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Health Care Brawl: All or Nothing Doesn't Work

C. Eugene Steurle

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ABSTRACT

The ongoing debate over health reform at times almost appears like a sporting event, with Democrats and Republicans trying to name winners and losers in passing or repealing legislation. But in my Fiscal Times op-ed this week, I explain why, when it comes to health reform, this winner-take-all mentality misses a major point: government programs, whether well designed or poorly designed, need to work within budget constraints. While such constraints inevitably identify losers relative to an open-ended budget (which, like deficits, can hide the losers), they do lead to far better budget and health policy.

The findings and conclusions contained within are those of the author and do not necessarily reflect positions or policies of the Tax Policy Center or its funders.

THE FISCAL TIMES: HEALTH CARE BRAWL: ALL OR NOTHING DOESN'T WORK

In today's world, health reform succeeds only if it goes hand in hand with reasonable budget constraints on health spending. But the debate beginning in the House today isn't about benefits versus costs. Instead, it's a winner-take-all spectacle like the Super Bowl. Vote "Yes" or "No" on rescinding recent health legislation. Yes or no on regulating Medicare. Thumbs up or down on the constitutionality of an "individual mandate."

Besides giving thumbs a workout and brains a rest, what does winning one of these simplistic binary debates really mean? Recently enacted health care reform has hundreds of pieces, some better than others, and both the old system and the partially reformed new system need major repairs. Congress always regulates what it subsidizes; the real question is how to regulate best. And the individual mandate — requiring the uninsured to purchase coverage — is only one piece of the system of requirements that must be made to fit together.

Health care constantly evolves: in two or three decades, half of what we pay for might be totally new procedures, technologies or medications. So health policy must evolve too:

- Adapt as do all forward-looking businesses and households.
- Avoid the trap of thinking that any of us can tell the next generation how to manage almost one-fifth of the economy.
- Maximize benefits within agreed-upon budgets.
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And that's where budget constraints come in. Simply put, you can't maximize benefits relative to costs if costs are excluded from the equation.

Cost constraints drive innovation: We fix things when they have to be fixed. In the health care system, consumers start complaining about the high cost of limited-value care, insurance companies start demanding services at more reasonable prices, and providers find more efficient ways to provide care.

Conversely, costs can only go up unreasonably in a fee-for-service system in which patients and doctors individually decide what bills to pass on to fellow taxpayers and policyholders. Witness the tripling of health's share of GDP from around 6 percent in 1965 to 18 percent in 2011.

Recent health reform did introduce some interesting experiments and new models. But, here again, these initiatives — like weight-control experiments on the value of exercise without limiting dietary intake — are unlikely to reduce cost growth if budget constraints aren't in effect. Resisting normal budget constraints while insisting on conflicting standards of perfection puts Republicans and Democrats in a mutual bind. Relative to today's mostly open-ended system, any cost-saving reform will necessarily generate some losers — somebody who has to get less or pay more, or some provider who has to accept less. Each political party always wants the other to pick the losers.

If simple budget principles guided policy, politics would adhere to a rule that each health program had to operate within a budget — one that would not grow automatically simply because private actors decided they wanted more services or private providers decided they wanted more money. That means that each health program must empower somebody — individuals, intermediaries or government itself — to say "No" to some prices and procedures to stay within budget. The legitimate debates — that really will never end in an evolving system — would then turn to the size of the budget and *who* should say "No," to *what* and *when*.

And that's where the Super Bowl mentality leads us astray. Today's yes/no votes don't work when neither the old system nor the newly reformed one can be sustained. Here are some questions House Republicans and Democrats should strongly consider before launching this week's debate on whether to rescind health care reform:

- Do we really want to go back to having more than 50 million nonelderly people uninsured (*old law*)? On the other hand, shouldn't we address the inconsistencies and sometimes perverse incentives in our four-tranche, almost-universal subsidy system of Medicare, Medicaid, insurance exchange subsidies and subsidies for employer-provided insurance (*new law*)?
- Do we really want to return to providing higher subsidies through the tax code for only the richest employees with the most expensive employer plans (*old law*)? Or give far higher subsidies to many employees simply because they join employer-employee groups that *don't* provide insurance (*new law*)?
- Do we really want to continue encouraging employers to drop health insurance because it has become so expensive (*old law*)? Or encourage employers to segregate lower-income employees into firms without employer insurance so they can get higher subsidies from the exchanges (*new law*)?

Moving beyond an over-simplified contest between two bad choices requires policymakers not simply to accept the basic principle that all subsidies must operate within a budget, but to adhere to the budget rule even when they don't like the health policy. Medicare could set prices to stay within a budget, or it can move toward premium support, or it can bundle fixed payment rates for people of given ages and conditions. But it wouldn't get an open-ended budget simply because lawmakers couldn't agree on one approach. If specific subsidies for employer-provided insurance are still provided, they must be subject to a growth-limiting spending cap. Exchange subsidies could be part of the system too, but the amounts need to be fixed so government costs can't soar.

The Chicken, the Egg and the Budget

Some feel that government health programs can't be put in budgets unless the entire health sector is put in a budget. But that's like arguing that we can't eat healthful food until all unhealthy options are eliminated. Future Congresses could and should adjust these programs regularly, but always within the rule that no program can be cut loose

from budget constraints. Nor could legislators enact programs that would be allowed to keep growing without new votes by successive Congresses.

Here's a quick test case: the current fight over the individual mandate. At base, this provision is a penalty on individuals who don't buy insurance for themselves — and an alternative to taxing individuals to buy insurance for others. Constitutional issues can easily be set aside if both parties were willing. The penalty could be assessed as a condition for receiving other benefits or tax breaks, such as a standard deduction or child credit (clearly constitutional). The two political parties could then compare within any given budget just how far proposals with different penalty and subsidy structures might increase insurance coverage. This requires more work than making a yes/no decision on the idea of an individual mandate, but it leads to far better budget and health policy. There you have it. It's almost impossible to solve today's big health issues without putting all programs on budgets whose limits must be honored and whose future growth is controlled by Congress. While demanding more honesty about winners and losers, budget constraints free up resources for other health and non-health priorities and push health providers and consumers to adopt those very efficiencies that health laws now discourage.

Eugene Steuerle holds the Richard B. Fisher Chair at the Urban Institute in Washington, D.C. and writes the on-line column "The Government We Deserve."