

Health Care and Inequality

Greg Moody, Director
Governor's Office of Health Transformation
Center for the Study of American Democracy
Kenyon College

April 11, 2014

www.HealthTransformation.Ohio.gov

I appreciate the invitation to join you.

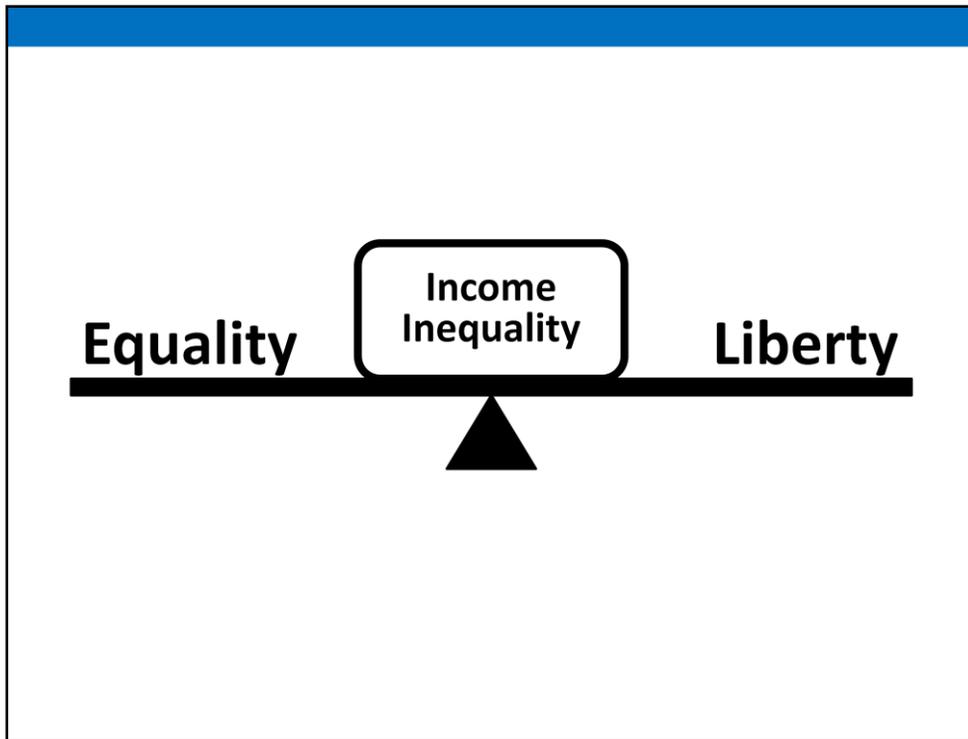
In addition to the nice things you said, I'm also a neighbor – we have a little farm just South of here on Hopewell Road. My kids have grown up on Middle Path.

I'm grateful to Kenyon and the Center for the Study of American Democracy for this opportunity to escape the day-to-day details of running government and “contemplate the timeless questions and fundamental principles that shape our democracy.”

I've been wrestling with questions about what is right to do in health care since 1992 when I was given my first health care assignment on the House Budget Committee in DC by then-Chairman John Kasich.

Now he's Governor and here we are in Ohio, still wrestling with what is right to do.

So where to begin? There's so much ...



Over the past two days, you've been wrestling with what is right to do in this equation.

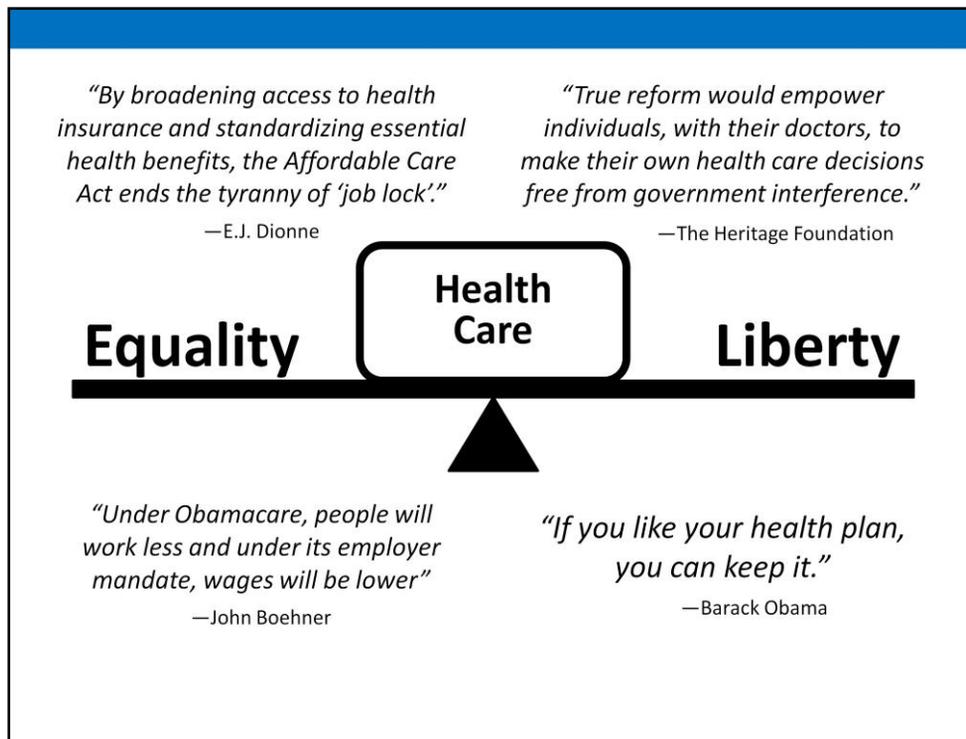
Liberty. The freedom of individuals to act, to make choices, take risks, and take responsibility for those actions – or not.

In the extreme, Liberty can tempt us toward avarice and greed, but these are tempered by our expectations for Equality – that certain rights will be protected, and everyone has a fair chance at a good life and an opportunity to participate in the benefits of society. In the extreme, Equality can average out distinction, and replace human potential with comfort.

The left talks about “rights” and the right hears “takers.”

And the right talks about free enterprise and the left hears “one percent.”

But our democracy is supposed to allow differences like that, and to balance these concepts so that something like justice is the result.



The same is true for health care – how do we balance competing ideas about what is just?

Is it to establish health care as a right, to define its terms, and ensure equal access as a public good?

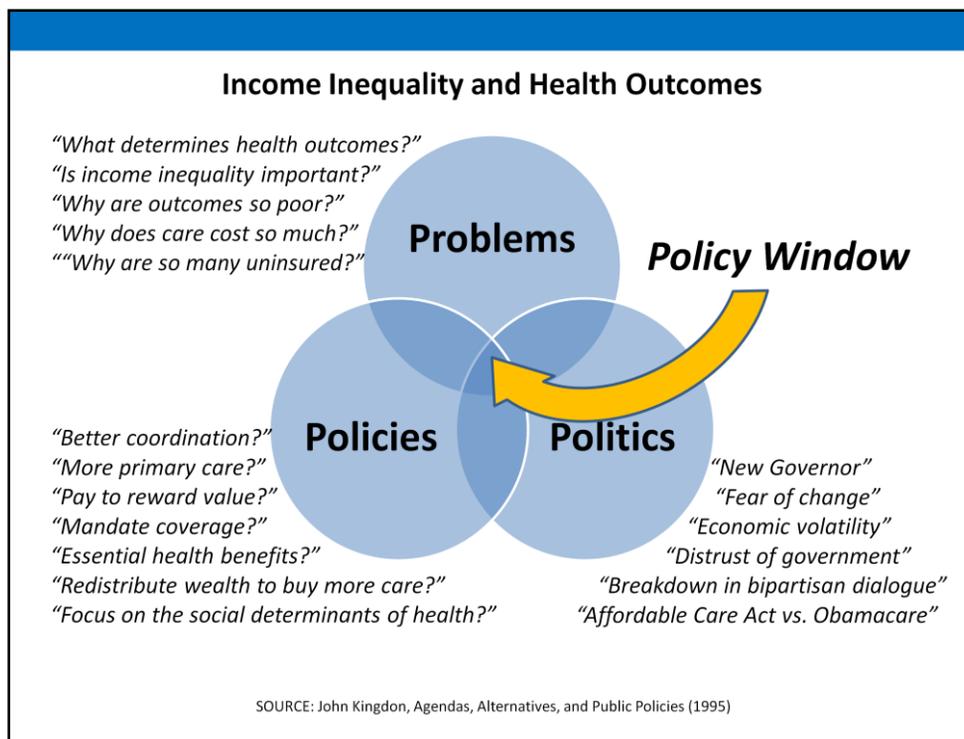
If we go too far, does it create unintended consequences, like an incentive to work less?

Is the purpose instead to empower individuals to make their own health care decisions, good and bad, without interference?

And how far do we take that – if you like what you've got, should you keep it no matter the impact on others?

Embedded in these positions is a complicated set of problems, hints at policy solutions, and politically-loaded choices – but they are in tension and the path forward is not clear.

It's just too complicated – we need to sort this out.



There is such a gap between “what we should do” and “what gets done.”

In my experience, the chance of getting something done goes up when these spheres are in harmony – action occurs in the overlap.

Is there a compelling problem? Does income inequality impact health outcomes? Why are health outcomes so poor?

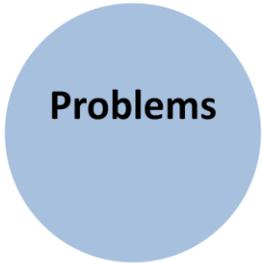
Is there a fix? Do we change care delivery? Or how we pay for care? Or how we use care?

And what do our politics allow? And will politics allow anything at all?

Back to the question of what is right to do, and our theme of income inequality, let’s look at an example in each sphere.

First, this issue of compelling problems ...

Income Inequality and Health Outcomes



Problems

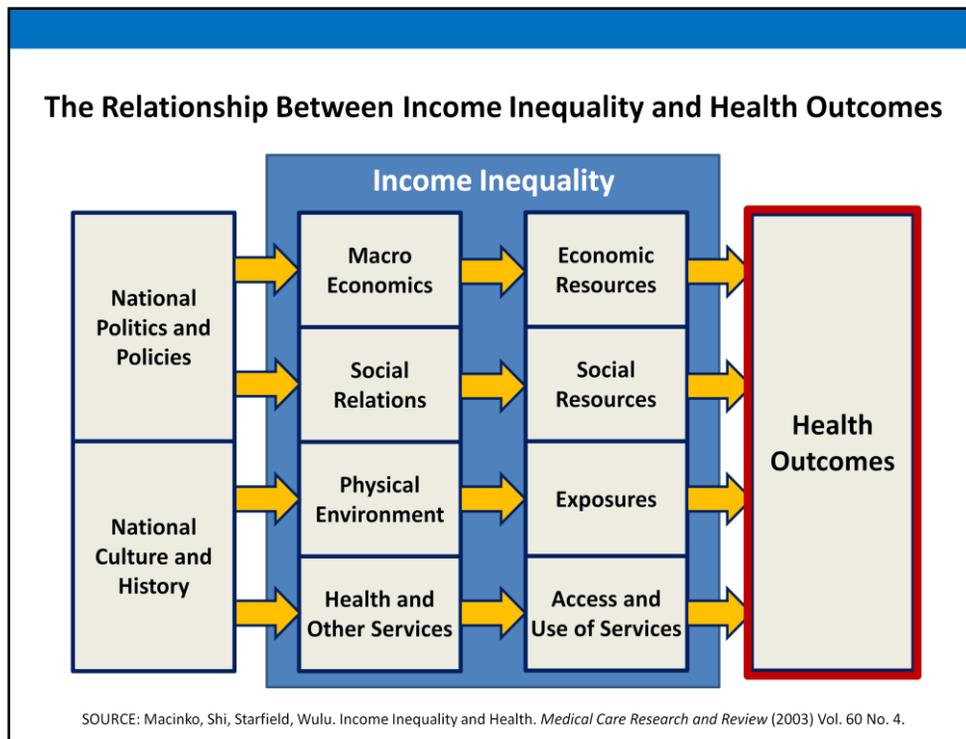
“Inequality in education, income and occupation exacerbates the gap between the health “haves” and “have-nots”

SOURCE: Nancy Adler and Katherine Newman. Socioeconomic Disparities in Health: Pathways and Policies. Health Affairs (2002).

Is this a problem – does income inequality exacerbate the gap between the health “haves” and “have-nots”?

It’s an important question – if we understand the relationship between inequality and health status, then we have a shot at making changes that might improve health outcomes.

Bear with me now, but to sort this out we need one more level of detail ...



Your discussion over the past few days has explored how our national politics and policies, culture and history impact income inequality.

And in turn, income inequality impacts our experience in society – what we can buy, who we know, where we live, and also what health care we have access to and how we use those services.

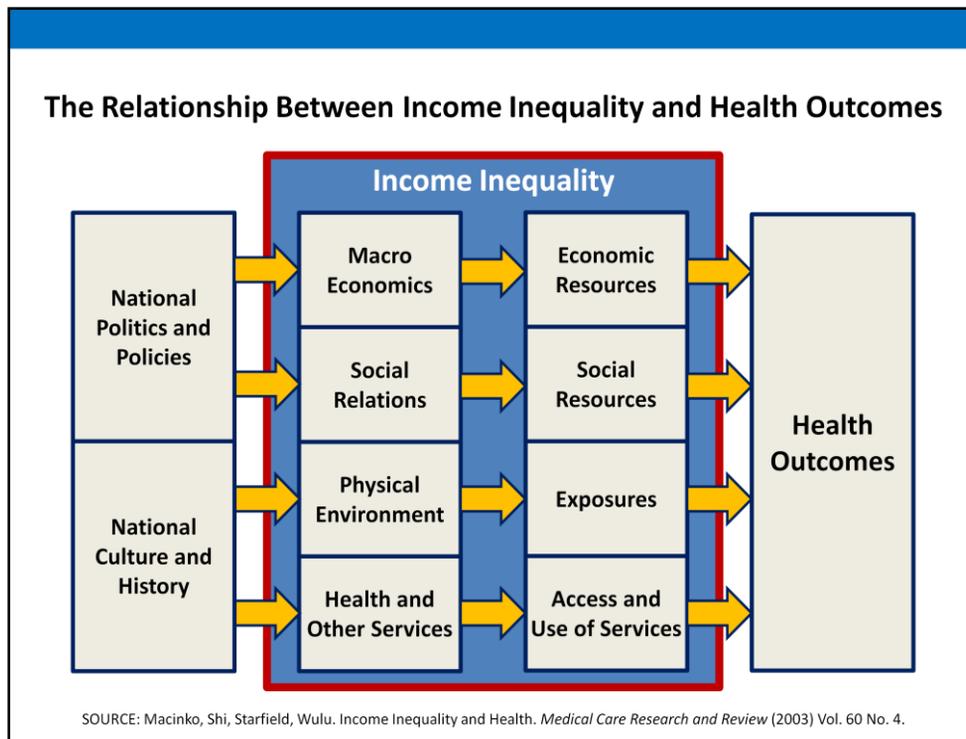
All of these income-sensitive factors – what I show here in the blue – have an impact on health outcomes.

Health outcomes are things like life expectancy, mortality, mental health and others.

The bottom line on health outcomes is that the United States excels at “rescue medicine” – we pull out the stops when you’re really sick.

But we do a poor job on the front end to prevent illness and promote wellness.

As a result, despite twice outspending every other industrial country, the United States ranks 26th in life expectancy, 31st in infant mortality, and so on.



Many of the factors that prevent illness and promote wellness are in this territory – it includes health care services and how we use those services, but it also includes other social determinants of health.

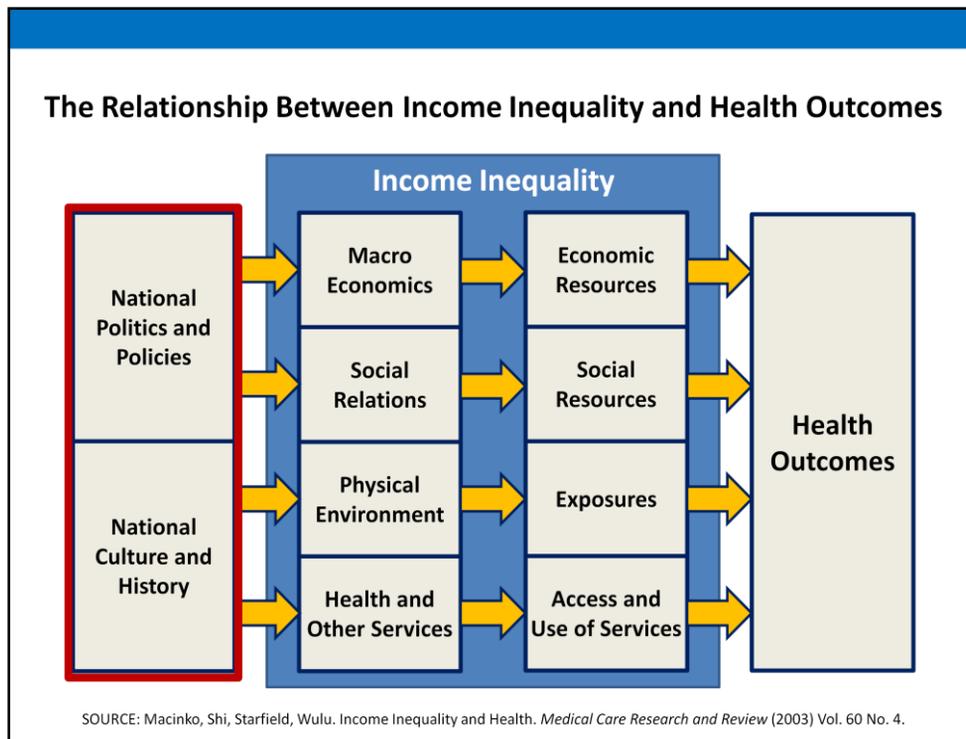
The overall economic environment – employment, cost of living – impacts our individual economic circumstances, including income, which then opens or closes doors to healthy social relations and healthy physical environments.

Social relations include class structure and community-level social capital, which turns out to very important to health outcomes in terms of our ability to access social support networks and cope when things go wrong.

Physical environment – where we live, the air we breath, characteristics of our community – these determine our exposure to external causes of injury, and also to unhealthy behaviors like drinking and smoking.

Finally, there is the human services infrastructure – health care but also education and welfare programs, and the extent to which individuals are able to access and use those services.

Everything in this box is interrelated, and we won't try to sort that out, but the key point is that a lot more than just health care determines health outcomes, and any meaningful improvement in health outcomes will require wading into these social determinants of health.



How far we can wade in is determined by our culture and history, and how those translate into national politics and policies.

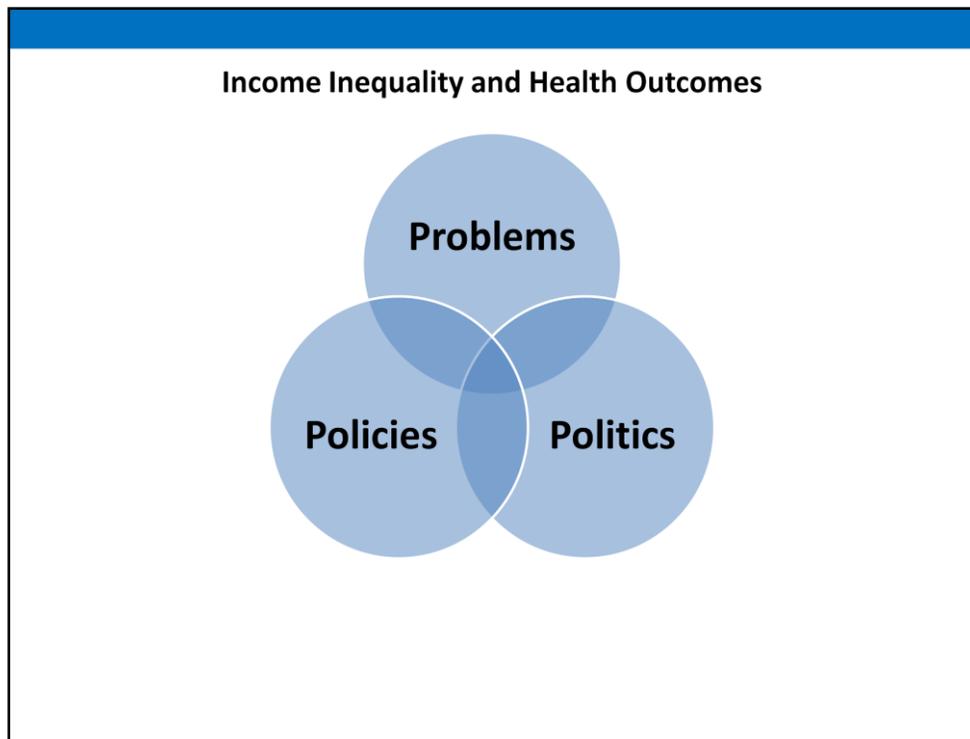
Examples include systems of governance, cultural attitudes toward welfare and charity, and historical patterns of social relations.

If poor health outcomes are a problem – and they are – our ability to act depends on how far our culture and history and politics will allow us to go.

President Obama’s Affordable Care Act is a complicated example of this.

To address the problem of poor health outcomes, the ACA proposed to increase access to care, but to do that it required one of the greatest income redistributions since the Great Society.

As a policy, it pushed the limits – which is why four years after enactment it’s still making headlines.



As we look at the relationship between income inequality and health outcomes, if it's a problem that income inequality exacerbates the gap between the health "haves" and "have-nots," let's take a look at the policies the President proposed to change that result.

Income Inequality and Health Outcomes

“The Affordable Care Act may do more to change the income distribution than any other recently enacted law”

Policies

SOURCE: Henry Aaron and Gary Burtless. Potential Effects of the Affordable Care Act on Income Inequality. *The Brookings Institution* (January 2014).

Specifically, this idea that the Affordable Care Act may do more to change the income distribution than any other recent enacted law.

This was not the stated objective – and had it been, the ACA might have run afoul of the culture and politics of the time and not made it across the finish line.

But in actual effect, the ACA will change the net incomes of Americans at all income levels.

How the ACA redistributes income

- Imposes new rating and pricing restrictions on health insurance markets that redistribute cost from healthy to sick and young to old
- Provides a federal subsidy to offset the cost of health insurance for low-income families, and allows states to expand Medicaid coverage for very low-income adults
- Uses the tax code to compel citizens to purchase and employers to offer health insurance – the Internal Revenue Service is the mechanism for redistribution

Here's how that works:

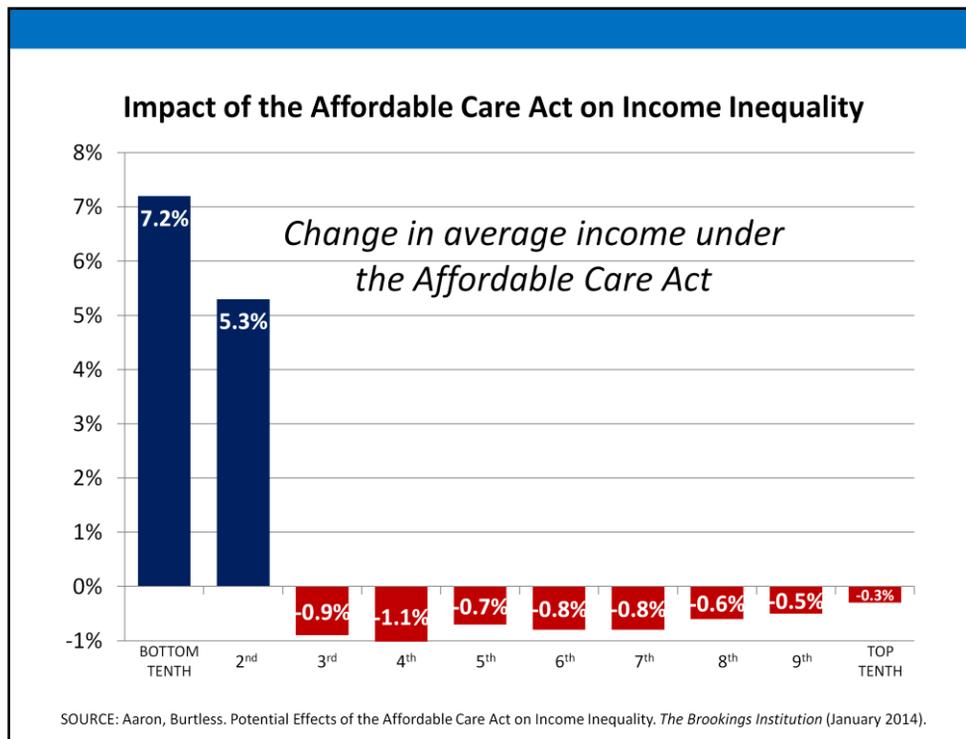
The Affordable Care Act redistributes costs from individuals who are healthy to those who are sick – and generally that means young to old.

It provides tax credits to help make private health insurance affordable for families with annual income up to \$94,000.

It requires employers to offer affordable health insurance to their full-time employees, and penalizes non-poor adults who don't take it.

The enforcement mechanism for all of this – the Tea Party loves this – is through the Internal Revenue Service.

The extent to which the ACA will redistribute income is the subject of a recent report from The Brookings Institution, and it looks like this ...



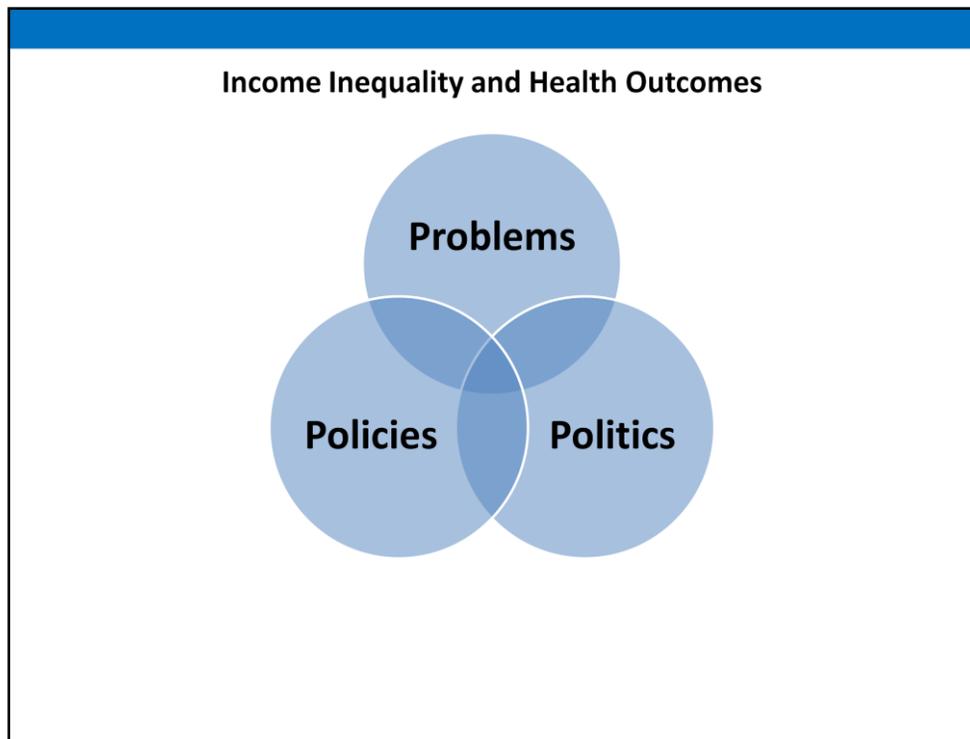
Henry Aaron and Gary Burtless project that incomes in the bottom one-fifth of the distribution will increase almost six percent – more than seven percent in the bottom one-tenth.

These are averages – most people already have insurance coverage that will be left largely unaffected by reform, and those who gain subsidized insurance will see bigger percentage gains in their income.

On net and under the broadest income measure, the gains and losses cause small proportional drops in income for Americans in the top three-quarters of the income distribution which offset the larger proportional gains obtained by Americans in the bottom quarter of the distribution.

Is this result a good thing or a bad thing?

.



It all depends – is the problem so urgent it merits such a dramatic policy response? Is it the right policy response?

These are very subjective questions that get sorted out and prioritized – and polarized – in the political sphere ...

Income Inequality and Health Outcomes

“We’re answering the call of history”

—Barack Obama

“It’s Armageddon”

—John Boehner

Politics

Obamacare either answers the call of history or brings about the end of times.

Really, we should all be concerned by the talking-point redux of the health care debate. It’s too complex for the banter our news outlets require and, as a result, quality ideas and looney tunes somehow receive equal attention.

We need to lean into complexity, research the problem, put policy options into competition with each other, and then choose a course our politics allow, or can be persuaded to allow.

Here I’ll use a recent example in Ohio – Governor Kasich’s decision to extend Medicaid coverage to more low-income adults.

Let’s start with some context on Ohio ...

2011 Ohio Crisis

- \$8 billion state budget shortfall
- 89-cents in the rainy day fund
- Nearly dead last (48th) in job creation (2007-2009)
- Medicaid spending increased 9% annually (2009-2011)
- Medicaid over-spending required multiple budget corrections
- Ohio Medicaid stuck in the past and in need of reform
- More than 1.5 million uninsured Ohioans (75% of them working)

For those of you who don't know him, John Kasich is a conservative Republican. He was the last budget chairman to balance the budget in Washington DC.

When he came into office as Governor of Ohio three years ago the state had an 8 billion dollar budget shortfall and only 89 cents in its rainy day fund.

We were nearly dead last in job creation.

Medicaid – that's the government health care program that covers one in five Ohioans and nearly half of all births – was growing nine percent every year.

And 1.5 million Ohioans were uninsured.

Not good.

Also, the Supreme Court had not yet made extending Medicaid coverage optional, so we were under a mandate to expand – a mandate we knew would swamp the system unless we got costs and program growth under control.

So three years ago, we launched an aggressive reform agenda that had an immediate effect ...

| 2011 Ohio Crisis | vs. | Results Today |
|--|-----|---|
| <ul style="list-style-type: none"> • \$8 billion state budget shortfall • 89-cents in the rainy day fund • Nearly dead last (48th) in job creation (2007-2009) • Medicaid spending increased 9% annually (2009-2011) • Medicaid over-spending required multiple budget corrections • Ohio Medicaid stuck in the past and in need of reform • More than 1.5 million uninsured Ohioans (75% of them working) | | <ul style="list-style-type: none"> • Balanced budget • \$1.5 billion in the rainy day fund • Ranked 5th in the nation in job creation (2011-2013) • Medicaid spending increased 3% annually (2012-2013) • Medicaid under-spending topped \$950 million (2012-2013) • Ohio Medicaid looks to the future and embraces transformation • Extended Medicaid coverage |

Today Ohio has a balanced budget with \$1.5 billion in the rainy day fund, and that by the way while reducing income taxes, cutting taxes on small businesses in half, and eliminating Ohio's estate tax.

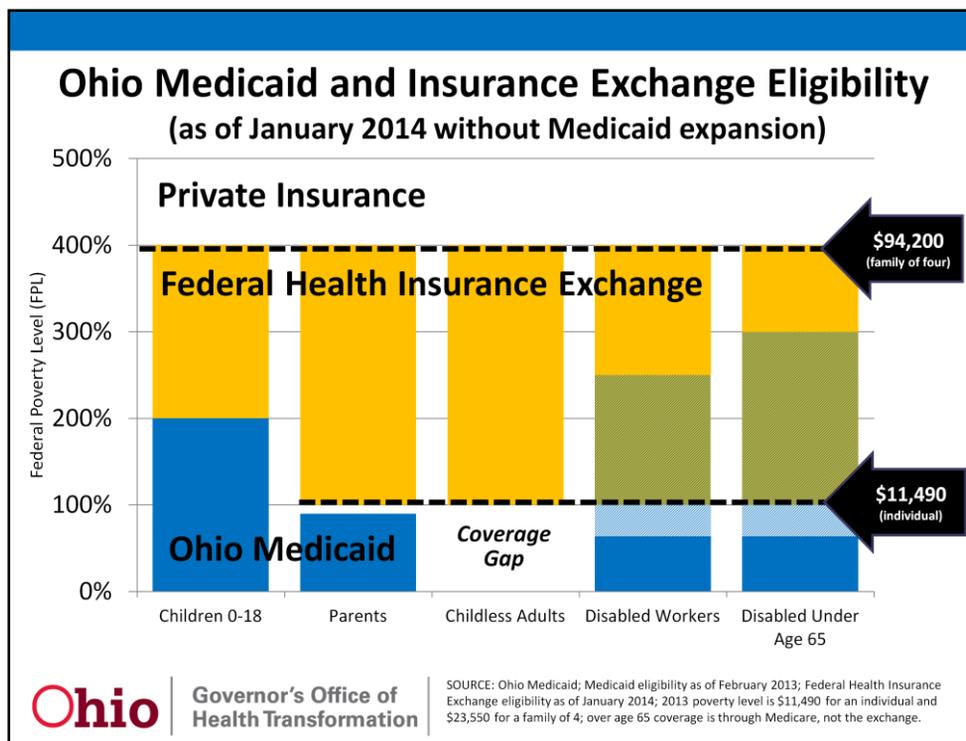
Today Ohio ranks first in the Midwest and 5th in the nation in job creation.

We held Medicaid spending to 3 percent annually and closed our last Medicaid budget almost one billion dollars under budget.

From this position of strength, we were able to consider different options related to extending Medicaid coverage – options that result in more Ohioans having access to health coverage without breaking the bank.

Since October, more than 100,000 uninsured Ohioans have received coverage as a result of the Governor's decision to extend Medicaid coverage.

But it was not easy ...



For Governor Kasich, extending Medicaid coverage was a matter of justice.

As a result of the US Supreme Court ruling, some of our most vulnerable citizens were left exposed to a coverage gap.

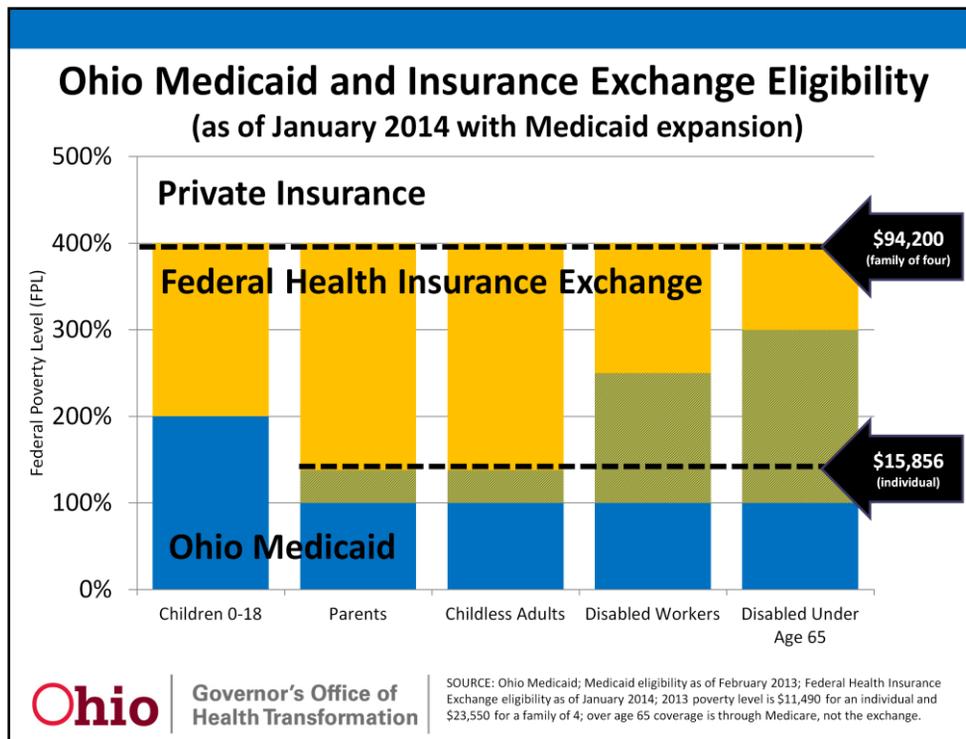
In Ohio, Medicaid covers children up to 200 percent of poverty and parents up to 90 – that’s the blue – but not childless adults.

The federal health insurance exchange will cover citizens with income between 100 and 400 percent of poverty – the yellow.

As a result, our most vulnerable citizens are left in a coverage gap, without access to Medicaid or support on the federal exchange.

In Ohio that gap includes 26,000 veterans. It includes many who work as health care providers for others but don’t themselves have coverage, many over age 55 looking for work but finding it difficult, and some who are unable to work because of mental illness or addiction but they have no regular source of care to recover.

We wouldn’t have designed a coverage program that looks like this, but it was the hand we were dealt and – knowing the political consequences but recognizing the pragmatic opportunity – Governor Kasich decided it is right to cover these groups, so we did.



We eliminated the coverage gap, but not without some drama.

A majority of Ohio’s House and Senate supported expansion, but moderate Republicans were concerned about a Tea Party primary if they took that vote, so expansion never came up for a vote.

We corrected that somewhat undemocratic result by taking the decision to the Ohio legislature’s controlling board ...



Controlling Board testimony to extend Medicaid coverage, Oct. 21, 2013

The Controlling Board is a subcommittee of the legislature with the interesting authority to adjust the state's federal appropriations.

Because the expansion is 100 percent federally funded for the first three years, we only needed 4 out of 7 controlling board votes to expand, and we got 5.

And the Ohio Supreme Court later upheld our authority to act as we did.

Fancy rooms like this I think match most American's view of how politics operates, but it's a misleading image.

Real problems, real policy development, and political strategy is more of a roll-up-your-sleeves activity.

To walk into this room ...

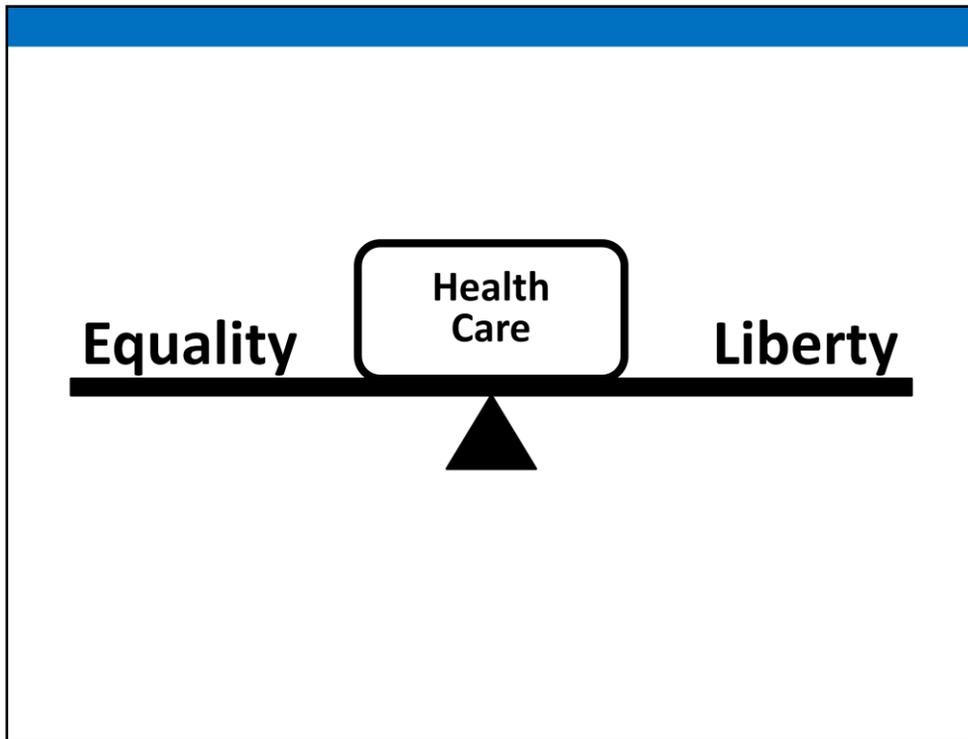


Governor Kasich's policy team preparing for Controlling Board, Oct. 16, 2013

... you first have to sit in this room for hours, and days, and months.

To do that – to be willing to do that – you have to connect it to something you believe.

And that brings us back around to where we started this conversation.



I'm still wrestling with what is right to do and always will.

Where do we calibrate the beautiful tension between these great ideas?

Our democracy is designed to wrestle with questions like that.

And the more we can create spaces like this to have that debate, the better.

Thank you.

Resources

- Henry Aaron and Gary Burtless. Potential Effects of the Affordable Care Act on Income Inequality. *The Brookings Institution* (January 2014).
- James Macinko, Leiyu Shi, Barbara Starfield, John Wulu. Income Inequality and Health: A Critical Review of the Literature. *Medical Care Research and Review* (December 2003).
- Nancy Adler and Katherine Newman. Socioeconomic Disparities in Health: Pathways and Policies. *Health Affairs* (2002).
- www.healthtransformation.ohio.gov