Will Health Care Reform Be Hijacked Once Again?

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http://www.dakotaday.com/index.php?option=com_content&view=article&id=78:will-health-care-reform-be-hijacked-once-again-&catid=16:economic-policy-perspective&itemid=19

With political friends like former Senator Tom Daschle, does President Obama need any enemies? The health care reform plan released June 17 by Daschle and other former Senate Majority Leaders Bob Dole and Howard Baker, both Republicans, represents the kind of 'bipartisan' compromise that could effectively emasculate health care reform under the Obama Administration. Unless a strong public plan that is available to everyone is part of the final reform package, I see little chance for either comprehensive cost control or universal and fairly priced health insurance coverage for American citizens.

President Obama has laid out the broad principles of health care reform that he feels are necessary both to expand health insurance coverage to most Americans and to bring overall health care costs in the country down to economically sustainable levels. U.S. health care costs now constitute 18 percent of gross domestic product, a far higher level than in virtually any other advanced nation, yet the U.S. ranks quite low in health care outcomes relative to other such nations. The combined employer/employee cost of health care coverage, for those who have employer-based coverage, has more than doubled between 2001 and 2009. This is making employer-based coverage increasingly unaffordable for both employers and employees, and private coverage is even more expensive for many people. The result is that 46 million Americans do not have health insurance coverage. It is absolutely insane that we as citizens have for so long tolerated a health care 'non-system' that is bankrupting many individuals and our overall economy.

Single payer health care

Unfortunately, apparently due to political caution, the President thus far has ruled out the health care option that undoubtedly is the most cost-effective: the 'single payer' option. (For an excellent discussion of the single payer option, see the May 22 segment of the Bill Moyers Journal: http://www.pbs.org/moyers/journal/05222009/profile2.html.) Single payer simply means that the government sets reimbursement rates and handles all claims and disbursements. Canada and most European countries have single payer systems, and their overall health care costs are much lower than in the U.S. By cutting out duplicative administrative costs and profits of private insurers, what economists call 'transactions costs' are greatly reduced. I have favored single payer systems since having the students in one of my Public Finance classes at South Dakota State University examine the economics of alternative health care systems nearly 20 years ago. Nothing I have read since then has persuaded me that any other system is equal or better, though there are variations on the single payer approach. The Canadian single payer system, for example, seems better to me than the British system.

Our Medicare system is a single payer system (though not the Supplemental and Prescription Drug Insurance options). It took 20 years of political struggle from the time President Truman called for a national health care program in this country in 1945 and the time national health care for some of our citizens, in the form of Medicare,

finally was signed into law by President Johnson in 1965. How many senior citizens would now willingly give up Medicare, a single payer system? Not many, I think. We are still waiting for a national health care program for the most of our under-65 our citizens, however.

If single payer systems are so effective and popular in other advanced countries, why is the political establishment reluctant to push that option in the U.S.? The objections come primarily from the private insurance industry, the pharmaceutical industry, and some (by no means all) segments of the medical community. The ways in which the objections often are framed perpetuate several myths.

Myth number one is that consumers of health care would give up choice with a single payer system. My response is, "What choice?" For 30 years prior to being eligible for Medicare a year ago, I had no real choice of health insurance. As a state employee, the only real choice for my family and me was the state employee plan or nothing. Either I could not afford anything else or I could not take the risk of private insurance being unaffordable down the road if preconditions arose or other circumstances should cause private premium rates to rise dramatically. For many under-65 people, their only real choices are like mine were: an employer-based plan or nothing. Farmers and other self-employed people generally have only private health insurance options, and those options can be prohibitively expensive. Healthy young adults they may sometimes be able to find affordable private insurance, but they could be only one serious illness away from economic catastrophe and medical preconditions that cause them insurance problems for the rest of their lives.

The second myth is that control of health care under a single payer system would shift from doctors and patients to the government. The fallacy here is in the view that doctors and patients are still in sole control now. We have been living with 'managed care' in one form or another for 20 years. The 'management' comes from all kinds of directions--including government (Medicare), private insurers, self-insurance pools (e.g., the South Dakota employee health plan), and health systems (e.g., whether or not you will be provided surgery if you do not have insurance). In fact, doctor and patient control of health care already is severely constrained. And if you are among the 46 million uninsured Americans, you have almost no control yourself. Management controls will continue to be necessary if costs are going to be brought under control, as they must be. However, a single payer system could bring much more consistency, coherence, and fairness to those controls. A single payer system like that in Canada would allow most patients in the U.S. as much or more control as they have now, and with greater fairness for citizens and lower overall cost to the economy.

Myth number three is that single payer systems necessarily involve long waits and diminished quality of health care. If the rich were to have to live within the same constraints as everyone else (wouldn't that be terrible!) in a single payer system, they might, in fact, have somewhat longer waits for some kinds of care than they do at present. But most accounts I have read and heard over the years indicate that for ordinary people, quality of care will be higher because of greater access to preventive and primary care and greater affordability of most kinds of care. And if the U.S. were to spend anywhere near the amount of money that we currently spend on health care (which most countries with single payer systems do not), waits for most kinds of care probably would not be any longer than at present. (Nicholas Kristof's June 11 article in the New York Times and Bill Mann's June 13 piece in Huffington Post provide insightful patient perspectives on the Canadian system.)

A 'public insurance option' for all people

It is not too late to put the single payer option on the table. But if that does not happen, can we get major coverage and cost control gains in health care reform without it? In my view, not without a very strong and universally accessible 'public insurance option'.

Unfortunately, a number of the health care reform proposals recently put forth look pretty weak in this regard. According to Ledyard King's June 18 Argus Leader article, the reform plan released by Daschle, Dole, and Baker settled on giving states more flexibility to develop their own public plans, rather than mandating a Federal health plan option that Daschle said he personally favored. Plans run by states apparently would consist of some kind of public insurance pools. The Daschle/Dole/Baker plan received a lot of pushback in the days following its release from progressives who favor a single payer approach or, at the very least, a strong public option. Daschle then seemed to do some back-peddling. In a rambling interview with Ezra Klein in Washingtonpost.com (http://voices.washingtonpost.com/ezra-klein/2009/06/an_interview_with_tom_daschle.html), Daschle is quoted as follows, responding to Klein's question about headlines saying Daschle was dismissing the need for a public plan: "I don't know where that came from. We've been pushing back on that all day. I didn't say that. I have said emphatically I support a public plan. A Medicare-for-all public plan. Any federal plan. For all the reasons that have been made for years. It's important for cost, for choice, for competition, for popularity. I strongly support it."

But, Daschle goes on in that interview to say, "What I did say is that I'm willing to compromise on most things to bring the package across the line. The plan we agreed to yesterday was that states could offer public plans with a federal fall back. That's not my first, second, or third choice. But given the concessions my colleagues made on universal coverage and an employer mandate and everything else, that's the essence of compromise."

What kind of compromise is that! Is a strong public option at the Federal level essential or not? And who is doing the compromising? Three ex-Senators, in this case. Daschle acts like this is a compromise about where we should go out to dinner on the weekend, rather than about the substance of health care reform that is at the very core of citizens' well being and economic vitality in this country for decades to come.

I am concerned that Daschle's wishy-washy attitude toward the public option represents the views of quite a few Democrats in the 'real' Senate, not just ones in the ex-Senate like Daschle. (We know where most Republicans in the Senate stand. Foursquare behind the private insurance industry, regardless of where that leaves ordinary citizens.) Senator Baucus, Chair of the Senate Finance Committee, seems luke-warm on the public option. One version of a plan under consideration in his committee reportedly would use a coop approach. Writing in Huffington Post on June 16, Robert Borosage says, "Even if a network of coops somehow arose to insure that people had an option, they wouldn't have the clout to hold costs down and force private insurance to compete." I think he's right.

Fortunately, at this point, the House leadership appears to be more progressive on the public option. On June 19, Senators Waxman, Rangel, and Miller, Chairs of the Energy and Commerce, Ways and Means, and Education and Labor Committees, respectively, released a draft health reform plan that reportedly includes a strong public health insurance option.

House passage of a health care reform bill with a strong public option is not necessarily assured, however. According to Bob Cesca, writing June 17 in Huffington Post, House 'Blue Dogs' Democrats do not support a government-run public health insurance option. A June 10 article in Politico by Patrick O'Connor and Chris Frates reports that the

Blue Dogs sent a letter to their House leadership stating that a public option should be created only if insurance market reforms and increased competition don't lower costs on their own. In reality, overall health costs are unlikely to be brought under control without a strong public option. So it sounds to me like the Blue Dogs are just trying to buy more time for the insurance companies. The vaunted 'fiscal conservatism' of South Dakota's Representative Herseth Sandlin and her fellow Blue Dogs seems not to include concern for the fiscal health of the overall economy and citizens at large.

Points of economic perspective

We saw health care reform hijacked during the Clinton Administration in the 1990s, and there is real danger of that happening once again. To help prevent that, I suggest we keep the following points of economic perspective in mind as the health care reform policy debate proceeds over the coming weeks:

All available evidence, and economic logic, suggest that a single payer system would provide the highest level of health outcomes for any given level of total spending in the economy.

The relevant costs to consider are all costs in society, not just government outlays. Congressional Budget Office (CBO) scores are based on government outlays and revenues. They are not measures of overall costs and benefits (health outcomes) in society. If a health care option that involves heavy government outlays is the best option from an overall, societal standpoint, then we should figure out a fair way to raise the necessary government revenues to finance that option. Sound economics, at both the public and individual level, involves being pragmatic. We have public roads, for the most part, rather than private roads, because it is just a lot less costly overall to organize and fund our road system that way. The same is true for public policing. That has resulted from economic pragmatism, not political ideology. We need to use the same pragmatism as we sort out and voice support for health care reform options.

If we are going to let political ideology--or sheer private greed--stand in the way of single payer health care in this country, then economic pragmatism suggests the need for a strong public option.

* This must be a Federal option that is available for all individuals, including individuals whose employers offer health care insurance. If public options are left to the individual states, coverage in many states will be pretty weak. And we will continue to have a highly fragmented and costly system nationwide.

* If an employee chooses the public plan, the employer match (if employers are required to provide insurance coverage) should go with the employee to the public plan. Also, employers should be free to simply provide their match to the public plan, rather to carry a private plan for their employees, if they so choose. (I am not convinced that tying health care funding to employment in any way is the best method for funding a portion of health care. Progressive corporate and personal income taxes would be a superior method of funding.)

* Safeguards must be created to prevent 'dumping' of patients with poor health or high risk onto the public option. Designing such safeguards is extremely difficult; that's one reason a single payer system is really preferable. Reimbursement criteria and rates for health care providers must be the same for the public and private insurance options; otherwise, providers may refuse to serve those on the public option. Forms and filing procedures for public and private options must be identical if transactions costs are to be reduced significantly.

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