Health Care

Principles:

Sound health care policy should have the following characteristics:

- **Patient-centered** – Putting economic purchasing power and decision-making in the hands of participants minimizes third-party reimbursements, which foster an environment of entitlement and unlimited demand for health care services.
- **Security for the sickest** – Any health care reform must work for the healthy as well as those who are sick or chronically ill.
- **Equitable tax treatment** – Tax policy should not favor health care purchased by employers over policies purchased by individuals, should not favor financing health care through insurance over paying out-of-pocket and should not favor high-income employees over low-income individuals and families.
- **Personal responsibility** – Health care reform should combine personal responsibility with financial involvement to incentivize program participation, reward compliance and support better personal health management. Incentives that reinforce a culture of health, well-being, self help and shared responsibility can have a significant effect on outcomes.
- **Access for all** – Targeted solutions such as high-risk pools for those with pre-existing conditions and subsidies for low-income individuals are more efficient than top-down regulations.
- **Transparency** – The effectiveness of market-based systems depends on an abundance of information that is easily available and understood by consumers. If properly integrated into care, information can be as important to health and health care as a medical test, medication or treatment. With good information people can achieve better health outcomes at lower costs.

Recommendations:

- Address distortions caused by federal tax policy by creating refundable tax credits and allowing unused credits to reimburse safety net providers
- Address pre-existing conditions by replacing costly regulations with high-risk pools

Facts:

- In 1960, more than 48 percent of total health care spending was paid directly by consumers. As of 2014, that number is now only 11 percent.[1]
- The U.S. inflation-adjusted, per-person expenditure for health care from all sources increased from $1,120 in 1965 to $9,523 in 2014.[2]
- The overall U.S. median annual expenditure for persons under age 65 with health-care expenses in 2012 was $1,000. This means that of the individuals who spent money on health care in 2012, half spent less than $1,000 and half spent more. The average annual expenditure for persons under age 65 with health-care expenses in 2012 was $4,186. This difference between the median and average clearly shows that there are a minority of individuals with high expenses. (These calculations do not include the 15 percent of the population that did not have health care expenses in 2012.)[3]
- Fifty percent of health care costs in the United States are attributable to lifestyle: smoking, alcohol abuse, improper diet, lack of exercise.[4]
- Roughly 75 percent of all U.S. health care spending is associated with patients that have one or more chronic health care conditions.[5]

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[1] National Health Expenditure Accounts, http://go.cms.gov/1Jy5kin
[2] National Health Expenditure Accounts, http://go.cms.gov/1Jy5kin
[3] "National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population," Agency for Healthcare Research and Quality, January 2013, http://meps.ahrq.gov/mepsweb/data_files/publications/st457/stat457.shtml
[4] National Institutes of Health, 2004

- Chronic conditions account for 83 percent of the total spending in Medicaid and about 96 percent of the costs of Medicare in the U.S..[6]
- Chronically ill patients receive approximately 56 percent of clinically recommended preventive health care services.[7]
- The seven most common chronic diseases in the U.S. are cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions and mental disorders.

Overview

Health care is the No. 1 fiscal challenge

The U.S. Government Accountability Office projects that non-health care spending (Social Security, defense, domestic programs, etc., excluding interest expense) is constant as a percentage of GDP over time, but health spending rises dramatically.[8] Unaddressed, this leads to unsustainable federal deficit spending.

This is occurring at the state and local government levels on a smaller scale, as health care spending crowds out other important budget areas such as education and transportation. Most importantly, the cost of health care is straining the budget of Georgia families.

Three underlying challenges

Health care is much too complex to address all challenges in one chapter. The best place to start is to address three critical policy issues that distort the current health care system: federal tax policy, the Emergency Medical Treatment and Active Labor Act (EMTALA) and coverage for pre-existing conditions.

Federal Tax Policy

Before World War II, most health care was purchased out of pocket and medical costs were in line with general inflation. With the outbreak of war, President Franklin D. Roosevelt and Congress implemented wage and price controls. Labor could not bargain for higher wages and business could not compete for labor by offering higher wages. To solve this compensation problem, the IRS (with the support of Congress) established that health benefits would not be controlled by wartime wage guidelines and employers could purchase health benefits tax-free.[9]

Predictably, when the government favors certain health care spending – employer-provided insurance over individually-owned insurance and insurance premium payments over direct, out-of-pocket expenditures – human behavior soon follows. Out-of-pocket spending declined from 48 percent in 1960 to 11 percent today.

The tax benefits of employer-provided health insurance, plus the efficiency of group insurance, led to large increases in employer coverage after World War II. The creation of Medicaid and Medicare in 1965 shifted even more health care spending away from individually owned policies.

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[5] "Reframing The Debate Over Health Care Reform: The Role Of System Performance And Affordability," Kenneth E. Thorpe, Emory University, 2007, http://content.healthaffairs.org/cgi/content/full/26/6/1560

[6] "Chronic Conditions: Making the Case for Ongoing Care," page 19, September 2004, http://bit.ly/1Kyqt19. The presentation is an update of a 1996 study by Catherine Hoffman and Dorothy Rice, "Chronic Care in America: A 21st Century Challenge."

[7] "Reframing The Debate Over Health Care Reform: The Role Of System Performance And Affordability," Kenneth E. Thorpe, Emory University, 2007, http://content.healthaffairs.org/cgi/content/full/26/6/1560

[8] U. S. Government Accountability Office, http://www.gao.gov/fiscal_outlook/federal_fiscal_outlook/overview

[9] http://www.thefiscaltimes.com/Articles/2012/10/01/End-the-Health-Care-Tax-Break-Reduce-Coverage

Today, only 5 percent of health insurance policies are purchased, paid for and owned by individuals just like automobile, homeowners' and life insurance.

Why is this problematic?

If someone else, whether an employer or the government, pays most of the bill for anything, individuals become more concerned about quality than cost, not balancing the two as when spending one's own money.

It is also inefficient to have a third-party pay for small, routine expenses, just as most people don't file a homeowners' insurance claim for small repairs.

Individuals are not concerned about changing their automobile or homeowners' insurance policy when they change jobs. For the majority of those who have employer-provided insurance, however, this is a real problem. Many people risk going uninsured while they are between jobs, hoping they will not incur large health care expenses.

Another problem is the progressive U.S. tax code: Higher-income Americans are taxed at a higher income tax rate. But that same progressivity becomes regressive when employer health benefits are excluded from tax. As Chris Conover pointed out in Forbes, Bill Gates receives a far higher subsidy to pay for his health coverage than does a Microsoft janitor.

The Emergency Medical Treatment and Active Labor Act (EMTALA)

Passed in 1986, EMTALA is a federal law that requires every hospital that accepts Medicare to treat all patients, even those who cannot pay for their care. But this creates a cost someone must pay. The federal government provides some funding for "uncompensated care," but it is far from adequate, creating what may be the biggest unfunded mandate in history.

Here is an example to highlight the challenge facing hospitals: Imagine going to your local hardware store to buy a $100 ladder. You stand in line with three other customers who are also buying ladders. The first tells the cashier, "Here's my government card that says I only have to pay $95." The cashier looks over to the manager and he nods his head. The second customer says, "I've got a government card that says I only have to pay $80." The manager tells the cashier to go ahead. The next customer says, "The government says you have to give me the ladder. I can't afford $100, but here's $5." The manager shrugs and nods his OK to the cashier. You finally step up to the counter and see the manager doing some quick calculations. He then walks over and says, "That'll be $220." He apologizes and says he has to make up the lost revenue from the other customers. You say, "Thank you very much, but I'm afraid I'm going to have to go to Home Depot!"

This example isn't too far off from what happens in many hospitals. In this example, the customers represented Medicare recipients, Medicaid recipients, uninsured patients and the privately insured. In this case, we estimated reimbursement rates for Medicare and Medicaid at 95 percent and 80 percent, respectively, and the collection rate for the uninsured at 5 percent.

Government funding for uncompensated care is rarely enough to make up for those losses, especially for rural hospitals with fewer patients with private insurance. Attempts to solve the problem by regulation – like certificates of need – are blunt instruments that do not fully address the problem and cause other unintended consequences.

Coverage for Pre-Existing Conditions

The appropriate use of insurance is financial protection in case of unforeseen, catastrophic events, such as a car accident, house fire or heart attack. Homeowners know, for example, that fires destroy a certain percentage of houses each year, but they have no way of knowing if their

house will be the one to catch fire. Since most people couldn't afford to rebuild their house without insurance, it makes sense to pay for the protection of an insurance policy.

Selling health insurance to someone with an expensive, pre-existing condition is like selling fire insurance to someone whose house is on fire. Even so, public opinion supports finding a way to help these individuals.

Several years ago, a handful of states implemented a regulatory approach to solving this challenge. Deciding it was unfair for insurance companies to refuse coverage due to pre-existing conditions, legislators enacted a regulation called "guaranteed issue" that required insurance companies to sell to everyone. Insurance companies, like any company, are not in business to lose money, so they calculated the expected cost of each individual's condition and charged an appropriate premium.

Legislators then decided that it was unfair for insurance companies to charge what they considered exorbitant premiums and passed a regulation called "community rating," which prohibits those with pre-existing conditions from being charged more than healthier customers. Insurance companies had no choice but to raise premiums for everyone. Young people, who rarely get sick, reacted to the increased prices by dropping their insurance. Losing these profitable customers caused more premium hikes, which caused more people to drop their insurance, and so on. This begins what the industry calls a "death spiral."[10]

Consider this rational response from a young person. Normally, the risk of foregoing insurance is that you could get sick and incur large medical bills you can't afford. But under these regulations, you can drop your insurance and use that money for something else and if you do get sick, you just go sign up for insurance and pay the same rates as everyone else. [11] Limiting enrollment periods have had some success in stopping this behavior, but it remains a problem.

Even after these unintended consequences, regulators didn't give up, arguing: "If those young people hadn't dropped out it would have all worked out fine. Why don't we pass a law to force everyone to buy health insurance?" And that is the reason for the individual mandate in the Affordable Care Act. In fact, ObamaCare incorporates all of these regulations, and then some. It also appears that ObamaCare may be entering its own "death spiral."

Recommendations:

Address distortions caused by federal tax policy by creating refundable tax credits and allowing unused credits to reimburse safety net providers

The most equitable way to enhance access to health care is through a refundable tax credit, which individuals could use to purchase private insurance and put any savings in a Health Savings Account. This eliminates the bias in the tax code in favor of employer-provided insurance vs. individually-owned insurance and for insurance vs. out-of-pocket payments. In order to avoid disrupting the employer-provided insurance market in the near term, under most proposals these tax credits would initially only be available to those who do not have access to employer-provided insurance since these individuals are already being subsidized through the tax code.

John Goodman, known as "the Father of Health Savings Accounts," explains how these tax credits could be used to address the uncompensated care issues caused by EMTALA: "There will always be some people who will turn down the offer of a tax credit. Instead of having the U.S. Treasury keep those unclaimed credits, some portion of the money should be sent to safety-net institutions in the communities where the uninsured live. Uninsured patients will probably be

[10] "Insurance Reform Goes Crazy," NCPA, November 23, http://healthblog.ncpa.org/insurance-reform-goes-crazy/
[11] States' Guaranteed Issue and Community Rating Reforms without a Mandate Failed," http://bit.ly/1SyxTTx

asked to pay their medical bills out of their own pockets. But if they cannot, the safety-net institutions will have a source of cash to pay for uncompensated care."

[This concept forms the basis of our alternative to Medicaid Expansion addressed in another chapter.]

Address pre-existing conditions by replacing costly regulations with high-risk pools

The majority of states avoided the problems of the regulatory approach to pre-existing conditions by creating high-risk pools. A high-risk pool creates a separate pool for the small number of individuals without insurance who have a pre-existing condition. This allows everyone else to remain in a large pool without regulations that distort rational pricing of policies.

To create a disincentive to game the system by going without insurance until sick, those who join the high-risk pool typically must pay premiums that are 25-50 percent higher than standard rates (what an average person their age and gender would pay). The actual medical costs of these sicker individuals are closer to 400 percent of standard rates. This difference is subsidized, either from the state's general fund or by allocating the costs to insurance companies in the state based on market share.

As of 2010, 34 states had voluntarily created high-risk pools. The Affordable Care Act funded high-risk pools in every state until the insurance exchanges were in place. Prior to this, Georgia had never funded a high-risk pool. At the end of 2011, 1,476 Georgians were signed up for the federal high-risk pool. These numbers are surprisingly low, considering the federal high-risk pools did not charge participants more than standard rates.

The main drawback to high-risk pools is that participants have limited choices. A long-term solution is a concept called "status change insurance," which allows an individual to insure against the possibility of developing a pre-existing condition. This policy would pay the additional costs related to the pre-existing condition when someone changes plans.[12]

[12] More on that idea is available here: "Health-Status Insurance: How Markets Can Provide Health Security," John H. Cochrane, Cato Institute, February 2009, http://bit.ly/1U5vlyA