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A Regrettable Reform

Fixing Obamacare's Worst Policies

Just a few weeks before the signing ceremony, President Barack Obama's dream of enacting sweeping health reform seemed to be not quite dead but not quite living either. *The Economist* compared his health reform proposal to a zombie movie, as if "Obamacare" were doomed to walk the Earth forever without any purpose, except to terrify the living.

That was, of course, back in February. By the end of March, the undead plan was very much alive. With a narrow edge in the House of Representatives, the president scored the political win that had eluded President Clinton a decade and a half earlier. The margin of victory was narrow enough that the debate goes on, even though the bill has been signed into law.

In part, the political uncertainty reflects the uncertainties of the plan itself: Obamacare is an improvised mix of expensive deals, vague compromises, and competing objectives. The package is so confusing that supporters find it hard to explain; so sprawling in its ambitions that it is open to attack on multiple fronts.

Democrats will spend the coming months vigorously defending the plan as ideal, while Republicans are set on a call for repeal. But neither position is quite straightforward. Even if Democrats retain control of Congress, they must move away from the slick talking points and consider the thorny task of implementation; even if Republicans retake one or both chambers of Congress this year, they cannot repeal the whole plan while President Obama remains in office.

To be clear, a full repeal of the bill, and its replacement with market-

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based reforms that would better serve consumers, would be the best policy option. But even while President Obama still holds his veto pen, congressional Republicans could begin working on incremental reforms aimed at undoing some of Obamacare's worst errors. When budgets and other bills are debated before Congress, Republicans, working with moderate Democrats, could push their agenda, offering specific amendments aimed at tempering the worst aspects of Obamacare. In this way, Republicans can borrow a page from the playbook of liberal Democrats who have spent decades using every legislative opportunity to push their vision of government-managed health care. (These Democratic efforts have included not just specific bills aimed at expanding Medicare, but also targeted amendments tacked onto legislation and budgets that have sought to restrict physician-owned hospitals, mandate certain types of coverage, grow the State Children's Health Insurance Program, and so on.) Where should Republicans focus? Three of the worst policies in the bill that might be able to attract sufficient bipartisan support for a pullback, especially if Republicans gain many seats in Congress, are health-insurance exchanges meant to spur competition that will instead strangle it with heavy regulations; a new technocratic committee to "guide" health care spending; and a tax on medical devices that will drive up cost inflation and impede innovation.

The first of these flawed policies that might be undone is the establishment in 2014 of insurance exchanges intended to increase competition—but likely instead to hamper it. During his campaign, President Obama supported the creation of a government-run Medicare-like insurance plan that would be available to individuals and employers. This "public option" for insurance would make the private insurers more competitive, Democrats believed, since the federal government would serve as a manager and regulator. When it became clear by mid-2009 that Democrats lacked the support to pass a public option through the Senate, they sought to encourage competition through other means: establishing a national health-insurance exchange.

In theory, a true national health-insurance market could do wonders to reduce the inflation of health-care costs. Today, competition is limited, with a few insurers dominating smaller state markets. This is in part a consequence of state regulations on health insurance, which force insurance providers to tailor their products to specific states. The most consequential state health-insurance regulations are benefit mandates—requirements that certain services or providers be covered by all plans. Consumers in states with many mandates (such as New York) can pay as much as four times more for basic coverage than their neighbors in states with fewer mandates (such as Connecticut).

The reason for the difference is simple: mandates serve as a subsidy for certain providers, since they force consumers to buy coverage they will

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probably never use, under the guise of consumer protection. For example, New Mexico law forces insurers to cover an "Oriental medicine" option in every policy. Likewise, a gay single man living in New York has fertilization treatments priced right into his insurance premiums by law. In Massachusetts, even a devoutly religious family of abstainers is legally required to pay for substance-abuse coverage.

Meanwhile, accidents of history (dating back to World War II-era wage and price controls) helped build employer-based insurance, leaving the United States with an unusual situation: millions of Americans choose their job for its health benefits. And many who might otherwise want to look for another job stay with their employer because of the benefits.

With those problems in mind, even the critics of Obamacare thought a national health-insurance exchange could have a salutary effect. The exchange would empower millions of consumers to buy from a national market, allowing people to opt out of mandate-heavy state markets (just as members of Congress are exempt from these regulations in their own health insurance plans). In a truly national insurance marketplace, consumers could choose to buy catastrophic-care insurance or shop for insurance plans tailored to their needs. Prices would be lowered both through increased competition and through the reduced effects of state mandates.

At least that was the theory—a theory that did not last long in the face of congressional mission creep. As soon as the legislative process began, Congress rushed to repeat the states' mistakes on a national scale, directly inserting mandates for everything from orthotics to maternity care.

Obamacare supporters publicly clung to their goal of reducing private insurance premiums, yet their stated goal was at odds with their actual legislation. While the new mandates might have helped individual members of Congress appear more caring to certain special interest groups, the growing mandate list would ensure that premiums rose—a fact that the Congressional Budget Office (CBO) confirmed in November 2009 when it estimated that the Senate bill then under consideration would have raised insurance premiums for millions of middle-class Americans by up to 13 percent over what they would otherwise cost by 2016. CBO's director later said that the legislation actually signed into law by President Obama would have a "quite similar" impact on premiums. And to make matters worse, the final legislation split up the national health exchange into fifty state exchanges, trampling any hope of reducing the impact of mandates within state markets.

In short, President Obama told Americans that he wanted to reduce private insurance premiums. But the bill he urged Congress to pass—the bill he signed into law—will *raise* premiums faster than if nothing had been done at all.

Obamacare's second major problem worth immediately undoing is

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its creation of a supposedly apolitical committee to make the inherently charged decisions involved in reducing spending on medicine.

For years, Congress has struggled to rein in government spending on health-care programs. Through the past three administrations, Congress has passed laws that would cut the rising costs of Medicare and Medicaid by cutting fees paid to medical professionals; Congress has always then overridden those cuts (a legislative dance known as the "doc fix"). Public spending on health care now basically equals the spending of the entire private insurance market in America, transforming the national health system into a *de facto* socialized insurance market and inflating the deficit by billions of new dollars every year.

Knowing that Congress would be unlikely to muster the willpower to reduce spending, White House budget director Peter Orszag lobbied fiercely for a "game-changer." In his previous service as director of the CBO, Orszag closely studied the United Kingdom's top-down approach to cost containment in health care policy. In 2009, he took the concept of "evidence-based" medical rationing to the Senate Finance Committee. Desperate for ideas to save money, Senator Max Baucus and his colleagues on the committee adopted the idea as their own.

The concept was simple. Orszag and his supporters believed that Congress would accept massive reductions in the Medicare budget if the cuts were recommended by an impartial board of medical professionals. The Obamacare bills offered up an "independent panel of experts," variously named IMAC (Independent Medicare Advisory Council), IMAB (Independent Medicare Advisory Board), or IPAB (Independent Payment Advisory Board), depending on the draft of the day. Congress could supposedly be relied on to accept the spending cuts if members were forced to give a single yea-or-nay vote to the entire slate of IPAB recommendations.

Orszag's enthusiasm for the British model is odd, as the strategy has been controversial and ineffective in Britain itself. The United Kingdom's own version of IPAB has been in business for more than a decade, operating under the Orwellian name of NICE, or the National Institute for Health and Clinical Effectiveness. Despite its name, NICE's real mandate is not to deliver "clinical effectiveness" but to save money, and it does so by rationing treatments. Using complex mathematical formulas to determine whether the cost of treatments is worth a "Quality Adjusted Life Year," NICE targets high-end surgical procedures, medical devices, and—especially—drugs.

In 2008, NICE was attacked for its rejection of the drug Sutent to treat kidney cancer, despite evidence that the drug could extend patients' lives by years. The London *Daily Mail* reported that NICE "admits the drugs work, but says that if they are approved, patients with other diseases will have to go without." That same year, NICE reversed its decision to limit coverage for

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Lucentis, an anti-blindness treatment, after popular outcry. In 2009, a coalition of doctors, patients, and marketers successfully contested NICE's analysis of an Alzheimer's drug. Time and time again, courts and patient petitions have forced NICE to revisit its decisions to reject treatments—no doubt with quiet pressure from the British government, which inevitably faces a firestorm when a controversial decision is announced.

Not only is it a never-ending source of controversy, but NICE has failed to actually "bend the cost curve," which is what its new American counterpart is supposed to do. Throughout the last decade, even with NICE and the backing of a socialized system, annual British health-care cost inflation has repeatedly exceeded that of the United States, rising as high as 7 percent over core inflation in the British economy.

Politics will always triumph over any structured attempt to ration benefits, regardless of how the rationing is packaged. It is inevitable. To return to an American example, consider the mammogram screening controversy in mid-2009. With medical concerns in mind, the U.S. Preventive Services Task Force recommended reducing mammogram screenings for some patients. Even the *perception* that the announcement was tied to rationed care forced Secretary of Health and Human Services Kathleen Sebelius to reject the recommendation—hardly an encouraging sign for Mr. Orszag's "game-changer."

If a NICE committee could not rein in costs in a socialized system, one wonders why Congress felt a similar entity could deliver savings in America's mixed system. But whatever the expected result, IPAB was a terrible strategic blunder. While legislative drafters tinkered with the name and the mandate, some feisty conservatives scored a hit by labeling the commission a "death panel," evoking the nightmare of plugs literally pulled on costly patients across America under rationed care.

In its effort to defend IPAB, the White House only added to the confusion. While Orszag praised the panel as essential to reform, Senators downplayed it as merely advisory. While the president insisted that Medicare was sacrosanct and seniors would never lose benefits, his advisors were equally adamant that a commission could find billions of dollars in savings.

IPAB was a grand exercise in buck-passing: the whole point of assigning responsibility for savings to a technocratic committee was to help members of Congress avoid having to make the hard decisions involved in rationing. The final legislation signed by President Obama reflected congressional efforts at damage control, with severe limits on the size and scope of the commission, and five years of delay before it has to start finding savings—in the end, the CBO predicts $15.5 billion in savings over ten years. Still, critics have every right to be concerned. If future Congresses look to enact savings within Medicare, the rationing mechanism now exists.

The third major policy error in Obamacare that can and should be

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undone even short of a full repeal appears in the health-reform bill's revenue section: a direct tax on "the sale of any taxable medical device…equal to 2.3 percent of the price for which so sold."

Let us put this new tax in context. In his first months in office, President Obama claimed his chief goal in reforming health care was to fight cost inflation. He even went so far in June 2009 as to describe health costs as "a ticking time-bomb." Aside from the extraordinary economic inefficiency of our third-party payer insurance system, those rising costs in the health sector have three fundamental causes. The first is an aging population. The second is increasingly unhealthy lifestyles. And the third is technology. Innovations by the American medical-device industry make it far easier to diagnose and treat complex illnesses. Back in the 1960s, the first cardiac-bypass surgeries were considered so risky that surgeons expected the procedure to remain rare—after all, only a rigorously healthy person could survive a bypass, and what rigorously healthy person needs heart surgery? Today, of course, heart bypasses are common. Aided by lasers, robotics, and cutting-edge diagnostics, doctors make surgical interventions on everyone from centenarians to unborn babies. And it isn't just dazzlingly sophisticated technologies that are improving medicine: portable blood-pressure monitors, insulin pumps, and other devices allow people to maintain wellness without costly visits to a clinic or hospital. Overall, delivering quality health care costs more because of these new technologies—but health care is also more effective as a result.

Taxing the development and distribution of medical devices is a shortsighted policy for two reasons. The first is economic: The tax will kill jobs, hurt manufacturers, and hamper innovation. Congress would never dream of raising taxes on Chrysler retailers or Ford manufacturers in the current recession. But what about American device companies like Medtronic, or Boston Scientific, or St. Jude Medical? The CEO of one medical-device manufacturer, Zoll Medical Corporation, told the *Washington Examiner* that the punishing new tax will likely cost his company between $5 and $10 million per year—and the company only had profits of $9.5 million in 2009. Just because these companies happen to be in the health sector, President Obama and his congressional allies saw no problem with taxing them—even though China is setting its sights on the medical-device market.

Which raises a related problem: If taxing a strong American industry at the worst moment possible is shortsighted, taxing these vendors to pay for health-care reform is simply foolish. After all, medical-device firms would certainly pass those costs to "end consumers"—in most cases, either a private insurer or a public health plan (Medicare, Medicaid, the VA). Passing on to consumers a 2.3 percent increase in costs means increasing the cost of delivering health care. Even as

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congressional leaders were talking up the need to fight health-care cost inflation, they were literally creating more of it in their own bill.

It remains too early to make predictions about the future of the new legislation; the political tea leaves are too difficult to read. Obamacare may result in an electoral shift this November, as the Republicans hope, or it may be embraced by the voting public, as the Democrats hope. But regardless of its implications for the ballot box, the health-care legislation is too expensive and it undermines much of what is good and right about the existing American system.

Even if the Republican "repeal and reform" agenda bears no fruit, a handful of moderate reforms could attract support from both parties to undo some of the legislation's worst flaws. Such reforms should create a competitive national market for health insurance. They should ensure that the doctor-patient relationship remains beyond the reach of Washington, starting by scrapping the meddlesome Medicare panel. And they should seek to foster an environment of innovation for American health care, including by eliminating the tax on medical devices.

These ideas ultimately stem from the principles of choice, competition, and personal responsibility—principles concordant with the way the other five-sixths of the U.S. economy is organized. Moving forward, it is critical that all health-care legislation reflect these principles, starting with the efforts to fix the sweeping bill the president just signed.

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