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# Block Grants Can Match National Health Care Goals to Local Differences

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Cite as: Mark V. Pauly. 2019. Block Grants Can Match National Health Care Goals to Local Differences. *Health Management Policy and Innovation,* Volume 4, Issue 3.

## Several Healthcare Goals Have Widespread Acceptance in the U.S.

There are some propositions about improvements in the healthcare and health insurance system on which I think there is general agreement in the U.S. Across the political spectrum, there is near universal agreement on three goals for the system: access, in which all people in the country have access to all cost-effective care; high quality and safety; and efficiency such that the real resource costs of providing quality appropriate care be as low as possible and grow as slowly as possible over time.

A fourth goal is not shared by strict single-payer advocates but is held by many moderate Democrats and independents and virtually all Republicans. This is the goal of choice. Because people differ, it is desirable that they have choices about how to receive care and how to finance it along with enough information to make those choices. [1]

The fourth goal—of choice—captures several related objectives.

- **Consumer value:** Choice of provider should reflect individual consumer values.
- **Financial protection:** Choice of insurance should involve adequate financial protection

combined with incentives conducive to the first three goals.

- **Appropriate use:** Incentives should increase the use of care that is underused, relative to the cost-effective quantity, reduce the use of care that is overused, and choose quality that reflects any trade-offs between cost and quality.
- **Cost-based decision-making:** Incentives to patients and providers need to take cost into account when deciding on how to deploy or use resources.

## Proposal

How might these goals be achieved in a way that is politically feasible in a setting where parties disagree at the federal level, and in a way that nevertheless comes close to the efficiency goal of lowest cost to satisfy diverse preferences?

These goals can be achieved *by a system on national healthcare block grants administered by states in a way acceptable to each state's voters, subject to nationally determined performance measures.*

## Differences in Healthcare Preferences

### *Individual preferences*

Individuals as consumers and voters have varying preferences about the values they place on different social healthcare goals—which are high or low priority, which are essential, and which can be sacrificed if compensated by higher achievement of another goal. Many differences in an individual's preferences over health policies are intrinsic to that person and not the result of misinformation, indoctrination, or errors in logic.

Some differences are related to strongly held prior beliefs about what does and does not work well—such beliefs may eventually yield to evidence but not easily. Some of the differences are associated with differences in incomes or command over resources within acceptable bounds and some are due to differences in preferences given income. Some are related to trust of collective choice or the market, as well as values and esthetic preferences on what constitutes an attractive social order.

People with different preferences often cluster geographically. Majorities in some states have a

taste for collective choice and majorities in other states trust individual choices in markets. People also place differences on assessing the probabilities of different outcomes. For example, people differ on how likely they think it is that a for-profit hospital or insurer will provide high quality for the price, or be able to have lower cost levels or growth.

***Differences across states***

Each state in the U.S. has a method by which it makes collective choices, generally beginning with popular vote translated into policies implemented either by the houses of the legislature and the executive. For example, some states elect insurance regulators while others have the executive branch appoint them. While it is well known that no mechanism for aggregating diverse preferences about collective activities can ever be perfect, we will assume these processes are stable in place and are accepted as reflecting the "will of the people" in that geographic area. [2]

We assume that the welfare of the population of any state is of greater concern to voters in that state than the welfare of populations in other states, but that some concern extends to those populations as well. [3] The "external" concern can be expressed through the central or federal government in the form of rules that govern how any funds provided by the federal government to a state are spent. It can also be expressed by federal matching ratios, although that has the risk of subsidizing waste.

## National Objectives That Take Differences into Account

Here we take the simple approach that the views of those in the rest of the country can be captured by specifying for each state a set of metrics or goals—such as proportion uninsured, premiums and subsidies for higher than average risks, use of cost-effective care, and levels or rates of growth in medical spending. Conditional on achieving these goals, the idea is that a state may choose any method to do so and any other program features its democratically elected political decision-makers prefer.

For example, a state may impose price controls on hospitals or doctors as long as doing so does not result in levels of use of care below the cost-effective level, or it may permit risk rating of all insurance as long as it maintains target levels of coverage of all insureds and high-risk insureds.

Choice of metrics to reflect concerns of citizens of other states will need to be made by some agreed upon set of rules. There may be “constitutional” rules to choose metrics that bind all states, but they should be kept to a minimum in terms of number and intrusiveness.

## Mechanisms for Allocating National Healthcare Resources to States

### *Block grants*

Block grant amounts from the national budget, potentially administered by the Department of Health and Human Services, would be made available to each state as long as it met the standards for outcomes. Some formula tied to income, poverty, and current spending would be used to determine the amount of the grant.

The state would have to spend the grant amount on health, but if it spent more it would bear the full cost of that additional spending and recoup the full savings from any spending reduction down to the level of the grant. If a state fell short of those standards, some sanction or mandate would have to be imposed, but it should be one that led closer toward rather than further away from the outcomes.

For example, consider the controversy over work requirements for able-bodied adults under Medicaid. I am sure that a majority of voters in some states are concerned that such a policy might discourage deserving people from applying or remaining in the program while in other states majorities think such a policy will increase the value and dignity of work habits. Let states add requirements if they so choose but evaluate the effect on Medicaid enrollment, uninsureds, health outcomes, and work effort. If a state administers a work requirement such that bureaucratic delays and excessive strictness drive many into being uninsured, it would be penalized, while if other states are willing to count the feeling some have that work is unpleasant and stressful as a medical condition, they would have to spend more of their state’s money to pay for a heavier case load.

### *Criteria and options*

Using block grants conditional on achieving goals and allowing different states to make different calls on how to attain those goals is a better way of resolving controversy than political

argument at the national level which, even if resolved, will necessarily lead to more uniform and less preference-sensitive outcome than permitting states to do different things. This approach is a way to get policy moving toward achieving universally held goals.

**Targeted funds.** The block grant funds and the rules are to apply primarily to low-income people and high-risk or sick people. There is no implication that insurance for the average-risk middle class and above needs to be of major concern because they buy it on their own, ignoring the tax exclusion.

**Insurance options.** States specifically could choose different methods for making insurance more attractive to consumers by taking smaller bites out of consumer budgets relative to the benefits insurance provides. Premiums could be lower for lower risks as a way of offering coverage that provides true expected value to them.

**Political vs. consumer choice.** Grants to states give state politicians more freedom of choice and they might or might not respond by giving consumers more choice. If limiting consumer choice discourages coverage, penalties would kick in, as would occur if offering more choice confused consumers and they declined coverage.

**Consumer value metric.** We need to consider whether a metric for how closely what consumers value matches the insurance and care delivery options they face can be constructed and be included as one of the criteria. If some reasonably large subset of consumers is highly dissatisfied, it could be offered the option of using markets in other states, but it would be better to reward better matching directly.

**Options for high-risk populations.** High risks could be given the option of coverage at premiums reasonably related to their incomes by a number of devices among which states could choose, including high risk pools, reinsurance, requirements for guaranteed renewability at class average premiums, or community rating—subject to the proviso that coverage levels be sustained for lower risks as well as higher risks.

**Financial risk protection.** Protection against financial risk—even if there is no impact on health—by insurance markets in a state could be a performance criterion. The goal would be to protect wealth as well as health.

**Competition.** States could choose to have competitive insurance plans supplied by private commercial firms, private nonprofits, or the public sector as long as regulations and subsidies were neutral and goals of coverage and consumer satisfaction were attained.

**Information sources.** Private or public competitive suppliers of additional information on insurance plans and medical care suppliers could be chosen by states, as well as methods to encourage sellers to provide accurate information on low priced products.

**Insurance and jobs.** Consumers ideally could choose to take jobs that come with particular insurance plans or receive funds they could use to buy individual insurance with the same tax owed either way. States are limited in the extent they can offset the tax exclusion so some federal policy changes may be needed—and many are better than the appropriately maligned "Cadillac tax." [4]

## Looking Forward: Block Grants Suit Bipartisan Objectives

This state-based approach of block grants is consistent with the national structure of the U.S. and with the goals of many stakeholders. Both Republican and Democratic think tanks and policy organizations have been paying more attention to using the states to break at least some of the logjam that seems sure to persist at the federal level.

### References

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