White House Shifts Away from Public Option after Protests

By Ben Domenech

As hundreds of thousands of citizens gathered in Washington, DC to protest government expansion and rising deficits, President Barack Obama and his Democratic allies on Capitol Hill shifted their goals on a national health care overhaul from a so-called “public option” plan to other ideas.

Following the president’s September 9 address to a joint session of Congress in which he laid out his requirements for health care legislation, Senate Finance Committee Chairman Max Baucus (D-MT) released his version of a health care overhaul, dropping the public option in favor of state health care co-ops and an individual mandate.

According to John Calfee, a resident scholar at the American Enterprise Institute in Washington, DC, the Baucus legislation still contains several measures closely following Obama’s outline.

“These ‘consensus’ measures include much of what the president laid out in his speech to Congress: guaranteed issue

IRS Requirement in Health Care Bill Raises Privacy Concerns

By Aricka Flowers

Provisions in the proposed national health care overhaul bill that some observers say undermine privacy protections for citizens are raising concerns.

The most recent version of HR 3200 under consideration by Congress would create the post of Health Services Commissioner, who would have access to the personal information of health insurance applicants.

Also in the current draft of the bill, the Internal Revenue Service is directed to divulge taxpayer identification and other personal data, including the number of dependents, modified adjusted income, and filing status of applicants.

Supporters of the measure say the information is necessary to evaluate eligibility for government-subsidized health insurance, but opponents say it will allow government to pry...
Obama Shifts from Public Option

Continued from page 1

of insurance, guaranteed renewal, limits on lifetime expenses, cross-border exchanges, high-risk pools, some token cost-saving addressing of waste, fraud, and abuse in Medicare, and, of course, an individual mandate,” Calfee said. “It’s got pretty much everything but a full public option.”

Divided Democrats
Although it’s consistent with the president’s remarks, Baucus’s plan met with immediate negative responses from some of his fellow Senate Democrats. Sen. Jay Rockefeller (D-WV) blasted the Baucus plan in remarks to reporters, saying it amounts to a massive tax on middle-income Americans and specifically for coal miners in his state.

“There is no way in its present form that I vote for it,” Rockefeller said, “unless it changes in the amendment process by vast amounts.”

Rockefeller, who serves on the Finance Committee, has a constituency that includes many union members, many of whom have so-called “gold-plated” health care plans, subject to higher taxes under the Baucus measure.

“Virtually every single coal miner is going to have a big, big tax put on them because the tax will be put on the company and the company will immediately pass it down and lower benefits,” Rockefeller said. “So that’s not really a smart idea. In fact, it’s a very dangerous idea, and I’m not even sure the coal miners in West Virginia are aware this is what is waiting if this bill passes.”

Taxing Health Insurance
During the 2008 presidential campaign, Obama repeatedly promised not to raise taxes on middle-income families, and he criticized his opponent, Sen. John McCain (R-AZ), for considering an individual mandate, described in television ads at the time as a tax on health insurance. “We will end up with something,” Rockefeller said. “What that something is, we’ll have to wait and see.”

There is no way in its present form that I vote for [the Baucus health measure] unless it changes in the amendment process by vast amounts.”

Jay Rockefeller
U.S. Senator - West Virginia

In a September 20 interview with Obama on ABC News’ This Week, George Stephanopoulos asked: “Under this mandate, the government is forcing people to spend money, fining you if you don’t. How is that not a tax?”

“No. That’s not true, George,” Obama said. “For us to say that you’ve got to take a responsibility to get health insurance is absolutely not a tax increase; ... you can’t just make up that language and decide that that’s called a tax increase.”

“I don’t think I’m making it up,” Stephanopoulos said, invoking the Merriam Webster’s Dictionary definition of “tax” as “a charge, usually of money, imposed by authority on persons or property for public purposes.”

“George, the fact that you looked up Merriam’s dictionary, the definition of tax increase, indicates to me that you’re stretching a little bit right now,” Obama said. “Otherwise, you wouldn’t have gone to the dictionary to check on the definition.”

Critical Period
Regardless of whether voters view the individual mandate as a tax, and despite continued protests against the plans, health policy experts believe some form of reform legislation will pass the Senate by the end of November, with the aim of ironing out any differences with the more-liberal House legislation in conference.

“We will end up with something,” Calfee said. “What that something is, we’ll have to wait and see.”

Benjamin Domenech (bdomenech@heartland.org) is managing editor of Health Care News.

IRS Provision Raises Concerns

Continued from page 1

into individuals’ privacy.

“Despite the fact that there is no official health care reform bill to look at, the current proposal to share private taxpayer information with the proposed Health Choices Administration should trouble every American,” said Twila Brase, president of the Citizens’ Council on Health Care in St. Paul, Minnesota. “The day any government agency outside the IRS has access to the financial and insurance status of every American citizen is the day when every American citizen becomes a government target for higher taxes and individualized penalties.”

Paul Gessing, president of the Rio Grande Foundation in Albuquerque, New Mexico, says inclusion of the tax collection agency is meant to intimidate.

“The reality is that the [health care] legislation relies on government coercion to accomplish its goals,” Gessing said. “No government agency is more coercive or feared than the IRS. Given the need for both coercion and trillions of additional tax dollars to fund reform efforts, it is no surprise the legislation would expand the power of the IRS to snoop on average Americans in order to make sure that they are complying with this raft of regulations, mandates, and demands on their resources.”

Brase also is concerned an originally limited requirement to share citizens’ personal information could expand to include more government agencies gaining access. She says constitutionality concerns compound the problems.

“To suggest that citizen financial data be made available to even one government agency outside of the IRS is to plan for it to be made available in the future to every government agency outside the IRS,” said Brase. “This would be patently unconstitutional. Personal privacy is an essential ingredient of freedom, as the Fourth Amendment makes clear.

“If this provision becomes law, I expect every federal official who deems it their right to know will eventually be given access to detailed financial data on all Americans,” Brase concluded.

Aricka Flowers (atflowers2@gmail.com) writes from Chicago.
Can You Keep Your Own Plan Under Health Care Overhaul?

By Sarah McIntosh

President Barack Obama has repeatedly said if you like your current health insurance plan you can keep it under his proposed overhaul—but does the legislation match the rhetoric?

According to John C. Goodman, president of the National Center for Policy Analysis, the answer is “no.”

“All the bills differ, but basically very few people have a plan that will satisfy the federally mandated benefits and cost sharing. So almost everyone will be affected,” Goodman said. “Estimates of how many will lose their employer-provided coverage and go into a government-regulated, government-run exchange run as high as 120 million.”

The current version of HR 3200 requires (Section 122(b)) health plans to meet government standards and qualifications. If your current plan does not meet the guidelines, you cannot keep it—which NCPA Senior Fellow Devon Herrick says will cause the elimination of many high-deductible plans popular with younger Americans, and will undercut other plans down the road.

“Telling consumers, ‘If you like what you have, you can keep it,’ is really not a promise politicians have the power to keep,” Herrick said.

Decreasing Competition

Younger people won’t be the only ones affected.

“We estimate five million seniors will lose their Medicare Advantage plans once Obama cuts $177 billion out of the program,” Goodman said. “We estimate five million seniors will lose their Medicare Advantage plans once Obama cuts $177 billion out of the program.”

Herrick concurs.

“The inability to keep your current health insurance plan or have a chance to decide among plans in the market—either because your current plan does not meet government requirements or because it is driven from the marketplace by a public option—is a particular concern.

“Health care is a very personal thing,” said Christie Raniszewski Herrera, director of the Health and Human Services Task Force at the American Legislative Exchange Council in Washington, DC. “When bureaucrats decide on a one-size-fits-all plan for everyone, they make health care decisions based on what is best for the government, not what is best for an individual patient.”

Herrick concurs.

“Consumers can make better decisions for their own families because they know their own unique needs better than a bureaucrat in Washington,” Herrick said. “For instance, a family might prefer a health savings account (HSA), where they save funds year-to-year for when their health needs rise. Yet a bureaucrat might believe cost-sharing is bad, as many public health advocates do, and want to discourage if not outright prevent families from owning an HSA.”

Melanie Fowler, a 20-something undergrad majoring in accounting at Wichita State University in Kansas, is worried about the potential loss of freedom.

“It is important for me to choose my own health care because my needs are not the same as everyone else’s,” Fowler said. “I know my own needs best.”

Sarah McIntosh (mcintosh.sarah@gmail.com) teaches constitutional law and American politics at Wichita State University in Kansas.

**INTERNET INFO**

H1N1 Vaccine a Preview of Gov’t-Run Health Care

By Celeste Altus

As the winter flu season approaches, many are watching the federal government’s handling of H1N1 vaccines as a preview of national, government-run health care.

The virus, also known as swine flu, is expected to afflict millions of people this fall, and the government is distributing vaccines. Shortages and delays in the vaccine’s development have resulted in the establishment of priority groups to receive first treatment.

“The 2009 H1N1 influenza virus never went away this summer, and it’s starting to cause increased disease this fall,” said Rear Admiral Anne Schuchat of the U.S. Centers for Disease Control and Prevention. Southeastern states represent a large portion of the fall cases, attributable to school starting earlier there than in the rest of the country.

Not Complicated

Paul Howard, director of the Center for Medical Progress at the Manhattan Institute, said the swine flu vaccine is one of the few types of medical service the government can handle.

“[G]overnment is incapable of advance preparation for a health care problem, even with ample warning.”

IRWIN STELZER, DIRECTOR
ECONOMIC POLICY STUDIES
HUDSON INSTITUTE

“The government can do vaccinations well or badly, depending on how it plans or funds the process, and how it encourages drug companies to participate in making the vaccine,” Howard said.

Howard noted this should be a simple process. Because the vaccine is a single product, distribution to mandated recipients and other non-mandated populations should be straightforward.

“It’s the kind of thing the government does. If it wants to hand out everyone a scoop of vanilla ice cream, it can do that. And it can do that well,” Howard said. “So we will see how it plays out. It’s so much less complicated than running a health care system.”

‘Can’t Practice Medicine’

Others remain skeptical. Irwin Stelzer, director of economic policy studies at the Hudson Institute, calls swine flu a “test case” and says the government is in over its head.

“After years of tabulating data on ordinary seasonal flu, the government does not know how many people will want to be vaccinated and how many would rather take their chances with the flu than with a possible reaction to the vaccine,” Stelzer said. “What does this tell us about President Obama’s plan for extending government’s role in managing our health care system? First, that government is incapable of advance preparation for a health care problem, even with ample warning.”

Ryan Ellis, tax policy director of Americans for Tax Reform in Washington, DC, believes H1N1 will expose government’s limitations.

“There’s a reason the Founding Fathers gave the government only a few things to do: It can do only a few things well,” Ellis said. “The government can blow stuff up, it can collect taxes, it can enforce contracts, protect people from harm, and even build a decent road every now and again. What it can’t do is practice medicine. They’ve screwed it up every time it’s been tried.”

Celeste Altus (celeste.altus@gmail.com) writes from Martinez, California.

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[Image]
CBO: Health Care Spending Will Increase Deficit

By Rick Docksai

While a world leader in productivity, wealth, technology, and personal freedom, the United States is also fast becoming a leader in national debt, which may weigh heavily on the ultimate economic effect of national health care reform.

With a total debt equal to 60.8 percent of its gross domestic product, the United States currently ranks 24th of 126 countries in the CIA World Factbook—outpacing China, Great Britain, Sweden, and the entire continent of South America.

According to the Congressional Budget Office, this ranking is only going to rise in the foreseeable future, as a June 2009 CBO report forecasts the debt will reach 79 percent of GDP by 2035.

Rising Health, Retirement Spending

The primary cause for America’s climbing debt is the new wave of costs for Medicaid, Medicare, and Social Security, which are expected to be strained by the swelling ranks of baby boomer retirees and a steady increase in health care expenses as the population ages. Medicare and Medicaid will rise from about 5 percent of GDP in 2009 to about 10 percent in 2035, while Social Security rises to about 6 percent in 2035.

These trends spell serious trouble for taxpayers. As debt accumulates, lenders overseas will charge higher interest rates to cover the risks. According to Brian Riedl, a budget analyst for The Heritage Foundation in Washington, DC, the federal government pays $170 billion a year in interest on its debt now, which will balloon to $806 billion a year by 2019.

“We will see a gradual decrease in our cost of living as a result of decreased consumer spending—funds being used to pay off rising interest rates,” said Riedl.

Drastic Measures Considered

Riedl believes the U.S. government will face dramatic choices: Print more money, raise taxes, drastically cut spending, or go into default. The decisions made at the national level on health care policy could accelerate this process.

In the World Economic Forum’s (WEF) 2009-2010 Global Competitiveness Report, the United States—which the annual report has consistently ranked first in the world for competitiveness—was surpassed this year by Switzerland. According to the WEF, the reason for the change is America’s lack of “macroeconomic stability. ... Repeated fiscal deficits have led to burgeoning levels of public indebtedness, which are presently being exacerbated by significant stimulus spending.”

The Obama administration cites the deficit-raising rise in health care costs as all the more reason why Congress should enact the president’s proposed health care overhaul.

“The debate about health insurance reform boils down to a choice between two approaches,” Obama said in an August 8, 2009 address. “The first is almost guaranteed to double health costs over the next decade ... and bankrupt state and federal governments. That’s the status quo. We can either continue this approach, or we can choose another one.”

But while the status quo is costly, reports indicate Obama’s alternative plan will be even costlier. Congress’s Joint Committee on Taxation calculated the House and Senate versions of the Democratic bill would add, respectively, $239 billion and $587 billion to the deficit over the next 10 years.

Care Rationing Expected

Those expenditures might be worth it if they produce savings at the ground level, but the CBO has scored every version of the health care legislation as increasing costs.

“Doing nothing is not an option: Legislation must ultimately be adopted that raises revenue or reduces spending or both,” the CBO report authors wrote.

Given that adding 40 million people to the health care system will inevitably expend resources and raise prices, Riedl believes prices might get so high Washington will have to step in to alter supply or demand.

“Washington’s solution will have to be price controls and rationing. Those will be the only ways to keep costs down with the massive increases in demand the health care system can’t afford on its own,” Riedl said.

Riedl’s suggestion: “Let’s avoid a situation where we’ll face a choice between massive spending cuts, massive tax hikes, and massive debt.”

Rick Docksai (rick.docksai@gmail.com) writes from Washington, DC.
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Kennedy’s Death Affects Health Care Debate

By Celeste Altus

The August 25 death of U.S. Sen. Edward Kennedy (D-MA), a lifelong champion of universal government-run health care on a national level, was felt particularly in the political debate over health care reform.

Kennedy, whose Senate career was marked by his negotiating ability and authority on domestic policy, was considered the face of the universal health care crusade for decades. As President Barack Obama, whom Kennedy supported from the early days of his presidential campaign, attempts to pass a sweeping health care overhaul, Kennedy’s ability to forge agreements is missing from the current effort to materialize his dream.

Grace-Marie Turner, president of the Galen Institute in Alexandria, Virginia, said Kennedy was both respected and liked by colleagues on both sides of the aisle during his 47 years in the Senate.

“While he always was firm in his liberal views and I seldom agreed with him, Sen. Kennedy did listen to his Republican colleagues and worked to forge compromises,” Turner said. “That bipartisan spirit has been markedly missing during his absence from the Senate this year. The health reform legislation making its way through Congress is rigid and aggressively liberal, without any evidence of bipartisanship, and it is rightly facing a firestorm of opposition.”

Offered as Tribute

Sen. Robert Byrd (D-WV) has asked for the bill to be named after Kennedy in hopes of improving its chances of passage.

Obama, in a televised speech to Congress in September, spoke about Kennedy, implying passing Obama’s reforms would be a tribute to the late senator. “[Kennedy] expressed confidence that this would be the year that health care reform—that great unfinished business of our society,’ he called it—would finally pass,” Obama said.

“I think it is too late,” Turner said. “The American people understand the huge impact this legislation would have on the lives of 300 million Americans, and they are not going to be swayed by sentiment. The debate will continue.”

Pragmatism, Compromise

Paul Howard, director of the Center for Medical Progress at the Manhattan Institute, agrees with Turner.

“I think the part of Kennedy’s legacy I hope would help further the debate is the part of it that was pragmatic, [the recognition] that more regulation was not necessarily better regulation, and that reaching across the table to get things done in a pragmatic way would impact the quality of care people would have access to,” Howard said.

Howard said Democrats are instead taking a position arguing, “We’re going to push legislation through whether or not we get Republican support because that’s what Ted Kennedy would have wanted.”

Kennedy’s legacy was one of pragmatic compromise to get a bill passed, even if it didn’t have everything he wanted, agrees Brenda Gleason, an author and president of Washington, DC’s M2 Health Care Consulting.

“His absence has left many left-leaning policymakers in the capital desperately wanting to do something for Teddy, or do what Teddy would have done,” Gleason said. “The trouble is, everyone is using this as a rallying cry for defending whatever their particular position is. In reality, what ‘Teddy would have done’ is compromise and get all the cats herd-ed to get some kind of reform bill passed.

“Kennedy’s passing could turn out to be pivotal if no one else is willing to pick up the ball and run with it—that is, put constituents before ideology and do something, even if it’s not perfect,” Gleason added.

Continued Division Expected

Howard does not believe Kennedy’s death will be enough to rally the country in support of the plan or induce Congress to compromise.

“The Kennedy name is, rightly, an institution in American politics. But Ted Kennedy is not someone viewed as a trans-political figure,” Howard said. “Independents, conservatives, and moderates look at him and a lot of the time disagree with him. [Kennedy’s death] may rally Democrats to push harder for what they want, but it’s unlikely to push the country. The culture wars of the 1990s were too bruising for people to forget that so quickly.”

“Kennedy’s passing could turn out to be pivotal if no one else is willing to pick up the ball and run with it—that is, put constituents before ideology and do something, even if it’s not perfect,” Gleason added.

“I think the part of Kennedy’s legacy I hope would help further the debate is the part of it that was pragmatic, [the recognition] that more regulation was not necessarily better regulation ...”

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Public Option Could Drive Out Private Insurers

By Sarah McIntosh

While Senate Majority Leader Harry Reid (D-NV) and other supporters of the proposed public option, a government-backed health care plan that would compete against private insurance plans, claim it will help keep the private insurance industry “honest,” opponents raise concerns it would set up an uneven playing field.

“Introducing a new government plan into the health insurance market would distort the market. ... Private companies could not compete with a government plan that receives huge taxpayer subsidies in start-up funds, has the ability to set prices, and has federal policing authority.”

GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE

By Sarah McIntosh

Six years after Maine created what many hailed as an innovative public health care initiative, the plan has failed to live up to its goals.

In 2003 Maine passed the Dirigo Health Initiative with the intent of providing coverage for all of Maine’s uninsured by 2009 without requiring any new taxes. It was expected to be paid for entirely by savings in Maine’s health care system.

“Instead of saving money, the Dirigo Health Initiative has cost taxpayers $155 million over five years, and that’s just in subsidies and administrative costs,” said Tarren Bragdon, president of the Maine Heritage Institute in Portland. “While the plan was touted as a solution to covering all of the state’s uninsured by 2009, instead it has covered only 3 percent of Maine’s uninsured population.”

High Costs

The initiative included a subsidized public option insurance program, designed by the state government and administered by a private insurer. Taxpayer dollars were used to pay for the plan, and it was marketed by the state.

After six years, Maine has spent more than $155 million to cover just 3,400 uninsured enrollees, and Bragdon says enrollment is projected to drop further.

“Dirigo Choice premiums increased four times faster than the Maine State Employee Health Plan premiums,” said Bragdon. “Dirigo has also led to significant crowd-out of private insurance. Only one-third of Dirigo Choice enrollees were uninsured at the time of purchasing the government plan. Dirigo had a crowd-out rate of 64 percent.”

Because of the subsidized plan’s high costs, the state had to close it to new enrollees in 2007.

Larger Lessons

Also in response to high costs, “the Dirigo Health Agency has cut benefits in recent years” and shortchanged providers, Bragdon said. “Dirigo Choice paid only 72 cents in medical claims for every dollar in premiums collected.”

Christie Raniszewski Herrera of the American Legislative Exchange Council in Washington, DC says Dirigo’s failure provides larger lessons.

“The government will not ‘compete’ unless it can change the rules to win,” Herrera said. “In the case of any public option plan, government will serve as both a regulator and a competitor. This defies the meaning of competition.”

John LaPlante, editor of StateHouseCall.org, agrees the Maine example is instructive.

“It reminds us of why federalism is so valuable,” said LaPlante. “Maine has engaged in a costly experiment that has fallen far short of its goals. That is bad for the people of Maine, but those of us who live elsewhere can be thankful we haven’t yet been subjected to something like this.”

Sarah McIntosh (mcintosh.sarah@gmail.com) teaches constitutional law and American politics at Wichita State University in Kansas.
Insurance Reforms Spotlight States’ Failures

By Janet Neilson

Experiences around the nation show many of the reforms supported by President Barack Obama with the intent of improving America’s health care system already have been tried and failed at the state level.

In Tennessee, which developed and launched a public option for health insurance in 1994, the program failed to reduce health care costs or increase competition.

The state’s Medicaid expansion program, called TennCare, was intended to make it easier for Tennesseans to get health insurance. Instead, it resulted in long waiting lines and threatened to bankrupt the state.

According to Brian Lapps, who served as director of TennCare in 1999, people consumed the “free” health care services without restraint, which led to huge cost overruns.

Lapps says what’s being contemplated in Washington today “is in a lot of ways a rerun” of the measures Tennessee undertook, which eventually swallowed up 34 percent of the state’s budget, even with the federal government covering two-thirds of the cost.

“Nobody is talking about a bare-bones option for the government plan. In Tennessee, with TennCare—Medicaid—you had the richest option of all health insurance plans. Only the government could do that."

BRIAN LAPPS
FORMER DIRECTOR, TENNCARE

“Nobody is talking about a bare-bones option for the government plan,” Lapps said. “In Tennessee, with TennCare—Medicaid—you had the richest option of all health insurance plans. Only the government could do that.”

Drew Johnson, president of the Tennessee Center for Policy Research in Nashville, said the TennCare failures “will likely return” under a similar federal system.

Other states have tried to expand coverage via “community rating” mandates, where insurance premiums must be set independently of an individual’s health status. This is typically combined with “guaranteed issue” mandates requiring insurers to take all applicants regardless of preexisting medical conditions, to ensure high-risk people can get insurance.

But according to a 2008 study by the National Bureau of Economic Research, while the mandates do make insurance more affordable for high-risk policyholders, the substitution of high-risk individuals for lower-risk ones in the insurance pool results in higher overall premiums, pricing more people out of the market and ultimately increasing the number of people without coverage.

In New York and New Jersey, the only states with pure community rating mandates in the individual insurance market, costs are substantially higher than elsewhere. Average insurance premiums in both states are nearly twice the national average, according to America’s Health Insurance Plans.

Finally, in Massachusetts, where many of the proposals now under consideration at the federal level already have been put in place, the number of uninsured has fallen but the state now has the most expensive family health insurance premiums in the country, according to a study published by the Commonwealth Fund in August.

Janet Neilson (mihealthfacts@mackinac.org) is a health communications associate at the Mackinac Center for Public Policy in Michigan.

A Lively Account of Fluoridation and its Discontents

Since its first implementation in Grand Rapids, Michigan, in 1945, public drinking water fluoridation and its attendant conflicts, controversies, and conspiracy theories serve as an object lesson in American science, public health, and policymaking. In addition to the arguments on the issue still raging today, the tale of fluoridation and its discontents also resonates with such present concerns as genetically modified foods, global warming response, nuclear power, and environmental regulation.

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A richly and considerably told tale of American science and public life, The Fluoride Wars offers an engrossing history to both interested general readers and specialists in public health, dentistry, policymaking, and related fields.
Maternity Ward Bed Shortages Plague U.K.

By Aricka Flowers

Scores of women are giving birth outside of maternity wards in the United Kingdom because the government-run system lacks beds and midwives.

U.K. health officials admit to the lack of accommodations for expectant mothers, as reports show close to 4,000 births took place outside of hospitals last year, a 15 percent rise since 2007.

The National Health Service (NHS) is in charge of hiring the nation’s midwives and has promised to hire another 3,400 in the near future, but officials at the Royal College of Midwives say at least 5,000 more hires need to be made in order to provide patients with quality care.

According to U.K. Conservative Party member and Shadow Secretary of State for Health Andrew Lansley, since 1997 the number of NHS maternity beds has been cut by 2,340, or 22 percent, while birth rates have continued to rise.

Twila Brase, president of the Citizens’ Council on Health Care in St. Paul, Minnesota, says this is a prime example of the problems that occur when health care is managed by the government.

“This example shows the dangers of bureaucratic, impersonal, government health care,” said Brase. “Every mom and every baby has maternity ‘coverage’ in the NHS, but actual care is hard to find. If there is no care when you need it, what good is it to be covered? When it comes to health care, government systems promise much and deliver little.”

Rationing Concerns

Paul Gessing, president of the Rio Grande Foundation in New Mexico, says the maternity ward crisis in the U.K. is a testament to why a market structure works best in giving patients access to care.

“Most rational people would argue that a midwife, at minimum, should be present at the birth of a child, but Britain’s NHS has other priorities,” said Gessing. “This is the essence of how free-market distribution of resources works better than even the highest-minded distribution on the part of government bureaucrats.”

Rationing has become a hot-button issue in the health care reform debate. Although the U.K.’s maternity ward problem may not be an intentional case of rationing, and instead just a miscalculation, Brase says it provides important lessons.

“Rationing of health care comes in all sorts of forms and flavors,” said Brase. “The bureaucrats at the NHS know women are being forced to deliver babies outside of hospitals, yet they refuse to increase access to care. Socialized medicine is bureaucrat-centered medicine, not patient-centered medicine. A health care system that knowingly puts mothers and babies at risk is a system that does not care for mothers and babies.”

Rationing has become a hot-button issue in the health care reform debate. Although the U.K.’s maternity ward problem may not be an intentional case of rationing, and instead just a miscalculation, Brase says it provides important lessons.

President Delays Nomination for Crucial Post

By Thomas Cheplick

Nine months into his term, President Barack Obama has yet to nominate anyone to lead the nation’s primary health care agency, the Centers for Medicare and Medicaid Services (CMS).

The agency provides health services to more than 98 million Americans and has an annual budget of more than $700 billion.

“Certainly, it is perplexing that they have not found anybody for one of the most important health care agencies in the government,” said James Capretta, a health care policy fellow at the Ethics and Public Policy Center in Washington, DC. “And it does not give one confidence that handing over a lot more power in health care to the federal government is going to lead to stable and steady leadership.”

Avoiding Embarrassment

Diana Furchtgott-Roth, a senior fellow at the Hudson Institute, believes Obama is “probably somewhat embarrassed” about taking so long to fill the position.

“I do not think [the lack of a CMS nominee] has anything to do with him intending to cut the Medicare budget. Many people would love this position, but making political appointments to a position like this is very difficult, because you have to go through somebody’s background, go through every [potential] embarrassment of prospective candidates,” Furchtgott-Roth said. “And President Obama needs to find someone like [former Administrator Mark B.] McClellan, too—one who has a unique blend of qualifications, someone who has been both a physician and has managerial expertise.”

McClellan, who served as CMS head from 2004 to 2006, was supposed to be replaced by budget expert Kerry Weems, who was nominated by President George W. Bush in May 2007. But the Democratic majority in the U.S. Senate declined to confirm Weems, and the position has remained vacant.

Cutting Medicare

Mark V. Pauly, a professor of health care policy at the University of Pennsylvania’s Wharton School of Business, says Obama’s desire to cut the Medicare budget is precisely why he has not nominated someone to head CMS.

The health care overhaul proposals under consideration in Congress call for Medicare cuts of more than $120 billion over the next decade and could end the popular privatized version of Medicare known as Medicare Advantage, used by more than 10 million seniors.

“A lot of what will be needed is going to have to come out of the Medicare budget, and it just may be better to arrange a health care reform deal with nobody in place at CMS to act as that staunch defender of the agency,” Pauly said.

Thomas Cheplick (thomascheplick@yahoo.com) writes from Massachusetts.
Medicare Reimbursement Cap Called Unlikely to Stop Fraud

By Thomas Cheplick

Responding to serious Medicare fraud and corruption in Florida’s Miami-Dade County, where five doctors from one clinic were found guilty of racketeering over the past three years, the Centers for Medicare and Medicaid Services is proposing a nationwide cap on Medicare reimbursements for treating in-home patients with chronic ailments.

The plan would limit reimbursements to chronically ill patients needing in-home treatments to 10 percent of total costs. If approved, the cap likely will take effect in January 2010. Officials estimate it will save the government $340 million a year and significantly reduce fraud and corruption.

But John R. Graham, a health care policy fellow at the Pacific Research Institute, does not think the cap will reduce Medicare corruption nationwide or in Miami-Dade, where costs have risen 20 times faster than anywhere else in the country.

“Rolling back Medicare reimbursements to 10 percent does not stop the fraud,” Graham said. “How does that stop fraud? Committed Medicare fraudsters are going to figure out how to make money. Stuff like this is just a good headline.”

Avoiding Investigations

Graham believes CMS should start investigating allegations of fraud more actively instead of imposing arbitrary caps.

“The way to stop fraud is to investigate fraud,” Graham said. “If you suspect fraud, you don’t do a crude reimbursement rollback, you investigate.”

But Harvard University Medical School Professor Michael E. Chernew argues many people don’t understand how difficult it is to investigate alleged fraud and waste in Medicare.

“CMS is really trying to do a reasonable job under a difficult situation. It’s challenging fighting fraud,” Chernew said. “The challenge is, CMS treats different patients with different needs, and it is very difficult to identify care that is unnecessary and fraudulent for one person but not for another.”

Michael E. Chernew, Professor Harvard University Medical School

Patient Control Recommended

Chernew says CMS is likely to do more to fight fraud as health costs rise.

“We have reached a point in terms of spending that America simply cannot afford to rely on health care systems anymore that provide access with lax oversight,” Chernew said.

Graham believes the solution is to give patients more control.

“Implementing a ‘cash-for-counseling’ system will give the Medicare patient control of the money, instead of the Medicare private contractor, who answers to the CMS bureaucracy,” Graham said. “The Medicare patient knows if he is getting the necessary service or not.”

Thomas Cheplick (thomascheplick@yahoo.com) writes from Massachusetts.

Health Care Co-op Plan Raises More Questions

By Sarah McIntosh

Facing criticisms of its proposed public option plan, the White House announced in mid-August President Barack Obama is open to a government-chartered cooperative approach.

Pearl Hahn, a policy analyst with the Grassroot Institute in Hawaii, cautions such a plan could crowd out private plans.

“Unlike a true co-op, which is controlled by its members, such a co-op would be funded by the federal government and run by the Secretary of Health and Human Services,” Hahn said. “A co-op would be especially dangerous to private plans if it offers a wide range of benefits and artificially low premiums, in which case more citizens would be crowded out of their existing insurance plan.”

Chartered Co-ops

Under a plan supported in the U.S. Senate by Sens. Max Baucus (D-MT) and Kent Conrad (D-ND), the federal government would set up chartered co-ops in states. But unlike rural electrical or food co-ops, which are owned by users and workers, the federal government would own these co-ops for several years before turning over some control to patients.

John LaPlante, editor of StateHealthCall.org, says these co-ops would have “several problematic features.”

“First, they would enjoy the implicit backing of the federal treasury,” LaPlante said. That support “would be a permanent, built-in advantage for federal co-ops.”

In addition, LaPlante noted, “There are some governance issues. Since they would be either direct or indirect creations of the federal government, would states be able to regulate them to the same extent that they regulate commercial insurers?”

Public Option, Different Name

Sally Pipes, president of the Pacific Research Institute in California, says there really isn’t much difference between the public option and the co-op approach. Details of both plans remain unclear, but Pipes believes the co-ops plan has several of the same problems as the less-pleasantly named public option.

“The government will place new regulations on insurers, including not allowing companies to ‘discriminate against’ patients based on a preexisting condition or their medical history,” Pipes said. “As a result, the cost of insurance will increase, not decrease. I think the government’s plan will be priced cheaper than private insurance. Ultimately, private insurance will be crowded out, and all of us will be in the public option.”

In the end, Pipes says, co-op health care will be rationed and U.S. citizens will face waiting lists as long as those in Canada and other nations where the government is the primary insurer.

“Ultimately, federally initiated co-ops would bring at least as many problems...as they would solve,” LaPlante agreed.

Sarah McIntosh (mcintosh.sarah@gmail.com) teaches constitutional law and American politics at Wichita State University in Kansas.
Pay-for-Performance Study Results Disputed

By Thomas Cheplick

Hospitals included in a Medicare pilot project linking payments to government evaluations of the quality of care provided to patients saw sharp decreases in the number of people who died from heart attacks. Advocates of “pay-for-performance” initiatives have hailed that result, and it has prompted U.S. Senate Finance Committee Chairman Max Baucus (D-MT) to propose a broader program for it in his health care legislation.

But Dr. Philip Alper, a clinical professor of medicine at the University of California-San Francisco and the Robert Wesson Fellow in scientific philosophy and public policy at the Hoover Institution, says pay-for-performance programs have negative consequences and ultimately raise health costs.

“So much of pay-for-performance is basically an assemblage of information. Large practices or medical institutions, which are highly computerized, have enormous advantages over other hospitals or smaller practices.”

DR. PHILIP ALPER
CLINICAL PROFESSOR OF MEDICINE
UNIVERSITY OF CALIFORNIA-SAN FRANCISCO

Raising Costs
Alper likens pay-for-performance initiatives to one-shot bonuses, which raise the cost of health care over time.

“Do we assume the higher quality of care provided by pay-for-performance is the new standard of care?” Alper asked. “We are not going to keep adding pay-for-performance bonuses, so before long the new care provided by pay-for-performance becomes standard, and part of the cost. Before long, the cost of care has risen.”

But Stuart Guterman, assistant vice president for Medicare’s Future at the Commonwealth Fund, a private foundation in New York City, disagrees.

“Pay-for-performance sends a message through the price structure that quality is something we want to reward and that we are willing to pay for,” Guterman said. “And that is a better signal than our current fee-for-service structure.”

Guterman believes the U.S. health care system needs pay-for-performance initiatives to give medical providers a list of steps for each patient, cutting payments if the steps are not followed, to ensure quality care.

“The current system is just sending the wrong signal,” Guterman said. “Pay-for-performance has an important part to play if we want to change the health care financing structure of our country.”

Gaming the System
But Alper notes pay-for-performance programs are naturally subject to exploitation by providers.

“Depending on your level of computerization, you can use the numbers to obtain pay-for-performance awards. So much of pay-for-performance is basically an assemblage of information,” Alper said. “Large practices or medical institutions, which are highly computerized, have enormous advantages over other hospitals or smaller practices. At any rate, most pay-for-performance literature has not shown long-term benefits.”

Guterman admits the evidence of success for these projects is spotty.

“The evidence overall of pay-for-performance is mixed,” Guterman said. “Though if we want an alternative way to pay for care, and basically get the fee-for-service system out of the way, pay-for-performance has a role.”

Thomas Cheplick (thomascheplick@yahoo.com) writes from Massachusetts.
Patients Accept Incentives for Improvement

By Tabassum Rahmani

A review of the first two years of West Virginia’s alternative Medicaid program shows some positive results for patients willing to accept incentives to improve their health through personal action.

The report is a performance review of Mountain Health Choices, which replaced West Virginia’s traditional Medicaid program for healthy adults and children in March 2007. The review was conducted through a survey of 1,074 Medicaid recipients by the West Virginia Bureau for Medical Services, with the goal of identifying areas of focus for improvement and future research.

Mountain Health Choices offers two plans—basic and enhanced. Patients are placed on the basic plan by default. To get the enhanced version, which includes expanded prescription drug plans and weight-loss treatments, an applicant must sign a responsibility plan detailing what’s expected of him or her.

The study found adults who selected the enhanced plan were more likely to report having worse health, a higher incidence of obesity, more doctor visits, and more prescriptions per month than those who remained in the basic plan. The differences between children enrolled in the basic and enhanced plans were minimal.

Tami Gurley-Calvez, an assistant professor at West Virginia University’s College of Business and Economics, noted, “It is clear that those on the enhanced plan had worse health and used more services than those on the basic plan.”

Helping Low-Income

According to Dennis Smith, a senior fellow at The Heritage Foundation’s Center for Health Policy Studies in Washington, DC and author of a recent paper, “Health Care Reform in West Virginia: A Lesson from the States,” the new study refutes some misperceptions about Medicaid and shows the positive side of giving people more options.

“The importance of the study is to show that most of the Medicaid population is healthy,” Smith said. “We should be helping low-income individuals. We should help people on Medicaid participate in the rest of the health care system like everyone else.”

INTERNET INFO


Value of Prevention as a Cost-Cutter Doubted

By Loren Heal

While President Barack Obama has repeatedly touted prevention as a cost-cutting measure and a key element of his health care reform plan, funding preventive health care does not appear to lower costs, according to Sally Pipes, author of Top Ten Myths of American Health Care.

Although prevention is often a medically advisable process, Pipes, executive director of the Pacific Research Institute in San Francisco, and other health care experts point out it’s not generally a cost-cutting measure.

In fact, they say, prevention often costs more than waiting for problems to occur and then treating them. Pipes notes countries with government-run medical systems typically forgo preventive medicine as not cost-effective.

“We have a global budget, it’s too expensive to have a [prostate exam] every year, or have it as a regular thing, or, say, a colonoscopy for people over the age of 50. Those just aren’t part of routine prevention, because they’re expensive tests,” Pipes said. “The only way you can control costs is to control the supply of what you’re providing.”

No ‘Magic Bullet’

Dr. James Bruehler, a professor of economics at Eastern Illinois University, says preventive medicine does not save money at the individual level either. He points out individuals must weigh the reduced probability of ailment against the costs of unnecessary and often expensive testing.

“When you take large numbers of people and aggregate them,” Bruehler said, “the reduced probability of ailment turns into the fact that small numbers of people are prevented from getting the ailment, but it is essentially in the calculation either way. If it made sense to everyone at an individual level, it would make sense in the aggregate.”

Michael Tanner, a senior fellow at the Cato Institute in Washington, DC, says he believes prevention is unlikely to improve health and would not be effective as a cost-cutting measure even if it succeeded.

“Prevention is the magic bullet that’s [supposedly] going to give [the Obama administration] all kinds of savings it can use to finance health care reform, and it’s just not there.”

INTERNET INFO

Top Ten Myths of American Health Care, Pacific Research Institute, 1998. $19.95 on Amazon.com
Health Overhaul Could Force Doctors to Quit

By Paul Hsieh, MD

A September 15 Investor’s Business Daily editorial revealed stunning poll data showing 45 percent of American physicians “would consider leaving their practice or taking an early retirement” if Congress passes President Barack Obama’s proposed health legislation.

As a practicing physician, I’m not surprised. These numbers mirror the sentiments I’ve heard expressed by my colleagues. I’ve been in practice for more than 15 years, and I’ve never seen physician morale as low as it is today.

Older physicians have told me they’re glad to be “getting out” and retiring soon. Medical students have asked me whether they should switch to engineering or pharmacology before it’s too late. Physicians in the middle of their careers are just hoping to survive any “reform.”

The same IBD poll also showed an overwhelming majority—65 percent—of physicians oppose the proposed expansion of government in medicine. They have every reason to be concerned.

Unwanted Consequences

One reason many physicians are skeptical of the proposed reform is because they already know what government-run health care is like, in the form of Medicare. Many proponents of universal health care want to create “Medicare for all,” claiming it’s a model of efficient, compassionate care.

But as The New York Times reported in April, more doctors are opting out of Medicare for two simple reasons: “reimbursement rates are too low and paperwork too much of a hassle.”

Physicians also have seen the problems in states like Massachusetts that have attempted to implement universal health care, and they worry about its implications for the rest of the country. The plan announced by Sen. Max Baucus (D-MT) is based closely on Massachusetts’ plan, including mandatory insurance, subsidies for low-income residents, and strict new regulations on insurers specifying whom they must cover, what benefits they must provide, and what they can charge.

Skyrocketing Costs

As a result, insurance costs have skyrocketed, raising the costs of the state subsidies. In response, the state has cut back on its payments to physicians and hospitals.

“Every time I have a Medicaid patient, it’s like handing them a $20 bill when they leave,” Dr. Katherine Atkinson, a primary care physician in Amherst, Massachusetts, told the Times for an April 5 story. “I never went into medicine to get rich, but I never expected to feel as disrespected as I feel. Where is the incentive for a practice like ours?”

Because of perverse government incentives punishing physicians for taking patients covered by the state’s “public plan,” many patients face long waits for care—as much as a year for a routine physical exam in western Massachusetts. And this is despite the fact that Massachusetts “has the highest physician-to-population ratio of any state, in primary care as well as overall,” according to the New England Journal of Medicine.

Expanding the Massachusetts plan to the national level would multiply this problem by 50.

Rewarding Doctors

Finally, physicians worry universal health care will compromise their ability to practice according to their own best judgment and conscience.

Obama’s “stimulus package” included $1 billion for “comparative effectiveness research” in health care. Writing in the August 18 edition of The Wall Street Journal, Harvard professor Martin Feldstein noted the government’s eventual goal is to use this research to cut costs and ration medical care by “implementing a set of performance measures that all providers would adopt” and by “directly targeting individual providers ... (and other) high-end outliers.”

In other words, your doctor would be rewarded if he practiced according to federal guidelines and punished if he strayed too far from them.

If you have abdominal pain due to gallstones, who should decide whether medication or surgery would be “most effective” for you? The doctor who felt your abdomen, heard your heart murmur, saw your ultrasound, and knows your drug allergies? Or the bureaucrat who got his job by telling the right joke to the right person at the right Washington cocktail party?

Most physicians I know aren’t in the field primarily for the money, although they do expect to be fairly compensated for a job that requires rigorous study and costly training. They do it because they love their work, including the ability to apply those years of training to benefit their patients. They passionately want to use their skills according to their best medical conscience.

To practice good medicine, a doctor must be left free to use his reason, his experience, and his judgment. Obama’s health care plan would destroy your physician’s willingness and ability to use his mind for your benefit.

Some doctors will grit their teeth and still try to do their best for their patients. But they will have to waste hours arguing with bureaucrats, while their less-conscientious colleagues can just punch a clock and go home. How long will the better doctors continue working under a system that constantly punishes them for their virtues? And when the good doctors finally retire or quit in frustration, what kind of doctors will remain?

Will your doctor be one of them?

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["P"]hysicians worry universal health care will compromise their ability to practice according to their own best judgment and conscience.

The U.S. Census Bureau released new statistics on the number of uninsured Americans in its annual report on September 10, sparking discussion of what the statistics mean and some surprising information about the incomes of the uninsured.

The Census Bureau found an estimated 46.3 million Americans lacked health insurance in 2008, according to findings from the Current Population Survey (CPS). The proportion of Americans who lack health insurance grew by one-tenth of a percentage point, to 15.4 percent in 2008, up from 15.3 percent in 2007. According to the report, the uninsured level has remained virtually unchanged for the past 15 years, hovering around 15 percent.

There is considerable disagreement about how the uninsured figures from the Census Bureau should be interpreted. According to Thomas Miller, a fellow at the American Enterprise Institute in Washington, DC, although the CPS is intended to track only individuals who are uninsured for an entire year, people tend to report being uninsured for shorter durations.

“The widely cited CPS statistic is considered closer to an estimate of those who were uninsured at the point in time surveyed, rather than the number of people uninsured for the entire year,” Miller said.

‘Massive Fraud’
Michael Cannon, director of health policy studies at the Cato Institute, believes supporters of government-run health care misuse CPS figures for political purposes.

According to Cannon, the CPS measures only the number of uninsured on any given day, not over a long period, and many of the uninsured quickly regain coverage.

“The Current Population Survey, and its estimate of 46 million or so uninsured, has been the occasion of a massive fraud on the public,” said Cannon. He says the number of Americans who are uninsured for the entire year “is more like 20 to 30 million—and many of those are already eligible for government programs or can afford to purchase health insurance.”

In 2003, the CBO compared data from the Survey of Income and Program Participation and data from the Medical Expenditure Panel Survey and concluded the CPS figures overstated the long-term uninsured by counting people as uninsured for an entire year who were actually uninsured for a shorter time. When those lacking coverage for only a short time were excluded, the true number of uninsured fell to between 21 and 31 million.

Overcounting the Uninsured

The September Census Bureau report also reported the large number of uninsured households that have what might be considered sufficient income to afford health coverage. Nearly 10 million uninsured individuals live in households earning more than $75,000 annually. Approximately 13.7 million uninsured adults and children live in households earning less than $25,000 annually, a group who largely qualify for Medicaid or the State Children’s Health Insurance Program (SCHIP). Research by the BlueCross BlueShield Association has estimated up to 14 million uninsured individuals qualify for public coverage but have not enrolled.

Many of the low-income people counted as uninsured may actually have Medicaid coverage, according to Jacob Klerman, author of a new paper on the uninsured, published in the journal Health Affairs. “The undercount is three to six million,” Klerman said. “The Medicaid undercount refers to people who erro-

INTERNET INFO

“Understanding the Current Population Survey’s Insurance Estimates and the Medicaid ‘Undercount’,” by Jacob A. Klerman et al., Health Affairs, September 10, 2009: http://content.healthaffairs.org/cgi/content/short/hlthaff.28.6.w991

Health Care Reform Should Begin with Ending Fraud

By Sen. Tom Coburn and Jim Frogue

During his September 9 prime time address, President Barack Obama said health care in America is “a system that is currently full of waste and abuse” where “too much of the hard-earned savings and tax dollars we spend on health care don’t make us any healthier.” In fact, he said, there are “hundreds of billions of dollars in waste and fraud” in Medicare that “don’t improve the care of seniors.” We agree.

We believe fraud constitutes at least 10 percent ($100 billion) of the nearly $1 trillion taxpayers will spend on Medicare and Medicaid this year. That is likely a conservative estimate. Harvard's Dr. Malcolm Sparrow, author of the seminal book License to Steal (Basic Books), estimates the losses could easily be in the 20 percent to 30 percent range, even as high as 35 percent, but he insists we shouldn’t have to guess. He believes the government should measure the losses and report them accurately.

The American people firmly support anti-fraud efforts. In a July 2009 Zogby poll, 88 percent of respondents identified “eliminate fraud” as their preferred way to pay for modernizing our health care system. “Reduce medical errors” came third on that list with only 72 percent support.

Moreover, an Insider Advantage poll, also from July, found that by a margin of 61-27, Americans believe the issues of fraud and waste in Medicare and Medicaid should be addressed prior to the creation of a new government-run health program.

Rampant Fraud
The story of convicted murderer Guilleremo Denis Gonzalez illustrates the vulnerability of government-run health programs to fraud.

Gonzalez was released from prison in 2004 after serving a 12-year sentence for murder. Two years later he bought a Medicare-licensed equipment supply company and duly notified Medicare authorities that he was the new owner. In 2007, he submitted $586,953 in false claims to Medicare and got paid for some of them. In 2008, he is alleged to have killed and dismembered a man.

The fact that a convicted murderer with a seventh-grade education could so easily become a supplier to our largest health program and begin defrauding it illustrates how pervasive fraud is in America’s government-run health care programs. If only the Gonzalez case were an isolated incident.

Florida’s Miami-Dade County is notorious for health care fraud. There are more licensed home health agencies in Miami-Dade County than in the entire state of California. In 2005, billing submissions from Miami-Dade to Medicare for HIV infusion therapy were 22 times higher than the rest of the country combined.

New York also has a serious problem with fraud. In 2006, a private study of New York’s Medicaid program found one-quarter of the expenses from the $44 billion that program cost that year cannot be explained.

More Accountability
In August, Medicaid’s internal inspector said the program’s current data-gathering capabilities are not timely, accurate, or comprehensive for detecting waste, fraud, and abuse. Essentially, one of the largest government-run health programs admits it has no idea how much fraud occurs as a result of its antiquated computer systems and collection methods.

In January 2009, the Government Accountability Office reported 10 percent of Medicaid payments made in 2007, or $32.7 billion, were improper. Last summer, U.S. Sen. Charles Grassley (R-IA) and a group of leading senators estimated there is $60 billion of waste, fraud, and abuse in the Medicare program annually.

For years, Congress has known the problem of health care fraud, particularly in Medicare and Medicaid, is massive. Yet, instead of targeting the crooks who are stealing from poor and elderly Americans dependent on Medicaid and Medicare, Congress routinely deals with runaway Medicare and Medicaid outlays by slashing payments to honest doctors and hospitals. That is a long-term recipe for total collapse of our health care system.

This past May, Sen. Coburn, co-author of this article, introduced a health care reform bill, the Patients’ Choice Act, along with Sen. Richard Burr (R-NC) and Reps. Paul Ryan (R-WI) and Devin Nunes (R-CA). Besides increasing patient choice, lowering costs, saving states $960 billion, and putting government health spending on a sustainable course, the Patients’ Choice Act would use private-sector technologies to significantly reduce waste, fraud, and abuse. This could save taxpayers about $100 billion a year.

Credit Card Model
Congress should look to the credit card industry as a model of fraud containment. ... Fraud in that industry is one-tenth of 1 percent, while fraud in Medicare and Medicaid is at least 100 times higher.

"Americans believe the issues of fraud and waste in Medicare and Medicaid should be addressed prior to the creation of a new government-run health program."

“Congress should look to the credit card industry as a model of fraud containment. ... Fraud in that industry is one-tenth of 1 percent, while fraud in Medicare and Medicaid is at least 100 times higher.”

Tom Coburn (http://coburn.senate.gov) is a family doctor and Republican U.S. senator from Oklahoma. James Frogue (info@healthtransformation.net) is vice president of the Center for Health Transformation and editor of the new book Stop Paying the Crooks (CHT Press, $19.95). This column was distributed to the press for general release and is printed with the authors’ permission.
Gov’t-Centered Health Care Overhaul Bound to Fail

By John C. Goodman

Why is Washington having so much trouble reforming health care? And why, if Congress passes a major overhaul, are the problems of cost, quality, and access almost certain to get worse?

Answer: Because Washington doesn’t understand health care. Almost no one in Congress understands health care as a complex system.

When they campaign, most politicians claim health care problems could be solved with a few simple reforms. Now that it’s time to legislate, they are discovering the issue is exceptionally complicated. In fact, there is no solution that even comes close to being simple or easy.

Economic Ramifications

That’s because the economy is a highly complex system. Yet instead of being careful about tampering with it, state and national policymakers have completely suppressed normal economic forces in virtually every aspect of health care. What we are left with is almost certainly the most complicated market of all, with no reliable model with which to understand it.

In complex systems, a change of parameter in one place inevitably causes other—often surprising and unforeseen—changes elsewhere.

Perturbations intended to bring about one result inevitably have other, unintended consequences. In health care, the unforeseen surprises are even more palpable because reforms are inevitably designed by people who either deny the existence of economic incentives or routinely ignore them.

I suspect most members of Congress were genuinely surprised to learn that:

• If a children’s health program is offered for free, half the enrollees will be from families that drop their private insurance to get it.
• A highly subsidized “exchange” outside the workplace would cause millions to drop their employer-provided coverage.
• Given the chance, millions of people would leave Medicaid for highly subsidized private insurance.

“In health care, the unforeseen surprises are even more palpable because reforms are inevitably designed by people who either deny the existence of economic incentives or routinely ignore them.”

• Spending $1 trillion over 10 years would ultimately reduce the number of uninsured by only 20 percent.

Perverse Incentives

One thing economists are confident about is this: No matter how complex the system, the incentives faced by the individual actors matter a great deal. And if all the actors in a complex system have perverse incentives, the social outcome is likely to be undesirable.

In health care, almost everyone faces perverse incentives. When people act in their own interests, they usually impose external (social) costs on others. This means the social cost is likely to exceed the social benefit for every actor at every margin.

Total spending on health care is the outcome of about 300 million patients and about 800,000 doctors all interacting in complex ways. But it is also the simple, straightforward sum of what I and my doctors spend on my care plus what you and your doctors spend on your care over 300 million people. No matter what else happens, if my doctors and I don’t change what we are doing for me, and you and your doctors don’t change what’s being done for you—and so forth—aggregate spending will not change.

No Idle Resources

If I am a representative patient, every time I spend a dollar, only 13 cents will come out of my own pocket. That means my incentive is to consume care until it is worth only 13 cents on the dollar to me. This is very wasteful, but I’m wasting your money (you being the other members of my insurance pool), not mine.

Under current reform plans, third-party coverage would become much more expansive, and we would have to pay only four or five cents out of pocket for every dollar we spend. Because this is a complex system, it is very hard to predict how all this new spending will affect the system as a whole. But we can be fairly confident total spending will rise—and probably by a lot.

Now consider the problem of access. Millions of uninsured people will obtain insurance, and millions of people who are currently insured will get more generous insurance. These people will use their newfound coverage to try to obtain more care. But where will they get it?

As you look around the health care system, how many idle resources do you see? How many primary care physicians have empty waiting rooms? How many ERs have no patients waiting to be seen? And if there are no significant idle resources, how will the increased demand for care be met?

Clearly, there will be a rationing problem, and those paying below-market rates (Medicaid patients, etc.) will experience more severe problems than others. This is precisely what is happening in Massachusetts right now—waiting times to see doctors in Boston are more than twice as long as in any other U.S. city.

Improving Incentives

For more than two decades, numerous scholars have outlined ways to reform the health care system by improving the incentives faced by the actors in it.

Congress is choosing a different course. Under the reforms being considered, almost everyone’s incentives will become worse, not better.

The tragedy is that Congress is almost completely unaware of the harm it is about to unleash. (At least that’s the charitable assumption.) The irony is that this same tragedy has been repeated in almost every other developed country in the world, so we should know better.

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The NIH reports 190,000 hospital deaths are due to errors.

You’d think we would reward doctors who report problems – even call them heroes.

But instead, they face retaliation and punishment – even loss of their ability to practice medicine.

THIS MUST STOP!

Tell Congress you want patient safety, not hospital politics, to come first

www.AAPSonline.org

Doctors who are most vocal in reporting problems are usually those who face retaliation within the hospital system.

Traditionally, physicians have reviewed other physicians with the goal of improving the quality of care.

That is known as good faith peer review. It’s an internal process that allows a committee to revoke hospital privileges.

Sham peer review, on the other hand, is peer review done in bad faith, for some purpose other than protecting patients.

Originally intended to protect patients from a few bad doctors, peer review is now misused to silence physician whistleblowers.

It has become the weapon of choice to eliminate the most conscientious physicians.

Instead of called heroes, they are labeled as “disruptive” and face hardball tactics taught by lawyers in secret courses for hospitals.

And sometimes other doctors abuse the process to get competitors out of the picture.

How can they get away with this?

Because Congress passed legislation that allows it.

The Health Care Quality Improvement Act (HCQIA) was passed in 1986. Although supposed to improve quality health care, it has had the opposite effect.

In fact, the lawyer who wrote the bill now makes money teaching those secret hospital courses on how to use the law to punish the whistleblowers.

The law provides a shield of almost absolute immunity for bad faith, malicious peer reviewers. They can convict a doctor for any reason they see fit and get away with it.

Unlike the court system, there is no appeal, no due process.

Fewer and fewer physicians are willing to risk their career and livelihood to protect patients in hospitals.

It is easier and far safer for physicians to simply look the other way and remain silent.

Act now to protect yourself & your family!
The physician’s creed to “First, do no harm” also is a warning to America’s policymakers and leaders as they consider massive changes to our health sector. Our freedom to make basic decisions about life, liberty and our health is at stake.

The Galen Institute invites you to sign our petition, which urges decision-makers to use the following principles to judge any health reform proposal:

✔ No new government-run health insurance plan
✔ No one-size government-dictated package of health benefits
✔ No requirement on individuals to buy this expensive coverage
✔ No new jobs-killing mandates on employers
✔ No federal institution controlling private health insurance
✔ No government intrusion into our medical privacy
✔ No federal government control over the practice of medicine through a federal health board, comparative effectiveness review, or other government intrusions into doctor-patient medical decision-making

OUR VISION: Only those reform proposals that preserve the freedom, innovation, and quality of American medical care should be supported. We believe we need fairer subsidies to level the playing field for those who are uninsured, and that a better-functioning, more competitive and transparent marketplace would cover more people and deliver the higher-value care we seek.

We believe health decisions should be made by doctors and patients, not by government bureaucracies.

Do you agree?
Please sign our petition urging officials to Do No Harm to health care.

Learn more at www.DoNoHarmPetition.org

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