Reining in Health Care Costs

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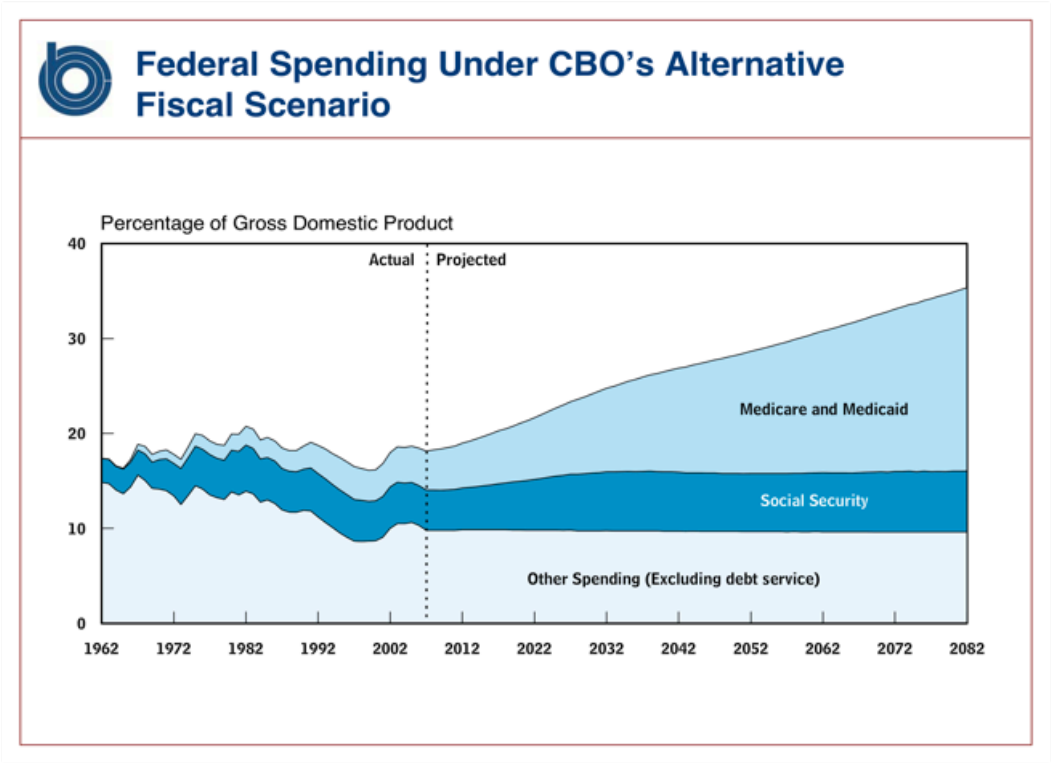
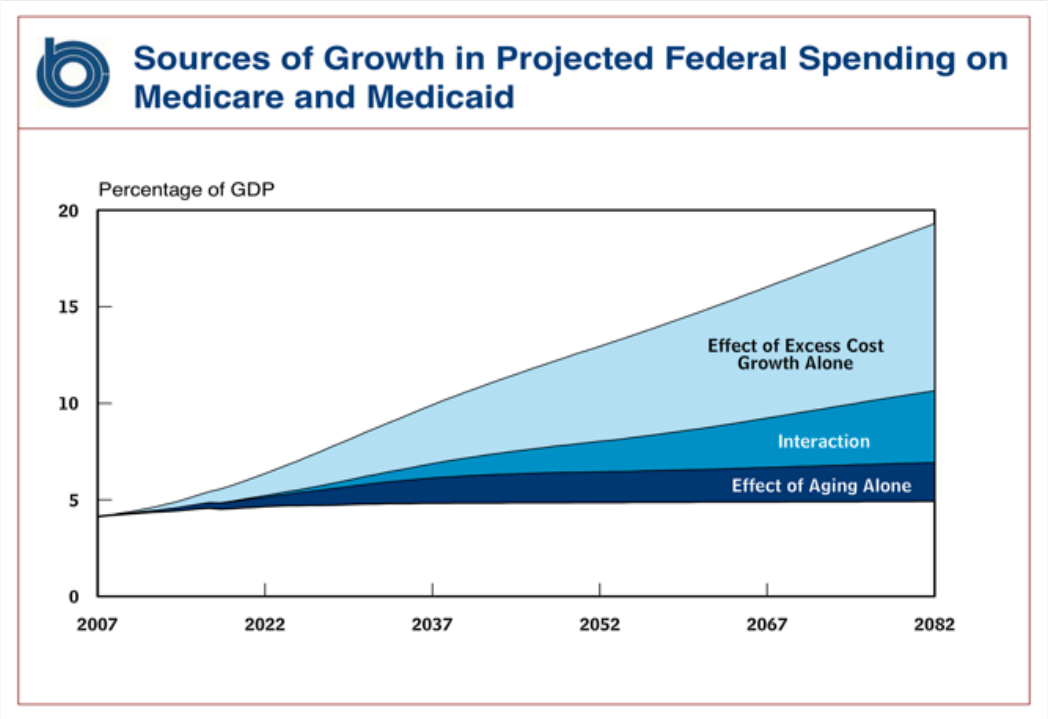
In late October of 2008, Barry Bushue, President of the Oregon Farm Bureau, surprised me with an invitation to join a Federal Deficit Task Force being created by the American Farm Bureau Federation (AFBF). I thought about my resolve to say "no" more often, but decided to accept Barry's offer. I was appointed, along with eight other farmers from across the U.S. Our Task Force held two-day work sessions each month through most of 2009 and was charged with developing a plan that the AFBF membership would support.

When I flew to Washington D.C. for my first meeting, I'd thought very little about healthcare costs. I believed the alarming growth of the projected federal deficits was due to Social Security and the retirement of the baby-boomers. Almost immediately, I learned I was wrong. The first of many experts who spoke at our meetings showed these two slides from a recent Congressional Budget Office report.





Almost all the projected deficits are due to Medicare and Medicaid and they are increasing primarily because of rising costs—not more baby boomers. During the rest of the year, our task force spent much of its time discussing health care. Unfortunately, by the time we finished, the financial crisis and the resulting explosion in the short-term federal deficit had combined with the controversy surrounding ObamaCare to change the political landscape and sidetrack interest in reforms aimed at reining in costs.

I was able to lobby our recommendations through the Oregon Farm Bureau House of Delegates, but the AFBF never endorsed them. However, by the end of 2009, I was hooked. Since then, I've spent much of my free time trying to figure out why U.S. medical costs are growing so rapidly.

Rising healthcare costs should concern wheat farmers for at least three reasons:

1. Over the last ten years, total healthcare costs for a typical family of four have been rising by more than 8% per year and have now reached $20,728. Employers pay part of these costs for many workers—the average employer contribution was $12,144 out of a total insurance premium of $17,258 in 2012.

2. Without effective reforms, Medicare and Medicaid will slowly crowd out everything else in the federal budget, including agricultural research, crop insurance, conservation, and other farm programs.

3. Rising health insurance premiums and Medicaid costs are already causing the State of Oregon general fund to be reallocated, with less money available for the OSU College of Agricultural Sciences and for wheat research. The cost of health insurance provided by OSU to its employees is now over $15,000 per year, with participants paying even more for family coverage.

Why does the U.S. spend almost twice as much per capita on healthcare as other advanced countries and what can be done? As you might expect, this isn't an easy question to answer. However, understanding three characteristics of our current system helps point the way forward:

1. The way we purchase medical care differs fundamentally from the way most other goods are purchased. Normally, when we go shopping, we start with a clear idea of what we want. When we go to our doctor, we usually don't know what medical care we need and our doctor's first job is diagnosing our problem. We learn from our doctor what treatment we should purchase. Doctors have a unique dual role in both recommending and providing treatment. Market competition doesn't do its normal job of holding down costs when sellers determine the amount of services they provide.

2. The majority of doctors and hospitals now bill for each service they provide. This fee-for-service payment system rewards more care. The great majority of doctors are honest and don't order care just to pad their incomes. However, considerable uncertainty often exists about whether a treatment or test will benefit a particular patient. With our fee-for-service payment system, the easiest and most rewarding path is to go ahead and order the procedure. The fear of malpractice suits also provides an incentive to over treat. Good evidence exists that approximately one-third of medical care in the U.S. provides no benefit to the patient.

3. Someone else pays most of our health care bills. In the U.S., governments pay for 49% of health care and employers pay 35%. Consumers directly pay only 12%. Our way of financing health care causes the great majority of Americans to view rising costs as someone else's problem. The view that employer-provided insurance is a free benefit is largely an illusion. Many studies have shown that workers ultimately end up paying the cost with reduced wage growth.

I believe two fundamental reforms are needed to save our health care system. First and most important, the way we pay doctors must change. Fee-for-service payments should be phased out. Doctors and hospitals should receive a fixed (capitated) payment to provide all the care for each of their patients. Unless the size of the insurance pool is large, the amount of this capitated payment needs to be adjusted based on each patient's age and medical history.

Capitated payments provide incentives to reduce ineffective treatments. Medicine should be reorganized more like the Health Maintenance Organizations (HMO's), e.g. Kaiser Permanente. The movement toward HMO's stagnated in the late 1990's when HMO's were criticized for withholding needed care. The rapid adoption of electronic medical records now makes monitoring the quality of care easier. Groups of local doctors could use electronic records to review outcomes in their area and certify that individual patients are receiving the care they need.

Second, health care financing must change so more Americans benefit financially from the reforms necessary to rein in costs. Two reforms are important—giving better incentives to choose a capitated insurance plan and automatically funding the cost of government medical programs with a dedicated tax. [1]

After examining many options, our Task Force (nine conservative farmers) ended up supporting a new system of federal health care vouchers for all Americans. The amount of the voucher should be adequate to purchase a basic health insurance plan. Vouchers could be financed by eliminating the tax deduction for employer-provided health insurance and by a new healthcare tax (probably a broad based value-added tax or some other form of consumption tax).

In many ways, our recommendations were similar to the Medicare reform plan announced recently by Senator Wyden and Congressman Paul Ryan. Under their plan, both private insurance companies and traditional Medicare would announce each year their cost for providing a standard bundle of basic medical services. The size of the voucher would be set so it just matches the cost of the second least costly plan. My belief is that HMO-style plans featuring capitated payments will have lower costs and would be fully financed by the vouchers. Anyone wanting to stay with fee-for-service plans—either traditional Medicare or higher cost private plans—could do so, but only by paying any extra costs out-of-pocket. A person buying the lowest cost plan would receive money back.

Financing health care with federal vouchers would have another benefit. It would sever the current link between employment and healthcare. Employers would no longer need to worry about the cost of health insurance when hiring employees and workers could change jobs without fear of losing their access to care. Everyone – including the self-employed, such as farmers – would have access to the same portable healthcare coverage.

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[1] Higher deductibles and co-pays are another reform often suggested. Co-pays can be beneficial in discouraging patients from over-using medical services. However, if out-of-pocket costs are raised too high, patients will postpone preventive care and not seek timely treatment of chronic conditions. Costs will then increase. Unfortunately, the cost of most medical tests and treatments has risen to a level that exceeds reasonable deductibles and co-pays.

The public would be more likely to support Medicare and Medicaid reform if the rising costs of these programs caused an automatic increase in the taxes used to pay for them. Lifetime benefits under Medicare are now three times the value of Medicare taxes—with the government providing a lifetime subsidy to high-income earners of over $200,000. The rapid increases in Medicare and Medicaid costs are currently being financed by bigger federal deficits. This situation is unsustainable and unfair to future taxpayers. Medical costs should be separated from other parts of the federal budget and financed by a new value-added tax that automatically increases as costs rise. This change alone would solve almost all the U.S.'s long-run deficit problem. It would also provide a powerful political incentive to support more efficient delivery of care—since failure to implement reforms would cause taxes to increase automatically.

This spring, Governor Kitzhaber and the Oregon Legislature worked together to implement an innovative Medicaid reform plan, the Coordinated Care Organizations (CCO). The CCO will better coordinate care and use capitated payments. Senator Wyden has worked with Republican leaders to develop several reform plans, including his recent work with Congressman Ryan. I believe the national debate about controlling medical costs is just getting started and I'm proud that Oregon is leading the way.