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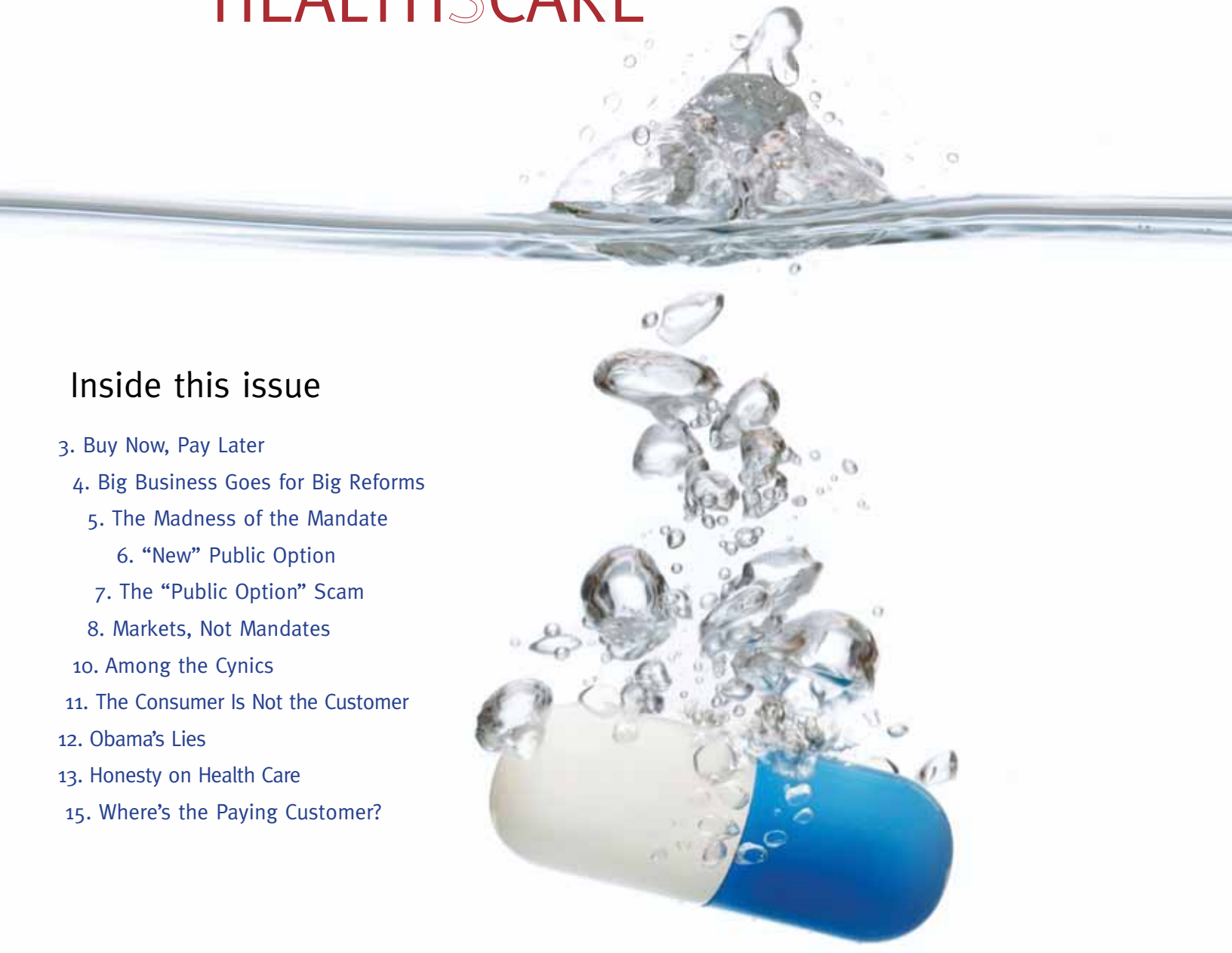
HEALTHSCARE



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From the Editor

On October 7, *Reason* associate editor Peter Suderman wrote an essay for *The Wall Street Journal* on "The Lesson of State Health-Care Reforms." What insights did readers of the 2 million-circulation newspaper learn? That the major provisions of ObamaCare have already been tried in the United States, and have demonstrably led "to increased costs and reduced access to care."

As the debate over potentially overhauling one-sixth of the U.S. economy has raged on during the spring, summer, and fall, Reason has been right in the thick of the argument, agitating for customer-based reform, truth-based debate, and market-based approaches to improving a deeply flawed system. In other words, we have been fighting the Obama administration's heat with the light of rationalism, using our three major platforms (*Reason* magazine, *Reason Online*, and *Reason.tv*), and publishing articles in outside outlets across the country.

The impact is being felt as far as Capitol Hill itself, where, as the *L.A. Times* has noted, "Republican members of Congress have started spouting *Reason* magazine-style arguments" against the most authoritarian elements of the reform plan, such as criminal sanctions against citizens who don't purchase health insurance.

In this first edition of *Reason Reader*, you'll find a sample of the scores of health care articles that we've produced during this absolutely critical season, hammering home the theme that, as in all policy endeavors, embracing liberty, choice, and transparency is both the morally just and economically efficient way to produce better outcomes.

Thanks to your ongoing support, we have been able to make a difference in a debate that will impact the country significantly for decades to come. Please stay tuned to *Reason.tv, Reason Online,* and the print edition of *Reason* for more incisive coverage on health care, and feel free to send me tips and feedback on these and other pieces we're running.

And thank you again for supporting Free Minds and Free Markets!

Sincerely,

Matt Welch
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Buy Now, Pay Later

The health care cost-control conundrum.

By Peter Suderman

Listen to liberal advocates of health-care reform and you'll hear two constant refrains: We must expand coverage to everyone, and we must control costs. Democrats tend to sell this as a package deal, a sort of political version of the Billie Mays pitch—but that's not all! And while they've put forth a number of plans that would expand coverage by varying degrees, the tacked-on bonus—as is the case with most infomercials—is essentially a scam: Claims that the Democrats' current proposals will rein in health-care spending are sketchy at best.

Nor is that surprising. Despite all the talk of cutting costs, the tacit plan, from the beginning, has been to pass reform by building a coalition that would collectively agree to give members whatever they wanted now, while cheerfully talking around the serious budgetary complications posed by universal coverage.

This strategy was sketched out in a March *New York Times* article on lessons learned by advocates of national reform during the recent overhaul of the Massachusetts health-care system, which expanded coverage but saw costs rise sharply. According to backers of the Massachusetts overhaul, however, that was a necessary ingredient in the recipe for reform. The Times piece quoted an array of strategists and stakeholders agreeing that, as Washington attempted to implement reforms similar to those in Massachusetts, the key would be to focus on building the coalition—presumably through deal-making and handouts—while carefully avoiding anything more than platitudes on the sensitive issue of spending. Defenders refer to it as an "incremental approach," but seedy salesmen have long used the same gimmick to unload get-it-out-the-door-now stinkers under a different name: Buy Now, Pay Later!

Subsequently, this year's health-care debate in Washington has featured a raft of insider deals and stakeholder handouts—to everyone from Wal-Mart to the drug industry—as well a lot of talk about cost-control without much substance to back it up. That's partly due to a string of sobering reports from the Congressional Budget Office that have made the fiscal aspect impossible to ignore. The independent office says that the current path for the country's health-care entitlements is "unsustainable," and, without major changes, will likely cause "substantial harm to the economy."

And those changes, the CBO says, are not to be found in the current legislation. To the contrary, CBO chief Douglas Elmendorf told members of the Senate Budget Committee, the legislation would "significantly expand the federal responsibility for health-care costs," adding $202 billion to the federal deficit by 2019.

Both Massachusetts and Obama have, in the past week, announced strategies they hope will deal with the problem of paying for health care. A Massachusetts health-care commission voted unanimously to end fee-for-service payments to doctors and other medical practitioners in favor of capitation, which means care providers are paid per patient rather than per service. Obama, meanwhile, came out in favor of a commission of his own, the Independent Medicare Advisory Commission (IMAC).

Problem is, capitated payments are deeply unpopular: Doctors stand to make less money, while patients find themselves in the hands of providers with the financial incentive to provide as little care as possible.

Details on IMAC are still vague, but according to Office of Management and Budget Director Peter Orszag, the commission—which is really just an expanded, more powerful version of the current Medicare advisory group, MedPAC—would "have the authority to make recommendations to the President on annual Medicare payment rates as well as other reforms." The idea is to keep politically motivated legislators out of the business of determining Medicare pay rates and reimbursements. But rather than insulating health care from legislative politics, it insulates legislators from the political backlash against rationing and restrictions on care. IMAC would essentially turn Medicare into a government-run HMO, sticking seniors with micromanaged coverage—and perhaps exacerbating the potential for care shortages as doctors look to avoid treating those covered by low reimbursement rates.

The fact is, health-care costs are rising across the developed world, even in the most widely praised systems. Britain, for example, has kept total health-care spending as a percentage of GDP lower than many other Western countries through stingy, centrally rationed care, but its costs are on the rise, and its National Health Service is facing a severe financial crunch. And while advocates of liberal reform hold up countries like France and the Netherlands as models of high-quality care, even boosters must admit that these countries, too, face troublesome rising costs.

Health-reform advocates here in the states think savings may be found in a number of other measures—health IT, comparative-effectiveness review, various changes in provider payment structures—but all are untested. They also have important political constituencies invested in their defeat. That makes them tough issues for politicians who like to sell the public on the wonders of their plans while sweeping the costs and complications aside. In other words, like the dearly departed Billy Mays, politicians are pitchmen—always urgently, enthusiastically peddling something new and shiny in the desperate hope that you, their political constituents, are buying. ■

This article can be found at:
reason.com/archives/2009/07/24/buy-now-pay-later

Big Business Goes Big for Health Care Reform

Why drug companies and insurance providers are backing ObamaCare.

By John Stossel

"What disturbs Americans of all ideological persuasions is the fear that almost everything, not just government, is fixed or manipulated by some powerful hidden hand," Frank Rich wrote in Sunday's *New York Times.*

That manipulation should disturb us. But contrary to Rich, it is not the work of "corporatists" who have sprung up to attack progressive reforms proposed by Obama and the Democratic majority. Manipulation is what we got many years ago when we traded a more or less free market for the "progressive" interventionist state. When government is big, the well-connected always have an advantage over the rest of us in influencing public policy.

Observe: Although President Obama and big-government activists demonize health-insurance companies, the companies "are still mostly on board with the president's effort to overhaul the U.S. health-care system," the *Wall Street Journal* reports; and ...

Although the activists criticize Big Pharma, "The drug industry has already contributed millions of dollars to advertising campaigns for the health care overhaul through the advocacy groups like Healthy Economies Now and Families USA. It has spent about $1 million on similar advertisements under its own name," the *Times* reports.

Big Pharma and Big Insurance want Obama-style health-care reform?

It's not so hard to understand. "The drug makers stand to gain millions of new customers," the *Times* said.

And from the *Journal:* "If health legislation succeeds, the [insurance] industry would likely get a fresh batch of new customers. In particular, many young and healthy people who currently forgo coverage would be forced to sign up." No wonder insurers are willing to stop "discriminating" against sick people. (Forget that the essence of insurance is discrimination according to risk.)

"No one hates capitalism more than capitalists." In this case, big business wants to shape—and profit from—what inevitably will be an interventionist health-care reform.

Not that Big Pharma and Big Insurance like every detail of the Democratic plan. Drug companies don't want Medicare negotiating drug prices—for good reason. If it forces drug prices down, research and development will be discouraged. (Depending whom you believe, Obama may or may not have agreed with the drug companies on this point.)

As for the insurance companies, they worry—legitimately—that a government insurance company—the so-called public option"—would drive them out of business. This isn't alarmism. It's economics. The public option would have no bottom line to worry about and therefore could engage in "predatory pricing" against the private insurers.

But despite these differences, the biggest companies in these two industries are on board with "reform."

It illustrates economist Steven Horwitz's First Law of Political Economy: "No one hates capitalism more than capitalists." In this case, big business wants to shape—and profit from—what inevitably will be an interventionist health-care reform. Can you think of the last time a major business supported a truly free market in anything?

In light of all this, it's funny to watch Democrats and their activist allies panic over the protests at congressional town meetings around the country. Tools of the corporate interests! they cry. But anyone opposing "socialized medicine" at the meeting can't be a mouthpiece for big business because, as we've seen, big business supports government control. Conservative groups may be encouraging people to vent their anger at congressmen who pass burdensome legislation without even bothering to read it, but that's no reason to insult the protestors as pawns. What's wrong with organizations helping like-minded people to voice their opinions? Why do Democrats, such as Speaker Nancy Pelosi, dismiss citizen participation as "AstroTurf"—not real grassroots—only when citizens oppose the kind of big government they favor?

They weren't so dismissive when George W. Bush was president and people protested—appropriately—his accumulation of executive powers.

"When handfuls of Code Pink ladies disrupted congressional hearings or speeches by Bush administration officials," Glenn Reynolds writes, "it was taken as evidence that the administration's policies were unpopular, and that the thinking parts of the populace were rising up in true democratic fashion. ... But when it happens to Democrats, it's something different: A threat to democracy, a sign of incipient fascism ... House Speaker Nancy Pelosi calls the 'Tea Party' protesters Nazis...."

So when lefties do it, it's called "community organizing."

When conservatives and libertarians do it, it's "AstroTurf."

Give me a break. ■

John Stossel's weekly column is distributed by Creators Syndicate. This article can be found at:
reason.com/archives/2009/08/13/big-business-goes-big-for-heal

The Madness of the Mandate

What's wrong with the government forcing individuals to buy health insurance.

by Peter Suderman

Over the summer, the health-care debate focused on the controversy over the so-called "public option"—a government-run insurance plan intended to offer a low-cost alternative to private insurers. But squabbling over the public plan has diverted attention away from the true centerpiece of all current reform efforts: an individual mandate requiring every American to buy health insurance. Even without any form of public option, a nationwide mandate opens the door to de facto government control over the entire insurance industry, while potentially killing off the low-cost plans that could truly revolutionize American medicine.

An insurance mandate is a crude solution to what many liberals consider the primary problem with America's health-care system: the large number of uninsured. One of the most frequently repeated statistics in the health-care debate is that there are 47 million people without health insurance in the U.S. Anyone looking for a way to get all of those people insured is left with only one option: force them to get insurance.

Problem is, the 47 million statistic is misleading. And even with a mandate, health reform legislation is projected to leave tens of millions uninsured.

Let's start with the 47 million figure. The number is presented as a static fact, but instead it's the total number of people who go uninsured for even a single day each year. The number also includes several million illegal immigrants, 11 million individuals who already qualify for some form of government health assistance, and 18 million individuals who make more than $50,000 a year, many of whom presumably could buy insurance but simply choose not to.

Meanwhile, mandates don't actually bring everyone into the system. Some people simply wouldn't comply. Others would choose to pay a penalty in order to avoid buying insurance. The latest report from the CBO estimated that the health-care plan put forth by the Senate Finance Committee would leave "about 25 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants)."

In other words, a mandate is, at best, a leaky solution to an incredibly exaggerated problem. Yet advocates claim that it's the only way to cover everyone and bring down costs. In the real world, however, that's just not true.

As Cato Institute health-policy analyst Michael Cannon pointed out in a recent paper, mandate supporters often argue that, by bringing everyone (or nearly everyone) into the insurance pool, a mandate will save money on so-called "uncompensated care"—the unpaid-for care doled out to free-riders throughout the nation's emergency rooms. But according to the Urban Institue, a left-leaning think tank, uncompensated care only accounted for about 2.2 percent of health spending in 2008. So, at most, savings would amount to measly 2.2 percent—and that's before accounting for the additional costs imposed by a mandate.

And those costs can be significant. As Cannon explains, "when government makes health insurance mandatory, it must define a level of coverage that satisfies the mandate." That means that many lower-coverage, lower-cost plans no longer make the cut—and premium costs go up. As Cannon calculated based on a study by Massachusetts Division of Finance and Policy, mandatory coverage requirements can "increase the cost of insurance by as much as 14 percent—or nearly $1,700 per year for family coverage." Two-and-a-half years after first imposing a mandate, the state now has the dubious honor of having the nation's most expensive health insurance premiums, and the future looks even more grim: Insurers have already announced plans for double-digit hikes next year.

Nor does the existence of a mandate guarantee that public spending on health-care will be kept in check. Indeed, the opposite has occured in Massachusetts. The state's medical spending is so out of control that, according to the Boston Globe, state insurance commissioners now worry that it "could threaten the state's model health insurance law and bankrupt employers and patients."

Supporters claim the Massachusetts plan has been a success because it's increased the percentage of people in the state with health insurance. And it's true. Estimates suggest that, these days, the percentage of uninsured in Massachusetts numbers somewhere between 2.2 and 4 percent (although given that 86 percent had insurance before the mandate took effect, this isn't as much of an accomplishment as they claim). But what good is insurance if the program that funds it isn't sustainable? Even among those who view the plan as a model for the nation, there's concern that skyrocketing costs "threaten the long-term viability of the initiative."

Meanwhile, a mandate's minimum coverage requirements would effectively outlaw low-cost health-care solutions like health-savings accounts (HSAs) that let individuals pay for care out of accounts they control—and, unlike traditional insurance plans, have a legitimate (if not yet definitive) record of lowering health-care spending.

But in Washington's current reform-crazed atmosphere, sensible ideas like giving consumers more control over their health-care don't stand a chance. Instead, liberal reformers appear to have succumbed to the power of compulsory insurance. And if they get their way, it won't be long before we're all in the grips of mandate madness. ■

This article can be found at:
reason.com/archives/2009/10/09/the-madness-of-the-mandate

New Public Option, Same As the Old Public Option?

Are health insurance co-ops a good idea?

By Ronald Bailey

"I strongly believe that Americans should have the choice of a public health insurance option," declared President Barack Obama last June. The Democratic leadership in the House of Representatives duly rammed through 1,018 pages of health care reform, including $2 billion in seed capital to establish a public health insurance option.

In the face of raucous opposition in scores of town hall meetings, Obama backed down in late August from his government-run health insurance scheme, saying, "The public option, whether we have it or we don't have it, is not the entirety of health care reform."

Instead, Sen. Kent Conrad (D-N.D.) floated a plan for creating consumer-owned nonprofit health insurance cooperatives as an alternative to the Democratic plan. He sees rural electric cooperatives and agricultural cooperatives as models for his health insurance cooperatives.

Many Americans are familiar with neighborhood food co-ops in which members join and then purchase a variety of produce, meats, and other groceries at cost. Some 120 million Americans are served by various co-ops according to the National Cooperative Business Association.

The details are still fuzzy, but reports suggest that under Conrad's plan the medical co-ops would receive $3 to $4 billion in start-up funds from the federal government and operate under a national structure with state affiliates at first. Afterwards, they would function independently, living solely off the premiums charged to co-op members, and maintaining the same financial reserves that private companies do in order to cover any unexpectedly high claims. Ideally, membership would be around 500,000 to give the co-ops sufficient bargaining power with physicians, hospitals, and drug companies. "For those against a public option because they fear government control, the co-op structure has some appeal because it's not government control," declared Conrad. "It's membership control, and membership ownership."

Health care co-ops could function in two ways. A co-op might be a group of consumers who band together to negotiate the best coverage deal from private insurers. Or like mutual life insurance companies, a health insurer could be a co-op owned by its member policyholders. Policyholders would be pushing for the co-op to cut costs to keep premiums low while simultaneously encouraging the co-op's management to expand benefits. As members, co-op policyholders would not likely try to control costs by denying claims or limiting access to medical care.

The conservative Heritage Foundation cautiously agrees that such medical cooperatives might be marginally useful, but correctly worries that government start-up funding of co-ops would lead to federal control since Congress would justify its further interference on the grounds that federal officials are stewards of taxpayer dollars.

Fostering more competition among health insurers is a great idea. Right now, most states are dominated by one or two insurers. To really get co-ops going, Congress and the administration need to change tax laws to grant nonprofit tax status to mutual health insurance companies just like credit unions enjoy today. Congress also needs to give consumers the same tax breaks for getting insurance from a co-op (or any other private insurer) as they currently get from their employer. But more competition could also be had by the simple expedient of passing legislation allowing insurers licensed to sell policies in one state to offer them to residents of any other state. This would immediately create a competitive nationwide market for individual health insurance policies.

One reason we don't have much health insurance competition right now is that the proliferation of coverage mandates in each state operates as a barrier to entry for many insurers, keeping them from expanding into new states. Mandates also lessen the scope for competition since all policies must essentially offer the same coverage. The Council for Affordable Health Insurance identified 2,133 mandated benefits in a 2009 report, and estimates that state and federal mandates increase the cost of basic health coverage by between 20 and 50 percent. "Mandating benefits is like saying to someone in the market for a new car, if you can't afford a Cadillac loaded with options, you have to walk," notes the report.

Democrats are, however, unlikely to give up on the dream of a public health insurance scheme in favor of truly private co-ops or real competition. Sen. Charles Schumer (D-N.Y.) has recently said that he could support the idea of health insurance co-ops. But Schumer insists that what he calls "co-ops" must be national in scope, jump-started with $10 billion in federal government funding, have the power to negotiate payment rates to medical providers nationwide, and be governed by a presidentially-appointed board of directors. Discerning any differences between Schumer's idea of co-ops and the government health insurance option that the Democrats in the House of Representatives have already passed would take the equivalent of a public policy electron microscope.

Co-ops, implemented a certain way, will essentially be their public option. Senate Majority Leader Harry Reid (D-Nev.) summed up Democratic intentions well: "We're going to have some type of public option, call it 'co-op,' call it what you want." Sen. Orrin Hatch (R-Utah) has clearly been listening to his colleague from Nevada. In *The New York Times*, Hatch noted, "You can call it a co-op, which is another way of saying a government plan."

If it stinks like a skunk, it's most likely a skunk. And no matter what health care co-op plan emerges from the Democratic Congress in September, it is unlikely to pass this smell test. ■

This article can be found at:
reason.com/archives/2009/08/18/new-public-option-same-as-the

The 'Public Option' Health Care Scam

Why Obama's plan won't work.

By Steve Chapman

Some statements are inherently unbelievable. Such as: "I am an official of the government of Nigeria, and I would like to deposit $60 million in your bank account." Or: "I'm Barry Bonds, and I thought it was flaxseed oil." And this new one: "I'm Barack Obama, and I favor more competition in health insurance."

That, however, is the claim behind his support of a government-run health insurance plan to give consumers one more choice. The president says a "public option" would improve the functioning of the market because it would "force the insurance companies to compete and keep them honest."

He has indicated that while he is willing to discuss a variety of remedies as part of health insurance reform, this one is non-negotiable. House Democrats, not surprisingly, included the government plan in the 1,000-page bill they unveiled Tuesday.

It will come as a surprise to private health insurance providers that they have not had to compete up till now. Nationally, there are some 1,300 companies battling for customers. Critics say in many states, one or two insurers enjoy a dominant position. But market dominance doesn't necessarily mean insufficient competition.

Microsoft's dominance of software didn't prevent the rise of Google, and Google's dominance of search engine traffic didn't prevent Microsoft from offering Bing. If a few health insurance providers were suppressing competition at the expense of consumers, you'd expect to see obscene profits. But net profit margins in the business run about 3 percent, only slightly above the median for all industries.

Supporters of the "public option" think it can achieve efficiencies allowing it to underprice existing insurers. But efficiency is to government programs what barbecue sauce is to an ice-cream sundae: not a typical component.

There are reasons, though, to think that the president's real enthusiasm is not for competition but for government expansion. Free-market advocates want to foster competition by letting consumers in one state buy coverage offered in other states. If WellPoint has more than half the business in Indiana, why not let Indiana residents or companies go to California or Minnesota to see if they can find options that are cheaper or better?

But the administration and its allies show no interest in removing that particular barrier to competition. Maybe that's because it would reduce the power of state regulators to boss insurance companies around.

Nor does Obama believe in fostering competition in other health insurance realms—such as existing government health insurance programs. John Goodman, head of the National Center for Policy Analysis, suggests letting Americans now enrolled in Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) select a voucher to buy private coverage if they want. Don't hold your breath waiting for the administration to push that idea.

Supporters of the "public option" think it can achieve efficiencies allowing it to underprice existing insurers. But efficiency is to government programs what barbecue sauce is to an ice-cream sundae: not a typical component. Nor is there any reason to think Washington can administer health insurance with appreciably lower overhead than private companies.

Medicare supposedly does so, but that is partly because it doesn't have to engage in marketing to attract customers, which this program would. It also spends less than private companies combating fraud and unwarranted treatments—a type of monitoring that spends dollars while saving more.

As the Congressional Budget Office has pointed out, "The traditional fee-for-service Medicare program does relatively little to manage benefits, which tends to reduce its administrative costs but may raise its overall spending relative to a more tightly managed approach." False economies are one reason Medicare has done a poor job of controlling costs.

But a public program of the sort Democrats propose doesn't have to control costs, because in a pinch it can count on the government to keep it in business. Competition is healthy, but how are private companies supposed to compete with an operation that can tap the Treasury?

Students of the Obama economic policy will also note a curious consistency in its approach to economic issues. Some problems, like the near-collapse of General Motors and Chrysler, came about because competition worked very well at serving consumers and punishing poorly run companies. Some problems, such as high health insurance premiums, came about because competition allegedly didn't work so well. In both cases, the administration proposes the same solution: more federal spending and a bigger federal role.

Will introducing a government-run insurance program work? After all, that Nigerian financial scam works. Just not necessarily the way you hope. ■

Steve Chapman's twice-a-week column is distributed by Creators Syndicate. This article can be found at reason.com/archives/2009/07/16/the-public-option-health-care

Markets, Not Mandates

How medical markets would improve health care and reduce costs.

By Ronald Bailey

The New York Times calls it "possibly the most complex legislation in modern history." The health care "reform" currently being hammered out by the Democratic leadership of the House of Representatives already clocks in at $1 trillion and 1,000 pages—and it's nowhere near done. But one thing is clear: the legislation attempts to substitute top-down mandates from a centralized bureaucracy for the distributed decisions made by millions of consumers, physicians, and insurers acting in a marketplace. This will fail.

While congressional reform efforts screech and shudder along, let's take a moment to dream: What would real reform look like? It would be consumer driven, transparent, and competitive.

Right now consumers are locked into the health insurance and health care plans that their employers choose, thanks to previous government meddling with the health care system and the tax code. Consequently, most consumers simply don't have a clue what their health insurance costs. They have no way to reduce those costs, and no incentive to do so, even if they could.

Harvard University business professor Regina Herzlinger is stuck in exactly the same place as most Americans—her employer, in this case, the president of Harvard, buys her health insurance for her. "I wouldn't permit him to buy my house or my clothing or my food for me. Yet as my employer, he could take up to $15,000 of my salary each year and buy my health insurance for me, without knowing anything about my preferences or needs. It's ridiculous." Indeed it is.

The first step toward real reform is to give consumers responsibility for buying their own health insurance. The employer-based health insurance system must be dismantled, and the money spent by employers for insurance should be converted to additional income.

Third party payments are the main source of dysfunction in the American health system. "The devil systematically built our health insurance system," once suggested Princeton University health economist Uwe Reinhardt. As evidence, Reinhardt pointed out that it "has the feature that when you're down on your luck, you're unemployed, you lose your insurance. Only the devil could ever have invented such a system."

So the first step toward real reform is to give consumers responsibility for buying their own health insurance. The employer-based health insurance system must be dismantled, and the money spent by employers for insurance should be converted to additional income. This would immediately inject cost consciousness into health insurance decisions.

Since governments have been intervening in and distorting medical markets for more than a century, there are no examples of truly free-market medicine in any of the developed countries. (Switzerland is probably the nearest that any developed country comes to having a free market in health care and health insurance.) So it is impossible to know what might have happened had health care markets been allowed to evolve. While there are hints of what a market system might look like embedded within our current mess, much of what could happen under medical markets is tough to predict. Nevertheless, here's one partial vision of how a system of competitive health care and health insurance might develop if real reform were adopted.

The typical American might purchase high-deductible health insurance policies that would cover expensive treatments for chronic diseases such as heart disease, cancer, AIDS, diabetes, multiple sclerosis, or the catastrophic consequences of accidents. Coverage would also include expensive treatments such as heart surgery, organ transplants, dialysis, radiation therapy, etc. In addition, Americans would be able to buy health-status insurance that would guarantee that they could purchase health insurance at reasonable prices in the future.

The good news is that such policies are available even now. A quick check on online health insurance clearinghouse eHealthInsurance pulls a quote of $131 per month from Anthem Blue Cross Blue Shield for a single 55-year-old male with a $3,000 annual deductible, no co-pay after the deductible, reasonable pharmaceutical benefits, and lifetime maximum benefits of $7 million, with a health savings account (HSA) option. With HSAs, consumers make annual deductible contributions, which lowers their income tax bills, and then take tax-free withdrawals to pay for routine uninsured medical costs. That was the cheapest plan, but over 80 other insurance policies were available. Of course, as deductibles went down, the prices for other plans went up.

So markets mean more choice in health care, but would they make it cheaper as well? President Barack Obama famously read surgeon Atul Gawande's *New Yorker* article, "The Cost Conundrum." Gawande argues that medical costs are high because incentives are skewed toward providing ever more treatment as a way for physicians to earn more money. Gawande analogizes health care to building a house without a general contractor. Without someone keeping an eye on what's really necessary or desirable, house buyers would pay an electrician for

See next page

every outlet he recommends, a plumber for every faucet, and so forth. Doctors get paid for each procedure they recommend. Curing patients becomes an incidental side effect of their treatments. What matters, says Gawande, is not who pays.

Gawande gets his diagnosis right, but botches his prescription. Cost-conscious general contracters exist in the housing market because of consumer demand, not government mandate. Similarly, consumer choices have driven the housing market to create the huge variety of options including high-rise condos, gated communities, rental apartments, manufactured housing, townhouses, and suburbs filled with ranch houses, Tudors, and Cape Cods. Competition in medicine would force physicians, hospitals, pharmaceutical companies, and other practitioners to figure out ways to reduce costs. Perhaps a medical general contractor model would prove most effective at lowering costs, but why not let some people go a different route?

Gawande also argues that consumers are not in a position to negotiate prices. In the New Yorker article, Gawande and Texas cardiologist Lester Dyke try to imagine how an elderly woman might bargain over bypass surgery. Gawande writes:

"They discuss the blockages in her heart, the operation, the risks. And now they're supposed to haggle over the price as if he were selling a rug in a souk? "I'll do three vessels for thirty thousand, but if you take four I'll throw in an extra night in the I.C.U."—that sort of thing? Dyke shook his head. "Who comes up with this stuff?" he asked. "Any plan that relies on the sheep to negotiate with the wolves is doomed to failure."

But Gawande and Dyke miss the crucial point—markets force the wolves to compete among themselves and end up benefiting the sheep. Cardiac surgeons and all other physicians would be vying with one another for patients helping to push down the costs. Competition would provide a strong impetus for medical practitioners to provide consumers with good information about the effectiveness of various treatments and drive innovation. Heart patients in future medical markets would be in a much better position to consider the risks, benefits, and costs of bypass surgery, stenting, pharmaceuticals, and/or stem cells for treating their disease.

Markets force the wolves to compete among themselves and end up benefiting the sheep.

Once consumers are unleashed, the medical marketplace would be transformed. Most likely, a lot of routine care would be done through retail health centers located in shopping malls, drug store chains, and mega-stores. Such centers would not be staffed with physicians but with nurse practitioners or other qualified personnel. Consumers would generally pay for routine, everyday care directly out of their health savings accounts.

Competition would also transform the medical information market, making it radically transparent. In fact, baby steps toward transparency have already begun. Angie's List now allows consumers to submit reports about their experiences with physicians. Sources of information for medical comparison shopping would proliferate, just as there are now dozens of publications devoted to comparing the features and prices of cars, computers, guns, and vacations. A core of savvy shoppers in the medical market will mean better price and quality comparisons for everyone.

Wondering what shopping in a competitive medical market might be like? Check out the admittedly clunky California government's common surgeries and cost comparison website. Browsing reveals that the cost for heart valve replacement varies from $72,000 to $368,000, and the cost for angioplasty varies from $9,000 to $204,000. Other websites, such New Choice Health, enable consumers to go shopping for relatively routine procedures like colonoscopies, laparoscopic hernia repair, and MRI scans. Prices for colonoscopies in Washington, DC, for instance, vary from $580 to $1,386, hernia repair from $974 to $2,519, and abdominal MRIs from $936 to $1,960.

Opponents of markets in health care worry that patients in extremis will be in no position to negotiate. Actually, the slow progress of the kind of chronic illnesses that are driving up health care costs—cancer, coronary artery disease—allow consumers time to shop around for suitable treatments. Prostate cancer patients can evaluate and choose between options like watchful waiting, various radiation therapies, surgery, and soon, a new biotech immunological treatment. Information gathering would take no more time than the current wait for a follow up appointment.

Finally, one would expect that competition would spark that virtuous cycle in which innovation progressively drives down costs, just as it has in so many other areas of commerce. Medical care would become ever more affordable and thus reduce the perceived need for government intervention on behalf of the poor. In the meantime, the government should dismantle its medical entitlement programs—Medicaid, SCHIP, and Medicare—and use those funds to provide vouchers to the poor who could then purchase health insurance and health care in the private market.

Why bother outlining a vision of how market reforms of health care might play out? Perhaps the impending collapse of top-down reform proposals will open up a policy discussion about how markets can improve health care and reduce its costs. One can dream, anyway. ■

This article can be found at:
reason.com/archives/2009/07/28/markets-not-mandates

Among the Cynics

When it comes to health care reform, Obama doesn't believe reasonable people can disagree.

By Katherine Mangu-Ward

It's funny—I don't feel like a fearmongering naysayer. And I haven't gotten a check from a health insurance lobbyist in ages. Actually, come to think of it, I've never gotten a check from the insurance lobby.

But Obama says that I am, along with (pick your poll) 30 to 60 percent of Americans who are not on board with massive government intervention in one of the biggest and fastest growing sectors of our economy. So it must be true.

I do have all the hallmarks of the cynic. "In the coming weeks, the cynics and the naysayers will continue to exploit fear and concerns for political gain," President Barack Obama wrote in *The New York Times* on Sunday, after gazing into the near future of the health care debate and seeing a dystopia full of "scare tactics." And it's true. I am "exploiting" "concerns." By expressing them. In print. In conversation. My 30 to 60 percent fearmongering brethren and I, cynics that we are, just keep having concerns.

We fearmongers and our "concerns" wield an unholy power over the political process. How else to explain what happened? A plan—noble in reason, infinite in faculties, in form admirable—was presented to the American people. The obvious genius of the plan failed to carry it through intact. As more details were revealed, more and more people got antsy about the whole endeavor. They mentioned their concerns to their congressmen, sometimes loudly. Congress got cold feet, and now everyone is sitting in time out, thinking about what they did wrong.

When Obama, the man of hope, tells this story, it sounds like a failure of the democratic process, corrupted by special interests who somehow forced all those people to holler at town meetings and forced me to write this article. Again, though, without the actual writing of checks. But someone of a non-cynical nature might equally see this story as a great success of participatory democracy, with representatives accountable to the people.

Obama saw the health care cynics coming a mile away. Back in the misty days of January 2007, he warned the Democratic National Committee about us. The "cynics," he predicted, would fight health care reform. "With such cynicism, government doesn't become a force of good, a means of giving people the opportunity to lead better lives; it just becomes an obstacle for people to get rid of. Too often, this cynicism makes us afraid to say what we believe. It makes us fearful. We don't trust the truth." He blended together his own health care plan, government as a force for good, and truth into a delicious rhetorical smoothie, and they ate it up.

But times have changed and on Saturday, in Grand Junction, Colorado, Obama indulged in a little psychologizing of the now-ascendant Other. He said he understood "why people are nervous" but then he clarified: "Whenever America has set about solving our toughest problems, there have been those who have sought to preserve the status quo. And these struggles have always boiled down to a contest between hope and fear." The people who are nervous are just timid, more susceptible than average to the "special interests" who do things like "use their influence" to get their "political allies to scare the American people." And they are contagious, passing on the fear themselves.

Sometimes it seems that Obama ascribes opposition to his agenda to a simple failure of intelligence, or perhaps perception. "What the cynics fail to understand," said the brand spanking new president on inauguration day, "is that the ground has shifted beneath them—that the stale political arguments that have consumed us for so long no longer apply."

Or perhaps people just have the facts wrong. If they weren't blinded by falsehood, surely they would hop right on board. On Thursday, this exchange between White House press secretary Robert Gibbs and ABC's Jake Tapper entertained the White House press corps for a couple of minutes. After squabbling over polls, (which might or might not show that more Americans disapprove of the president's handling of health care reform than approve, but that either way an awful lot of people didn't dig the plan) it finally got down to this:

TAPPER: ...why are they not with the president?

GIBBS: Look, I think part of it is some of these misconceptions.

Everyone needs someone to mischaracterize while engaging in political battle—remember all those Islamists who "hate our freedoms"? But the strangest thing about Obama's cynics-and-naysayers gambit is that it's no gambit at all. Every single time Obama implies (or says outright) that the people who disagree with him are confused, that they aren't listening properly to what he is saying, they they are in the thrall of liars, or that they are fearful or mean-spirited—he's doing it in good faith.

Obama's path is so clearly illuminated by the light of his own reason, he simply can't entertain another possible way of being, a different set of beliefs, held by an intelligent person who is well-informed and well-intentioned—or so his language about cynicism, fear, and lies strongly implies. His assumption of bad faith or idiocy on the part of his opponents is done, it seems, with a pure heart. ■

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The Consumer Is Not the Customer

Both parties promise to preserve one of the health care system's central problems.

By Jacob Sullum

The other day, I was trying to figure out why the paycheck deduction for my health insurance was higher than I had expected. When I called my insurer to ask what the total premium was, the customer service representative said it was none of my business.

Three-fifths of Americans, the share with employer-provided health insurance, are in the same situation: Since someone else buys insurance for them, using money they would otherwise receive as wages, they are in no position to shop around and typically do not even know the true cost of their coverage. This disconnect between payment and consumption is one of the central problems with the current health care system, contributing to rapidly escalating costs, insecurity, and the general lack of choice and competition. Yet both Democrats and Republicans insist upon preserving it.

Outlining his health care reforms last week, President Obama was at pains to reassure the public that "nothing in this plan will require you or your employer to change the coverage or the doctor you have." In fact, he said employers should be forced to provide health insurance (or, alternatively, contribute to a fund that subsidizes premiums).

Obama presented himself as the protector of job-based medical coverage against those "on the right" who "argue that we should end employer-based systems and leave individuals to buy health insurance on their own." That approach, he warned, represents "a radical shift that would disrupt the health care most people currently have."

The disconnect between payment and consumption is one of the central problems with the current health care system, contributing to rapidly escalating costs, insecurity, and the general lack of choice and competition.

Meanwhile, the Republicans, whose last president and last presidential candidate both proposed eliminating the tax incentives that encourage employers to offer health insurance in lieu of higher pay, seem to have abandoned that idea. One of their main complaints about Obama's plan is that it would reduce the number of Americans covered through their jobs.

Senate Minority Leader Mitch McConnell (R-Ky.) warns that one Democratic health care bill "would cause 10 million people with employer-based insurance to lose the coverage they have." The Republican National Committee claims "over 88 million people" who are covered through work "would lose current insurance under government-run health care."

It's no mystery why each party portrays the other as bent on destroying employment-based medical coverage. Surveys find that a large majority of people who have such insurance are happy with it. According to a recent Zogby poll, 77 percent of Americans oppose "taxing employer-provided health care benefits."

Yet it's the tax-free status of those benefits that favors them over cash compensation, maintaining a bizarre system in which most Americans get their health insurance—unlike their car, life, or homeowner's insurance—through their employers. As a result, they are insulated from the actual price of their insurance and are more likely to have plans with low deductibles that cover routine medical expenses as well as large, unpredictable costs. In choosing among providers, drugs, and courses of treatment, they have little incentive to economize and usually do not even know the relative costs of the various options.

The artificial dominance of job-based plans, along with misguided restrictions on where insurers can sell policies and what types of coverage they can offer, has stunted the development of alternatives. Even so, the large price difference between the job-based and individual insurance markets (some of which may be due to differences in the age and health of policy holders) suggests the savings that are possible when people decide how to spend their own money: In 2007 the average annual premium for nongroup health insurance was about $2,600 for single-person coverage and $5,800 for family coverage, compared to $4,500 and $12,100, respectively, for job-based plans.

In addition to enhancing competition and controlling costs, cutting the link between employment and health insurance would relieve the insecurity that many Americans feel about going without coverage when they lose or leave their jobs. Obama is right that it would be "a radical shift"—*radical* in the sense that it goes to the root of the current health care mess. ■

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reason.com/archives/2009/09/16/the-consumer-is-not-the-custom

Obama's Lies Matter, Too

The President pushes back against health care misinformation, then spreads a bunch of his own.

By Matt Welch

On Wednesday night a broad chunk of the American left, and an overlapping circle of media commentators, got what they'd been aching for since the beginning of August: A presidential bitch-slap of the lying liars who've been, in the words of stereotypical *L.A. Times* columnist Tim Rutten, "crowding out nearly all substantive and realistic discussion of the critical issues surrounding healthcare reform."

"But know this," President Barack Obama said in one of several such satisfying passages in his health care speech last night. "I will not stand by while the special interests use the same old tactics to keep things exactly the way they are. If you misrepresent what's in the plan, we will call you out."

Salon Editor in Chief Joan Walsh could barely contain herself at this nearly Snoop Doggesque display. "'We will call you out' on lies," she Tweeted. "love it!"

It is telling that so many people who claim to be speaking on the side of Truth, Justice, and the American Way of Journalism have consistently focused their outrage-o-meters at individual townhall attendees, political broadcast entertainers, and the lesser lights of a lame (if resurgent-by-default) opposition party, while letting walk nearly fact-check-free the non-irrelevant occupant of 1600 Pennsylvania Avenue. If calling out lies and misrepresentations about a significant policy proposal is such pressing journalistic business—and it should be!—you'd think the watchdogs might start with the guy doing the proposing.

The lies last night began in Obama's opening paragraph. "When I spoke here last winter," he began, "credit was frozen. And our financial system was on the verge of collapse." In fact, Obama spoke on Feb. 24, at least six weeks after credit markets began to thaw, and one week after he proclaimed that the passage of his $787 billion stimulus marked "the beginning of the end, the beginning of what we need to do to create jobs for Americans." Obama's speech that day wasn't about staving off a collapse, it was about cleaning up the mess and tackling long-ignored issues. Such as health care.

It's never encouraging when a politician who desperately needs to convince skeptical Americans of his fiscal sobriety starts off by slurring his words. As you might then infer, Obama was just warming up. "Insurance companies," the president announced, "will be required to cover, with no extra charge, routine checkups and preventive care, like mammograms and colonoscopies," in part because such prevention "saves money." Looks like someone forgot to tell the Congressional Budget Office, or other non-White House sources that have analyzed the cost-benefit of prevention.

Again and again last night, the president's numbers didn't add up. "There may be those—particularly the young and healthy—who still want to take the risk and go without coverage," he warned, in a passage defending compulsory insurance. "The problem is, such irresponsible behavior costs all the rest of us money. If there are affordable options and people still don't sign up for health insurance, it means we pay for those people's expensive emergency room visits." No, it means that, on balance, the healthy young don't pay for the unhealthy old. The whole point of forcing vigorous youth to buy insurance is using their cash and good actuarials to bring down the costs of covering the less fortunate.

Such fudges reveal a politician who, for whatever reason, feels like he can't be honest about the real-world costs of expanding health care. "Add it all up, and the plan I'm proposing will cost around $900 billion over ten years," he said, trying hard to sound like those numbers weren't pulled out of Joe Biden's pants, and won't be dwarfed by actual costs within a year or two. "We've estimated that most of this plan can be paid for by finding savings within the existing health care system–a system that is currently full of waste and abuse," he said, making him at least the eighth consecutive president to vaguely promise cutting Medicare "waste" (a promise, it should be added, that could theoretically be fulfilled without drastically overhauling the health care system). Any government-run "public option," he claimed, somehow "won't be" subsidized by taxpayers, but instead would "be self-sufficient and rely on the premiums it collects."

And in a critical, tic-riddled passage that many of even his most ardent supporters probably don't believe, Obama said: "Here's what you need to know. First, I will not sign a plan that adds one dime to our deficits–either now or in the future. Period." In case you couldn't quite read his lips, the president repeated the line for emphasis. Then: "And to prove that I'm serious, there will be a provision in this plan that requires us to come forward with more spending cuts if the savings we promised don't materialize."

If that "one dime" formulation sounds familiar, that's because Obama made—then almost immediately broke—the same promise regarding taxes on Americans earning less than $250,000 a year. Surely the no-new-deficits pledge is headed for the campaign dustbin faster even then that "net spending cut" we'll never see.

Such bending of the truth-curve matters, I daresay even more than the pressing issue of Marc Ambinder's "umpiric objections" to having the media take a former Republican vice presidential candidate seriously as a health policy commentator. Aside from the disturbing—if-predictable aspect of a com-

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Wanted: Honesty on Health Care

The president's health care lies might be injurious to your health.

By Shikha Dalmia

President Barack Obama walked into the Oval Office with a veritable halo over his head. In the eyes of his backers, he could say or do no wrong because he had evidently descended directly from heaven to return celestial order to our fallen world. Oprah declared his tongue to be "dipped in the unvarnished truth." *Newsweek* editor Evan Thomas averred that Obama "stands above the country and above the world as a sort of a God."

But when it comes to health care reform, with every passing day, Obama seems less God and more demagogue, uttering not transcendental truths, but bald-faced lies. Here are the top five lies that His Awesomeness has told—the first two for no reason other than to get elected and the next three to sell socialized medicine to a wary nation.

Lie One: No one will be compelled to buy coverage.

During the campaign, Obama insisted that he would not resort to an individual mandate to achieve universal coverage. In fact, he repeatedly ripped Hillary Clinton's plan for proposing one. "To force people to buy coverage," he insisted, "you've got to have a very harsh penalty." What will this penalty be, he demanded? "Are you going to garnish their wages?" he asked Hillary in one debate.

Yet now, Obama is behaving as if he said never a hostile word about the mandate. Earlier this month, in a letter to Sens. Max Baucus (D-Mont.), and Ted Kennedy (D-Mass.), he blithely declared that he was all for "making every American responsible for having health insurance coverage, and making employers share in the cost."

But just like Hillary, he is refusing to say precisely what he will do to those who want to forgo insurance. There is a name for such a health care approach: It is called TonySopranoCare.

Lie Two: No new taxes on employer benefits.

Obama took his Republican rival, Sen. John McCain (R-Ariz.), to the mat for suggesting that it might be better to remove the existing health care tax break that individuals get on their employer-sponsored coverage, but return the vast bulk—if not all—of the resulting revenues in the form of health care tax credits. This would theoretically have made coverage both more affordable and portable for everyone. Obama, however, would have none of it, portraying this idea simply as the removal of a tax break. "For the first time in history, he wants to tax your health benefits," he thundered. "Apparently, Sen. McCain doesn't think it's enough that your health premiums have doubled. He thinks you should have to pay taxes on them too."

Yet now Obama is signaling his willingness to go along with a far worse scheme to tax employer-sponsored benefits to fund the $1.6 trillion or so it will cost to provide universal coverage. Contrary to Obama's allegations, McCain's plan did not ultimately entail a net tax increase because he intended to return to individuals whatever money was raised by scrapping the tax deduction. Not so with Obama. He apparently told Sen. Baucus that he would consider the senator's plan for rolling back the tax exclusion that expensive, Cadillac-style employer-sponsored plans enjoy, in order to pay for universal coverage. But, unlike McCain, he has said nothing about putting offsetting deductions or credits in the hands of individuals.

In other words, Obama might well end up doing what McCain never set out to do: Impose a net tax increase on health benefits for the first time in history.

Lie Three: Government can control rising health care costs better than the private sector.

Ignoring the reality that Medicare—the government-funded program for the elderly—has put the country on the path to fiscal ruin, Obama wants to model a government insurance plan—the so-called "public option"—after Medicare in order to control the country's rising health care costs. Why? Because, he repeatedly claims, Medicare has far lower administrative costs and overhead than private plans—to wit, 3% for Medicare compared to 10% to 20% for private plans. Hence, he says, subjecting private plans to competition against an entity delivering such superior efficiency will release health care dollars for universal coverage.

But lower administrative costs do not necessarily mean greater efficiency. Indeed, the Congressional Budget Office analysis last year chastised Medicare's lax attitude on this front. "The traditional fee-for-service Medicare program does relatively little to manage benefits, which tends to reduce its administrative costs but may raise its overall spending relative to a more tightly managed approach," it noted on page 93.

In short, extending the Medicare model will further ruin—not improve—even the functioning aspects of private plans.

Lie Four: A public plan won't be a Trojan horse for a single-payer monopoly.

Obama has repeatedly claimed that forcing private plans to compete with a public plan will simply "keep them honest" and give patients more options—not lead to a full-blown, Canadian-style, single-payer monopoly. As I argued in my previous column, this is wishful thinking given that government programs such as Medicare have a history of controlling costs by underpaying providers, who make up the losses by charging private plans more. Any public plan modeled after Medicare will greatly increase this forced subsidy, eventu-

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mander in chief falling far short of telling the whole truth, there are practical impacts of presidential prevarications that should worry even those who'd rather live in China than in an America without universal coverage.

As the reform supporter and professional skeptic Mickey Kaus noted before the speech, "Obama doesn't need to get 'Republicans on board.' He doesn't need to get Blue Dog Democrats on board. He needs to get voters on board." Again last night, Obama invoked the boogeyman of "special interests" who "lie" in order "to keep things exactly the way they are," despite the fact that the special interests in this case are lining up to support the president, and that the critics of his plan tend to bemoan, not defend, the status quo. Opponents of his plan, he said, were "ideological"; Ted Kennedy's support for health care reform, meanwhile, "was born not of some rigid ideology, but of his own experience." Obama said his door was "always open" to those bringing "a serious set of proposals," and he slammed that door shut on any attempts to break the almost universally unloved link between employment and insurance. He yearned to "replace acrimony with civility," then got Democrats stomping on their feet with attacks against the Iraq War and "tax breaks for the wealthy." The center of the debate, as always, was wherever he chose to stand.

And above all else, Obama chose to shadowbox against the more extreme claims of the Sarah Palins of the world, rather than engage the most serious of the skeptics' arguments. No, the administration doesn't "plan to set up panels of bureaucrats with the power to kill off senior citizens," but what about the possibility of government cost-cutters frowning upon expensive hip replacement surgeries for the chronically old? No, the proposal doesn't amount to a complete "government takeover" of health care, but it does continue to expand the government's role (and, promises aside, expenses) in ways that make a deficit-whiplashed nation nervous. No, "no one would be forced to choose" a public option, but what about the argument that incentives would eventually push Americans from private insurance to the public plan?

There was one line in the speech last night that pointed to an alternative, more promising future: "My guiding principle," Obama said, "is, and always has been, that consumers do better when there is choice and competition." Unfortunately, the president evinces zero understanding of how increased regulation can reduce consumer choice, even or especially when the government joins the competition. And even if he did see the connection, we'd have good reason to suspect that he wouldn't talk about it openly with the American people. That, ultimately, worries me more than a senior citizen who wants to keep the government out of Medicare. ■

This article can be found at:
reason.com/archives/2009/09/10/obamas-lies-matter-too

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ally driving private plans out of business, even if that weren't Obama's intention.

But, as it turns out, it very much is his intention. Before he decided to run for office—and even during the initial days of his campaign—Obama repeatedly said that he was in favor of a single-payer system. What's more, University of California, Berkeley Professor Jacob Hacker, who is a key influence on the Obama administration, is on tape explicitly boasting that a public plan is a means for creating a single-payer system. "It's not a Trojan horse," he quips, "it's just right there."

At the very least, such a plan would always carry an implicit government guarantee that, should it go bust, no one in the plan would lose coverage. This guarantee would artificially lower the plan's capital reserve requirements, giving it an unfair edge over private plans. What's more, it is simply not plausible to expect that the plan wouldn't receive any start-up subsidies or use the government's muscle to negotiate lower rates with providers. If it eschewed all these things, there would be no reason for it to exist—because it would be just like any other private plan.

Lie Five: Patients don't have to fear rationing.

Obama has been insisting that the rationing patients would face under a government-run system wouldn't be any more draconian than what they currently confront under private plans. This is complete nonsense.

The left has been trying to address fears of rationing by trotting out an old and tired trope, namely, that rationing is an inescapable fact of life because every system rations whether by price or fiat. But there is a big difference between the two. Genuine rationing occurs when someone else controls access—how much of a particular good I can consume.

By that token, Obama's stimulus bill has set in motion rationing on a scale unimaginable in the land of the free. Indeed, the bill commits over $1 billion to conduct comparative effectiveness research that will evaluate the relative merits of various treatments. That in itself wouldn't be so objectionable—if it weren't for the fact that a board will then "direct financing" toward approved, standardized treatments. In short, doctors will find it much harder to prescribe newer or non-standard treatments not yet deemed effective by health care bureaucrats. This is exactly along the lines of the British system, where breast cancer patients were denied Herceptin, a new miracle drug, until enraged women fought back. Even the much-vilified managed care plans would appear to be a paragon of generosity in comparison with this.

Obama has repeatedly asked for honesty in the health care debate. It is high time he started showing some. ■

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Where's the Paying Customer?

Health care reform isn't serious until the patient is at the center of the picture.

By Nick Gillespie

As someone under 60 with what passes for private health insurance and, far more important, access to actual health care (insurance and care are two very different things that are routinely and wrongly conflated in discussions of "reform"), I realize that I wasn't the primary audience of President Barack Obama's speech last night. In this, I am more representative than you might think. About 80 percent of people under 65 (who are covered by Medicare) have coverage and upwards of 80 percent of people with health care rate their service very favorably.

Yet as the father of two young kids whose backs are already bowing under the weight of the debt and future taxes our nation has wracked up in the past couple of decades, I'm more than a little concerned. Especially when Obama's speech failed to clarify even the most basic points for which he seemed to be reaching. Those of us who have coverage through existing private and public plans, he explained, can sit tight. Nothing will change. All uninsured people will be forced to get coverage, but precisely what that means is vague, to say the least (especially since half of them could either afford coverage now or qualify for existing programs). Then there's his claim that a plan which will cost almost $1 trillion dollars over the next 10 years will not only not cost us anything but will actually save us money in the long haul. No government official—and certainly not a president who came into office vowing to veto pork-barrel spending and implement a net spending cut and then did the exact opposite—has credibility on that score.

On a more basic level: Is the so-called public option in or out? Without saying it has to absolutely, definitely be part of any reform, Obama likened the mythopoetical public option to public universities that compete with private universities to increase choice for consumers. Leaving aside a host of questions about the analogy, college costs are among the few that have been rising with the speed and intensity of medical costs. So how would this sort of competition reduce costs, one of the main goals, says Obama, of any health care reform worth the name? Indeed, the obvious similarity between higher ed and health care is that both systems rely on a third-party payer system where expenses are heavily subsidized (by employers, tax breaks, parents, federal grants, special loans, you name it) and the end consumers (patients, students) are shielded from knowing the full cost of the services they consume.

And when we look at rising costs, what's to be done with Medicare, which Obama singled out for inviolable preservation (it's "a sacred trust" to him) yet denounced as spendthrift? Following a report by his own economic advisers that said around 30 percent of Medicare spending could be cut without any reduction in quality of service, Obama says we need to squeeze existing government programs for savings that will largely pay for the reforms, which include measures such as capping out of pocket costs and mandatory coverage of routine diagnostic tests such as mammograms that will certainly increase consumption of health care. It's a no-brainer to squeeze a program that wastes 30 percent of its budget, but it begs the question of why it has never been done. Not since Obama took office, and not since Bush expanded Medicare spending by hundreds of billions of dollars on prescription drugs (a plan whose price tag more than doubled in less than five years), and not since LBJ's actuaries underestimated the future cost of Medicare in 1990 by roughly 644 percent.

Obama proudly proclaimed that his plan would "cost around $900 billion over the next ten years" but that it would "not add to our deficit." This is simply not credible and, as my colleague Matt Welch points out with regularity, is exactly what Obama has promised regarding his overall spending plans, which most certainly have added to our deficits for as long as we dare look into the future.

One of the great problems with health care reform is that it always takes place, perhaps necessarily, either at the most grandiose level of abstraction ("Now," thundered Obama, "is the time to deliver on health care," as if it's an easily defined commodity) or the least insightful level of anecdote ("One man from Illinois," intoned the president, "lost his coverage in the middle of chemotherapy because his insurer found that he hadn't reported gallstones that he didn't even know about").

Here's a more basic question when it comes to controlling costs: The easiest way to do this is to make the person doing the buying actually pay the price. You haggle more when the change is coming out of your own pocket. Or, alternatively, you splurge because you're worth it. Earlier this year, my coverage changed from a conventional network preferred-provider plan with a standard co-pay for prescription drugs to a high-dollar deductible plan in which I essentially pay the first $2,000 dollars of medical care I consume in a year (any unused money rolls over in a Medical Savings Account that I can use in the following year). As my doctor prescribed me a brand-name drug, I thought about the cost and whether there were any possible alternatives. For the first time I can recall, I actually had a conversation with my doctor—right there, in the examination room—about medical costs. We settled on a generic alternative, saving me roughly $75 on that particular transaction. More recently, we had a similar conversation, in

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Customer

which he didn't know the costs of a name-brand drug and a generic alternative—a sign that the medical system has a long way to go in terms of customer service. Imagine going into an auto shop and the mechanic not being able to quote you the price difference between a new and refurbished part.

Yet exchanges such as the ones above are small examples of price signals being injected into a system that has consciously erected a series of mufflers, walls, and funhouse mirrors precisely to make it impossible for consumers to even know what they are paying, much less how to evaluate alternative plans of action. The blame here is shared by government policymakers, insurance bureaucrats, and medical providers, all of whom have some stake in a status quo that serves them tolerably well. Any reform that doesn't explicitly and transparently harness the same basic market forces that have driven down prices and improved quality throughout the economy over the past several decades simply will not work at containing costs and thus, expanding access (cheaper, better goods and services, whether we're talking about automobiles or plane tickets or gourmet coffee, have a way of leaching out into every level of society).

Doctors and other health professionals, who assiduously work to limit the number of health care providers in a given field, bitch and moan all the time about how Medicare, Medicaid, and private insurers are driving down reimbursements for basic procedures. Yet somehow the overall cost of health care goes up, up, up. It's because the system, including the vague reforms being championed by Barack Obama in a speech designed to lay out his plan in detail, really don't do anything to empower the person at the center of the drama—the patient, the customer—with the sort of choices that might actually trigger changes that will either curtail costs or, same thing, improve the range and quality of services so that we are happy with the money we're shoveling out.

Until that discussion gets underway, any so-called reform will fail to deliver on anything other than empty promises. ■

This article can be found at:
reason.com/archives/2009/09/10/wheres-the-paying-customer