
Centralizing America's health care

The future of US health policy under Obama

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So far, President Barack Obama has expressed his preference for increased government involvement in the way health care is financed and administered in the United States.

"We have done more in 30 days to advance the cause of health care reform than this country has done in an entire decade," proclaimed Obama after signing a \$787 billion "stimulus" package in mid-February (Biden and Obama, 2009). In its final form, the law that was passed included \$150 billion in new annual public spending allocated to health care reform: \$87 billion for Medicaid, \$24.7 billion for COBRA¹ health insurance, \$19.2 billion for health information technology (IT), \$10 billion for the National Institutes of Health, and \$1.1 billion for comparative effectiveness research (Turner, 2009).

In addition to the controversial stimulus package, one of the first pieces of legislation signed by President Obama was the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA),² which expands federal funding for children's health insurance coverage (SCHIP) by \$33 billion over the next four years (Henry J. Kaiser Family Foundation, 2009).

Obama also recently asked Congress for an additional \$634 billion to be included in his budget for a "health care reform fund" (Pear, 2009, Feb. 26).

A new national health plan

ALTHOUGH the administration has not yet put forth all the details of its plan to

reduce the number of people without health insurance in the United States, it has given some indications as to the eventual structure of what it calls a "new national health plan" (White House, 2009).

The new public scheme would be modeled after the health plan already available to federal employees, and would be administered through a National Health Insurance Exchange (Obama, 2008). The public plan, which would be available to all Americans, would operate in competition with private insurance. The exchange would regulate the prices of insurance products for all participating insurers (public and private), and would offer subsidies to low income individuals to purchase a private plan or the new public plan.

There are many concerns being raised throughout America's health policy community regarding this proposal. Among these concerns is the worry that the new public plan could "crowd out" private plans. It has been suggested that, as with Medicare and Medicaid, the government may use its political power, economies of scale, and regulatory authority to obtain prices for medical goods and services that are lower than those paid by the rest of the market. This would create an unfair competitive advantage for the new public plan in terms of cost (Moffit, 2008). Furthermore, under these proposals, private insurers would not be able to deny coverage because of pre-existing medical conditions, and would be forced to charge all customers the same price, regardless of age or medical history (White House, 2009). This restriction on risk-adjusted premium pricing

would make it even more difficult for private insurance companies to compete. Consequently, more people would choose the public option, crowding out the availability of private insurance.

In addition, many worry that the new public plan would eventually be funded at the taxpayers' expense. The political influence over price and benefits in the public plan would create incentives for elected officials to subsidize the costs of the public plan through taxes. The history of previous government interventions in health insurance markets in the United States is not encouraging. Research indicates that the current Medicare and Medicaid programs are financially unsustainable (Sisko et al., 2009).

Furthermore, National Center for Policy Analysis (NCPA) President John Goodman contends that if a large number of people purchased the public plan and the plan resembled Medicare (likely offering lower fees than those charged by the private insurers), there would be unavoidable pressure "to evolve into a two-tier payment system with two-tier quality of care" (Goodman, 2008). However, considering that Obama's goal is to ensure that all Americans have an equal opportunity to access the same quality of health care, such a two-tiered health care system would not be what Obama wants.

A tightly controlled market led by a much cheaper government health insurance plan would also increase the possibility of moving towards a single-payer system if individuals began to drop their private coverage for the public alternative (Moffit, 2008). The idea that Obama's new public plan will lead to a

single-payer system has not only been expressed by single-payer opponents (Turner, 2009, Feb. 27), but has also been put forth by universal health care advocates as a means of strategically achieving a single-payer health care system in the long run. In early 2008, Paul Krugman, professor of economics and international relations at Princeton University, suggested that the Obama administration should introduce more “regulation, subsidies, mandates, plus public-private competition that could eventually lead to single-payer.” Krugman argued that a single-payer system is politically impossible in the short-term, but contended that if the above-mentioned policies were introduced, a single-payer system could be achieved over time (Krugman, 2008).

Centralized comparative effectiveness review

ONE of the most controversial proposals introduced by President Obama is the use of comparative effectiveness research as a means of controlling health care costs. The proposed Federal Coordinating Council for Comparative Effectiveness Research would conduct research and compare drugs, medical devices, and other methods of treating specific conditions. Supporters of the research council hope that by deciding which procedures and medical devices should be used, the council would be successful at reducing costs associated with expensive and ineffective medical treatments (Pear, 2009, Feb. 15).

However, some health policy experts wonder if the government would be best suited to perform this task. As Michael Cannon of the Cato Institute notes, “experience suggests the benefits of taxpayer-funded research may be zero” (Cannon, 2009a). Cannon argues that when federal agencies produce research that questions the value of a particular medical treatment, political pressure from industry is

usually successful in persuading the government to disregard the significance of their findings. Economic theory suggests that the government is not in the best position to provide objective comparative effectiveness research, as it often suppresses the private production of goods and services. In contrast, Cannon con-

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tends that a free market approach to comparative effectiveness research would increase the probability that providers and patients would use it (Cannon, 2009a). Under such an approach, independent third party organizations or industry representatives could conduct comparative effectiveness research, instead of the government. Grace-Marie Turner, president of the Galen Institute, argues that increasing government involvement in cost-effectiveness research would significantly distort incentives and “stifle medical innovation” (Turner, 2009, Feb. 27).

It has also been suggested that comparative effectiveness research would simply be used by the federal government as a means of controlling costs. For example, Peter Pitts, president of the Center for Medicine in the Public Interest, argues that “as currently organized, comparative effectiveness will be used to increase government control over the practice of medicine and introduce price controls” (Pitts, 2009). This is precisely what Dr. Scott Gottlieb, physician and resident fellow with the American Enterprise Institute, found when he studied the British health care system under the National Institute for Clinical Excellence (NICE)—that NICE’s real mission is to shelter Britain’s health care budget. Gottlieb found that since 2000, NICE has denied patients access

to over 200 of the newest cancer drugs that have shown to offer clinical benefits, which are currently being paid for in the United States by American insurers and Medicare (Gottlieb, 2008, Oct. 18).³

Finally, should the government become more involved, comparative effectiveness research would likely be

comprised of broad population averages (a one-size fits all approach) and would overlook the unique medical needs of individual patients (Pear, 2009, Feb. 15).

Centralized and subsidized information technology

HEALTH information technology (IT) is another area where Washington is planning to expand its reach. Under Obama’s proposal, hospitals would have a mandate to collect and report data on health care expenditures and outcomes, with the goal of reducing administrative costs while improving clinical outcomes (White House, 2009). A recent study has shown that an increased use of information technology leads to lower mortality rates, fewer complications, and lower overall costs (Amarasingham et al., 2009). However, skeptics in the health policy community are concerned that the significant funding for health IT does not pass the cost-benefit test (Cannon, 2009b), and past experience suggests that these apprehensions are warranted.

A recent *New York Times* article looked at the Marshfield Clinic, a health clinic in Wisconsin that has been one of the country’s leaders in innovative health IT. The author points out that the clinic can show quantifiable savings in certain areas, “but has scant proof they

outweigh the millions spent in the past and the \$50 million-a-year technology budget" (Lohr, 2008, Dec. 26).

Similarly, a 2008 study on the costs and benefits of health information technology published by the Congressional Budget Office (CBO) found that savings were observed in certain settings, but that health IT alone would not produce significant savings. The study affirmed that IT could reduce costs if broader system-wide incentives were in place to encourage savings (Congressional Budget Office, 2008).

While some people in the health care community believe that health information technology is critical, many find the task better suited to the private sector where the appropriate economic incentives are in place. Greg Scandlen, president of Consumers for Health Care Choices, notes that the British government has gone way over budget in its attempts to implement more information technology for its National Health Service (NHS). According to Scandlen, the market is in a better position to test and refine new ideas, and thus health IT should be examined from a market-oriented perspective instead of a government one (Scandlen, 2009). As Turner argues, a great deal must be done to improve American health care, but "more government is not the answer" (Turner, 2009, Feb. 27).

Conclusion

THE significant funding allocated to health reform in February's stimulus package and Obama's almost immediate extension of COBRA demonstrate that the new president has made health care reform one of his top priorities. A number of other controversial proposals, such as giving the federal government the ability to negotiate drug prices for Medicare recipients and allowing the importation of medicines from other developed countries, are also being debated among health experts.

On the political side, Tom Daschle's withdrawal as Obama's nominee for Secretary of Health and Human Services temporarily took some of the steam out of Obama's proposals. However, on March 2, Obama formally nominated Kansas Governor Kathleen Sebelius as Secretary of Health and Human Services. While governor of Kansas, Sebelius tried to implement policies similar to those now proposed by the Obama administration.

Notes

1 COBRA (Consolidated Omnibus Budget Reconciliation Act) is a program that allows people who have lost their jobs to keep their employment-based health insurance coverage for approximately 18 months (Centers for Medicare and Medicaid Services, 2008).

2 Formerly known as SCHIP (State Children's Health Insurance Program), CHIPRA expands federal funding for low-income uninsured children (over the next four years) who are not eligible for Medicaid. The program, which was supposed to expire in 2007, was reintroduced to Congress on two separate occasions in 2007; however, then-President George W. Bush vetoed the bill both times (Henry J. Kaiser Family Foundation, 2009).

3 Although not necessarily correlated, Gottlieb points out that cancer survival rates are significantly higher in the United States than they are in the United Kingdom.

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