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ObamaCare Is All About Rationing

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Although administration officials are eager to deny it, rationing health care is central to President Barack Obama's health plan. The Obama strategy is to reduce health costs by rationing the services that we and future generations of patients will receive.

The White House Council of Economic Advisers issued a report in June explaining the Obama administration's goal of reducing projected health spending by 30% over the next two decades. That reduction would be achieved by eliminating "high cost, low-value treatments," by "implementing a set of performance measures that all providers would adopt," and by "directly targeting individual providers . . . (and other) high-end outliers."

The president has emphasized the importance of limiting services to "health care that works." To identify such care, he provided more than $1 billion in the fiscal stimulus package to jump-start Comparative Effectiveness Research (CER) and to finance a federal CER advisory council to implement that idea. That could morph over time into a cost-control mechanism of the sort proposed by former Sen. Tom Daschle, Mr. Obama's original choice for White House health czar. Comparative effectiveness could become the vehicle for deciding whether each method of treatment provides enough of an improvement in health care to justify its cost.

In the British national health service, a government agency approves only those expensive treatments that add at least one Quality Adjusted Life Year (QALY) per £30,000 (about $49,685) of additional health-care spending. If a treatment costs more per QALY, the health service will not pay for it. The existence of such a program in the United States would not only deny lifesaving care but would also cast a pall over medical researchers who would fear that government experts might reject their discoveries as "too expensive."

One reason the Obama administration is prepared to use rationing to limit health care is to rein in the government's exploding health-care budget. Government now pays for nearly half of all health care in the U.S., primarily through the Medicare and Medicaid programs. The White House predicts that the aging of the population and the current trend in health-care spending per beneficiary would cause government outlays for Medicare and Medicaid to rise to 15% of GDP by 2040 from 6% now. Paying those bills without raising taxes would require cutting other existing social spending programs and shelving the administration's plans for new government transfers and spending programs.

The rising cost of medical treatments would not be such a large burden on future budgets if the government reduced its share in the financing of health services. Raising the existing Medicare and Medicaid deductibles and coinsurance would slow the growth of these programs without resorting to rationing. Physicians and their patients would continue to decide which tests and other services they believe are worth the cost.

There is, of course, no reason why limiting outlays on Medicare and Medicaid requires cutting health services for the rest of the population. The idea that they must be cut in parallel is just an example of misplaced medical egalitarianism.

But budget considerations aside, health-economics experts agree that private health spending is too high because our tax rules lead to the wrong kind of insurance. Under existing law, employer payments for health insurance are deductible by the employer but are not included in the taxable income of the employee. While an extra $100 paid to someone who earns $45,000 a year will provide only about $60 of after-tax spendable cash, the employer could instead use that $100 to pay $100 of health-insurance premiums for that same individual. It is therefore not surprising that employers and employees have opted for very generous health insurance with very low copayment rates.

Since a typical 20% copayment rate means that an extra dollar of health services costs the patient only 20 cents at the time of care, patients and their doctors opt for excessive tests and other inappropriately expensive forms of care. The evidence on health-care demand implies that the current tax rules raise private health-care spending by as much as 35%.

The best solution to this problem of private overconsumption of health services would be to eliminate the tax rule that is causing the excessive insurance and the resulting rise in health spending. Alternatively, Congress could strengthen the incentives in the existing law for health savings accounts with high insurance copayments. Either way, the result would be more cost-conscious behavior that would lower health-care spending.

But unlike reductions in care achieved by government rationing, individuals with different preferences about health and about risk could buy the care that best suits their preferences. While we all want better health, the different choices that people make about such things as smoking, weight and exercise show that there are substantial differences in the priority that different people attach to health.

Although there has been some talk in Congress about limiting the current health-insurance exclusion, the administration has not supported the idea. The unions are particularly vehement in their opposition to any reduction in the tax subsidy for health insurance, since they regard their ability to negotiate comprehensive health insurance for their members as a major part of their raison d'être.

If changing the tax rule that leads to excessive health insurance is not going to happen, the relevant political choice is between government rationing and continued high levels of health-care spending. Rationing is bad policy. It forces individuals with different preferences to accept the same care. It also imposes an arbitrary cap on the future growth of spending instead of letting it evolve in response to changes in technology, tastes and income. In my judgment, rationing would be much worse than excessive care.

Those who worry about too much health care cite the Congressional Budget Office's prediction that health-care spending could rise to 30% of GDP in 2035 from 16% now. But during that 25-year period, GDP will rise to about $24 trillion from $14 trillion, implying that the GDP not spent on health will rise to $17 billion in 2035 from $12 billion now. So even if nothing else comes along to slow the growth of health spending during the next 25 years, there would still be a nearly 50% rise in income to spend on other things.

Like virtually every economist I know, I believe the right approach to limiting health spending is by reforming the tax rules. But if that is not going to happen, let's not destroy the high quality of the best of American health care by government rationing and misplaced egalitarianism.

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