the Atlantic

The State-Level Future of Healthcare Reform

While the national debate over Affordable Care remains deadlocked in dispute, local-level reform trends towards bipartisan convergence.

By Eric Schnurer

April 10, 2015

The Supreme Court's ruling in King v. Burwell, whatever it may be, won't mark the end of Obamacare. On the other hand, Obamacare itself was never intended to be the last word on the country's healthcare needs. At the state level—where, unlike Congress, elected officials actually have to govern—Republicans are already proposing and even enacting their own approaches to healthcare reform. The likely result is a national consensus, at some point in the future, on a plan that both parties could have agreed upon a long time in the past.

The current health insurance debate is stuck in a larger national dispute over whether the government or the private sector has all the answers. But neither the left's persistent hope for a single-payer system, nor the right's all-encompassing belief in the blessings of unfettered markets, represents a likely political outcome—let alone a reasonable policy solution. The most likely compromise has been known for some time, but as the two parties have grown farther apart on everything, especially healthcare, this outcome has been lost. Now, it is slowly re-emerging, piecemeal and unnoticed.

Even during the original debate over the Affordable Care Act, proponents admitted that experience would necessarily yield improvements in a complex, comprehensive, and controversial experiment. The fundamental problems in our healthcare system—which have little to do with whether government or the private sector pays for health insurance, on which the debate has largely centered since then—are multiple and interrelated, meaning that any solution will be complicated and require a lot of time and adjustment. And, of course, it will require government involvement.

The American healthcare system is more expensive and yet delivers inferior care, relative to those of other developed nations. A higher percentage of Americans go without coverage for their healthcare needs than in any other advanced economy; for those who do have private coverage, the costs of care remain a heavy, and growing, burden.

These problems tend to reinforce each other. For instance, the cost of care for those lacking coverage get absorbed by those who have it. An emphasis on expensive, technologically-advanced treatments for catastrophic illnesses raises costs across the board, driving many away from obtaining less-critical care that could keep more people healthy. And due to an historical anomaly—to avoid World War II wage-and-price controls, employers began offering health benefits instead of raises—most Americans receive their healthcare through insurance heavily subsidized by someone else, and not really resembling "insurance" in the traditional sense at all. These policies cover normal, quotidian care needs, rather than simply providing security against expensive "black swan" events. Health plans today look more like prepaid usage plans for cell phones.

As conservatives have long argued, third-party payment structures—not just government programs but also private insurance—lead to overconsumption and price inflation. Make people feel the price of the care they consume and, pretty soon, needless procedures and ever-escalating inflation will decline. Any long-term solution will involve shifting from the current "insurance" model and instead paying providers for keeping people healthy. Both Obamacare and Republican alternatives move in that direction.

But a better, cheaper system still won't automatically be affordable to all. That can be remedied through income-based subsidies, however, rather than government-provided healthcare. This basic prescription—income-related government subsidies in a competitive insurance market structured around health promotion—is similar in pertinent respects to the healthcare plan advanced by Democratic presidential candidate Bill Bradley in the 2000 campaign and praised by the right-wing Cato Institute (famous for devising the "individual mandate" idea central to Obamacare and now rejected by Republicans). Republican states are now adopting this model with the Obama administration's support, although with some features (subsidy caps and high deductibles) that disadvantage people more the poorer they are. In the long term, then, convergence is likely sometime in the future—with comparatively minor quibbles over details—on a plan that both parties could have agreed upon a long time in the past.

* * *

The Affordable Care Act created federal tax subsidies to help moderate-income families buy insurance policies on government-run "exchanges" designed to make insurers compete for their business. At issue in King v. Burwell is whether these subsidies are available in states that chose not to establish their own exchanges but, rather, let the federal government establish one instead, by default. This matters because, without the subsidies, many families won't be able to afford to comply with the requirement to buy insurance (the infamous "mandate"), and the exchange system at Obamacare's heart will—it is alleged—collapse.

If the Supreme Court so decides, however, that won't really end Obamacare. Rather, it would essentially end Obamacare in red states. But it would survive in blue states.

That's essentially what the Court gave us in 2012 when it took it upon itself to rewrite and save the statute by declaring that states had the constitutional right to opt-out of expanding Medicaid—the government-run insurance program for the poor—to cover the near-poor with incomes up to 138 percent of the federal poverty level. As a result, the Medicaid expansion—along with the exchanges designed to help those above that threshold afford private coverage—went ahead in Democratic states. States under Republican control, for the most part, turned the deal down. The nation thus began a striking experiment in federalism, in which, basically, liberal states will get the more-or-less liberal idea of healthcare reform and conservative states will get to stick with less government and the pre-Obama healthcare system everyone loved so much. Somewhere down the road, we'll get to see who's happier.

States that rejected Obamacare also chose not to set up their own exchanges, so, under the law, the federal government set up exchanges for them. If the Obamacare challengers win in King v. Burwell, nothing will change in blue states—but red states, which already rejected coverage for the near-poor, can say sayonara as well to middle-class subsidies.

This has struck fear into the hearts of not just the law's supporters, but also, belatedly, those of many Republicans. The reason is simple: Many middleclass families (and thus likely voters) will see their insurance costs skyrocket, heading into an election year, for reasons wholly attributable to conservative opposition to Obamacare. As a result, Republican leaders in Congress have been scrambling in recent weeks to make clear that they won't leave these voters (and their insurance companies) without some form of subsidy. While the easy fix would simply be to clarify in statute that the subsidy language is intended to apply to federal as well as state exchanges, that would be too, well, Obama. So congressional Republicans have proposed several variants that, essentially, provide some similar form of subsidy, but not too much, and not for too long (basically, just until they can get past the 2016 elections).

The story is more complex at the state level. Some believe that exchanges collapsing in two-thirds of the states will cause the system to implode everywhere. But this is unlikely given that insurance rates are set on a state-by-basis, even on federally-run exchanges. A "death spiral" in one state—in which healthier consumers opt-out of high-priced coverage, leaving only sicker ones who push the cost even higher—shouldn't affect the viability of the market in other states. Perhaps even more importantly, many of the states in question are already planning to institute their own state-run exchanges, if the Court requires them to do so in order to preserve subsidies for their citizens. That underscores the fact that opposition to Obamacare is at least as much about objecting to Obama as objecting on any real policy basis.

In fact, only half of the 35 states under partial or full GOP control rejected all participation in Obamacare. All 15 states under complete Democratic control adopted Obamacare in full. That leaves 18 "red" states in which there was some gubernatorially-led attempt to sign on to most or all of the federal program, and in 15 of these it either was successful or (in two cases) is still pending before the legislature. Of the 13 Republican-controlled states that have adopted the

Medicaid expansion, just over half—seven of them—did so without demanding any changes whatsoever in the federal program (although New Hampshire's Republican legislature has since changed its mind and requested some alterations). In sum, Republican states are only slightly more likely at this point to reject Obamacare entirely than to accept it in some form, and, more tellingly, of those that have decided to take the federal money, just under half even bother to insist upon changes to make it more "conservative."

Where a conservative alternative has been formulated, the proposed changes from standard Obamacare—while clearly more consistent with long-standing Republican philosophy—have been fairly mild. First, there have been a certain number of predictable attempts to shave benefits and impose work requirements. The major focus of benefit restrictions, however, has been non-emergency medical transportation, which, as a major cost item for many states, smacks more of budget concerns than any general desire to slash benefits. Another, more severe limitation sought by some states is to delay the start-date for benefits until the state gets around to approving an individual's application; under federal law, Medicaid benefits must be provided with "reasonable promptness" to eligible beneficiaries, and coverage can extend back retroactively to three months before when the beneficiary actually applied. Conservatives also tend to insist that public benefits should come with a work requirement.

Beyond that, the requested Republican modifications to Medicaid expansion have centered on ideas that many Democrats would find acceptable and—in some cases—have even proposed themselves. These fall into three basic categories:

- Some partial financial responsibility.
- Incentives for healthy behavior.
- "Premium assistance"—which reflects the conservative preference for government aid in buying private insurance over government-provided insurance.

Partial financial responsibility for public beneficiaries is hardly a new concept: there is a widespread belief, not confined to conservatives, that people both better appreciate and are less demeaned by benefits to which they contribute in at least some small part. Thus, even the Children's Health Insurance Program (CHIP) enacted by a Democratic Congress under President Bill Clinton required small monthly premium payments. The idea that beneficiaries should bear some utilization cost is particularly strong in healthcare, where "co-pays" are common in both public and private plans to encourage some assessment by the consumer as to whether the (usually expensive) service is really needed. The focus of contention in the future will revolve, as always, around exactly what cost and benefit levels are appropriate; for instance, some GOP states have sought to impose rather large financial penalties on emergency room use retroactively deemed unnecessary, while others have sought to impose small monthly premiums even on recipients below the poverty line, which federal law currently prohibits. But this is more an argument over details than first principles.

Incentives for healthy behavior are hardly controversial any longer, either—although they were as recently as five years ago, when new federal regulations stopped then-Governor (now Senator) Joe Manchin of West Virginia, a Democrat, from including them in his state's Medicaid program. In fact, incentivizing consumers to pursue healthy lifestyles and intelligent healthcare choices is an element of all current approaches to lowering costs and improving care for all Americans—including Obamacare. To date, all such proposals—including the four Medicaid expansion waivers (in Iowa, Indiana, Michigan, Pennsylvania) so far approved by the Obama Administration—have involved positive incentives (such as waived copays or premiums) for those who pursue desired activities, as opposed to penalties for those who don't. Any ultimate solution probably involves paying providers for keeping people healthy—what's now called "Pay for Performance."

But health promotion is a long-term pursuit. Building it into the healthcare system will require coverage plans that take a long-term interest in the customer: Private companies might do a good job of this—but the government is likely to do better. Employer-based health insurance, especially in a world of increased job mobility, is unlikely to foster the required continuity—some other, broader and more permanent, basis of coverage (again, say, government) is probably needed. Consumers at least should be free to choose between public and private options.

That brings us to what may be the primary issue to Republicans in reforming healthcare: "premium assistance," or using public funds not to offer Medicaid benefits to the expansion population but rather to subsidize purchase of private insurance. In what was dubbed the "private option," Arkansas became the first state to go this route in a compromise between the Obama Administration and Arkansas' GOP legislature brokered by former Democratic Governor Mike Beebe. Iowa, Indiana, and New Hampshire have since followed suit, while Republican governors in Tennessee and Utah—and a Democrat in Montana—have attempted unsuccessfully to persuade their GOP-controlled legislatures to do so.

As with all such issues, there are policy details that cut both ways. For instance, both Arkansas and Iowa want to test whether enrolling expansion beneficiaries in the same coverage available to moderate-income families on the exchanges will reduce the number of families needing to go back-and-forth between one form of coverage or the other as their income, and thus eligibility status, fluctuates. That would seem to make good sense. On the other hand, subsidizing private insurance poses countervailing risks of dropped coverage because of limited enrollment periods or changes in employment status – and, of course, it presents the problem inherent in all voucher-type programs, that the government subsidy is inadequate to make purchase of the private plan affordable, especially where the choice of private plans is limited to what's on offer from a particular employer.

But the key issue facing Republicans interested in premium assistance is ideological: the role of government in the nation's future.

* * *

Even those generally suspicious of the ability of government to provide services available in the private marketplace might acknowledge the exceptional nature of healthcare. A single payer system, it is argued, would reduce costs of duplication, bureaucratic overhead, and excessive profits in the private insurance market, while the gains in risk-spreading amongst the widest possible insurance pool would more than offset the loss of price competition.

Realistically, however, government displacement of the entire private insurance market is unlikely to occur anytime soon in this country. Nor, would I argue, should it: Government needs competition just as much as the private sector. The best arrangement, in my view, would be a private market "policed" through a competitive public alternative.

With or without such a public option, the nation's healthcare future clearly lies with private insurance. The main question is the extent to which government will subsidize its purchase to make it affordable for more Americans. In King v. Burwell, conservatives are now—somewhat to their own chagrin—fighting such subsidies for moderate-income families, simply to spite Obamacare. They would do better to go in the opposite direction and push to expand the subsidy system—rather than government-provided insurance—for poorer families, as well. In fact, a little over a decade ago this appeared to be the bipartisan future. It still could be.

Why not move all Medicaid recipients—existing and expanded—into private health plans? Government's role then would be simply to provide a means-tested subsidy for private coverage. I was asked last year to figure out how one GOP governor could obtain the budgetary advantages of expanding Medicaid coverage at federal expense while reducing, rather than expanding, the numbers on a government-provided product (and without having to admit to accepting federal funding); I was interested in helping square this circle because the result would be health insurance for tens of thousands of additional near-poor people. The obvious answer was to convert Medicaid completely to government-subsidized but privately-provided coverage—something Republicans advocated more than a decade ago, until centrist Democrats like Bill Bradley started to embrace the idea, too. Such an approach would then—as the Arkansas and Iowa experiments suggest—also integrate easily with Obamacare's middle-class subsidies, creating a single, simple, universal but privately-based system of healthcare for all.

Of course, this would require liberals to accept that the goal of government in this area ought to be to ensure affordable coverage—not necessarily to provide it. And it would require conservatives to admit that government has a role to play that must, at a minimum, involve stepping in to ensure that Americans have a right not to die, or otherwise suffer serious threats to their health, just because the private market doesn't provide for their needs. Now, that would be a healthy compromise.