Reforming the U.S. Health Care System: Where There's a Will, There Could Be a Way

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Periodically, the tensions and contradictions emanating from the big, marvelously innovative, highly inequitable, and hugely expensive U.S. health care system force a general reassessment of the way this country finances and delivers health care for its citizens. One of these periods appears to be approaching—although, as Ted Marmor pointed out over a decade ago, coalitions preferring the status quo almost always prevent these reassessments from resulting in more than incremental change (Marmor 1994). Today, more than 46 million people are uninsured, families with health insurance fear that they may lose it, firms with household names seek ways to extricate themselves from providing health insurance for their employees, and the new Deficit Reduction Act of 2005 permits doctors and hospitals to deny services to Medicaid recipients who cannot meet required co-payments and deductibles. In an early 2006 article, the *Economist* asserts that the "world's biggest and most expensive health care system is beginning to fall apart"; it also suggests that health reform is "one of the most complicated challenges facing America's economy" ("Special report: America's health-care crisis" 2006). Why has health care become a major challenge to the U.S. economy and to economic policymakers? At least three developments explain the growing importance of health reform as an economic issue.

Clearly, the health care sector is now very large and touches most aspects of the U.S. and New England economies. In 2004, spending on medical care amounted to 16 percent of U.S. nominal gross domestic product (GDP)—more than consumers spent on food, clothing, and energy in total and about equal to all business investment in plant and equipment. Furthermore, health care's share of nonfarm employment is

now 9 percent and growing—that is roughly akin to manufacturing's shrinking share of the workforce. In New England, health care looms even larger, accounting for almost 12 percent of regional employment. In the future, this sector is almost certain to absorb an even greater share of GDP; for, as Organisation for Economic Co-operation and Development (OECD) data suggest, as national incomes rise, countries generally choose to spend a growing share of their income on health and health care (Figure 1.1).[1]

With health care spending projected to reach 22 percent of GDP by 2025 (Council of Economic Advisers 2006), it becomes increasingly important that U.S. policymakers be able to measure accurately health care output, prices, and productivity—no easy task. Currently, the most familiar measure of health care costs is probably the medical care consumer price index (CPI), which measures inflation in consumers' out-of-pocket costs for medical care, a fraction of total health care spending. For a variety of reasons, the medical CPI has been increasing a lot faster than the core CPI, helping to boost broad measures of inflation and labor costs as well. In addition, rapid medical cost inflation has contributed to

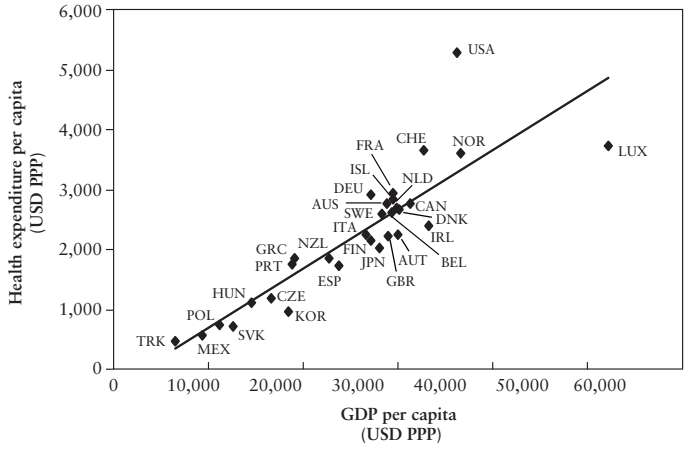

Figure 1.1
International Comparison of Per Capita Spending: Health Care versus GDP
Source: OECD, 2002.

a widespread impression that productivity in the U.S. health care sector may be rather low. By contrast, a growing body of recent research provides evidence of significant productivity gains in health care for patients suffering from specific widespread problems, such as cataracts, depression, and heart attacks. But do these findings apply to the entire health care sector? Indeed, international data indicate that the United States spends far more per person on health care than would be expected given its per capita income (Figure 1.1),[2] while data on expenditures and outcomes suggest that this country's extra spending may not be particularly productive (Figure 1.2).[3]

A second reason for economists' concern about the health care system reflects its possibly distorting effect on the operation of the U.S. labor market. Compared with other OECD countries, employment-based insurance plays an unusually large role in the U.S. health care system, where it finances about 40 percent of U.S. health care spending. But, of course, not all employers offer health insurance. And from 1993 to 2003, the share of private-sector workers actually participating in employer-provided medical plans fell from 63 to 45 percent, in part reflecting workforce

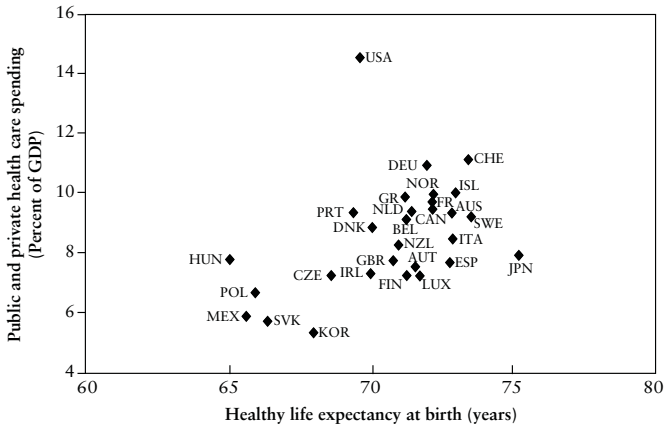

Figure 1.2
International Comparisons of Health Care Spending versus Healthy Life Expectancy, 2002
Source: OECD, 2002.

shifts from full-time to part-time, and union to nonunion, status. In addition, a smaller share of workers who are offered health insurance now choose to take it—most likely because a growing fraction of employers are requiring workers who elect this benefit to contribute more toward its cost (Wiatrowski 2004). Another factor may be the increase in two-worker households.

Are these employment-based financing arrangements affecting the supply or demand for labor in this country? Do they influence the structure of employment, encouraging a shift toward the use of temporary or contract labor? Does our health care system distort our labor market and reduce its flexibility? Policymakers are concerned about the answers to these questions.

Finally, turning to fiscal issues, the "tax-financed" share of health care is estimated to have reached about 60 percent in 1999,[4] up from 55 percent in 1990 and a higher percentage than most people might expect. The large and rising share of publicly funded health care puts pressure on federal and state budgets, limiting those governments' nonhealth policy options. According to the Social Security and Medicare Trustees Reports of 2005, total Medicare expenditures will rise as a share of GDP from 2.6 percent currently to 13.6 percent in 2079. If so, Medicare expenditures will exceed those for Social Security in 2024 and will represent twice the cost of Social Security in 2079 (Figure 1.3). Moreover, at the state level, many governments have taken steps to expand the scope of Medicaid in order to extend health insurance coverage to particularly vulnerable groups, such as children. This trend has placed an increased burden on state budgets (Figure 1.4). How the nation and individual states address these imbalances—whether through increased taxes, reduced benefits, or increased borrowing—will affect U.S. interest rates, private savings and investment, and international capital flows.

Prompted by its interest in these issues, in June 2005, the Federal Reserve Bank of Boston brought together economists, health practitioners, and policymakers to examine the topic, "Wanting It All: The Challenge of Reforming the U.S. Health Care System." This essay summarizes the themes and the consensus-based prescriptions for action that emerged from that conference.

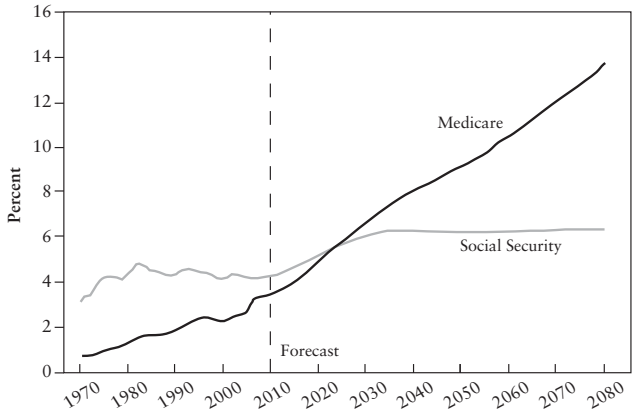

Figure 1.3
Social Security and Medicare Costs as a Share of GDP
Sources: Medicare Trustees Report, 2005, and *Social Security Trustees Report, 2005*.

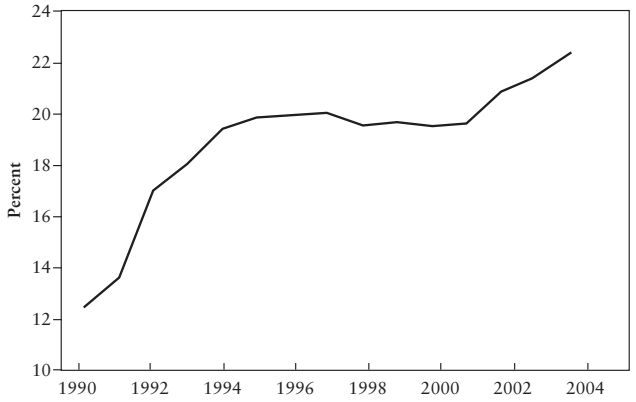

Figure 1.4
Medicaid as a Share of State Expenditures
Source: National Association of State Budget Officers, *State Expenditure Report, 1990–2004*.

Defining the Health Care Challenge—"The Problem with No Obvious Solution"

This country's health care goals include broad, secure access to "appropriate," high-quality care based on active discovery and innovation at an "acceptable" (aye, there's the rub!) cost to the ultimate payer. All industrial countries share these goals, although, as Kieke Okma points out, not necessarily the weights they assign to them. For example, Europeans tend to put more weight on access to care than do Americans, who seem to put consumer choice at the top of the list and access toward the bottom. But in the end, by "wanting it all," every country struggles with the inherent conflicts between these goals. In particular, since all countries adopt new medical technologies as they become available, all struggle to contain the rapid pace of growth in health care costs. And most could put more emphasis on prevention and achieving good health.[5]

These inherent conflicts reflect the essential value of health care to many consumers (patients). They also reflect, as William Nordhaus points out, society's embrace of "specific egalitarianism"[6] as well as its reluctance to ration health care by price or even by regulation. Obviously, these attitudes do not accord well with an equally widespread lack of political will to pay for other people's health care. And these inconsistencies are only exacerbated by information asymmetries; by the absence of cost consciousness among consumers; and by limited competition among providers and health plans. Finally, Richard Frank and others raise a host of behavioral issues that further compound the situation, issues that include patient-doctor inertia, rules of thumb, excessive optimism, and myopia regarding the need to save for medical emergencies. These inherent conflicts lead David Cutler to call health reform "a hard problem"; Nordhaus to call it "a very hard problem"; and Henry Aaron to call it "the problem that won't go away."

Measuring and Valuing Health Care

David Cutler and William Nordhaus both demonstrate that improvements in public health and medical care have added enormously to our standard of living over the past century. Nordhaus even concludes that the value of the gains stemming from improvements in health status equals

the value of all other gains in consumption over the past 25 years. Not surprisingly, then, as physicians have become more effective and societies have grown wealthier, people have chosen to spend a higher share of their incomes on health care—they value what doctors can do for them. In addition, as Cutler points out, health care turns out to be highly price elastic; properly measured, some quality-adjusted health care prices are actually falling, and people spend more in response. Moreover, as Cutler also demonstrates, cost-benefit analysis of specific interventions, like treatment for heart attack, finds that such interventions are clearly "worth" their cost, based on common assumptions regarding the economic value of the additional years of life resulting from the intervention. For example, $30,000 in expenditures for a 45-year-old cardiac patient leads on average to three years' longer life. Since three years' longer life has a discounted present value of $120,000 by common estimates, the return on the investment is 4 to 1.

But, as Cutler also notes, the fact that much of today's health care is highly *valued* (particularly by individual doctors, patients, and their families confronting specific medical crises) does not necessarily make it *affordable* (particularly to taxpayers, to whom hypothetical patients are mere statistics). Nor does this high valuation mean that all health care dollars are well spent. Cutler suggests that at least 20 percent of health care spending is wasted, while Wennberg, Fisher, and Skinner (who find that Medicare spends half as much per patient in Minnesota as in Miami with equally good results) conclude that the waste in Medicare is closer to 30 percent.[7] But *underspending* also contributes to the inefficiency of the U.S. health care system. For example, too little is spent on prevention and chronic disease management—for the insured as well as for the uninsured. And the system often does a poor job of coordinating different aspects or phases of a patient's care, such as the transition from acute to chronic care, or the transfer of records from one hospital or doctor to another.

Improving Efficiency: Consumer Incentives, Provider Incentives, and Technology

Prescriptions for reducing the inefficiencies plaguing the U.S. health care system include making consumers more sensitive to the costs of their medical care, making providers more responsible for health care outcomes, and encouraging better use of information and communication technology throughout the health care system. To start with consumer awareness, most analysts, including those at the Boston Fed conference, agree that the tax subsidy for employer-provided health insurance, which currently cuts federal tax revenues by about $200 billion per year (Council of Economic Advisers 2006), reduces cost consciousness and should be eliminated for the nonpoor.[8]

A second, newly popular approach to encouraging patients to be more cost conscious involves increasing the availability of low-cost insurance with high deductibles and high co-payments, combined with health savings accounts (HSAs) or health reimbursement arrangements. Together, these elements make up "consumer-driven health care" (CDHC), which, to be effective, requires that health care cost information be widely available and of significance to patients making health care decisions. While several conference participants, including Stuart Altman, Alain Enthoven, Mark Pauly, and Gene Steuerle, see some merit in aspects of consumer-driven health care,[9] many attendees are concerned that CDHC will encourage underutilization of preventive care, particularly by low-income individuals who are unable to afford the high co-payments and deductibles. And such concerns appear to be warranted, judging by a recent study, which finds that, for reasons of cost, 35 percent of individuals with CDHC plans skipped or delayed health care, compared with 17 percent of persons with comprehensive health plans.[10] In addition, conference participants, including Richard Frank, Robert Galvin, Sherry Glied, and David Meltzer, point to the general absence of the information regarding health care costs that would be required to make CDHC work; the reluctance of doctors and patients to discuss matters of cost; the importance of advice from family and friends; and the prominence of inertia in determining patient choice of health care providers.

As for motivating providers to improve efficiency, many conference participants see considerable promise in "pay for performance," a reimbursement system that rewards providers for good outcomes and for following prescribed protocols for vaccinations and other preventive care—that is, for doing what they ought to do. A smaller group, led by Alain Enthoven, advocates combining pay for performance with support for integrated delivery systems like Kaiser Permanente in California and Harvard Vanguard in Massachusetts. Such systems are built around

a core multi-specialty group practice that has a significant share of its revenues based on per capita prepayment. Additionally, members of the practice are encouraged to adhere to up-to-date clinical standards developed by the team.[11] According to Enthoven, integrated delivery systems, also known as "delivery system HMOs," should be sharply distinguished from "carrier HMOs," rather inclusive networks of unaffiliated physicians generally working under fee-for-service arrangements. In choosing to receive care from an integrated delivery system, an individual is opting to hire a general contractor, to use a Karen Davis metaphor, rather than to deal with the plumber, the roofer, the painter, and the candlestick maker individually. Obviously, the individual's care is likely to be better coordinated; in addition, between capitation and patient inertia regarding choice of doctor, the system's managers have considerable incentive to provide good preventive care and disease management, using nonphysician providers whenever appropriate.

But while Kaiser, Mayo, and Harvard Vanguard are widely acknowledged to provide great care, integrated delivery systems are not popular outside of California and, to a lesser extent, Massachusetts and Connecticut. Why not? Chernew and Glied suggest that people fear precommitting to a narrow set of doctors before knowing what their medical needs may be and that such systems may require too much travel. But in their eyes, the major deterrent is likely to be resistance to switching doctors, a reluctance that has fostered the spread of preferred provider organizations (PPOs) and other almost universally inclusive networks of independent providers. Richard Frank and David Meltzer also raise some behavioral concerns about the efficacy of practice guidelines and pay for performance, noting that physicians tend to be overly optimistic, overly confident, and very reluctant (or uncertain how) to change their ways. In the end, while most observers view integrated delivery systems and pay for performance as likely to improve the efficiency of the U.S. health care system, no one claims that these options will keep health care expenditures from rising as a share of income. And, as Chernew points out, the more efficient the system becomes, the harder it is to avoid the painful trade-offs between quality and access.

Turning to technology, while almost everyone agrees that advancing medical technology is the primary driver of rising health care costs—"it's the technology, stupid," to quote Mark Pauly—many conference participants remain convinced that better use of information and communication technology holds great promise for improving the efficiency of the complex, disjointed U.S. health care system. According to Mongan and Brailer, for example, electronic medical records will do far more than cut paperwork and reduce error; more important, they will also drive medicine toward evidence-based practice. Galvin, Brailer, Davis, and Mongan all see huge potential in a national effort to identify and spread best practices and to develop and publicize quality measures. Nevertheless, Pauly and others suspect that, even with better consumer and provider incentives as well as improved information and communication technology, U.S. policymakers will likely need to find a graceful, politically acceptable way to slow the adoption of new or unneeded medical technology for the insured middle class.

Employer-Based Health Insurance: Pros and Cons

In the United States, members of the middle class generally obtain their health insurance through employer-provided health benefits. Although employment-based insurance crops up in many countries, this arrangement has played an unusually dominant role in the United States. In the 1940s, U.S. employers constrained by wartime price controls were encouraged to compete for workers by offering tax-subsidized health benefits in place of higher wages; today, employer-provided benefits are the primary source of health insurance for the non-elderly. These employment-based arrangements cover 63 percent of the non-elderly population; by contrast, public programs like Medicaid and Medicare cover just 17 percent (Figure 1.5). As Brigitte Madrian points out, the result is a highly fragmented system where thousands of employers define the health insurance options available to their workers and where even Medicaid comprises 50 different state programs. Does this employment-based system serve the country well?

Many conference participants, including Alain Enthoven and Henry Farber, answer "no." They describe the system as "hopelessly flawed" and a "terrible idea," because it leaves millions of people without access to affordable health care, bears most heavily on low-wage workers, and makes the U.S. labor market less flexible and dynamic. To start with this last point, just 60 percent of U.S. employers offer health insurance to

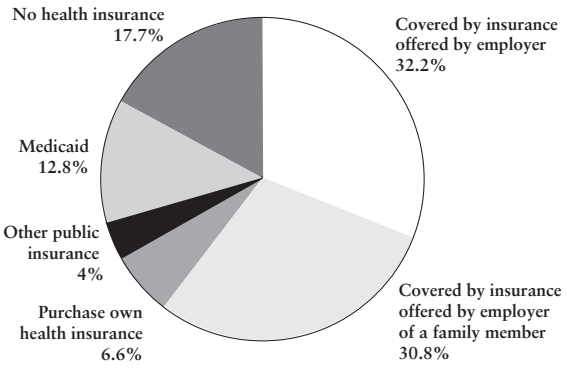

Figure 1.5
Health Insurance Coverage of the Non-Elderly
Total exceeds 100 percent because people may get coverage from more than one source.
Source: Employee Benefit Research Institute, 2003.

any part of their workforce, and that share has been declining in recent years as health benefits have grown more costly. As a result, Madrian and others find that worker demand for affordable health insurance and employer efforts to minimize the cost of offering this benefit distort labor market decisions, reducing labor market flexibility and worker productivity. On the supply side, the availability of affordable health insurance significantly affects individual decisions regarding where to work or whether to work at all. Further, because employer-provided health insurance is not portable, insurance contracts exclude pre-existing conditions; and because people hate changing their doctors, the employer-based system tends to discourage labor mobility, producing a phenomenon known as "job lock"[12]—even "wedlock" on occasion. More important, perhaps, on the demand side, employers face an incentive to substitute part-time or temporary workers for full-time workers in order to avoid health insurance costs. Similarly, firms may ask existing full-time staff, who already have health benefits, to work more hours, instead of hiring more full-time workers, who will add to insurance costs. Given the evidence that workers do, in fact, pay for their health benefits through lower wages as economic theory would suggest, such employer efforts to minimize health

insurance costs may seem puzzling. But it is not clear that the wage-benefit trade-off is either immediate or one-for-one. For example, as Joseph Newhouse points out, minimum wage laws limit employers' practical ability to shift big increases in insurance costs to low-wage workers. Nor is it easy to ask current workers to pay for big increases in the cost of retiree insurance, especially since, as Farber notes, mature firms like GM now have more pensioners than active employees.

In addition, Enthoven, Farber, and Galvin agree that many employers are ill equipped to purchase health insurance for their workers. Few small employers have a good understanding of health care issues, and employer/worker interests may not coincide. For example, while employers clearly have an interest in attracting healthy, productive workers, management's interest in their workers' long-term health may have declined in recent years as average job tenures have fallen and lifetime employment has virtually disappeared.

On the other hand, as Altman, Galvin, and Pauly argue, large firms with good benefits departments deliver very responsive health care to their workers in a very efficient manner. These firms have taken the lead in promoting fitness and wellness programs, in encouraging pay for performance, and in developing accessible information on provider quality and costs. Further, as Galvin emphasizes, in an employer-linked system, decisions regarding the use of new technologies are market based. Without these market signals, how would the nation determine how much to invest in desirable medical innovation? Would a single-payer system with a "politically acceptable" global budget do as well?

Fiscal Pressures

Even now, the federal government's existing responsibilities for health care are projected to create extraordinary fiscal—and political—pressures in the decades ahead. Although political and media attention has so far focused primarily on the need to address the Social Security "crisis" approaching with the retirement of the baby boom generation, the government's future commitments under the Medicare and Medicaid programs loom considerably larger, as Henry Aaron, Stuart Altman, and others emphasize.

To draw the comparison more precisely, the baseline, or intermediate, estimate from the Congressional Budget Office (CBO) projects that federal spending for Social Security will rise from 4.2 percent of GDP in 2005 to 6.4 percent in 2050. By contrast, in the intermediate case, federal spending for Medicare and Medicaid, also 4.2 percent of GDP today, is projected to reach 12.6 percent of national output by midcentury (Figure 1.6). Unfortunately, however, the CBO's intermediate projection assumes, as do the Medicare trustees, that Medicare and Medicaid spending per enrollee will exceed per capita GDP growth by just 1 percentage point per year—an unrealistic assumption judging by U.S. history and by international trends. As the CBO points out, Medicare-Medicaid spending (and health care spending more generally) has, in fact, grown an average of 2.5 percentage points faster than per capita GDP since 1970. Again, this gap largely reflects technological improvements, not population aging. If these trends continue, Medicare-Medicaid spending will account for 22 percent of GDP in 2050—almost 18 percentage points more than currently.[13] Further, as Henry Aaron points out, because the private and public sectors share responsibility for health care spending in this country, at current trends, health care will claim about half of all U.S. income and

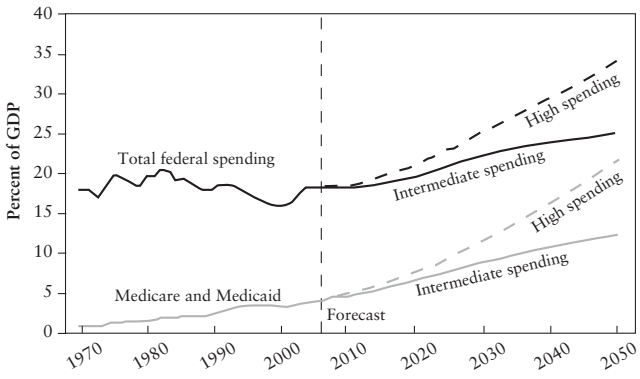

Figure 1.6
Projections of Federal Spending
Source: U.S. Congressional Budget Office (2005).

all of the increase in economic output by midcentury. Valuable as health care is, is this outcome realistic?

Confronted with these prospects, what will the U.S. electorate do? Among the alternatives Aaron posits, one course might be to continue, by default, along the current path and simply pay the bill. This option would allow increasing our nonhealth standard of living for a while, but, as health care came to claim all of the growth in economic output and then more, the situation could turn unsustainable—if the share of economic output devoted to education, research and development, and crucial infrastructure began to shrink, economic growth itself would slow. As an obvious, desirable alternative, U.S. policymakers could redouble their efforts to make the health care system more efficient; but, as already discussed, a better-targeted system requires more spending in some areas and less in others, making the net savings likely not very large. To curb Medicare spending specifically, Congress could pass restrictive legislation, increasing the Medicare eligibility age to 67, for example. While this change might encourage people to work longer, it would not save much money, because the young elderly are reasonably healthy. Congress could also increase Medicare deductibles, co-payments, and premiums,[14] but, as Aaron notes, these changes would simply shift costs to the private sector or reduce the elderly population's access to medical care. While Medicare administrators could, for example, conceivably slow the pace at which they approve Medicare coverage for new technologies, the boomer generation, as Stuart Altman observes, has always been a demanding, spending lot, even in their 30s and 40s; thus, he doubts they will permit substandard care for the elderly (and poor?) to reemerge as they age.

How, then, is the nation going to pay this medical bill? Assuming that the current gap between the growth in health care costs and the growth in GDP continues, meeting current Medicare-Medicaid commitments, Henry Aaron calculates, will require doubling payroll and income tax revenues as a share of GDP by 2040. Even slowing the increase in health care spending to 1 percentage point above per capita GDP growth would mean raising tax revenues by 6 percent of GDP by 2040. But, according to Stuart Altman, the United States is a "tax-phobic" nation with an Eleventh Commandment proscribing tax rates above 18 percent to 19 percent of

GDP, while Joseph Newhouse notes that U.S. tax revenues have exceeded 20 percent of GDP on just one occasion in the post-World War II era.

Our options are limited—both collectively as a society and individually. The more we choose to emphasize individual responsibility, the more cost conscious the system will be, but the more access for the poor and the seriously ill will become problematic. In the end, U.S. voters will have to decide what they are willing to spend for other people's health care, for, as Alan Weil points out, while people are willing to spend a lot for their own health care, it is less clear what they are willing to spend on the care of others. In Henry Aaron's view, resolving these issues will impose major stresses on the democratic polity of this country in coming decades.

Wanting It All, Getting Much of It—Areas of Agreement

Most of the health care experts attending the Boston Fed's June 2005 conference appear to agree with Karen Davis, whose remarks argued that we actually do know how to achieve much of what we want for the U.S. health care system—even including broader access—and we should "just go ahead and do it." Within this group of analysts, all tend to cite the same list of ways to increase the efficiency of the U.S. health care system and move it toward the production possibility frontier. In their view, some good steps to take include encouraging the increased use of pay for performance and integrated delivery systems—with ongoing efforts to understand the behavioral issues that might undermine their spread and effectiveness. They also advocate added emphasis on primary and preventive care and disease management as well as broader use of communication and information technology to identify what works. Less obviously, perhaps, most experts also support renewed efforts to improve consumer cost consciousness by eliminating tax subsidies for employer-provided health benefits and, to a lesser extent, by additional provision of consumer-directed health plans. While the conference attendees admit that individually these measures will not save a lot of money, 10 percent here and 15 percent there will begin to add up.

Moreover, these experts broadly agree that insuring the uninsured would require relatively modest amounts of additional money: less than $100 billion a year, a sum that represents less than 5 percent of current health care spending, or roughly the amount of money returned to taxpayer pockets by recent below-average tax rates.[15] This money could prevent 18,000 premature deaths a year among the under-65s, according to Jim Mongan. On net, the extra cost is likely to be modest because the uninsured already get some medical care, often in emergency settings, and because providing preventive care and disease management for these people would actually be more efficient over time.

Thus, once again, these analysts concur that the nation should "just do it"[16] and move to provide universal coverage without waiting until we figure out how to control health care costs. As Judy Feder argues, the uninsured minority have been held hostage to our unwillingness to slow the growth of health care spending for the well-insured majority for 50 years. Henry Aaron concludes that universal coverage may be a necessary precondition for controlling overall health care spending; others argue that universal coverage must come first, because cost control without coverage would mean squeezing low-income people out of the system.

As a result, the conference participants generally advocate using any cost savings reaped from the reforms discussed above to fund broader health insurance coverage. As one example, Alan Weil suggests making employer payments for health insurance benefits taxable and using the resulting revenue gains to fund universal coverage.

Where Achieving Consensus Becomes a Challenge

Beyond the large areas of agreement just reviewed, two issues—the role of employer-based insurance and the most appropriate way to control the growth of U.S. health care costs—defy consensus. To start with the first issue, conference attendees clearly have differing views on the merits of this country's employment-based system, with some viewing it as a disaster and others finding it an efficient organizing mechanism as well as a progressive force. But whatever their views on its merits, many analysts, including Altman, Feder, and Newhouse, are convinced that the employment-based system is crumbling badly, because, as Galvin notes, many employers are seeking to escape from providing health insurance. That explains why employers are responding with enthusiasm to consumer-driven health care (CDHC); while they truly do believe that consumers

must become more cost conscious, they are also looking for an exit strategy. Thus, Galvin predicts, 20 to 30 percent of all workers will soon have HSAs, which will drive out traditional health insurance just as 401(k)s drove out defined benefit pensions. Employers do not want to abandon their employees, but CDHC provides them with an acceptable way out.

Unfortunately, however, CDHC and HSAs may not work well for low-income workers, who may opt to buy low-premium insurance but be unable to pay the required deductibles, co-payments, and other large, but less than "catastrophic"[17] expenses, or who may opt out of buying health insurance altogether. These people will swell the ranks of the uninsured or the Medicaid population because, as noted above, many states are making imaginative efforts to redefine their Medicaid programs to let them cover nontraditional beneficiaries. (See the box on page 21 for a description of recent state initiatives in New England.)

But, as Alan Weil points out, the fiscal stresses at the state level are becoming enormous. As a result, the U.S. Congress passed the Deficit Reduction Act of 2005 to give the states new leeway to charge premiums and raise co-payments for Medicaid benefits. Moreover, for the first time ever, this law allows states to end Medicaid coverage for people who fail to pay these new premiums and permits doctors, hospitals, and pharmacies to deny services to Medicaid recipients who cannot make the required co-payments. To judge from current trends, the end result of employer efforts to avoid health care costs may be a de facto single-payer (or largely single-payer) system, but one in which impoverished people can be denied needed health care. For analysts who favor employer-based insurance, the only way to stem this tide may be to return to the list of live policy options "pay or play" laws that require all employers to either provide health benefits or contribute to a state insurance pool.

The conference attendees also fail to reach consensus on further ways to curb the growth in health care costs beyond those that would position the U.S. health care system to operate at maximum efficiency, although most agree that such efforts would have to include limiting insured middle-class access to valuable new technologies. At one extreme, a de facto single-payer system would require a global budget. Would such a budget fund optimum investment in new technologies, Bob Galvin wonders, or would a market-based system do a better job? Also envisioning an ongoing role for private insurance, Mark Pauly suggests that insurers develop low-cost insurance with limited access to new interventions and technology, and tout these products as "prudent care" in order to slow the adoption of possibly dangerous (and clearly expensive) new technologies. By contrast, Gene Steuerle would focus on finding ways to encourage cost-saving, rather than cost-increasing, new technologies. Nevertheless, privately funded health care would set the standards for all, because, as Jim Mongan points out, while we find price rationing acceptable in the case of hotels, we naturally find it far less palatable in the case of health care. Still, nonprice rationing through government or private-payer limits leads to unacceptable queues and shortages. In the same vein, Nordhaus sees some attractions in Oregon's system of ranking medical interventions, as cost-benefit analysis and good sense would suggest, and then drawing a line where the health care budget is totally absorbed. Although the Oregon system has many problems and critics, and, after all, only applies to Medicaid patients, Nordhaus argues that it is logical and flexible, responding to both technological and fiscal developments.

In the end, conference participants conclude, the major challenge posed by the U.S. health care system remains summoning the political will to make these difficult allocational decisions in a responsible and equitable way. Failure to meet this challenge would have serious consequences for the U.S. macro economy and polity—as well as for every individual family's well-being.

Box 1.1
Health Insurance Reform in Three New England States

The last several years have seen private health insurance premiums rise and the ranks of the uninsured swell, while state budgets have come under increased fiscal pressure, limiting expansion or compelling cuts in existing programs. Nevertheless, some states have managed to summon the political will to implement health reform strategies that stretch health care dollars by using a portion of state money to leverage private, federal, and additional state funds in order to expand coverage and improve program efficiency. Initiatives of the New England states include using federal Medicaid waivers and State Children's Health Insurance Program (SCHIP) waivers to expand coverage to nontraditional beneficiaries; enacting "pay or play" laws; and creating group purchasing arrangements.[18] The programs of three states are explored here.

Rhode Island

In 1993, Rhode Island applied for a Medicaid 1115 waiver, permitting it to conduct a demonstration project, RIte Care. The project provides comprehensive coverage to families on the Family Independence Program (formerly AFDC) and eligible uninsured pregnant women, parents of children 18 and younger, and children up to age 19. RIte Care experienced a higher-than-expected take-up rate, resulting in fiscal pressure. In 2001, in an effort to reduce the cost burden without cutting eligibility, the state obtained a SCHIP 1115 waiver, converting the parents of children eligible for public health coverage from Medicaid to SCHIP and, in so doing, receiving a higher SCHIP federal match for these enrollees. Additionally, Rhode Island created RIte Share, a premium-assistance program for RIte Care-eligible families with access to approved employer-sponsored health insurance. RIte Share leverages employer dollars, resulting in savings to the state for every family enrolled in this plan instead of in RIte Care, which has a full public subsidy. Under RIte Share, the state pays the employee's share of work-based insurance premiums (families above 150 percent of the federal poverty level make contributions according to a sliding scale), the employee's co-payments, and wraparound coverage for Medicaid benefits not included in the employer's health plan.

The results of RIte Share are encouraging. The Rhode Island Department of Human Services (DHS) has determined that subsidizing a family in RIte Share plus providing wraparound services costs the state slightly more than half the expense of covering the family through the RIte Care managed care plan. Thus far, DHS has transitioned 4 percent of the RIte Care population into RIte Share, resulting in a savings of about 2 percent of the program.

Maine

Maine's Dirigo Health Plan, created in 2003, aims to increase access to affordable health insurance coverage, slow the growth of health care costs, and improve the quality of care. One component, DirigoChoice, offers affordable health care insurance, through private carriers, to small-business employees, the self-employed, individuals without access to employer coverage, and dependents of these eligibles. The program pools employee, employer, state, and federal funding sources to be able to deliver reduced-cost health insurance.

To increase coverage for its low-income population, Maine obtained a federal waiver to extend its state Medicaid program, MaineCare, to parents with incomes under 200 percent of the federal poverty level and to childless adults with incomes up to 125 percent of the federal poverty level. For working persons who are ineligible for MaineCare and whose income is below 300 percent of the federal poverty level, the state provides assistance in purchasing DirigoChoice coverage on a sliding scale. Both the sliding scale and the MaineCare expansion are financed by redirecting a portion of the disproportionate share hospital (DSH) allocation.

In an effort to contain health care costs, the Governor's Office of Health Policy and Finance now sets explicit targets for quality, cost, and access to health care, and establishes a budget to assist in resource allocation. In a move to increase transparency, Maine requires that average charges and payments accepted for commonly performed procedures be posted at each provider site. In addition, Maine has expanded the reach of its certificate-of-need program to cover functions and expenditures regardless of the site of care and has put voluntary limits on the growth of insurance premiums and health care costs. Mandatory provider use of health care information technology has also been proposed.

In its first nine months, DirigoChoice enrolled more than 7,000 residents and achieved $43.7 million in savings for the Maine health care system. However, enrollment was lower than expected, and a survey of enrollees found that only one in four was uninsured at the time they purchased state-subsidized insurance. The majority of DirigoChoice enrollees simply switched from other private insurance.

Massachusetts

In Massachusetts, April 2006 saw a bipartisan bill break political gridlock and potentially extend health care coverage to the state's 500,000 uninsured. The new legislation combines the individual mandate championed by conservatives—that all individuals should have health insurance—with liberal measures, such as large subsidies to help low-income individuals buy insurance, and a proposed employer mandate—that all firms with 11 or more employees should provide health insurance. Under the legislation, the approximately 200,000 uninsured Bay State residents who can afford to buy health insurance will be required to purchase it or face tax penalties. To help these individuals acquire coverage, the state will create a group purchasing arrangement, allowing individuals and small businesses to buy insurance as one entity.

The state's additional uninsured comprise two groups: (1) 100,000 individuals who qualify for Medicaid but are not signed up for it, and (2) 200,000 individuals who do not qualify for Medicaid but are too poor to buy health insurance on their own. Those who qualify for Medicaid will be enrolled in it, with the cost split between the state and the federal government. For the second group, those earning up to 100 percent of the federal poverty level will receive coverage at no cost, while those with incomes between 100 percent and 300 percent of the federal poverty level will pay a portion of the premium, based on a sliding scale. Funding for both groups will come from (1) state funds set aside to pay hospitals and other providers for treating the uninsured, as well as (2) $385 million pledged by the federal government if the state can show it is on a path to reducing its number of uninsured. Funding would also come from the proposed pay or play provision of the new law, which requires all employers with 11 or more

employees to provide health care insurance or to pay an annual penalty of $295 per worker.

Rhode Island, Maine, and Massachusetts have implemented innovative policies to address the rising ranks of the uninsured and to control health care costs. While none of these plans to date has provided a solution to all of the challenges that the health care system currently faces, they do offer innovative ideas and reinvigorate the ongoing national debate.

Notes

1. Population aging will contribute modestly to this trend as well.

2. Many health economists argue that it is foolish to expect the income elasticity of health care spending to be similar across countries and particularly foolish to expect the relationship to be linear. Furthermore, this country's "outlier" status largely reflects the fact that the United States pays its health professionals relatively well, not that the U.S. system is inefficient. However, GDP does provide one constraint on health care spending, and one might ask *why* U.S. health professionals earn relatively high wages.

3. Looking beyond the healthy life expectancy data shown in the chart, the United States also uses more cardiovascular procedures per capita than Australia and Canada, with less effect in terms of reduced mortality from heart disease. The United States also ranks near the bottom of OECD countries in terms of infant mortality and years lost to premature death, in part reflecting the uneven distribution of health care resources in this country.

4. "Tax-financed" includes Medicare and Medicaid, health care spending for the military and their dependents, health benefits for government employees, and the value of tax subsidies for employer-provided health benefits (Woolhandler and Himmelstein 2002).

5. However, Okma argues that some single-payer systems are quite good at prevention. She notes that the Germans are good at disease management—for instance, by sending cardiac patients to spas to learn how to change their lifestyle by exercising and losing weight.

6. "Specific egalitarianism" is the belief that a program or service should be distributed equally across all people, as with voting, the wartime draft, and primary and secondary education.

7. Even worse, a study by the Institute of Medicine finds that medical error is the eighth-largest cause of death in the United States (Wennberg, Fisher, and Skinner 2002).

8. This subsidized system also places low-wage workers at a comparative disadvantage, because health insurance premiums loom larger relative to their wages than they do for highly compensated workers.

9. Gene Steuerle points out that most people, including health economists, have no idea that total health care spending per household averaged $16,000 in 2003.

10. Furthermore, 42 percent of those with high-deductible plans spent 5 percent or more of their income on health care (premiums and out-of-pocket items) compared with 12 percent of those with more comprehensive plans (Frontsin and Collins 2005).

11. In a somewhat narrower setting, David Meltzer also notes how the development of "hospitalists," physicians who specialize in providing inpatient care, has cut costs and improved the quality of hospital care delivered both by the hospitalists and by other physicians who work with them.

12. However, because most workers are relatively healthy, Mark Pauly suspects that job lock is unlikely to be a major concern. The growing number of two-worker households also helps to alleviate this problem.

13. According to the CBO long-term outlook, the intermediate path would result in primary spending (defense, Social Security, Medicare and Medicaid, and other noninterest expenditures) rising from 17.5 percent of GDP in 2005 to 25 percent in 2050. The higher path would see primary spending soar from 17.5 percent of GDP to 34 percent (Congressional Budget Office 2005).

14. Making a dent would require some big changes. According to Aaron, just to keep Medicare costs from rising faster than GDP would require boosting the eligibility age for Medicare to 83 in 2040 or reducing Medicare's share of health care spending by the elderly from 60 percent currently to 23 percent in 2040.

15. Federal tax revenues have averaged 18.3 percent of GDP over the past 30 years, but were just 17.5 percent of GDP in 2005.

16. The mechanisms for doing so vary and could include broadening eligibility criteria for Medicare, Medicaid, the Federal Employees Health Benefits Plan, and other health plan purchasing organizations, instituting an employer or individual mandate, or shifting to a single-payer system.

17. Low-premium, high-deductible health insurance plans do tend to cover catastrophic medical expenses.

18. The strategies employed by states include reinsurance, high-risk pools, and limited benefit plans. This section covers only a subset of the New England states' utilization of federal waivers and other state health system reforms.

References

Congressional Budget Office. 2005. *The Long-Term Budget Outlook*. Washington, D.C.: U.S. Congressional Budget Office.

Council of Economic Advisers. 2006. *2006 Economic Report of the President*. Washington, D.C.

Frontsin, P., and S. R. Collins. 2005. Early experience with high-deductible and consumer-driven health plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care survey. *EBRI Issue Brief* No. 288.

Marmor, T. 1994. The politics of universal health insurance: Lessons from past administrations? *Political Science and Politics* 27: 194–198.

Special report: America's health-care crisis. *Economist*, January 28, 2006, 24–26.

Wennberg, J. E., E. S. Fisher, and J. S. Skinner. 2002. Geography and the debate over Medicare reform. *Health Affairs*, Web Exclusive. http://content.healthaffairs.org/cgi/reprint/ hlthaff.w2.96v1.pdf. Accessed April 18, 2007.

Wiatrowski, W. J. 2004. Medical and retirement plan coverage: Explaining the decrease in recent years. *Monthly Labor Review* 127: 29–36.

Woolhandler, S. and D. U. Himmelstein. 2002. Paying for national health insurance—and not getting it. *Health Affairs* 21 (4): 88–98.