OPPORTUNITY 08
Independent Ideas For Our Next President

Meeting the Dilemma of Health Care Access
Extend Insurance Coverage while Controlling Costs

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Summary

Health care is the nation's largest—and, in many respects, most important— industry. It is a large share of the nation's economy and a major source of employment, to be sure, but, by improving people's health and reducing disability, it promotes productivity across the economy and improves quality of life. The dollar value of Americans' improved health over the last three decades approximates the value of all other economic growth combined, and much, though not all, of that gain is traceable to improved health care.

The U.S. health care sector is growing rapidly, and, on the private side (hospitals, doctors' offices, clinics) provides jobs for more than 15 million people. Government programs pick up about half of the tab.

- In 2008, total health care spending is projected to reach $2.4 trillion, or 16.5 percent of the U.S. Gross Domestic Product (GDP)—accounting for a larger share of GDP than any other single industry.
- The federal government spends more on health care than on Social Security and national defense combined, the next most costly items.
- Between 2007 and 2024, federal spending on Medicare and Medicaid (measured as a share of GDP) is projected to double, and, by 2036, to triple.

In addition to rising costs that are straining public and private budgets, the financing and delivery of health care is marked by pervasive problems:

- Although *total* benefits from health-care-related reductions in mortality and morbidity vastly exceed the increase in *total* health care spending, additional dollars spent at a given time appear to buy little or nothing of value.
- Geographic variation in spending is large, with residents of high-spending regions gaining no apparent benefit in health status or longevity.
- Nearly 46.6 million Americans had no health insurance coverage in 2005, and millions more had minimal coverage. If current cost trends continue, the number of uninsured will keep rising, potentially reaching 56 million by 2013. Quality is seriously flawed. The Institute of Medicine has estimated that each year between 44,000 and 98,000 Americans die because of medical errors. Millions more receive the wrong care or fail to receive appropriate care.
- Well under 10 percent of those who suffer injury or death from medical negligence receive compensation for these mistakes. Though few are compensated, much is spent on cumbersome administration of the malpractice system. And inept providers face only weak incentives to improve their skills or cease practicing.

The next President and Congress will confront major health policy decisions with far-reaching effects on the life of virtually every American. What candidates say about health care policy will therefore be central in voters' judgments about whom they will support. This brief guide to health care reform describes basic characteristics of the U.S. health care system and four broad strategies for change.[1] Most likely, the next President will have to choose some variant of the following specific options:

- increasing consumers' share of health costs through high-deductible insurance, as an alternative to expanding employment-based coverage
- incremental change to strengthen and extend employment-based health coverage, through reinsurance or making federal insurance programs (Medicare, Medicaid, or the Federal Employees Health Benefits Program) more widely available
- universal health insurance by means of "Medicare-for-all"

[1] A companion paper describes more detailed strategies in three key areas: Medicare reform, improving the quality of health care, and reform of the malpractice system.

- support for state-level reforms—which may be the most politically feasible of these alternatives

Context

Compared to the 10 other wealthiest nations, the United States spends nearly twice as much per capita on health care, yet life expectancy at birth is shorter—77.5 years versus 79.3 years—and infant mortality rates are higher—6.9 versus 4.4 deaths per 1000 live births. Our health care system spends so much because it treats more patients intensively and with higher technology care than do most other nations and because the unit price of health care services is higher. In addition, our financing system is uniquely cumbersome and costly.

In truth, the United States does not have a health care financing "system," but rather a bedlam of uncoordinated payment arrangements. In most other developed nations, one or a few organizations pay hospitals and physicians, often through annual budgets or simple formulas (such as set fees per patient day). But here, money flows to providers based on complex price lists for services rendered, detailed diagnoses of patients at admission, and myriad contractual arrangements. Payments come from various federal agencies (primarily the Centers for Medicare and Medicaid Services, the Defense Department, the Indian Health Service, and the Veterans Administration), from every state, from hundreds of counties and municipalities that run public hospitals, from thousands of insurers (each regulated by one of 50 independent state insurance regulatory agencies), from tens of thousands of self-insured employment-based plans (subject to federal regulation), and from the millions of patients who directly pay for at least part of the cost of care they receive.

In all developed nations, health care spending has outpaced income growth for decades. Between 1960 and 2004, annual health care spending grew 2.7 percentage points a year faster than income in the United States and Japan, 2.6 in France, 1.9 in the United Kingdom, 1.8 in Germany, and 1.5 Canada, according to the OECD. The size of this differential depends on public policy, changes in the average population

age, the pace of technological change, and GDP growth in the specific country. During the 1990s, the gap between growth of health care spending and income temporarily vanished in the United States, as managed care encouraged modest restrictions on use of health services and billing scandals triggered aggressive federal government efforts to root out fraud and over-billing by hospitals and physicians. However, the gap reemerged in 2000, and, if it persists, health care's share of total spending will inevitably rise.

Technological Change: Is Health Care Different From Other Industries?

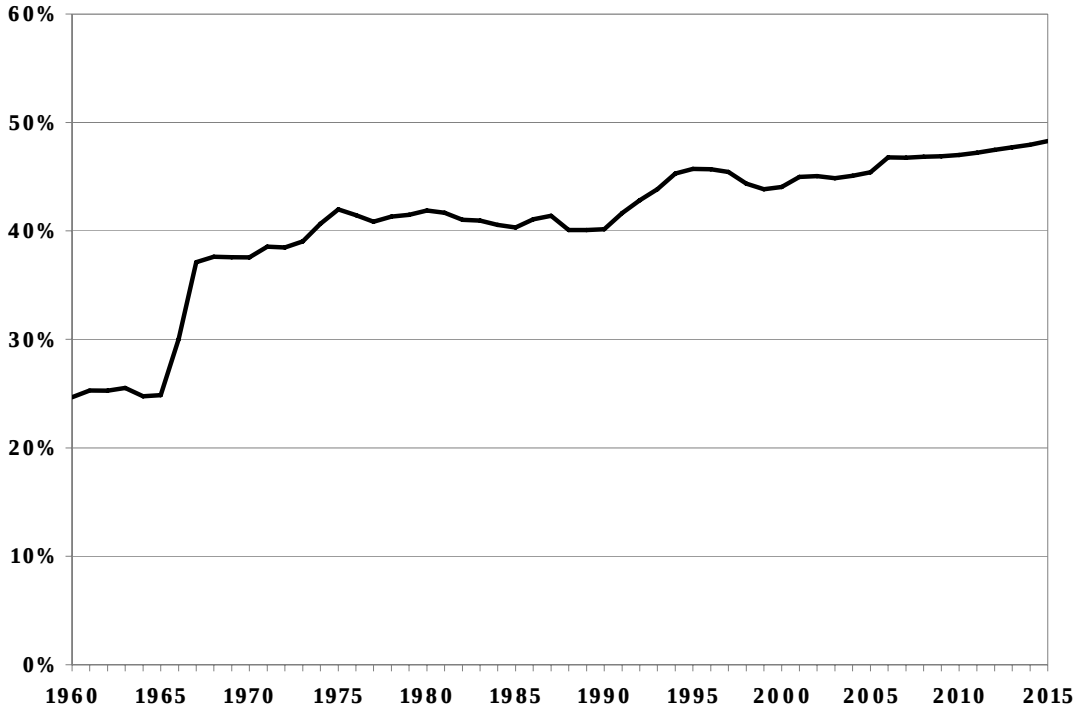
How technological change affects health care spending is much misunderstood. Technical advances usually result in lower prices, but increased total spending, as the technology is widely adopted. This pattern has been evident in transportation (rail, air), entertainment (movies, television, recorded music), telecommunications, and data processing. That technological advance has increased health care spending seems obvious. The impact on price is less clear. Official health price indices are seriously flawed. The fundamental problem is that it is very hard to measure quality and to value capabilities that did not exist previously. Careful studies of the price of treating victims of heart attacks and mental illness, however, indicate that improved technology has lowered prices after adjustment for improvements in quality.

People generally celebrate technological advances, as demonstrated by their spending patterns. They buy a DVD player to replace their VCR; they upgrade their home computer. In other words, they think the goods are worth what they cost or more. By contrast, many analysts believe that, because health insurance pays for most or all of care, the link between payment made and value received is broken, and much health care spending goes for services that provide few benefits relative to cost. The challenge is to squeeze out low- and no-benefit uses and bring down prices without unduly sacrificing beneficial care.

Health Care Spending: Public

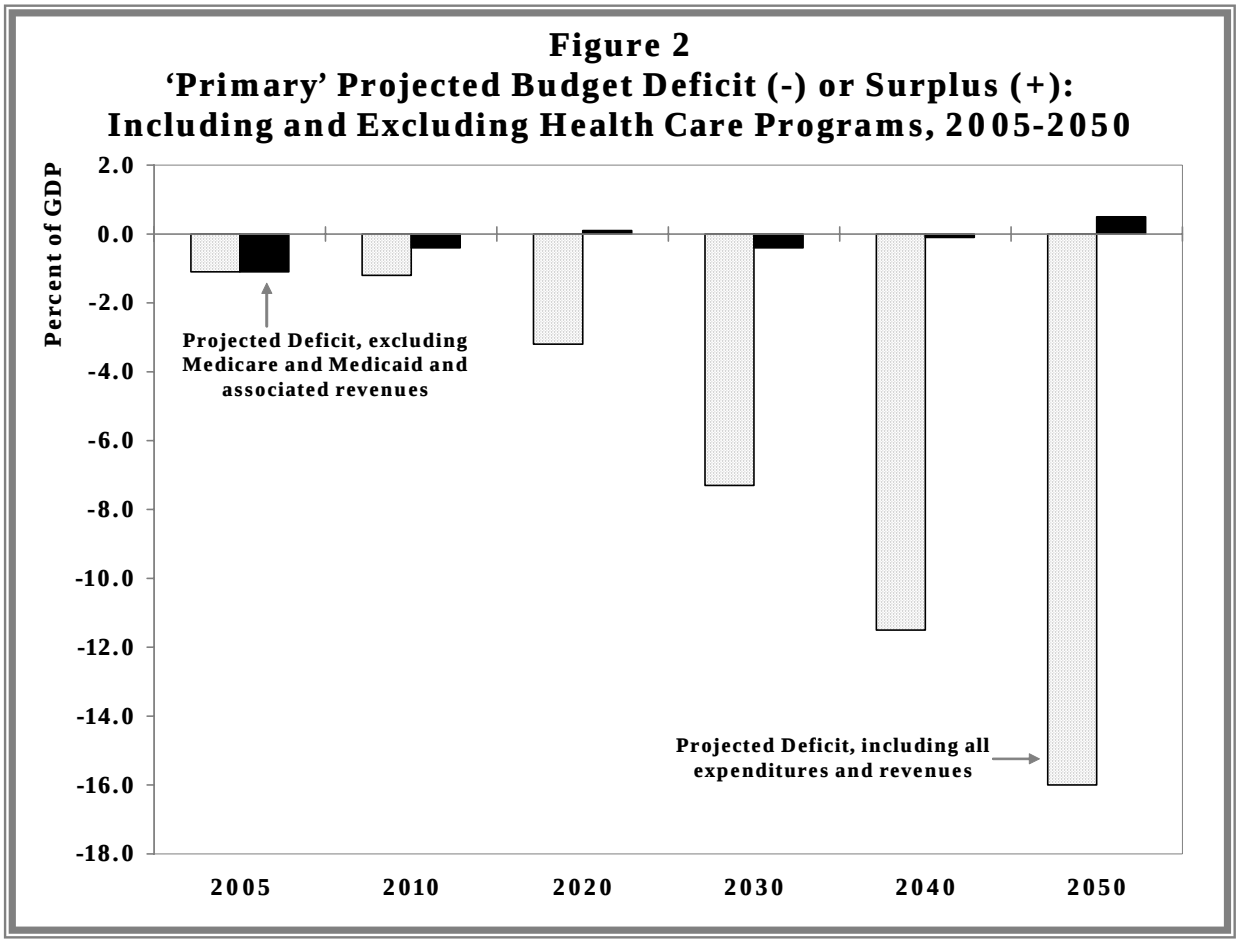
Federal and state governments pay for a large and growing fraction of health care spending, principally through Medicare and Medicaid (Figure 1), with other programs covering Native Americans, veterans, and the military and their dependents. Government health care spending is expected to continue increasing rapidly, less because of the much ballyhooed aging of the baby boom generation than because per capita health care spending is expected to continue to grow much faster than income.

Figure 1
Government as Percent of Total Health Care Spending, 1960-2015



Current projections indicate that total federal spending will grow far faster than revenues between 2005 and 2050, producing large and unsustainable deficits. The projected growth of Medicare and Medicaid spending is responsible for all of the gap (Figure 2). To say that future budget problems are traceable to excessive government spending on "entitlements" in general is therefore misleading. If Medicare and Medicaid expenditures and all revenues earmarked or currently committed to them are

removed from the equation, projected government revenues will be adequate to pay for all other government spending, including growing outlays on such entitlements as Social Security, food stamps, and the Earned Income Tax Credit.

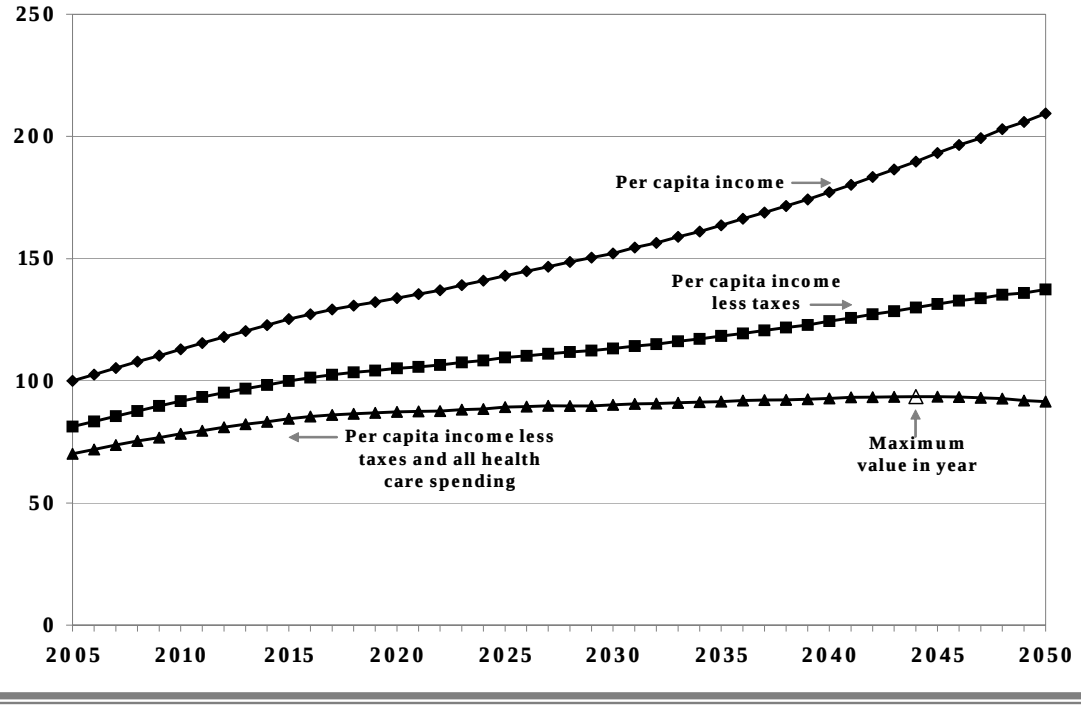


Of greater importance, the economic challenge that arises from increases in health care spending is the result of increases, not just in government spending, but in private spending, too. Unless the U.S. citizenry is prepared to allow health care standards to fall when people become old, disabled, or poor, private health care spending increases must be controlled, in order to significantly slow the growth in Medicare and Medicaid spending.

The stakes in achieving such control are enormous. If health care spending outpaces income growth by 2½ percentage points a year—a bit less than the historical average of the past four decades—and if economic growth proceeds at the rate projected by the

Congressional Budget Office, per capita income available for purposes other than health care will still grow strongly for the next decade, but then will stagnate and eventually fall (Figure 3). Simply put, the United States faces a *health care financing challenge—public and private*—that it cannot ignore. It does *not* face a *general*, *government entitlement* problem.

Figure 3
Real Per Capita Income, Per Capita Income less Taxes, and Per Capita Income less Taxes and All Health Care Spending, 2005-2050



Health Insurance Coverage

Trends in health insurance coverage are not encouraging. Overall, coverage has fallen gradually and unevenly for two decades. The availability and generosity of employment-based insurance oscillates with the business cycle, and recently the proportion of Americans with this type of coverage has fallen sharply. Government-sponsored health insurance, particularly Medicaid and the State Child Health Insurance Program (SCHIP), has taken up some of the slack. As a result, a larger fraction of U.S. children had health insurance in 2004—more than a quarter of them covered by

Medicaid—than in any other year since 1987, when comprehensive statistics were first published.

Continued rapid growth of health care spending threatens our system of employment-based health insurance. The average annual health insurance premium for a family—$10,880 in 2005—about equaled the earnings of a full-time, minimum-wage worker. Economists argue about whether small changes in the minimum wage much affect employment, but few doubt that doubling the minimum wage would cause many workers to become unemployed.

Perceptions that employer-based insurance is providing less generous benefits and requiring higher deductibles and other cost-sharing are widespread. Unquestionably, out-of-pocket spending has risen since 2000, but so has per capita health care spending. The net result is that the *share* of total health care spending paid directly by individuals actually has not increased, nor has the share paid by insurance fallen.

Reform Choices Addressing System-wide Cost Control and Increased Insurance Access

Rising costs and narrowing coverage mean that the next President must decide whether to push reform of the U.S. health care system, and, if so, how. The electorate has every right to expect each candidate to tell them whether he or she will make system-wide reform a top priority and, if so, which of the following four broad strategies they propose.

High-Deductible Insurance

The Bush Administration sought to make high-deductible health insurance the norm, and the next President could sustain that effort. Under this approach, patients must pay directly for health care spending up to a dollar limit higher than most current insurance plans require. Beyond that limit, insurance would cover all or nearly all costs of care. Tax incentives would encourage most people to set aside monies in special health savings accounts (HSAs) to pay for most outlays below the deductible.

The government would subsidize HSA deposits for low-income households. Unused balances would eventually be available for general consumption or for bequests, which advocates claim would encourage account holders to spend these dollars more carefully than they do when insurance lets them spend "other peoples' dollars." They predict that the growth of health care spending would slow, making health insurance more affordable and thereby slowing or reversing the loss of insurance coverage.

The effect of such plans is more complex than this simple argument suggests. Large deductibles do greatly reduce spending, compared to first-dollar coverage—perhaps by as much as 30 percent. But few people have first-dollar coverage now. Furthermore, spending by some people would likely increase, notably by the currently uninsured who, because of tax incentives or reduced premiums for high-deductible insurance, could finally afford coverage. The bottom line is that net savings are hard to gauge.

Incremental Change

The second strategy seeks to strengthen and extend employment-based coverage, rather than replace it. One means to this end would be for the federal government to provide reinsurance for all health spending above some threshold. The most immediate effect of such reinsurance would be to reduce insurance premiums, in effect shifting costs that are now paid through a premium to tax financing. Like any subsidy to insurance, this would make insurance more affordable and so decrease the number of uninsured. Nonetheless, there is some consensus across the political spectrum that unless the subsidy were large (that is, unless the reinsurance threshold were low), the reduction in the number of uninsured would be modest. One advantage of this approach is to decrease the cost to insurers of covering people deemed to be bad risks, making insurance somewhat more available to them. In general, the effects of this strategy on consumers may be weak. Approximately half of large and medium-sized establishments self-insure and commonly buy reinsurance already. In the individual and small group markets it would reduce the insurers' incentive to select against bad risks, but it would not eliminate it, since even with reinsurance such individuals would be unprofitable.

A second incremental strategy would be to authorize currently ineligible individuals or groups to 'buy in' to Medicare or to the Federal Employees Health Benefits Program (FEHBP). The right to 'buy in' could be extended to employer groups or other organizations. Premiums could be actuarially fair or subsidized. And, a third strategy would be to expand Medicaid eligibility—for example, to parents of currently eligible children.

The major advantage of the incremental strategy is also its principal weakness. It disrupts current arrangements least and requires few large shifts in financing that might necessitate large tax increases, generate windfall reductions in costs for businesses, or impose large payments on individuals. For these same reasons it would do little or nothing to simplify the current crazy-quilt of financing arrangements. Nor is it clear how it could significantly reduce the alarming growth in health care spending.

Medicare-for-All

A sizeable minority of Americans has long embraced the principle that a single, nationally uniform insurance plan should cover all Americans. One current embodiment of that strategy would enroll everyone in Medicare with a single menu of benefits financed jointly by earmarked taxes and premiums. As now, Medicaid could cover some or all premiums, cost-sharing, and additional charges for low-income enrollees. Medicare beneficiaries would continue to be able to join health maintenance organizations, where available, and Medicare would pay their premiums in place of covering standard benefits.

No advocate of Medicare-for-all has fully explained how it would work. Would employers be required to pay taxes equal to some or all of what they now spend on health insurance for employees? If so, how would the taxes be designed? What charges, if any, would be imposed on employers who currently do not offer health insurance benefits? In general, how would revenues be raised to cover insurance costs? What premiums and cost-sharing would people face? And, what relief from

these charges would low-income households receive? Would supplemental insurance, which most Medicare beneficiaries now have, be folded in? Would people now eligible for Medicaid shift to Medicare? Any candidate that embraces this approach should be prepared to answer such questions.

State-sponsored Reform

The final option is one of procedure. It arises from frustration that national decisionmakers have been unable to agree on how to reform health care financing for seven decades and from recognition that the same system may not be optimal for a nation as large and diverse as the United States. Under this approach, the federal government would authorize individual states or groups of states to develop their own plans to extend health insurance coverage. If their plans met certain standards, the federal government would defray part of the costs of extending coverage, its payments calibrated to the state's progress in doing so. Congress would have to waive some restrictions in current federal health care programs so that states could combine funds in new ways. As states gather experience on what works, consensus on a national reform strategy might emerge. Alternatively, we might come to accept differing state or regional systems that reflect economic and political differences. Meanwhile, some of those now without health insurance would be covered.

This approach offers greater promise for extending health insurance coverage than it does for immediately controlling the growth of health care spending. It could build on experiments taking place across the country, as states try desperately to fill the vacuum in federal policymaking. It skirts the need for an elusive national consensus. It also might avoid a congressional showdown, since it already has garnered bipartisan support. In short, encouraging state-sponsored reforms may offer the only politically achievable way to extend health insurance coverage in the near future.

What No One Will Mention

No reform strategy that extends health insurance coverage to most of the nearly 47 million uninsured will immediately slow the growth of health care spending. On the

contrary, added expenditures by the newly insured will boost health care spending, at least in the short term. But achieving long-term control of government health care spending will require near-universal coverage, unless the nation is willing to offer health services to the elderly, disabled, and poor that are grossly inferior to those available to other Americans. First, to slow the growth of spending on a sustained basis, the federal government would have to adopt regulations to control outlays (which are generally accepted in other nations that spend far less than we do), including limits on total and institution-specific spending. Without near-universal coverage, hospitals and other health care providers that are subject to these spending controls would of necessity curtail care for the uninsured. The result could be widespread rationing of effective therapies for those now insured through public programs, with potentially serious health care consequences. On the other hand, elimination of waste and inefficiency in the current system could reduce the severity of any required rationing or delay its necessity. Second, the currently fragmented organization of U.S. health care financing precludes effective limits. Our costly "non-system" of health care financing needs to be streamlined and simplified before effective cost control is even possible. Thus, *achieving universal coverage is a necessary precondition to effective cost control.*

Whether universal coverage would be sufficient to solve the problem of rising health care costs is unclear. To rein in health care spending will require rationing—the elimination of health care services that are not worth what they cost. Rational resource reallocation presupposes that we know a great deal more that we do currently about which services cost more than they are worth, that we can develop fair and politically acceptable limits, and that we will be willing to enforce them.

Concluding Observations

As population aging proceeds and the menu of beneficial medical technologies continues to lengthen, per capita health care spending will increase. Consequently, the disposition of employers to drop coverage and of employees to refuse it even when it is offered will grow. These insecurities intensify during economic recessions.

Presidential candidates will feel strong pressure to speak to the issue of expanding health insurance in the face of rising health care costs. The four strategies outlined above each promises to extend insurance coverage, some more than others, and provide a starting point for that conversation.

About the Authors and the Project

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Opportunity 08 aims to help 2008 presidential candidates and the public focus on critical issues facing the nation, presenting policy ideas on a wide array of domestic and foreign policy questions. The project is committed to providing both independent policy solutions and background material on issues of concern to voters.

Additional Resources

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