



Three Roadblocks on the Road to Health Reform

By Robert B. Helms

As Barack Obama prepares to assume the presidency, discussions of his health care reform proposals will become more prominent. Private health insurance, Medicare, and Medicaid, as currently configured, are obstacles to reform. If we want real reform, we have to change the open-ended payment policies of these three key health care components.

The election is over and the health care reform debate has entered a new phase. President-elect Obama has restated his commitment to health policy reform and has made several appointments to his new team of health policy leaders. Several members of Congress are issuing new health reform plans and jockeying to be leaders in what many are saying is the best chance for health reform in decades.

If history is any guide, the road to health care reform will not be an easy one. Presidents Truman, Carter, Reagan, Clinton, and Bush (G. W.) have all proposed comprehensive reforms that have all been rejected by Congress. President Johnson succeeded in getting Medicare and Medicaid passed in 1965, but these were new public programs for the aged, poor, and the disabled, not an overall reform of the health care system.

In fact, many health policy analysts point out that Medicare and Medicaid adopted the basic payment policies of private insurance, thereby making overall reform even more difficult. As we have seen time and again, making a lot of noise about health reform does not guarantee change.

What do we want from reform, and what will it take to get us there? To answer this question and see why reform is so difficult, let us look at the three largest components of our health care system—

private health insurance, Medicare, and Medicaid—and look at how they work. Each of these major sectors of our health care system creates a roadblock to reform. Each is an open-ended system of payment that encourages everyone involved—consumers and providers—to use more resources than they would in a more normal, less-insured market.

First Roadblock: Private Health Insurance

In 2007, private health insurance and direct payments by individuals accounted for 46 percent (\$1.04 trillion) of total health expenditures (\$2.3 trillion). The modern form of private health insurance began in the 1930s, but the industry's major growth occurred after World War II. The percentage of those with hospital coverage increased from 10 percent (12.3 million) in 1940 to almost 90 percent (178 million) by 1975.

Modern drugs and new medical knowledge increased the demand for medical care. But since medical care was expensive to only a small number of sick people, it created an opportunity for the development of commercial health insurance. Consumers could agree for the payment of a relatively small premium in exchange for the promise of an insurance company to pay the larger costs of a medical event if such treatment became necessary. Increases in the population and higher family incomes also boosted demand for health insurance.

Robert B. Helms is a resident scholar at AEI. A version of this article appeared in the November 2008 issue of *ChamberLink*.

Furthermore, a somewhat unintended change in tax policy made it advantageous to acquire health insurance through employers rather than as individuals, as one might do with life, fire, or auto insurance. During WWII the National War Labor Board excluded the value of employer-provided health insurance from its wartime wage controls.

An unintended consequence of this policy was to induce employers to offer more health insurance as a way around the limits on wages. After the war, this tax treatment effectively lowered taxes for those American workers who could get health insurance from their employer. As a result, the exclusion of the value of employer-provided health insurance from taxable income increased the demand for employer-based health insurance relative to individual insurance. Since the tax exclusion was open-ended, it created strong incentives for employees and unions to bargain for more extensive coverage (more coverage of physician care, drugs, mental health, etc.) and less cost-sharing.

This kind of health insurance covered more people and more medical services, but did so in a way that encouraged more expenditure with little regard to the cost-effectiveness or value of the services. The tax treatment of health insurance is still open-ended, giving employers and insurers little reason to develop more cost-effective health insurance policies.

Second Roadblock: Medicare

The second major sector of our health care system is Medicare, the government program providing health care for the aged and the disabled. In 2007, Medicare expenditures accounted for 20 percent (\$444.7 billion) of total health expenditures. Medicare originally adopted the payment policies used by private insurance in the 1960s, the practice of paying the cost of the claims submitted by licensed physicians and hospitals. This fee-for-service system is still in place for about 82 percent of the Medicare population. The remaining 18 percent are in the Medicare version of managed care.

Like private health insurance, Medicare's fee-for-service payment system is open-ended. As such, it creates incentives to submit more claims as a way of receiving more payment. The more the government clamps down on payment rates, the greater the incentive to submit more claims. Thus, spending rises with little worry about either the medical or economic effectiveness of the services. The result is very high increases in the cost of the program and dire predictions of impending bankruptcy.

Third Roadblock: Medicaid

The third major sector of our health care system is Medicaid, the joint federal and state program covering the poor and the disabled, including many of those in nursing homes. In 2007, Medicaid expenditures were 15 percent (\$336.5 billion) of total health expenditures. Operating under federal rules, the states still have a lot of flexibility about how they run their state programs: who they will cover, what benefits they will provide, and what payments they will make to providers. Compared to private insurance and Medicare, Medicaid programs in most states have the reputation of paying the lowest rates.

The present system of open-ended payment policies continues to reward wasteful spending rather than a careful consideration of costs and benefits.

These frugal payment policies save some money but force many patients to seek care in hospital emergency rooms because they cannot find a physician that will accept Medicaid patients. The payment rules also bring about early and inappropriate admission of the aged and disabled to nursing homes when the rules do not allow them to use more cost-effective care to stay in their homes. The federal government and many of the states are trying to reduce inappropriate nursing home use through new programs.

Medicaid programs suffer from the same open-ended payment policies we have seen in the other two sectors—policies that encourage excessive use of services with little regard for their value. But this is not the only problem with Medicaid.

The program suffers from an additional open-ended payment policy that inflates the cost of the program at both the state and federal level. Medicaid is an open-ended entitlement funded by both the federal and the state governments. The federal government matches qualified state expenditures based on a formula that gives higher matching rates to states with lower levels of per capita income. In 2008, Mississippi got the highest matching rate, 76 percent, while 13 of the wealthiest states—such as New York and Connecticut—received the minimum matching rate of 50 percent. This payment policy, designed to advantage the low income

states, ends up inducing the wealthier states to expand their program relative to the poorer states. This causes more federal dollars to flow to states with higher per capita incomes, not the states that have the largest populations of poor people and people without health insurance. For example, in 2006 Vermont received \$7,753 in Federal Medicaid payments per poor person in poverty (state population at 125 percent or less of the federal poverty line), Rhode Island received \$6,817, and New York received \$6,462. At the other end of the scale, federal Medicaid dollars per poor person were \$2,014 in Nevada, \$2,150 in Texas, and \$3,354 in Mississippi. This poor distribution of federal Medicaid dollars will continue to increase as long as the present open-ended payment policy continues.

Getting Around the Roadblocks to Real Health Care Reform

Medical and health policy journals are now full of articles, mostly written by physicians, about what is wrong with our present system and what it will take to reform it. These articles put major emphasis on the need to base medical decisions on new knowledge about medical outcomes and cost-effectiveness, on more attention to lifestyles and prevention, and the use of computers (IT) to improve efficiency.

These are obviously good ideas that would lead to improvement, but people must have an incentive to do these things before any real progress will be made. The present system of open-ended payment policies does not encourage this kind of change because it continues to reward wasteful spending rather than a careful consideration of costs and benefits. If we want to get to real reform, we have to change the open-ended payment policies of private insurance, Medicare, and Medicaid, the three principal financing sources that now funnel money to physicians, hospitals, and other providers.

There are many proposals designed to replace the existing open-ended payment policies with a fixed or limited payment. For example, to reform employer-based health insurance, the simplest proposal is to cap the amount of health insurance that a firm can provide tax free. This would create strong incentives for firms and insurance companies to redesign their health insurance policies so that their costs stay below the cap. Designing these more cost-effective policies would give everyone more reason to seriously consider the value of IT, prevention, and evidence on medical outcomes. More complicated proposals along these lines involve adding a refundable tax credit to assist low-income people to purchase health insurance.

Medicare reform proposals envision giving each eligible person a fixed voucher that could be used to purchase one of several federally approved health plans. Each plan would be required to cover a set of defined benefits and compete with other plans to provide quality service to Medicare beneficiaries.

Proposals to reform the Medicaid program also take a variety of approaches all designed to provide a fixed payment to the individual or to the state. The federal formula could be modified to allocate federal money to the states based on each state's population of the poor and disabled. The states could also be given more incentives to use managed care plans that would have stronger incentives to effectively manage the care of the disabled and those with chronic conditions. State experiments have shown much promise for programs that allow more of these beneficiaries to receive care in their homes rather than in nursing homes.

What we all seem to want from health reform is a better system that will provide us with higher quality care and greater economic value. To achieve this kind of reform will require us to end the open-ended payment systems we now have and replace them with systems that reward quality and value. The longer we wait to start, the more difficult this kind of change will be.