

# Health Care Reform

## What Should We Expect?

by Gregg Davis

### Background

**D**uring the 1920s, there was a running joke: “There are two classes of people in hospitals: those who entered poor and those who leave poor.” Five years later, private health insurance emerged. Today, particularly for those without health insurance, the problems remain the same. And suspicion of the industry adds to our angst. A 2006 Harris Poll found that between 40 percent and 50 percent of the American public believes health insurance companies, managed care, and drug makers are among the least trustworthy organizations in the United States. A University of Connecticut professor even developed a “Healthcare Economic Misery Index” to gauge the amount of misery caused by the lack of health care insurance and the rising cost of health care.

Almost all agree that something systemic is inherent in health care that makes it different from other sectors in the economy. In polls across the country, fixing health care is right up there with fixing the economy. Emotions are high on both sides of the health care debate, as evidenced by President

Obama’s visit to Belgrade this summer where both supporters and opponents of the Obama-style reform showed up in large numbers. It’s not only an emotional issue but a financial one as well.



Google health care reform, and over 22 million options are generated. Concern over health care is not new. Over the last four decades, growth in the cost of delivering health care has persistently exceeded the overall average growth rate in the economy by nearly 2 percentage points. So as the size of the pie grows for the economy, the size of the slice gobbled up by health care is increasing even faster. That means less pie for everything else, clearly an unsustainable trend.

Compared to other developed economies, we spend more on health care in absolute terms (nearly \$8,000 per capita) and in relative terms (16 percent of our GDP). Absent reform, our country will spend nearly 20 percent of GDP on health care by 2017. That doesn’t leave much for everything else we desire and need.



Polls support the notion that to most people health care is a merit good, something that all are entitled to and no different than the right to food, shelter, and clothing. But not everyone has the same access to health care. In Montana, access isn't just limited by lack of insurance or cost but also by geography, and in some cases the lack of health care providers. Montana has 210 federally designated Health Professional Shortage Areas. These areas have a shortage of primary medical care, dental, or mental health providers. Only five of the state's counties escape designation as a Medically Underserved Area, an area that has too few primary care providers, high infant mortality, high poverty and/or elderly populations. For residents living in these areas, access is problematic, whether it's due to geographical or income status.

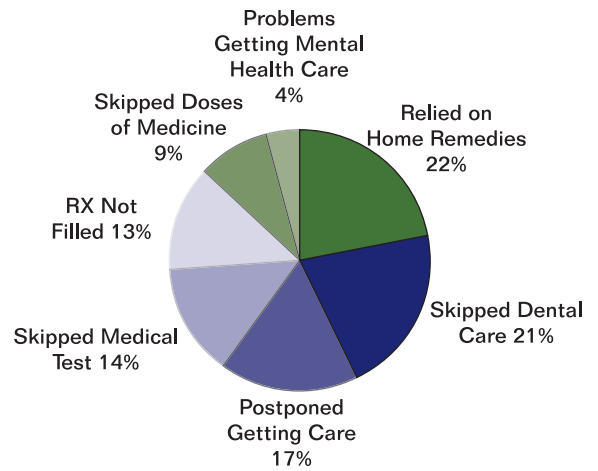
### What Issues are Behind Health Care Reform?

The issues driving health care reform are basically twofold: access to health care for the uninsured and cost. A recent Kaiser Health Tracking Poll shows that more than half of all Americans have cut back in some way on medical spending as a result of health care costs. (Figure 1). Over a third of households state they have used over-the-counter drugs or relied on home remedies instead of seeing a doctor. A similar number have canceled dental care. Other reactions to the cost of health care included skipping recommended doses of medicine or not filling prescriptions at all. Almost three of 10 people report postponing recommended medical care, some for a chronic illness such as diabetes and some for minor or major surgeries.

For most Americans, access to health care and its affordability are assured through employment, either as an employee or as the spouse or dependent of an employee with a provider-sponsored health care plan. This explains why many report that they are satisfied with their present health care coverage (Figure 2).

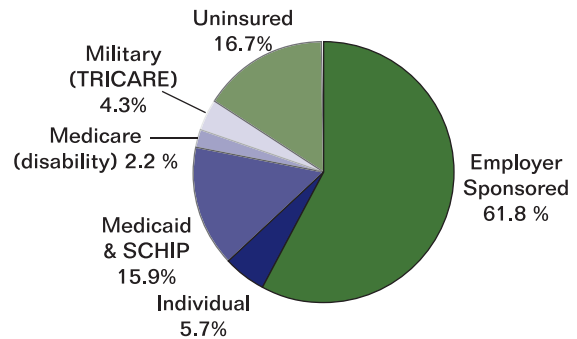
In Montana, almost six in 10 of the non-elderly population obtain their health insurance through employers. Two in 10 are uninsured, and fewer than one in 10 has individual health care coverage. But for workers in firms of fewer than ten employees, employment-based insurance may be harder to come by. Forty-nine percent of workers in firms with fewer than 10 employees held employment-based health insurance, compared to 77 percent of employees in firms with more than 100 employees. In Montana, nearly 80 percent of all private establishments have fewer than 10 employees. Nationally, only 11 percent of those without access to employer-sponsored insurance purchases coverage in the individual market. Individuals who have individual health insurance have median incomes over twice that of the uninsured, and almost 35 times the net wealth (Didem et al.).

**Figure 1**  
**Response to Health Care Costs**



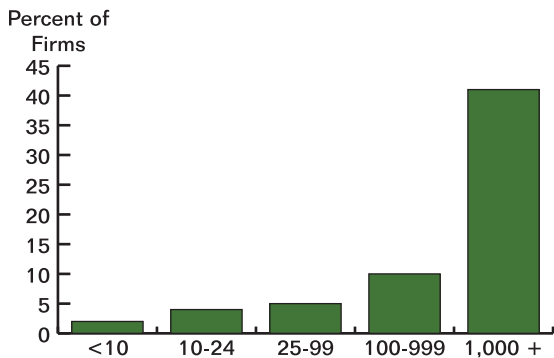
Source: The Henry J. Kaiser Family Foundation, February 2009.

**Figure 2**  
**Health Insurance Coverage for the Non-Elderly, Percent, by Source, 2008**



Source: Joint Committee on Taxation, Background Materials for Senate Committee on Finance Roundtable on Health Financing, (JCX-27-09), May 7, 2009.

**Figure 3**  
**Private Firms Offering Health Insurance to Retirees, by Employee Size**



Source: Employee Benefit Research Institute, Issue Brief, July 2006.

Of the 46 million uninsured people, nearly 20 percent live in high-income households and have the economic means to buy insurance but choose not to, according to several studies (Antos). Estimates of the number of “voluntarily uninsured” vary, and the policy response required to bring these voluntarily uninsured into any insurance pool will prove to be challenging.

The Urban Institute estimates that the uninsured cost the health care system \$83 billion in 2008, which is paid for through higher public subsidies and increased charges to patients with health care insurance. The uninsured also are users of the emergency room, one of the most expensive points of entry for health care delivery. In fact, the uninsured are responsible for nearly one in five hospital-based emergency room visits (U.S. Department of Health and Human Services).

Even for the Medicare-insured population, paying medical bills may be a problem. The Employee Benefit Research Group estimates that a couple – age 68 today living until average life expectancy – will need \$300,000 to cover Medicare premiums and out-of-pocket expenses. Medicare covers on average only half of the health-related expenses for retirees. In addition, employer-sponsored health care insurance for retirees may not be an option in the future. According to the Agency for Healthcare Research and Quality, only 13 percent of private establishments in 2003 offered benefits to Medicare eligible retirees, down from 20 percent in 1997. As Figure 3 shows, employer-provided health care insurance for retirees is less likely the smaller the firm. So for many Montana workers, these benefits may not be offered. Other employer trends include tightening eligibility requirements for employer-provided benefits, capping benefits, and terminating subsidies altogether for workers hired or retiring after a designated date.

## Who are the Uninsured?

According to Census Bureau estimates, 46 million people in the United States were uninsured in 2007. In Montana, a state with a population just under 1 million, nearly 150,000 are uninsured. Most estimates of the uninsured population come from the Census Bureau’s Current Population Reports. Under this modeling methodology, any individuals reporting themselves as uninsured are counted, whether it is for a week, month, or year. Therefore some caution must be exercised in assuming all uninsured are without insurance for the entire year.

The profile of the uninsured is diverse but disproportionately includes the poor not already on Medicaid, part-time workers, the less educated, the young, single parents, Native Americans, and both urban and rural poor who lack the financial resources to access private care. Data provided by the Medical Expenditure Panel Survey show that even for those working full time, the lack of health insurance is related to:

- **Income** – 40.8 percent of those earning 125 percent or less of the federal poverty level are uninsured compared to only 4.2 percent of those earning over 400 percent of the federal poverty level;
- **Age** – 17.9 percent of 18-24-year-olds are uninsured compared to 8.7 percent of 50-64-year-olds;
- **Education Level** – 36 percent of those without a high school education are uninsured compared to only 6.4 percent with at least some college;
- **Employment** – 28.5 percent of the self-employed are without health insurance, compared to 3.4 percent of those working for firms with 100 or more employees.

## What’s Driving Health Care Costs?

Prices everywhere are increasing. That \$2.75 cappuccino that you bought this morning cost just \$1.50 20 years ago. But what’s different about health care prices is that they consistently run higher than general inflation in the economy. Finding ways to reduce costs isn’t enough; we must address what is driving the costs.

Experts have advanced several possible root causes of health care inflation. Some argue that because we have more per capita income than other developed countries, we can afford more health care. Our productivity allows us to enjoy more choices on the health care menu. Add insurance to higher incomes, and the consumption of health care increases even more. Over utilization and misuse of health care services only add to the problem.

The favorable tax treatment of health insurance and medical expenses also fuels demand by insulating the consumer from the full cost of health care services. There is also a hidden cost imposed on the government in the form of lost tax revenues. The Joint Committee on Taxation estimates that \$288 billion in tax revenue is lost each year due to the tax-exempt treatment of employer-sponsored health insurance, the deductibility of medical expenses, and the exclusion of Medicare benefits from income, health savings accounts, and other programs.

Our aging population contributes to costs by changing the way health care is used. Older people spend more on average (almost twice as much per capita) for health care than younger users. As the baby boomer population ages, future health care services will be in high demand. The Census Bureau estimates that of the 78.2 million boomers, 330 per hour turn 60.

Supply side factors also contribute to health care inflation. Fee-for-service rewards providers based on the number of services provided, not necessarily on the quality, or appropriateness of care. The declining number of primary care physicians means more of us consult specialists instead of accessing lower cost levels of care first.

Finally, soaring medical malpractice premiums and the practice of defensive medicine by risk-averse medical doctors also contribute to the rising cost of health care delivery.

## What Should Health Care Reform Address?

Polls show that Americans are concerned about both cost and providing insurance for people who do not have it. Can reform achieve universal coverage? Success in Massachusetts came with higher costs than originally anticipated. In the first two years after the legislation was passed, more than half the estimated 650,000 uninsured gained coverage through many of the reform programs available to residents, but the costs were higher than expected. The Congressional Budget Office estimates that the Kennedy proposal for universal coverage would have cost nearly \$1 trillion over the next decade, or \$62,500 for each of the 16 million newly insured. Hawaii imposed an employer-sponsored health insurance mandate in 1974. A recent study found that the employer mandate was not an effective means for achieving universal coverage. Employers simply increased the use of part-time workers to escape the mandate. Debates on universal coverage will continue since employer-sponsored coverage has fallen every year since 2000.

Reform must also consider cost and how the programs are financed. Nothing is really free. Someone has to pay, either directly as a consumer, or indirectly as a taxpayer through

higher taxes, or as an employee who accepts a lower wage, reduced hours, or both in response to higher costs for employer-provided health care insurance.

Ideally, reform will promote a system where access is improved for millions of Americans without further driving up costs.

And ideally reform should finance programs without adding to the federal deficit, and ultimately, our country's growing national debt. Still another challenge is that reform should restrain cost increases without sacrificing quality or choice for the consumer. And particularly in an environment of rising unemployment, reform should increase access, control costs, and maintain choice without adding to unemployment. An Urban Institute study for the Blue Cross/Blue Shield Foundation of Massachusetts (Holahan et al.) used a regional model to estimate the impacts of universal coverage. They found that the increased spending that would accompany universal coverage would add to the income and employment base in Massachusetts. The increases in employer and employee payments, together with increased taxes to finance the program, would reduce income and employment. But the net effect was found to be positive; the positive impacts from increased health care slightly offset the negative impacts from higher taxes. This result assumed that most of the foregone consumption resulting from higher taxes was on goods and services produced outside the state, while most of the increased health care spending occurs within the state. Whether or not this scenario would play out the same nationally is questionable.

## Conclusion

There is little low-hanging fruit to pick for accomplishing all that health care reform hopes to do. And it is apparent that preserving choice is important to many. A June 2009 CNN/Opinion Research Corporation poll revealed what trade-offs people were willing to make with three health care reform goals: insurance for all, choice of providers, and lower costs. Thirty percent supported a plan where costs were lowered, all were insured, but no choice was possible. When choice was allowed, but not all would be insured, the percentage favoring the plan increased to 44 percent. But a plan that allowed choice, insured all, but didn't lower costs received the most favorable approval rating, 59 percent. At least in terms of this poll, people are willing to trade cost for choice and increased access. Many of the protests against the government plan address the loss of choice many fear. This sentiment was voiced



by Scott Gottlieb of the American Enterprise Institute when he said, “Our founders thought politicians should be accountable when it comes to citizens’ right to life, liberty and the pursuit of heart surgery.”

Debate also will continue on the merits of an exchange, or connector, cooperative, call it what you will. Here the discussions are as varied as viewpoints on health care reform itself. Who should be included in the exchange – should it be all private insurers, all public, or a mix between the two? Would exchanges encourage competition and force prices down, or would it be the end of private insurance as we know it?

What role should price play in health care reform? An Urban Institute Health Policy Center study found that higher Medicaid reimbursement fees did not increase physician participation rates and had little impact as well on the number of office visits by Medicaid recipients (Zuckerman et al.). Reform will stand the best chance of success if all interested parties agree that changes are needed on multiple fronts.

The Iowa Committee for Value in Healthcare was on the right track when it declared, “The people who provide goods and services attempt to contain costs while offering high quality to the greatest number of consumers. The goal for health care should be no different. Ample evidence exists that improving value is possible, but not without a transformation in provider practices, purchaser coverage agreements, and patient expectations.”

This may be easier said than done. Over half of us believe significant reform can occur without changing the existing delivery of health care, and an even higher percentage believe we can implement reform without driving costs up.

All markets ration goods and services in some way: price, budget, geographical access, or time in queue. Often we look at other health care systems as the answer. Germany has reformed its delivery system 14 times since 1980, and reform was again the topic in the Bundestag elections in September.

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– Scott Gottlieb  
American Enterprise Institute

The Clinton administration thought they had the solution in the National Health Security Act. This act had managed care, regional alliances to negotiate lower prices, universal coverage through employer mandates and all financed through higher taxes. The program was doomed to failure, and in the words of one scholar, “Technical experts designed it, special interests argued it, political leaders sold it, journalists more interested in the political ramifications than its contents kibitzed it, advertising attacked it. There was no way for the average American to understand what it meant for them.”

Reform of some shape will have to occur because our present health care cost trajectory is unsustainable. Exactly when and what shape that reform takes we’ll have to wait and see. □

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## References

- Antos, J. “A Look at Health Care Reform by the Numbers.” American Enterprise Institute for Public Policy Research. July, 2009.
- Didem, B., Banthin, J., Encinosa, W. “Wealth, Income, and the Affordability of Health Insurance.” Health Affairs. Volume 28, Number 3, May/June 2009.
- Holahan, J.L., Blumberg, L.J., Weil, A., Clemans-Cope, L., Buettgens, M., Blavin, F., Zuckerman, S. 2005. “Roadmap to Coverage, Synthesis of Findings.” Urban Institute Report for the Blue Cross Blue Shield of Massachusetts Foundation. October 2005.
- U.S. Department of Health and Human Services. Nationwide Emergency Department Sample News Release. July 15, 2009. [www.hhs.gov/news](http://www.hhs.gov/news).
- Zuckerman, S., Williams, A., Stockley, K. 2009. “Trends in Medicaid Physician Fees, 2003-2008.” Urban Institute Health Policy Center. April 28, 2009, Washington, D.C.