Is Obamacare's Failure Intentional, to Promote Medicaid-for-All?

By Devon Herrick Filed under Health Alerts, single payer on October 11, 2016 with 17 comments

A recent commentary in the Wall Street Journal announced, "Obamacare's meltdown has arrived." Health insurance premiums all over the country have skyrocketed. Numerous insurers have pulled out of state and federal exchange marketplaces. Many consumers have only one choice of health insurer and can choose from only a couple different plans. State health insurance CO-OPs have been falling like dominos and the program is now all but defunct.

None of this should have come as a surprise. Over the years I've heard conspiracy theories that Obamacare was designed to fail to nudge a reluctant nation one step closer to a single-payer system of socialized medicine. Think of this as Medicaid-for-All.

Bernie Sanders famously advocated for single-payer socialized medicine during his campaign. In 2011, the Vermont legislature passed a bill to create a single-payer initiative. Green Mountain Care was abandoned in 2014 by Vermont's governor — a Democrat — as being too costly. Green Mountain Care was going to require an 11.5 percent payroll tax and an additional sliding-scale income tax that topped out at 9.5 percent. Despite the heavy tax burden, a single-payer system in Vermont was projected to run deficits by 2020.

A similar initiative is now taking place in the pothead capitol of Colorado. Amendment 69, popularly called *ColoradoCare*, would create a taxpayer-funded health insurer. ColoradoCare would replace most forms of private health insurance and would cover nearly all state residents, including Medicaid enrollees. Federal health insurance programs, Medicare, TRICARE and the VA would remain separate.

ColoradoCare would be funded by a 10 percent payroll tax and a 10 percent tax on nonwage income. The payroll tax could not rise without voter approval and the income subject to the tax would be capped at $350,000 for individuals and $450,000 for couples.

Proponents tout potential savings in lower overhead, no need for profits, no need for marketing and no high executive salaries like are common at a for-profit insurers. That argument is bogus. An analysis by the Colorado Health Institute (CHI) found the program would operate in the red from day 1 and the deficits would grow each year. The CHI analysis also found the "savings" from lower overhead, less administrative costs, lower hospital fees would about equal the "new expenses" from covering the uninsured and higher utilization by people whose taxpayer-funded care is now nearly free. In other words, the savings from a Single-Payer program in Colorado is a big, fat goose egg.

The CHI analysis found the program would almost breakeven in its first year (2019). In 2019, ColoradoCare would cost about $36 billion, losing only $253 million. By 2028, ColoradoCare would run an $8 billion deficit — more than $100 per member per month.

Spending just on hospitals will be approximately $11 billion in 2019. Of this a single-payer system would save only about $800 million on hospital costs (about 7 percent). This is a pittance of the projected $36 billion in total medical spending.

Why so little? The proponents of Medicaid-for-All fail to appreciate that single-payer systems implemented at the state level do not really represent single-payer systems with true monopsony power, like Canadian Medicare or the British National Health Service (NHS).

The Vermont experiment expected hospitals and doctors to accept fees that were about the same as what Medicare pays. Medicare pays hospitals about 70 percent of what private insurers pay and reimburses doctors about 80 percent of rates paid by private insurers. ColoradoCare would pay fees more generous than Medicare, but presumably less than private insurers.

This brings up an important point for all you Singe-Payers People out there. Allow me to clue you in on a dirty little secret about Single-Payer. To really lower costs, Single-Payer systems have to strong-arm providers into accepting *lower fees* and *reduce* unnecessary utilization (not encourage it). All health care systems — including single-payers — have to use rationing techniques. In most markets, *prices* are the standard form of rationing. In health care systems that don't use prices, individuals have to be discouraged from getting expensive care in other ways. In Canadian Medicare this is done by limited access to high-tech equipment. Other forms of non-price rationing include *rationing by waiting* and exercising monopsony power. By definition, a single payer is a monopsony — the only purchaser of a good or service. If you are the only purchaser in the state, you can dictate the prices you are willing to pay. Hospital and physician fee negotiations are basically "take it or leave it." Economic theory suggests a monopsony should set prices where most providers participate, but enough exit to create a slight

shortage, which is where rationing by waiting comes in. To significantly reduce medical expenditures under a single payer system, hospital fees would have to be lower than what Medicare pays today. Doctors, medical device makers and drug companies would face a similar squeeze on fees and prices.

Most Single payers also refuse to pay providers piecemeal. Canadian Medicare does not reimburse hospitals on a fee-for-service basis. Neither does the NHS. Rather, hospitals are allocated a fixed, annual budget. From this budget, hospitals are expected to care for all patients who need care in the area. To actually save money, a true single payer system in the United States would have to allocate a similar (at-risk) global budget based on hospitals' licensed beds and occupancy. Hospitals would probably receive token payments for treating actual patients, since hospital districts would not want to compensate area hospitals for doing nothing. Years ago British and Canadian hospitals were accused of keeping seniors in the hospital to recuperate long after they could have been discharged to a nursing home. Warehousing convalescing seniors was cheaper than admitting new patients, who were sicker. These convalescing patients were called "bed blockers" because they allowed hospitals to treat fewer new admissions.

A single payer is not some magical entity that rains down savings from Heaven by being unconcerned about profit. Rather, a single-payer is a more like a predatory HMO with no competition. It is currently in vogue for hipsters to matter-of-factly announce the simple solution to health reform is single payer. Be careful what you wish for.

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1. *Barry Carol* says:

   October 11, 2016 at 1:24 pm

   It would probably be good for the country to try single payer at the state level somewhere so it could definitively fail once and for all. If CO wants to try it, that's fine by me. If NJ wants to try it, then not so much.

   I think the notion that the ACA was deliberately designed to fail gives the designers of the legislation way too much credit. They're not that smart. Medicare and coverage provided by large employers are seeing costs grow more slowly than they grew prior to the ACA implementation. Even federal Medicaid spending is up less than 4% for the first 11 months of this fiscal year according to the CBO. The exchanges are failing because of adverse selection. That's not an issue for the rest of the insured population.

   Reply

   - *Devon Herrick* says:

     October 11, 2016 at 1:40 pm

     You make a good point. The last place I would try single-payer is a small state with porous borders like Vermont. Many of the people who work in the state do not live there and pay taxes. Many of the people who live there work outside the state. Colorado is a different story. None of the states it borders have much of a presence close to the border. However, it still isn't large enough to have any real pricing authority. People point to Medicare as an ideal

model. They forget that Fee-for-Service Medicare has problems and Medicare Advantage is administered by private firms.

Reply

2. *Ron Greiner* says:

October 11, 2016 at 1:33 pm

Devon – YOU know that Obamacare herds Americans into dangerous employer-based health insurance and over-priced Medicaid. The government protects the large insurance company MONOPOLIES and could care less about the uninsured. I don't think that a single payer system, to reduce profits, is really the goal.

The corruption is so bad that President Trump will repeal Obamacare and then families will be able to purchase low cost health insurance once again in the land of the free.

Medicaid will cost over $25,000 a year for a broke family of 4 here in Tampa Bay (zip code 34691). In contrast, a 30-year-old couple and 2 children can get a major medical Short-Term-Medical PPO for $310.33 a month with a $5,000 deductible. What a scam being played on the taxpayer and the American citizen. There are 850,000 doctors in the PPO network and 6,900 hospitals.

Like MIT Gruber said, "Thank GOD that Americans are brainwashed and stupid."

President Trump will repeal Obamacare and make America great again — Vote Trump

Reply

- *Bart I* says:

  October 12, 2016 at 8:12 pm

  How is short-term medical less dangerous than employer coverage?

  Reply

  - *Ron Greiner* says:

    October 13, 2016 at 9:33 am

    ERISA doesn't stop STM lawsuits for one. Democratic MN Gov. Mark Dayton says, "The Affordable Care act is not Affordable!"

    What's his problem with Obamacare premiums going up over 50%?

    Reply

3. *Lee Benham* says:

October 11, 2016 at 9:32 pm

Screw it! I give up. I'm voting democrat across the board this election. Where do I sign up for all my free crap?

Reply

- *Ron Greiner* says:

  October 12, 2016 at 8:46 am

  You are voting for Hillary the TRAITOR? Hillary gave America's uranium to Russia – it's too sick – she needs to go to prison along with a lot of DC politicians.

  Jon Rappoport asserts – If you're Putin and you're sitting in Moscow, and the uranium deal has just dropped this bonanza into your lap, what's your reaction—after you stop laughing and popping champagne corks? Or maybe you never really stop laughing. Maybe this is a joke that keeps on giving. You wake up in the middle of the night with a big grin plastered on your face, and you can't figure out why…and then you remember, oh yeah, the uranium deal. The US uranium. Who's running the show in America? Ha-ha-ha. Some egregious dolt? Maybe he's

a sleeper agent we forgot about and he reactivated himself. And this Foundation—how can the Clintons get away with that? And she's going to be the next President? Can we give her a medal? Can we put up a statue of her in a park? Does Bill need any more hookers?

You shake your head and go back to sleep. You see a parade of little boats carrying uranium from the US to Russia. A pretty line of putt-putt boats. You chuckle. Row, row, row your boat…merrily, merrily, merrily, merrily… life is but a dream.

Reply

- *Bart I* says:

October 12, 2016 at 8:12 pm

> Where do I sign up for all my free crap?

Colorado.

Reply

4. *Bob Hertz* says:

October 12, 2016 at 4:54 pm

Ron, the short term plan that you mention would not be available to the 30 year old spouse if she was pregnant. And if she got pregnant while on the policy, she almost certainly could not renew it.

This is still a good policy for a lot of people. Just that there is always a reason for extremely low prices.

Reply

5. *Bob Hertz* says:

October 12, 2016 at 5:08 pm

Note to Barry and Devon:

I agree that the failure of the ACA was not strategic or deliberate.

The model for the ACA, if anyone is interested, was the managed competition program promoted by Alain Enthoven and adopted fully in Denmark.

http://www.allhealth.org/briefingmaterials/wsj-naik-1166.pdf

This called for multiple insurers, a tough mandate, full community rating, and a 6.5% payroll tax which was mainly to fund a strong risk adjustment program.

Instead the Pelosi crew debuted with a weak mandate, age rating, and chump change for risk adjustment.

Reply

- *Devon Herrick* says:

October 12, 2016 at 5:11 pm

Yeah I agree it was a poor attempt at *managed competition*. It also lacked the conformist, homogeneous, healthy population that is more characteristic of Denmark.

Reply

6. *Bob Hertz* says:

October 13, 2016 at 7:56 am

Devon, thanks also for your point about global budgets for hospitals. The true believers about single payer, Drs. Himmelstein and Woolhandler, have been calling for global budgets for 25 years.

The idea is not without appeal. If hospitals got the bulk of their funding from taxes, not user fees, they would become more like fire departments. The fire department does not need to know if a fire victim has insurance; the fire department does not need a billing department to try and collect from insurance companies; the fire department does not need to work for nothing, cost shift, or hire collection agencies to collect from uninsured fire victims. This has got to produce a cheaper hospital system.

However — the actual operation of a global budget is almost impossible to imagine in the USA. A bureaucracy like CMS would analyze population density or whatever, and then decide that the Sandstone MN hospital should have a budget of $5 million.
Fine, but what if Sandstone's current budget is $10 million? (this would happen a lot in rural areas.)
The result would be layoffs, and anyone who lives in a small town as I do knows that hospital jobs are an absolute pillar of the middle class.

As for a CMS bureaucrat dictating the budget of the Mayo Clinic, give me a break.

One single payer advocate a few years ago suggested that the government should just buy all the private hospitals. For how many trillion dollars?

No, we just have to limp through more modest attempts to hold down hospital inflation.

Reply

- *Devon Herrick* says:

  October 13, 2016 at 8:52 am

  Bob you raise an important point. Lobbyists for providers would fight tooth and nail to prevent meaningful payment reform. Actually, the hospital in Sandstone MN might benefit from treating people who under the old system would not have had insurance. But, teaching hospitals in Massachusetts would necessarily have to be weaned off the public trough. Some hospitals might have higher cost-sharing than others. That does not offend me.

  At first glance I'm a little leery of your fire department analogy. Public pensions and pay is relatively high, the locations somewhat political and it's hard to measure productivity. In my town the fire truck follows just about every time an ambulance is dispatched as a "training" exercise.
  With hospitals there would likely be some bureaucratic version of a Medicare Cost Report, where a global budget is a function of patients treated, their (stripped down) diagnoses codes, and equipment purchased. An empty hospital would get nothing. A hospital at capacity with higher acuity would get more than a hospital with 85% occupancy (that was filled with bed blockers).

  One thing I find so strange about the Canadian system is how MRI machines set idle while people wait for weeks to get a scan. Why cannot those machines run 24/7? For that matter, how come I'm never given the option of getting an MRI or a surgery at 3:00am rather than 8:00am? General Motors runs their plants 24 hours a day. But a lot of medical equipment sits unused most of the time.

  Reply

  - *Barry Carol* says:

    October 13, 2016 at 9:52 am

    A key difference between fires and medicine is that except for small fires that can be quickly extinguished with a fire extinguisher, a fire doesn't typically resolve itself until after it causes a lot of damage and burns itself out. By contrast, a lot of medical issues do resolve themselves within a day or two. If people knew they could go to a hospital and not have to pay anything, they may be inclined to go just to seek reassurance if nothing else. Demand for medical care could be potentially infinite if no payment was due from either patients or insurers. Demand for firefighters is far from infinite because people know if they have a fire that won't resolve itself and will only seek fire-fighting services under those circumstances.

    As for hospital budgets, I could envision trying something like the following. A community hospital within a region gets a base amount per licensed bed that's enough to cover perhaps half of fully allocated costs at a normal, sustainable occupancy rate. The rest of needed revenue is generated the way it is now but at much lower fully transparent prices that are largely paid by patients or by insurers after a fairly high deductible is met. Moreover, an empty bed would be paid a slightly higher amount than an occupied bed but still not enough to cover fully allocated costs.

    I think Switzerland does something like this by covering about one-third of hospital operating costs through general tax revenue. Academic medical centers would also need to be paid enough to cover their education

and research missions on a fully allocated basis so those costs wouldn't have to be built into the prices they charge for care.

Reply

- *Ron Greiner* says:
  October 13, 2016 at 10:03 am

  A key difference between fires and medicine is that fire departments are not destroying the future like Socialized Medicine in America.

  Our debt, what we are doing to our children, our grandchildren and all future generations of Americans is beyond criminal. Thomas Jefferson and other founding fathers warned that government debt was simply thievery from future generations, and they were exactly right. If future generations get the chance, they will look back and curse us for what we have done to them.

  Earlier today I looked up our national debt, and it is currently sitting at $19,688,773,606,117.54. That means that Barack Obama has officially become "the 9 trillion dollar man".

  Healthcare has become one big fat ugly bubble.

  Reply

7. *Bob Hertz* says:
   October 13, 2016 at 11:55 am

   I like your approach, Barry, but covering one third of hospital costs through federal funds would I think require $200-$300 billion a year. Maybe Medicare would be paying less, and some money can come from that source.

   However I am always wary of funding one gov't program through anticipated savings from an existing program.

   Reply

8. *Barry Carol* says:
   October 13, 2016 at 12:14 pm

   40% of Medicare costs are attributable to Part A which is hospital care. Another 40% is for Part B and a large part of that pays doctors for care that takes place within a hospital setting. More and more of those doctors are salaried employees of hospital systems. The same ratios also apply to commercial insurance claims for those with employer coverage and people who buy policies on the individual insurance market or the ACA exchanges. I'm not sure what the Medicaid breakdown is but a bigger piece of that program pays for skilled nursing care and home healthcare. Any incremental financing would most likely have to come from a value added tax assuming savings for Medicare and Medicaid would not be enough to implement an approach like this.

   Reply

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