risk. According to Harvard economist and Obama adviser David Cutler, rating restrictions unleash adverse selection, which drives comprehensive health plans from the market. That rations care by forcing many consumers to accept less coverage than they would prefer. Rating restrictions also encourage insurers to avoid the sickest patients or skimp on their care -- another form of implicit rationing.

If those dynamics sound familiar, there's a reason. Congress already imposes a loose form of rating restriction on most of the market by prohibiting employers from charging different employees different premiums. Some 20 states already impose rating restrictions on health insurance sold to individuals.

When the Left claims that government programs do a better job of containing costs than private insurance, what they mean is that government does a better job of hiding costs -- such as the monetary and non-monetary costs it imposes on patients and providers. Pacific Research Institute economist Ben Zycher points out that the taxes required to run Medicare destroy economic activity, making that program's administrative costs "between four and five times [those] of private health insurance."

The greatest danger of the Democrats' reform plans, however, lies in the fact that they would hamper and cut short thousands of lives by preventing markets from improving quality.

Though America produces more new medical technologies than any other country, the way we deliver medical care is often backward and dangerous. We lack basic conveniences present in other sectors of the economy, such as accessible electronic records. Doctors too often do not coordinate the services they provide to a shared patient. The number of medical errors is frightening -- an estimated 181,000 severe errors per year in hospitals alone, resulting in up to five times as many deaths as result from a lack of health insurance. And, yes, we lack crucial comparative-effectiveness research about which treatments work better than others.

Each of these failures can be laid at the feet of government, specifically Medicare. The reason has to do with the difference between two ways of paying providers. Prepayment (also known as "capitation") is a payment system in which providers receive a fixed budget to care for a defined patient population. It encourages providers to invest in electronic medical records (EMRs), care coordination, error reduction, and comparative-effectiveness research. Kaiser Permanente, a prepaid health plan, leads the industry in these areas precisely because prepayment allows the Permanente Medical Group to keep any money it saves -- by, for example, using EMRs to avoid duplicative tests or medical errors.

Medicare's "fee for service" payment system, on the other hand, pays providers an additional fee for each additional service or hospital admission. That actually penalizes providers that try to improve those dimensions of quality. EMRs help avoid duplicative CT scans by saving and making accessible the results of previous scans. But Medicare will pay for a second scan. And a third. And a fourth. So a provider that invests in EMRs is not only out the cost of the computer system, but also receives fewer payments from Medicare.

The story with medical errors is similar, but more horrifying. If a medical error injures a patient who then requires additional services, Medicare will pay not just for the services that injured the patient but also for the follow-up services. That's right: Medicare pays providers more when they injure patients. Again, if providers invest in error-reduction technologies, they are not only out that initial investment, but Medicare penalizes them with fewer payments.

Rather than allow a level playing field for all payment systems, so that competition forces them all to improve, government tips the scales toward fee-for-service. Medicare is the largest purchaser of medical services in the U.S., and it operates largely on a fee-for-service basis. According to former Medicare chief Thomas Scully, "in many markets Medicare and Medicaid comprise over 65 percent of the payments to hospitals, and more than 80 percent in some physician specialties." No wonder a recent New England Journal of Medicine study found that only 1.5 percent of non-federal hospitals use a comprehensive EMR system. Name any quality innovation that might save money by avoiding unnecessary services -- EMRs, bar-code scanners for prescription drugs, surgery checklists. Medicare blocks them all. The Left bemoans the resulting quality problems, yet is desperately trying to subject even more of the market to the very stagnation Medicare introduces. Massachusetts, with its commission to develop a single payment system for its entire health-care sector, is diving head first into the cement. It makes no difference if government chooses a different payment system than Medicare's. The problem isn't the particular payment system, but the lack of competition from other systems.

Surgeon and scholar Atul Gawande writes: "When we've made a science of performance . . . thousands of lives have been saved. Indeed the scientific effort to improve performance in medicine . . . can arguably save more lives . . . than research on the genome, stem-cell therapy, cancer vaccines, and all the other laboratory work we hear about in the news. . . . Nowhere, though, have governments recognized this." Medicare has spent four decades and billions of dollars penalizing providers who try to save those lives, or develop the tools necessary to do so.

We don't need to go to Canada to find horror stories about government-run health care. One hundred thousand deaths each year from medical errors should be frightening enough.

Before the great health-care debate of 2009 is over, some Democrats and even some Republicans will reassure us that we can reach universal coverage without creating a new government entitlement if only we mandate "personal responsibility" the way Massachusetts did. If Massachusetts has taught us anything, it is that individual and employer mandates are a new government program. They effectively socialize health care by compelling participation in the marketplace, dictating what consumers purchase and at what price, eliminating both economical and comprehensive health plans, and raising taxes. Massachusetts shows that mandates lead ultimately to government rationing by granting government even more power to decide how providers will be paid and how they will practice medicine.

The coming debate is not just about the freedom to make one's own medical decisions. It is about life and death. If we insist on a dynamic and competitive market, health care will be better, cheaper, safer, and more secure. If we go in the direction of new government programs, mandates, and price controls, we will see higher costs, more medical errors, more uncoordinated care, and more lives lost because people with government "insurance" nevertheless couldn't find a doctor who would treat them.

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