



*American Enterprise Institute for Public Policy Research*

## The Case for Real Health Care Reform

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Every decade or two, politicians embark on a crusade to reform the American health care system. Theodore Roosevelt pushed for national health insurance in his 1912 run for president under the Progressive party banner. More recently, Harry Truman, John Kennedy, Lyndon Johnson, Richard Nixon, Jimmy Carter and Bill Clinton advanced health insurance proposals in presidential campaigns or while in office.<sup>1</sup> Johnson, building on the initiatives of his predecessor, oversaw the creation of Medicare and Medicaid. Clinton's sweeping proposal for national health insurance failed, but he subsequently signed into law a small government insurance program for children.

Barack Obama has taken on the task of major health reform and, unlike his predecessors, he might succeed—in the sense that Congress could pass broad legislation. However, given the views of Congressional leadership, it is less clear that legislative success would yield a sustainable health care system based on values shared by most Americans.

The current health reform debate is the latest battle ground for the hearts and minds of the people. As we learned when that phrase was last popular,<sup>2</sup> tactical victories in health reform will lead to strategic failures if the policy we pursue is fundamentally at odds with the core interests, behaviors, and beliefs of most of our fellow citizens.

### **Symptoms of an Untenable System**

There is little question about the need to reform America's health care system. Each year we spend an increasingly large share of the nation's output for health care, but a significant portion of that spending is likely to have provided little if any value to the well-being of patients.<sup>3</sup> The number of people who do not have health coverage is also growing, despite the vast sums being provided as subsidies for government health programs and private insurance.

If current trends continue, national health spending will nearly double over the next decade—rising from \$2.2 trillion, or 16.2 percent of gross domestic product (GDP), in 2007 to over \$4.3 trillion, or 20.3 percent of GDP, in 2018.<sup>4</sup> Health spending is projected to grow at an average rate of 6.2 percent a year, about 50 percent faster than growth in the economy. By 2035, total health spending could exceed 30 percent of GDP.<sup>5</sup>

This rapid growth in overall health spending is mirrored in the federal budget. In 2007, federal outlays for Medicare and Medicaid totaled \$425 billion, or about 15 percent of the budget.<sup>6</sup> By 2035, those programs could grow to more than a third of total federal spending.<sup>7</sup> Because spending is rising much more quickly than program revenue, the Medicare trust fund for Part A is projected to run short of money in 2017.<sup>8</sup>

These spending figures are cause for alarm. The rapid growth of health spending has placed increasing pressure on everyone's budgets—consumers, employers, and all levels of government. Premiums for health insurance offered through employers have doubled over the last decade, outstripping growth in wages.<sup>9</sup> Between 1999 and 2008, premiums for family coverage purchased through an employer increased 3.5 times faster than workers' earnings.<sup>10</sup> Rising federal health costs threaten to crowd out education, energy, transportation, and other policy priorities. According to the Congressional Budget Office (CBO), "the rate at which health care spending grows relative to the economy is the most important determinant of the country's long-term fiscal balance."<sup>11</sup>

Current health spending trends are fiscally unsustainable for the federal government, and they impose a rising burden on families that will ultimately prove unbearable.<sup>12</sup>

Moreover, increasing costs make health insurance unaffordable to larger numbers of people. Over 45 million people—15.3 percent of the population—were uninsured in 2007, up from 38 million in 2000.<sup>13</sup> Policies that effectively rein in health spending can promote both a more sustainable system and insurance coverage for many more individuals.

Increasing federal insurance subsidies or expanding eligibility for federal programs can make insurance more affordable and accessible to the uninsured. Policies intending to achieve universal coverage could add \$1.8 trillion to the nation's health bill over the next decade.<sup>14</sup> But simply asking others to pay more is ultimately self-defeating unless we find ways to reduce health costs while preserving a high-value health system. As Sen. Max Baucus (D-Mont.), chairman of the Senate Committee on Finance, has written, "excess spending must be eliminated and dollars put to better use, not only to correct the imbalances of the current health system, but to offset the high costs of much-needed comprehensive reform."<sup>15</sup>

Although much public attention has focused on expanding coverage for the uninsured, that goal is tied to our efforts to reform the delivery system and to establish a responsible financing system that is sustainable into the future. There are two basic ways to finance a reformed health system: raise revenue or reduce health spending.<sup>16</sup> We will undoubtedly do both. What matters is whether we take advantage of this moment in history to promote greater efficiency, greater consumer involvement, and smarter health purchasing—to achieve better health outcomes while living within a realistic budget constraint.

## **The Democratic Solution**

Although legislative language is yet to be finalized, the outline of health system reform supported by mainstream Democrats is clear. A useful characterization of their major reform themes is presented in a briefing paper presented to the Senate Committee on Health, Education, Labor, and Pensions (HELP) chaired by Sen. Ted Kennedy (D-Mass.).<sup>17</sup> The “new vision for American health care” touted by this document is actually an old one backed up by new regulations and restrictions.

The Kennedy plan is a no-holds-barred restructuring of the health sector that would further centralize a market already dominated by government decision making. The tone is soothing, but the proposals are steel-edged.

*Mandates.* The code word for mandates is “personal responsibility,” a term that has a reassuringly Republican tone. Families and individuals would be required to buy government-prescribed health insurance, with federal standards on what benefits must be covered. That insurance would cover a wide array of medical services, perhaps (as President Obama and others have said) “coverage as good as your Congressman’s.”<sup>18</sup> Can’t afford it? Not to worry, the government will give you a subsidy paid for by the shrinking pool of taxpayers.<sup>19</sup>

Employers would also “take responsibility” by paying to cover their workers with insurance meeting the government standard. That seems reasonable to those who believe that employers who do not now offer such benefits are, somehow, profiting unfairly. If the big companies can pay for health insurance, why shouldn’t all firms have to pay their fair share?

This view overlooks some inconvenient facts. Health benefits are part of the worker’s total compensation, which includes wages, retirement contributions, and other benefits. In the aggregate, workers in a firm earn every cent of their compensation regardless of whether health insurance is part of the pay package. If a mandate for employer coverage is imposed, that adds new labor costs for firms not previously providing the benefit. Those new costs must be paid for, either by reducing wages or other benefits or by reducing the number of people employed at the firm. The mandate acts as a tax on labor, reducing the growth of employment and wages.

The resulting burden on workers could be substantial if the mandated coverage is generous (and costly).<sup>20</sup> For some workers, this trade-off between health insurance and other compensation would be worthwhile. They may have pre-existing conditions that make it difficult to purchase coverage at a price they are willing to pay, and the mandate could provide them access to lower cost insurance. But other workers, particularly those who are young and healthy, would not view the mandated coverage as a good deal.

Similarly, the tax effectively imposed by the insurance mandate would not be borne evenly across firms. Larger or more prosperous firms that already satisfy the health insurance mandate would be unaffected. However, even large firms may find that their benefit package or the amount of the firm’s “contribution” is below the level demanded by Congress, particularly if health costs continue their rapid rise into the future.

Small firms not currently offering health coverage would be more severely impacted by a health insurance mandate. Such firms often are under financial pressure and have little ability to adapt to new costs without laying off workers, cutting back hours, or reducing pay. Workers who are less central to the firm's operation are likely to be the first to feel the adverse effects of the mandate, particularly since job opportunities at other companies may also be reduced in response to the increase in costs imposed by the mandate. Minimum-wage workers, whose pay cannot be reduced, are the most likely to lose their jobs if an insurance mandate is imposed.

*Insurance regulation.* The Kennedy plan would “make health insurance work for all Americans” by imposing new regulations on the insurance industry. Individually, the proposed regulations may seem reasonable. Insurers would have to take on all comers (“guaranteed issue”) and offer coverage to all beneficiaries every year (“guaranteed renewal”). Insurers would not be able to limit the covered benefits or increase premiums on the basis of the applicant's health (“no medical underwriting or pre-existing condition requirements”). Premiums could only be set based on family composition, age, and where the family resides, and there would be limits on how much an insurer could charge (“fair premiums”).

Together with a minimum benefit package that would likely exceed what is often purchased by consumers who buy on the individual market (rather than through an employer), these regulations would drive up the average insurance premium paid by consumers. Younger, healthier people would see sharply higher insurance costs, while older, less healthy people would benefit from lower premiums and greater availability of comprehensive coverage. This is unavoidable. Insurers must cover their costs, and if their ability to tailor their products and prices to the market is restricted, then premiums will rise if the insurers are to remain in business.

This is not an argument for a completely unregulated insurance market. Some regulations, when implemented carefully, can accomplish what financial incentives alone cannot. For example, most people would agree that insurers should carry reserves in the event that they have an unexpectedly high volume of claims in a year. Rather than risking having no protection because the insurer has become insolvent, most people are willing to pay a higher premium, particularly if the additional payment is modest. The additional premium cost paid by beneficiaries as a result of regulation may be justified if important social goals are met, but that evaluation is inherently subjective.

Regulation can go too far and destabilize the market. For example, guaranteed issue could undermine insurance if individuals are able to enroll and disenroll at will. That would permit people to have coverage only when they “need” it—when they are about to incur a medical expense. If no one pays a premium except when they are sick, there is no pooling of risk and no insurance. Consequently, there have to be restrictions on guaranteed issue, perhaps requiring that the individual purchase coverage when it is first offered (such as when the person is initially hired by a firm or when he can purchase non-group coverage in the individual insurance market). Similar concerns are raised if the

insurer's ability to manage risk and set reasonable premiums is restricted by the imposition of multiple regulations.

Insurers quickly realized that health reform under the Democrats would include heavy regulation and made clear the *quid pro quo*.<sup>21</sup> They would accept virtually any new restriction as long as everyone is required to purchase their product. Faced with what might be a political *fait accompli*, it is not surprising that the insurance industry has sought to make a deal whereby they can remain in business and make a profit (even a sharply reduced profit).

*Public plan.* The deal offered by insurers has not yet been agreed to by the Democratic leadership, who seem bent on making them back away thanks to another imperative from the left: the public plan. A “publicly sponsored and guaranteed” health plan would ensure “fiscal discipline and full accountability” in the market, according to the Kennedy briefing paper. Although there is agreement among Democrats on this point, there is dissension in the ranks about how the public plan should be structured.

At one extreme is the “Medicare-for-all” model, which would either allow anyone to buy into Medicare or a separate government plan that operates on the same rules as Medicare. Other variations are possible, and the public plan need not adopt all of Medicare's policies.<sup>22</sup>

In response to complaints from health care providers that Medicare payment rates are too low, the public plan might use Medicare's payment structures but allow higher rates (for example, the Medicare rate plus 10 percent). Congress might require that all providers participating in Medicare must also participate in the public plan, or might create an incentive for Medicare providers to participate in the public plan without a mandate. The public plan might adopt Medicare policies on what services are covered, or it might create its own coverage policy.

At the other extreme is a publicly-sponsored plan that operates independently of Medicare and any other government program.<sup>23</sup> Such a plan might be operated by a federal agency (other than the Centers for Medicare and Medicaid Services), state governments (modeled after state employee health plans), or through a regulated consortium of insurers (dubbed a “cooperative”).

Proponents assert that a public plan would compete on the same basis as private plans. They argue that greater market power and lower administrative costs give the public plan an advantage in negotiating low provider payment rates. Consequently, the public plan could offer good benefits at low premiums and force private plans to cut back their own costs to be competitive.

If those claims about the effectiveness of public health insurance were true, we might not be considering health system reform today. Medicare is the proof. The largest single payer for health services, Medicare accounts for 20 percent of national health spending and heavily influences private insurance and medical practice through its complex

regulatory structure. The program has a lackluster record of cost containment<sup>24</sup> despite lagging behind private insurers in offering benefits attractive to consumers.<sup>25</sup> Consequently, Medicare has a \$37.8 trillion shortfall between projected spending and revenue over the next 75 years.<sup>26</sup> Medicare is at the center of the long-term entitlement spending crisis, a fact public plan advocates prefer not to discuss.

The one apparent advantage of the program—low administrative cost—is partly an illusion, caused by the failure to count all the costs. For example, the Social Security Administration incurs costs for enrolling Medicare beneficiaries that are not reported as Medicare spending because they are covered by an agency other than the Centers for Medicare and Medicaid Services (CMS). Health care providers also bear administrative costs for their Medicare patients that are not compensated.

Those savings are illusory in another sense. Failure to actively manage Medicare lowers administrative spending but is likely to increase spending on fraudulent claims.<sup>27</sup>

There is no evidence to suggest that a new public plan would operate more effectively than Medicare. The program's pricing policies are driven by politics, not economics. Medicare does not “negotiate” prices with providers any more than the Internal Revenue Service negotiates with you on your income taxes. The political imperative is to ensure seniors virtually unlimited access to providers and health services. Medicare cannot negotiate because it is not prepared to walk away from the table without a deal.<sup>28</sup>

Instead, Medicare uses its legal authority (not its market power) to fix prices using formulas that rarely, if ever, reflect actual market conditions. For short periods, Medicare can lower its payment rates below levels necessary to clear the market. However, over time, Medicare rates are likely to exceed market-clearing prices. This is a one-sided bet: providers who think they are underpaid let Congress know about it, but those who are overpaid never mention it. The political incentives all point toward higher program costs with little regard to promoting efficient delivery of health care.

Why, then, are private insurers up in arms over the prospect of a public plan?<sup>29</sup> If the public plan is as inefficient as Medicare, surely private insurers need only outperform that plan a little to maintain their market share and profit margins. But here again, politics intrudes.

Sen. Kennedy not only wants to create a public plan, he also wants to “guarantee” it. That means indemnifying the public plan for any unexpected increase in program cost, much as Medicare Part B cannot run short of funds because any shortfall automatically—without legislation—triggers a transfer from income tax collections. A public plan having legal and political authorities not available to any other insurer would not be allowed to fail.

With proud parents in the Congress who can ensure “fairness” by loading private insurers with new requirements and restricting their ability to serve their customers, a single-payer health system could become a reality if consumers shift to the favored public plan.

According to one estimate, if a public plan using Medicare payment levels was open to all, 119 million people would drop private coverage and enroll in the public plan.<sup>30</sup> That represents a two-thirds reduction in private insurance, which currently covers about 170 million people.

*Health insurance exchange.* Experts on both sides of the political divide have proposed a health insurance “exchange” to offer individuals a choice of health plans, better information on the plans, and one-stop shopping.<sup>31</sup> Examples of insurance exchanges include the Federal Employees Health Benefits Program (FEHBP), the Massachusetts “connector,” and the California Public Employees Retirement System (CalPERS). In addition, private brokers, such as eHealthInsurance, offer a range of choices to consumers in the individual (non-employer) insurance market.

Many people with employer-sponsored coverage have only one choice of health plan, and even in larger companies the options are often limited to what a single insurer can offer—typically a preferred provider organization (PPO) that operates on a fee-for-service basis, a health maintenance organization (HMO), and a high-deductible plan that includes a health savings account (HSA). Lower-wage workers often fail to enroll in their company’s health plan because the benefits do not seem worth the cost, particularly if the worker is young and healthy.

An insurance exchange could give such workers more affordable options. The fundamental policy question is, will policymakers permit individuals to decide for themselves what kind of insurance they buy at what price? Opening up the exchange to employees as well as people who are not eligible for employer coverage could result in the flight of young, healthy employees from their employer’s plan. In such a case, premiums for the remaining older, less healthy workers would rise, further driving out those who can find more affordable coverage through the exchange.

For that reason, some advocates would require workers to enroll in their company’s plan rather than giving them a wider range of choices through the exchange. That approach would preserve the hidden cross-subsidies between workers within a firm that disadvantage those least able to afford health insurance. Rather than reinforcing the market inefficiencies of this system, a health insurance exchange open to all could create new pressures on insurers to offer lower-cost, high-value plan options.<sup>32</sup>

Although an exchange could make it easier for individuals to buy their own insurance, it also would serve as a mechanism to impose regulations on private plans that drive up insurance costs or distort insurance choices. It is possible to imagine an insurance exchange with a light regulatory touch in a reformed health system. It’s called FEHBP. Whether operated at the federal or state level, an exchange modeled after FEHBP can offer consumers meaningful insurance options and the information necessary to make sound purchasing decisions—with minimal regulation. But that implies an improbable moderation of views among some Democratic leaders, whose hostility toward private insurance is apparent.

## Principles of Real Health Reform

Inside every American beats the heart of a subversive. Most of us don't think of ourselves as subversive, of course. We think we're adapting to changing political and economic circumstances the best way we know how. The problem, for social planners, is that we don't always embrace the latest vision of social responsibility. Particularly when the vision is at odds with our own self interest.

This is the reason why general public agreement on what should be included in health reform is necessary. If the populace does not agree, the reform will not work. Onerous provisions will be ignored, worked around, or even repealed.<sup>33</sup> This transcends the debate over bipartisanship in Congress. Even if Democrats and some Republicans agree on reform legislation, lack of popular acceptance could frustrate the reformers' goals.

That lesson should have been learned by health reformers 15 years ago, but their focus has been on the tactical errors of the Clinton health reform rather than on the reform's strategy and underlying philosophy. President Obama has received high marks for not repeating President Clinton's mistakes. Obama did not name a polarizing figure to head his health reform efforts (although he was saved from that mistake when Tom Daschle's \$100,000 tax problem<sup>34</sup> came to light). He did not convene secret meetings in the White House with 630 experts to hash out the details of his reform.<sup>35</sup> Obama has avoided dictating the details of reform to his former colleagues on the Hill, but he has deployed his campaign ground troops to stoke support for the general concept of health reform.<sup>36</sup>

Thus far, the President's approach seems to have avoided the pitfalls that would doom a major political initiative. The stakeholder groups—doctors, hospitals, pharmaceutical companies, insurers, employers, unions, and others—have all sworn their allegiance to reform in the hope that they will be able to influence the shape of the legislation.<sup>37</sup> That's the rub. Everyone cannot be a winner, compromises will be made, and someone has to pay for whatever Congress passes. This is where the Clinton reform failed. Even if Obama succeeds in passing major legislation, there is no guarantee that patients, purchasers, and providers will respond to the new directives the way policymakers might imagine.

What could turn a political victory into a substantive defeat is the regulatory bent of the legislation's authors. Despite a patina of market rhetoric, the Democrats' health reform would centralize many of the decisions made in the health sector. Financial incentives are never enough. Instead, the government's experts will decide when an insurance plan is not good enough or a treatment is not effective enough.

There is suspicion, and even hostility, for health care companies that openly seek to make profits, even though the difference between for-profit and not-for-profit health firms is razor-thin. Key policymakers act on the belief that government has a moral obligation to protect individuals from health risks and the uncertainties that markets create. Patients who only recently became health care consumers will once again become patients, less than equal partners in decisions that affect their health, happiness, and wallet.

The alternative to top-down control over the health system is a reform that acknowledges the value of entrepreneurship and competition in health care, and that recognizes the corrosive effects of personal and corporate dependency on government largesse. A market-based health reform would promote innovations in medical science, health care delivery, and financing that might never emerge from a regulation-heavy system driven from Washington.

Many of those private-sector innovations are hailed by policymakers who support reforms that would discourage future improvements in the health system. For example, integrated delivery systems such as the Mayo Clinic or the Geisinger Health System are widely recognized as offering high-quality, cost-effective health care. Those systems developed out of the insight and experience of entrepreneurs who thought they knew a better approach to health care delivery and were willing to risk substantial investments of time and money to prove it. They were not directed by government policy, and they have continued to perfect their business models without the need for government subsidies.<sup>38</sup> If they had been wrong in concept or execution, those organizations would have failed in a competitive market.

Without the discipline of the market, success or failure is measured with a different yardstick. Inefficiency and lower-quality care are likely to persist in a government-dominated health system because of the political difficulties of making changes in established programs. Preference for the status quo is a key reason Congress has failed to enact previous health reforms, even when the public agrees that significant change is needed.<sup>39</sup>

How, then, to build a health reform that is both acceptable to the public and sustainable into the future? I offer five organizing principles and some examples of policy changes that could be adopted as part of comprehensive reform.

*Support those who need the help.* Even in the best of times, the federal government has limited resources to address pressing social problems. Those resources are more tightly squeezed in the current recession. A broad expansion of public programs or subsidies to provide universal coverage probably exceeds our ability to cover the additional cost. Instead, Congress should focus its attention on those who are in the greatest need.

Persons with serious health conditions and no access to employer-sponsored coverage are generally not able to purchase health insurance or can only purchase coverage with significant benefit exclusions and higher premiums. Because people tend to buy insurance based on their anticipated medical needs, insurers use medical underwriting to reduce adverse selection in the individual (non-group) market. This is less of a problem for group insurance, which more effectively pools health risks because a third party (often an employer) makes the purchasing decision for the group.<sup>40</sup>

Under a highly regulatory reform favored by some policymakers, a requirement on insurers to “guarantee issue” coverage to all applications would drive up premiums in the

individual insurance market to account for the higher health care costs of older and sicker people who now have coverage. To avoid pricing them out of the market, Congress would impose rating restrictions to limit how much premiums would be allowed to vary.<sup>41</sup> But the higher average premiums would make insurance less attractive to young healthy people, thus requiring a mandate to buy coverage that is a poor deal for them.

Layer after layer of regulation must be applied because people acting in their own self-interest would impede the accomplishment of a worthwhile social objective: insuring high-risk<sup>42</sup> people who do not now have coverage.<sup>43</sup> A more focused approach could resolve the market failure without imposing new restrictions on everyone.

Existing subsidies could be redirected to provide more help for those who face high premiums costs because of their poor health. The federal government provides more than \$225 billion annually in tax subsidies to individuals who purchase health insurance through their employers.<sup>44</sup> Under this tax exclusion, the amount that an employer contributes to the insurance premium is not counted as taxable income to the worker. Workers who have higher incomes and more expensive health insurance receive higher subsidies than those with low incomes and affordable coverage. People who do not have access to employer coverage are not subsidized when they purchase insurance in the individual market.

The tax exclusion could be limited, with the additional federal revenue converted into a risk-adjusted tax credit available to everyone who buys health insurance. Such a subsidy could provide additional funds for those who cannot afford coverage because they have a pre-existing health condition or are low income.

State high-risk pools offer another way to provide coverage for people with serious health conditions who have been refused insurance in the individual market or whose coverage is limited and expensive. The pools offer private insurance and typically cap premiums at 150 percent of the average rate for a healthy person.<sup>45</sup> Such pools must be subsidized since everyone in the pool has health problems and there is little ability to spread the cost.

The major criticism of high-risk pools is that they are not well-funded.<sup>46</sup> States often levy a premium tax to generate revenue for the high-risk pool, but that tax is borne primarily by people buying in the individual market and not those who have employer coverage (and who are generally better able to afford insurance). A broader-based tax or risk-adjusted tax credits financed by limiting the tax exclusion could solve the financing problem.

Health insurance is not the only way we can help those most in need. Federally-subsidized community health centers and other public clinics fill an important gap in our health care delivery system, providing primary and preventive care to low-income neighborhoods and relieving some of the pressure felt by hospital emergency rooms as demand for services grows.

*Promote effective competition.* The rising cost of health care is uppermost in the minds of the public and a major reason for the growing numbers of uninsured Americans. A more competitive insurance market would reward health plans for developing options that offer better value to consumers. Various mechanisms have been proposed that might increase competition among insurers, such as allowing insurers to offer coverage in any state if they fulfill at least one state's regulatory requirements. In addition, the Federal Trade Commission could increase its antitrust enforcement actions to promote more effective competition among health care providers.

Greater competition in Medicare could also yield better value for seniors and taxpayers. Some changes, such as the use of competitive bidding in place of formula-based pricing for services in traditional fee-for-service Medicare, could be adopted without a major program restructuring.

Medicare's pricing formulas are imprecise, resulting in excessive reimbursement for some services and insufficient reimbursement for others. That, in turn, distorts the allocation of resources in the health sector and is a major reason why primary care is in short supply in many parts of the country. Formulas can only guess at the correct structure of prices in a market, and they generally get it wrong. Competitive bidding can force the market to reveal the lowest price Medicare could pay and be assured that beneficiaries would have sufficient access to care.

More dramatic improvement in Medicare performance is possible by promoting competition between fee-for-service Medicare and private plans operating in Medicare Advantage (MA). Changes in the bidding process for MA plans coupled with the requirement that fee-for-service Medicare participate in the bidding on an equal basis could reduce program costs and make the fee-for-service option more responsive to enrollee needs.

*Promote informed choice.* Information is the key to more informed decision making in the health sector. Consumers faced with a choice of health plans need information that facilitates comparison shopping. The FEHBP offers its members information on health plan choices that permit such comparisons, without also imposing excessive restrictions on what plans may offer.

There is a greater challenge in developing reliable and accessible information about treatment alternatives and the quality of care offered by different providers. Every patient encounter generates information about medical care, but much of that information is filed away and inaccessible.

The barriers to better collection and exchange of patient information are substantial. A multitude of health information systems are in use, but most do not communicate with other systems. Large hospital systems see the business case for improved information systems and many have undertaken major system redesigns. However, small medical practices have limited ability to finance and install modern patient electronic records. Privacy concerns must be addressed. Decisions must be made about who should have

access to patient data and how those data should be used to improve our knowledge of both the effectiveness of alternative treatments and the performance of providers in delivering care.

Despite the challenges, there is general agreement that we should make better use of the information that is currently trapped inside the medical system. The debate is over the role of the government in using such data to dictate rather than inform treatment decisions.

*Create appropriate financial incentives.* Comprehensive health insurance, including most employer plans and government insurance programs, create perverse incentives that make consumers and their providers insensitive to the full costs of medical care. Those incentives promote high utilization of health services, driving up spending and making health insurance more expensive. At the margin, the value of those services may not be worth their cost.

Congress could restructure federal subsidies to promote price awareness and more efficient use of services. The tax exclusion for employer-sponsored health insurance provides an open-ended subsidy that encourages the purchase of high-premium plans that cover most of the cost of even the most routine service. Capping the amount of that subsidy or replacing the exclusion with a risk-adjusted tax credit would encourage employers to offer better-value coverage.<sup>47</sup>

Medicare could also be restructured to promote more efficiency. As an entitlement, Medicare guarantees a level of health benefits that is not bound by firm spending limits. The entitlement is as much for providers as it is for beneficiaries, since it ensures payment for the wide range of services covered by the program. A premium support system would set a fixed government contribution for each beneficiary, adjusted for their income and health status.<sup>48</sup> Beneficiaries would be able to purchase more expensive plans, but the additional cost would be their own responsibility.

More targeted incentives could be implemented in Medicare to promote the use of more effective services. The program could follow the lead of some private health plans in reducing copayments for drugs or other services known to be effective in the treatment of chronic diseases.<sup>49</sup> Such a policy should avoid providing incentives for use of services, including many preventive treatments, which are not cost-effective for large patient populations.<sup>50</sup>

*Look beyond the confines of medical care.* What is sometimes lost in the heated debate over health care reform is that universal coverage is not the ultimate objective of public policy. Health insurance is one means to the end of healthier, more productive lives. Health insurance can improve access to medical services, but that alone is not enough to ensure progress toward the broader objective.

It is now widely recognized that more health care does not necessarily mean that people will be healthier or live longer. Area studies by the Dartmouth Atlas group demonstrate

the wide variation in medical practice across the country without corresponding variations in patient outcomes.<sup>51</sup> Such findings have been used to argue for policies that might reduce spending in high-cost areas, which might improve efficiency without reducing (and possibly improving) the quality of care.<sup>52</sup>

But the doctor can only do so much. A person's state of health depends on many factors—genetic, lifestyle, occupational, environmental. Greater access to medical can help, but it is likely that seat belt laws and smoking reduction have done more to improve health and longevity than expensive clinical services. Health promotion—that is, avoiding disease—could have more “bang for the buck” in terms of reducing the need for health spending than policies to expand health insurance.<sup>53</sup>

Some employers have modified their health benefit programs to promote employee awareness and to encourage behavioral changes. For example, Safeway adjusts the premiums paid by their employees based on whether they use tobacco or maintain healthy weight, blood pressure, and cholesterol levels.<sup>54</sup> This is not purely altruistic; if successful over the long term, the company could benefit from lower absenteeism and disability rates.

This example also demonstrates the interaction of federal reform policies and ongoing efforts to improve the health system. If Congress imposes community rating on all health plans, the Safeway initiative to promote better worker health behavior would have to be scrapped.

## **Conclusion**

Congress will come to a political crossroad some time this fall. Policymakers could enact a top-down health reform that further centralizes power and decision-making in Washington, following in the footsteps of the auto industry takeover. Or they could enact a reform that levels with the American people about what is possible, and what is necessary.

A market-based health reform is no panacea and will not produce an instant cure for the many problems facing the health system. Neither will a highly regulatory approach to reform. We should strengthen effective competition that rewards initiative, a system that does not protect poor business decisions with unearned taxpayer dollars. We should provide help where it is most needed, and give consumers (and their doctors) the tools to make good decisions about their insurance and their medical care. We should lay the foundation for a new understanding of the rights and responsibilities of individuals, and we should take steps to ensure that the reforms enacted this year are sustainable over the long term.

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<sup>1</sup> “American Presidents and Health Reform: A Chronology,” *HHN Magazine*, February 2009; [http://www.hhnmag.com/hhnmag\\_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/02FEB2009/0902HHN\\_CoverStory\\_WebExtra&domain=HHNMAG](http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/02FEB2009/0902HHN_CoverStory_WebExtra&domain=HHNMAG) accessed June 6, 2009.

<sup>2</sup> Lyndon Johnson used the term repeatedly in describing U.S. efforts during the Viet Nam war.

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<sup>3</sup> Micah Hartman et al., “National Health Spending In 2007: Slower Drug Spending Contributes To Lowest Rate Of Overall Growth Since 1998,” *Health Affairs*, January/February 2009; 28(1): 246-261; CBO, *Geographic Variation in Health Care Spending* (Washington: CBO, February 2008) and references cited therein.

<sup>4</sup> Andrea Sisko et al., “Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook,” *Health Affairs*, March/April 2009; 28(2): w346-w357.

<sup>5</sup> CBO, *The Long-Term Outlook for Health Care Spending* (Washington: CBO, November 2007).

<sup>6</sup> CBO, *The Budget and Economic Outlook: An Update*, (Washington: CBO, September 2008).

<sup>7</sup> Author’s calculation based on CBO, *The Long-Term Budget Outlook* (Washington: CBO, December 2007), Table 1-2 (“Alternative Fiscal Scenario”).

<sup>8</sup> Boards of Trustees, *2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund* (Washington: U.S. Government Printing Office, 2009).

<sup>9</sup> Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey* (Menlo Park: Kaiser Family Foundation, September 2008).

<sup>10</sup> Kaiser Family Foundation, “Cumulative Changes in Health Insurance Premiums, Inflation, and Workers’ Earnings, 1999-2008,” September 24, 2008; <http://facts.kff.org/chart.aspx?ch=707> accessed June 6, 2009.

<sup>11</sup> CBO, *Key Issues in Analyzing Major Health Insurance Proposals* (Washington: CBO, December 2008), p. 20.

<sup>12</sup> Alice M. Rivlin and Joseph R. Antos (eds.), *Restoring Fiscal Sanity 2007: The Health Spending Challenge* (Washington: Brookings Institution, 2007).

<sup>13</sup> Carmen DeNavas-Walt et al., *Income, Poverty, and Health Insurance Coverage in the United States, 2007* U.S. Census Bureau, Current Population Reports, P60-235 (Washington: U.S. Government Printing Office, 2008).

<sup>14</sup> Author’s calculation based on Jack Hadley, et al., “Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs,” *Health Affairs*, September/October 2008; 27(5): w399-w415. Calculation assumes an average growth rate of 7 percent a year for the incremental health spending from extending coverage to everyone.

<sup>15</sup> “Finance Chairman Baucus Unveils Blueprint for Comprehensive Health Care Reform,” press release, November 12, 2008.

<sup>16</sup> Sources of new revenue include premiums paid by the formerly uninsured as well as tax revenue. For an analysis of numerous options to raise federal revenue or cut federal outlays to finance health reform, see CBO, *Budget Options Volume I: Health Care* (Washington: CBO, December 2008).

<sup>17</sup> Senate HELP Committee, “A New Vision for American Health Care: Strengthening What Works and Fixing What Doesn’t,” Briefing Paper, May 21, 2009.

<sup>18</sup> John Michael Spinelli, “Obama Picks Ohio for ‘Closing Argument’ Speech,” *Ohio News*, October 27, 2008; <http://thejournal.epluribusmedia.net/index.php/state-news/ohio-news/197-obama-picks-ohio-for-final-argumentq-speech> accessed June 6, 2009.

<sup>19</sup> The number of individual income tax returns filed with the Internal Revenue Service rose from 129.4 million in 2000 to 138.4 million in 2006, but the number of taxable returns fell from 96.8 million to 92.7 million. See David Campbell and Michael Parisi, “Individual Income Tax Returns, 2000,” *SOI Bulletin*, Fall 2002; and Justin Bryan, “Individual Income Tax Returns, 2006,” *SOI Bulletin*, Fall 2008; <http://www.irs.gov/taxstats/productsandpubs/article/0,,id=130681,00.html#4> accessed June 6, 2009.

<sup>20</sup> If the minimum benefit necessary to satisfy the mandate was limited to protection against catastrophic losses, which affect a small percentage of the population, the cost would be fairly modest and the impact on workers would be attenuated. At least in the short term, small employers may be able to raise their product prices somewhat without losing many sales, which could also help minimize the immediate impact on workers. Requiring nearly first-dollar coverage for a broad range of medical services would impose substantial costs on workers, and employers in that case would seek to reduce other labor costs to maintain their position in the product market.

<sup>21</sup> AHIP, “Propose Guaranteed Coverage for Pre-Existing Conditions and Individual Coverage Mandate,” Press Release, November 19, 2008; <http://www.ahip.org/content/pressrelease.aspx?docid=25068> accessed June 6, 2009.

<sup>22</sup> John Holahan and Linda Blumberg, *Can a Public Insurance Plan Increase Competition*

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and Lower the Costs of Health Reform? Urban Institute Health Policy Center, 2008; [http://www.urban.org/health\\_policy/url.cfm?ID=411762](http://www.urban.org/health_policy/url.cfm?ID=411762) accessed June 6, 2009.

<sup>23</sup> Len M. Nichols and John M. Bertko, *A Modest Proposal for a Competing Public Health Plan*, New America Foundation, March 2009; [http://www.newamerica.net/publications/policy/modest\\_proposal\\_competing\\_public\\_health\\_plan](http://www.newamerica.net/publications/policy/modest_proposal_competing_public_health_plan) accessed June 6, 2009.

<sup>24</sup> One study found that Medicare spending has grown less rapidly over long periods of time than private insurance spending; see Cristina Boccuti and Marilyn Moon, "Comparing Medicare And Private Insurers: Growth Rates In Spending Over Three Decades," *Health Affairs* March/April 2003; 22(2): 230-237. Other analysts argue that adjustments to reflect differences in covered benefits between Medicare and private coverage reverses that conclusion; see Joseph R. Antos, "Comparing Medicare and Private Health Insurance Spending," Heritage Foundation *WebMemo* no. 250, April 8, 2003; Joint Economic Committee, *Health Insurance Spending Growth – How Does Medicare Compare?* June 10, 2003; and Walton Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP*, forthcoming, AEI Press.

<sup>25</sup> The most obvious example is Medicare's prescription drug benefit under Part D, which Congress authorized in 2003—decades after an outpatient drug benefit had become a standard benefit in comprehensive private insurance plans.

<sup>26</sup> Boards of Trustees, *2009 Annual Report*.

<sup>27</sup> Kerry N. Weems and Benjamin E. Sasse, "Is Government Health Insurance Cheap?" *The Wall Street Journal*, April 14, 2009; <http://online.wsj.com/article/SB123966918025015509.html> accessed June 7, 2009.

<sup>28</sup> Although Medicare is technically a monopsonist (the sole purchaser of health care goods and services for its beneficiaries), its market power is greatly attenuated by the need to satisfy political as well as economic goals. The program can set prices for services that are below those that would be established in a competitive market with many buyers and sellers, but only for limited periods of time. Over the long term, Congress would take action to force very low Medicare prices up even though that would increase program outlays. This is illustrated by the repeated interventions by Congress to prevent physician payment reductions called for by the Sustainable Growth Rate (SGR) formula.

<sup>29</sup> Les Masterson, "Insurers Will Do Just About Anything to Avoid Public Plan," *HealthLeaders Media*, May 13, 2009; [http://healthplans.hcpro.com/content/232960/topic/WS\\_HLM2\\_HEP/Insurers-Will-Do-Just-About-Anything-to-Avoid-Public-Plan.html](http://healthplans.hcpro.com/content/232960/topic/WS_HLM2_HEP/Insurers-Will-Do-Just-About-Anything-to-Avoid-Public-Plan.html) accessed June 6, 2009.

<sup>30</sup> John Sheils and Randy Haught, *The Cost and Coverage Impacts of a Public Plan: Alternative Design Options*, Staff Working Paper No. 4, The Lewin Group, April 6, 2009; <http://www.lewin.com/content/publications/LewinCostandCoverageImpactsofPublicPlan-Alternative%20DesignOptions.pdf> accessed June 7, 2009.

<sup>31</sup> Robert E. Moffit, "What Federal Workers Are Doing Today that You Can't," *WebMemo* #604, Heritage Foundation, November 8, 2004; Senate HELP Committee, "A New Vision for American Health Care."

<sup>32</sup> To minimize the impact of adverse selection, in which sicker people are more likely to enroll in insurance, some argue that everyone must be required to buy coverage. However, a mandate would substantially weaken the incentives of insurers to develop better products at more attractive prices.

<sup>33</sup> The Medicare Catastrophic Coverage Act of 1988 was repealed a year later in response to vocal opposition to the legislation after it was enacted (including a confrontation between a mob of seniors and Rep. Dan Rostenkowski, then-chairman of the House Ways and Means Committee). See David A. Hyman, *Medicare Meets Mephistopheles* (Washington: Cato Institute, 2006), pp. 43 ff.

<sup>34</sup> Keith Epstein, "Daschle, Too, Has a Tax Problem," *Business Week*, January 30, 2009; [http://www.businessweek.com/bwdaily/dnflash/content/jan2009/db20090130\\_613364.htm?chan=top+news\\_top+news+index+-+temp\\_news+%2B+analysis](http://www.businessweek.com/bwdaily/dnflash/content/jan2009/db20090130_613364.htm?chan=top+news_top+news+index+-+temp_news+%2B+analysis) accessed June 8, 2009.

<sup>35</sup> Lawrence R. Jacobs and Robert Y. Shapiro, *Politicians Don't Pander: Political Manipulation and the Loss of Democratic Responsiveness* (Chicago: University of Chicago Press, 2000), pp. 77 ff.; [http://books.google.com/books?id=WoWm7r4Q2BMC&pg=PA77&lpg=PA77&dq=clinton+health+reform+task+force&source=bl&ots=OQ3o\\_R\\_0VC&sig=38O27FVHD70nqQhoBHEh8zJJrky&hl=en&ei=KS8tSuORJ96ptgfexNDLCA&sa=X&oi=book\\_result&ct=result&resnum=5](http://books.google.com/books?id=WoWm7r4Q2BMC&pg=PA77&lpg=PA77&dq=clinton+health+reform+task+force&source=bl&ots=OQ3o_R_0VC&sig=38O27FVHD70nqQhoBHEh8zJJrky&hl=en&ei=KS8tSuORJ96ptgfexNDLCA&sa=X&oi=book_result&ct=result&resnum=5) accessed June 8, 2009.

<sup>36</sup> Stephanie Condon, "Obama Mobilizes Grassroots Support For Health Care Reform," *CBS News Political Hotsheet*, May 28, 2009; <http://www.cbsnews.com/blogs/2009/05/28/politics/politicalhotsheet/entry5046747.shtml> accessed June 8, 2009.

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- <sup>37</sup> John Reichard, "Obama's Gamble: Making Health Care Components Mesh," *CQ Politics*, June 6, 2009; <http://www.cqpolitics.com/wmspage.cfm?docID=news-000003136735> accessed June 8, 2009.
- <sup>38</sup> For example, Geisinger instituted a better-managed system for heart bypass operations in 2006 that enforces sound clinical practices and provides a kind of financial guarantee to patients; see Reed Abelson, "In Bid for Better Care, Surgery With a Warranty" *New York Times*, May 17, 2007.
- <sup>39</sup> Robert J. Blendon et al., "What happened to Americans' support for the Clinton health plan?" *Health Affairs*, Summer 1995; 14(2): 7-23.
- <sup>40</sup> Mark A. Hall, "Perspective: Of Magic Wands And Kaleidoscopes: Fixing Problems In The Individual Market," *Health Affairs* Web Exclusive, October 23, 2002, W353-W358.
- <sup>41</sup> Community rating requires insurers to charge all applicants the same premium regardless of health status, age or other factors. Modified community rating allows some variations in premiums (although generally not related to health status).
- <sup>42</sup> "High risk" is a common misnomer used in discussions of health insurance. The problem discussed here arises because people with serious health conditions are nearly *certain* to incur high health care costs over the next year, not because there is a high degree of *uncertainty* about their health spending in the near future.
- <sup>43</sup> Scott Harrington and Tom Miller, "Perspective: Competitive Markets For Individual Health Insurance," *Health Affairs* Web Exclusive, October 23, 2002, W359-W361.
- <sup>44</sup> Joint Committee on Taxation, "Background Materials For Senate Committee On Finance Roundtable On Health Care Financing," Report JCX-27-09, May 8, 2009; <http://finance.senate.gov/JCT.pdf> accessed June 20, 2009.
- <sup>45</sup> Janet Stokes Trautwein, "Perspective: Options And Opportunities For Individuals And Families In The Private Health Insurance Market," *Health Affairs* Web Exclusive, October 23, 2002, W387-W390.
- <sup>46</sup> Deborah Chollet, "Perspective: Expanding Individual Health Insurance Coverage: Are High-Risk Pools The Answer?" *Health Affairs* Web Exclusive, October 23, 2002, W349-W352.
- <sup>47</sup> Robert B. Helms, "Taxing Health Insurance: A Tax Designed to Be Avoided," *AEI Health Policy Outlook*, June 2009.
- <sup>48</sup> CBO, *Designing a Premium Support System for Medicare* (Washington: CBO, December 2006).
- <sup>49</sup> A. Mark Fendrick and Michael E. Chernew, "Value-Based Insurance Design: A 'Clinically Sensitive' Approach to Preserve Quality of Care and Contain Costs," *American Journal of Managed Care*, January 2006; [http://www.ajmc.com/media/pdf/AJMC\\_06janFendrickEdit18to20.pdf](http://www.ajmc.com/media/pdf/AJMC_06janFendrickEdit18to20.pdf) accessed June 13, 2009.
- <sup>50</sup> Louise B. Russell, "Preventing Chronic Disease: An Important Investment, But Don't Count On Cost Savings," *Health Affairs*, January/February 2009; 28(1): 42-45.
- <sup>51</sup> [www.dartmouthatlas.org](http://www.dartmouthatlas.org).
- <sup>52</sup> Elliott S. Fisher et al., "Fostering Accountable Health Care: Moving Forward In Medicare," *Health Affairs*, March/April 2009; 28(2): w219-w231.
- <sup>53</sup> For a discussion of the debate over prevention versus treatment, see Ron Z. Goetzel, "Do Prevention Or Treatment Services Save Money? The Wrong Debate," *Health Affairs*, January/February 2009; 28(1): 37-41.
- <sup>54</sup> Steven A. Burd, "How Safeway is Cutting Health-Care Costs," *Wall Street Journal*, June 12, 2009, A15.