

STATE OF THE ART

A CONTINUING SURVEY OF TECHNOLOGY AND SOCIETY

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The Road to Rationing

How 'Medicare Plus' Will Destroy Private Insurance

The next great public policy debate in the United States will involve a health care reform idea championed by an academic who has no medical background and doesn't serve in the Obama administration, and whose original proposal was published in a largely unread book.

Jacob S. Hacker first caused a stir in 1997 when, as a Yale graduate student, he described the failure of President Clinton's health care efforts in *The Road to Nowhere*. In the years since, he has continued to criticize Democratic overambition on health policy, eventually fashioning his own alternative. His idea has become the focus of a heated and increasingly bitter debate on Capitol Hill. House Speaker Nancy Pelosi, a Democrat, has declared it essential for any health care reform; Republican Senator Mitch McConnell

calls it a deal-breaker. Conservative and liberal organizations are gearing up for a grand skirmish.

The idea? Americans would have a new government-run plan, modeled after Medicare, as an option for health insurance. No one would be compelled to enroll in it. Democrats contend that people would have more choice, and the competition would improve all coverage.

Though it may seem modest, the Democratic idea of introducing a public-plan option is worth fighting over. For the Republican minority in Congress and even for moderate Democrats, this is the line in the sand. They believe that instead of encouraging competition, the public-plan option will actually undermine it, will increase red tape, and will exacerbate inefficiencies in the health care system. It could

even spell the beginning of the end of private insurance.

At first blush, allowing the public and private sectors to compete seems perfectly reasonable. In the United States today, numerous government-funded organizations compete with the private sector. Consider the state university systems, which boast world-class institutions. University students have the freedom to choose between state colleges and private universities, and post-secondary education is better for it—Harvard is strengthened by UCLA.

Well-run public institutions have many things in common. For one, they have (relatively) strong, independent leadership that is not micromanaged by centralized bureaucrats. They also compete with rivals: When a public or private university underperforms, it loses out—in talented professors, in students (and their tuition dollars), and in research grants.

Would health care be different? As Kathleen Sebelius, the new Secretary of Health and Human Services, noted in her confirmation hearing, some states already offer state employees membership in government-run plans that compete with private insurance. It's worked in Kansas, Sebelius assured the Senate Finance Committee, and it can work for the country.

And no one doubts that health care needs more competition. In many states, one or two health insurance carriers dominate the market. Even where several options are available, employees rarely see them: the majority of

small businesses give their workers a “choice” of exactly one plan. Opening up the markets, in this case by offering public coverage, seems reasonable enough. When polled, unsurprisingly, more than 70 percent of Americans favor this idea. But how to do it?

Enter Jacob Hacker. Now a political science professor at the University of California at Berkley, Hacker is a champion of universal health insurance. But he's also a student of the Big Failure: In his book on the collapse of the Clinton health care plan, he concluded that it was too complex, and he believes that the main Democratic alternative in the years since ClintonCare—a massive expansion of Medicare—would be politically unworkable. In “eschewing piecemeal solutions” and instead ambitiously “insisting on full-bore national health insurance,” Hacker wrote in *Slate* in 2006, the left is “biting off too much.” Such a “Medicare for all” proposal, he wrote, is tantamount to a single-payer system—one like Canada's, where taxpayer dollars pay for the vast majority of health care services. Hacker fawns over the apparent efficiencies, lower costs, and better health outcomes of the Canadian system, and he acknowledges the long list of liberals who support such a proposal in the United States. But he feels that a single-payer proposal would be bitterly unpopular with the millions of Americans who “stubbornly” like their employer-based coverage.

Hacker instead prefers to take what he considers a middle road: instead of

shooting for a single-payer system, he proposes giving employers the *option* of enrolling their workers in a Medicare-style plan. His proposal for “Medicare Plus,” outlined in a 2001 paper, envisioned a government plan that would address the concerns of small businesses, relieve states of the burden of growing Medicaid costs, and help insure more Americans. He revised his proposal a few years later, rebranding it “Health Care for All.” He hired the Lewin Group, a respected health-care consulting firm, to predict the impact. Its findings: half of all non-elderly Americans would ultimately be enrolled in the public plan.

Proposals to overhaul American health care are a dime a dozen; indeed, Hacker’s original paper was published in a book filled with proposals from across the political spectrum. But his central idea has a certain charm: It emphasizes choice. It empowers, rather than pushes. It seems like an incremental reform, rather than a radical transformation. As a result, Hacker and his plan have gained influence among Democrats. In 2007, he had the extraordinary opportunity to brief all three major Democratic presidential candidates on his proposal—and all three signed on.

President Obama’s proposal isn’t quite the Medicare Plus that Hacker originally designed. The president’s proposal involves a public plan to compete with private ones, but as in Hacker’s plan, participation is voluntary. As candidate Obama emphasized on the campaign trail, in his plan, “If

you’ve got insurance through your employer, you can keep your insurance.” The proposal has won support from expected quarters. The *New York Times*, for instance, enthuses: “A new public plan—to offer consumers greater choice, keep the private plans honest and, one can hope, restrain the relentless growth in health care premiums and underlying medical costs—seems worth trying.”

The key to Hacker’s plan is his insight that the Medicare program—universal health insurance covering Americans sixty-five and older—is very popular and widely understood. Fashioning a public plan after Medicare is thus politically feasible and, in its own way, simple. Forget the charts (and the charts explaining the charts) of the ClintonCare debacle—this idea sells itself.

But is it practical? Medicare doesn’t function like private health insurance carriers, which negotiate directly with care providers. Rather, Medicare pays fees to physicians, hospitals, and other providers based on a list of services and compensation drawn up by the Centers for Medicare and Medicaid Services.

In terms of public-private competition, this arrangement is extremely problematic. Let’s return to the university analogy. Remember that universities are bound by certain market realities: UCLA needs to pay good wages for talented professors. After all, a particularly bright chemist or nuclear engineer can always find work at Harvard or other universities if

UCLA doesn't pay up. But Medicare isn't bound by market pricing—it *sets* prices in committee. What's more, since Medicare's regulations make it very difficult for hospitals to refuse Medicare patients, it's not as though providers can rebel. The enormous power of the federal government (as opposed to state governments) to impose pricing on providers renders meaningless the comparisons between a national public-plan option and experiments in, say, Kansas. (The other feature of successful public institutions—their autonomy and strong leadership—also seems unlikely in a Medicare Plus environment, given the astounding number of regulations and rules governing federal programs.)

In April 2009, the Lewin Group, the same respected organization originally hired by Hacker to study his proposal, reviewed the potential enrollment of the public-plan option. The study noted that “Medicare premiums would be lower than private premiums because of the exceptional leverage Medicare has with providers.” The result? Lewin Group vice president John Sheils didn't mince words: “The private industry might just fizzle out altogether.”

The Lewin paper concluded:

If the public plan is opened to all employers... at Medicare payment levels we estimate that about 131.2 million people would enroll in the public plan. The number of people with private health insurance would decline by about 119.1

million people... a two-thirds reduction in the number of people with private coverage.

The Lewin Group readily acknowledged the limitations of attempting to model the effect of legislation when no bill is even before Congress—in Sheils's words, it's like “nailing Jell-O to the wall.” And others, including Greg Scandlen of Consumers for Health Care Choices, have suggested that the Lewin study may have erred by overstating the administrative costs of existing private plans, by understating how Medicare now warps health care providers' behavior, and by ignoring the hidden costs of Medicare's clunky bureaucracy. If anything, though, those concerns only reinforce the 2009 Lewin study's conclusion: if the federal government uses its enormous pricing and regulatory powers to undercut premiums, it will result in a massive exodus from private insurance to the artificially cheap public plan.

Hacker immediately issued a paper responding to his critics, although he strangely doesn't address their central criticism. His main concern seems instead to be making things easier for the *government*—pushing everyone into a large insurance pool with equal subsidies for private and public plans, standardized benefits, and limits on marketing. He envisions a government body overseeing all this, ensuring fairness among public and private insurance carriers, and protecting patients from excessive co-pays or inadequate benefits. (All these ideas

were aired by the Obama campaign in 2008.) The evolution of Hacker's plan is striking: he originally proposed that the federal government would just offer up a public plan; now his plan makes government the regulator, coordinator, and administrator for non-employer-provided insurance, as well as executor of its own insurance plan.

How does Hacker respond to the argument that the public plan would have an unfair pricing advantage?

Critics of Medicare prices respond that public plan bargaining is at odds with market pricing and simply unfair. The first charge—that Medicare prices are administered rather than set in the market—is true, but irrelevant. All health plans, public and private, use administered prices. A free market for health services is unrealistic, requiring that people shop around for individual treatments and pay the full cost themselves. In a world of insurance, administered prices are inevitable. Indeed, price bargaining is exactly what HMOs and other big health plans were supposed to do—only Medicare appears to do it better.

This is deeply disingenuous. Hacker's critics don't argue that health care prices should be set by a perfectly pure market, but rather that competition and market forces are essential to keeping costs low—and that Hacker's plan would destroy those market forces.

Hacker then tries to rebut the charge that Medicare, as it is currently

structured, results in "cost-shifting"—that is, Medicare essentially makes patients on private plans shoulder part of the costs of treatment for people on Medicare.

As for the unfairness of Medicare pricing, the evidence that Medicare underpays providers is much weaker than commonly believed. Exaggerated charges of cost-shifting made by groups representing providers and insurers are based on the faulty assumption that any payment differentials between Medicare and private plans represent cost-shifting. In effect, these accusations presume that all payers should pay the same rates and that the total level of payments to providers is appropriate. The whole point of bargaining, however, is to gain volume discounts and restrain total spending—insofar as doing so is consistent with ensuring good access to providers and high-quality care. So far, there is little evidence that Medicare bargaining has undermined access or quality.

But there is significant evidence that cost-shifting is a real problem. For example, a 2006 study in the journal *Health Affairs* concluded that about 17 cents of every dollar in relative reductions in Medicare payments to private hospitals are shifted onto private patients—resulting in about 12 percent of the total increase in private payer prices between 1997 and 2001. This is not just an unfair aspect of Medicare's

current structure; it also threatens Hacker's own plan, because if private insurance disappears, those informal subsidies to Medicare go away, too.

Also absent from Hacker's analysis is any acknowledgement that Medicare already sits on a sinking foundation. Medicare spending has basically risen in tandem with private sector health care costs, if the analysis excludes drug benefits (historically not covered by Medicare). That's in part because hospitals have gamed Medicare pricing by billing more procedures (quantity) to compensate for the lower per-service prices that Medicare offers. They also use more high-tech procedures with lucrative reimbursements, which add to inflationary pressures in the health care system. By ignoring Medicare's rising costs, Hacker conceals the true price of his plan.

The end result of Hacker's plan would be massive new federal involvement in health care. Rather than helping the private sector tame health inflation, Washington would suddenly be paying for most of it. Eventually, costs would need to be reined in. Uncle Sam's first tactic could well be to impose more price controls on providers. Once most people are in the public plan, price controls will bite, and bite hard. Why? The votes of the elderly will be offset by younger, healthier voters who feel the pinch of the necessary higher taxes. Subsidies to the oldest and sickest patients will be cut (think Alzheimer's and cancer), and medical innovation will slow to a crawl in the name of cost control. Access to health care will be rationed.

(When proponents of government expansion in health care want to cite a popular example, they point to Medicare. They don't mention the *other* Great Society health-care program, Medicaid. Medicaid is a joint federal-state program that covers the poorest citizens, with states paying just over 40 percent of the costs. The program has serious quality and access problems. Studies have found, for example, that Medicaid patients have worse outcomes for diseases like AIDS and cancer than those with private insurance. State policymakers use many crude tools to restrain program costs—low and slow reimbursements for physicians, restrictions on access to newer prescription drugs—which keep Medicaid patients from getting needed care or force them into acute-care settings unsuited to chronic illnesses.)

For a system like the one Hacker proposes to work, the federal government would eventually need to rein in private insurance companies, pushing ever more people toward the public plan. President Obama's promise of allowing people to keep their employer-coverage would be rendered meaningless. This is no exaggeration—in fact, it's the natural course of socialized medicine in other Western countries. In Canada, for example, government health care began with grants to build hospitals (1950s), then limited and comprehensive public coverage (1960s and 1970s, respectively), then an outright ban on private health insurance (1980s)—followed by sweeping attempts to limit the supply of health

care in the name of cost constraints (1990s). Theodore Marmor, the former Johnson advisor and longtime booster of socialized medicine, has even conceded this point in a paper he recently coauthored for the *Annals of Internal Medicine*, noting that no other mechanism for controlling costs—including those President Obama has been touting since his campaign: prevention, comparative effectiveness, and initiatives with information technology—has ever worked in public health care systems.

In short, Professor Hacker's proposal will lead the United States to health care run by a massive, expensive, inefficient, and innovation-killing government bureaucracy. Instead of seeking to expand *government* health insurance, we should expand access to affordable *private* health insurance.

For those not covered by their employer, health insurance is feverishly expensive. A family plan in New York costs more than \$12,000 a year. But an interstate comparison yields surprising results: a family policy can cost a fraction of that amount in Wisconsin (about \$3,000). Why the extraordinary difference? In many states, regulations force people to buy coverage for certain conditions or treatments, driving up the price of the most basic policy. For example, in forty-six states, health insurance must cover chiropractor services; in thirteen states, it must cover in vitro fertilization; in eleven states, it must cover acupuncture services. People who want to try to conquer their nicotine habit with a needle in their foot should

have that right, but should this service really be required?

Other states have gone further, demanding that no one can be refused insurance (this is called "guaranteed issue") and that everyone pay the same price, regardless of age or health status ("community rating"). Combining these ideas—as legislators have required in New York and Massachusetts—makes it easy for people to game the system, waiting until they are ill before getting health insurance. The resulting system is expensive and dysfunctional.

Only by reducing the regulatory burden will Washington get to the root of the problem. There are different ways of doing this, but among the simplest would be to permit people to buy health insurance across state lines, thereby weeding out the regulations by increasing competition between jurisdictions. (Members of Congress have exempted themselves from state regulations; why shouldn't the rest of us enjoy the same arrangement?)

Let's also recognize the problems with the existing U.S. system of employer-based health insurance. The tax code today favors wage-and-salary workers. Thus, an executive with a gold-plated health insurance plan will receive this benefit tax-free but his out-of-work cousin (or his early-retiree brother) who wants a bare-bones policy will be forced to pay in after-tax dollars. Even the self-employed are not treated equitably by the tax code; they get a deduction but not one equal to the benefit received by wage-and-salary employees. Why

not cap the health-insurance tax exclusion and extend it to others who want to pay for their own insurance? And because some would opt out of their employers' plans, this incremental step would start divorcing Americans from job-based insurance—but gradually and on a voluntary basis.

Finally, Americans don't just need competition in health insurance to tame rising costs—they need to take their own health seriously. American health care, as it is currently structured, gives people little reason to attend to diet, exercise, and other health concerns. Employer-based and government-provided health insurance can offset the financial consequences of bad health habits since all the people in a corporation pay the same premium regardless of their health status. Thus, someone who overeats and never exercises may have his diabetic medications subsidized by a health-conscious colleague working two cubicles down the hall. If, as we so often hear, obesity is a

major national problem, why not offer an incentive for better choices? One approach would be to offer Americans a small tax rebate if their doctor certifies that they have a BMI (Body Mass Index) under 30.

These three ideas would bring greater choice to American health care. They would also help instill in the system the oldest of American virtues: personal responsibility. While they may not be as flashy as promising Medicare for everyone who wants it, these prudent proposals would at least move the system toward a sustainable future instead of a costly and inefficient government bureaucracy.

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