

HEALTH REFORM IN NORTH CAROLINA

Get Health Reform Right, Not Quick

John Hood

No one can doubt that the American health care system is broken and needs fundamental change. No one can doubt that North Carolina, in particular, exhibits all of the problems inherent in the current system and would benefit significantly from well-structured reforms. So why do I argue policymakers should slow down? Because the last few months of public debate have revealed a shocking and debilitating level of ignorance, misunderstanding, and misrepresentation that can only result in legislation destined to hike costs, harm quality, and hamper the nation's economic recovery.

Some politicians, commentators, and activists have lodged similar complaints about recent health care protests. But their rhetoric has been rougher and targeted at the wrong actors. They've accused conservative politicians and commentators of lying about President Obama's plan, scaring seniors with false statements about Medicare cuts and death panels, and doing the bidding of nefarious special interests in health care who want to protect the status quo. Some of the claims by critics of the Democratic plans have indeed been intemperate, inexact, or exaggerated. But for the most part, public opposition to those plans has arisen for understandable and legitimate reasons—and the critics have, in my judgment, exhibited superior knowledge of and candor about the issues involved than have the president and his allies.

Is this just a case of ideological name-calling? Not at all. While partisans and lobbies have thrown bombs at each other for years, health care economists and policy analysts from across the spectrum have been engaged in a serious, far-reaching exploration of the complex issues of health care finance and delivery. Just in the past decade, there has been an explosion of research published by Health Affairs, economic journals, and think tanks across that nation ranging from the Cato Institute and American Enterprise Institute on the right to the Brookings Institution and Urban Institute on the left.

By no means am I suggesting that this freewheeling discussion has yielded a policy consensus. Some analysts think that we need to adopt a national version of health care along the Massachusetts Connector model, which mixes some choice and competition features with new taxes, mandates, and insurance regulation. Some think we need to expand Medicare and Medicaid, set up a new "public option," or otherwise move further towards the government being the primary and perhaps the only financing mechanism for medical care. Still others—I am among them—believe that we need to adopt measures that allow and encourage the development of consumer-driven health care that addresses issues of cost, choice, and portability.

Despite this disagreement, there are some common myths that health care economists of all stripes reject but that the president and other advocates of current reform plans continue to propagate. These are not minor quibbles. They go to the very heart of why the nonpartisan Congressional Budget Office and other neutral arbiters have scored the proposed bills as far more expensive than advertised¹—and that, in turn, helps to explain why they're in trouble. Here are some examples:

Prevention

Policymakers continue to assert that we can reduce health care costs in the long run by reducing the ranks of the uninsured. Because the assertion is inherently counterintuitive—adding more consumers with more buying power into a market tends to bid up costs, not drive them down—advocates further assert that spending more money on preventive care today will save money tomorrow by reducing incidence of disease or the need for more expensive treatments. This may sound plausible, but it is no exaggeration to say that virtually no reputable expert on health care finance believes it to be true.²

Don't take my word for it. "On average, preventive care does not save money," said Paul Van de Water, a senior fellow at the liberal Center on Budget and Policy Priorities. Similarly, Len Burman of the Tax Policy Center, a joint venture of Brookings and the Urban Institute, recognizes that while preventive care is a good thing and may well alleviate much suffering, it isn't a tool for financing health care reform. "Advocates think they can cut health care spending by expanding health care spending," Burman said, but that is false.³

Cost-Shifting

A related notion, popular among lobbyists for current health insurers and medical providers, is that a substantial amount of the recent run-up of health care costs comes from having to provide expensive emergency room treatment to the uninsured. Reformers assert that by expanding government programs or subsidies to insure these patients, the system as a whole will save a lot of money and the currently insured will see less cost-shifting pressure on their premiums. This is another plausible-sounding notion that doesn't bear up to careful economic scrutiny. For one thing, uncompensated medical care to the uninsured, while bothersome for providers, does not represent a large enough tail to wag the medical inflation dog. It makes up somewhere between 3%-4% of total health care spending in the United States, depending on the measurement.⁴ Insuring the uninsured won't make most of those costs disappear. It will just change somewhat who pays what to whom. In fact, as a matter of public finance, the uninsured as a group already offset most if not all of this uncompensated care due to the higher income and payroll taxes they pay when compared to similarly situated Americans with tax-deductible insurance premiums.⁵

Should public subsidies of emergency room care be more explicit and rational? Of course. I also like WakeMed CEO Bill Atkinson's proposal to reform the Emergency Medical Treatment and Active Labor Act to give hospitals more authority to engage in triage at the point of contact—to refer uninsured patients with nonemergency conditions to providers other than emergency rooms.⁶ But such situations are not the primary drivers of medical inflation and addressing them won't generate nearly enough savings to finance grandiose federal health reforms.

Profit and Administrative Costs

Advocates of making government either the dominant or the single payer for medical services are fond of demonizing private health insurers for squandering vast amounts of the national health care budget by delivering profits to shareholders, compensating CEOs, and administering medical claims. Once again, the economic literature and basic statistics disprove these arguments.

The average profit margin in health insurance is a little less than 4%.⁷ If there was some way to eliminate it entirely, that wouldn't save enough to curtail medical inflation noticeably or to subsidize coverage for the uninsured. But even that would be an overstatement of the potential "savings," reflecting a misunderstanding of what profit is. Any large-scale enterprise, private or public, must raise sufficient capital to invest in assets and cover unforeseen costs. Profits represent the return to shareholders for investing their money in building and operating the business. Government-run health insurance programs also have to pay to acquire necessary capital. Taxpayers bear this cost in part through tax compliance—higher levels of taxation require costlier efforts to collect and comply with the tax code—and by paying interest to holders of government debt. These costs may not show up in simplistic comparisons of national health care spending, but they are very real.

As for the broader issue of administrative cost, once again the picture is far more complicated than simplistic measures can capture. Analysts routinely overestimate administrative costs in the private sector—by including such expenditures as regulatory compliance and providing consumer information—and underestimate the administrative costs of Medicare and Medicaid—by ignoring costs located elsewhere in the federal budget (including the IRS) or shifted to providers.⁸ Manhattan Institute economist Benjamin Zycher conducted an important study of true administrative costs in 2007 and found that shifting to government-run insurance would not save nearly enough administrative costs to finance care for the currently uninsured.⁹

These are just some examples of commonly held assumptions that are based on incorrect or incomplete understanding of health care economics. Reform programs that promise to finance massive increases in

government expenditure through relatively painless initiatives are fiscal time bombs, as the Congressional Budget Office and others have pointed out.

Instead of trying to rush through legislation that would grant the federal government massive new powers over one-seventh of the nation's economy, policymakers should calm down, slow down, and start with reforms that won't break the bank or throttle insurance markets. Analysts of varying ideological backgrounds agree with this gradualist approach.¹⁰ Here's my short list:

- Equalize the tax treatment of employer-based and individually purchased health insurance. Without the tax bias, far more Americans could have personal, multi-year health insurance policies that manage their risk of catastrophic medical expenses and are fully portable during future job losses, career changes, or relocations.
- Require the advance publication of real price information by hospitals, doctors, and other medical providers, while arming patients with savings accounts and other incentives to shop around and consume care more wisely. Wasteful consumption of medical services is a far, far bigger part of the health care bill than most of the targets of the current political invective.
- Free up markets for medical services by allowing nurse practitioners and other low-cost providers to deliver more care, reducing the barriers to entry for new doctors and nurses, and eliminating certificate-of-need regulations that protect incumbent providers from competition.

While it would be nice to get health care reform quickly, it would be better to get health care reform right.

REFERENCES

- 1 Elmendorf DW. *Preliminary Analysis of America's Affordable Health Choices Act of 2009*. Washington, DC: Congressional Budget Office; July 17, 2009.
- 2 Goodman J. The price of prevention. *Governing* website. <http://www.governing.com/article/price-prevention>. Published April 1, 2008. Accessed September 23, 2009.
- 3 Cheplick T. Prevention brings less-than-expected savings. *Health Care News*. 2009;10(8):5.
- 4 Hadley J, Holahan J. How much medical care do the uninsured use, and who pays for it? *Health Aff*. Web exclusive. <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.66v1/DC1>. Published February 12, 2003. Accessed September 23, 2009.
- 5 Cannon MF. Fannie Med? Why a "public option" is hazardous to your health. Policy Analysis No. 642. Cato Institute website. http://www.cato.org/pub_display.php?pub_id=10382. Published July 27, 2009. Accessed September 23, 2009.
- 6 Atkinson W. A proposal for jump-starting national health care reform. *NC Med J*. 2009;70(4):346.
- 7 Industry summary. Yahoo! finance website. http://biz.yahoo.com/p/sum_qpm.html. Published September 25, 2009. Accessed September 23, 2009.
- 8 Matthews M, Matthews MR. Medicare fraud: what government can learn from the private sector. In Frogue L, ed. *Stop Paying the Crooks: Solutions to End the Fraud that Threatens Your Health Care*. Atlanta, GA: The Center for Health Transformation; 2009:92-93.
- 9 Zycher B. Comparing public and private health insurance: would a single-payer system save enough to cover the uninsured? Medical Progress Report No. 5. Manhattan Institute for Policy Research website. http://www.manhattan-institute.org/html/mpr_05.htm. Published October, 2007. Accessed September 23, 2009.
- 10 Aaron HJ. The pitfalls of overreaching in health reform. *Health Aff*. 2009;28(2):184-187.

John Hood is the president of the John Locke Foundation, a public policy think tank based in Raleigh.