PERSONALLY SPEAKING

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CRAM-DOWN CRIPPLING HEALTH CARE

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Cram-down is the expression used today to describe the forced easing of mortgage terms in order to rescue a homeowner from default and foreclosure. In brief, cram-down is a court-ordered reduction of the balance owed on a home mortgage allowing the homeowner who has filed for personal bankruptcy to reduce his/her monthly payment and forcing the mortgage holder to write off a portion of the unpaid balance.

Cram-down is a fundamentally unjust practice because it forces the mortgage holder to accept less from the homeowner than they both agreed to originally and voluntarily and to which they committed themselves in a written contract. The principle of equivalence states that the parties to any exchange agreement are ethically required to exchange things of equal value and impose equal burdens on one another. With cram-down the mortgage holder is forced to accept a new contract where the benefits and burdens shift in favor of the homeowner. It's the coercion that offends our sense of justice.

On the other hand, cram-down is defended as necessary to protect the homeowner who presumably has been making a good-faith effort to keep up with his/her monthly payments but simply is overwhelmed financially. In the end, cram-down is doubly unjust when the loss to the mortgage holder is greater than gain to the homeowner. At best cram-down is an act of mercy which silently and coercively redistributes income from mortgage holders to homeowners.

Cram-down has been a regular practice in health care financing for years. There are three basic types of cram-down in health care. The first type involves third-party payers, including private health insurance companies and public insurers such as Medicare, along with public welfare programs such as Medicaid and SCHIP (State Children's Health Insurance Program), which often do not fully reimburse health care providers including hospitals, physicians, and others for services rendered. To illustrate, it is not unusual for a third-party payer to force the provider to accept one-half or even less of the charges submitted for services rendered to a specific patient.

The second type involves patients who present at a hospital emergency room and must be treated under the provisions of a 1986 federal law which fines a federally-funded hospital and physician up to $50,000 for refusing to admit a person in need of emergency care even if that person has no way of paying for the services rendered or refuses to pay. In some

cases, the hospital may stabilize and transfer such a patient -- a "no-pay"-- to another facility in a practice known as "dumping."

The third type closely resembles mortgage cram-down in that the patient who cannot pay seeks relief through bankruptcy.

In addition to dumping, there are at least four other responses to cram-down from health care providers. First, they refuse to accept or consult on patients whose third-party payers are well known for cram-down. Second, they run large numbers of patients through their office-based practice to compensate for cram-down thereby in effect running a "Medicare/Medicaid mill." Third, they close their office-based practice and retire or in some instances become hospitalists hired and paid by a hospital to render care to patients in their area of specialization. Fourth, they reduce their work effort by quietly walking away from parts of their overall practice to which for years they volunteered their support or accepted as a part of their duty even when the reimbursement did not cover their costs.

One of the first bills passed by Congress and signed by President Obama was H.R. 2 which extends health coverage to an additional 4.1 million children who previously were not covered by SCHIP. Obama is reported to have said that this expansion is "a down payment on my commitment to cover every single American." In other words, it is a big step toward universal health care.

The added cost of SCHIP which allows states to get full access to federal matching funds to cover children in families with incomes up to three-times the poverty threshold ($63,000 for a family of four) is to be paid from a 62 cents increase in the federal tax on cigarettes and similar increases on other tobacco products. Even before H.R.2 was passed, SCHIP was known for cram-down. It likely will retain that reputation among providers under the expanded coverage.

The increase in the tax paid by smokers and users of other kinds of tobacco products may not yield the estimated $30 billion in additional revenues over the next five years because the cigarette business for years has been plagued by counterfeit cigarettes and counterfeit federal tax stamps which are sold to merchants attracted by the wider profit margins available selling counterfeit products to an unsuspecting public. The increase in the tax makes counterfeiting even more lucrative. Actual federal revenues from this source which fall short of the expected $30 billion could intensify cram-down.

To cope with cram-down some providers are transforming their practices so that their patients are seen by a nurse-practitioner rather than a physician without necessarily changing their fee structure. Access to care is provided though it may not be the same quality of care available from a physician. This option is attractive because hiring and paying a nurse-practitioner instead of a physician, at the same time maintaining the same fee structure, reduces the financial impact of cram-down.

Cram-down is a form of forced income redistribution. Private insurers do it to hold down their expenses and thereby offer coverage at lower premiums. Public payers, both state and

federal, do it to hold down budget deficits and to avoid having to raise taxes to cover the additional cost of expanded coverage. Universal health coverage, as promised by the Obama administration, will lead to more cram-down, more restricted access to quality health care, and more income redistribution unless steps are taken to provide the necessary revenues to cover the costs of that care. Without the funds to arrest cram-down, universal health coverage does not fix a financially broken health care system. Quite the contrary, it violates the first principle of health care: do no harm.

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