

ELECTION 2008

## Symptomatic Relief, but No Cure — The Obama Health Care Reform

Joseph R. Antos, Ph.D.

A central premise of Senator Barack Obama's campaign for the presidency is that America is ready — this time — for sweeping health care reform. He has laid out a vision for reform that promises health insurance for (nearly) everyone, with coverage as good as that enjoyed by members of Congress. According to the campaign, the Obama plan would shift most of the 46 million uninsured Americans into health plans, strengthen employer-sponsored insurance, increase the efficiency of the health care delivery system, and save the average family \$2,500 a year on their insurance premiums. These hopes are too audacious to be believed.

The Obama plan offers a host of policy proposals that, in the main, address the symptoms but not the underlying disease that afflicts the health care system. We surely could use some symptomatic relief. However, failing to address the perverse incentives that drive health care spending inexorably upward, making insurance unaffordable for millions and shaping (or misshaping) the practice of medicine, will leave us worse off than we are today (see graphs).

Consider how the plan handles the decline of employer-sponsored health insurance. Most Americans with insurance purchase it through an employer, and a decline in employer-sponsored insurance means more people without coverage or

on federal programs. However, the market share of employer-sponsored insurance fluctuates with the business cycle: it rose during the economic boom of the 1990s but has fallen over the past decade (see graphs). In 2007, it accounted for 70% of all insurance coverage.

To prevent further declines in employer-sponsored coverage, the Obama plan would impose a “play-or-pay” policy. Employers would be required to make a “meaningful contribution” to the cost of their employees' health plan or pay a tax that would help pay for a new public health insurance plan. Supporters of this approach argue that it is only fair that business carry some of the burden of expensive health care premiums.

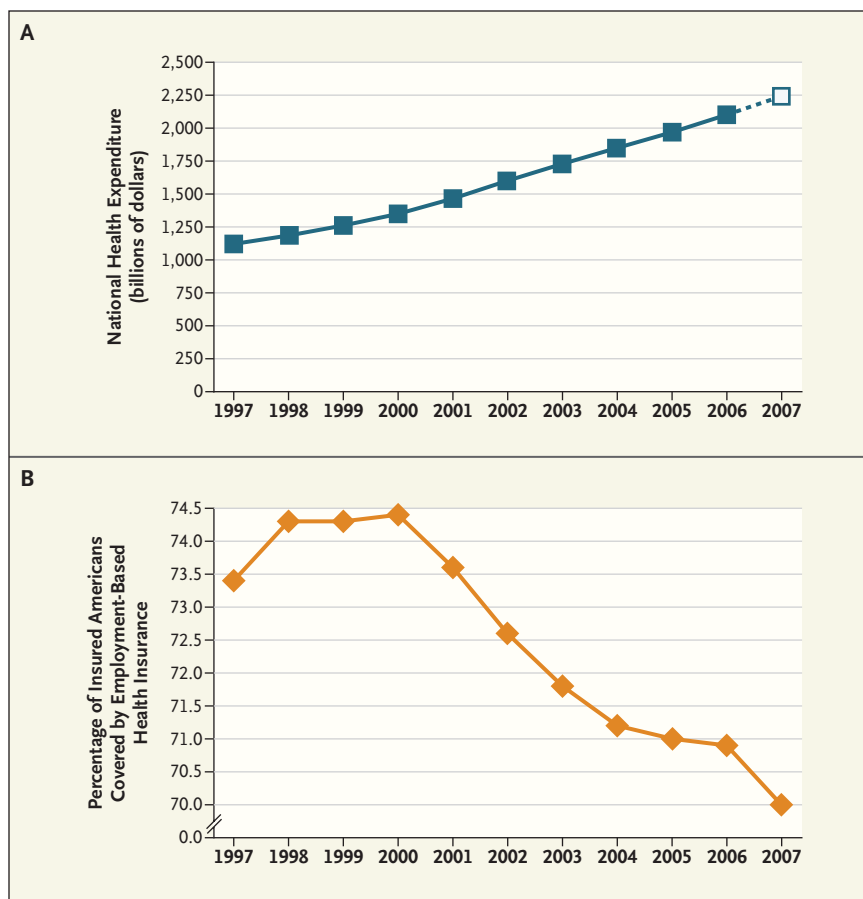
The only problem with this argument is that workers, and not business, ultimately bear the full cost of their health benefits. Employers offer insurance as part of an employee's compensation package. The total value of the compensation depends on the employee's productivity, regardless of the split between wages and benefits. To maintain the same level of health benefits when costs increase, employers cannot increase wages as rapidly as they would otherwise. That helps to explain why productivity has grown faster than earnings over the past decade.

Imposing a play-or-pay man-

date increases the cost of labor for employers who did not previously offer health-insurance coverage or whose contribution was lower than the new federal requirement. The added cost would be covered by lowering wages or benefits or reducing employment. The firm might also raise the price of its products, but that would reduce sales and eventually reduce the company's scale of operations. The mandate is effectively a tax on labor, and labor would eventually shoulder the cost.

A play-or-pay policy probably would not be effective in expanding employer-sponsored insurance. Employers who already offer generous health benefits would not have to change their compensation structure. Other employers would choose to “pay” rather than “play” unless the new tax were more expensive than the cost of paying the mandated amount for insurance, which is politically implausible. Small firms would be exempted from the mandate and offered a subsidy of up to half the cost of the premiums if they provided health benefits. But even with that inducement, many small firms would choose to avoid facing the financial risk of rising health care costs.

The Obama plan also aims to correct the problems of the individual (or nongroup) insurance market. Families buying insurance in the nongroup market face



**Total U.S. Health Care Expenditures (Panel A) and Percentage of Insured Americans Who Were Covered by Employment-Based Health Insurance (Panel B), 1997–2007.**

Data on expenditures through 2006 are from the Center for Medicare and Medicaid Services; the 2007 datum is a projection from Keehan et al.<sup>1</sup> Data on insurance are from the U.S. Census Bureau.

higher premiums for less generous coverage. Senator Obama would create a new national health plan that would be available to everyone with no questions asked about health status or preexisting conditions. Premiums would be community-rated, guaranteeing that everyone would pay the same rate.

Although the campaign rhetoric is unclear, one is left with the impression that the national health plan would be similar to the typical plan offered under

the Federal Employees Health Benefits Program (FEHBP). That means a pricey plan. The Blue Cross–Blue Shield standard plan that is popular with federal workers offers good coverage for about \$12,000 a year. Less expensive plans exist, but they typically require high deductibles and substantial copayments.

A generous plan requires premiums that would be unaffordable to many of the uninsured unless there was also a generous subsidy from taxpayers. A more

basic plan would have more affordable premiums, but beneficiaries would face higher out-of-pocket costs if they became seriously ill. Lower premiums and skimpier benefits are not what the Democratic political base thinks it has been offered.

To help families purchase insurance, the Obama plan would establish a health insurance “exchange” similar in some ways to the FEHBP. Private insurers would be required to participate in the exchange and could no longer market directly to individuals. The exchange would permit no underwriting and require community rates and benefits at least as good as those of the national health plan.

Conservatives have long argued that Americans need a choice of health plans. The Obama plan accepts this idea but minimizes the competition among insurers that makes choice matter. If insurers must compete for business, they have an incentive to develop innovative insurance designs that could promote better use of health care services and lower premiums. By setting what is likely to be a high benefit standard and imposing uniform pricing and other regulations, the Obama plan would severely limit the scope of competition among insurers.

The plan would also reduce adverse selection — a form of market failure that occurs when a health plan enrolls a disproportionate number of high-cost beneficiaries. Obama’s proposed regulations are intended to prevent actions (such as medical underwriting or limiting bene-

fits) that are designed to protect insurers against adverse selection but that also disadvantage such persons. The goal — ensuring that everyone has access to insurance that promotes positive medical outcomes and protects against financial ruin — is not in dispute. The means are. Community rating coupled with a potentially high minimum benefit would deter innovation by insurers, who could not offer coverage with a lower actuarial value at lower premium rates even if they found a more efficient way to provide benefits. Despite guaranteed issue, insurers would fine-tune their benefit structure or other aspects of their plans (for instance, limiting access to specific therapies or specialists) in order to avoid high-cost patients. The rules proposed by the Obama plan would reduce the options available to consumers, some of whom would rather consume less (or more) health care than Con-

gress would require. In its determination to avoid market failure, the Obama plan substantially increases the risk of government failure and regulatory gridlock.

Reforms as sweeping as the Obama plan come with a big price tag. According to the campaign, federal health care spending could increase by as much as \$65 billion a year — but only after \$200 billion a year in cost savings. The usual suspects show up as savers: health information technology, disease management, prevention, and comparative-effectiveness research — all important ideas, but none likely to produce savings any time soon. Reducing the insurance industry's overhead costs is also on the list, but that is not where the real money is.

Early in his campaign, Obama recognized that the success of health care reform rests on the plan's ability to slow spending growth and make health care

affordable for everyone. His plan would reorganize the health-insurance market — but not change the basic financial incentives in the system that drive up spending. Although the plan would significantly increase the number of Americans with health insurance, it remains to be seen whether that would come at a price Americans would be willing to pay.

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1. Keehan S, Sisko A, Truffer C, et al. Health spending projections through 2017: the baby-boom generation is coming to Medicare. *Health Aff (Millwood)* 2008;27:w145-w155.

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## BECOMING A PHYSICIAN

# Living Unlabeled — Diagnosis and Disorder

Lisa Rosenbaum, M.D.

I'm at the end of my second year of residency, and for 2 years I have had a pain in my left hip. I've convinced myself that this pain is an overuse injury from running, but running is my antidote to any life stress; residency has made this outlet even more crucial. Though the pain has not interfered with my ability to work, sitting on airplanes is unbearable, sitting at restaurants is tolerable only if I keep

half my bottom off the chair, and my running pace has deteriorated to a crawl. It's remarkable how long a resident can go without sitting down. I procrastinated for 15 months before seeing an orthopedist, and then 9 more months before getting the MRI he ordered. Yesterday, I finally had it done.

Today, I easily put it out of my mind as I rush through the hospital halls, which, since it is

mid-June, are buzzing with the energy of the incoming interns. Seeing them, I recall the rush and terror of starting internship, of my first night on call. My first admission was a young woman with a sulfa rash. Although three different people essentially told me what was wrong with her before she even arrived on the floor, I was graciously allowed the illusion of making my first diagnosis as a doctor. I discon-