Backgrounder

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The Real Price of a Public Health Plan: Less Innovation and Lower Quality

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Last year, then-Senator Barack Obama declared that, "[i]f I were designing a [health care] system from scratch, I would probably go ahead with a single-payer system."[1] Representative John Conyers (D–MI), with 75 co-sponsors in the House of Representatives, has introduced legislation to create a single-payer national health insurance—a system run and funded by the federal government.[2] Opinion polls, however, show that most Americans value their current private health insurance, provided primarily through employers, that they want choices in health coverage, and that they are wary of government-run enterprises.

Recognizing lack of public support, proponents of the single-payer system have now shifted tactics: President Obama has repeatedly promised Americans that they will be able to keep their current health insurance. The Administration and Congress are now considering a "compromise" proposal to create a new public plan that would "compete" directly against private health plans in a national health insurance exchange. Independent analysis indicates that this "compromise" would kick millions of Americans out of their existing private coverage.[3]

While the proponents of such a proposal say that they want "fair" competition between the public and the private sectors, the details of these proposals tell a very different story. One objective of the public plan is to engineer artificially lower prices for medical services through the imposition of Medicare-style price controls. Such Medicare-style payment levels would undercut the market share of existing private health

Talking Points

- Most Americans value their current private health insurance, desire choices in health coverage, and are wary of government plans.
- Recognizing the lack of public support, proponents of government-run health care have shifted tactics: President Obama has promised Americans they will be able to keep their current health insurance. The Administration and Congress are now considering a "compromise" for a new public plan that would "compete" directly against private health plans.
- Independent analysis indicates that this "compromise" would kick millions of Americans out of their existing private coverage.
- Key supporters of a new government plan do not intend to compete with the private sector on a level playing field, but to overwhelm it through a series of benefit designs, mandates, and special federal subsidies provided by higher taxes.

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plans, and, combined with a mandate on employers, stack the incentives against workers in private employer-based health insurance by encouraging their employers to dump them into a new government-run health plan, regardless of their personal preferences in the matter.

In Congress, this "post-Clinton" strategy to achieve government-run health care would consist of a number of incremental but sequential steps, including the creation of a national health insurance exchange to regulate out of existence any health plans not favored by federal officials, and an employer mandate to accelerate the dumping of workers into the new government-run health plan.[4] Much of this would be done through stealth. Congress would try to avoid many of the thorniest issues by leaving it up to the bureaucracy to fill in the blanks.

Inequities. There are, of course, real inequities in the current financing and delivery of American health care, mostly created by Congress through the federal tax code. For Americans who receive health insurance through their place of work, Congress provides unlimited tax relief on the value of their benefits. Congress imposes a tax penalty on Americans who do not or cannot get health insurance through work, which includes the vast majority of the uninsured, requiring them to purchase health insurance with *after*-tax dollars, which often makes the purchase of coverage prohibitively expensive. For low-income people, there is no direct assistance in purchasing the coverage of their choice, leaving millions with no alternative but to rely on government programs like Medicaid (assuming they are eligible), which has a record of providing limited access to quality health care. This official unfairness directly contributes to higher rates of uninsurance, higher than necessary health care costs, and a breakdown in the continuity and quality of care.

Rather than addressing these specific problems, proponents of a new government-run health plan view it as a transformational mechanism to abolish the entire existing health care system. Professor Jacob S. Hacker, professor of political science at the University of California at Berkeley and the leading proponent of a new government-run health plan, believes that the current system is "enormously wasteful, ill-targeted, inefficient, and unfair."[5] Beyond that, says Hacker, America's "health financing system is an economic and moral disaster."[6]

While these kinds of shrill attacks have become more commonplace in recent years among liberal policy analysts, they are routinely combined with

1. Amy Chozick, "Obama Touts Single-Payer System for Health Care," *Washington Wire* (WSJ Blogs), August 19, 2008, at *http://blogs.wsj.com/washwire/2008/08/19/obama-touts-single-payer-system/* (April 17, 2009).
2. The United States National Health Care Act (H.R. 676); Alex Wayne, "Advocates of Single-Payer Health System Say White House Left Them Out," *Congressional Quarterly*, March 4, 2009, at *http://www.calnurses.org/media-center/in-the-news/2009/march/advocates-of-single-payer-health-system-say-white-house-left-them-out.html*.
3. The number of Americans who would lose their private coverage would depend on the payment and eligibility conditions imposed by Congress in the creation of a new government-run health plan. According to the Lewin Group, a nationally prominent econometrics firm based in Virginia, an estimated 119 million Americans would be transitioned out of private coverage into a government-run health plan if Congress were to employ Medicare payment rates and open eligibility. The result would be that a total of 131 million Americans would find themselves in the government health plan. See John Sheils and Randy Haught, "Cost and Coverage Impacts of a Public Plan: Alternative Design Options," Lewin Group *Staff Working Paper* No. 4, April 6, 2009, at *http://www.lewin.com/content/publications/LewinCostandCoverageImpactsofPublicPlan-Alternative%20DesignOptions.pdf* (April 17, 2009).
4. See E. J. Dionne, Jr., "Not Yesterday's Health Fight," *The Washington Post*, April 23. 2009. "The public-option idea is a clever halfway house." Dionne concludes, "[i]f a bill passes this year, enhancements in the program down the road will not be seen as controversial but as inevitable."
5. Jacob S. Hacker, "Health Care for America: A Proposal for Guaranteed, Affordable Health Care for all Americans Building on Medicare and Employment-Based Insurance," Economic Policy Institute *Briefing Paper* No. 180, January 11, 2007, p. 1, at *http://www.sharedprosperity.org/bp180.html* (April 17, 2009).
6. Jacob S. Hacker, "Thinking Big on Health Care," Thinking Big, Thinking Forward: A Conference on America's Economic Future, February 11, 2009, at *http://www.ourfuture.org/files/Thinking_Big_Feb_2009_Hacker.pdf* (April 17, 2009).

false promises of a superior system of care run directly by government officials. But these ideological promises have little basis in fact. Indeed, congressional rhetoric notwithstanding, health care quality would play a minor role in the new schematic, especially in light of the proponents' reliance on traditional Medicare to deliver high-quality health care. In reality, Medicare, which has enormous gaps in coverage and is persistently plagued by congressionally engineered inefficiencies, provides no such thing.

The Politics of Government-Controlled Health Care

By creating a new government-run health plan, its proponents would achieve the same political objective as would a single-payer system—and it would be able to do so without stirring the traditional fears that accompany the expansion of government control. Writing in October 2006, Professor Hacker observes:

> There's much to be said for a single-payer system. Countries that have taken this route spend much less to provide secure insurance to everyone than the United States does to provide incomplete and insecure coverage to less than 85 percent of the population. Yet these advantages—guaranteed coverage and effective cost control—could be achieved without going all the way to a single national program, with all the public skepticism and political opposition that such a program would surely engender. Yes, Americans like Medicare and yes, Medicare is easy to explain. But that doesn't mean most people are ready to say everyone should be covered by Medicare. Many of us remain stubbornly attached to employment-based health insurance, and proposing to abolish it entirely is likely to stir up fear as well as gratitude.[7]

Bypassing Regular Order. Earlier this year, two days before President Obama took office, Professor Hacker wrote that the "greatest lesson of the failure of comprehensive health reform in the past is that politics comes first. If real estate is about location, location, location, health reform is about politics, politics, politics."[8] Hacker further advised that the "core elements of reform need to be put in the budget, where they are free of the threat of a Senate filibuster (which requires 60 votes to overcome), and organized pressure will need to be put on Republicans and wavering Democrats to ensure they do the right thing."[9] In summary, says Professor Hacker, such is "the kind of bargain that could give compromise a good name—if the left would pursue it."[10]

It appears that with the strong support of the congressional leadership in the House of Representatives, at least, the Left is indeed prepared to pursue such a strategy, bypass regular order for consideration of health care reform, and attempt to enact a major overhaul of the American health care system without a bipartisan consensus.

Killing Private Coverage. In a recent policy brief, "The Case for Public Plan Choice in National Health Reform," Professor Hacker makes the case for how, under his "hybrid approach," a "public plan choice" could compete with private health insurance plans.[11] But his earlier work on creating a "Medicare-Plus" program underscores the point that the concept of peaceful coexistence between a new government health plan and private health plans is unlikely. In a June 2001 paper for the Economic and Social Research Institute,[12] Professor Hacker provided some detail, absent from the current debate, on how "large scale incrementalism" would lead "to the difficult yet necessary journey toward universal

7. Jacob S. Hacker, "Better Medicine," *Slate*, October 10, 2006, at *http://www.slate.com/id/2151269/?nav=tap3* (April 17, 2009).
8. Jacob S. Hacker, "Politics Comes First," posted by *CommonHealth*, January 18, 2009, at *http://www.commonhealth.wbur.org*.
9. *Ibid.*
10. *Ibid*.
11. Jacob S. Hacker, "The Case for Public Plan Choice in National Health Reform," Institute for America's Future, p. 1, at *http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf* (April 17, 2009).
12. Jack A. Meyer and Elliot K. Wicks (eds.), *Covering America: Real Remedies for the Uninsured* (Washington, D.C.: Economic and Social Research Institute, 2001), p. 6.

health insurance in the United States."[13] While President Obama has repeatedly promised that under his health care reform agenda, those who wanted to would be able to keep their private health insurance, Professor Hacker's analysis suggests that this outcome would be highly unlikely:

> Although reliable forecasts will require micro-simulation modeling, a very rough high-end estimate based on earlier data is that approximately 50 percent to 70 percent of the non-elderly population would be enrolled in Medicare Plus when the program was fully implemented. Put more simply, the plan would be very large—certainly larger than was contemplated (at least openly) by any of the sponsors of play-or-pay proposals in the past, when critics loudly charged that a public plan with a third of the non-elderly population was an abandonment of the American way. These critics will resurface whatever the size of the public plan. But this is an area where an intuitive and widely held notion—that displacement of employment-based coverage should be avoided at all costs—is fundamentally at odds with good public policy. A large public plan should be embraced, not avoided. It is, in fact, key to fulfilling the goals of this proposal.[14]

In other words, Professor Hacker—a key champion of this proposal—does not intend for the new government plan to compete with the private sector: He intends to overwhelm it through a series of benefit designs, mandates, and special federal subsidies provided by higher taxes. All of these components would be designed to give the politically appointed managers of the new government plan all advantages over their private sector "competitors." Under this design, there will be fewer and fewer private health plans. Of course, this is the basic idea.

Medicare's Gaps in Quality

Much of Professor Hacker's proposal focuses on *why* health care would be more efficient under the auspices of government officials. He also emphasizes the values of equality and fairness in the financing and delivery of care. Conspicuously light in his presentation of the issue is exactly *how* this proposal would increase the quality of care for Americans. He seems to simply assume that it would.

There are different definitions of health care quality. One way of measuring quality is whether patients receive the right diagnosis and the right treatment at the right time. As a practical matter, quality is a function of access to competent and timely professional medical care.

When Professor Hacker does target the quality issue, he misses the mark. He uses the example of Medicare. He asserts, for instance, that "Medicare already shows unique quality advantages over private insurance that would carry over to a new public plan for the non-elderly. Elderly Americans with Medicare report that they have greater access to physicians for routine care and in cases of injury or illness than do the privately insured."[15]

This issue of access deserves a closer examination; for the evidence is not as conclusive as Professor Hacker suggests. According to a recent report in *The New York Times*, a growing number of physicians, particularly internists, are dropping out of Medicare altogether because of low Medicare reimbursement rates and the burden of Medicare paperwork.[16] Moreover, according to the *Times,* a Texas Medical Association survey of that state's doctors found that while 58 percent of Texas doctors accepted new Medicare patients, only 38 percent of primary care doctors did so.[17] Patients go to hospital emergency rooms for a variety of reasons, but one of the reasons is that going to the emergency room is the only way some people can see a doctor at all. According to a study

13. *Ibid.*, p. 100.
14. *Ibid.*, p. 91.
15. Hacker, "The Case for Public Plan Choice in National Health Reform," p. 14.
16. Julie Connelly, "Doctors Are Opting Out of Medicare," *The New York Times*, April 2, 2009.
17. *Ibid.*

conducted by the National Center for Health Statistics, patients covered by private insurance made fewer visits to hospital emergency rooms and outpatient hospital departments than did patients covered by Medicare.[18]

Likewise, in his references to Medicare's advantages in delivering high-quality care, Professor Hacker cites the work of the Medicare Payment Advisory Commission (MedPAC). But MedPAC makes no such claims about Medicare as a quality leader. In fact, MedPAC warns that Medicare's well-known design deficiencies and its financial problems will certainly inhibit its delivery of high-quality care. In its June 2008 report to Congress, "Reforming the Delivery System," MedPAC states that "Without change, the Medicare program is fiscally unsustainable over the long term and is not designed to produce high-quality care."[19] In his positive description of Medicare as a "quality leader," Professor Hacker also references the work of Karen Davis and Sara Collins, top policy analysts at the Commonwealth Fund, which appeared in the *Health Care Financing Review.* In their article, "Medicare at Forty," however, Davis and Collins conclude that "Medicare needs to move more aggressively *to* become a leader in promoting high-quality, high-efficiency care for Medicare beneficiaries and for all Americans" [emphasis added].[20] This is a somewhat tamer perspective.

The Role of Private Plans. In their discussion of Medicare, Davis and Collins suggest that Medicare falls far short of the widespread popular perception of it. They note that Medicare covers only 58 percent of beneficiaries' health care expenses, which is one reason why Medicare beneficiaries almost always have private supplemental coverage. This may indicate that using beneficiary "satisfaction surveys" might not be accurate in making useful comparisons between Medicare and private coverage. Obviously, the vast majority of Medicare beneficiaries do not rely on Medicare alone. Instead, Medicare beneficiaries heavily rely on additional benefits provided through their employers' private health plans, private Medi-gap or, if they are poor, Medicaid. It should also be noted that today roughly one out of five Medicare beneficiaries is enrolled in Medicare Advantage plans, an increasingly popular system of competing private health plans that offer a richer variety of health benefits, including prescription drugs.[21] It is precisely Medicare Advantage, however, that is the target of congressional cutbacks.

Medicare Payment. Excess health care costs are driven by both over-utilization of resources (for example, prescription of too many drugs) and under-utilization of lower-cost care that could have prevented a higher-cost health problem. There is little or no evidence that traditional Medicare has the solution to this problem. MedPAC has made a number of recommendations regarding the use of "pay for performance" as a principle of Medicare payment, as well as the use of "comparative effectiveness" research in determining what is or is not appropriate in the delivery of medical care. But MedPAC concedes that "in the current Medicare FFS (fee-for-service) payment system environment, the benefit of these tools (for increasing efficiency and improving quality) is limited for two reasons. First, they may not be able to overcome the strong incentives inherent in any FFS system to increase volume. Second, paying for each individual service and staying within current payment systems (e.g., Medicare's complex physician-fee schedule or the hospital inpatient PPS) inhibit changes in the delivery system that might result in better coordination across services and lead to efficiencies or better quality across these systems."[22]

18. Susan M. Schappert and Elizabeth A. Rechsteiner, "Ambulatory Medical Care Utilization Estimates for 2006," National Health Statistics Report No. 8, August 6, 2008, Table 1.
19. Glenn Hackbarth, "Report to the Congress: Reforming the Delivery System," MedPAC, Washington, D.C., June 13, 2008.
20. Karen Davis and Sara R. Collins, "Medicare at Forty," *Health Care Financing Review*, Vol. 27, No. 2 (Winter 2005–2006), p. 61.
21. For a description of the Medicare Advantage program, see Robert E. Moffit, "The Success of Medicare Advantage Plans: What Seniors Should Know," Heritage Foundation *Backgrounder* No. 2142, June 13, 2008, at *http://www.heritage.org/Research/HealthCare/upload/bg_2142.pdf*.
22. Hackbarth, "Report to the Congress: Reforming the Delivery System," p. xi.

MedPAC further points out that "Medicare has some control over pricing (i.e., the rates it sets administratively for health care services) but much less control over getting recommended care or avoiding unnecessary care. FFS payment systems encourage service volume growth regardless of the quality or appropriateness of care."[23] In short, Medicare is not by any means the "quality leader" some of the champions of a new government-run health plan choose to describe it. It is as much a captive and protector of the *status quo* as any other payer in the American health care system.

The notion that Medicare has been successful in adopting payment reforms that substantially improve the quality of patient care is simply not borne out by the evidence. The RAND Corporation for example, has published research on the "Effects of Medicare's Prospective Payment System [PPS] on the Quality of Hospital Care": "PPS proved effective at curbing cost growth. However, because it contained incentives for hospitals to shorten stays and to choose the least expensive methods of care, PPS raised concerns about possible declines in the quality of care for hospitalized Medicare patients."[24] The RAND researchers found mixed results with improvement for three patient groups and no change for two others. They concluded that PPS did not lead to declines in hospital quality of care. But since they also found that more Medicare patients were discharged in unstable conditions, they recommended that additional data be collected and further research be conducted.

Measuring Quality. Can Congress effectively mandate quality of care when medical professionals themselves are not definitively certain how best to measure it? Dr. Jerome Groopman and Dr. Pamela Hartzband, both of Beth Israel Deaconess Medical Center in Boston and Harvard Medical School, outlined several examples of the inherent problems of tying payment to rigid government quality metrics. Writing recently in *The Wall Street Journal*, they describe how "pay for performance"—a key Medicare payment initiative of both the Bush and the Obama Administrations—has resulted in physicians dropping noncompliant patients and patients with complex medical needs.[25]

A new government-run health plan's purpose is not necessarily to correct the current flaws in the quality of care that is delivered by Medicare, Medicaid, and private insurance. There is no reason to believe that Congress will be more capable of finding the missing ingredient of quality than it has in the current government plans that it manages (and micromanages) and funds each year. If the Medicare FFS payment system is a problem, as MedPAC suggests, Congress should change this outdated Medicare payment system. But, of course, Congress does not do that. MedPAC has recommended since 2003 that Congress adopt a "pay-for-performance" system for payment of doctors and hospitals in Medicare. Whether the Medicare "pay for performance" initiative is a good idea or a bad idea—there is serious division of opinion on this point among the professionals—the fact remains that Medicare has not changed its administrative payment system; it is a system that rewards neither quality nor the provision of value to Medicare patients.

Creation of a new government plan is merely a diversion from the core issue that under existing Medicare administrative payment systems—precisely the payment systems that champions of the new government-run plan routinely applaud—inefficiency is richly rewarded and innovation is soundly punished. In the management of back pain, MedPAC provided a clear example: "[T]he Virginia Mason Medical Center in Washington state reported to the Commission that its lower back pain initiative greatly reduced insurance companies' cost for members with lower back pain but, under standard FFS payment rules, decreased the center's revenues."[26]

23. *Ibid.*, p. 7.
24. "Effects of Medicare's Prospective Payment System on the Quality of Hospital Care," RAND Corporation, 2006, at *http://www.rand.org/pubs/research_briefs/2006/RAND_RB4519-1.pdf* (April 17, 2009).
25. Jerome Groopman and Pamela Hartzband, "Why 'Quality' Care is Dangerous," *The Wall Street Journal*, April 8, 2009, at *http://online.wsj.com/article/SB123914878625199185.html* (April 17, 2009).
26. Hackbarth, "Report to the Congress: Reforming the Delivery System," p. 7 (internal citation omitted).

Blocking Change: The Medicare and Medicaid Record

Medicare, in the view of Senator Max Baucus (D–MT), chairman of the Senate Finance Committee, is the model for the new government-run health plan to compete with private plans. The new government plan would supposedly be a fount of change and innovation.

The record of Medicare tells a very different story. There is little evidence that Congress is willing to adopt policies that would result in decreasing revenues to hospitals, physicians, nursing homes, and other providers. Congress has blocked several program integrity initiatives launched by the Centers for Medicare and Medicaid Services (CMS), including competitive bidding for durable medical equipment under Medicare, and Medicaid regulations on targeted case management, cost limitations, outpatient hospital services, and Graduate Medical Education. It bears repeating that under the President's budget, government health care spending will increase by about $1 trillion over the next 10 years.

Professor Hacker, among others, has argued that a new government plan modeled after Medicare is essential to health care reform because "public insurance has a better track record than private insurance when it comes to reining in costs…."[27] The proposition that government will be more business-minded, or a better negotiator, than the private-sector providers faced with profit-minded market competition, and, therefore, will somehow raise health care quality and improve patients' outcomes and satisfaction while lowering prices below the market level, is a major leap of faith. Proponents are asking taxpayers to suspend decades of experience to the contrary, and ignore the real costs of the Medicare entitlement. Medicare is accumulating trillions in unfunded liabilities, promised benefits without dedicated financing, while annually shifting billions of dollars in health costs to individuals and families in private health insurance. Medicare costs much more than the amount formally identified in its annual budget.

Consider the argument over cost control more closely. If the benchmark of reform is controlling costs, which is a point of Professor Hacker's argument, and if one believes, depending on the years used for comparison, that Medicare is truly superior to the private sector in the delivery of medical care, then, logically, Medicaid, the huge federal-state program for the poor and the indigent, must be even better. Medicaid covers even more people (63 million), is even tougher as a price setter, using its market power to cram down physician and hospital reimbursement, and pays doctors and hospitals even less than Medicare.

Medicaid Lessons. Medicaid's record at controlling costs includes the facts that there are major gaps in access to care and that many providers are reluctant to participate in the program. Reuters recently reported that major pharmacies in Washington state are pulling out of the Medicaid program.[28]

As Congress considers the role of government in health care reform, it would indeed be helpful to look at the history of government as a health care provider and that of a current government health plan, Medicaid. It is important to also examine Medicaid because its expansion is likely to be included in any health care legislation or may well be the "fallback" plan for Congress. If broader legislation stalls, adding 7 to 15 million people to Medicaid would allow Congress and the Obama Administration to claim it made a down payment toward universal coverage. Such a maneuver would be a mistake. States, which provide 43 percent of Medicaid funding, cannot afford their share of the current obligations. Congress has already acknowledged this reality by providing an $87 billion Medicaid bailout in the American Recovery and Reinvestment Act of 2009.

Historically, state and local hospitals, nursing homes, and clinics have participated as health care providers. Public hospitals experienced a boom after World War II aided by government-financed construction. Use of hospital outpatient departments increased more than 300 percent between

27. Hacker, "The Case for Public Plan Choice in National Health Reform," p. 1.

28. "Walgreen to Cut Washington State Medicaid Business," Reuters, March 30, 2009, at *http://www.reuters.com/article/domesticNews/idUSTRE52T7KA20090330* (April 17, 2008).

1944 and 1965.[29] The delivery of health care entered a new phase in the 1960s as population shifts occurred between urban and suburban areas. As a result, "many of the largest public hospitals became stages of conflict where physicians, nurses, and hospital staff struggled to provide adequate care in deteriorating physical plants that were often ill-equipped and poorly provisioned."[30]

The impact of Medicare and Medicaid hit public hospitals in the early 1970s as health care choices expanded. Given a choice of hospitals and doctors, millions of Americans voted with their feet and left the public hospital system. During the 1970s and 1980s, many government entities determined that they could no longer afford the significant public subsidies necessary to govern or support large government facilities. Government officials were also concerned about the cost of future obligations associated with retiree benefits. In some cases, the value of the land on which many government facilities were located was viewed as a potential source of revenue and economic development and thus provided an incentive to sell assets. Across the country, for these reasons and others, government divested itself from the direct delivery of health care.

Where government health care institutions lingered—in states as different from each other as California, Louisiana, and New York—state and local governments struggled with quality and cost issues at major institutions, even in recent years. After years of failing quality-of-care surveys, Martin Luther King, Jr. Hospital in Los Angeles was dramatically downsized and all but closed in August 2007. Burdened with massive debt associated with decades of denial and refinancing, New York state ultimately adopted the December 2006 recommendations of its Commission on Health Care Facilities in the 21st Century. By the end of the transformation process in 2011, one-fourth of all hospitals in New York will be reconfigured. Approximately 2,800 nursing home beds will be eliminated.[31]

State Lessons. In the current discussion over whether a government health plan should be created as an alternative to private plans, we would do well to consider why states are moving away from traditional Medicaid FFS toward the increased use of contracts with the private sector. Until the 1990s, access to health care under Medicaid typically meant access to hospital-based and community-based public providers. Many states moved away from the FFS system in order to expand access, improve quality, and lower costs compared to the traditional model of government-run health care.

Research on quality of care suggests that the Medicaid population is better served when included among the general population rather than segmented off into a separate program. In a study of the quality of care for children, researchers found that "[t]he mean performance across all quality and access indicators for plans with commercially enrolled children was significantly higher than that of plans with Medicaid-enrolled beneficiaries with the exception of adolescent well visits."[32] Moreover, "[f]or Medicaid and commercially enrolled children served by the same health plan, the mean performance scores for commercially enrolled children statistically significantly exceeded that for their Medicaid counterparts for each clinical quality and access indicator except adolescent well visits."[33] The lesson on quality and access is to keep low-income populations in the same system and under the same private health plans as everyone else. That is where both quality and equality will be realized.

Why More Government Spending Does Not Produce Higher Quality

Professor Hacker's concerns about waste and inefficiencies in the current health care system are

29. *The Safety Net*, National Association of Public Hospitals and Health Systems, Spring 2006, p. 9.
30. *Ibid.*
31. See New York State Department of Health, *Report on Implementation of the Report of the Commission on Health Care Facilities in the Twenty-First Century*, 2008.
32. Joseph W. Thompson, M.D., *et al.*, "Quality of Care for Children in Commercial and Medicaid Managed Care," Vol. 290, No. 11 (September 17, 2003), at *http://jama.ama-assn.org/cgi/content/full/290/11/1486* (April 17, 2009).
33. *Ibid.*

not off the mark. As noted, the truth is that there is indeed a great deal of waste and inefficiency in the current health care system—and much of it, if not most of it, is directly generated by wrongheaded government policies. Many students of American health care problems, ranging from then-Senator Hillary Clinton to former House Speaker Newt Gingrich, have concluded that, for purposes of expanding coverage and improving care, there is already enough money in the current health care system. Realigning market incentives and re-targeting the vast array of existing government subsidies would go a long way to improving the system.

The congressional leadership, however, and President Obama have shown no interest in pursuing such a course, and instead want to increase health care spending, not curb it, intending to pump yet more money into government programs and the traditional third-party payment system that drives the health care sector of the economy. Although President Obama has promised that American families would save an average of $2,500 in their health care bills annually—more than $2 trillion over 10 years—he has also prepared a budget that will, in the view of independent analysts, increase total health care spending by about $1 trillion over the same time period. It is hard to imagine how this contradiction can be reconciled.

In any case, simply pumping more money into the current health care arrangements—government programs and employment-based health insurance—is highly unlikely to improve quality of care for patients. The Nelson Rockefeller Institute of Government recently issued a report, "Medicaid and Long-Term Care: New York Compared to 18 Other States," that concludes: "Unfortunately, New York's broad range of services and higher spending have not produced a higher quality of care. The state is about average or slightly above average on measures of quality. The comparisons in this report show that New York has room to improve quality and lower costs."[34] The actuarial firm Milliman, Inc., estimated that 25 percent of hospitalizations for Wyoming's long-term care population were avoidable.[35]

Government Control. Government regulations typically measure process and conformance, not necessarily quality. How regulations can stifle quality improvement is rarely examined. All too often, our systems are "average" rather than "best." Giving government a greater role in regulating providers is not likely to change results. We are not suffering from a lack of regulation in Medicare and Medicaid.

For example, in order to participate in Medicare, home health agencies are required to report on 41 standardized data measures under the Outcome and Assessment Information Set (OASIS).[36] The public can find state-by-state measurements of patient improvement ranging from healing of surgical wounds to ability to use the telephone. This information is updated every six months. But state-by-state data that show averages do not inform consumers about the performance of individual providers. Under-performers still participate in Medicare and payment systems provide little distinction between lower, average, and higher performers.

Furthermore, federal, state, and local officials are often presented with competing interests, including that providers benefit financially from inefficiencies in the delivery system that so many now oppose. Los Angeles's MLK Hospital remained open for years despite public outrage over high-profile deaths and injuries resulting from sub-standard care and incompetence. A two-tiered system of care persisted for years in Louisiana despite widespread concerns over patient care. The notion that running health care decisions through a government filter will purify the outcome or is more likely to protect the public interest simply does not reflect reality.

34. The New York Health Policy Research Center, "Medicaid and Long-Term Care: New York Compared to 18 Other States," prepared for the New York State Department of Health, February 2009, p. 14.
35. Bruce Pyeson, Kathryn Fitch, and Susan Panteley, *Medicaid Program Redesign: The Long Term Care and Developmentally Disabled Programs*, Milliman, Inc., September 15, 2006, p. 12.
36. See Centers for Medicare & Medicaid Services at *http://www.cms.hhs.gov/OASIS* (April 17, 2009).

Conclusion

Congress is on a fast timetable to overhaul the American health care system. It is closely following President Obama's prescriptions to centralize health care decision-making in Washington. The Senate Finance Committee is expected to consider health care reform legislation in June of 2009.

The President has repeatedly promised Americans that they would be able to keep the health insurance that they have today if they wished to do so. But the proposal to create a new government-run health plan to "compete" with private-sector plans would make such a promise impossible to keep. Instead, the likelihood is that millions of Americans would lose their existing coverage, regardless of their personal preferences in the matter, and be pushed into the new public plan or Medicaid. Moreover, inasmuch as Medicare is the common model for a new government-run health care plan, it is fair to examine Medicare's record on delivery of high-quality health care. Professor Hacker's insistence notwithstanding, Medicare is not a quality leader in health care, and there is also evidence that current enrollees in government-run health plans are having problems with access to health care.

No question: America's $2.4 trillion health care system needs to be reformed. Policymakers at the state and federal levels can work together to increase access to affordable health insurance and improve the quality of care. But destroying the private health insurance of millions of Americans through rigged "competition" with a new public health plan, funded by taxpayer subsidies and artificial pricing, will result in *reduced* choice and competition, *less* innovation, and a *lowering* of overall health care quality. If champions of a single-payer health care system think they have the best option for America, let them offer that option on the floors of the House and Senate for a full and open debate.

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