

Replacing Obamacare: Financing an Affordable Safety Net Without Rationing or Government Deficits



NATIONAL RIGHT TO LIFE CONVENTION
WASHINGTON DC, JUNE 2012

BURKE J. BALCH, J.D. – DIRECTOR, ROBERT POWELL
CENTER FOR MEDICAL ETHICS

JENNIFER POPIK, J.D.

Elements of Talk

- Belief that growth in health care spending must be curtailed is **WRONG**
- Real problems: income distribution and method of government financing
- How to assist those who can't afford insurance without suppressing health care spending
- Clarify what “rationing” means
- Harmful rationing in the PPACA

Sherry Glied

- Assistant Secretary for Planning and Evaluation
- Department of Health and Human Services
- *Chronic Condition: Why Health Care Reform Fails* (1997)



Glied Is Not Alone . . .

- William J. Baumol, “Do Health Care Costs Matter?” *The New Republic*, Nov. 22, 1993, *Professor of Economics at New York and Princeton Universities*
- David F. Bradford, *Professor of Economics and Public Affairs, Princeton University Woodrow Wilson School of Public and International Affairs*
- Edward Wolff, *Professor of Economics, New York University*
- Eli Ginzberg, *A. Barton Hepburn Professor of Economics, Columbia University*
- Joseph P. Newhouse, *John D. MacArthur Professor of Health Policy and Management, Harvard University*

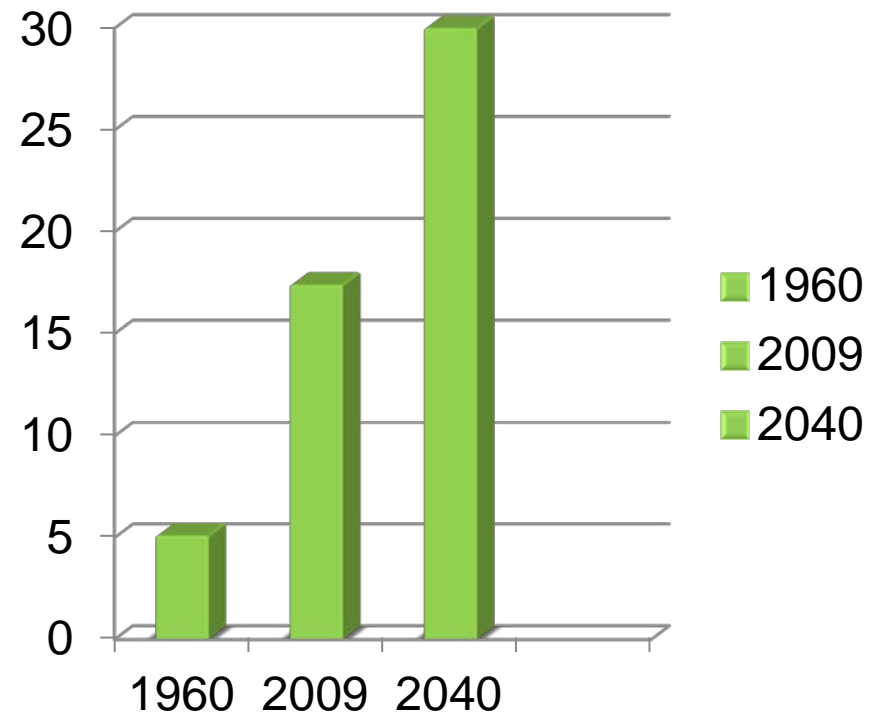


Rising Health Care Spending

- Per capita health care spending up 4% annually each decade since 1940s

Health Care as % of Per Capita Gross Domestic Product

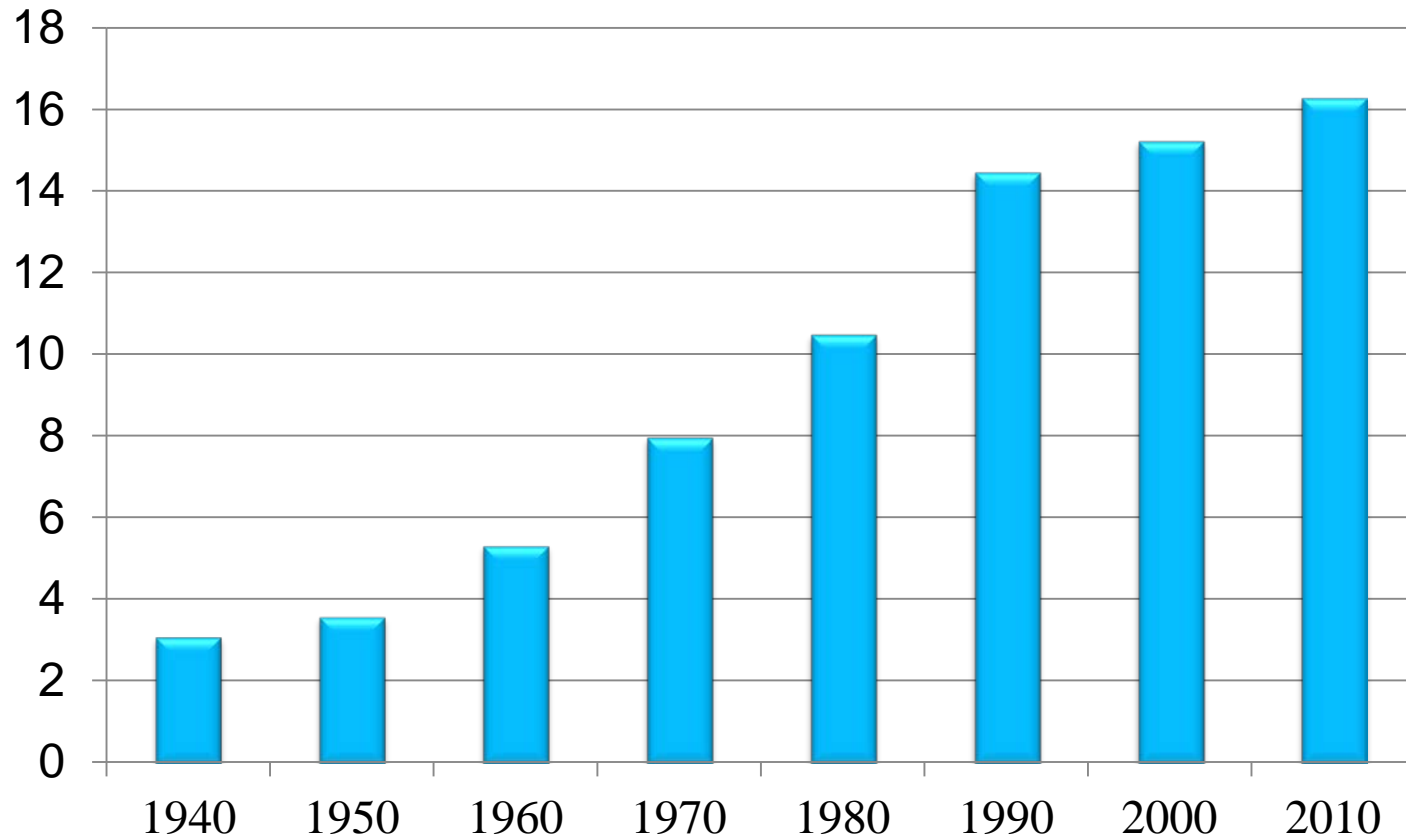
1960	2009	2040 projected
5.1%	17.4%	30%



Source: OECD Health Data 2011

<http://stats.oecd.org/Index.aspx?DataSetCode=SHA>

Health Care Spending as a % of Personal Consumption Expenditures



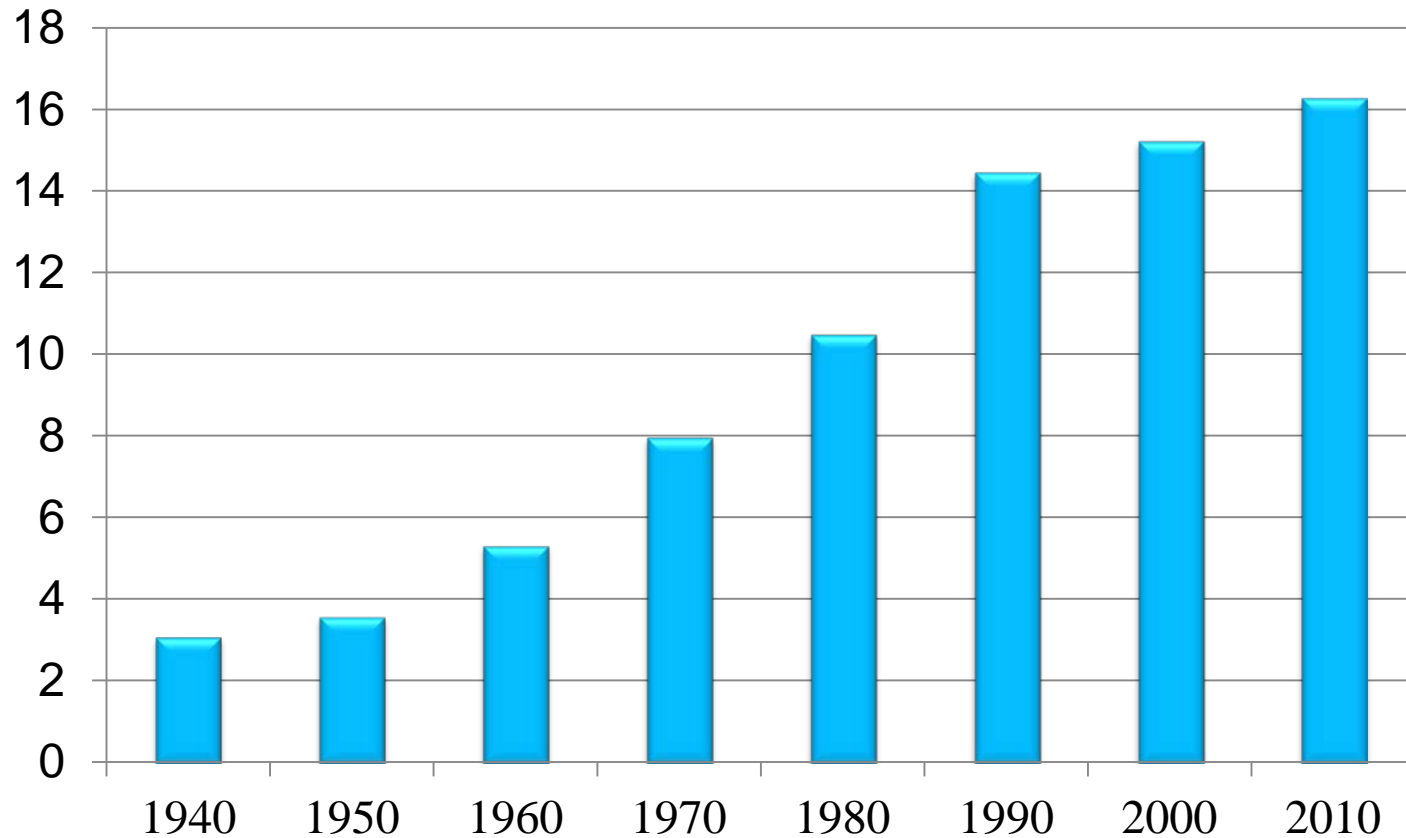
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Data Source: (CEA 1991, 2011.) Available at <http://origin.www.gpoaccess.gov/eop/tables09.html>

The Paradox

- Appearance:
 - HC costs eating up ability to pay for other goods and services (ultimately unsustainable)
- Reality:
 - Rising productivity in other goods and services is freeing up resources to use to save lives and preserve health

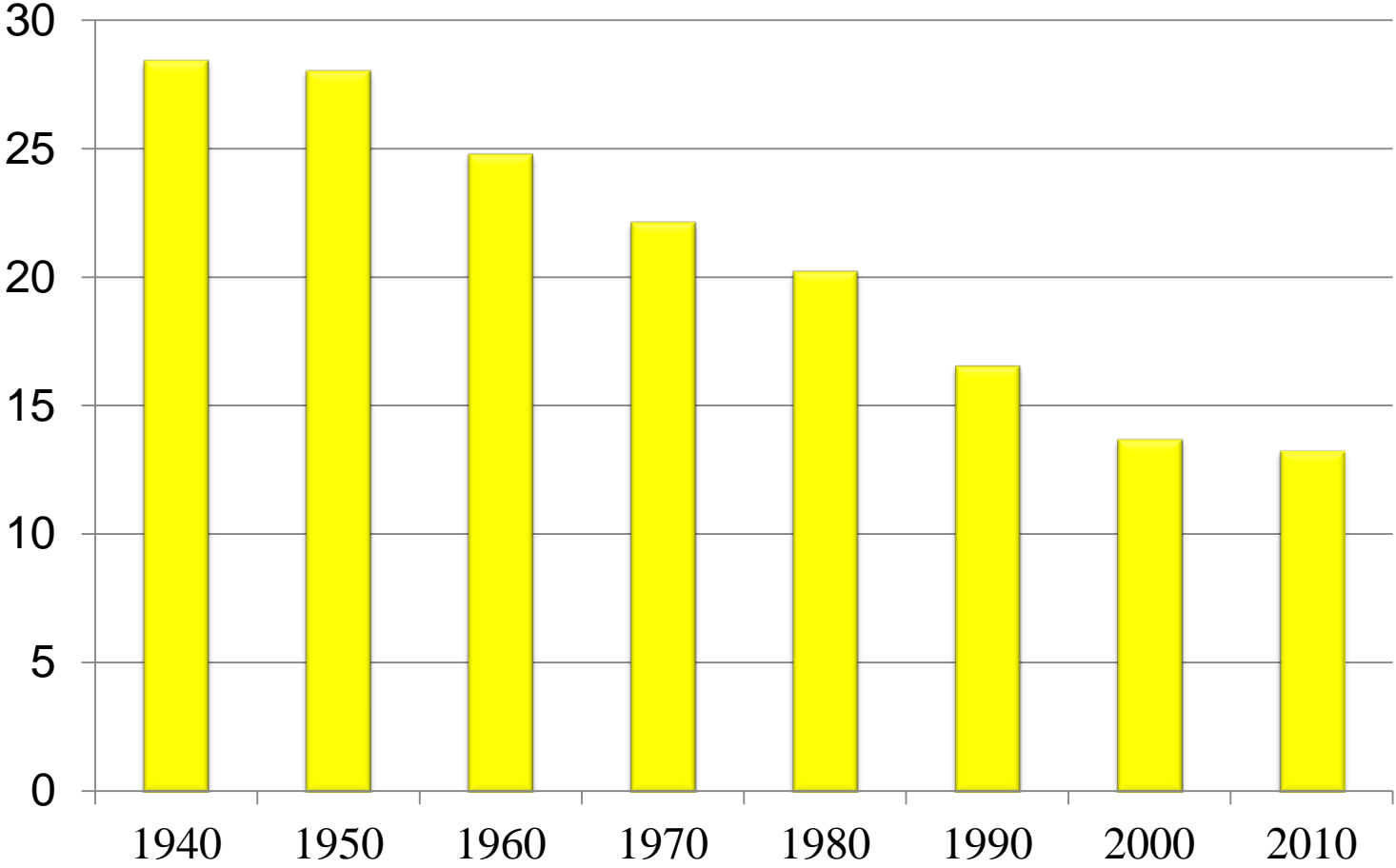
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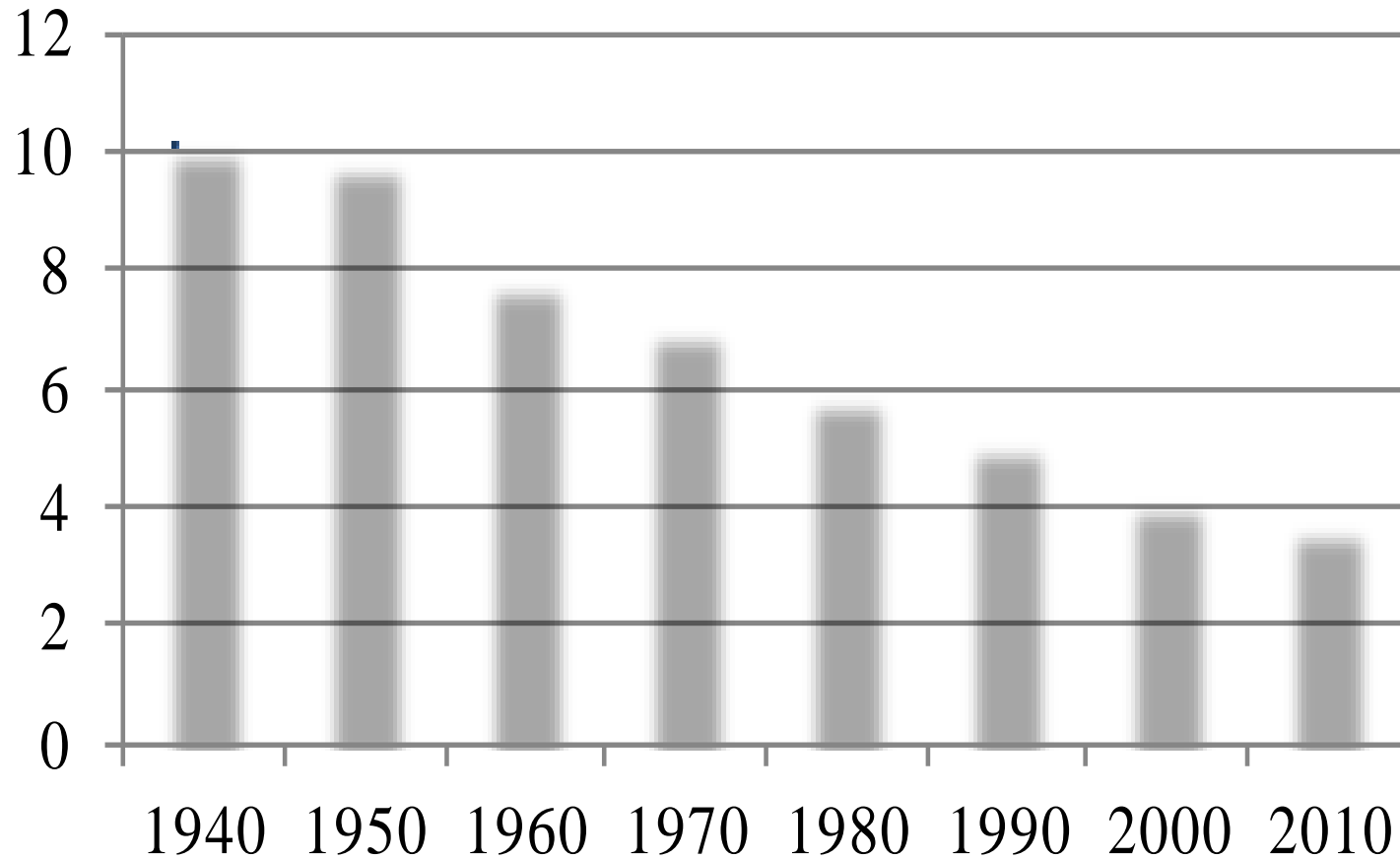
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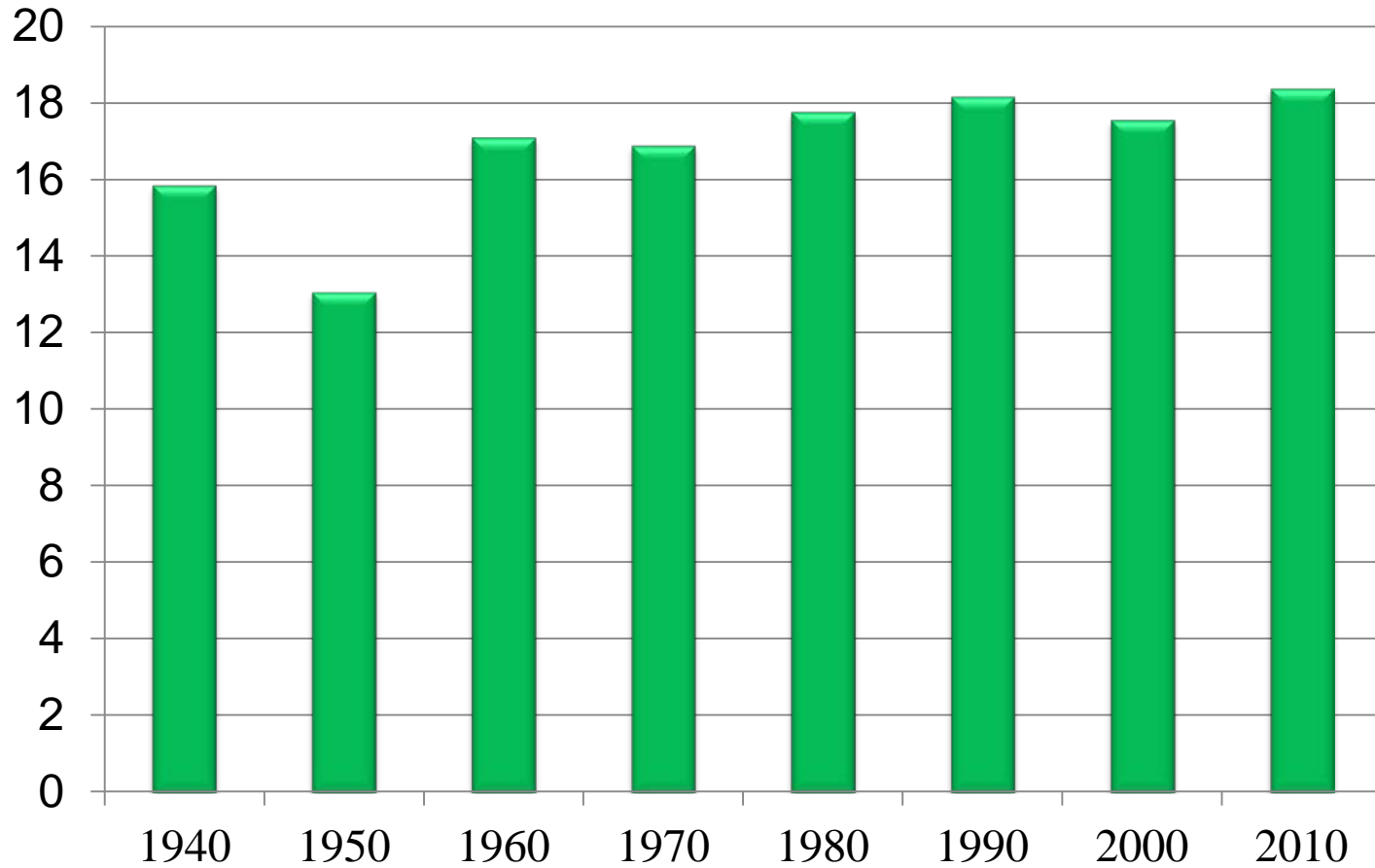
Food as a % of Personal Consumption Expenditures



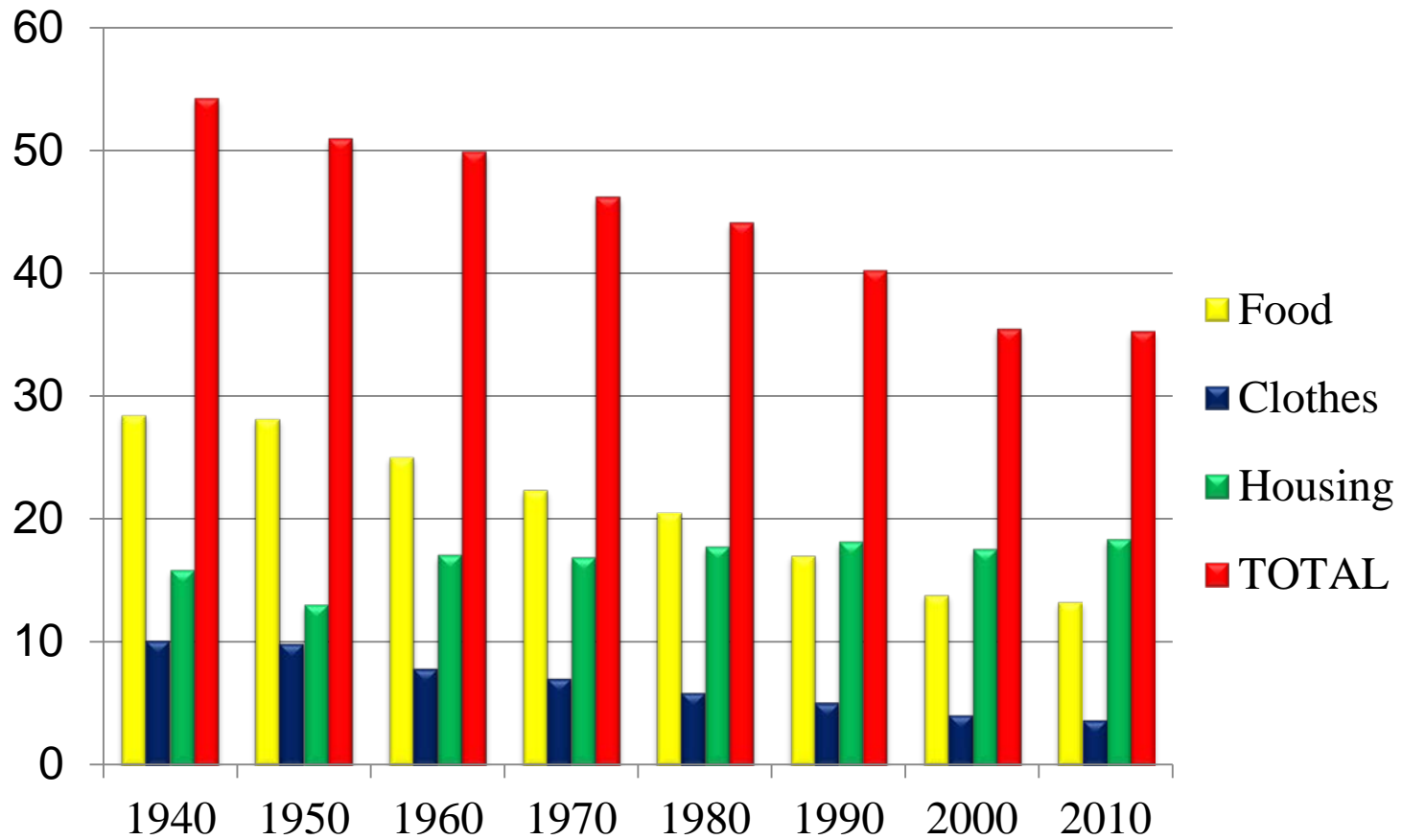
Clothing and Shoes as a % of Personal Consumption Expenditures



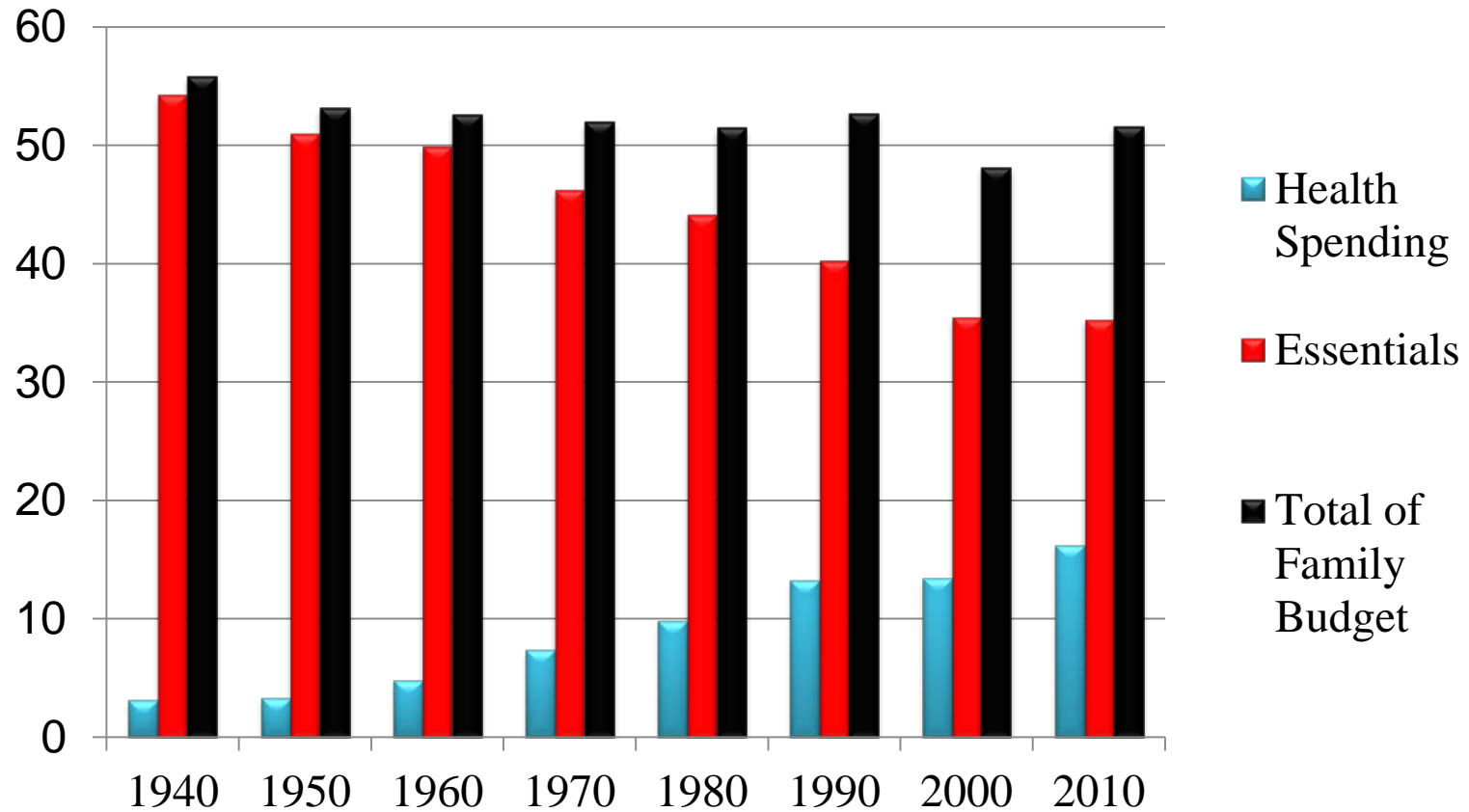
Housing as a % of Personal Consumption Expenditures



Food, Clothing & Shelter Combined as a % of the Family Budget

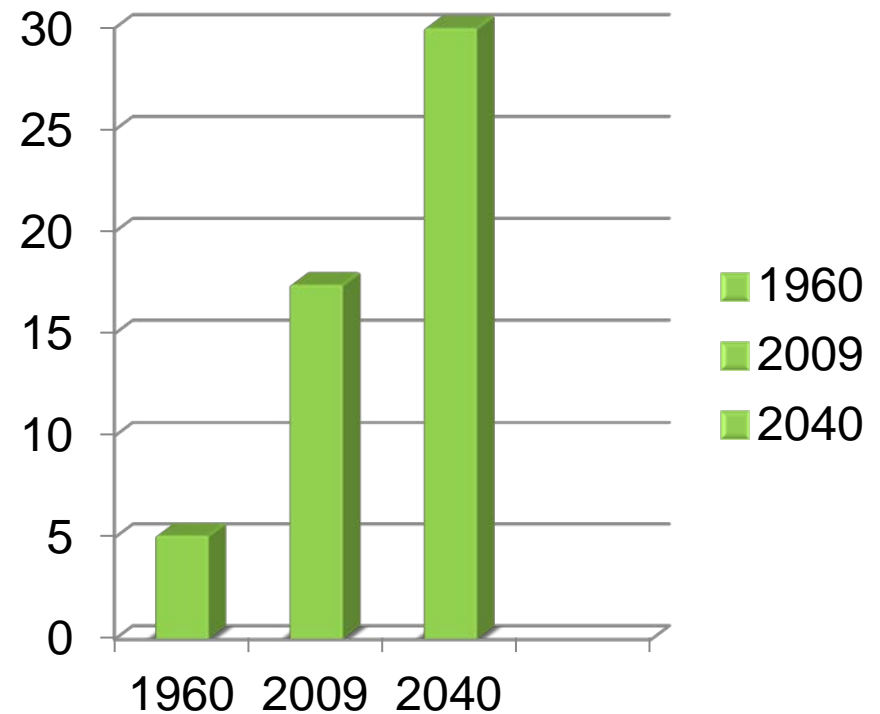


What the Family Spends on 1. Essentials and 2. Essentials & Healthcare Combined



Health Care as % of Per Capita Gross Domestic Product

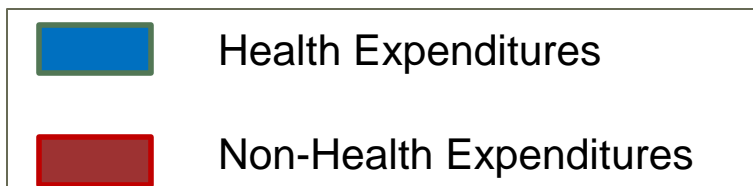
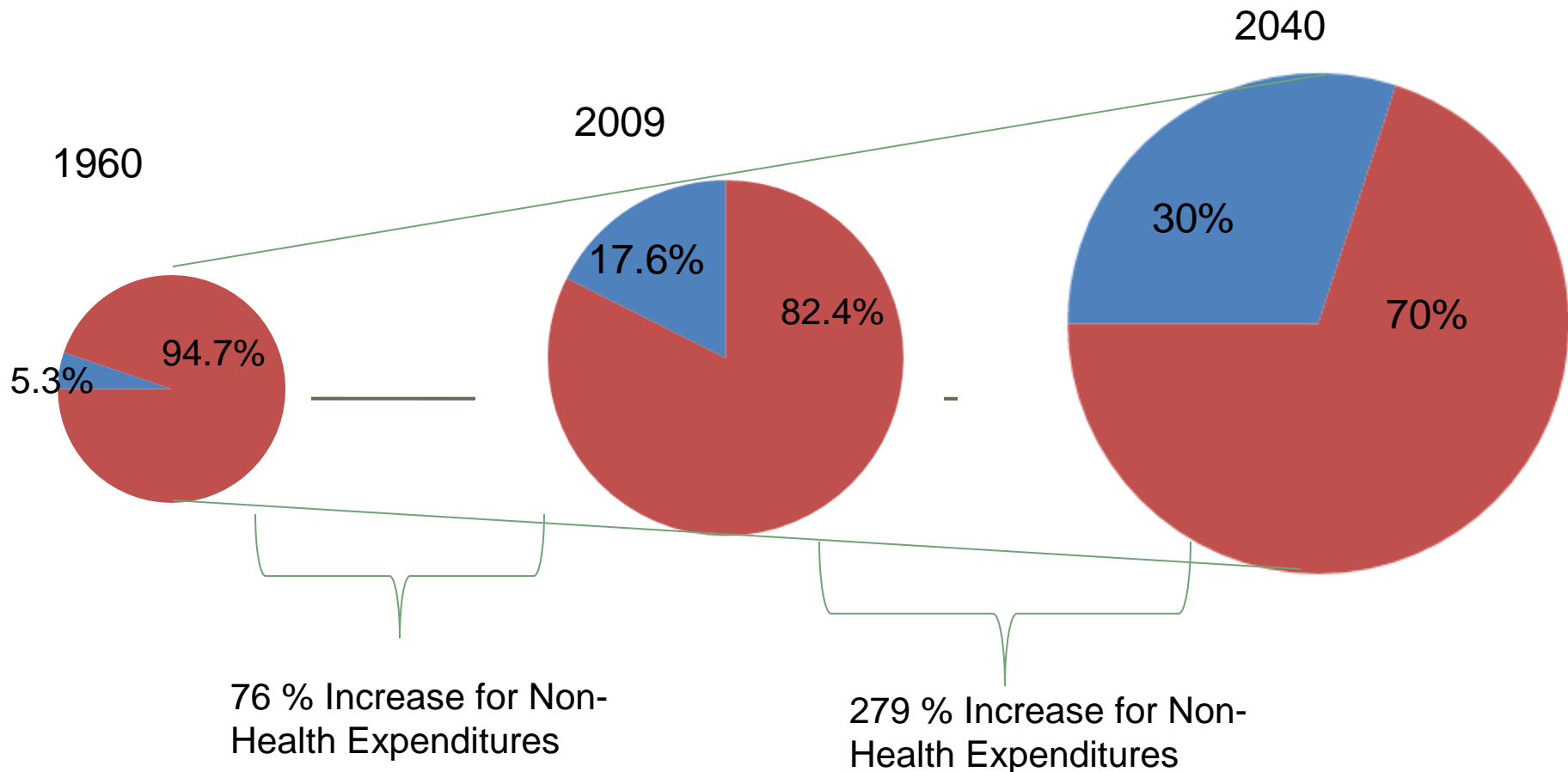
1960	2009	2040 projected
5.1%	17.4%	30%



Source: OECD Health Data 2011

<http://stats.oecd.org/Index.aspx?DataSetCode=SHA>

American Health Expenditures and Per Capita Gross Domestic Product



Sources: available on request to bbalch@nrlc.org

Conclusions

- *NOT* that American health care system is ideally efficient and can't be improved
- *BUT* if improvements are made in cost-effectiveness, we shouldn't necessarily expect growth in health care spending to abate – we might just get more and better health care

Glied (1997) pp. 213-14



- “Health care costs will rise because medicine will be able to do more for people.
- “Most Americans will grumble about the increase in costs but they will pay for more care, just as they have done for the past 65 years.
- “People who cannot see well will gladly work more hours to fund better eyesight, when medical advances enable them to do so. . . .

Glied (1997) pp. 213-14



- “People who cannot walk will willingly move to smaller dwellings if doctors offer them a chance to purchase physical mobility in exchange. . . .
- “People at risk of strokes will skip vacations to buy artery cleaning that promises to diminish these risks.
- “People in pain will sacrifice much of their other consumption for respite.

Glied (1997) pp. 213-14



- “People whose incomes rise will buy more health care without giving up anything they have today.”
- “Simply put, health costs will continue to rise.”

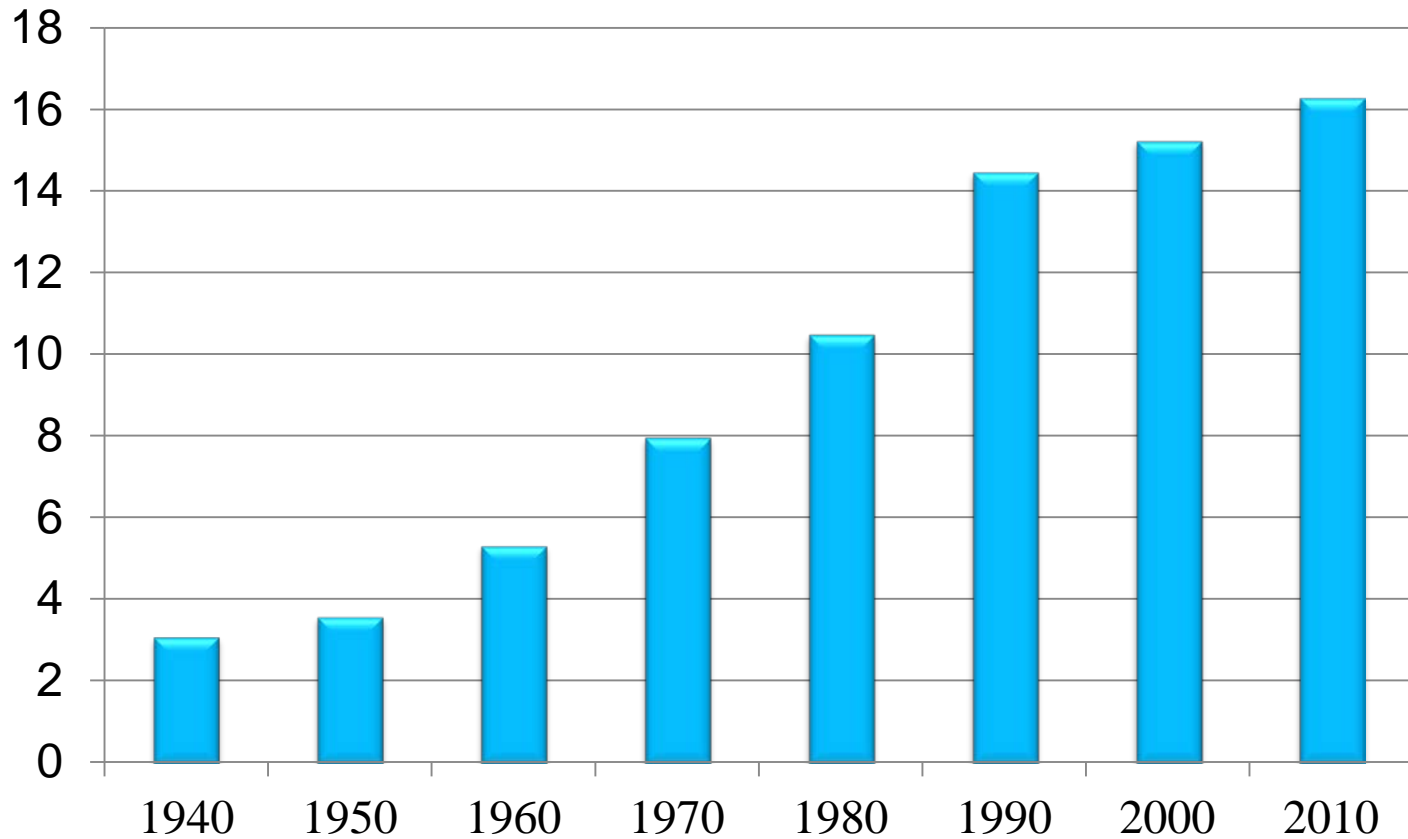
Conclusions

- If improvements are made in cost-effectiveness, we shouldn't necessarily expect growth in health care spending to abate – we might just get more and better health care
- **CAVEAT:** Government-imposed limits could *artificially* prevent Americans from putting resources into health care that they otherwise could and would do
- **As we'll see later, that's *exactly* what the PPACA does**

Bottom Line:

- As long as American productivity keeps increasing (in the long term), America can afford to continue to increase the resources used to save lives and preserve health
- **Real problem:** providing safety net for those whose incomes are not average, and its implications for government budgets

Health Care Spending as a % of Personal Consumption Expenditures

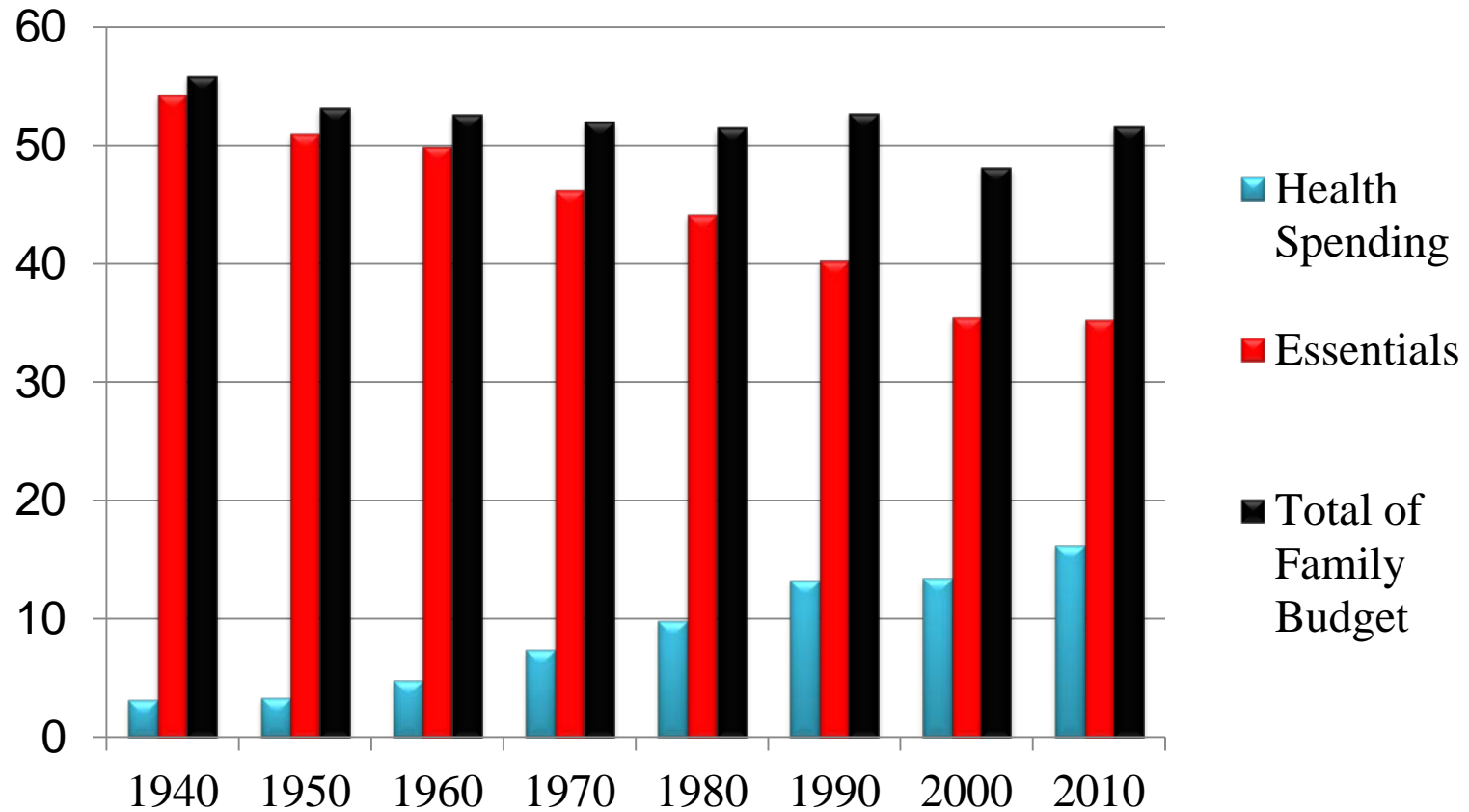


The Real Problems

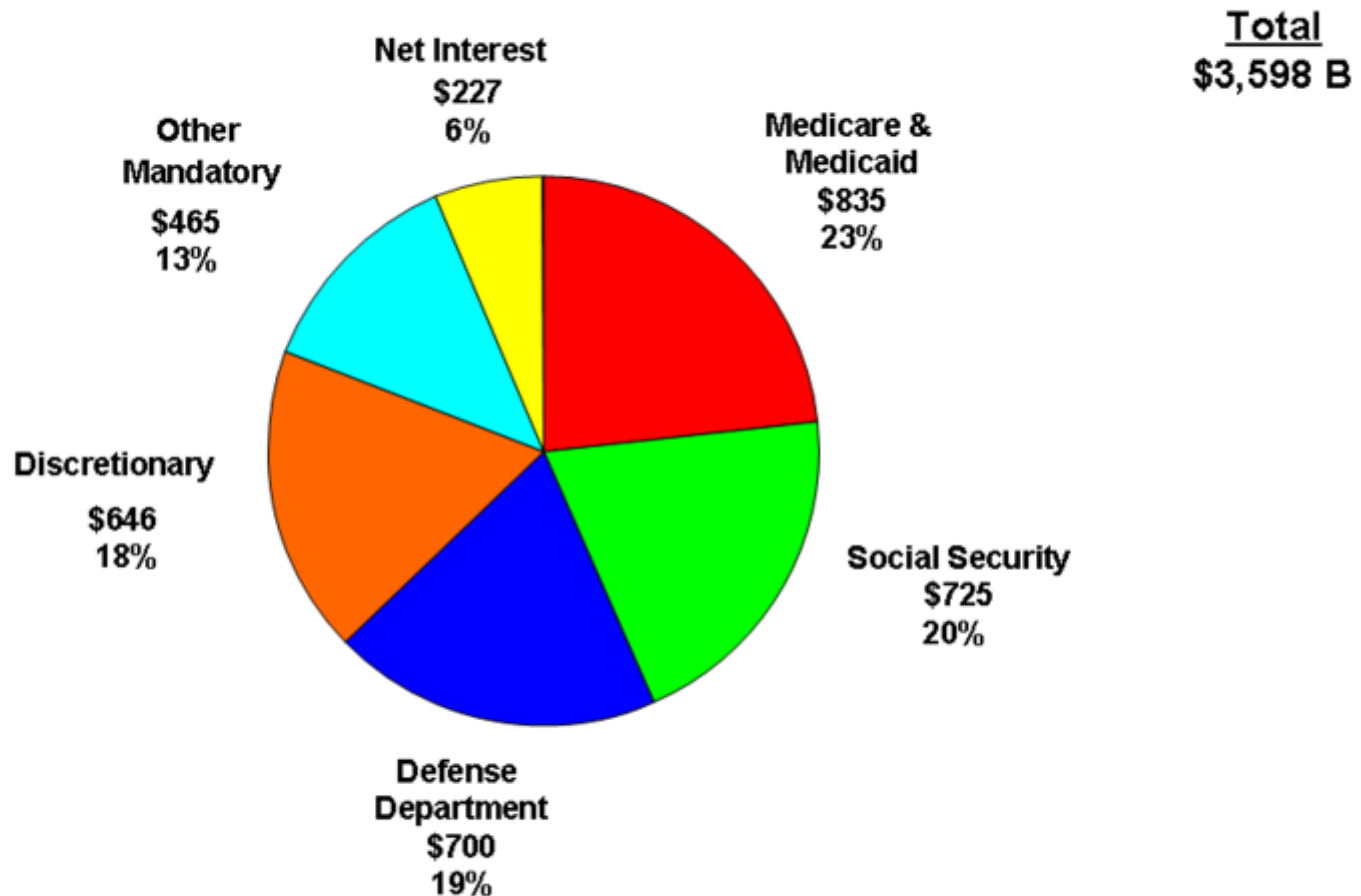
- REAL: Distribution of income increases not equal
 - Those with less-than-average income increases have genuine difficulty coping with health care cost increases
 - Number of uninsured rises among low income
- GOVERNMENT ACTS TO HELP: Medicaid, CHIP, now PPACA

But government does not benefit equally with private sector from productivity increases in areas other than health care – the productivity increases that reduce the resources needed and free up resources for health care

What the Family Spends on 1. Essentials and 2. Healthcare Combined



U.S. Federal Spending – Fiscal Year 2011 (\$ Billions)



Source Data: CBO Historical Tables

The Problem with Financing Health Care Subsidies from General Revenues

- REAL: General fund government revenue (taxes) can't keep up
- Productivity increases in non-health sectors of whole economy allow more resources for health care
- BUT non-health sectors of gov't budget DON'T see similar productivity increases

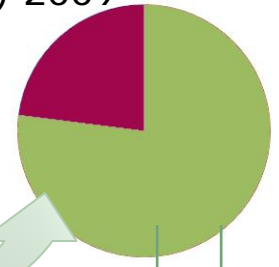
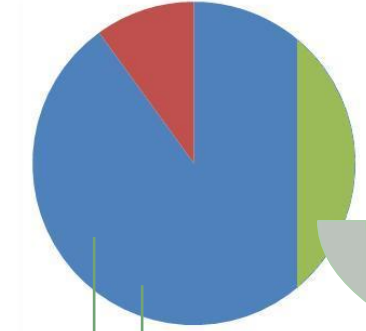
PRIVATE SECTOR SPENDING- GDP

GOVT. SPENDING- FEDERAL BUDGET

17.4 % (spent on H.C) 2009

23% (spent on H.C) 2009

15.1% tax rate to fund the Federal Budget



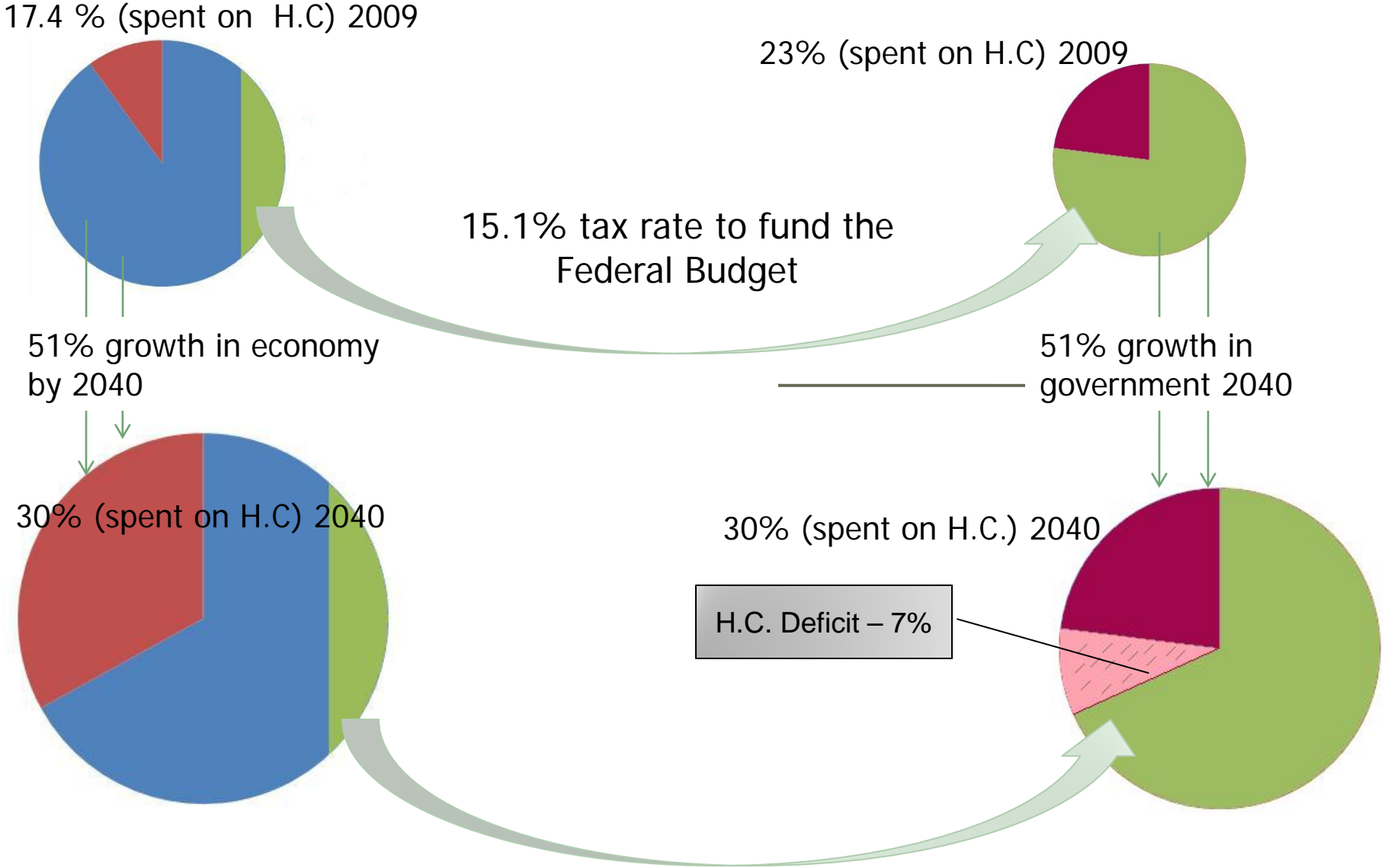
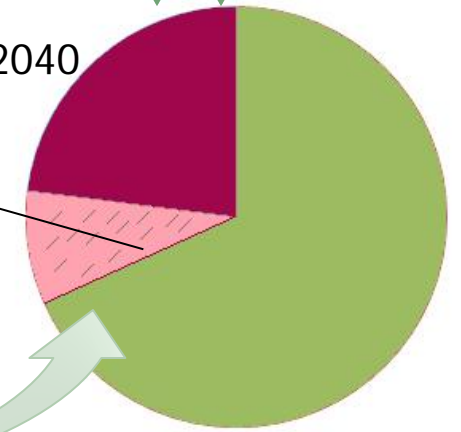
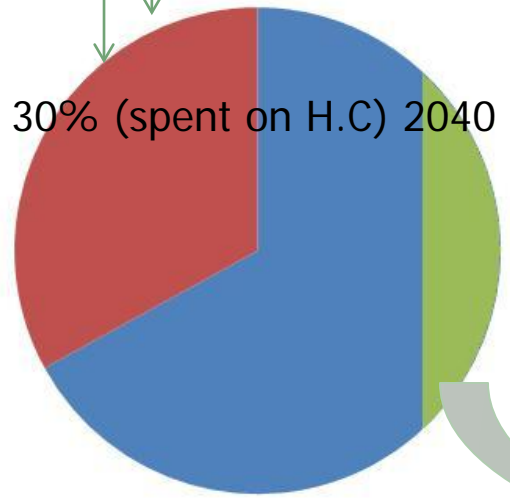
51% growth in economy by 2040

51% growth in government 2040

30% (spent on H.C) 2040

30% (spent on H.C.) 2040

H.C. Deficit – 7%



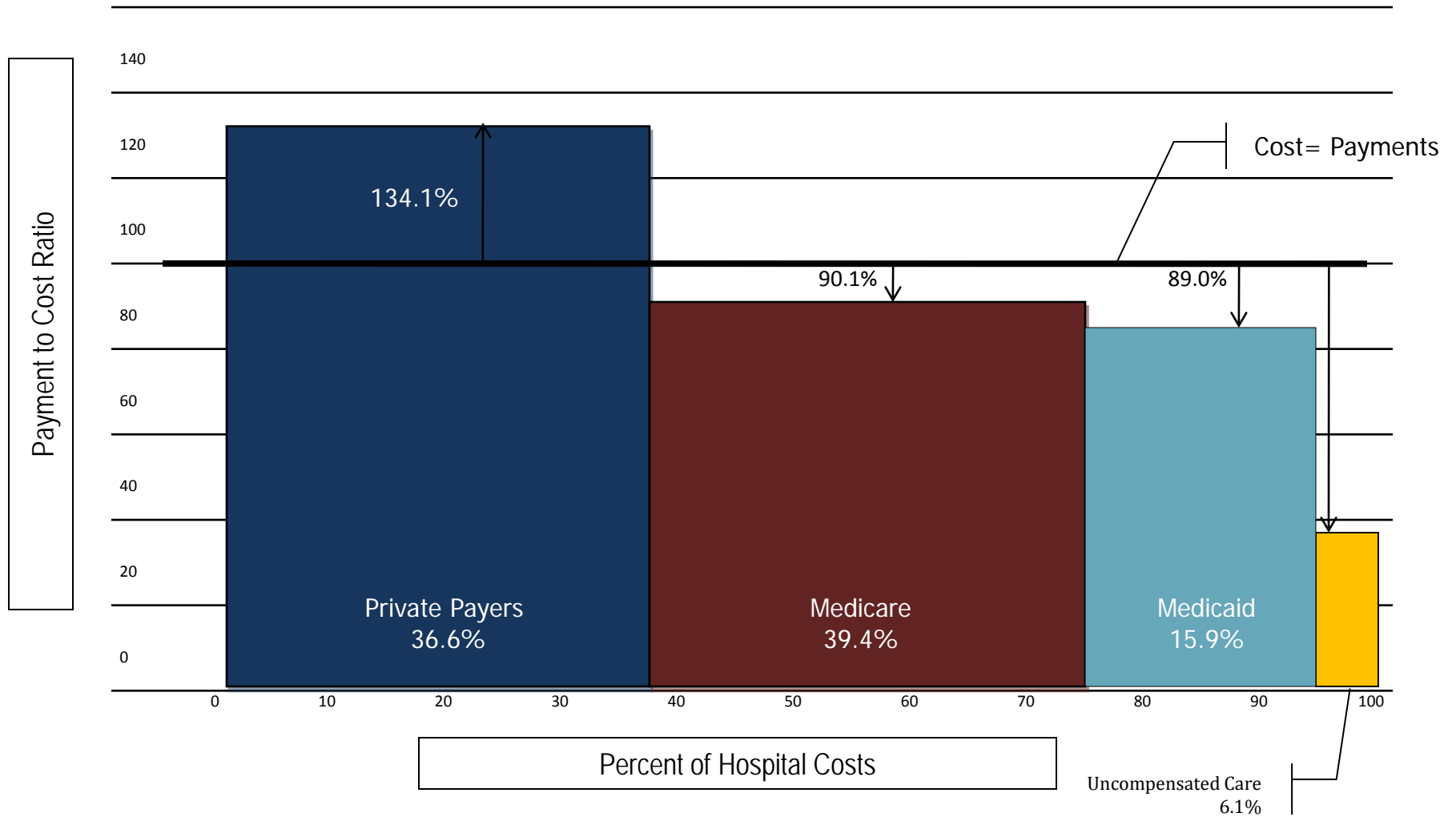
Disparity Pushes Policy-makers

- To limit the unsustainable pressure for ever-higher government health care payments drawn from general fund revenues
- Government policy-makers seek to “bend the cost curve” and limit the growth in *all* HC spending, private as well as public

Understanding Private Sector Cost-Shifting

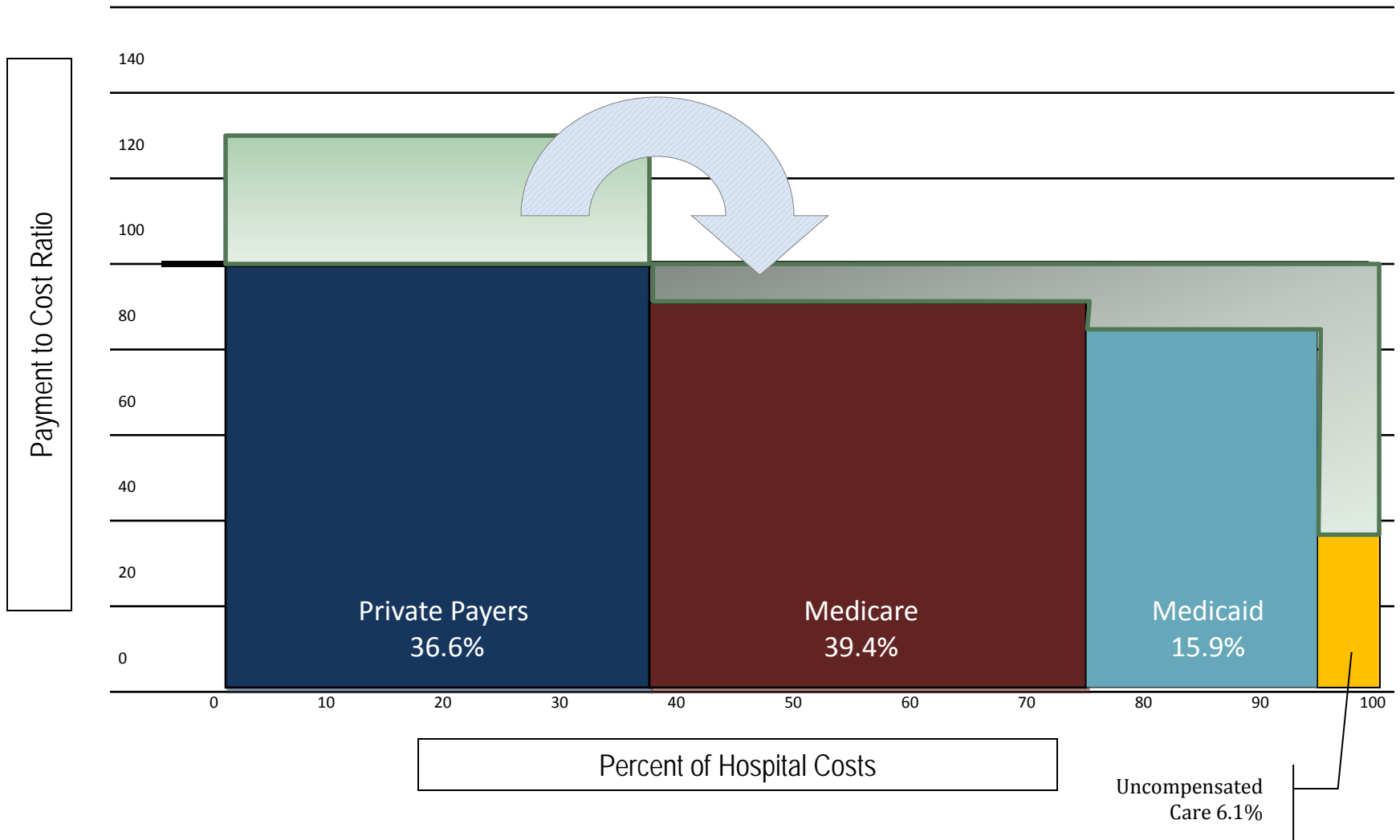
- Faced with unsustainable health care cost increases, government actors tend to avoid unpopular benefit cuts, and focus on limiting the reimbursement rate for health care providers
- Many health care providers assert they are then forced to charge higher rates to privately insured patients to make up for what they lose on governmentally insured patients (and on the uninsured EMTALA requires hospital emergency rooms to serve)

Hospital Cost Shifting- The Hidden Tax (as of 2009)



Source: American Hospital Association and Avalere Health, Avalere Health analysis of 2009 American Hospital Association Annual Survey data, for community hospitals, *Trendwatch Chartbook 2011, Trends Affecting Hospitals and Health Systems*, March 2011, Tables 4.5-4.6 at <http://www.aha.org/research/reports/tw/chartbook/ch4.shtml>

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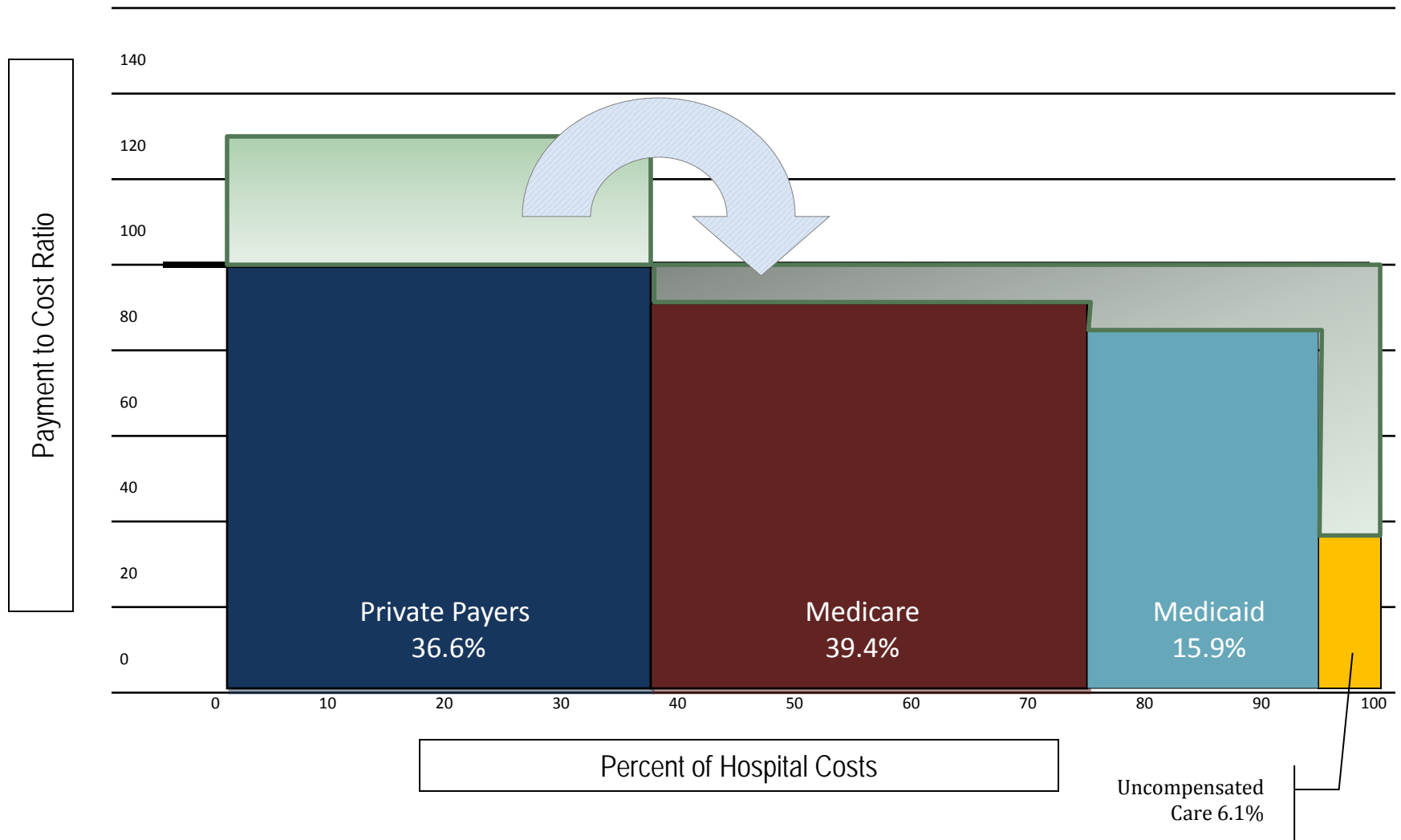


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Private Sector Cost-Shifting as a Solution

- Key advantage of private sector cost-shifting is that it can grow ***proportionately*** with the resources the private sector allocates to health care
- I.e., yields a % of what is actually spent on health care

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Degree of Current Private-Sector Cost-Shifting Hotly Disputed

- Scholarly literature, CBO, and MedPAC have argued:
 - cost-shifting occurs in non-competitive markets where hospitals have market power
 - but in competitive markets it is replaced with cost-cutting

Private Sector Cost-Shifting as a Solution

- Regardless of extent to which it presently occurs
- Provides a basis for understanding feasibility of providing for those with low incomes without governmentally imposed restraints on growing allocation of private resources to health care

Problems with Private Sector Cost-Shifting at the Level of the Provider

- Uneven
 - Suburban hospital may have few uninsured & on Medicaid, but profit from higher payments from privately insured
 - Inner city hosp may have many uninsured & on Medicaid but few privately insured

PROPOSED SOLUTION:
COST-SHIFTING AT THE
LEVEL OF THE INSURER

To make easier to understand

- Begin with abstract, but unrealistic, approach --- to make the concept clear
- Move to more complex, but practical, concrete plan

Proposed Solution:

Cost-Shifting at the Level of the Insurer

- Analogy of high-risk pools for automobile insurance in many states
- Could require health insurers to offer (sliding scale) discounted health insurance to those unable to afford in proportion to insurer's market share
- Insurers pass along costs of subsidizing insurance in premiums for all -- private sector cost-shifting

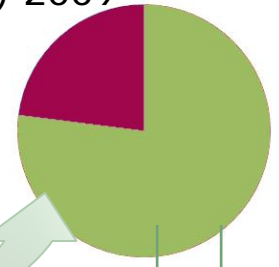
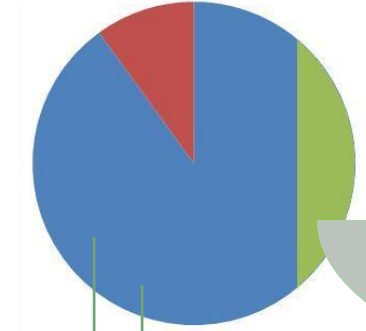
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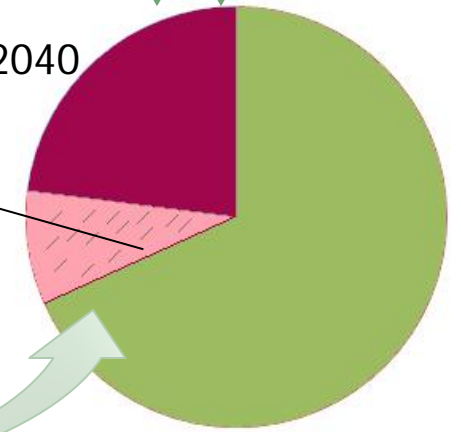
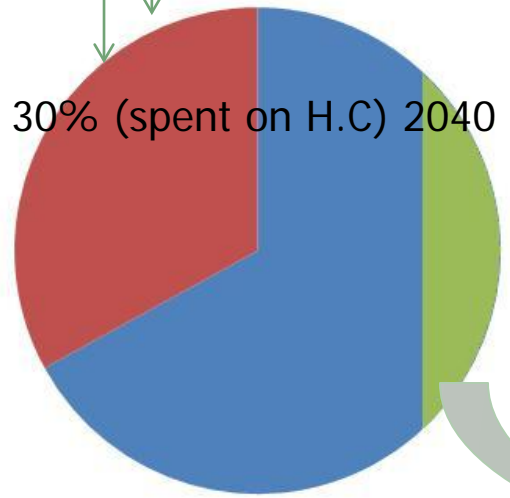
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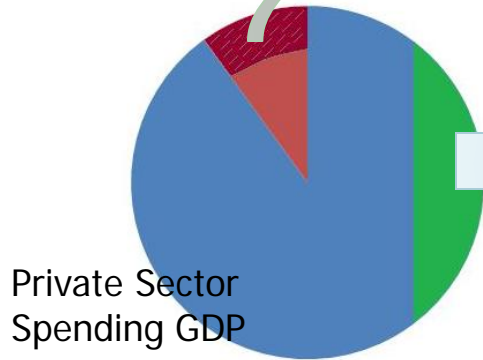
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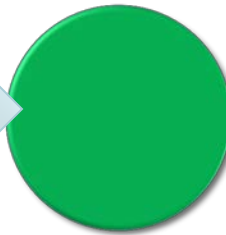
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17.4 % (spent on H.C) 2009



15.1 % Taxes

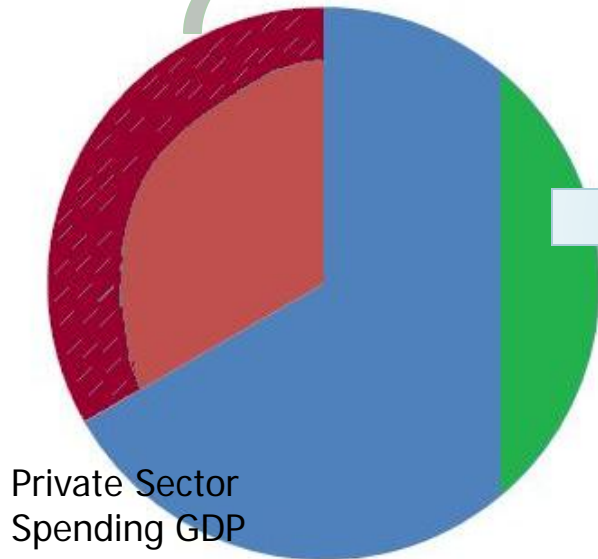


Government Expenses

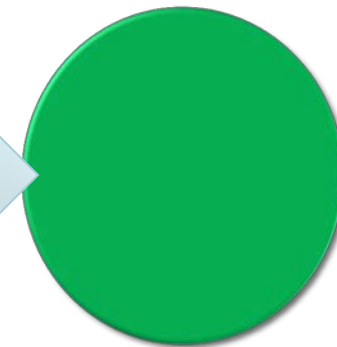


Amount for Health Care

30% (spent on H.C) 2040



15.1% Taxes



Government Expenses



Amount for Health Care

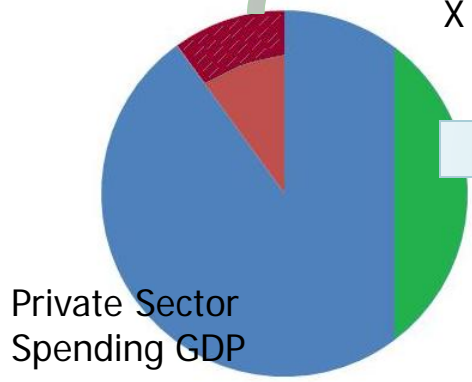
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Proposed Solution:

Cost-Shifting at the Level of the Insurer

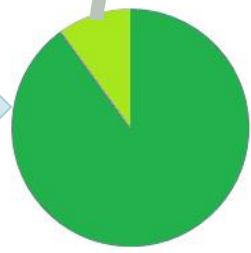
- Require health insurers to offer (sliding-scale) discounted health insurance to those unable to afford in proportion to share of market
- Provide sliding-scale vouchers based on *existing* levels of government funding for health care (e.g., Medicaid, CHIP)
- Insurers pass along *additional* costs in premiums for all

17.4 % (spent on H.C) 2009

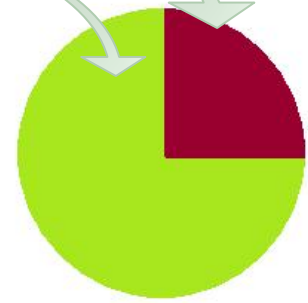


X dollar Amount for HC →

15.5% Taxes →

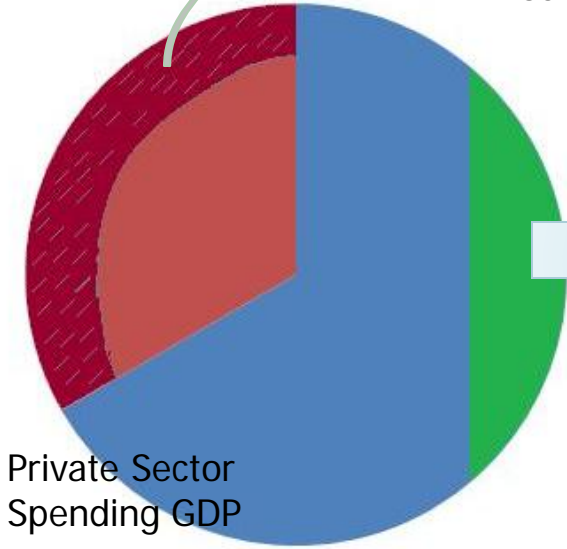


Government Expenses



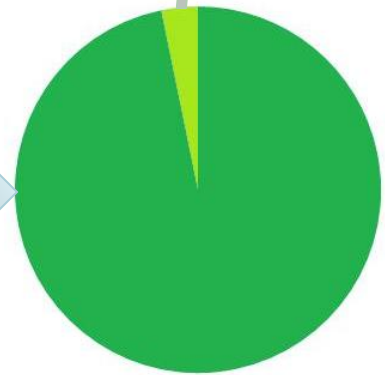
Total Amount for Health Care

30% (spent on H.C) 2040

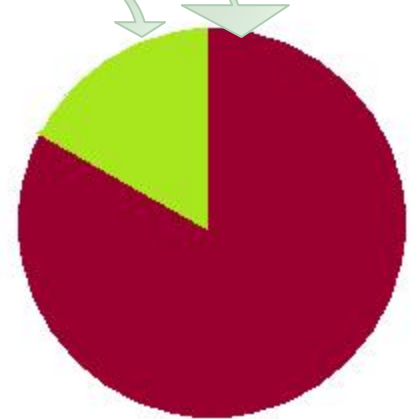


Same X dollar Amount for HC →

15.5% Taxes →



Government Expenses



Total Amount for Health Care

How Employers Decide

- Health insurance too costly – can go bankrupt
- Health insurance too meager – can lose workers to competitors
- *Balance* costs and benefits

The Virtuous Use of the Free Market

- When cost of insuring those who cannot afford it passed on to those who can
- Employers unconsciously factor in their share of subsidizing those who can't afford insurance in their cost/benefit balancing

ADVANTAGES

- Funding is tied to what people who can afford to do so *themselves choose to pay for health insurance* rather than being tied to government budgets. This:
 - Keeps health care costs to what people collectively, through individual decisions, decide they can afford to pay
 - Does not limit health care below what people, through such decisions, are willing and able to pay

Consequence

- America won't spend more than it can afford on health care
- America **WILL** spend **AS MUCH** as it **CAN** afford on health care

COMPARE AND CONTRAST WITH PPACA

BUT FIRST:

What IS “rationing”?

Orentlicher

- “[R]ationing of health care is inevitable. Not even the wealthiest society can provide every medical treatment that might provide some benefit to some patients.”
 - “Rationing of Health Care: It’s a Matter of the Health Care System’s Structure,” 19 Ann. Health L. 449, 449 (Spring 2010)
- Claim is since we cannot have *unlimited* health care, health care will always be “rationed,” whether by the government or by simple inability to pay for it
- Equates lack of infinite resources with rationing

What Is Rationing?

- Few can afford unlimited vacations
 - Are vacations therefore “rationed”?
- Few can afford to eat out at expensive restaurants for every meal every day of the year
 - Is food “rationed”?

Would ordinary people say that in 2011 America rations ...

- Meat ?
 - Butter ?
 - Tires ?
 - Gas ?
-
- In WW II, rationing coupons were required to buy any of these

The true meaning of rationing

- “Government allocation of scarce resources and consumer goods, usually adopted during wars, famines, or other national emergencies.”
 - *Britannica Concise Encyclopedia*

Difference in meaning not = to lack of compassion

- “Inability to purchase because of lack of funds is not rationing” doesn’t = “we should neither care about nor address problem of those who can’t afford HC”
- REAL QUESTION: Can we assure adequate HC to those who can’t afford it without imposing rationing on all?
- ANSWER already provided: key is financing subsidies that grow based on increases in private sector spending on HC, rather than on general revenues

RATIONING IN THE PPACA

The Financing Fatal Flaw

- Original proposal for 35% excise tax on “high-cost” insurance plans
 - Stated motive (discourage such plans) erroneous
 - Effect might have been similar to Glied proposal of 30% health tax
- However, under pressure from unions and others, the excise tax was so limited it is unlikely to be an adequate source of financing

So how does PPACA limit HC spending?

- **Independent
Payment Advisory
Board (IPAB)**

- Target set significantly below current and projected rate of growth in health care spending (President Obama now calling for target to be lowered still further from that in the 2010 law.)

IPAB Must Limit HC Spending Growth to the LESSER OF:

Year	Limit
2015	Halfway between medical and general inflation
2016	Same
2017	Same
Later Years	Nominal GDP per capita + 1% [President Obama has proposed lowering to Nominal GDP per capita + .5%]

Year	% below projected spending
2015	.5 %
2016	1%
2017	1.25%
2018	1.5%
Later Years	1.5%

Independent Payment Advisory Board

- Public focus has been on Medicare
- Little discussion of much more drastic and far-reaching requirement:
- As a result of the Lieberman Amendment, same limits IPAB is to enforce with regard to government Medicare payments are to be applied to private health care expenditures

Independent Payment Advisory Board

- IPAB directed to make recommendations every 2 years, starting in 2015
- “to slow the growth in national health expenditures” – i.e., *nongovernmental* spending

Independent Payment Advisory Board

- The recommendations are to include those that federal Department of Health and Human Services “can implement administratively”
- HOW will HHS enforce?

“Quality” Measures

- HHS empowered to impose on hospitals, doctors, & other health care providers
- One uniform set of practice standards specifying under what circumstances treatment can – and *cannot* – be given

Enforcement

- Doctors who give treatment not permitted by “quality” measures disqualified from contracting with the insurance plans all Americans will be required to have (individual mandate)

Independent Payment Advisory Board

- **IPAC**



- Aim: push *private* HC spending down
- Recommendations every 2 years

- **HHS**



- Imposes “quality” standards
- HC providers must comply or lose insurance contracts

- **Patients**

- Can't get HC exceeding standards

COMPARATIVE DISADVANTAGES

PPACA Rationing vs. Government-enforced Private
Insurer Cost-Shifting

Problem with Centralized Practice Standards to Ration Health Care

- Can't say it better than Orentlicher!
- “In theory, it might make sense to rely on a national commission to develop rationing rules for physicians and hospitals to implement, but there are far too many rationing decisions that doctors face for them to rely on formal guidelines. . . .
- ‘There are literally thousands, if not millions, of different medical decisions that must be made for patients. . . .
 - “Rationing of Health Care: It’s a Matter of the Health Care System’s Structure,” 19 Ann. Health L. 449, 454 (Spring 2010), *quoting* Orentlicher, “Paying Physicians More to Do Less: Financial Incentives to Limit Care,” 30 U. Rich. L.Rev. 155, 168-9 (1996).

Problem with Centralized Practice Standards to Ration Health Care

- “When should patients with difficulty breathing be admitted to the hospital?”
- “When should patients who have gallstones have their gall bladder removed?”
- “How long should patients remain in the hospital after delivering a baby, undergoing an appendectomy or receiving a kidney transplant?”
 - Id.

Problem with Centralized Practice Standards to Ration Health Care

- “Even if detailed guidelines could be developed, many of them would likely become outdated by the time they were issued. Medical knowledge is constantly evolving, so only reasonably general guidelines can account for changes in information and technology.”
 - Id.

Problem with Centralized Practice Standards to Ration Health Care

- “As the experience in the U.S.S.R. and other centrally-planned economies illustrate, governments or commissions fail when they try to determine which goods to produce and how many to produce.”
 - “Rationing of Health Care: It’s a Matter of the Health Care System’s Structure,” 19 Ann. Health L. 449, 458 (Spring 2010),

Government vs. Free Market

- Much ideological contention
- Instead, focus on pragmatic approach

Government vs. Free Market

- Resource allocation: free market far more efficient than central planning
- Free market does nothing to provide safety net

Insurance Cost-Shifting

- Availability of competing insurance plans provides better check and balance on denial of needed HC even as it promotes efficient HC
 - Contrast Orentlicher view that “monitoring,” malpractice liability, & bonuses for quality care can provide adequate safeguards
 - “Controlling Health Care Costs Through Public, Transparent Processes: The Conflict Between the Morally Right and the Socially Feasible,” 36 Iowa J. Corp. Law 807, 818, 820.

Government's Role Transitions More to Regulator Than Subsidizer

- Government regulates:
 - Defines minimum insurance package that must be available to those with low income
 - Determines income eligibility for sliding scale premiums
 - Enforce “rules of the road” -- especially regarding insurance companies’ duty to provide contracted care and “fair share” of discounted insurance, as well as antitrust and other measures to ensure robust competition
- Does not finance growth in HC spending out of general revenues:
 - Coverage of uninsured and those with low income does *not* depend on income or payroll taxes but on cost-shifting tied to the health insurance people choose

What Glied Says About a Health Tax Equally Applies to Insurance Cost-Shifting

- “[I]t would make the level of sustainable national health spending an outcome of a private-decisionmaking process, not a constraint imposed arbitrarily from above. Health care financing would mimic the dynamic nature of health care itself. Health care revenue would rise when costs rise.”
 - *Chronic Condition: Why Health Reform Fails*, p. 221



Insurance Cost-Shifting

- Most important advantage – avoids the PPACA’s artificial imposition of economically unjustified limit on allocation of resources to health care
- Consequently, no need for the rationing that, based on IPAB recommendations, HHS will implement by “quality” measures imposed on health care providers
- For more information:
- www.nrlc.org/HealthCareRationing/Index.html