

The Political Economy of Health Care Reforms

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Ch. 1 - Introduction

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Health care is an important component of an economy that involves the provision of goods and services by both the private and public sectors, economic and other regulations, and public policies. As health care technologies have advanced rapidly in the past few decades and the demand for health care continues to grow, health care expenditures have been increasing steadily in industrialized nations. In the United States, for example, health care expenditures as a share of the gross national product (GNP) grew from 7.4 percent in 1970 to 9.3 percent in 1980, and to 12.4 percent in 1990. It reached more than 15 percent of the GNP in 1995. Changes in the health care supply and demand have prompted changes in health care finance, insurance, and service delivery. Health care reforms have become an ever-present subject in federal as well as state politics for the past decade. Although there have been no sweeping changes in legislation at the federal level, significant changes have been taking place in the health care sector.

The chapters in this volume address some important aspects of health care reforms, including Medicare reform, managed care and its effect on the health care system, efforts to cover the uninsured, the effect of health insurance on labor market and employment decisions, and the role of tax policy in health care in the past and the future. While conducting sound and solid economic analyses of health care issues, the authors of the chapters all recognize the political implications as well. This political economy approach puts the discussion of health care reforms in the proper perspective, since health care involves many stakeholders and its reforms inevitably have political as well as economic repercussions.

Medicare reform is central to health care reform efforts, because more than 39 million people currently get insurance and health care through Medicare. As Medicare is tax financed, its reform is extremely difficult economically, and politically as well. Len Nichols's chapter explains these difficulties and contrasts two leading proposals for Medicare reform, one from the current congressional health policy leadership and the other from the Clinton administration.

Nichols identifies two fundamental sources of Medicare's long-run financial strain. One is purely demographic; there were 3.9 workers per beneficiary in 1998, but there will be only 2.3 by 2030. The other source of strain is cost growth; while overall health care costs in the United States have been rising as a share of income, Medicare costs have been growing even faster than general health care costs for the past 30 years. Simplified calculations indicate that some payroll tax increase is inevitable as the share of our population over 65 increases in the first half of the twenty-first century. Nichols proposes that the key to minimizing this tax increase is to control the rate of growth

in costs per beneficiary, and that the cost reduction can only be accomplished by a fundamental restructuring of incentives for beneficiaries, health plans, and fee-for-service Medicare. The principles of structural reform are to offer beneficiaries incentives to choose lower-cost health plans and health service delivery arrangements, and to make health plan pricing policy efficient. However, efficient plan-pricing systems that are available to large private companies may not work well in Medicare, because Medicare confronts additional constraints such as concerns for geographic equity and income equity.

Having stated the principles for Medicare reform, Nichols then evaluates two major proposals that emerged in 1999, the Breaux-Frist proposal, which grew out of the Bi-Partisan Commission's plan, and President Clinton's plan, which was a response to the former. The two proposals share some important principles. First, they both have competitive price incentives for beneficiaries, plans, and fee-for-service Medicare. Second, both proposals make prescription drugs an optional part of the Medicare benefit package. Finally, both have provisions that protect low-income and high-risk individuals and address geographic cost differences. However, the two proposals differ in their treatment of three key features: the amount of the government contribution toward health plan enrollment choices by beneficiaries, use of national averages to influence local competition, and adjustment for geographic differences in price and utilization to Medicare beneficiaries. An example constructed by Nichols indicates that, in general, the Breaux-Frist proposal imparts stronger incentives for health plan efficiency. However, beneficiaries would pay more on the margin for all private plans under Breaux-Frist. Finally, Nichols points out that major health care policy changes can only be achieved with a broad bipartisan consensus, and he outlines a compromise that could result from the two proposals.

Another aspect of the health care system that has attracted a lot of attention in recent reform efforts is managed care. Managed care developed out of various efforts to contain costs in the 1970s and 1980s, as health care costs increased rapidly during that period. The growth of managed care has raised important questions about its impact on the well-being of patients and the structure of the medical care system in general. Much of the public debate about these issues has been conducted using opinions and anecdotes. In his chapter titled "Managed Care and Social Welfare: What has Managed Care Really Done to the U.S. Health Care System?", Laurence Baker provides and synthesizes evidence on the impacts of managed care on care, outcomes, satisfaction, and expenditures of patients, as well as on the overall structure and functioning of the health care system. A large number of studies have produced some consistent and convincing conclusions. In terms of treatment, the studies find that managed care patients use the hospital less than patients in indemnity plans. As managed care imposes restrictions on patient choices and other inconveniences, HMO plan enrollees are less satisfied with their plans than enrollees in other types of plans, primarily indemnity or preferred-provider organization plans. However, research on health outcome on the whole fails to find a consistent pattern either for or against managed care. Finally, studies on expenditures frequently report that managed care patients spend less on health care than patients in indemnity plans.

Baker then reviews evidence about the impact of managed care on the overall health care market, because the presence of managed care in an area may influence care for patients enrolled in other plans —the so-called “spillover effect.” These studies find that overall spending and spending for non-managed care patients is lower in areas where managed care has a high market share. Studies also suggest that managed care can influence the number and types of providers, the capacities of the health care system, and the ways in which the system is organized. For example, researchers report that areas with high HMO market share had fewer hospital beds in the mid and late 1980s, that managed care prompted consolidation in provider markets, and that managed care slowed the adoption of many technologies, particularly high-cost, infrastructure-intensive new technologies. Again, there is little evidence on health outcomes from these market comparison studies. Based on the findings about the impact of managed care on the health care system, Baker raises a number of important questions about the future development of the health care system. How will managed care affect the development of the delivery system; for instance, technology advancement and the training of medical professionals? To what extent can managed care further reduce medical costs? These questions have important policy implications.

Jonathan Gruber addresses health care reforms from a different perspective and asks what should and can be done to provide health insurance to the uninsured in the United States. Despite expansions in the Medicaid program in the past 15 years, there are more than 43 million people uninsured, representing over 18 percent of the non-elderly population. In his chapter, “Covering the Uninsured: Incremental Policy Options for the United States”, Gruber first identifies who the uninsured are in the United States. Then, drawing lessons from Medicaid expansion efforts across the United States over the past 15 years, he discusses a number of policy options to extend coverage to the uninsured, and their effectiveness and efficiency.

Of the 43 million uninsured in the United States, almost 11 million are children. Nearly 60 percent of the uninsured are in families where the head of the family is a full-time, full-year worker. This fact has motivated continued efforts to increase coverage through the expansion of employer-provided insurance. Based on cost-efficiency arguments, Gruber proposes that the government should pursue a “filling the cup from the bottom” policy that places priority to those groups that have little other recourse to insurance. The policy should encourage efforts to make insurance available to those who are already eligible for Medicaid but have not taken it up. Further expansions of public insurance up the income scale can certainly extend coverage to the uninsured and is an approach taken by the recent Children’s Health Insurance Program (CHIP).

One problem with this approach, however, is that the coverage may be extended to people who already have private insurance. To mitigate this crowd-out effect, state programs can take advantage of the flexibilities built into the CHIP by making the benefits less generous than Medicaid and introducing premiums and co-payments for services. Incremental changes in tax subsidies can also extend coverage to some of the uninsured. The current system of tax subsidies leaves three groups without subsidies for the purchase of health insurance: those who work for firms that do not offer health insurance, those who are neither employees nor self-employed, and those who work for firms that do not offer a Section 125 plan that allows employees to contribute their share of health

insurance premiums on a pretax basis.

Recently there have been a number of proposals to expand the tax deductibility of health insurance. Gruber points out that expansive tax policies may not be able to increase coverage to a sizable fraction of the uninsured. Moreover, generous tax credits may induce those who have group insurance to switch to highly subsidized nongroup insurance. Insurance portability and other mandates and insurance market reforms can also reduce the number of the uninsured. However, Gruber cautions that although private insurers are free to raise premiums, government interventions generally will not be effective in extending coverage to the uninsured.

Health care reforms are complex because changes in the health care system may affect other aspects of the economy in a significant way. For instance, types of health insurance and their availability have important implications to labor market behavior of individuals as well as firms. Brigitte Madrian's chapter explains the link between the health insurance market and the labor market, and how health insurance arrangements affect decisions regarding employment, retirement, and career changes. Madrian first points out that, of the many pieces of the health insurance system in the United States, the most significant one is employer-provided health insurance, which provides coverage to 64 percent of the non-elderly U.S. population. Because some types of health insurance are provided as a condition of employment while other types are more readily available when individuals are not employed (for example, Medicaid), health insurance has an important impact on the decision of employment itself.

Madrian estimates that individuals with access to retiree health insurance leave the labor market about 6 to 18 months earlier than those who do not have access to such insurance. These individuals are also more likely to retire before the age of 65. Moreover, individuals with access to retiree health insurance are much more likely to make a gradual transition from work to retirement than those without retiree health insurance. As the fraction of employers offering retiree health insurance has fallen by almost half over the past 15 years, and some Medicare reform proposals consider to raise the Medicare eligibility age from 65 to 67, it is predicted that these changes are likely to increase the average retirement age. Based on her own and other research, Madrian asserts that health insurance institutions also affect unskilled single mothers' decisions on working or taking welfare, married women's decisions on participating in the labor force, and decisions on changing jobs and self-employment.

Health insurance may also affect the labor demand decisions of employers. The fixed-cost nature of health insurance gives firms an incentive to reduce the labor costs by hiring fewer employees at longer work hours and fewer but more productive employees. Similarly, as part-time workers are exempt from the nondiscrimination rules as required by the tax treatment of employer expenditures on health insurance, employers may choose to hire part-time workers in lieu of full-time workers as a way to economize on insurance costs. Madrian concludes that because there have been significant changes in the health insurance market in the United States over the past 15 years, it is important to understand the relationship between health insurance institutions and the labor market, and to evaluate the impacts of health care reforms on the labor market and the economy as a whole.

Catherine McLaughlin's chapter in a way is a complementary piece to Madrian's, as it provides more detailed evidence regarding how firms and consumers make their choices under the current health insurance system in the United States. Ninety percent of the firms with 100 or more employees choose to offer some kind of health insurance to their workers, while less than half of the firms with less than 10 employees choose to do so. Small firms are less likely to offer employees health insurance mainly because of the high premium relative to their revenues; they typically face higher premiums than larger firms. Another reason for not offering health insurance is that employers believe that workers can get health insurance from their spouses and may wish to trade health insurance for higher wages. Indeed, a survey conducted by McLaughlin and Zellers reveals that in firms where employers responded that their employees' ability to get insurance elsewhere was an important reason for not offering insurance, 73 percent of the employees did obtain health insurance from other sources.

McLaughlin also finds that higher paid workers are much more likely to be offered health insurance. Only 43 percent of workers earning less than \$7 per hour are offered health insurance by their employers, whereas 93 percent of those earning more than \$15 per hour are offered. The availability of another source of insurance enables workers to choose employment in small businesses that do not offer employee health insurance, or simply choose not to participate in the employer-provided insurance. Of the workers who choose not to participate, 75 percent have other group coverage, usually through a spouse's plan. Finally, of those workers who participate in the employer-provided health insurance, half of them have no choice in plan; most are offered only a traditional fee-for-service plan. About one-third of those who have choice in plans are offered one or more managed care plans. For many workers, the choice of their employers determines the choice of plans.

As health care is either directly financed by taxes, such as Medicare and Medicaid, or subsidized by certain tax exemptions, such as employer-provided insurance and insurance for the self-employed, health care reforms inevitably involve tax policy. Robert Helms's chapter discusses the role of tax policy in shaping the health insurance and health care markets and its implications to health policy reforms. Helms asserts that tax policy since World War II contributed significantly to both the rate of growth of private health insurance and many attributes of its structure and performance. In particular, tax policy caused group health insurance to grow at a much faster rate than individual insurance. He argues that the tax treatment of health insurance introduces inefficiencies into the health markets, increases the costs of health insurance and medical care, and makes it more difficult for low-income workers and the self-employed to purchase health insurance.

In view of recent policy debates, Helms notes that the serious proposals to reform the health insurance market have one feature in common; they all involve some variation of tax credits. He then evaluates the effectiveness of the proposed tax credit programs by referencing several studies by health economists. He primarily focuses on the elasticity studies to evaluate how health insurance expenses respond to tax credits. He concludes from these studies that a tax credit will be more effective in reducing the number of the uninsured than a tax deduction. A refundable tax credit will be more effective in reaching relatively more of the low-income than a flat dollar tax credit. In

addition, it seems that low levels of tax credit will have relatively small effects on the purchase of health insurance.

The chapters in this volume reflect the opinions of six leading health economists on certain important issues of health care reforms in the United States. While they can only cover part of the complex health care reforms, they all conduct insightful analyses of the issues concerned, in terms of economic consequences and political implications that changes in the health care system will bring about. The analytic frameworks and the insights provided in this volume will be valuable for understanding and evaluating further developments of health care reforms, which will surely remain a central issue of the U.S. public policies for years to come.