PERSONALLY SPEAKING

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PUBLIC HEALTH INSURANCE LEADS TO FEDERAL CONTROL OF HEALTH CARE

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The White House's public health insurance option will lead inevitably to a single-payer system. For years both Medicare and Medicaid have "crammed down" reimbursement rates for services rendered by hospitals and health care providers including pharmacies such that they have been forced to shift unreimbursed costs to other payers notably private insurance companies. Thus, private health insurance rates are higher today in part because Medicare and Medicaid do not reimburse adequately for services provided.

In some cases, reimbursement is below the actual cost to the provider for services rendered. The Louisiana Hospital Association states that in FY2008 Medicaid "cram down" exceeded $150 million. The Louisiana legislature is proposing to cap reimbursement for neonatal care at roughly 50 percent of the average cost of care in a neonatal intensive care unit. Any hospital with an intensive care unit for newborns will have to figure out how to handle expenses above that cap. The reason for setting this limit is the State's current budget crisis forcing deep cuts in Medicaid reimbursement.

The problem is not limited to Louisiana. The Henry Kaiser Family Foundation reported earlier this year that the "economic downturn is affecting *every state budget and Medicaid program,* in some cases causing severe distress." It follows that Medicaid "cram-down" will become even worse, leading to more cost shifting where private insurers are forced to pay a portion of cost of care for indigent patients which Medicaid does not reimburse resulting in higher private health insurance premiums.

With the Obama administration's public health insurance option the same "cram down" practice will continue in order to bring down federal expenditures on health care. This practice will force providers to shift unreimbursed costs to private insurers, forcing them to raise premiums, and enticing persons and companies with private coverage to switch to the less expensive public insurance program. Inevitably, the only remaining insurance program will be public health insurance – a single-payer system. Bright university students who in the past were willing to undertake the costs and rigors of a pre-med program and medical school followed by years of specialized training and often long hours under the threat of a malpractice lawsuit will think twice about a career in "cram-down" medicine.

President Obama claims that the public health insurance option does not amount to socialized health care because under his plan the federal government does not assume *ownership* of health care facilities and therefore does not transform those who work in the system into public employees. True enough, but a single-payer system is one in which the government *controls* health care. Private ownership with federal control is a fine distinction without a real difference.

Twenty-five years ago Canada adopted a single-payer health care system that many would like to see adopted in the United States. Even now, however, the Minister of Health reports that the system's most prominent concerns are patient charges and queue jumping, practices which restrict access to care. Queue jumping involves private-pay patients who are moved ahead of others for medically necessary health services. Patient charges involve private physicians ("extra-billing") and facilities ("user charges") charging patients for those services. The provincial governments are required to report those practices to the federal government and are penalized accordingly.

Senator Kennedy has introduced a health reform bill which runs 615 pages in length and would greatly expand the role of government in the health care system. Mayo Research Institute will review and comment on Kennedy's bill in a future report.

Virtually any student of economics will tell you that whenever a product or service is offered free of charge, it is overused. With greater federal involvement in health care, expansion and overuse are predictable, imposing heavy demands on the federal Treasury and intensifying "cram down." Some providers will be driven out of the system; others will walk away. Some will take only private-pay patients or as in Canada allow private-pay patients to jump the queue ahead of others covered by the single-payer plan. The health services which the market no longer allocates will be allocated by politicians and government bureaucrats.

What is being sold to Americans today as access to quality, affordable health care is unattainable for one compelling reason. Americans want the best care available, but as the record shows are not willing to pay for it. "Cram-down" reduces what Medicare and Medicaid pay providers for *rendering* health care services. It does not reduce the cost of *providing* those services. Unless and until the American public learns that lesson, there is no fixing a system which is financially broken.

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