Perspective

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Empower Patients, Not Bureaucrats

by John R. La Plante

Governor Brad Henry wants the legislature, and voters, to approve a tax increase on tobacco. The money, he says, would go to extend health insurance and Medicaid coverage to the uninsured poor.

OCPA has argued elsewhere that hiking the tobacco tax is a bad idea. But let's look at the spending side of the governor's health-care plan. So far, the debate has focused on how local governments will be compensated for some related loss of sales tax revenue, and whether tribal stores will have an unfair advantage. Regardless of these issues, the question needs to be asked: Is the governor's plan a good way to extend health insurance to the uninsured? It all depends on the details.

Roughly 650,000 people, or some 19 percent of the state's residents, are without insurance. A cigarette tax increase of 52 cents a pack[1] is expected to raise $130 million. Combined with federal and private sector funds, this is expected to provide up to $500 million [2] that can be used to extend health insurance to 200,000 Oklahomans.[3]

Who Are the Uninsured?

For many people, going uninsured is only a temporary problem. The Congressional Budget Office estimates that in any given year, only 29 percent of the country's uninsured have been without insurance for over 12 months. Nearly half of the uninsured at any time (45 percent) are that way for four months or less.[4] And of course, some are young, healthy adults and some are wealthy individuals.

In Oklahoma, three-quarters of the uninsured are adults aged 18-64, while the remainder are children.[5] According to the Kaiser Family Foundation, more than half earn less than $14,128 a year.[6] Under current income guidelines, many of them would qualify for Medicaid. They may choose not to participate, or simply be unaware of the program. On the other hand, almost one-third of the uninsured have incomes that are 200 percent or more of the federal poverty level.[7]

State health secretary Tom Adelson has said that the program, if enacted, would emphasize the private market. "Less than half" of the new participants would be included in Medicaid.[8] The governor's budget book further suggests that "employers with existing group coverage or health coverage through other providers will receive premium assistance for their qualifying employees."[9]

It is clear, then, that Medicaid will be involved in some way. But how much? A large role for the program could spell trouble for taxpayers, medical providers, and patients. In recent months, the Oklahoma Health Care Authority (OHCA), which runs Medicaid, has had to close down its SoonerCare Plus program after the departure of a contractor left it in violation of federal rules. The move cost the state $11 million in transition costs, and proved disruptive to enrollees.[10]

The problems with OHCA go much deeper than the latest crisis, however. Physician dissatisfaction has been a chronic issue. A survey of doctors conducted in 2002 by the Oklahoma State Medical Association found almost all questioned (97 percent) said that reimbursement rates failed to cover the cost of treatment. Seven in ten reported difficulties in simply getting paid.[11] Not surprisingly, 50 percent of physicians reported reducing the number of Medicaid patients they treated. Thirty-five percent were no longer taking new

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Medicaid patients, and 20 percent were no longer treating any Medicaid patients.

Low reimbursements rates – public policy on the cheap – are not the only way in which physicians and patients suffer. At a legislative hearing, one physician reported that in a single month up to five percent of his Medicaid patients had been moved to another doctor, without their consent or even knowledge.[12] Speaking of the relationship between doctors and the OHCA, Scott Cyrus, a pediatrician from Tulsa, said "There's such a distrust to their authority."[13] It was little wonder, then, that Governor Keating called for the elimination of the authority in his 2002 budget. Dr. Jay Gregory of Muskogee endorsed the idea. "Close the Health Care Authority," he said, "and roll all of its responsibilities and duties to other appropriate agencies."[14]

Since Medicaid enrollment is no guarantee of treatment, and since OHCA management has generated such ill will, adding more people to the program it oversees is clearly not a good idea. The governor and his health secretary would do well to emphasize the private sector.

What Will Be Covered?

Regardless of where insurance will be provided, another pressing question remains: What kind of insurance would be provided? According to Henry's office, "the Governor's budget proposes that a basic insurance plan be provided by the Health Care Authority for individuals and employees. Alternately, employers with existing group coverage or health coverage through other providers will receive premium assistance for their qualifying employees."[15]

Will a "basic insurance plan" offered through OHCA be a true, low-cost insurance that pays for unpredictable, catastrophic events? Or will it be a much more elaborate plan that encourages excessive spending on routine medical care? The history of SoonerCare – increasing enrollments and expanding benefits – is not encouraging. The result may turn out to be Cadillac coverage that will cover only a relatively few.

Even if private-sector insurance is emphasized, there is still room for error. The state should not, for example, limit the value of the employer subsidies through excessive regulation. If, as Secretary Adelson says, "our hope is that we will be able to partner with the private market,"[16] the success of this proposal depends on letting the market be the market. If it becomes an avenue for increasing insurance regulation, it will only contribute to the problem of uninsurance.

In fact, the state ought to consider loosening many of the regulations it already has in place on private-sector insurance. Government rules contribute to the cost of premiums, pricing them out of the reach of small businesses and low-wage earners.

Mandated benefits, for example, contribute to the cost of insurance, ranging anywhere from 4 percent to 22 percent, depending on the state.[17] (Under mandates, a policy must pay for everything from hair transplants to infertility treatments.) Of small employers surveyed nationwide, 20 percent mentioned mandates as the reason they did not offer insurance.[18] Here in Oklahoma, legislation to add to the number of mandated benefits has been considered by the current legislature. If tax dollars are funneled through a state program, the motivation for special interest groups to lobby for more mandated benefits will only increase.

We Need Another Way

Private insurance is to be preferred over Medicaid expansion. But in the long run, more fundamental reform is required. For example, people should not have to change their health plans and doctors and so forth simply because they change jobs. Much of the work at promoting affordable health insurance needs to be done at the federal level, which currently favors employer-paid insurance through $137 billion worth of tax deductions.[19]

There is still room for the state to act, however. Oklahoma could use its offices to promote the availability of the federal Health Coverage Tax Credit, which is available to people who have lost their jobs through foreign competition. Nationally, only five percent of those eligible take advantage of it, perhaps because they have not heard about it.[20]

The state could also publicize the value of Health Savings Accounts, which greatly improve on Medical Savings Accounts. The contributions to and earnings in these accounts are tax-

free, as are withdrawals for medical expenses. Coupled with a catastrophic policy, HSAs are a way for people to buy affordable coverage and build a healthy nest egg. If Oklahoma uses HSAs whenever it spends taxpayer dollars – whether for public employees or for those enrolled in public programs – both the taxpayer and the patient win.

Rather than spending new or existing money on yet another government program, or sending the money to employers, Oklahoma could give targeted individuals refundable tax credits, which they could use to buy individual insurance policies. These could be a powerful adjunct to HSAs. The idea behind HSAs, by the way, is nothing new. It's simply giving people more control over money spent on their health care. Oklahoma already uses vouchers in Medicaid. It has Home and Community-Based Services (HCBS) waivers for 20,000 people.[21] As shown by similar "Cash and Counseling" experiments in Florida and other states, an educational component to the voucher approach is essential.

Conclusion

In a world of voluntary choice, universal coverage is unrealistic. The governor's proposal lives within that world by using, to some extent, employer-based insurance. That's the good news. The bad news is that the plan may still involve enrolling people in the statist quo – Medicaid. Allowing the OHCA to ensnare more patients and physicians in its red tape is a bad idea.

The model of third-party-paid-and-administered health care, in place since World War II, has led to excessive spending and extensive and expensive insurance regulations. It has also brought soaring premiums that price out of the market many people who do not work for large companies. Those who do not work are eligible for a Medicaid system that ill-serves both patients and medical providers. Low-income wage earners, meanwhile, are too poor to afford insurance, but too well off for Medicaid. Better insurance coverage treatment for both groups lies not in expanding an unreformed public program. The better path is a combination of policies that promote basic insurance, respect personal choices, and encourage saving for routine, predictable expenses.

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Endnotes

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