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Congress Breaks Obama Promise on Government Role in Health Care

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One of the reasons Americans are understandably wary of the current health care legislation moving through Congress is that the specifics of legislation do not match the rhetoric of the President. To defuse public suspicions, researchers at the Urban Institute recently published a study trying to persuade ordinary Americans that "[c]urrent national health reform proposals would not cause 'a government takeover of health care.'"[1]

However, what President Obama actually promised is that reform "will keep government out of health care decisions."[2] Like the definition of what constitutes a tax, whether the President is keeping his promise depends on how one defines the word *takeover*.

The Wrong Yardstick. The thrust of the Urban analysts' argument is that growing fears of a federal takeover of American health care are unfounded because the federal government will not own hospitals, nor will all the physicians in America be federal employees. Thus, they write, "Nothing in pending proposals would increase the proportion of care provided by publicly owned hospitals or by publicly employed physicians."[3] They contrast the Veterans Administration, which does own facilities and employs doctors, with Medicare, which reimburses private providers.

Curiously, they do not mention the government-run health care system that has operated under the Department of Health and Human Services (HHS) for more than 50 years: the Indian Health Service (IHS), which directly employs more than 15,000 individuals and operates hospitals, health centers, and other clinics. Per capita expenditures under the IHS are $2,349 per user, compared to the total U.S. population of $6,538.[4]

If per capita expenditures are the measure of efficiency, the IHS model would be the winner hands down. But poor access to health care is clearly an issue with the IHS, which may perhaps be the reason the report does not reference it as a means of showing how well government run health care can work.

Species Vary. It would also be wrong to conclude that the Veterans Administration or IHS models are the only forms of government-controlled health care.

The Urban analysts opine that the proposed government-run health insurance option, like that which is proposed in the House bill (H.R. 3200), will be just like any other private health plan. Of course, inasmuch as the federal authorities have never run anything remotely like a private insurance health plan, it is hard to imagine how such a public health insurance option will actually operate.

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In the House bill, the "public option" is described in a mere seven and one-half pages of text, leaving considerable discretion and unprecedented power in the hands of the executive branch.[5] Section 221 specifies, "In designing the [public] option, the [HHS] Secretary's primary responsibility is to create a low-cost plan without comprimising [*sic*] quality or access to care."[6] That leaves a lot of room for the exercise of government power and thus political—as opposed to private—decision making.

Concentrated Power. Under the House bill, for example, what are the limits of political power? Where is the line inappropriately crossed, say, when the congressionally created commissioner of the new Health Choices Administration and the HHS Secretary define health benefit coverage and the delivery system? At what point do these regulatory interventions insert themselves into the practice of medicine? For example, will there be:

- A drug formulary?
- Limitations on the number or types of drugs?
- Limitations on the amount, duration, and scope of services?
- Prior authorization?
- Physician profiling?
- Excluding physicians for ordering too many tests?
- Different types of managed care?
- HMOs?
- Only one national HMO?
- Selective contracting for any types of providers?
- National coverage decisions on new technologies?

No one, including the Urban analysts, knows the answers to these questions based on the House legislative text alone. If any of these measures are adopted—all of which insert bureaucracy into the practice of medicine to some degree—then the size of the federal "takeover" is proportionate to the number of people in the government plan. Authors of the legislation apparently believe the number of people in the government plan will be large, because Section 223 essentially drafts every provider currently in the Medicare program.[7]

The Myth of "Negotiation." Some proponents of the House bill insist that the government health plan will not use its leverage in the marketplace to muscle out private competition. This is perplexing. If the government plan is not "big enough" in terms of the number of covered lives, then it does not have sufficient market share to use leverage against doctors and hospitals. Without such leverage, it cannot lower costs.

For years, some Members of Congress have supported legislation to allow the HHS Secretary to "negotiate" prices of prescription drugs. *Negotiation* is a polite word for something very different: price fixing. *Coercion* is more accurate.

How does it work? The same way states—led by California—have done it for years in Medicaid: getting supplemental rebates from drug manufacturers. California threatens to limit access to a manufacturer's products unless the manufacturer lowers its price. California then gets deeper discounts because the manufacturer cannot afford to forfeit the state's business.

1. Stan Dorn and Stephen Zuckerman, "Current Health Reform Proposals: No Government Takeover of American Health Care," Urban Institute, September 2009, at *http://www.urban.org/uploadedpdf/411952_current_health_reform.pdf* (September 23, 2009).
2. Press release, "News Conference by the President," the White House, July 23, 2009, at *http://www.whitehouse.gov/the_press_office/News-Conference-by-the-President-July-22-2009* (October 7, 2009).
3. Dorn and Zuckerman, "Current Health Reform Proposals," p. 3.
4. U.S. Department of Health and Human Services, Indian Health Service, "IHS Fact Sheet: Year 2009 Profile," at *http://info.ihs.gov/Profile09.asp* (September 23, 2009).
5. America's Affordable Health Choices Act of 2009, H.R. 3200, Subtitle B, 11th Cong., 1st Sess., Sections 221–226, pp. 116–128.
6. *Ibid.*, p. 116.
7. *Ibid.*, p. 124.

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While it is true that physicians participating in the government health plan would not be direct employees of the federal government, their income will be increasingly dependent upon what federal officials decide to pay. The more people join the government plan, the more their physicians will depend on the federal government for their income. Federal funding will not just affect the market; it will *become* the market—doctors and hospitals will not be able to opt out or avoid it.

Just as California has used its leverage to force drug manufacturers to accept lower payments, so too would the federal government force doctors and hospitals to accept lower reimbursement. If reimbursement falls "too low," as the experience of state Medicaid programs show, beneficiary access to services is threatened. It is ironic that congressional proponents argue that the federal government is not a threat to access to care when Section 1121 of the bill proposes to "fix" the sustainable growth rate for physicians under Medicare at a cost of $228 billion.[8]

Obviously, no one, including the Urban analysts, can say how future events will unfold. Should the House bill become law, for example, after four years doctors and hospitals would be paid essentially what the federal government wants to pay: "The [HHS] Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordability and the efficient delivery of medical care."[9]

Drafting Doctors. The idea that doctors will somehow be free from government coercion is naïve. Under Section 223 of the House bill, every medical professional currently in the Medicare program would be, in effect, "drafted" into the new government health plan.

How is requiring every current Medicare provider to join the public plan—unless the HHS Secretary agrees to let that provider out—not a government takeover?

More Dependency. CBO estimates that under current law, there will be 74 million people by 2019 who are served by Medicaid for at least some part of the year.[10] Assuming the State Children's Health Insurance Program continues, another 7 million children will be covered if current enrollment stays the same. Another 60 million individuals will be served by Medicare.[11] Approximately 8 million will be served by both Medicare and Medicaid, leaving a net Medicare and Medicaid population of about 126 million people. CBO estimates another 11 million individuals will be added to Medicaid under H.R. 3200, and 30 million individuals will receive new government subsidies, bringing the total number of individuals receiving some form of government assistance for health care to about 174 million.

Again, the government market will be so large that doctors and hospitals will be forced to increase their government business, which will displace their private business. Yet the President has also warned, "Medicare costs are consuming our federal budget.… Medicaid is overwhelming our state budgets."[12] The history of Medicare and Medicaid shows that government budgets control costs by cutting eligibility, cutting benefits, or coercing providers—which in turn limits access to health care.

Inevitable and Unprecedented. Under current law and assumptions, by 2019, the Medicare Trust Fund will have been depleted for two years; it will

8. See Dennis G. Smith, "The Baucus Health Bill: A Medicare Physician Payment Shell Game," Heritage Foundation *WebMemo* No. 2629, September 25, 2009, at *http://www.heritage.org/Research/HealthCare/wm2629.cfm.*
9. America's Affordable Health Choices Act of 2009, p. 123.
10. Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2009 Baseline: Medicaid," at *http://www.cbo.gov/budget/factsheets/2009b/medicaid.pdf* (September 28, 2009).
11. Congressional Budget Office, "CBO's March 2009 Baseline: Medicare," March 24, 2009, at *http://www.cbo.gov/budget/factsheets/2009b/medicare.pdf* (September 28, 2009).
12. Press release, "Remarks by the President at the Opening of the White House Forum on Health Reform," March 5, 2009, at *http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-at-the-Opening-of-the-White-House-Forum-on-Health-Reform* (October 7, 2009).

then no longer be able to pay its bills on time. Furthermore, the President has also vowed not to raise taxes on the middle class—a shaky promise in light of the transactions now occurring in the Senate Finance Committee—and to not increase the deficit by one dime. With the collision of all of these events, a government "takeover" in the form of greater government control over health care financing and the practice of medicine is inevitable.

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