Can We Afford Our Healthcare?

Robert B. Helms
Resident Scholar
American Enterprise Institute

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Maybe

But it will require substantial reform in 3 areas:
- Tax policy affecting private health insurance
- Medicare payment policies
- Medicaid financing
The Politics of Health Policy

Are the Stars Aligned for Health Reform?

Senator Kennedy’s Task Force

Public Opinion favors reform
Past Attempts to Reform Health Policy

- President Truman and National Health Insurance
- President Nixon’s offer
- The Reagan era
- President Clinton’s Health Security Act

Health Econ 101

- Prices matter
  - To buyers
  - To sellers

- Insurance (Public or Private)
  - Lowers the perceived price to the consumer
  - Increases the volume demanded (moral hazard)

- Supply of health care
  - Mostly services -- Is very labor intensive (income to people)
  - Medical products – innovation constantly changing
  - Facilities – long-term capital investments make adjustments difficult

- Open-ended payment policies create strong incentives to increase spending
  - With weak incentives to seek value
  - Result is inefficient, flat-of-the-curve health care delivery
National Health Expenditures
Projected to be $2.3T in 2007

Private Insc 34%
Medicaid 15%
Medicare 20%
Other Public 12%
OOP 12%
Other 7%
Private 7%
Source: CMS, NHE

The Private Sector
Projected to be $1042 B in 2007

Private Insc
Medicaid
Medicare
Other
Private
Source: CMS, NHE
WWII Wage and Price Controls

- Two programs to control wartime inflation
  - Office of Price Administration (OPA)
    - Price controls and rationing of consumer commodities (e.g., sugar, coffee, butter, tires)
  - National War Labor Board (WLB)
    - Control of wartime wages
    - Settlement of labor disputes to assure wartime production

National War Labor Board

- 1943: War Labor Board and IRS ruling that employer fringe benefits did not count as taxable wages
- But could not exceed 5% of wages
The Post-War Period

- 1954: Exclusion of health insurance from taxable income confirmed by the Congress
- Post-war period
  - Medical advances increased cost of medical care and the demand for health insurance
  - Rapid growth in health insurance coverage

Private Hospital Insurance Coverage
Group versus Individual, 1940-1975

Note: Employer group is the total of persons covered by Blue Cross/Blue Shield plus insurance company group policies.
Growth in Third-party Payments, 1960-2000

Effects of Tax Policy

- Higher prices
- Lack of access
- Winners & Losers

• Higher prices
• Lack of access
• Winners & Losers
Medicare
Projected to be $448 B in 2007

Other Public  OOP
Medicaid  Private Insc
Medicare  Other
          Private

Source: CMS, NHE

Medicare Expenditures 2007

Hospital 46%
Other 12%
Rx Drugs 11%
Home Health 5%
Other Prof Care 3%
Physician Services 23%

Enrollment:
FFS 82.4%
MA 17.6%
### Medicare Income and Expenditures

#### Percent of GDP

**Historical**

**Estimated**

- Total expenditures
- HI deficit
- General revenue transfers
- State transfers
- Premiums
- Tax on benefits
- Payroll taxes

**Calendar Year**

- 1966
- 1976
- 1986
- 1996
- 2006
- 2016
- 2026
- 2036
- 2046
- 2056
- 2066
- 2076

**Source:** 2008 Medicare Trustees Report, Figure II.2

**Note:** Projections are based on the intermediate assumptions from the 2008 Trustees Report.

### Medicaid - Projected to be $191 B Federal + $146 B State in 2007

**Source:** CMS, NHE
Four Types of Medicaid Benefits
CBO Projections in Billions

Source: CBO, Medicaid Spending Growth, July 13, 2006, Table 4.

Medicaid State Matching Rates,
FY 2008

13 States with 50% FMAPs
- California
- Colorado
- Connecticut
- Delaware
- Illinois
- Maryland
- Massachusetts
- Minnesota
- New Hampshire
- New Jersey
- New York
- Virginia
- Wyoming

10 States with highest FMAPs
- Mississippi 76.3%
- West Virginia 74.3%
- Arkansas 72.9%
- Louisiana 72.5%
- Utah 71.6%
- New Mexico 71%
- District of Columbia 70.0%
  (set by law, not by formula)
- Idaho 69.9%
- South Carolina 69.8%
- Kentucky 69.8%
- Montana 68.5%

Source: KFF State Health Facts
Two Types of Ratchet Effects

- **Total Budget Effect**
  - Expand Medicaid relative to other state programs

- **Interstate Effect**
  - Wealthier states expand Medicaid relative to poorer states

- **Subject to Two Constraints**
  - Each state’s budget capacity - taxing authority
  - The federal bureaucracy’s rules and regulations - NASHP’s “Tug of War”

The Medicaid Commission’s Recommendations

- Did not address FMAP reform or financial gaming
- Recommended greater state flexibility and simplified waiver process
- Emphasis on LTC
  - Especially care coordination for dual eligibles
- Recommended a new Medicaid Advantage proposal
  - Consolidate present funding sources - states receive a risk-adjusted capitated payment
  - Allow states to set up state or private coordinated care plans
  - Optional state participation
  - Beneficiaries could opt out of state system
Payment for Dual Eligibles: Current FFS Policy

Go to Hospital or Nursing Home

Stay at home Go to Physician

No Coordination of Care

Payment from:

Medicare Part A

Medicaid

Medicare Part B

State $ Federal Match

Payment for Dual Eligibles: Seeking a Better Way

Go to Hospital or Nursing Home

Stay at Home Go to Physician

State or Private Health Plan

Provides Coordinated Care And Payment

Medicare Part A

Medicaid

Medicare Part B

State $ Federal Match
Cost of Entitlement Programs

By 2050
19% of GDP
66% of federal spending

Social Security
Medicare
Medicaid

Source: CBO Long Term Budget Outlook, 2007

Entitlement Growth Will Force Political Change

2007
Discretionary Spending 36%
Interest Spending 9%
Mandatory Spending 55%

2018
Discretionary Spending 31%
Interest Spending 6%
Mandatory Spending 63%

Source: CBO Budget Projections, 2008
Can We Afford Our Healthcare?

- Maybe
- But only if we reform the distorted incentives we now have in public and private markets
- We have to create pervasive incentives:
  - For consumers to seek value in medical consumption
  - For providers to compete on the basis of quality and cost-effectiveness
  - For everyone to invest more in prevention and IT
- Mandating coverage will not assure access to effective coverage:
  - look at the UK, Canada, and Medicaid

Are the Stars Aligned for Health Reform?

“All the players in health care reform . . . came to the political process with strong convictions in support of their first-choice proposal. For each of these groups, their second-favorite choice was the status quo.”

Stuart Altman, as quoted in Health Affairs, 2001.