Toward Real Health Care Reform

Paul Howard and Stephen T. Parente

March 23, 2010, marked a watershed in American politics. On that day, amid much fanfare and ceremony at the White House, President Obama signed into law the largest expansion of American government in more than four decades.

The enactment of the Patient Protection and Affordable Care Act — passed by slim single-party majorities in both houses of Congress, and in the face of intense public opposition — forces us to confront some very basic questions about what we Americans want for our country. Will we continue to increase the size and scope of the entitlement programs that threaten our fiscal future, or will we begin to trim them back for the sake of American prosperity? Can we abide exploding health-care costs, or should we act to restrain them before they suffocate our economy? Is a more socialized health-care system the only way to expand access to doctors, hospitals, and quality medical treatment? Or are there ways to help people who lack health insurance without undermining the coverage and care that other Americans enjoy?

Obamacare's enactment poses these questions, rather than answering them, because the law's ultimate fate is still uncertain. Its provisions remain deeply unpopular with American voters; most of its purported benefits will not take effect for almost four years; and Republicans around the country have vowed to run on a platform of repealing it — both in this year's congressional elections, and in 2012.

A full repeal of the law would of course be a difficult political

---

Paul Howard is director of the Manhattan Institute's Center for Medical Progress and managing editor of Medical Progress Today.

Stephen T. Parente is director of the Medical Industry Leadership Institute and Minnesota Insurance Industry Professor of Health Finance in the finance department of the University of Minnesota's Carlson School of Management.

proposition. Yet those who want to restrain the growth of health-care costs — and of America's welfare state — have no choice but to try. Simply tinkering around the legislation's edges will not do. Any meaningful effort to mend what is wrong with the bill will require profound transformations of its key provisions, and such a piecemeal assault would be no less of a political challenge than full repeal (and no less likely to meet with President Obama's veto pen, as long as he is in office). So if the goal is to advance genuinely patient- and market-friendly health-care policies — and to offer a serious alternative to the government rationing and price controls that now seem to loom over the horizon — there can be no "reform" without "repeal."

More than health care is at stake. The outcome of this debate over the next four years will set the tone of American social policy — and define the relationship between citizens and their government — for decades to come. The question is not whether we will have a welfare state: As the late Irving Kristol put it in 1993, "the welfare state is with us, for better or worse." Our challenge, Kristol argued, is to ensure that the nation's social safety net is "consistent with the basic moral principles of our civilization and the basic political principles of our nation."

Many Americans would agree that government should help the poor and the elderly secure access to decent health care, help those excluded from the health-insurance market gain coverage, and help root out some of the inefficiencies that plague the health-care sector. But it must do so in a way that takes economic realities seriously, and respects America's moral and political traditions — including our longstanding emphasis on individual choice, open competition, and limited government.

This is a very tall order. But the best place to start is by reflecting honestly on just how American health care came to this pass — and determining what genuine solutions to our health-care dilemmas should look like.

The Missed Opportunity

Conservative reformers should have no illusions about how they got to this point: They failed to act when they had the chance, especially during the presidency of George W. Bush.

The demise of President Bill Clinton's health-care initiative in 1994 severely (if temporarily) curbed the ambitions of liberal health-care reformers. When their sweeping ambitions for universal coverage met

with painful defeat, liberal interest groups opted instead for a gradual approach — pushing for the incremental expansion of existing government health-care programs, and urging the creation of modest new ones. Thanks to these efforts, Medicaid — the joint state and federal health-insurance program for the poor — expanded rapidly during the 1990s, with enrollment rising from 25 million to 43 million and costs more than doubling. And in 1997, President Clinton enjoyed bipartisan support when he signed legislation creating the State Children's Health Insurance Program, which today covers about 7.7 million children from low-income families.

These policy band-aids did not, however, address the fundamental causes of rising health-care costs. The underlying problems with our health-care system therefore only continued to grow; after a brief pause in the mid-1990s, American health-care costs began to rise sharply again at the end of the decade. The increase caused yet more small- and medium-sized businesses to drop or scale back health-care coverage for their workers — and the portion of Americans receiving coverage through their employers declined from almost 67% in 2000 to 58.5% in 2008. Those businesses that continued to provide insurance for employees found themselves unable to control costs, often devoting more money to their workers' health care than to many operations critical to the success and profitability of their companies. Meanwhile, rising health-insurance premiums — which, on average, have roughly doubled in the past decade — contributed to wage stagnation and a growing sense of anxiety about health care among middle-class Americans. And doctors, for their part, voiced frustration with the increasing administrative burdens imposed on them by public and private insurers.

But while advocates of expanding government's role in health care fine-tuned their agenda, and while real-world problems worsened, Republicans mostly stayed silent. President Bush's most noteworthy health-care achievement — the addition of a prescription-drug benefit to Medicare in 2003 — did inject some much-needed competition and choice into the program, helping to hold down drug costs while still providing valuable coverage to senior citizens. But the administration did not push for reforms to the broader health-care-entitlement apparatus, or do anything meaningful to address Medicare's immense long-term deficit. Health Savings Accounts — another well-intended, if modest, program initiated during the Bush years — provided one bright spot:

They now count about 10 million subscribers, and have achieved some success in changing consumer behavior. But these figures, encouraging as they might be, represent only a tiny fraction of America's private insurance market of about 177 million people.

Other ideas — like allowing small businesses to pool together to buy insurance at the bulk rates enjoyed by their larger competitors, or permitting the purchase of insurance across state lines — were never advanced with much focus or vigor. And the one idea that might have moved American health care decisively in the direction of market incentives — President Bush's proposal to end the tax exemption for employer-provided health insurance and replace it with a standardized tax deduction for coverage ($7,500 for individuals, $15,000 for families) — was not even presented publicly until early 2007. By then, the Democrats had retaken Congress, and Bush had lost any ability to implement major initiatives.

Simply put, when Republicans dominated Washington — controlling both the White House and Capitol Hill — they did not make health care a top priority. Their failure to do so, and their unwillingness to address the country's structural health-care problems, left a critical opening for President Obama and the Democratic Congress.

A STEP IN THE WRONG DIRECTION

As in 1994, the Democrats last year originally framed their push for universal coverage as an effort to control health-care costs (or, as Obama-administration officials often put it, to "bend the cost curve" downward). Exploding costs are indeed at the heart of our health-care dilemma, crushing federal, state, local, and family budgets and leaving millions unable to afford insurance. But owing to misguided ideological commitments — as well as the political exigencies of passing some bill, any bill — the final product was by no means an exercise in fiscal restraint. On the contrary: The new law is likely to inflate premium costs, increase government spending, displace millions of insured Americans, and lead to price controls that will hinder innovation and politicize health-care decisions — all of which will make real reform increasingly difficult.

Why will Obamacare so widely miss the cost-cutting mark? In large part because the various policies it puts in place do not aim to address the core problem of health-care costs at all. Rather, the Patient

Protection and Affordable Care Act is designed to address a *symptom* of the cost problem: the fact that roughly 50 million Americans do not have regular access to health insurance.

According to the Congressional Budget Office, the Democrats' legislation will devote about a trillion dollars over the next decade to cutting that number roughly in half — leaving 23 million people uninsured in 2019. This reduction would be achieved through a combination of mandates, regulations, subsidies, and entitlements.

Some people who do not have insurance today because they choose — for reasons financial or otherwise — not to buy it may change their minds, once they face the new law's mandates forcing them to either buy insurance or pay a fine (of $695 or 2.5% of their income, whichever is higher) every year. Some people who now have jobs that do not provide insurance will be covered because their employers (if they employ more than 50 people), too, would have new inducements: a fine of $2,000 per employee per year for not offering insurance. (Though it is worth noting that some other employers who *do* now offer insurance will stop providing this benefit, because the fine will cost them less than offering coverage, and the new law will give their workers other options for obtaining subsidized health insurance — this time on the taxpayer's dime.)

Still other people — those who cannot now get health-care coverage on their own, or whose employer-based coverage will be eliminated — will use new "insurance exchanges": highly regulated marketplaces, run by the states, that will allow participants to choose among private insurance plans (people who cannot afford to pay the premiums will receive government subsidies based on their income levels). And, finally, some people whose incomes are below about 133% of the federal poverty line will become newly eligible for Medicaid.

These last two initiatives — the state exchanges and the Medicaid expansion — account for (by far) the largest portions of those who will be newly insured under the law: If Obamacare is fully implemented, CBO estimates that by 2019 there will be 24 million Americans purchasing insurance in the exchanges, and some 16 million new Medicaid recipients. Meanwhile, 3 million *fewer* people will receive employer-based coverage, and 5 million fewer people will buy insurance in the individual market, than would have been the case otherwise.

These adjustments mean that the federal government, and to some

extent state governments, will now pay a greater portion of the high costs that have made insurance inaccessible for many Americans. But simply shifting the burden of who pays for health insurance onto the taxpaying public will not curtail those costs. Thus the new programs created by Obamacare will not address the fundamental problem with our system, and in some key respects will make it worse — driving up costs for both the government and for individual citizens.

The bill's champions argue that it will actually ease the strain on the federal budget, citing CBO estimates that the law will reduce the deficit by $143 billion during its first 10 years. Unfortunately, these "gains" merely reflect a cynical manipulation of the CBO scoring process. The legislation is written in a way that double-counts $53 billion in Social Security revenues and $70 billion in premium payments to be collected for a new long-term-care insurance program; it also ignores as much as $115 billion in implementation costs to get the law's various provisions and programs up and running. And this is to say nothing of the law's half-trillion dollars in new taxes and fees — which, though they will obviously help offset Obamacare's costs over the next 10 years, may also have unanticipated (and unfavorable) consequences for America's economic growth and long-term budget projections.

Most important, the new law proposes approximately half a trillion dollars in cuts (made over the next 10 years) to physician and hospital reimbursements under Medicare. Of course, these "savings" are extremely unlikely to materialize: The measures required to produce them would be very unpopular with seniors and (according to the Medicare actuary) would crush many of the health-care providers who now offer services to Medicare recipients. In a recent report forecasting the new legislation's effects, the actuary in fact notes that, in Obamacare's first decade, about one in every six such providers could become unprofitable and go out of business (or stop working with Medicare patients altogether). Faced with a choice between that disastrous outcome and a vague promise to save taxpayer dollars, it is not difficult to imagine how Congress will act.

Moreover, the Congressional Budget Office did not account for the expense of securing the health-care bill's passage. In order to obtain the backing of the American Medical Association, Democrats pledged to repeal cuts in Medicare physician payments that were mandated by a 1997 law but have been put off every year since 2003. This permanent

"doc fix," as it is often called, is likely to cost $276 billion over the next 10 years — and yet it appears nowhere in the CBO estimates for Obamacare, because it will be enacted by separate legislation.

Beyond its implications for the federal deficit, the law is also poised to increase overall spending on health care in the United States. It would first do so directly, by increasing federal spending on health care and therefore inflating prices. The CBO estimates that by 2019, spending on the new entitlement will grow by about 8% each year — even faster than the 7% average annual growth of public and private health-care spending over the past decade. Independent analysts like the Lewin Group also project hundreds of billions of dollars in new health-care spending throughout the economy as a result of Obamacare. And the Medicare actuary estimates that, by 2019, the law will increase overall national health-care spending by a net total of $311 billion.

Still, the president and his allies insist the law will help contain health-care costs, claiming that it includes numerous cost-saving experiments. And there are indeed some pilot programs in the bill — for example, an initiative to test bundling payments for care, so that rather than paying providers for each service, Medicare would pay them a per-patient fee for a person's entire course of treatment (thereby encouraging more careful use of funds). Some of these projects may well save a little money at the edges; others, like increasing disease screening and focusing on prevention, may improve care but will also inevitably inflate costs.

If prior experience with Medicare pilot programs is any guide, such small experiments are also likely to be watered down or scrapped altogether under pressure from doctors and lobbyists. Their effects will in any case be negligible: Because the law does not change Medicare's overall payment practices, it creates no incentives for private-sector efficiency — and thus no incentives or mechanisms to keep the exploding costs of health care in check.

Moreover, premiums are also likely to rise as a result of new regulations imposed on the insurance industry. These regulations prohibit limits for lifetime and annual coverage; mandate a wider range of preventive-care services that must be funded by insurers; and require that insurers follow practices like guaranteed issue (meaning no person can be denied coverage due to his age or health) and community rating (meaning every customer pays the same premiums, regardless of age or

health). Inevitably, these requirements will increase the cost of coverage for younger and healthier applicants.

The Congressional Budget Office estimates that these new regulations will drive up premium prices by approximately 10 to 13% in the individual market. (Other analysts believe we are likely to see much more significant increases in the near term.) And since the state-run insurance exchanges, as well as the premium subsidies that go along with them, will not be up and running until 2014, it is quite possible that the spike in premium costs will increase the number of Americans who cannot (or will not) get insurance over the next few years. Indeed, Health Systems Innovation (a health-economics analysis firm) predicts that by 2013, on the eve of the individual mandate and the creation of the insurance exchanges, 53 to 56 million Americans will be uninsured — up from about 50 million today.

Higher premiums will also make it difficult for many insured Americans to keep the coverage they now have. The Medicare actuary estimates that about 14 million people will lose their employer-based coverage by 2019, as smaller employers terminate coverage and push workers into Medicaid or state exchanges. As more and more people come to rely on some government support for their health insurance — and as the costs of insurance premiums rise across the board — the new government premium subsidies established by Obamacare will only become more expensive, again increasing the program's overall cost.

This scenario — rising health-care costs and increasingly expensive subsidies that will become unsustainable over time — is consistent with what is happening in Massachusetts, which implemented health-care reforms in 2006. Before the reforms, Massachusetts had one of the nation's lowest uninsured rates, but also an expensive and dysfunctional individual insurance market. The reforms that state lawmakers enacted included mandates on individuals and businesses, a highly regulated state health-insurance exchange, a Medicaid expansion, and large premium subsidies for the poor. Since then, subsidy costs have risen much faster than expected, and overall health-care cost increases in the Bay State continue to outpace the national average. Massachusetts is a case study in what happens when government expands insurance coverage without curbing underlying cost pressures.

Massachusetts also gives us a preview of how the politics of Obamacare will play out. Over the past few months, insurers in the

Bay State have demanded permission to impose double-digit premium increases — because guaranteed-issue and community-rating rules, combined with the weak individual mandate (which punishes a decision not to buy insurance with a fine that costs less than insurance), leads people not to carry insurance until they become sick and need it. This in turn keeps healthy people out of the risk pool, increasing costs for everyone else and subjecting insurers to an unsustainable financial squeeze. Massachusetts governor Deval Patrick has responded by implementing de facto price controls on the industry, setting off a court battle that is likely to drag on for months.

Like the Massachusetts plan, the new federal health-care legislation has a weak individual mandate; it also gives the Department of Health and Human Services the power to review insurance-rate increases, setting up a similar conflict. In a recent *Forbes* article, University of Chicago law professor Richard Epstein described the scenario that is likely to unfold:

> The federal program has a convoluted structure that allows the states to require price rebates on the recommendation of the federal government. It's likely that they will invoke that power when rates skyrocket to meet the stiff ObamaCare mandates. So private health insurers and/or health care providers will go bankrupt unless [they] receive a massive tax bailout, for which there is quite simply no available or potential federal revenue.

Meanwhile, several of the new law's key provisions are sure to prove untenable soon after their enactment. For instance, the state-run insurance exchanges that go into effect in 2014 will be open to the uninsured and to people in the individual market — but not to Americans receiving insurance through their employers. As a result, a family that buys insurance in the newly created exchanges will be eligible for government premium subsidies that a family getting job-based coverage cannot receive — even if the two families' incomes are exactly the same. Knowing that their workers are getting a raw deal, employers will have added incentive to pay the relatively small penalty under the legislation and dump their employees into the exchanges. Indeed, just this spring, an internal memorandum prepared by human-resources consultants for AT&T — and obtained by the House Ways and Means Committee — showed that,

even after paying the fine for ceasing to offer health insurance to its workers, the company would save almost $2 billion per year by ending insurance coverage (while employees would still be taken care of thanks to the coverage provided by the exchanges).

Many companies — both large and small — will come to the same conclusion as AT&T. They will know that even if they pay the new law's fines, they can still save money by not providing insurance for their workers; those workers will then become eligible for the same government benefits enjoyed by those who were uninsured or buying coverage in the individual market. The only losers in the equation are the insurance industry — which will be subjected to enormous instability as a result of massive shifts in coverage arrangements — and the federal taxpayer, who will have to shoulder the inevitable increase in government spending.

In short, Obamacare aims to treat the symptom (the uninsured) without treating the disease (health-care costs). Not only will it fail to control these costs, but it will in fact cause them to rise — in turn squeezing patients, doctors, and insurers as regulators inevitably turn to price controls in a desperate attempt to salvage some shred of fiscal solvency.

Beyond inflicting great harm on America's health-care sector and public finances, the law will also prove very unpleasant to consumers and voters. The upside, however, is that this creates an opening for opponents to make the case for serious alternatives — alternatives that, unlike Obamacare, truly offer a cure for what ails America's health-care system.

real health-care solutions

A serious, realistic plan for healing American health care should consist of five components.

First, it should create real interstate insurance competition. Today, state regulations have effectively established 50 separate insurance markets, each with its own coverage mandates, requirements, and limits; this fragmentation has, in turn, severely limited the degree to which market forces can exert downward pressure on prices. A broader national market in health insurance would give consumers many more options to choose from — and so would give insurers an incentive to offer cheaper products, thereby increasing the number of people who could afford health-insurance plans. Indeed, a study commissioned in 2008 by the Department of Health and Human Services found that

the number of uninsured Americans could be reduced by 8 million simply through effective interstate insurance sales. The study goes on to show that the ability to purchase insurance across state lines would be of particular benefit to patients with chronic illnesses, as well as to people who live in states where insurance is now especially expensive or heavily regulated — two groups that are disproportionately uninsured. Reformers should therefore press for legislation to allow consumers to buy insurance offered anywhere in the country — through mechanisms like nationwide exchanges and multi-state compacts, or from private firms like the online insurance clearinghouse eHealthInsurance (which has already expressed its desire to sell national plans, if federal and state laws were changed to allow them).

Second, real health-care reform would replace Obamacare's subsidies with a single defined credit or voucher for the purchase of basic (at the very least catastrophic) health insurance. The credits could be supplied either through exchanges or directly through the tax code; in either case, consumers who find coverage for less than the full amount of the voucher should be able to keep the savings — thus providing an incentive for insurers to create more efficient and affordable provider networks (and for individuals to gravitate towards those plans).

Such vouchers should at first be available to people with low incomes who need help purchasing insurance in the individual market. Over time, however, they should be made available to all Americans — funded by gradually phasing out the tax deduction for employer-provided insurance, thus helping to move our system toward a market in which individuals, rather than employers, control their coverage and can keep it as they change jobs.

One way to achieve this gradual phase-out would be to replace President Obama's "Cadillac Tax" (a levy on especially expensive employer-based insurance plans, those costing $27,500 or more for a family) with a "Buick Tax." Such a policy would curtail the tax exemption for employer-based plans in a way that would affect many more people — permitting, for instance, an exemption only for plans costing less than $13,500 for a family (along the lines of a reform the Bush administration proposed in 2007). This policy would raise new revenue that could be used to subsidize coverage for people with lower incomes; it would also address what economists agree is one of the largest drivers of health-care inflation — the illusion that employer-provided health

insurance is free. In fact, in late 2009, the Joint Committee on Taxation found that a "Buick Tax" would allow for a completely budget-neutral system of subsidies that could cover 17 million of the uninsured — about the same number of people who will be subsidized under Obamacare. And because the "Buick Tax" would affect only employer-based coverage — and not policies purchased on an individual basis — it would encourage the development of a more functional individual market for coverage.

Third, any meaningful health-care reform must include an overhaul of Medicaid. Rather than vastly expanding the program while leaving its structure largely untouched, as the new health-care law does, reformers should move a large number of Medicaid beneficiaries (namely, the able-bodied poor) toward a system of vouchers for private health insurance. Medicaid's open-ended entitlement would then apply only to the most dependent recipients — like the disabled or chronically ill — who are genuinely incapable of work, while most recipients could participate in the larger health-insurance market. [Elsewhere in this issue, John Hood argues for Medicaid reforms in greater detail.]

Fourth, reformers should fix the Medicare program, instead of using it as a slush fund to finance yet another new entitlement.

While few dispute that Medicare is in need of some repair, the "reforms" proposed by Obamacare — across-the-board payment cuts to hospitals and physicians — are politically unsustainable, and therefore unrealistic. Moreover, using the "savings" from such cuts to pay for a new health-care entitlement (as the new law proposes), rather than to fill the growing fiscal hole in Medicare itself, is irresponsible. Reformers should pursue ways of means-testing the program, so that low-income seniors get the most help. And they should take up the bipartisan proposals suggested by the Breaux-Thomas commission in the late 1990s — most notably transforming Medicare into a program in which seniors receive a defined benefit (a cash voucher) to buy the private health insurance of their choosing, rather than open-ended payments for every service provided to them. Indeed, a similar (and successful) market is now in place for the Medicare prescription-drug benefit — one of the only federal health-care programs to come in under budget, thanks to real competition and choice.

Such a transformation of Medicare should be undertaken gradually; for the most part, it should leave those already in the program as

they are and change benefits only for incoming and future recipients. But it is precisely because reform's implementation should be gradual that it should begin as soon as possible, so that there is time to pull Medicare — and the federal budget as a whole — back from the fiscal abyss.

Finally, reformers should look to robust high-risk pools to address the problem of insuring Americans with pre-existing medical conditions. Such pools are regulatory mechanisms by which states require insurers to cover people who have pre-existing conditions (and who meet certain qualifications), but then subsidize those people's premiums. This allows people with pre-existing conditions to get coverage they can afford in the individual market, rather than undercutting the entire market just for their benefit. High-risk pools with a stable, dedicated source of funding — perhaps supported by a modest assessment on insurance policies in the rest of the market — would be a smart way to ensure that these patients can get coverage without driving up costs for younger and healthier patients. [James Capretta and Thomas Miller argue for such risk pools in greater detail elsewhere in this issue.]

Taken together, these five steps would address the key problems with our health-care system: exploding costs, too little portability and flexibility of coverage, horrendously inefficient entitlement programs, and a lack of access for those with pre-existing conditions. Rather than putting government bureaucrats at the center of our system, these five reforms would let patients and doctors make choices for themselves. Instead of telling insurers what products and prices they must offer, insurers would compete with policies designed to meet consumers' specific needs at prices they can afford. Rather than vastly expanding the American welfare state and bankrupting the country, these proposals would arrange economic incentives for improved efficiency and lower costs. And instead of precipitating a wholesale transformation of the relationship between the American people and their government, they would offer discrete solutions to specific problems. These principles for reform — not Obamacare — point the way to the improved health-care system Americans want, and deserve.

THE DEBATE CONTINUES

One way or another, the system created by the Patient Protection and Affordable Care Act will have to be replaced; the fiscal and policy

booby traps hidden among its various provisions mean that the law is simply unsustainable as currently written. The real question, then, is what comes next. Facing rapid cost increases and interminable struggles between regulators and insurers, some on the left will likely argue that government should create a public option to compete with private insurers, or just open Medicare to all Americans. If champions of market-based health-care reforms do not articulate and defend a better alternative, public frustration with the consequences of Obamacare could well lead toward a Canadian-style single-payer system — President Obama's preferred approach, as he has said on multiple occasions.

Proponents of a market-based health-care system may not agree on the exact size of various tax credits or vouchers; they may have differences of opinion on the ideal funding sources for various reforms; and they may spar over the role of state and federal regulation in ensuring robust competition within the national health-care market. But given the magnitude of what they *do* agree on — and the very dire consequences should they fail — reformers must keep these smaller disputes in their proper perspective, work together to hash out the details, and present a united, vigorous defense of their proposals to the American public.

If they do not, repealing Obamacare will do little to change the trajectory of American health care. Without a credible alternative rooted in these five principles for reform, the "next step" is certain to be only more of the same — and government will, by default, assume the responsibility that pro-market reformers will have abdicated. The passage of Obamacare has not sealed that fate, but its full implementation just might. Time, then, is of the essence — and the countdown to 2014 has already begun.