Obama's Gamble: Doubling Down on a Flawed Insurance Model

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"What this plan will do is make the insurance you have work better for you…And here's what you need to know...I will not sign a plan that adds one dime to our deficits...now or in the future, period."

So spoke President Barack Obama in his address to Congress earlier this month, for the first time laying out more specific goals for healthcare reform. To persuade the American people to support his health reform agenda, the President has made two simple promises. First, his plan will benefit everyone who already has health insurance. Second, his plan will not add to the nation's yawning budget deficit. Both claims are essentially false, and examining them offers economic lessons for reform.

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MANDATES WILL INCREASE COSTS AND IN THE LONG RUN RESTRICT SERVICES

The Administration's plan will impose mandates that employers provide coverage, mandates that individuals obtain coverage, and mandates about the form this coverage will have to take. These will remove the freedom to choose one's health-insurance plan, because government, in its effort to correct perceived inequities, will dictate which healthcare services must be covered and which healthcare providers must be used.

The proposed unprecedented intrusion of government into private markets will have adverse effects on people with insurance in both the short and the long run.

The mandates will lead to large increases in the cost of health insurance for everyone. Research studies have shown that as people become insured, especially under a health plan that offers broad coverage and low co-payments, they consume more healthcare services. The best estimates indicate that each newly insured person will approximately double his or her health spending.[1]

With 30 million to 40 million newly insured persons under the Administration's plan, aggregate healthcare demand will increase significantly. But when demand expands prices increase. We estimate that the higher demand will increase health insurance

premiums for the typical family plan by about 10 percent.[2] Because an employer-sponsored family insurance plan cost $12,680 in 2008, this translates into an increase of about $1,200 in the typical annual premium.

The mandates will also have adverse additional, longer-run consequences. According to provisions in both House and Senate bills, mandated plans must have low copayments and provide coverage of healthcare services that is at least equal in scope to today's typical employer-sponsored plans. But these very flaws are responsible for high and rising healthcare costs—flaws that stem directly from the misguided tax exclusion for and the extensive state regulation of health insurance. By locking in these flaws, the mandates will inhibit the innovation needed to reform U.S. healthcare. How then will government ultimately rein in costs? It will curtail access to healthcare services by erecting barriers between patient and healthcare provider.

THE DEFICIT WILL GROW DESPITE SOARING TAXES

The current House and Senate bills will also break the President's second promise—not to add to the deficit. In part because the health insurance that the Administration's plan forces people to buy is expensive, the plan proposes to give individuals large financial subsidies to partially offset the cost. The entitlement-based subsidy, combined with the proposed Medicaid expansion, would add between $700 billon and $1.2 trillion to federal spending over the next decade, according to the Congressional Budget Office. The new entitlements would come on top of existing federal healthcare entitlements that the government has been neither able to control nor finance.

A portion of the additional spending is to be financed by savings from the existing federal healthcare programs. But, thus far, the alleged savings come mainly from cutting future Medicare payment rates. History suggests these savings won't materialize.

For the past 25 years, Congress has repeatedly 'cut' payment rates. Yet Medicare's expenditures have continued to outstrip its dedicated revenues. New taxes have been required but revenues still can't keep up with expenses. In the early 1990s, Congress removed the cap on Medicare's taxable wage base. Today, the Medicare Board of Trustees projects that the Hospital Insurance Trust Fund will be bankrupt in eight years.

More importantly, cutting payment rates is not reform. Ultimately, such price controls will lower the quality of healthcare and reduce the supply of health services, just as price controls have in every market where they've been tried. Congress's near-exclusive reliance on such cuts is revealing. The federal government simply has no idea how to reform its current insolvent healthcare programs, much less how to properly design a new one.

Reform will be partly financed by higher taxes. The House bill proposes to raise the highest personal income tax rate by 5.4 percentage points. This is on top of the Obama Administration's plan to raise the top rate by another 4.6 percentage points next year. The combined 10-percentage-point increase raises the top income tax rate to 45 percent—an economic growth-destroying level not seen since the early 1980s. Sen. Max Baucus (D-Mont.) proposes, instead, to tax some health insurance premiums.

In neither bill do higher taxes finance the proposed additional spending. Should the Medicare savings fail to materialize, as we

predict, the spending in either bill will add more than $100 billion per year in perpetuity to the already soaring national debt.

MOVING FORWARD ON HEALTHCARE REQUIRES REALISTIC PLANNING

Returning to President Obama's address: "We did not come to fear the future. We came here to shape it." But shaping needs a well-thought-out plan. To move forward, the country must begin to have two separate debates. The first debate centers on how to improve current health insurance arrangements in order to rein in the epidemic of health spending that too often fails to provide good value for money.

The second debate should center on additional steps to improve access to healthcare for those who cannot afford it. However, this debate must be separated from the issue of insurance coverage. Many currently insured Americans, no doubt, would be willing to pay some additional amount if extending health insurance coverage actually improved the health of the uninsured.

The hard reality is that there exists little evidence that it does. Helen Levy and David Meltzer, in a 2008 review of research in the *Annual Review of Public Health*, summarize the overwhelming conclusion of academic research by concluding: "The central question of how health insurance affects health, for whom it matters, and how much, remains largely unanswered at the level of detail needed to inform policy decisions." We must experiment with alternatives, such as further expansions of community health clinics, special assistance for the chronically ill, and other programs that might not supply traditional services but could have a big impact on people's health.

Comprehensive, low-deductible, low-copayment insurance has brought us to where we are today. The Administration's plan to expand and lock-in this flawed paradigm will ultimately defeat the goal of making health services more affordable for everyone. Fortunately, there are other options. These include policies that encourage more cost-conscious healthcare choices, greater competition among health insurers, and reduce the practice of defensive medicine.

President Obama claims to support these ideas, but the plan he outlined is not consistent with these claims, and neither is the Senate Finance Committee bill. The American people should ask for a second opinion.

Letters commenting on this piece or others may be submitted at submit.cgi?context=ev.

NOTES

1. Ward and Franks (2007), and Hadley, Holahan, Coughlin, and Miller (2008).
2. Hadley, Holahan, Coughlin, and Miller (2008) estimate that extending coverage to the uninsured would add approximately 5 percent to national health spending. Under the assumption that the Administration's plan would seek to cover approximately 80 percent of the uninsured, it would add approximately 4 percent to national health spending. If the supply of health services is inelastic in the short run, then a 4 percent increase in demand would lead to an increase in price of $0.04 / e$, where e is the price elasticity of demand for health services. As we discuss in Cogan, Hubbard, and Kessler (2005), estimates of e from previous research range from -0.2 to -0.7. At $e = -0.2$, a 4 percent increase in demand would lead to a 20 percent increase in prices; at $e = -0.7$, a 4 percent increase in demand would lead to an approximately 6 percent increase in prices.

REFERENCES AND FURTHER READING

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