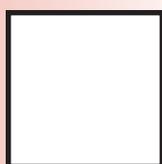


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Medicaid Financing: Challenges for Missouri and the Nation

*Selected papers of a conference co-hosted by
the Federal Reserve Bank of St. Louis;
the Weidenbaum Center on the Economy, Government,
and Public Policy at Washington University in St. Louis;
the Center for Health Policy at Washington University in St. Louis;
and the Missouri Foundation for Health
June 8, 2007*

Medicaid in the United States

Tommy Thompson

Medicaid—The Need for Reform

John Holahan and Alan Weil

Commentary

James W. Fossett

Mandatory and Affordable Health Insurance

Len M. Nichols

Commentary

Thomas Stratmann

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Editor's Introduction

Thomas A. Garrett

The Federal Reserve Bank of St. Louis co-hosted a one-day conference on Medicaid finance on June 8, 2007. Co-hosts included the Weidenbaum Center on the Economy, Government, and Public Policy at Washington University in St. Louis, the Center for Health Policy at Washington University in St. Louis, and the Missouri Foundation for Health. Titled “Medicaid Financing: Challenges for Missouri and the Nation,” the conference intended to provide attendees with a nontechnical description of the major issues surrounding Medicaid financing in Missouri and the nation.¹ The conference coincided with pending legislation in the Missouri legislature (SB 577) that would modify various provisions relating to Missouri’s medical assistance program. The Missouri Health Improvement Act of 2007 was signed into law by the governor of Missouri on July 2, 2007.

To provide diversity of views and experiences, the conference brought together physicians, hospital administrators, state health officials, and nationally recognized academic scholars and policy-makers. The conference format consisted of presentations by academic scholars as well as several panel sessions involving health officials, physicians, and hospital administrators. This issue of *Regional Economic Development* contains selected papers from the conference.

¹ More information on the symposium can be found at <http://research.stlouisfed.org/conferences/medicaidconf/index.html>.

MEDICAID IN THE UNITED STATES

Tommy Thompson, former Governor of Wisconsin and former U.S. Secretary of Health and Human Services, provided the keynote address. Governor Thompson discusses three major problems facing the future of Medicaid and the U.S. health care system: The rising costs of health care and its effect on America’s competitive position in the global economy, a decrease in the number of companies offering health insurance, and the inability of the federal government to prevent the insolvency of Medicaid in the coming years. Governor Thompson outlines several solutions to the problems facing Medicaid and the U.S. health care system. The first is that of prevention and education versus treatment—because preventing an illness is cheaper than treating it. Governor Thompson outlined several key areas for prevention dollars: tobacco use, diabetes, and obesity. In addition to prevention, Governor Thompson argues that more funding should be used for medical technology that would reduce medical errors in the treatment of patients.

MEDICAID—THE NEED FOR REFORM

In the first paper of the conference, John Holahan and Alan Weil outline the major issue facing Medicaid—rising costs—and argue that recent policy initiatives will not significantly curb Medicaid spending. Reasons cited by the authors include moral hazard, excessive benefits packages,

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Garrett

and rapid enrollments due to the decrease in employer provided insurance.

The authors present four options for Medicaid reform, each that would, the authors argue, ensure the sustainability of the Medicaid program. One reform would require states to increase coverage to certain income levels for parents and childless adults, with the aim of establishing uniform coverage across states and reducing the number of uninsured. Another reform would increase federal matching rates or services for selected populations or services. A third reform plan would shift responsibility for some services or populations wholly to the federal government while shifting others wholly back to the states. The final reform plan would end the Disproportionate Share Hospital Program. Holahan and Weil provide cost estimates for each reform option.

In his discussion, James Fossett focused on health care politics and choices that federal and state governments are going to be able to make in the near term. He acknowledges the rapid growth in health care spending but argues that state and federal governments will be unable to devise any reform plans, including those proposed by Holahan and Weil, to deal with Medicaid and health care in general. Specifically, Fossett argues that military spending, the federal budget, and weakening state revenue growth all limit the chances that any Medicaid reform will be achieved in the next several years.

MANDATORY AND AFFORDABLE HEALTH INSURANCE

Len Nichols argues that a reformed health care system in the United States should provide universal coverage and a more efficient delivery system. Nichols stresses, however, that universal coverage does not imply only government provision of health care, but rather cooperation between the public and private sectors to provide health care to all citizens. He outlines several universal financing arrangements that support tax-financed, single-payer (or Medicaid for all) programs, as well as mandates on employers and employees to purchase private health insurance. To ensure universal cov-

erage, Nichols argues that any reform should create an effective health insurance market, all individuals should be required to purchase health insurance, and there must be substantial subsidies for low-income individuals and families, among others. Nichols then suggests that the success of any health care system is dependent upon the delivery system. He outlines three elements of an effective delivery system.

In his discussion, Thomas Stratmann argues that more free market solutions to health care should be considered by policymakers, and he points out several problems with the current system. Subsidization of health care creates an overuse of health care services, thus driving up costs. In addition, the expected treatment of illness creates an incentive for individuals to participate in behavior that is conducive to ill health, such as drug abuse, smoking, etc. Stratmann argues that the uninsured in the United States are primarily healthy and young, so their need for health insurance is relatively low and forcing insurance upon these individuals would create extra costs. Finally, Stratmann argues that catastrophic health insurance should be mandated. The costs of such a reform would be relatively low because catastrophic events are infrequent, and no additional funds would be needed to finance such coverage for those with lower incomes because they are covered by Medicaid.

PANEL DISCUSSIONS

In addition to the two academic papers, two panel discussions (not included here) were also held during the conference. For the first, two hospital administrators and two physicians from Missouri discussed their ideas for Medicaid reform and why such reforms are needed. The last session of the day consisted of a panel of health policy experts and state administrators who discussed the future of Medicaid. Panelists shared their views on likely reforms in Missouri as well as the nation. Each panel session provided the audience an opportunity to understand the highly political nature of Medicaid financing in Missouri.

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Medicaid in the United States

Tommy Thompson

Thank you very much and good morning. Ladies and gentlemen, if we want to understand Medicaid, we must look at the overall picture. We can't do it in isolation. What I would really like to have you do is to think about how you could change the system because the system has got to be changed dramatically to survive.

Health care in America, I believe, is the best in the world. Now, you can find countries that do better in prenatal care. You can find a country that does better on longevity or on mental disease and defect. In any one area of health care, you can find a country that is probably doing something better than the United States. But overall, holistically, if you are going to become sick, you will want to receive care in a U.S. city such as St. Louis because you have got an outstanding, outstanding health care system here. You've got some of the best researchers, some of the most talented people in the world right here in St. Louis. So if you are going to get sick, no matter where you are in the country, you will want to get back to St. Louis to be taken care of. I think it is pretty common for Americans to feel this way. If our health care system is this good, we surely want to preserve it.

The health care system in America is under a great deal of stress and strain. It's not only Medicaid, it's the total system. Right now we are spending \$2 trillion on health care. You may want to take some of these figures down because I think they are really relevant. Two trillion dollars is what we expend now on health care. That's 16 percent of

our gross domestic product (GDP). And within seven years that's going to double to \$4 trillion and that's going to go to 21 percent of GDP in America. When you reach this level, you put a lot of companies in St. Louis and in the Midwest out of any kind of competitive advantage in the international arena, because health care costs for countries around the world are much smaller percentages of GDP than those in the United States.

For instance, Japan is the second largest economic power right now, soon to be overtaken by China. Right now, Japan is spending about 7¹/₂ percent of GDP on health care and may reach 8 percent when we reach 21 percent here in the United States. If we are going to be competing against Japan, we are going to see what is already taking place in the automobile sector: At the beginning of this year, General Motors was the largest automobile manufacturer and seller of cars in the world. They pay \$1,725 per automobile to sustain their employee health care system. Toyota, a Japanese company, spends \$225 dollars per automobile. So every car that General Motors sells costs an extra \$1,500 for the company to produce.

We have seen the toll this has taken on General Motors and Ford. According to business projections, Toyota was not supposed to overtake Ford until the end of this year; they overtook Ford in January of this year. They were not supposed to overtake General Motors until the middle of next year; they overtook General Motors and became the largest automobile manufacturer in the world in April of this year. This is indicative of the challenges that

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the high price, high cost of health care will impose upon all manufacturers and firms that sell internationally—especially over the next seven years, with the doubling of our health care costs. If you are in business or if you are in the Federal Reserve System, you have got to be concerned about the terrible cost of health care and how you are going to be able to allow America to continue to compete internationally, especially with the Chinese. So it is an immediate problem.

The second immediate problem involves employer-provided health care coverage: During and after the second World War there was a law passed that enacted rules and regulations preventing businesses from increasing wages. Companies, in order to keep their best employees and continue to recruit good employees, offered health insurance. A lot of companies started offering first-dollar coverage, which means that all of an employees health care was paid for by company health insurance, which was sponsor owned and negotiated by the employer. Over the years, insurance costs have gone up and companies have started to withdraw from comprehensive employee coverage, especially in the past 10 years. The 82 percent of employees who have historically been covered by company health care plans has been declining to about 60 percent. It's probably on its way down to 45 percent. For companies with 50 or fewer employees, it's already in the low 50s.

As coverage by employers decreases, there will be more pressure on Medicaid—more uninsured and more government control of health care. And because the cost of health care is going to continue to rise, the problems are going to get worse: Fewer people are going to be covered by employer-provided health insurance, and co-pays are going to increase. The good side of that is that there has been an upsurge of attention and interest across America in consumer health care. For the first time, higher co-pays and/or less employer contributions to health insurance are prompting health care questions: How much is this procedure going to cost? Do I need this patented drug or can I get a generic drug? For the first time in America we are starting to educate ourselves about health care and we are starting to ask questions, which I think is extremely positive. Even though the

employers are backing off, the fact of the matter is that this employer withdrawal is starting to make employees and consumers much more knowledgeable about health care.

The third big driver that you have to take into consideration is going to directly impact Medicaid because so many states and so many policymakers are expecting the federal government to take over Medicaid. What I am going to tell you is going to point out that Medicaid is not going to be helped by the federal government. The reason being is that by the year 2014, seven years from now, Medicare starts to go broke. Medicare right now takes up $2\frac{1}{2}$ to 3 percent of GDP. In 75 years that's going to jump to 15 percent, and the unfunded liabilities of Medicare in 75 years are going to be \$68 trillion dollars. To put this number in it's proper perspective, the entire GDP in America right now is a little under \$13 trillion. So this surge in costs is huge, and Medicare is going to start going bankrupt in the year 2013 or 2014.

Congress has been taking the money out of Medicare. And, likely until 2013 or 2014, Medicare will continue to shed an excess of funds. That excess money has gone into the United States Treasury. Do you know what happens to money that goes into the United States Treasury? It's spent. Congress has spent this money and continues to do so. Come 2014 there will be no more excess money coming in, and Medicare is going to come over and say, "Pay us: Those IOUs that you have been giving out for 28 years...Write us a check." Congress will say, first off, that they don't have any excess money coming in. Moreover, the Medicare surpluses were being used to fund other government programs. The first thing Congress will have to do is to take other taxpayer monies to supplant the money that Medicare was funding in those programs. Secondly, on those IOUs to Medicaid, they won't have any money to pay them. The Iraq War has cost us \$8.5 billion per month and that's not going to be paid off for many years, even if we stop the war this year. Medicare has got the first draw on those IOUs that the government has sent and Congress doesn't have the money.

In 2014, Congress is going to be faced with three objectives, I believe. They are going to have to first come up with the money, and there are

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several ways to do this: They could go to a complete price control system and a rationing of health care on elective surgeries, on elective appointments to your doctor—which they can do—and ratchet down the cost. But Washington University in St. Louis, for instance, is going to be adversely impacted because there will be no money coming in. Or they could go to a government-controlled, nationalized system, which some of you in this room support. I don't. The reason I don't support it is because it will stifle innovation completely. I want to find a cure for breast cancer because my mother-in-law died from it, my wife had it, and my younger daughter had it. I want to find a cure for breast cancer, and I don't want to stifle innovation, so I'm not for a nationalized health care system.

Another option is to raise huge amounts of taxes. Congress could roll back all of those tax breaks we've been given. If they were to reinstate those taxes and then double them, that would stabilize Medicare. That's the background. Those governors and state legislators that believe that Washington is going to fix Medicaid by coming in with new dollars—well, it's not in the cards.

I ask you now to put your hat on and say you are a governor. You're the governor of Missouri, and you want to be able to fix Medicaid and take care of the uninsured and underinsured in this state. Let's take a look at Medicaid. Medicaid is a combination program. It was instituted as a result of Medicare, to follow it and supplement it. To fill in the gaps. It was sort of a strange phenomenon. The federal government pays about 55 percent on average of state Medicaid costs. But that percentage varies by state. Some states get 70 percent, other states get 50 percent, but on average it's 55 or 45 percent. The federal government pays 55 percent and for that payment they say there are 32 programs or policies that states can add on and have complete discretion over and we will fund 55 percent; but there are some mandatory programs for children and mothers that we are going to require every state to have and we are going to set those rules.

Medicaid is a partnership between the federal and state governments in which states have the option of putting in voluntary programs, which every state has a portion of. My home state of Wisconsin has got the maximum. Other states do,

too. Missouri does not. Anyway, you can put in these voluntary programs, which the federal government will fund at 55 percent on average, and you have to fund all the mandatory programs put out by the federal government as well. With that as a background, then, how do we fix the system and how do we change health care and at the same time specifically fix Medicaid?

I tell governors, *think boldly*. Be bold and courageous. Because, just stop and think practically, if you have an entity and you are in business and somebody comes up to you and says I will give you 55 percent of your cost and all you have to do is come up with 45 percent, how much of that money will you take? Me, I would take as much as I could get. I would put every voluntary program in. I would put in as courageous and as aggressive a program as I could have for my state because the federal government is going to pay 55 percent.

The federal government quakes when I say this because they don't want states to think that way. But if you stop to think about it, if you are a banker or in a business and somebody comes in and says if you want to expand your business I'll give you 55 percent and all you have to come up with is 45 percent, wouldn't you take as much as you could get? It's an open-ended proposition on Medicaid, and that's why I don't understand the timidity of governors. It's a blank check, and if you consider health programs for children, it's even a better deal. The federal government will give you 70 percent for those, and all you have to come up with is 30 percent. If you want to go into technology, there are some programs for which the federal government will give you 90 percent and all you have to come up with is 10 percent. I, for the life of me, do not understand why states don't completely bankrupt the federal government. It's a wide-open thing.

I tell you this as a background, and then I look at welfare reform because I started welfare reform in this country. What I did is I brought welfare mothers into the governor's residence in Madison and I asked them why they didn't work. They said, "If we go to work we lose our health insurance." I said, "If I give you health insurance will you go to work?" They said, "Yes, but if I go to work who is going to take care of my children?" I said, "If I pro-

vide you with day care will you go to work?" They said, "Yes, but I dropped out of school when I was thirteen and I have no job skills." I said, "If I give you job skills, day care, and health care, will you go to work?" They said, "Yes, but most of the jobs are in the suburbs and I live in the central city." I said, "I'll provide you transportation. Will you go to work then?" They said, "Yes."

And welfare reform was born. When I started welfare reform, governors and policymakers in this country said it couldn't be done: "Welfare reform cannot take place. It's a way of life and you are just going to get hurt, Tommy." I said, "No, I'm going to try it because I want to give people a chance to get out of poverty, and the only way to get out of poverty is by working." I didn't want to be cruel. I wanted to be compassionate and give people the assistance to help themselves. It was born at the dinner table at the mansion in Madison with the welfare mothers.

Once I started, the governors who originally told me not to do it saw that I was getting some success and they started copying me. John Engler said, I'm smarter than Tommy Thompson. If he can do it, I can do a better job. Then Arnie Carlson, then Terry Branstad, and it spread across the country. Then the federal government noticed the states were getting good recognition and reducing welfare and decided they had better get into the act. They would have never done it except for the fact that the states had done it.

Why do I tell you that story? I tell you that story because when I was secretary of Health and Human Services, Mitt Romney came to me from the state of Massachusetts, and Ted Kennedy, too, and said if you could give us a waiver, Tommy, so that we could use our disproportionate share money, the federal dollars that come back to the federal government, we can set up a health insurance program that will cover under Medicaid all of the uninsured in Massachusetts. I jumped at it. I didn't know he was going to be my opponent. I jumped at giving him the waiver, so that he could try something, because in the back of my mind I knew what was going to happen. It was the last waiver that I handed out. Then I went on the speaking circuit on health care.

I always put this out as a bet. I bet anybody in the audience \$100 to \$5 that there will be 25 states this year that are going to offer some kind of solution on health care on the uninsured and Medicaid. The reason I was so sure on this is because of my experience on welfare. I knew that once a governor does something and gets some good public recognition and publicity, others are going to copy it. Governors love to go to conferences. I did the same thing. I was a governor for 14 years. You go to a conference, you find out what's the best program out there that's working, and then you run back to your home state, change a couple of things, and take credit for it. I knew that's what happened on welfare. I knew that's what would happen in health care, and that's exactly what's happening across America: Massachusetts, Vermont, New Hampshire, California, Missouri, Wisconsin, Michigan, Illinois, Minnesota—you name it—Iowa—they are all trying something new. Because one state started it, it's starting to spread.

Ladies and gentlemen, the beauty of this is that great opportunities exist. Come 2008, the presidential election is going to take place. Democratic candidates are talking about a single-payer nationalized system. Republicans, except for me, are talking about putting a tourniquet on health care. I'm talking about a complete transfusion and transformation, and that's where you come in today. We are here today to talk about Medicaid. I'm trying to set the stage for you so that you do know now that we have problems facing us in 2014. The federal government is not going to fix them, but the federal government's got a piggy bank and there is no limit to what you can do innovatively in your state to pull in federal dollars to help you fix your problems in Missouri.

So let's get started. Now we look at health care and at the fact that you have a responsibility as the governor of Missouri to make your health care system effective, efficient, and expanded to cover the underinsured and uninsured. Currently, \$2 trillion is spent on healthcare, and Medicaid is 20 percent of your Missouri budget. You've got to realize that, for every \$1 in Medicaid costs, as a governor you pay only 45 cents. A governor has to think, I have a real opportunity here. You look at health care and you find out that 93 percent of

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that \$2 trillion is spent on patients who go to their doctor or the hospital *after* they're already sick. It is called a curative system. The money is spent to get you well after you get sick. That isn't health care. Consider your car: After so many miles, you take it in for an oil change, grease job, etc. But you don't take your own body in for maintenance. You wait until it collapses and go to the hospital; you've got cancer and then it costs a heck of a lot more money to get you well. There's hardly any money, only 7 percent of that \$2 trillion, that is used to *keep you well*. So don't you think the first thing we should do is have a transformation and put the emphasis on wellness? Let's see if we can keep some individuals out of the hospital.

So, after transforming the system, after trying to transform the curative system to a wellness and prevention system, you look at the next big challenge. And the biggest area, especially for poor people, is chronic illness. Seventy-five percent of the cost of health care, including costs for Medicaid (in fact, *especially* costs for Medicaid) is for chronic illnesses. When Willie Sutton and Jessie James were asked why they robbed banks, they said, because that's where the money is. So if we want to fix Medicaid, we want to be able to put the emphasis on wellness but most importantly on education and getting people to understand chronic illnesses because that's where the big money is. You want to change that. You want to have the best system and the healthiest people in Missouri so you can go brag about it.

The first thing you want to do is address the biggest health care issue, which is tobacco use. People don't understand this, that tobacco use is *still* the biggest problem related to chronic illnesses in America. Four hundred and forty-three thousand Americans died last year of tobacco-related illnesses. Just as I did when I was secretary, when I was governor of Wisconsin I went around in the morning and took cigarettes out of my employees' mouths as they were smoking outside the door. Sometimes I got slapped. Sometimes I got cussed. One day I walked around and an elderly gentleman was taking a drag and didn't know what to do with his cigarette when he saw me coming. So he put it in his pocket. It caught his shirt on fire, but he stopped smoking. Then I got so irritated that I

banned all the smoking on all of the property owned or leased by HHS. I made any employee who wanted to smoke go over to EPA and smoke. A complete embarrassment.

Let's return to our imagined role as governors now. Here's what I would do if I were governor of Missouri. I would put a dollar tax on every pack of cigarettes sold, and I'm a Republican. That's a tax, ladies and gentlemen, but I wouldn't let the government have the money because 70 percent of smokers want to quit. Which is a tremendous opportunity, ladies and gentlemen, to put that dollar-a-pack tax into a fund only for smokers to draw down to quit. Can you imagine the change, the transformation of public health if you did that, for patches, for counseling, for doctors? And you would be able to have a huge impact. On the federal government level, I would require nicotine to be regulated by the FDA. Baby aspirins: How many of you take a baby aspirin every day? I do. Baby aspirins have to be regulated by the FDA, and baby aspirins are used to improve your health and circulation system, while nicotine isn't regulated and it killed 443,000 Americans last year. Does that make any sense to any rational person in the public arena? So then we take care of tobacco.

The next big health issue is diabetes. Diabetes is just huge. Eighteen million Americans last year had type II diabetes, a lot of those in the Medicaid arena. This year, 21 million. One year later and it's 21 million Americans. Costs went from \$135 billion to \$145 billion in both direct and indirect cost for the health care system. There are 41 million more Americans, ladies and gentlemen, some in this room that are walking around that are pre-diabetic and within five years will be diabetics, and then the cost will go to \$400 billion. One out of every five dollars going into the health care system will be needed for diabetes if we don't make changes.

Dr. Peck has spoken about the National Institutes of Health (NIH). The NIH is a great research engine for the world, and we should double its funding again, which would achieve significantly better results than some of the other programs funded by federal government expenditures. But the NIH did a study that says, if you walk 30 minutes per day and lose 5 to 10 percent of

your body weight, you reduce the incidence of type II diabetes by 60 percent. We can walk and we can watch our body weight, which leads us then to a third big challenge: obesity. Obesity and diabetes are epidemic among minorities.

We need to look at obesity. We can look at the mirror and say chunky is good, but slim is better. I tell my business clients that have cafeterias, and you should do it here on the campus of Washington University, give away salads or subsidize salads, vegetables, and fruits for a buck a serving. Charge \$5 for hamburgers, \$10 for cheeseburgers, and 20 cents per french fry and you will change the eating habits of your employees. Let's face it, if you are able to bring a nutritionist in and start teaching nutrition at the medical schools and make it a detailed subject—and especially counsel minorities—you have a tremendous chance to change Medicaid and health care for the better.

That also leads into cardiovascular disease, which is the number one killer of both men and women today in America. Here's an idea: It is not radical, but it is common sense. I've started a diet and you don't have to pay any royalties for using it. I want you to know that there are no food police in St. Louis. Although your mother and father and grandma and grandpa said you have to eat everything on your plate, no law says you have to do that. Take whatever you want and eat only half and you will lose weight. This is Tommy Thompson, I've lost 15 pounds doing that. I know it hasn't improved my looks any, but it has improved my strength and my ability to work harder. So we must take care of chronic illness.

This is where governors like you, policymakers, and businesses like the Centene Corporation come in. Now, I don't want you to think that I'm up here promoting Centene, but I like Centene and it's a great company. I want you to know that Centene manages diseases for Medicaid, and I'm not saying that just for you to hire Centene. That is not the thing I'm saying. You, as a governor, look at your Medicaid population. Twenty-five percent of your Medicaid population is using anywhere from two-thirds to three-quarters of your Medicaid budget. These are the individuals that are severely mentally and physically disabled, your diabetes population, people with severe asthma, and they are using up

two-thirds to three-fourths of your Medicaid budget. Don't you think it would be smart for you to address that problem?

The best way to do it is to manage those diseases. Hire disease managers. Do it yourself. Find out if individual people on Medicaid are taking their medicines. I'm going to give you a fact. This is a Pfizer study, which absolutely amazes me. Thirteen percent of Americans go in to see a doctor for a sickness and get a prescription and never take it to a drug store, never take it to a pharmacist. Another 14 percent take the prescription to the pharmacist and never pick it up. Can you believe that? Twenty-seven percent of people see a doctor for an illness and never go pick up the medicine. Another 60 percent, after five months, discontinue the regular use of medicines. They take it maybe day after day, for a few weeks, but then stop.

If in fact you were able to manage just the medicines and to find out whether people are actually complying with what the doctor said, you would have a tremendous reduction in cost, especially for that 25 percent who are severely ill. You have got to realize that you are going to get 55 percent of the cost of hiring disease managers paid for by the federal government; so, it only makes common sense, I would think, if you are a reasonable, visionary governor, that this is a great way to improve the quality of health, the quality of life of citizens while also holding down cost.

The next thing, ladies and gentlemen, in Medicaid is the huge problem in information technology. Doctors at Washington University, you would not allow a student to enroll in your school unless they had straight As. You will not allow a slacker like me, a C+ student, to get into medical school. Students attending this school must have excellent grades. You want the best. You want Dr. Peck to operate on you or Dr. Shapiro. They're smart. They're brilliant. But there is one subject that those individuals don't have to get an A in to be admitted into this wonderful medical school.

Do you know what that subject is? Handwriting. And I'll tell you, Dr. Peck, I don't know how you write but I would bet that your handwriting hasn't improved a bit in the past 50 years. Ninety-two percent of doctors still write out prescriptions,

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and one out of five of those prescriptions has to be corrected at the pharmacy: one out of five. That's 20 percent. Ninety-eight thousand Americans died last year—not my figure, but the Institute of Medicine's and doctors' own studies—as a result of medical mistakes. Fifty percent of those deaths were caused by the wrong medicine, the wrong amount, at the wrong time, to the wrong person.

If we had e-prescribing, you could input a patient's name and other characteristics into an electronic system and send and retrieve information. And I know you know what palm pilots are because I see so many of you looking at them as I'm speaking. Put your name in, Dr. William Peck (great guy, a little arrogant) and your whole medical history could be retrieved, including prescriptions you're taking. Let's say he comes in with a common cold and Dr. Shapiro examines him and he types in "common cold," or the cold that's going around in St. Louis now. It immediately comes up with the three to five drugs that will take care of that, and immediately any contraindicators will come up with the medicines he is already taking. Dr. Shapiro then will press another button and the bill goes to Centene: no handwriting, just a button. Then he presses another button and the script automatically goes down to the pharmacist. For the 13 percent of patients who don't take the script down there, it automatically goes down there. That's the technology of today, and you would reduce 50 percent of those error-related deaths overnight. Medicaid can help pay for that for your doctors, and your patients will be able to get better quality of care and therefore better quality of life.

The final aspect of information technology is a paperless working environment. Do you know what a 1040 is? Do you know what a W2 is? Large and small employers all fill out the same form, a W2, one form. How many forms does it take to file for Medicaid? How many forms must be filled out to go see a doctor when you are on Medicaid? How many forms must be filled out when you go into the hospital and apply for reimbursement? And how many of you can even understand what those forms say once you fill them out? And Medicare is even worse. If we are smart enough to have the most complex tax system in the world with one form and the most complex employment system

with one form, don't you think we should be smart enough to have one medical form or go completely paperless? We could save 10 percent of the cost of health care and more than that in Medicaid if we went paperless.

The final thing on Medicaid is that it is absolutely appalling to me that we walk around in this country with 47 million Americans that don't have insurance, and that's going to go up to 50 million unless something happens. You are in the role of governor now, and you look at this situation, and you look at the number of uninsured in Missouri, which is around 1 million. You look at that and first off you ask where they are going to go for their health care. Well, they are going to go to the emergency room. And what's the most expensive health care cost in the country? Emergency room visits, right?

We have 47 million Americans whose first stop for health care is the emergency room, the most expensive. Does any rational Missourian think that that is a smart system? If we go back to what I originally started with about prevention, wouldn't it be nice to have somebody not wait until they have to go to the emergency room but to be able to go to a community health clinic in Missouri and have a procedure, get a test done, or have cervical and breast examinations? So let's take a look at it. Let's fix this problem.

First let's make an assessment of the many uninsured that we have in the state, and a good share of that percentage of that 1 million are eligible for Medicaid. Instead of sending them to the emergency room, we can give them a card and the federal government is going to pay for 55 percent of the cost. Don't you think you should go out and enroll as many of those people that are uninsured or underinsured that are eligible for Medicaid and get them on your Medicaid rolls? Governors think just the opposite. Let's find ways to get them off, so let's send them to the emergency room where its going to cost more money. Who pays for people to go to the emergency room? Hospitals, the University, and everybody that has an insurance policy because everybody pays for part of the uninsured through their health insurance.

Let's be smart. We are governors now. Let's make an assessment and put those people in

Medicaid wherever we can, and then let's go out and do something really revolutionary. Let's put all of the uninsured into a class. One third of the individuals that are uninsured are individuals between the ages of 18 and 33. It's a good class, they just don't want to bother. I'm not going to get sick, I'm 18 years of age, I'm 21 years of age. I'm strong. I'm tough. I don't want to pay a bill. So one-third of them don't have health insurance. Thirty percent make over \$60,000 per year. Insurance companies like Centene would salivate over the fact that they can get a million more subscribers in Missouri under a managed care system.

Let's be smart. Let's tear down all the barriers on health insurance, and anybody that is licensed like Centene in Missouri can bid on any group, require the states to put them up for an insurable class, and allow the Centenes of the world to bid on them. Don't allow the state legislature, your state legislature, or Congress to put any mandates on what has to be in that policy. Let the private sector bid on it and you would be absolutely amazed, ladies and gentlemen, to see how many insurance companies would come into Missouri, bid against Centene to cover a million people, like we found in part D for Medicare. You would be able then to start covering the uninsured. And I think the uninsured should be required to have health insurance

in the same way we're required to have automobile insurance. You would be able to cover the uninsured in this way. I would also put a cap on costs so you could attract small companies to come back and offer health insurance, which, in this case, should be put out for re-insurance.

What I'm telling you, ladies and gentlemen, is that health care is exciting. It is exciting because of what we can do. It needs the best minds and the best ideas for Medicaid and for the total health care system to have it survive and expand and continue. But if you use my logic and if you use your own innovative ideas on these types of programs, we can cover the people in Missouri and we can make sure they are covered and that they get the best health care possible. It can be affordable and accessible for all of your citizens. That's what we have to do to save the system and make it better.

Ladies and gentlemen, I want to take your questions and I've already talked longer than I was supposed to, but I just get pumped up and I'm passionate about the subject. I just want you to know that it is exciting to be in health care right now, and the changes with the new innovations, the revolutions that are taking place in health care, are so stimulating and exciting that I can't imagine that more people are not involved.

Thank you very much.



Medicaid—The Need for Reform

John Holahan and Alan Weil

Recent administration proposals to address the rising cost of Medicaid will do little to contain costs or truly reform the program. The primary issues are the large differences among state Medicaid programs in coverage and benefits and the programs high and rising costs. In this paper, we describe and develop several options for Medicaid reform that would expand coverage, provide fiscal relief to states, shift responsibility for some or all of the cost of dual eligibles to the federal government, and eliminate or restructure the disproportionate share programs. A number of other issues are addressed, including Medicaid cost containment and the federal matching rate structure. (JEL I10, I18)

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Reforming the Medicaid program has been a major focus of the Bush administration and the Congress. The Deficit Reduction Act has already put forth some major changes to Medicaid, and the Bush administration has also approved several Section 1115 waivers that significantly change the program. Secretary of Health and Human Services Michael Leavitt also established a commission to consider fundamental reforms.

The primary diagnosis of the problem with Medicaid is the program's high and rising costs. Thus, most of the recent reform initiatives attempt to deal with containing program spending. In this paper, we argue that these recent policy initiatives (increased cost sharing, flexibility in benefit/design, and premium assistance) will not have significant effects on program spending and are not real reform. But while we do not believe that these initiatives will accomplish much, we do believe Medicaid does need reform for several reasons. We discuss these reasons and then present four alternative options as well, as cost estimates, for each. We then

discuss a number of remaining issues that are outside of these options and cost estimates.¹

It is important at the outset to note that the Medicaid program has provided great benefits to low-income Americans. The program provides insurance coverage to over 40 million Americans on a given day and to some 50+ million at any point during the year. Most of these would not have had coverage without Medicaid. As a result, the number of uninsured would have been much higher than the 45 million reported for 2005. Medicaid has been a major source of health care coverage for low-income pregnant women and children, and for the disabled. The program pays for about half of all births in the United States. It helps low-income elderly and disabled people pay for Medicare premiums and cost sharing. It is a major source of support for safety net hospitals and clinics. Finally, it is the backbone for the nation's long-term care system.

The proposals adopted by the Bush administration and the Congress in recent years are not likely

¹ This paper was excerpted from a larger version (Holahan and Weil, 2007).

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to have significant effects on program costs. The problem with Medicaid is often identified as one of moral hazard.² People face low costs at the point of service thus tend to overuse services. In addition, the program is accused of having a “Cadillac” benefit package—benefits far exceed those available to low-income working Americans.³ The administration and Congress’s solution to these problems is to provide states with greater flexibility to impose more cost sharing and to limit benefit packages. These policies may reduce overall use of program services but could also do great harm by reducing use of services that are vitally needed by low-income populations. The recent proposals also ignore the fact that Medicaid in essence solves the rationing problem that cost sharing is designed to solve by keeping provider payment rates low, reducing access to providers, and thereby reducing utilization.

The real reason for spending growth in Medicaid is primarily due to two things: (i) enrollment growth that can be traced to the erosion of employer-sponsored insurance, particularly for low-wage workers, and increases in income inequality—both have meant that more people qualify for Medicaid under existing eligibility standards; and (ii) an increase in the incidence and recognition of disability resulting in a consistent (approximately) 3 percent increase in the number of disabled enrollees. Finally, the health care inflation that has plagued the entire health care system also affects Medicaid (Holahan and Ghosh, 2005, and Holahan and Cohen, 2006).

Recent research (Hadley and Holahan, 2003/2004) has shown that, on a risk-adjusted basis, Medicaid costs are not higher than for low-income people with private insurance (see Figure 1): Statistical studies that control for disability and the presence of chronic illness show that private coverage for the same population would be more costly. Spending would increase from \$719 to

\$795 for children and from \$3,145 to \$4,410 for adults (2001 dollars) if people on Medicaid were given private coverage, not including the likely increase in administrative costs. Furthermore, Medicaid costs have not been growing faster than private insurance (see Figure 2).

But while recent diagnoses and solutions do seem misguided, we do believe that Medicaid does need reform. We highlight four reasons.

First, Medicaid costs are a growing burden for states. Although Medicaid costs per enrollee are not high in comparison with costs in the private market, Medicaid enrollment growth coupled with medical care inflation is clearly forcing health care spending to increase faster than the rate of growth in state revenues.

Second, the variation among states in coverage and provider payment rates is extremely large and difficult to accept, given the large national stake in financing the program, i.e., at least half of the money in each state is federal dollars. Thus, we believe how these funds are used is a national concern and the variation that we observe is inconsistent with the best interest of the nation (Holahan, 2003, and Spillman, 2000).

Third, a related issue is that eligibility standards are extremely complicated, difficult to understand, and restrictive—that is, they exclude populations, including childless adults, that have very low incomes and are in need of better access to health care.

Finally, the creative financing arrangements that states have used over the last 15 years, while typically legal, have also led to a considerable amount of mistrust between the federal and state governments (Coughlin and Zuckerman, 2003, and Rousseau and Schneider, 2004). They have led to the transfer of funds to state governments with little or no state matching payments, a practice that is clearly inconsistent with the fundamental nature of the program.

ALTERNATIVE OPTIONS

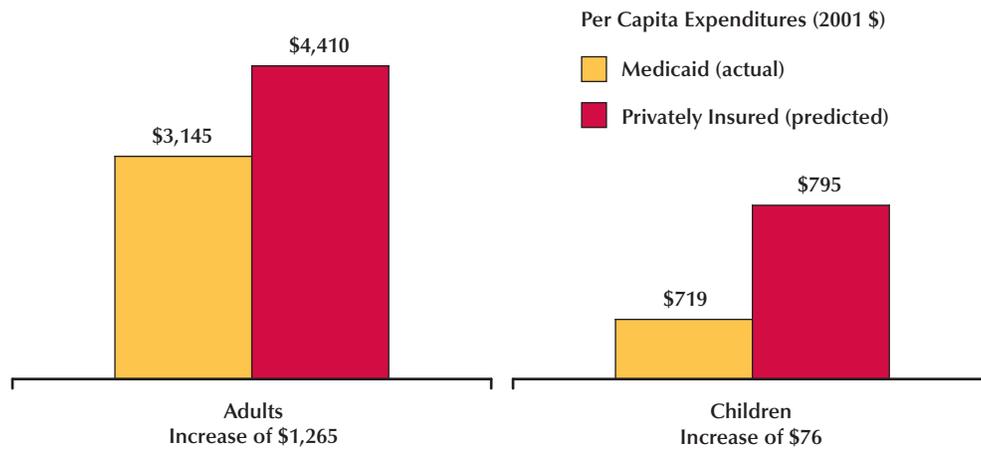
We propose four options that will address these problems. All have somewhat different objectives. All are designed to cost about the same amount to

² Although not specific to Medicaid, the general case for overuse as a concern is set forth in Council of Economic Advisors (2006) and Cannon (2005).

³ References by political leaders to Medicaid as a Cadillac program are legion. For example, see the radio address by Tennessee Governor Phil Bredesen, June 11, 2005; <http://democraticgovernors.org/news/280> (accessed February 9, 2007).

Figure 1

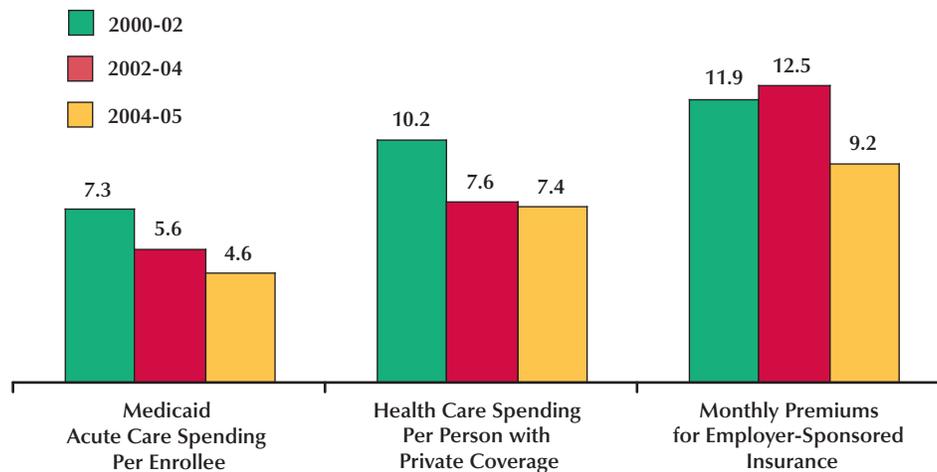
Medicaid Costs Are Not Higher Than Private Insurance on a Risk-Adjusted Basis



NOTE: All differences are statistically significant at the 5 percent level. "Adults" include ages 19 to 64. "Children" include ages 0 to 18.
 SOURCE: Analysis of Medical Expenditure Panel Survey data from 1996, 1997, 1998, and 1999 are from Hadley and Holahan (2003/2004).

Figure 2

Medicaid Costs Are Not Growing Faster Than Private Acute Care Services, 2000-05 (percent)



SOURCE: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 1999-2006; and Ginsburg et al. (2006).

the federal government and to provide about the same savings to states. They each will increase costs to the federal government more than they provide savings to the states. The net additional cost is overwhelmingly due to the coverage expansions that are a part of each option. The key components of reform are as follows:

1. States would be required to increase coverage to certain income levels for parents and childless adults and be given the option to offer coverage to individuals at higher income levels. This would establish a uniform base of coverage across states and reduce the number of uninsured. It would provide a base to build upon with other policies such as tax credits or income-related subsidies as, for example, has occurred in Massachusetts.
2. Responsibility for some services or populations would shift wholly to the federal government and some would shift wholly back to the states. In general, this shifting would involve some or all of the care for “dual eligibles”—those eligible for both Medicare and Medicaid—who would become the responsibility of the federal government. This would provide fiscal relief to states and give the federal government a central role in managing these high-cost cases. With some care shifted back to states, system efficiency would potentially improve, which would offset for the federal government the costs of their new responsibilities.
3. Federal matching rates for selected populations or services would be increased, e.g., “adults,” “acute care,” or long-term care, depending on the option. This would provide fiscal relief to states and an incentive to expand coverage—by lowering the costs to do so. Also, this would allow states to avoid cutbacks in times of fiscal stress because the benefits from contractions would be less.
4. The Disproportionate Share Hospital (DSH) program would be ended or reformed to severely curtail the practices of increasing federal matching payments with no real state contribution. In the paper, we focus on

DSH payments, but the intent is to include all similar practices.

Option I

The primary focus of this option is on expanding coverage for acute care services. It would provide a 30 percent enhanced match to cover all adults with incomes of up to 150 percent of the federal poverty level (FPL) and allow states to use the enhanced match to provide coverage to individuals at higher income levels. The State Children’s Health Insurance Program (SCHIP) would end, but Medicaid would be altered to have somewhat similar characteristics. There would be no enrollment caps, but there would be premiums and cost sharing for children of families with higher incomes, as in the current SCHIP program. Medicare premiums and cost sharing for acute care services for dual eligibles would become the responsibility of the federal government. The current “clawback” payments would be retained. (These are payments a state makes to the federal government for the state’s estimated share of drug payments they would have had to pay had there been no Medicare drug benefit.) This option would increase federal matching payments on acute care services by 30 percent. This would affect acute care services used by adults, children, and disabled populations who are not dual eligible. The matching rates for long-term care would be unchanged. The DSH program would be eliminated because there would be less of a need for this residual safety net as coverage expands, and any additional remaining needs would become a state responsibility.

Option II

Option II also places a strong emphasis on coverage expansion and fiscal relief for states, but extends the financial help to spending for long-term care. Option II would mandate that coverage be extended to all adults to 150 percent FPL and provide a 15 percent enhanced match to do so. Federal matching payments for all services, both acute care and long-term care, would be increased by 15 percent; SCHIP would stay a separate program. Federal matching payments for Medicaid and SCHIP would be 15 percent above the current

level for Medicaid. This would end the distinction between SCHIP and Medicaid, where children of families with higher incomes receive higher federal payments through SCHIP. It would federalize acute care services for dual eligibles, including eliminating the clawback payment now made by states. Option II would also eliminate DSH for the reasons given above.

Option III

Option III would focus more on long-term care because it assumes that the primary policy concern is the impact of an aging population on states. Option III would mandate coverage of all adults, but only to 100 percent FPL. There would be no change in current matching rates for acute care services. SCHIP would be unchanged and maintain the current higher federal matching payments. It would federalize acute care services for dual eligibles and eliminate the drug clawback. The major focus here would be an increase of 30 percent in federal matching payments for services for long-term care. This option would also restructure DSH. Because there is less of a coverage expansion than in other options, DSH payments would be maintained but redistributed so that the states would get the same amount per low-income person. This would deal with the current problem of poor distribution of funds: 10 states now get 71 percent of DSH payments, 5 states get more than \$1,000 per uninsured person and 16 states get less than \$100 per uninsured person.

Option IV

Option IV would be the largest change in current policy. It would mandate coverage of all adults to 100 percent FPL but there would be no change in matching rates. SCHIP would be unchanged and keep the current 30 percent matching rate. The major focus would be to shift all costs of dual eligibles to the federal government, including costs for long-term care; responsibility for costs for long-term care for non-dual eligibles would shift back to the states. This option would also eliminate the prescription drug clawback payment. Finally, DSH payments would be restructured as described in Option III.

Policy Changes Common to All Options

There are certain provisions that are common to all options. First, prescription drugs coverage would become a mandatory benefit. All states currently provide prescription drugs coverage, so this is not, in practice, much of a change. Second, there would be increased flexibility in the use of cost sharing above 150 percent FPL but not below. Third, there would be increased flexibility on mandatory benefits for adults but little or no change in benefits for children or the disabled. For example, benefits through the current Early Periodic Screening, Diagnosis, and Treatment Program would remain. Finally, there would be caps on enrollments in the new optional programs (i.e., programs beyond those mandated).

COVERAGE EXPANSIONS

We estimate the impact of coverage expansion using a detailed spreadsheet model that begins with the baseline of current coverage. The U.S. population is organized by children, parents, and childless adults; by income; by current insurance arrangements; and by four geographic regions. We model current eligibility for public programs in great detail for each state. We then apply “take-up rates” (the probability of individuals “taking up” the newly available coverage) to each group based on the current research evidence (Selden, Banthin, and Cohen, 1998; Dubay, Haley, and Kenney, 2002a; Dubay, Holahan, and Cook, 2007; and Davidoff, Yemane, and Adams, 2005). We also rely on the extensive literature on the crowding out of private coverage by public expansions (Blumberg, Dubay, and Norton, 2000; Cutler and Gruber, 1996; Dubay, 1999; and Lo Sasso and Buchmueller, 2004). We base our estimates of Medicaid spending on the Medicaid Management Information System for 2002, adjusting forward for inflation using several different sources to obtain 2007 estimates.⁴ Because those persons likely to come into the program through a coverage expansion are likely to be healthier than those in existing programs, we

⁴ Congressional Budget Office, March 2006 baseline.

Table 1**Estimated Cost of Expanding Coverage to 100 Percent and 150 Percent FPL**

	100 percent FPL	150 percent FPL
Change in coverage (millions)		
Medicaid	7,070	11,117
Employer	-924	-1,861
Nongroup	-967	-1,477
Uninsured	-5,167	-7,779
Cost to government (2006 \$ billions)	24.1	38.1
Regular matching rates		
Federal	14.0	22.2
State	10.0	15.9
30 percent higher match		
Federal	18.2	28.9
State	5.9	9.2

make an adjustment for the better health status of those new enrollees. We also assume a reduced benefit package for adults and make a downward adjustment (7.5 percent) to the cost of care for that population.

Table 1 shows the effect of the coverage expansions on Medicaid enrollment. An expansion to 100 percent FPL would increase Medicaid rolls by 7.1 million and to 150 percent FPL by 11.1 million. The majority of these new enrollees would be childless adults. The number of uninsured would fall by 5.2 million with an expansion to 100 percent FPL and by 7.8 million with an expansion to 150 percent FPL. The cost to the federal government would be \$24.1 billion and \$38.1 billion, respectively.

As shown in Table 2, each of the four options would increase federal spending by between \$41.1 and \$48.5 billion. At the same time, states would save between \$15.1 billion and \$22.6 billion. The net additional cost to the health care system would be between \$25.8 billion and \$29.7 billion. Option IV has the largest increase in federal spending and the greatest savings to states. Option I has the greatest net increase in cost to government as a whole.

The biggest impact on costs is the coverage expansion. For example, in Option I, the expansion to 150 percent FPL with a 30 percent enhanced match would increase costs to the federal govern-

Table 2**Change in Spending (2006 \$ billions)**

Option	Federal	State	Net
I	44.8	-15.1	29.7
II	44.6	-15.6	29.0
III	41.1	-15.3	25.8
IV	48.5	-22.6	25.9

ment by \$28.9 billion and to states by \$9.2 billion (see Table 1). The changes in federal matching payments would shift a substantial amount of money to the federal government and save states a considerable amount as well.

After expanded coverage, the next biggest impact on cost would come from changes in policies affecting dual eligibles. The cost of having the federal government pick up Medicare premiums and cost sharing for acute care services and retaining the current policy on the drug clawback would increase federal costs by \$7.5 billion and reduce state spending by the same amount. Federalizing acute care for dual eligibles but eliminating the clawback would increase the federal costs by \$14.1 billion and save states the same amount. Shifting all of the costs of dual eligibles to the federal govern-

Table 3
Impacts of Proposed Medicaid Reform Options by Region, 2006

Option	Northeast		Midwest		South		West	
	Federal	State	Federal	State	Federal	State	Federal	State
I	21.1	-16.8	28.4	-12.6	35.8	-11.7	34.0	-8.8
II	22.5	-18.0	29.5	-14.7	33.7	-6.6	35.9	-12.8
III	23.4	-19.8	28.4	-13.9	29.4	-7.3	29.3	-7.9
IV	33.8	-30.7	34.8	-22.3	27.1	-3.3	36.3	-16.7

NOTE: Spending data were adjusted to 2006 using the CMS-64 and Congressional Budget Office projections (March 2006 baseline).

SOURCE: Author's calculations based on population information from the March 2005 Current Population Survey and spending data from the 2002 Medicaid Management Information System.

ernment would shift \$47.7 billion from the states to the federal government.

These policies would have different effects across regions. The coverage expansions would have the biggest impacts on the south because coverage levels are currently lower there. The increases in federal matching rates would help the northeast the most because Medicaid programs in that region tend to have broader coverage and richer benefits than elsewhere in the country. Federalizing spending for dual eligibles also benefits the northeast the most, again because of broad coverage and richer benefits, particularly in long-term care. Cuts in DSH payments would hurt the northeast and the south the most. DSH restructuring would have an adverse effect on the northeast but would benefit all other regions, although not all states within those regions.

Table 3 shows these effects. For the northeast, Option IV offers the greatest increase in federal spending and greatest savings to the states. Because the northeast spends proportionately more on dual eligibles than other regions, it would benefit the most from shifting dual eligibles to the federal government. In contrast, the south is better off under Option I because of the increase in federal payments it would receive for broad coverage expansion. However, it would gain less from the increased matching rates because it spends less on those services currently.

OTHER ISSUES

There are a number of other issues that are important for Medicaid reform.

Cost Containment

Cost containment efforts historically have relied on controls over provider payment rates and increased use of managed care. Recent initiatives are attempting to introduce more cost sharing and benefit flexibility. As noted, these initiatives are likely to have relatively small effects. Rather, we believe that cost containment should be focused on the beneficiaries with the highest cost. At present, 7.5 percent of Medicaid beneficiaries account for two-thirds of Medicaid spending (Sommers and Cohen, 2006). There is a need for a large federal investment in both Medicaid and Medicare case management and care-coordination programs (Lieberman et al., 2003; and Thorpe and Howard, 2006). There is a need for changes in payment approaches to provide incentives for physicians to coordinate and manage the care of patients with multiple chronic conditions and to expand Medicaid managed care (with beneficiary protections) to more of the disabled (Anderson, 2005; Berenson and Horvath, 2003; Wagner, Austin, and Von Korff, 1996; and Medicare Payment Advisory Commission, 2006, Chap. 2). This is new territory to be sure, but clearly this is where the money is and where the focus of cost containment for spend-

ing on particularly low-income populations should be focused.

Provider Payment Rates

We believe the provider payment rates should be improved. This would improve the image of the program among providers as well as increase physician participation rates. Setting minimum standards and rates could become the responsibility of the Medicare Payment Advisory Commission. Medicaid payment rates could gradually be increased over time, i.e., to a minimum of 90 percent of Medicare rates.

“Creative” Financing

Creative financing, including all practices that bring in federal monies without real state or local matching rates, should be eliminated. We have focused on DSH in the discussion above, but there are a number of other similar arrangements such as upper payment limit programs, school-based clinic programs, and targeted case management (Allen, 2005; and Coughlin, Bruen, and King, 2004). These programs added at least \$13 billion to federal outlays in 2005 with unknown state matching contributions. The federal government should enforce current rules designed to reduce or eliminate all such practices (Schwartz et al., 2006).

Medicaid Participation

There should be an effort to increase participation rates in Medicaid. In general, participation rates of those eligible for Medicaid are slightly above 50 percent. Some states have much higher participation rates (Dubay, Haley, and Kenney, 2002b). There should be a combination of federal promotion and advertising as well as federal standards for outreach, income verification, and recertification. Higher participation rates would increase Medicaid enrollment and spending but also lower the number of uninsured, reducing the need for many government programs that support safety net providers.

Eligibility for Long-Term Care

Long-term care has generally not been discussed in the options presented above. Two areas,

however, are important. While it is important to deter deceptive practices (e.g., transferring assets to become eligible for Medicaid), deterrence is not likely to result in large budgetary savings (O’Brien, 2005). However, under the current requirements, people must “spend down” (i.e., spend large amounts of money) before becoming eligible for Medicaid. Thus, there is a need to permit people to retain somewhat higher levels of assets and income. The second issue is the extreme unevenness in the coverage of home and community-based services for impaired elderly and disabled people. Efforts should be made to permit states to expand coverage of home and community-based services in general and to people with higher income levels.

Change the Federal Matching Fund Formula

The federal matching formula should be reformed (Miller and Schneider, 2004). The current system now recognizes differences in incomes. It needs to be restructured to recognize differences in income distribution as well. For example, two states with the same income level could have very different proportions of their population in poverty and thus different needs for federal assistance. Centering the matching rate on income per person in poverty would end up shifting dollars to states with a more skewed distribution of income. If some of the other changes in matching rates and shifts in responsibility to the federal government that have been discussed in this paper were adopted, then all states would come out as winners, but some more than others. There is a need to increase matching rates with rising unemployment on a timely basis.

CONCLUSIONS

We have identified the following problems with Medicaid: large interstate variation in coverage, costs that are increasingly a burden to states, complex eligibility rules, and creative state financing. To address these problems, we propose to expand and provide a more uniform base of coverage and reduce the number of uninsured. These uniform standards would be easier for the states and federal

government to build upon, with further reforms designed to reduce the number of uninsured Americans. We would also shift more of the financial responsibility for Medicaid to the federal government and provide fiscal relief to states. We would give the federal government greater responsibility for managing the care of high-cost patients, which would also provide a strong incentive for the federal government to invest in learning how to manage these high-cost cases. Finally, our proposals would severely restrain the financial manipulations that are now too great a part of the Medicaid program.

The nation is now undertaking a new discussion over universal coverage. We believe Medicaid reform has to be part of that discussion.

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Commentary

James W. Fossett

I'll try to be brief: We have a saying at my home base at the Rockefeller Institute that the ideal conference is nothing but coffee breaks where people can talk to each other about what they need to know, and I wouldn't want to interfere with that.

Being John Holahan and Alan Weil's discussant is a tough job; you basically want to say "what they said" and sit down. They've given you a pretty good overview of Medicaid's recent history and put forward some worthwhile ideas about where the program should be headed next. Rather than rehash what they've already told you, I'd like to spend a little time talking about Medicaid and health care politics and how they affect the choices federal and state governments are going to be able to make in the short run. Health policy in general and Medicaid in particular are as much political and institutional problems as they are intellectual ones, and what reforms get passed may be different from what you might like to see.

Viewed through this lens, there's not a lot of cause for optimism. The best sound bite description of the current Washington health policy landscape is "gridlock"—there's no clear sentiment in favor of trying to push health coverage or Medicaid in any particular direction, and most of the major proposals that have been put forward have attracted significant opposition. The Bush administration has resorted heavily to administrative devices—encouraging certain kinds of waivers, reducing the use of creative financing techniques, trying to

eliminate graduate medical education—as its main means of Medicaid policymaking. The governors have been largely able to block Medicaid changes that they don't like—most recently, "block granting" Medicaid—but don't have a common vision for where they'd like to take the program beyond "give us more money and fewer restrictions." The most recent legislative success, if you want to call it that, was the Deficit Reduction Act, which didn't move Medicaid in any new directions, but rather gave the states more flexibility to do a lot of different things, which some of them are doing.

It's not clear this difficult situation is going to change very much going forward, even after the 2008 presidential election. It seems likely that the price of private health insurance and the number of uninsured will continue to increase. These trends will make health coverage a popular campaign issue—several presidential candidates already have proposals on the table—but there are several problems that may make major changes in Medicaid hard to achieve.

The biggest ones are Iraq and Afghanistan. The next president, no matter who he or she is, will inherit large, hot, expensive shooting wars in both those places, which will consume a lot of the available money and political capital. Second, to use a highly technical term, the federal budget is in the toilet and there are large multiple claims on resources. Even with a Democratic majority, Congress has been very grudging about smaller spending such as fully funding the State Children's Health Insurance Program and may well balk at the

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\$45 billion to 50 billion in new spending that the authors want to hand them.

Third, states may be less well-off than they are now. States have had it pretty good for the past couple of years where Medicaid is concerned: Revenue growth has been solid, and the combination of the Medicare prescription drug benefit and slow enrollment growth has kept Medicaid spending growth, for this year at least, below the level of growth in state revenues. Some states even have put their own health reform proposals in effect and more are considering them.

While things are good for states right now, they may not be staying that way. My colleagues at the Rockefeller Institute who follow state finances have just reported that state revenue growth is slowing down. Particularly in wealthier states such as mine, state income tax revenue is driven by the stock market as much as by the overall economy, and state sales tax collections have become more unstable as many states have eliminated or reduced taxation on clothing and food. A slide in the stock market or an overall economic slowdown could make state revenue pictures look worse in short order.

This economic vulnerability may mean that states are not likely to be enthusiastic about the authors' proposals to make them spend money by expanding coverage for adults or cause them to lose money by eliminating or reducing creative financing techniques such as the Disproportionate Share Hospital Program or upper payment limits. Expand-

ing coverage for adults is politically more difficult than for kids. The significant expansion in coverage for kids over the last 20 years has been one of the major success stories of the American public health insurance system: We do a much better job at covering kids than we once did, and disparities in coverage between states have narrowed dramatically. The politics were successful here—Southern governors were some of the earliest supporters of expanding eligibility for pregnant women and children, and, as Governor Thompson told you earlier, governors found it easy to campaign on doing things for kids, so states were competing with each other to expand coverage.

This model may not transfer well to adults. Kids are cute, popular, healthy, and cheap to cover; adults are not cute, not popular, more likely to be sick, and are decidedly more expensive. Even with the enhanced match proposed, covering adults to 100 percent of the poverty level or some other reasonable level will cost some states, particularly in the South, a lot of money that they may not want to spend.

So my prediction, which I'm making early enough for you to forget in case I'm wrong, is that we're *not* going to be able to pass major national changes in Medicaid anytime soon. What we might be able to do is make it easier for states to cover more adults and allow states to move ahead as they're able to, but large-scale changes in policy that call for spending a lot of money seem beyond our reach for the time being.



Mandatory and Affordable Health Insurance

Len M. Nichols

This paper asserts that America's health care system is broken and cannot be repaired with timid half-measures. It suggests that we need both universal coverage *and* a more efficient delivery system and that these are not competing objectives: Each is necessary to make the other possible. It further states that if we do not make health care more affordable and our delivery system more efficient and sustainable, a majority of Americans will be uninsured in short order. And the persistence of millions of uninsured impairs the efficiency we need to make health care and insurance affordable for all. Thus, contrary to conventional wisdom, this paper asserts that both universal coverage and delivery system reform must be pursued *simultaneously*. (JEL I110, I180)

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Health care costs continue to grow faster than incomes, and more and more working families are finding health insurance unaffordable. Four million Americans have lost private coverage since 2000, mostly because they cannot afford the contribution their employers require for increasingly less generous offerings. At this rate, by 2010, fewer than half of all Americans, the lowest percentage since 1960, will have employer-sponsored coverage. We may be near the breaking point of our mid-20th century employer-based system. Forward-thinking labor leaders, such as Andy Stern, president of the Service and Employees International Union, are voicing the compelling reality: The employer-based health insurance system as we have known it is unsustainable in a 21st century economy. Understanding their own impotence to reverse these trends, many employers agree, and like Lee Scott, CEO of Wal-Mart, are searching for ways to jump-start a national conversation about feasible alternatives.

There are only three credible universal financing arrangements: (1) tax-financed single-payer

insurance, or Medicare for all, (2) employer plus individual mandates to purchase private health insurance, or (3) individual mandates alone. (Each of the last two also requires low-income subsidies.) "Medicare for all" is technically feasible but requires a level of trust toward government decisionmaking that is simply not present now, nor likely to spread soon. In addition, most of the efficiencies of a single-payer system could be obtained within any program of mandatory coverage that eliminates the profit from avoiding high-risk patients.

Without purchase mandates, however, no insurance system can approach the level of efficiency we need; these mandates would prevent insurers and providers from using many scarce resources to avoid high-risk patients. So, in addition to the moral case—the Institute of Medicine estimates that 20,000 Americans die each year because the lack of health insurance prevents them from obtaining timely but routine care—there is a strong economic case for universal coverage.

Among the private insurance alternatives, the "individual mandate alone" option is by far the

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most congruent with the 21st century U.S. economy. That economy must remain flexible and reward mobile workers, so tying insurance to citizen-workers and not to firms makes perfect sense. At the same time, the U.S. economy will continue to generate many jobs with productivity levels that simply cannot support employer-provided health benefits plus a market wage. Thus, a mandate on employers would be counterproductive to efficient and shared economic growth, for many low-wage jobs would be lost. Finally, an individual mandate is consistent with individual responsibility, a central—but by no means the only—element of a new social contract that can spread opportunity and well-being through redefined social responsibilities as well. The New America Foundation will have more to say about that full social contract soon.

But universal coverage is not enough. Our health care system is so inefficient and prone to unsustainable cost growth that to pursue universal coverage without simultaneously seeking to contain costs would very soon add to our mounting fiscal problems.

We spend at least twice as much per capita on health care as our major trading partners, and we finance far more of it through employers, which puts us at a significant competitive disadvantage in the global economy. This is why health care system reform has become a “C-suite” issue: CEOs, COOs, and CFOs are focused on it like never before. Moreover, the health gains from our spending are mediocre compared with the rest of the world. The United States ranks an embarrassing 37th in the World Health Organization’s evaluation of health systems worldwide, next to Slovenia and Costa Rica.

We compare poorly because our three linked problems—high costs, mediocre quality, and unequal access—do not yield to the timid, incremental reforms we have tried to date. Despite our high spending, Americans get appropriate care only about 55 percent of the time. Individuals at the higher income levels get appropriate care only 2 percent more often, while individuals at the lowest income level get appropriate care only 2 percent less often. Thus, money actually buys very little quality per se. Geographic variation in the quality of care is stunning: An individual living in Utah

has a one-third higher chance of surviving cancer than a person living in North Carolina. Ineffective care adds unnecessarily to costs, which reduces coverage and stifles access.

We also suffer over 150,000 unnecessary deaths each year from avoidable errors and substandard care. The average person in Canada, Australia, or France is healthier and will live longer than the average American. Far more equitable access to high-quality primary care is a big part of the reason. There are 46 million uninsured in the United States, and their lack of timely access results in the lowest quality of care of all. The total economic costs of the uninsured—shifted medical costs plus lost productivity from extra absenteeism and premature death—have been estimated to be roughly equal to the public cost of the low-income subsidies necessary to finance universal coverage in this country. It is time we made a smarter economic bargain for health care.

The first step is to recognize that comprehensive health care reform—achieving universal coverage *and* cost growth containment—is not only necessary, it is doable. We can provide better care for more people, we can afford the necessary subsidies for our low-income population, and we can bridge the divides in our polarized national debate and politics. It will take leadership, compromise, and hard work, but political leaders in Massachusetts have shown us that it is certainly possible. There, a Republican governor and presidential aspirant was willing to use the word “all,” the Democratic legislature accepted the word “limit,” and together they are taking a giant step toward universal coverage.

Politically, the possibilities for national reform are greater today than ever before, not least because the barometers of system stress are worse than they were when Bill Clinton became president and health reform was on the agenda. In 1992, there were 33 million uninsured Americans; 13 million people have been added to the rolls of the uninsured since then. The average family health insurance premium today claims 18 percent of median family income, compared with 10 percent then.

Three qualitative differences may matter even more.

First, employers are increasingly determined to force politicians to address the question of reform because high health costs make it harder for them to compete in international markets.

Second, as cost growth forces companies to reduce benefits and shift costs to workers, more and more workers worry about losing coverage altogether, even in a strong economy. This is a sea change from the early 1990s, when the fear of coverage loss was recession-based. Now it is based on cost growth outstripping income growth, with no end in sight. As presidential aspirants in both parties are learning—in their home districts, in Iowa, and New Hampshire—voters are deeply worried about unaffordable health care.

Third, and most importantly, growing public awareness of the linkages among cost growth, quality gaps, and losing coverage makes the reform discussion different this time around. The Clinton-era debate was mostly about covering the uninsured and the income redistribution that would have been required to accomplish this. That argument was largely “zero sum”: some would gain coverage, and others would have to pay higher taxes to finance it. But if none of us is assured of getting quality care, and if all of us—including employers—are vulnerable to rising costs, then there is a positive-sum or win-win dimension to comprehensive reform now that makes it far more likely.

A WIN-WIN FORMULA FOR REFORM

Positive-sum reform provides something for everyone and demands shared responsibility as well. Essentially it entails building a universal coverage financing system on the backbone of a sustainable delivery system. Therefore, it must have numerous elements.

- ***It must be bipartisan.*** Effective reform will require features that moderates in both the Democratic and Republican parties can embrace—a program that preserves enough of the core values of each party’s base to permit each side to recognize its own narrative in the outcome. To achieve this, there must be individual responsibility as well as shared

responsibility, cost-containment as well as universal coverage.

- ***It must create an effective health insurance market.*** In this market, individuals and groups without good options today can benefit from administrative economies of scale and risk pooling. Market rules must be fair to individuals and reasonable for insurers, like those that govern very large employers, employer coalitions, and federal- or state-worker purchasing pools today.
- ***Individuals must be required to purchase health insurance.*** Even with subsidies and a functioning marketplace, some individuals will be unlikely to buy health insurance on their own, thereby shifting costs onto others in the event of their need for expensive care. To avoid such “free riding,” individuals must be required to pay their fair share toward health access for all. Purchase mandates are therefore essential under any formula for achieving universal coverage. Individuals could purchase insurance through their employers or efficient purchasing pools.
- ***There must be substantial subsidies for low-income individuals and families.*** A basic insurance package must be required, but in exchange it must also be affordable. This is essential for reasons of equity and efficiency alike. We cannot force people to buy policies they cannot afford. Even if this were politically feasible, it would force them to forego other necessities, which could have bad health consequences. If we try to mandate insurance without subsidies, some will remain uninsured and we will continue to pay for their late, inefficient care like we do now. A supplemental benefit package at zero or low cost is needed to cover cost-sharing for individuals with very low incomes or those with substantial health care needs, e.g., those who are in households with incomes below 150 percent of poverty or who are currently enrolled in Medicaid because of disability status. The basic package must be comprehensive (i.e., cover necessary physician, hospital, pharmaceutical, dental, and mental health services), but still have a cost-

sharing structure (coinsurance is preferable to high deductibles) that unsubsidized families could afford.

- ***Household subsidies should be financed by a dedicated and limited new tax.*** These subsidies can be partially financed, especially over time, with savings from the reform program, but there will need to be additional revenues dedicated to them, at least in the short run. It would be best to fill the gap with a dedicated stream from a new tax (e.g., a progressive consumption tax or a progressive value added tax), which would also serve as a budget constraint. Budget constraints and tax rates can and should be revisited over time as circumstances warrant, but having annual budget limits on subsidies may be necessary to construct a majority coalition for comprehensive reform.
- ***The new system should be citizen based, phasing out the employer's role.*** There are a number of options here, but it is important that employers should be seen as only one among many possible financing sources for health insurance coverage, with the understanding that they are not likely to be able to continue indefinitely in that role. The goal ought to be to keep current employer “money” in the game while relieving employers of the burden of negotiating health premium increases every year. A new insurance market pool and subsidy structure could aid such a transition. For example, firms might enroll their workers in a plan through a purchasing pool in year one, while maintaining their historical premium contribution levels. In year two, they could give their workers a raise at least equal to the previous year's premium contribution, plus some agreed-upon inflation factor, and from that higher base the workers could be expected to purchase insurance on their own unless eligible for a subsidy. (Tax preferences could also be converted at that point, perhaps from the open-ended exemption for employer-plus-employee section 125 plan tax-sheltered contributions today, to a fixed tax credit that might vary by income and/or risk class.) This transition would keep the “right”

amount of money flowing to health insurance in year two; thereafter, cost growth and affordability would be settled in the politics of citizen, state, and health care delivery systems, with the employer out of the picture.

This brings us to delivery system reform, which is central to the success and sustainability of the entire reform enterprise. In short, we urgently need to reorganize our delivery system to yield far more health “value” per dollar spent. There are three critical elements to creating a delivery system with a “culture of value.”

- ***An electronic health information system.*** This would give any clinician anywhere instant access to a patient's medical history, plus diagnosis and treatment options. The system would include web-based electronic health records, as well as medical-decision support tools so that best practices could be applied to every clinician-patient encounter. Today, a Las Vegas casino can determine the precise details of an individual's credit worthiness in real time, but no emergency room doctor in that city (or anywhere else in the United States) can find out what medications an unconscious person is on (unless that individual is being treated in the Veterans Administration system). An electronic information system will help us monitor care, protect patients, and improve the overall quality of health care in the United States.
- ***Turbo-charged incentives.*** We need a new set of payment incentives for both patients and providers. Today, we pay providers for conducting tests and carrying out procedures that may or may not be necessary or effective. And patients are often required to pay no more for expensive tests and procedures than for less expensive but equally effective treatment. This system encourages unnecessary treatments and results in low-value care. Smarter incentives would encourage patients and clinicians to use resources prudently while promoting high-quality, cost-effective care. Incentives for patients and providers should be mutually reinforcing, and they can be if they incorporate the same performance targets. For example,

HEALTH CARE FOR ALL AMERICANS

How to Fix Our Broken Health Care System:

- Create a health insurance market
- Require everyone to buy health insurance
- Subsidize low-income Americans
- Define a transitional role for employers
- Improve outcomes using an electronic information system
- Offer “turbo-charged” payment incentives to lower costs
- Provide high-quality care based on comparative technology assessment

clinicians should be paid more if diabetics under their care obtain all appropriate tests each year, and the patient’s copayment for such cost-effective, evidence-based tests should be zero. We will also need to reform our dysfunctional malpractice legal system. Evidence-based medicine, i.e., statistically supported best practices, must be a safe harbor against spurious malpractice claims. Guidelines can be developed and disseminated by private specialty societies and public research agencies to ensure their effectiveness and a smooth transition to evidence-based safe harbors.

- ***Comparative technology assessment.*** Advances in medical technology have saved lives and improved the quality of life for many, and future advancements are likely to have possibilities nothing short of breathtaking. However, the overuse of new technology has been the main culprit in driving up costs. Future advancements are likely to drive up costs even further, to the point of their being potentially catastrophic for the health of the U.S. economy. We need to establish processes for assessing the clinical value-

added of new technologies compared with existing treatment or diagnostic options prior to their widespread adoption and use. The FDA’s drug approval process is a case in point. Today, to get a drug approved for a specific use, a manufacturer must simply prove that the proposed new drug did not manifest serious side effects and is more effective than a placebo. We should require a higher standard for approval: New and more expensive drugs should be shown to be better than the best existing treatment for any given patient subpopulation. To compensate for the longer and more expensive trials this would require, we would probably need to lengthen the life of drug patents. We should apply the same logic to medical devices and new diagnostic or surgical techniques. Then we can become far smarter purchasers of costly new technologies.

THE POLITICAL GROUNDWORK IS BEING LAID

The good news is that a critical mass of stakeholders, opinion leaders, CEOs, union officials, and politicians agree that our health care system is on an unsustainable trajectory and must be reformed. Massachusetts has shown that comprehensive and bipartisan compromise is possible, and the American Medical Association’s recent call for an individual mandate approach to universal coverage is proof that former adversaries of wholesale reform now see its necessity.

The coming presidential campaign season will be an opportune time to debate larger visions about necessary and wise changes to our existing health care system. Large majorities of the electorate support and are willing to pay to ensure that all Americans have access to at least basic health insurance. Announced and potential presidential candidates have heard the rumblings of discontent and fear among the electorate. Our political system can find a bipartisan way for those fears to be addressed and the public’s preferences to be translated into affordable and effective health care for all Americans. The leaders that facilitate this transformation will be highly regarded indeed.



Commentary

Thomas Stratmann

Len Nichols identifies a number of problems in the current health care system. They include the rising cost of health care, the poor quality of services in the United States relative to some other countries, the possibility that employer-provided health insurance puts American employers at a competitive disadvantage in the global economy, and that many individuals are uninsured. I will discuss these issues in turn. I will then make some suggestions for improving the current health care system. Contrary to Len's proposal, I suggest making only *some* coverage compulsory—namely, catastrophic health insurance—and to not rely on extra taxes to finance health care services.

Currently the United States spends \$2 trillion on health care. The fraction of gross domestic product spent on health services has increased over many years, totaling now one-seventh of gross domestic product. Health care spending has risen because, on the supply side, quality of care has increased and often higher quality is associated with higher prices. But demand for health care services has also increased because of improved quality of health services and longevity. People live longer and thus demand more health care to maintain a high quality of life. Further, technological advances have given people more options for high-quality care. Treatment for ailments in the health care sector has a large discretionary component. Some people opt to be treated for mild depression, decreased mobility, cosmetic concerns, etc., others do not. As the quality of life-improvement services

increases, more people take advantage of these new options, as expected when quality of services rises faster than its price. This sum of circumstances can explain much of the increase in health care spending. At the same time, it would be interesting to know what would happen to demand if more patients were paying out of pocket.

To spend more on medical services and less on food or housing is an individual's choice, and from an economic perspective this is no problem if choices are not distorted, as for example through public subsidies. As we get richer as a nation, we may decide to devote more and more resources to health care, because our basic needs for food and housing are fulfilled, to further improve our quality of life.

An economist always thinks about so-called opportunity cost, that is, the value of a resource in an alternative use. Thus, from an economist's perspective, the question is not whether we spend too much on health care, but whether we can find some better ways to spend the \$2 trillion, either in the health care sector or in some other way.

Many of the improvements in longevity over the past century are attributable to improvements in health care. A recent article in the *Journal of Political Economy* by Kevin Murphy and Robert Topel (2006) has put a number on the value of this increased longevity: Between 1970 and 2000, the added value of increased longevity, after subtracting out the \$35 trillion in health care spending in this 30-year span, is over \$60 trillion. This shows

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that, at least in an absolute sense, our health care sector performs well.¹

But do we fare well when we compare the performance of our health care sector with that for other countries? It may be the case that other countries that have comparable or higher rates of longevity, and at the same time spend less on health care, have a more efficient health care system. But there are several reasons that this is not necessarily the case. First, many other countries ration quality-of-life improvements, such as knee replacement, preventive angioplasty, back surgery, and breast reconstruction after breast cancer, and this rationing involves significant costs because patients have to wait for a long time for treatment, as for example in Great Britain. Longevity is only one part of measuring the performance of health care systems, and when it comes to quality-of-life improvements, it is not obvious that other countries do better than the United States. Second, another indicator that the quality of U.S. health care services is high comes from the fact that the United States is a leader in medical research. In fact, many citizens from other countries come to the United States seeking medical treatment. Finally, cross-country comparisons are difficult to make because individuals change their behavior in response to medical progress. In my own studies, I have shown that individuals engage in more risky behavior when they expect to be treated for diabetes and drug abuse (Klick and Stratmann, 2006 and forthcoming). So if there are medical advances in some countries that treat the consequences of obesity (such as diabetes), some people in this country will be less vigilant in their diets because they know that they can take advantage of the treatment options if they gain weight and become diabetic. The resulting increase in obesity will therefore somewhat offset the benefits of technological progress. Because technological progress changes people's behavior and because countries differ in their medical progress, sometimes meaningful cross-country comparisons of health indicators are difficult to make.

Is employer-based health insurance making U.S. firms less competitive in the global market?

Employer contributions to workers' health insurance premiums increase the total cost of labor. The fact that employers pay some of workers' health insurance does not mean that they pay the premiums on top of wages. Employers pay workers less than they would have if employers had not paid the workers' health insurance premiums. So, in the end, workers pay for health insurance premiums through lower wages. Some may argue that this occurs only in the long run, but in this case, the long run is probably not so long. Clearly, when health insurance premiums increase, employers may not be able to reduce workers' wages immediately. But it may be enough to pay for the increased premiums by giving workers a lower increase in wages. Wages have been fairly flat over the past decades, suggesting that employers might have paid for the increased premiums by not increasing wages. So, the time lag to pass on premiums is not necessarily very long. And this means that the argument that employer contributions make employers less competitive in the market place is incorrect, as workers bear the burden through lower earnings.

Clearly, many CEOs complain about high health insurance premiums, but that does not mean that this is the true underlying cause of their failure to successfully compete. For example, the Detroit car manufacturers do not have competitive problems because of health insurance premiums. Foreign car manufactures in the United States are also paying health insurance premiums and are doing quite well in the United States. The problem for the Detroit car manufacturers can be traced to past promises they have made to their workers, not their current payments of health insurance premiums.

What are the economic reasons for the concern that 16 percent of the current U.S. population is uninsured, besides possible humanitarian concerns? The uninsured are primarily healthy and young. So it is possible to view their decision not to take up medical insurance as their free and legitimate choice. The argument most often advanced against this view is that this is not their free and legitimate choice because the uninsured impose costs on the insured. This is because emergency rooms are required to treat every person, and if the uninsured do not pay their bills, then hospitals,

¹ In these comments I draw on www.becker-posner-blog.com/, as well as the works cited at the end of this article.

taxpayers, or other insured people will pay for the costs of treatment. So, some individuals may decide not to become insured, because they know of the “free” emergency room treatment option. However, an article by Weber et al. (2005) in *Annals of Emergency Medicine* found no evidence that the uninsured are disproportionately visiting the emergency room. This study was based on interviews of 50,000 individuals who had visited the emergency room. The findings in this study may be due to the fact that the uninsured tend to be the young and healthy who have fewer reasons to visit the emergency room than the insured unhealthy individuals. Further, the incentive to visit the emergency room is not so strong, given that going to the emergency room is not particularly enjoyable, nor always the most appropriate treatment option for ailments.

Currently, those with employer-based insurance are subsidized by the government because workers do not have to declare the portion of the health insurance premium paid by the employer as taxable income. One problem with this arrangement is that it encourages workers to take, and employers to offer, more elaborate and expensive plans just because workers do not pay the full cost, for the tax deductibility benefits. Another problem is that this arrangement distorts the playing field between those who purchase insurance as individuals as opposed to through employers. One way to address this issue is to eliminate the tax exemption of employer-based plans. But if the goal is to get more people insured, it would make sense to extend the tax deductibility, up to a cap (to reduce the incentive to purchase expensive plans that offer little extra health benefits but are purchased only because they are subsidized) for individual plans. This tax deductibility would reduce the cost of individual plans, encouraging some of the currently 46 million uninsured to purchase health insurance.

Finally, it would make sense to mandate catastrophic health insurance. Catastrophic insurance covers events such as long-term illnesses that would deplete an individual’s or family’s resources. Compulsory catastrophic health insurance would reduce the likelihood that the uninsured free ride and push their costs of treatment off onto the insured and taxpayers. The cost of this policy would be low, because catastrophic events do not occur often. No additional subsidy would be required to help lower-income people to pay for this insurance, because they are already covered through Medicaid.

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