Conclusion

A Federal-State Framework for Market-Based Reform

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Despite criticism from some quarters, the health care system in the United States has significant strengths. The hospitals and clinics through which most Americans get their care are staffed by some of the world's most highly trained and accomplished physicians and these institutions have the capacity to deliver the finest and most sophisticated medical care found anywhere in the world. Most Americans have ready access to this care through third-party insurance arrangements provided by their employers, or in the case of seniors, by Medicare. Finally, U.S. health care is open to medical innovation in ways that other systems around the world are not. The resulting rapid pace of innovation that has occurred in recent decades has, in the main, provided a tremendous boost to the quality of patient care.

There are also many problems with American health care. These problems are aggravated by the Patient Protection and Affordable Care Act (PPACA) but they will remain even if the PPACA is repealed. These problems have worsened in the past three decades, to the point where a large percentage of the electorate believes real change is needed.

These problems include:

- Cost increases that exceed the levels that patients, taxpayers, or other

payers are either able or willing to pay

- Government spending on health care that is rising much more rapidly than the revenue base that pays for it, thus putting tremendous strain not just on governmental finances but also on U.S. economy and credit-worthiness
- A substantial number of Americans with pre-existing conditions who either cannot afford or cannot find insurance options that provide secure and sufficient coverage for their conditions
- A considerable number of working Americans who go without insurance for long periods or intermittently because they cannot afford it or it is not offered by their employers
- A surprisingly low and unpredictable quality of care in many settings

What the American health care sector needs most is the discipline, balance, and accountability that come from a functioning marketplace. Normally, competition among suppliers of services and products ensures that consumers get value for the money they spend. It also rewards entrepreneurs who find better ways to provide what consumers want and need. That is not the case with health care in the United States today. Americans looking to purchase affordable coverage face a marketplace distorted by current government policy and misallocated federal and state responsibilities. In a country as large and diverse as the United States , it is impossible to centralize key aspects of decision-making about health care in Washington, D.C. without running roughshod over the prerogatives of state and local officials as well as the rights and freedoms of individual citizens and their families.

Effective reform of American health care must be built on two key principles. First, only a functioning marketplace can impose needed cost discipline without sacrificing what is good and desirable about the quality of American medicine. Second, effective oversight and governance of health policy in the country will only occur in a system that respects federalism.

This chapter serves as a guide for members of Congress and state legislators on how they should, in practice, apply these twin principles. Effective policymaking requires a level of understanding about what is and is not working

in current federal and state policy, and also an understanding that neither the federal government nor the states can independently address the problems we face. The only answer to the health care riddle is a healthy, constructive federalism, wherein each level of government plays its proper role.

Distorted Federal and State Roles = Rapid Cost Escalation

The foundational document of our federal system of government enumerates in broad terms the powers to be exercised by the federal and state levels of government in economic matters. The Constitution gives the federal government the authority to regulate interstate commerce on matters which bear on the functioning of the national economy; the states hold authority over all matters not expressly reserved as federal concerns. Our constitutional framework provides the right boundaries for a well-functioning federalist approach to health care governance. The trick is to ensure that authority for political decision-making lies at the proper level of political accountability.

Health care will almost certainly always entail some level of shared oversight by the federal and state governments. On one level, health care is obviously a local economic good. In most instances, patients need the attention and care of trained and competent medical professionals in close proximity to where they live. That quite clearly means that the states will have great interest in overseeing the system of service delivery to ensure it is accessible for their citizens and of high quality.

At the same time, there is clearly a role for the federal government in health care. After all, communicable diseases can travel across state lines, and the free flow of persons and products throughout the country means that some coordination across the states is a legitimate concern of federal officials. Also, with rapid improvements in communications and information technology, more and more services will cross state lines and fall under federal jurisdiction.

Unfortunately, instead of a carefully constructed system of divided responsibility, our system of health care oversight and regulation has grown up on an ad hoc basis, driven mainly by well-intentioned policies at the federal

level that were enacted long ago but that now have dramatic unintended consequences.

Through tax and regulatory policies, the federal government has effectively nationalized health insurance oversight for many tens of millions of Americans (and that may be said without taking into account the dramatic centralization that would occur if PPACA is not repealed). This movement of power and control over health insurance to the federal government has occurred even though states have historically been the main regulators of all types of commercial insurance products.

Federal Tax Exemption and ERISA

The interplay of two key provisions of current federal health care law account for the shift in power to the federal government away from states. During World War II, the IRS made a regulatory decision to exempt employer-paid premiums from the federal definition of taxable income during the wartime era's tight wage controls. This significant tax break was codified after the war; it became the impetus for widespread adoption of employer-sponsored health plans in the 1950s and 1960s. Indeed, the principal driver for the U.S. adoption of a system of employer-based health insurance as the primary insurance platform for the working age Americans was federal tax law, which has made such coverage financially advantageous for both employers and employees.

As explained in Tom Miller's chapter *The Case for Competition and Choice through Healthy Federalism*, the federal tax treatment of employer-sponsored coverage provides an incentive for higher levels of spending rather than economizing. Today, employer-paid health insurance premiums do not count as taxable compensation for workers. No matter how expensive the health insurance premium, if the employer is paying, it is tax-free to the worker. Employees thus have a strong incentive to take more and more of their compensation in the form of health coverage instead of cash wages because health coverage is not taxable. For every dollar spent on health coverage, a worker receives a full dollar of coverage; whereas for every dollar received in

other forms of compensation, a portion goes to the government in the form of taxes.

Later, Congress enacted the Employee Retirement Income Security Act (ERISA), which regulates employer-sponsored benefit programs. The effect of the ERISA law and subsequent court decisions was to exempt employer-sponsored self-insured[1] health plans from state health insurance regulation. For many employers, that exemption is highly valued: it exempts their health plans from the myriad of benefit mandates that state legislatures across the country have adopted over the years. Importantly, by putting a large slice of the marketplace beyond their policy reach, the ERISA law has made it nearly impossible for states to take the lead in substantial health care reform.

Politically, these alterations to traditional, market-based health care arrangements have proven to be nearly impossible to correct. Americans working for the nation's largest employers have grown accustomed to, and comfortable with, the generous plans they now receive. Their employers do not have to deal with the idiosyncratic requirements of fifty separate insurance regulators. Together, large self-insured firms and their employees have become a powerful force in public debates about health care policy. They strongly resist changes that might disrupt how they go about their business.

Assertions that America's experiment in market-driven health care has failed because of out-of-control cost escalation is a false characterization of the historical development of health care in this country. The U.S. does not have an effective health care marketplace; rather the U.S. has a system that has been distorted by the misaligned incentives embedded in existing federal health care policies. Certainly, the federal tax exemption for employer-paid premiums has distorted the health care marketplace. But equally important distortions have come about from the establishment and expanding presence of federal regulations associated with the Medicare and Medicaid programs.

Medicare and Medicaid

Aside from employer-sponsored coverage, most other Americans are

insured through the federal government's giant public insurance programs, Medicare and Medicaid. These programs are highly valued by their enrollees, and for good reason. They are crucial to securing access to care for the nation's senior and low income households. Nonetheless, Medicare and Medicaid also contribute substantially to the problems which plague American health care too. For starters, because of their design, Medicare and Medicaid distort political incentives and accountability. More importantly, they also provide open-ended government subsidies that increase as costs rise. The result is a much-diminished incentive for insistence on high performance, efficiency, and quality in the provision of health care.

Though states retain prerogatives relating to the licensing of health care providers, the federal government has also become the dominant regulator of hospitals, physicians, and other providers of care through the Medicare program. When enacted in 1965, Medicare was supposed to be a third-party insurer with a minimal role in the oversight and regulation of the delivery of health care services. At the time, states had the clear lead in the oversight of medical practice. But Medicare's restrained role was short-lived. Within a few years of enactment, the bureaucracy running the program began to issue rules for the reimbursement of services. Since seniors are the heaviest users of health care services, no provider of medical care can ignore Medicare's regulatory demands. As a result, over the past four decades, hospitals and physicians have organized themselves entirely around Medicare's rules, with virtually no input from state governments.

Medicare's cost impacts are equally clear. Most program beneficiaries sign up with the traditional fee-for-service (FFS) insurance arrangement the program provides. The status quo allows enrollees to see any licensed service provider, with no questions asked. Medicare requires substantial cost sharing—including 20 percent coinsurance to see a physician and a more than $1,000 deductible per hospital admission—but this cost sharing is ineffective because some 90 percent of the enrollees also purchase some form of supplemental coverage, which pays for unreimbursed expenses. Thus, in most instances, Medicare's beneficiaries pay nothing extra when they get more care.

Congress and the Medicare program's administrators have tried to hold down Medicare's costs by paying less for each service provided. Those providing services to Medicare patients have responded over time by providing more services, and more intensive treatment, for the same conditions. In most cases, there is no incentive to opt for lower-volume care. Patients generally do not pay more money out of pocket when more services are rendered, and those providing services generate more income with each additional procedure or test. The bill is simply passed on to the Medicare program — and federal taxpayers.

The result of this dynamic is hardly surprising. The volume of services paid for by Medicare has been on a steady and steep upward trajectory for decades. According to the Congressional Budget Office (CBO), the real price Medicare paid for physician fees dropped between 1997 and 2005 by nearly 5 percent, but total Medicare spending for physician services rose 35 percent because of rising use and more intensive treatment per condition.[2]

Enacted in 1965 at the same time as Medicare, Medicaid, too, is structured in a way that undermines effective health care policy. Medicaid was set up explicitly to be a state-driven program; the program is financed by a system of federal matching payments for state-determined Medicaid spending. The federal share of Medicaid spending varies by state, but on average, federal taxpayers pick up 57 percent of every dollar of Medicaid expenses, and state taxpayers pay the rest.[3]

This approach to financing Medicaid undermines political accountability for budgetary costs. Neither the federal government nor the states are ultimately in charge, nor are they accountable. As one might expect, the federal government has over time imposed tighter and tighter rules on what states can and cannot do with federal Medicaid funding, much to the dismay of state governors and legislators. At the same time, states have sought to maximize federal Medicaid payments to ease their budgetary pressures. Indeed, much state spending, such as public health and mental health funding financed entirely by state taxpayers prior to the establishment of Medicaid, has over the past four decades found its way into the Medicaid budget.

Worse still, the current approach to financing Medicaid undermines political

incentives to insist on cost discipline. Governors or state agencies seeking to cut their state's Medicaid costs must cut the program by $2.30 to save $1.00 in state money because the first $1.30 belongs to the federal treasury. Not surprisingly, most state politicians do not find that a particularly appealing formula. So, instead of pursuing difficult and controversial reforms, they spend most of their energy working on ways to maximize federal Medicaid matching payments while simultaneously minimizing state costs.

The results are predictable: Medicaid costs have risen rapidly almost without interruption since the program was enacted, and, yet, there are still millions of low-income Americans who lack insurance.

The Big Picture

When these factors are taken together—Medicare's incentives for rising volume, unlimited federal matching payments for state-run Medicaid plans, and a tax subsidy for employer plans that grows with the expense of the plan—it is no surprise that U.S. health care costs are rising rapidly.

And the distortions do not end there. Because of the design of these subsidy arrangements, the biggest customers in our health system are not patients but the big payers of insurance claims filed by doctors and hospitals—namely, the federal government, the states, and the country's employers. The current payment structure goes a long way toward explaining the uneven quality of American health care. Workers who receive insurance coverage through their employers cannot change their insurance if their current plans require unnecessary and repetitive paperwork, and they have little choice in deciding which doctors and hospitals are covered in their networks. Moreover, doctors and hospitals organize their operations to maximize payments, not to use convenient and consumer-focused care to attract patients. The result is maddening bureaucracy, paperwork, and unaccountable service delivery.

Moreover, the opaque nature of today's taxpayer-supported insurance arrangements makes it difficult to recognize who benefits the most from the current system. In particular, it is not widely understood that the tax preference

for employer-paid premiums provides greater value for higher-income households that are in higher-rate tax brackets than for low-wage workers who most need assistance to pay for health coverage. According to Congress's Joint Committee on Taxation, in 2007, the average value of the tax preference for job-based coverage was about $2,000 for households with incomes between $10,000 and $30,000 per year and $4,600 for households with incomes between $200,000 and $500,000 per year.[4] Higher-salaried workers have the strongest incentive to consume the most expensive insurance.

Federal support for health insurance coverage through entitlements and the federal tax break for job-based plans help explain why the federal budget today is in deep deficit, and why the long-term outlook is daunting. According to the Congressional Budget Office (CBO), the federal government will run a cumulative budget deficit of $4.8 trillion over the period 2011 to 2021, following a two-year deficit of $2.7 trillion in 2009 and 2010.[5] And those projections assume that a $4 trillion tax increase will be imposed beginning in 2013. A realistic set of policy assumptions shows federal debt headed toward 100 percent of GDP.[6]

A major reason for all of this red ink – indeed, the most important reason – is runaway health costs, as reflected in federal spending on Medicare and Medicaid as well as the tax break for job-based coverage. According to the CBO, combined Medicare and Medicaid spending will reach $1.5 trillion in 2021, nearly double the spending in 2010.[7] Over the next 25 years, the CBO expects federal spending on the major health entitlements to rise from about 5.5 percent to 10.3 percent of GDP.[8]

Market-Driven Health Care vs. Government-Imposed Cost Controls

Debates over health care policy tend to be polarized, with a deep divide over what needs to be done to slow the pace of rising costs. On one side are the governmentalists who believe that central government management of prices and government reengineering of service delivery by doctors and hospitals can control costs without affecting the quality of care. This mindset has dominated

health policymaking at the federal level, most especially in the context of the Medicare program, for the better part of a half century. It has not worked.

It has not worked because the government does not have the capacity to make the difficult decisions required to build a high-value network of care provision. The private sector delivery models that are admired by the experts — like Geisinger Health System (Pennsylvania), the Cleveland Clinic (Ohio), and Intermountain Healthcare (Utah) — operate on a principle of provider exclusivity. They operate highly selective, if not totally closed, networks, that enable these providers to gain control over the delivery system. They drop or avoid low-quality performers, and establish tight processes to streamline care and eliminate unnecessary steps.

Despite years of demonstration projects and multiple initiatives, the federal government has not shown itself capable of building anything remotely similar to these models for the public insurance programs. When attempts have been made in the past to steer patients toward preferred physicians or hospitals, they have failed because politicians and regulators find it impossible to make distinctions among hospitals and physician groups based on disputable quality measures.

Instead, Congress and Medicare's regulators have cut costs through across-the-board payment rate reductions that apply to every licensed provider without regard to measures of quality or efficient performance. It is notable that despite all of the talk of "delivery system reform" in the PPACA, the way the new law cuts Medicare spending is with old-fashioned payment rate reductions, not new approaches to delivering care.

The alternative to the failed, top-down approach of government micromanagement is a functioning marketplace. The key to building such a marketplace is cost-conscious consumers.[9] Instead of a defined benefit entitlement, participants in a defined contribution system get a fixed-dollar payment from the government; they can use this payment to purchase an insurance plan of their own choice. If they select expensive coverage, they pay the difference out of their own resources. If they choose less expensive plans, they pay lower premiums and keep the savings. This structure provides a

powerful incentive for health system participants to find high-value plans that charge low premiums.

Critics argue that this type of reform will not control health care costs, and will only shift the burden and risk of rapidly rising costs onto individuals and away from the government. This way of looking at the impact and reach of a defined contribution reform represents a distinct case of tunnel vision. In a defined contribution system in which cost-conscious consumers seek out the best value for their money, cost-cutting innovations would be rewarded, not punished, as they are today. Physicians and hospitals would have strong financial incentives to reorganize themselves to increase productivity and efficiency to capture a larger share of what would become a highly competitive marketplace. *This is the only way to slow the growth of health-care costs without lowering the quality of care.*

Medicare Part D, the prescription drug benefit, which was enacted in 2003 and fully implemented by 2006, provides strong evidence of the value of approaches that draw on competition and consumer choice to control the growth of health care costs.

The Part D drug benefit was designed to harness the power of consumers looking for value. The new drug benefit requires no government-sponsored plan or option; instead, it is delivered entirely through private insurance plans that submit bids to the federal government. These bids are based on the premium amounts that insurers charge for providing drug coverage. The government then calculates, based on a weighted average of those bids, what it will pay on a regional basis. Importantly, the government's contributions do not vary depending on the plans selected by the beneficiaries. In essence, the government's contribution toward drug coverage becomes a defined contribution payment on behalf of Medicare beneficiaries. If a beneficiary selects a plan that costs more than the Medicare contribution, he or she pays the difference out of pocket. Conversely, selection of a relatively less expensive plan reduces the enrollee's out-of-pocket premium payments.

When it was enacted, the competitive drug benefit design had numerous critics.[10] Some argued that the program would not work because private plans

would decline to participate without a guaranteed share of the market. Others said the beneficiaries would not sign up for it because the competitive structure was too complex to navigate. Others said program costs would explode without government-regulated price controls.

All of these predictions proved to be wrong. Now in its sixth year of implementation, the program has exceeded all expectations. Some 90 percent of Medicare participants are in secure drug coverage of some sort, and public opinion surveys show that they are very satisfied with their insurance.[11] Most importantly, the program is coming in significantly under budget, with costs over the first decade running 42 percent below estimates at the time of its enactment.[12]

The Road Ahead to a Functioning Health Care Market

Diagnosing the problems in American health care, and with the approach taken in the PPACA, is not enough. It is crucial also to build a framework within which a functioning marketplace can deliver higher value, lower cost care. Doing so requires addressing several key questions:

- What level of government should address various actions that will move market reforms ahead?
- What strategy should elected leaders employ to remove federally created distortions to the health care market?
- How should we incorporate market-based reform with respect to issues like coverage for pre-existing conditions?
- How can federal and state governments help solve the Medicaid puzzle?

The final section of this chapter provides answers to these important questions.

State Administration of a Market-Based Reform

There are two temptations that must be resisted with regard to a market-based health care reform. The first is the temptation to federalize every decision. If current law and PPACA have tended toward centralization in the name of

increasing governmental control, reformers with a market-based orientation might be tempted to go in the other direction and impose their vision of a functioning marketplace with federal law and no room for states to play a role on behalf of their citizens. This would also be an error, and shortsighted. If the federal government makes all the decisions, the tendency of distant bureaucracies to build power and ignore the concerns of dissenting voices will eventually lead to even greater government controls than those that are present in today's system. Undoubtedly, the best protection against the federal government's tendency to overextend its reach is to have states serve as the main administrators of a market-based system.

The other temptation is to move too quickly, in the name of reform, to upend existing arrangements that have been built around the rules currently in place. This is a particular concern for the health insurance plans now sponsored by large employers for millions of American workers. Indeed, the fear that PPACA will impose unnecessary costs on these plans is a significant cause of the law's unpopularity among a sizeable plurality of the electorate.

A well-crafted reform must steer clear of both temptations and instead aim for an incremental set of market-based reforms that are implemented by the states within broad federal guidelines. In general, the division of responsibility can be delineated clearly. The federal government must reform the mechanisms for subsidizing health insurance so that they remain consistent with cost-conscious consumption and they create a lead role for the states in overseeing the regulation of consumers' insurance options. The federal government must also, however, make adjustments in the federal regulation of insurance to make sure to protect at some basic level all Americans who may develop an expensive health condition.

The key federal and state actions that will advance affordable insurance and high-quality care include the following[13]:

- Convert the federal tax preference for employer-paid premiums into a refundable tax credit; this initiative should start with workers in small firms and individuals who are not in stable medium or large employer-based plans today;

- Establish a federal-state partnership to protect those with pre-existing conditions, which takes the form of state administered high-risk pools financed by the federal government; and
- Reform the significant portion of the Medicaid program covering the non-elderly poor, allowing states to integrate these program participants into the same insurance arrangements which cover other working age Americans.

State Implementation of Federally-Financed Tax Credits for Coverage

In 2008, while running for president, Senator John McCain proposed to end the tax break for employer-paid health insurance premiums and replace it with a refundable tax credit for all insurance purchasers, whether they buy insurance through their employers or on the individual market.

There is little doubt that the McCain plan would have addressed many of the shortcomings prevalent in health care today. Under this plan, workers could acquire portable insurance, eliminating job lock (the tendency of people to stick with jobs they do not like just for the insurance), and closing gaps in coverage for those temporarily out of the workforce. Millions of workers who are now passive enrollees in their company plans would become cost-conscious consumers looking for value in the marketplace. With a fixed tax credit that does not change based on the insurance purchased, workers would have strong financial incentives to sign up for low-premium offerings, and insurers would have incentives to meet the market demand with lower cost insurance plans and greater efficiency.

Further, the universal tax credit would create incentives that will quickly lead to near-universal coverage. Every household would receive the tax credit — even ones that pay no income taxes. All experience indicates most households will buy something so as not to let the credit go to waste. Such a policy prescription would cause a dramatic reduction in the ranks of the uninsured.

Unfortunately, then-Senator Barack Obama relentlessly denounced the McCain plan during the 2008 campaign with distorted attacks and badly

damaged the idea in the public's mind. Moreover, the McCain plan's extensive reach may be too much for the country to take on all at once. Most Americans believe we need reform especially to provide better coverage for their fellow citizens. At the same time tens of millions of Americans are also generally satisfied with the insurance plans that their large employers provide for them today, and are very reluctant to have that disrupted.

A new effort to move toward a defined contribution tax subsidy for working age Americans must therefore separate the marketplace into two groups.

First, it will allow the well-insured (those in plans run by medium and larger firms) to remain covered by their current insurance plans. An upper limit on the tax preference for these plans can be established to encourage some additional cost discipline. Individuals working in smaller firms or lacking access to an employer plan will get a new refundable tax credit, similar to the one envisioned in the McCain proposal. This compromise allows a consumer-driven marketplace to become established, while avoiding the political problem of disrupting coverage for those who generally like what they have today.

States will play a critical role in such a reform blueprint. The only federal requirement that should be imposed *on insurers* seeking to offer coverage to credit-eligible Americans is that they provide an upper limit on financial exposure to health expenses for their enrollees. In turn, the states will determine the upper limit of financial exposure.

The states are best suited to serve as the locus of decision-making. States will decide what health benefits, if any, to require in the benefit packages offered by insurers to tax credit-eligible customers. They will decide the manner by which their citizens sign up for insurance plans, and the consumer information that drives enrollments. For instance, they could establish consumer marketplaces, like the Utah Health Exchange, or they could rely on private vendors to facilitate consumer shopping.

There are two federal requirements that should be universal for all states. The first is that states should be required to make it easy for citizens to designate their preferred insurance plan, and that once designated, the state will notify the U.S. Treasury to ensure payment of the credit to the appropriate plan. Second,

states should establish systems for assigning tax credit-eligible citizens to default plans should some citizens fail to make a choice on their own.

The key to making this work is cost-conscious consumer choice. With a fixed tax credit, when residents choose high premium plans, they must pay the extra premiums out of their own pockets. When they choose less expensive plans, they will get to use dollars saved for other health care expenses. Tax credit payments not used to pay insurance premiums will be deposited into individually-owned health savings accounts to be used to pay out-of-pocket health expenses on a tax-free basis.

Although many millions of Americans will remain outside of state insurance regulation due to the retention of ERISA and large employer-based coverage, the number will be limited and will likely decline slowly in ensuing years. As a result, a growing number of Americans will receive their insurance through state-regulated plans, which will give states enhanced leverage to oversee both insurance rules and the medical delivery system.

To ensure that this large influx of new state-regulated insurance enrollees is treated fairly, the federal government should also require states to establish a behind-the-scenes risk-adjustment system among private insurers offering plans in the new marketplace. Such a mechanism will require participating insurers to use formulae established in advance to share revenue from premiums with their competitors based on the risk profiles of those selecting their plans. Insurers serving more unhealthy enrollees than average will thus get compensation from insurers covering healthier-than-average groups. This will help states maintain a robust insurance marketplace where competition centers on delivering value for patients and insurance enrollees, not on avoidance of those needing more extensive medical care.

Covering Pre-Existing Conditions with State-Based High Risk Pools

A new system of refundable tax credits will go a long way toward broadening insurance coverage and reducing the ranks of the uninsured. But an additional step is needed to ensure those who develop an expensive health

condition are not penalized in a market-based insurance system: extend to all Americans who remain in continuous coverage protection against being assessed excessively high premiums based on risk profiles. As Tom Miller explains in his chapter *The Case for Competition, Choice, and a Healthy Federalism*, this objective can be achieved through a coordinated federal-state high risk pool initiative.

The changes necessary to make effective high-risk pools a reality are reasonably straightforward. Workers who leave job-based plans for the individual market should be able to do so without being required, as they are today, to stay in their former employer's plan for eighteen months. As Miller notes, many workers do not even realize that they must satisfy this requirement in order to retain their pre-existing condition protections. Instead of such a convoluted process, workers should be able to move directly from an employer-provided plan to an individual policy financed by a refundable tax credit without being denied coverage or assessed large premiums in cases where they develop an expensive health condition while insured.

Next, within a federal framework, there should be state-imposed limits on underwriting health insurance for people moving from the employer-based market to the individual market. The most effective approach would be to cap premiums for high-risk insurance enrollees who have maintained continuous insurance coverage at no more than a fixed percentage of standard rates (perhaps 150 percent).

Limiting premiums for these individuals means that they will be paying premiums that fall well short of what they would be charged with full underwriting. The difference will need to be bridged with transparent and explicit taxpayer subsidies, which in a reformed system can be achieved by adequately funding existing state high-risk pools. The annual federal cost of socializing the premiums for these high-risk individuals is likely somewhere between $10 billion and $20 billion annually.

Congress will have to provide these funds, and should do so in the form of a capped annual appropriation to the states. Congress should also give states wide latitude to determine how eligibility will be ascertained and compensated.

For their part, states will need to structure the risk pools in a way that

prevents private insurers from attempting to move insurance enrollees who are not truly high-risk out of their risk pool and into the publicly subsidized high-risk pools. States can accomplish that by giving independent health risk assessors the authority to penalize insurers for sending referrals to the high-risk pool of individuals who are determined not to be truly high-risk.

Once a worker has entered the individual insurance market, they should not have to face repeated health risk assessments, as can happen today when they switch insurance carriers. Instead, this new federal-state framework should stipulate that new entrants into the individual market would be required to get a risk evaluation only once; once approved for coverage in that market, they would have the right to renew their policies with any licensed insurer in the state based on their initial risk evaluation.

Also, to encourage as much enrollment in health insurance as possible, there should be a one-time open enrollment option for the uninsured to sign up for coverage and secure protection under the new pre-existing condition rules.

The approach to covering pre-existing conditions described above will not be inexpensive. But the cost of state high-risk pools will be a fraction of the cost of the PPACA, and the state pools lack the mandates and onerous rules contained in the PPACA. To address the issue of pre-existing conditions, transparent subsidies are preferable to the PPACA's innumerable insurance regulations.

Letting States Implement Market-Based Medicaid Reforms

The Medicaid program serves three distinct populations. First, there are the so-called dually eligible beneficiaries: individuals eligible both for Medicare and Medicaid. In the main, these are poor senior citizens who need extensive long-term care, often including nursing home stays. Second, there are the long-term disabled who are not elderly but who need support over a long period of time. Third, there are individuals and families enrolled in Medicaid for coverage of their primary and acute health care needs. In general, Medicaid was originally created to cover this last group of low-income individuals and families as part of a system of welfare support. Typically, Medicaid participants in this last group

are mothers with dependent children who receive cash welfare support from the state.

Those who would reform Medicaid need to formulate different strategies to deal with the different challenges of these distinct populations. The reform proposal presented here deals only with the third group of Medicaid users, those who are not elderly and not disabled, or roughly 75 percent of Medicaid enrollees.

Originally, states established automatic "categorical" Medicaid eligibility when they signed up an individual or family for cash welfare support; primarily, this occurred under the Aid to Families with Dependent Children (AFDC) program. In recent years, however, states have moved away from that approach. Eligibility for coverage is now more often based strictly on income tests. Yet even today, Medicaid is not integrated into or coordinated with the insurance system for working-age Americans. This lack of coordination between the two insurance systems creates serious problems for Medicaid beneficiaries: when poor individuals and families get better paying jobs, they often lose eligibility for Medicaid support. These individuals lose Medicaid eligibility even when they are faced with uncertain insurance prospects in the employer market. In effect, these arrangements act as a strong disincentive to secure better employment and move up the wage scale. Movement back and forth between Medicaid and private insurance plans can also disrupt ongoing relationships with physicians who are in private insurance networks, but not part of a state's Medicaid plan.

A move to replace both traditional Medicaid assistance and the tax preference for employer-paid health insurance with a refundable tax credit will open up new possibilities for explicit and beneficial coordination between the Medicaid program and the types of coverage normally available to working-age Americans. For example, using their authority to regulate benefits, levels of premium assistance, and other features of the insurance market, states can explicitly design the refundable tax credit so that it serves those who are eligible for Medicaid (though not the disabled or dually eligible). Such an approach will allow policymakers to restructure Medicaid so that it serves as supplemental premium support for the poor. In order to avoid creating large disincentives for

the beneficiaries to climb the wage and income ladder on their own, states can, over time, phase down the add-on Medicaid payments.

The federal portion of the restructured Medicaid program can, in fact, be converted into a per capita allotment system which is based on current federal spending for a state's Medicaid program. This would enable a movement away from today's system of federal matching payments to states and toward a system of fixed federal payments. The per capita allotment system will free states to manage funding in ways that are appropriate to each state, and remove the incentives that push federal matching payments upward every year.

Putting Medicaid enrollees into the same federal tax credit system as other working age Americans would facilitate portable insurance for low-income families who are struggling to move up the wage ladder. For instance, if states allowed their Medicaid-eligible citizens to use the federal tax credit to enroll in the same plans available to workers who also get the tax credit, then the Medicaid enrollees could keep their insurance plans even when they get better paying jobs.

Medicaid reform of this kind is a form of defined contribution health care. The Medicaid participants would get a large share of their premiums subsidized by the federal tax credit plus additional Medicaid support. But they would still face additional costs if they were to choose more expensive coverage options. This should encourage even the Medicaid population to seek higher value health care options.

In this reform, states would be given great flexibility to alter the mix of benefits, beneficiary cost-sharing, and the extent of managed care requirements much more so than what is currently allowable under Medicaid.

Since its enactment in the 1960s, Medicaid has mainly been considered a health insurance program for non-working welfare recipients and others who cannot access employer-sponsored coverage. Moving from a defined benefit to defined contribution structure, and freeing states to implement this program in a way that is consistent with other insurance regulation will dramatically reform the existing Medicaid program, a program which by the day proves less and less financially tenable. Utilizing a system of defined contributions, Medicaid

could be integrated into the same private insurance marketplace populated with workers and their families, allowing more seamless transitions as Medicaid recipients move into higher paying jobs.

Conclusion

The most serious medium- and long-term economic challenge our nation faces is that the federal government has committed itself to spending far more than it can collect in taxes. The government has made promises it cannot keep. The primary reason for this growing gap between liabilities and resources is the rapidly rising cost of federal health programs. The combined cost of Medicare and Medicaid is already 5.5 percent of GDP, and these costs are expected to double with the retirement of the baby boom generation.

One-off ideas for trimming individual federal reimbursements for medical care will not solve this problem. What is needed is a continuous, long-term, dynamic process that will lead those who deliver services in the health sector to provide better care at lower cost. What can bring that about?

PPACA is filled with provisions that are aimed at giving the federal government the power to re-engineer how American health care is delivered. Proponents of this point of view believe that the federal government has the know-how and the capacity to tweak reimbursement policies in ways that can prompt hospitals, doctors, and other providers to become more efficient.

There is no substantial evidence for this point of view. Indeed, instead of improving the efficiency of the health sector, budget cuts imposed by the federal government have tended to make matters worse with blunt, across-the-board cost-cutting. Politicians find it unpalatable to pick winners and losers among hospitals and physician groups by calling out providers that offer sub-standard care. As a result, to cut spending, they vote for across-the-board payment reductions. Over time, using payment reductions to cut costs has the predictable result of driving willing suppliers of services out of the marketplace. For this reason, many Medicaid patients have a difficult time finding a doctor who will care for them.

The alternative to the failed top-down approach of government micromanagement is a decentralized approach that allows individuals and states to find solutions that work for them. The most important feature of such a system is price-conscious consumers selecting among competing insurers and delivery systems based on price and quality.

With cost-conscious consumers looking for the best value for their money, cost-cutting innovations are rewarded, not punished as they are today. Physicians and hospitals have strong financial incentives to reorganize themselves to increase productivity and efficiency in order to capture a larger share of a highly competitive marketplace.

Building such a marketplace will require a number of changes at both the federal and state levels of government. Building a functioning marketplace will not work unless the states and federal government are working in concert to achieve it. The federal government must reform the way it subsidizes health insurance for workers and those on Medicaid, and it must close cracks in today's system of insurance protections for those with pre-existing conditions. States must then adjust the way they regulate insurance and run Medicaid in order to facilitate cost-conscious consumer choice and ease of administration for their citizens.

This policy prescription is complex, but the payoff will be immense. With a robust federal-state partnership, Americans will get a more affordable and more patient-focused health system. Indeed, they will get the kind of health system they have always wanted, a system characterized by high-quality care, predictable expenses, and the ability of customers to make informed choices that best suit their needs.