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Giving Health Care a Chance to Evolve

By ROBERT H. FRANK

INTRADE, an online betting site with an excellent record for predicting events, pegged the odds of the [Supreme Court](#) overturning [President Obama's health care overhaul law](#) at almost 80 percent.



When the court affirmed the law's constitutionality on Thursday, many forecasters were astonished. The ruling came by the slimmest of margins and was defended, in places, by deeply flawed economic reasoning. But it has paved the way for an orderly rehabilitation of America's gravely dysfunctional health care system.

It was a complicated case, in part because the reform legislation itself was seriously flawed. The law's drafters could have proposed a simpler and more efficient system — something more like the single-payer systems that have been adopted by most industrial countries.

But that would have meant abandoning the nation's current system of employer-provided health plans. That these plans are a catastrophically bad model for providing health care was beside the point. Forcing voters to abandon a status quo that most of them say they like would have doomed more ambitious proposals from the outset.

The important point is that because health reform had to be built atop the current system, each feature of the legislation upheld by the court was an essential precondition for that system's improvement.

Nearly every economic analysis of the health care industry rests on the observation that individually purchased private [insurance](#) is not a viable business model for providing medical services. Such insurance is broadly affordable only if most policy holders are healthy most of the time.

The fundamental problem is that insurers can often identify specific people — like those with serious pre-existing conditions — who are likely to need expensive care. Any company that issued policies to such people at affordable

rates would be driven into bankruptcy, its most profitable customers lured away by competitors offering lower rates made possible by selling only to healthy people.

Economists call this the adverse-selection problem. Because of it, unregulated private markets for individual insurance cannot accommodate the least healthy — those who most desperately need [health insurance](#).

Many countries solve this problem by having the government provide health insurance for all. In some, like Britain, the government employs the care providers. Others, like France, reimburse private practitioners — as does the [Medicare](#) program for older Americans.

The United States probably would have adopted one of those models had it not been for historical accidents that led to widespread adoption of employer-provided plans in the 1940s. To control costs of [World War II](#) mobilization, regulators capped growth of private-sector wages, making it hard for employers to hire desperately needed workers.

But because many fringe benefits weren't capped, employers spied a loophole: they could offer additional benefits, like health insurance. Its cost was deductible as a business expense, and in 1943 the Internal Revenue Service ruled that its value was not taxable as employee income. By 1953, employer health plans covered 63 percent of workers, versus

only 9 percent in 1940.

Eligibility for favorable tax treatment hinged on the plans being available to all employees, a feature that mitigated a serious defect. Although hiring workers with pre-existing conditions meant paying higher premiums, tight labor markets made many employers willing to bear that cost, because insurance was an effective recruiting tool.

Employer plans are thus a significant improvement over individual private insurance, but they are still deeply flawed. If you lose your job, you can lose your coverage. This problem has been cast into sharp relief by the persistent high unemployment in the wake of the financial crisis. In no other industrial country do we see communities organizing bake sales to help defray the cost of an uninsured neighbor's [cancer](#) treatments.

The decline in the number of workers covered by employer plans began long before the recent crisis. According to [census data](#), 65 percent of workers had employer-backed plans in 2000, but only 55 percent were covered by 2010. This decline has been driven in part by rapid increases in health care costs.

Economists agree that no matter how those costs are apportioned on paper, any money spent on employer-sponsored plans ultimately comes at the expense of wages.

Real wages have risen little in recent decades, and the prospect that they will keep stagnating portends further erosions in coverage. So even if we ignore the inherent failings of the employer model, it simply won't be able to deliver broad health coverage.

Modeled after proposals advanced by the Heritage Foundation, the American Enterprise Institute and other conservative research organizations in the 1990s, the main provisions of the president's health care law were intended to eliminate the most salient problems associated with the current system.

One provision establishes insurance exchanges, where participating companies must offer coverage to all customers, irrespective of pre-existing conditions. Another imposes a financial penalty on those who fail to obtain coverage — the individual mandate. And a third prescribes subsidies to make insurance more affordable for low-income families. (The Massachusetts plan engineered by Mitt Romney as governor in 2006 took an almost identical approach.)

WITHOUT each of its three main provisions, the law won't work. The individual mandate, of course, is the most debated. Critics denounce it as a violation of our liberty. Paradoxically, the slim majority on the court that affirmed the mandate's constitutionality seemed to embrace that view,

likening the mandate to requiring citizens to eat broccoli for their own good. The court defended the constitutionality of the mandate by calling it a tax rather than a penalty.

But that interpretation will strike many economists as a misreading of the mandate's purpose. It isn't that people should buy health insurance because it would be good for them. Rather, failure to do so would cause significant harm to others. Society will always step in to provide care — though in much more costly and often delayed and ineffective forms — to the uninsured who fall ill. To claim the right not to buy health insurance is thus to assert a right to impose enormous costs on others. Many legal scholars insist that the Constitution guarantees no such right.

No one can be sure how the law will play out. But its critics would be unwise to assume that it would have been easy to draft superior legislation had the law been overturned. Any new attempt would have taken the employer-based system as a starting point.

What's important now is how the health care sector will evolve under the new framework. And here, there are grounds for optimism. While the effects of the court's [Medicaid](#) restrictions aren't entirely clear, the law will certainly extend coverage to tens of millions who now lack it. In addition, new insurance exchanges will provide a broader array of care options. Increased competition tends to hold

costs in check, even while enhancing service quality, and there's no reason to expect the situation in health care to be different.

Many scholars have argued that private, nonprofit institutions like the Mayo Clinic are the most effective model of providing care, and not only because they can better coordinate across many specialties. They are also less likely than traditional fee-for-service practices to prescribe unnecessary tests and procedures. Given those advantages, such institutions, or ones that mimic them, might have spread even without health care reform. After all, employers have an interest in providing cost-effective care for their workers.

But no matter which model proves most effective, it is likely to spread faster in the competitive environment established by the insurance exchanges.

The new law will hardly be the final word on these issues. Though it takes tentative first steps on cost control, government budgets will be decimated unless we do much more to reduce inflation in medical services. And in Medicare, many tough decisions remain to be made about end-of-life interventions, and whether Medicare should become an optional form of coverage for those who aren't elderly.

The point worth celebrating is that last week's ruling will at last enable our distinctly dysfunctional health care system to evolve into something better.

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