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Alan Bock: Getting untangled

Solutions for America's reliance on employer-supplied health insurance don't need to include more government control.

Alan Bock

Sr. editorial writer
The Orange County Register
abock@ocregister.com

Our current health insurance system, whereby most people get coverage through their employers, was not the result of careful design by certified experts but came about through something of an historical accident. During World War II the government instituted wage and price controls through much of the economy. Given that so many young people had been conscripted or had volunteered to go into the armed services, unemployment was relatively low, and companies had an interest in retaining or attracting employees.

Since companies could not attract or retain employees by offering higher wages, many of them, often prodded by labor unions, began to offer company-paid health insurance in lieu of higher wages. Thus began the system of offering health insurance as one of several employee benefits.

The system has advantages, especially for people employed steadily by relatively large corporations. Aside from the minor inconvenience of having to choose what level of insurance one wants or, in some instances, what company one prefers – less applicable lately as costs have risen and companies have sometimes cut back to offering a single plan – steadily employed people don't have much to worry about. They may gripe about the level of insurance, or of insurance company policies that don't cover pre-existing conditions, or cancellations just when insurance is needed the most. But for the most part it's fairly simple, and recent polls show that some 80 percent of Americans are reasonably satisfied with their own health care coverage.

There are problems, however. Obviously, most unemployed people lose health insurance just when having it might be most important. Many part-time and about 17 percent of full-time employees do not receive health insurance. Smaller businesses not only have smaller risk pools, which usually means higher premiums, but they may find the cost and hassle of providing health insurance for employees too much; indeed, the percentage of nonelderly Americans with employment-based coverage declined from about 70 percent in 1987 to 62 percent in 2005.

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Insofar as treating health insurance and other fringe benefits as non-taxable under income tax laws amounts to an implicit subsidy, higher-income people with more generous health insurance (they tend to go together) get a larger subsidy than lower-income people, and people without employer-provided health insurance get no subsidy at all. That doesn't fit most peoples' idea of equitable.

People can lose their health insurance when they change jobs; even if there is no lapse between periods of employment, health benefits at a new job might not kick in for three months to a year. Workers with a medical problem may find themselves locked into their current job even though more attractive prospects beckon, if a new job's insurance doesn't cover pre-existing conditions. The percentage of self-employed people is probably less than it would be if employment were not the standard way to acquire health insurance. The current system weakens Americans' sense of security and decreases the flexibility and efficiency of the labor market.

In addition, having third parties, whether government or private insurance companies, pay medical costs, tends to increase demand for medical services. If services are effectively free or require only a small co-payment, most consumers will use them more than is absolutely necessary. This decreases the efficiency of the system.

All these problems make employee-provided insurance less than ideal, and certainly not a promising avenue for providing health insurance to every American.

If we were designing a system from scratch we probably wouldn't come up with this one. But we're not designing from scratch. Large, complex systems develop from particular circumstances. All European countries have some form of government–provided or "single-payer" health care, but they differ because they were instituted in different times and different circumstances. We have to build on or reform what we have, and large-scale changes in complex systems require a good deal of time and trouble – and are bound to have unintended consequences. Remember when all the experts thought HMOs would fix what ailed the health-care system?

Although President Barack Obama has not settled on a single reform proposal, in general he proposes to have more government involvement in health care through a variety of mechanisms, from requiring everyone purchase a government-approved insurance policy to mandates on all employers to provide insurance or pay a special tax to cover the government's costs of doing so, to a government-run "public option," to government-mandated policies to dictate what treatments and procedures – those deemed most effective by a government panel – will be covered.

This is curious, in that most European countries, deemed the model by most Obama-oriented reformers, are moving toward more market-oriented policies just as the U.S. is moving toward the model they are finding too expensive and inefficient. Richard Saltman and Josep Figueras of the World Health Organization say, "The presumption of public primacy is being reassessed." Pat Cox, former president of the European Parliament, said in a report to the European Commission, "We should start to explore the power of the market as a way of achieving much better value for the money."

Our own history should offer caveats about increasing government involvement in health care. As Michael Tanner of the libertarian-

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oriented Cato Institute has pointed out, when Medicare began in 1965 it was estimated that the annual cost of Medicare Part A would be $9 billion by 1990. It turned out to be $67 billion. "In 1987," Tanner writes, "Medicaid's special hospitals subsidy was projected to cost $100 million annually just five years later; it actually cost $11 billion, more than 100 times as much. And in 1988, when Medicare's home care benefit was established, the projected cost for 1993 was $4 billion, but the actual cost was $10 billion."

Economic theory and practice suggest that improving access to health care and moderating the costs can best be achieved not through centralized control but through competition. But how do we get there from here? It depends on how far you want to go.

Moving from almost complete reliance on employers for health care to having more individual, fully portable policies seems obviously desirable. Stuart Butler of the conservative Heritage Foundation has outlined a detailed plan for establishing insurance exchanges at the state level. Having a statewide exchange would increase the risk pool so individuals and employees of small businesses could participate in a range of programs. Over time employers would become facilitators rather than providers – arranging for deductions to cover premiums, etc., as they do now for taxes, but not directly providing the insurance.

Butler advocates a cap on exclusion of health insurance from taxable income and using that money to provide refundable tax credits for lower-income people. He doesn't mention allowing individuals to deduct money spent on health insurance from their taxable income, as corporations are now able to do, but that could be the single most important reform in the direction of insurance portability.

Robert Moffitt, Heritage's point person on health care, makes that case, and also advocates replacing Medicaid and SCHIP with a subsidy in the form of a voucher for lower-income people. Among the benefits would be emptying emergency rooms of people without insurance and returning them to their real purpose, saving hospitals considerable money.

Moffitt would also increase real competition, putting downward pressure on costs, through allowing people to buy health insurance across state lines, and allowing various trade associations, professional associations, unions, co-ops, civic and religious organizations to offer health insurance and get the same tax breaks that employers get. He would also impose transparency on the medical profession by mandating price disclosure (this could be done by insurance companies) for doctors and hospitals. "Americans know the price of gas from day to day but know almost nothing about the real cost of medical services," he told me.

Cato's Michael Cannon says the key problem in health care is that the wrong people control the money. The government controls about half of the money spent on health care, and insurance companies control about a quarter. The more that control is in the hands of patients/consumers the better the outcomes are likely to be.

Instead of Medicare, he would give seniors a voucher for health care – with larger vouchers for lower-income seniors and those with serious or expensive medical conditions. Initially it would be expenditure-neutral, but over time the growth in Medicare expenditures would decline, seniors would have more control over their health care, and the outcomes would be superior.

He would also enlarge the areas where Health

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Savings Accounts – high-deductible, lower-premium insurance with superior catastrophic coverage, which permit money saved over standard policies to go into a savings account that could be used for future medical expenses or retirement – are allowed. He would suggest (though not mandate) that employers, who now spend about $9,000 per year per employee on health care, simply give employees that $9,000 at the beginning of the year and let them spend it on their choice of insurance.

In addition to allowing consumers to purchase health insurance across state lines, Cannon would also have the federal government mandate that states recognize the clinicians' licenses of other states. This would make it easier for doctors and other practitioners to move to meet demand in other states, thus increasing competition and putting downward pressure on prices.

I would go further and liberalize scope-of-practice licensing restrictions so medical assistants, nurse practitioners and the like are permitted to perform a wider range of services that only MDs are allowed to perform now.

Finally, efforts to reduce the cost of medical services have to include lawsuit reform. It's been amusing-to-infuriating to hear various administration spokespeople carry on about unnecessary medical tests as proof of doctors' greed, when the main reason for them is "defensive medicine" designed to avoid lawsuits. Democrats can't say this because trial lawyers are such heavy contributors. Because of our federalist system this would have to be handled on a state-by-state basis. California, Texas and Indiana have taken some healthy steps and could provide models for other states.

There's a start.

Contact the writer: abock@ocregister.com or 714-796-7821