‘All or nothing’

MIT experts on the future of health-care reform: Congress should still think big

Peter Dizikes, MIT News Office

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Just over a week ago, passage of a landmark federal health-care bill seemed a dead certainty. But the flip of a single U.S. Senate seat has changed all that, leaving the Democratic Party highly uncertain about how — or whether — to proceed. Given the current flux in Washington, a panel of MIT health-care experts assembled yesterday to assess the situation, often hammering home the idea that political half-measures will yield little in tangible health-care results.

“You can’t break this bill apart and have it work,” said MIT economist Jonathan Gruber. “It’s all or nothing at this point. The Democrats, and essentially the president, have to decide if they’re willing to go for it all, or are willing to live with nothing.”

First, though, Gruber, a central architect of the Massachusetts health-care system that has served as the model for the congressional legislation, acknowledged his extreme chagrin over the political reversal that accompanied Massachusetts Republican Scott Brown’s victory last week in the special election to replace the late Sen. Edward M. Kennedy. “My kids are like, ‘Why are you so sad, daddy?’ ”said Gruber, speaking at The Stata Center. “I explained, ‘Imagine you worked on a term paper for a year, and you were about to hand it in, when someone turned off your computer and you lost all your work.’ ”

Brown’s victory has caused multiple fractures among Capitol Hill Democrats. Some legislators want to drop the health-care effort entirely; others say Congress should only pass popular portions of it, such as making it illegal to deny insurance based on pre-existing conditions; and still others want to reconcile the existing, separate health-care bills already passed by the House and Senate.

Gruber made it clear he favors the last position, telling the audience the health-care plan is like “a three-legged stool,” and “doesn’t work unless you have all three legs.” Those three pieces are reform of insurance markets (including banning those denials of coverage based on pre-existing conditions), the existence of an individual mandate requiring everyone to have insurance, and subsidies to make insurance affordable for low-income people.

For instance, simply allowing people with pre-existing conditions to sign up for insurance, Gruber argued, would be ineffective by itself. In that scenario, more people with pre-existing conditions would have coverage, rates would rise and lead healthy people to drop out of the insurance markets, and to compensate for those healthy people dropping out, insurance companies rates would raise rates further.

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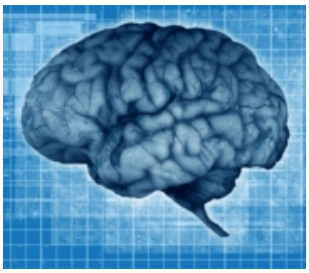

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MIT economist Amy Finkelstein discusses the obvious and hidden value of universal health-care coverage. Photo: Patrick Gillooly

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Yet even if a large-scale health-care bill passes, cutting health-care costs remains the "$2 trillion question," said panelist Joseph Doyle, an economist at the MIT Sloan School of Management. Many observers have noted in the last year that regional disparities in health-care expenditures around the U.S. have nonetheless yielded similar patient-care results. But Doyle's own research in Florida suggests otherwise. The city of Fort Lauderdale spends 30 percent more on heart patients than West Palm Beach, he stated, but has a mortality rate that is 30 percent lower. Instead, Doyle said, we would perhaps be better served by, among other things, incentives for hospitals to avoid care problems like re-hospitalization for the same illnesses: "Nobody likes to go back to the hospital."

Still, as MIT economist Amy Finkelstein pointed out in her remarks, the value of universal health-care coverage goes beyond the medical services rendered. The introduction of Medicare in 1965, a subject she has studied in detail, produced "a dramatic decline in the share of the elderly with large out-of-the-pocket payments," Finkelstein said, meaning that it left more senior citizens in better financial shape than they would have been without Medicare.

Moreover, Finkelstein argued, Medicare went hand-in-hand with an increase in technological innovation in the health-care sector (from procedures to devices to drugs), a scenario that could be repeated if a serious bill is passed by this Congress. "If you have insurance, the idea that whatever happens to people who are uninsured isn't going to affect you is a very misleading notion," Finkelstein explained. "When you increase the share of the population with insurance, you increase the market size for these technologies, and you almost surely increase the pace of development of these technologies in the future."

But will any bill at all emerge from Congress? Political scientist Andrea Louise Campbell sounded a skeptical note. "The American political system is very status-quo-oriented," she said, with a lot of "veto points," such as the current Senate convention that the Democrats need 60 votes to pass the legislation.

Those 60 votes would not be necessary if Congress elected to use the reconciliation process, which would essentially mean that the House would pass the Senate bill, then have both branches of Congress modify it, which would require just 51 Senate votes in the end. Yet as Campbell noted, that would still be difficult: 47 Democratic House members represent districts that the Republican nominee, Sen. John McCain, carried in the 2008 presidential election, and may be unwilling to back any health-care bill at this point.

Alternately, Campbell suggested, those representatives might prefer to pass popular-sounding segments of the health-care bill, like lifting the pre-existing conditions blockage, even if the policy results seem dubious. "What might be feasible politically, might be disastrous economically," Campbell said. "They might pick out certain features without the counterbalancing features that make the whole package work. That might end up accelerating the unraveling of the system."