



The Politics and Principles of Real Health Care Reform

By Joseph Antos

The health care system is ready for change, but the highly regulated reforms President Barack Obama and Congress are currently discussing are unlikely to reduce costs or improve outcomes. While purely market-based reform will not be a panacea for the problems in the American health system, market discipline is necessary for reforms to be successful. Congress can reform the health care system in a way that improves affordability, access, and quality for all Americans, but to do so, politicians should embrace five principles for designing effective, sustainable reform.

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.¹ 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 a small government insurance program for children into law.

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. Given the views of congressional leadership, however, it is less clear that legislative success will yield a sustainable health care system based on values shared by most Americans.

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The current health reform debate is the latest battleground for the hearts and minds of the people. As we learned when that phrase was last popular,² 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.

Key points in this *Outlook*:

- A highly regulated approach to health care reform is unlikely to reduce costs or improve outcomes.
- Market-based reform is not a surefire solution for the problems the system faces. But market discipline is necessary to make needed changes in established programs.
- Providing help to those who need it most and giving consumers and doctors the tools to make good decisions are important elements and key to making reforms effective and sustainable.

Politics: Is the Past Prologue?

Inside every American beats the heart of a subversive. Most of us do not think of ourselves as subversive, of course; we think we are adapting to changing political and economic circumstances the best way we know how. The problem for social planners is that Americans do not always embrace the latest vision of social responsibility, particularly when the vision is at odds with their self-interest.

This is the reason 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.³ 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 fifteen 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. Early on, Obama received high marks for not repeating Clinton's mistakes. Obama did not name a polarizing figure to head his health reform efforts (he was saved from that mistake when Tom Daschle's \$100,000 tax problem came to light).⁴ He did not convene secret meetings in the White House with 630 experts to hash out the details of his reform.⁵ 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.⁶

The president's approach initially appeared to have avoided some of the pitfalls that would doom a major political initiative. The stakeholder groups—doctors, hospitals, pharmaceutical companies, insurers, employers, unions, and others—all swore allegiance to reform in the hope that they would be able to influence the shape of the legislation.⁷ That is 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.

The regulatory bent of the legislation's authors could turn a political victory into a substantive defeat. Despite a patina of market rhetoric, the Democrats' health reform would centralize many of the decisions made in the health

sector. In their version of health reform, 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 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 wallets.

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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 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 those developed by 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.⁸ 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 to 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.⁹

Five Principles for Effective Reform

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, and those resources are more tightly squeezed in the current recession. Broadly expanding 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 anticipated medical needs, insurers use medical underwriting to reduce adverse selection in the individual (nongroup) 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.¹⁰

Under the highly regulatory reform favored by some policymakers, a requirement on insurers to “guarantee issue” coverage to all applicants would drive up premiums in the individual insurance market to account for the higher health care costs of the older and sicker people who would 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.¹¹ 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-risk¹² people who do not now have coverage.¹³ 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 premium costs because of poor health. The federal government provides more than \$225 billion annually in tax subsidies to individuals who purchase health insurance through their employers.¹⁴ Under this tax exclusion, the amount 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, and the additional federal revenue could be 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 preexisting 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.¹⁵ 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.¹⁶ 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 on 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 number 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 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, but competitive bidding can force the market to reveal the lowest price Medicare could pay and still 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 enrollees' 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 Federal Employees Health Benefits Program 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 different providers offer. 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,¹⁷ 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. In contrast, small medical practices have limited ability to finance and install modern patient electronic records. Privacy concerns must be addressed, and 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.

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Despite the challenges, there is general agreement that we should make better use of the information 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, creates perverse incentives that make consumers and their providers insensitive to the full costs of medical care. Those incentives promote high use 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.¹⁸

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 because 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 income and health status.¹⁹ Beneficiaries would be able to purchase more expensive plans, but the additional costs 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.²⁰ Such a policy should avoid providing incentives for use of services, including many preventive treatments, which are not cost-effective for large patient populations.²¹

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 that wide variations in medical practice across the country do not necessarily correspond with variations in patient outcomes.²² 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 while improving) the quality of care.²³

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 care 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.²⁴

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 employees based on whether they use tobacco or maintain healthy weight, blood pressure, and cholesterol levels.²⁵ 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, Safeway would have to scrap its initiative to promote better worker health behavior.

Conclusion

Congress will come to a political crossroad sometime 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.

Notes

1. “American Presidents and Health Reform: A Chronology,” *Hospitals & Health Networks Magazine* (February 2009), available at www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/02FEB2009/0902HHN_CoverStory_WebExtra&domain=HHNMAG (accessed June 6, 2009).

2. Johnson used the phrase repeatedly to describe U.S. efforts during the Vietnam War.

3. 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 former representative Dan Rostenkowski [D-Ill.], then-chairman of the House Ways and

Means Committee). See David A. Hyman, *Medicare Meets Mephistopheles* (Washington, DC: Cato Institute, 2006), 43–44.

4. Keith Epstein, “Daschle, Too, Has a Tax Problem,” *Business Week*, January 30, 2009, available at www.businessweek.com/bwdaily/dnflash/content/jan2009/db20090130_613364.htm?chan=top+news_top+news+index+-+temp_news+%2B+analysis (accessed June 8, 2009).

5. 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), 77–78.

6. Stephanie Condon, “Obama Mobilizes Grassroots Support for Health Care Reform,” CBS News Political Hotsheet, May 28, 2009, available at www.cbsnews.com/blogs/2009/05/28/politics/politicalhotsheet/entry5046747.shtml (accessed June 8, 2009).

7. John Reichard, “Obama’s Gamble: Making Health Care Components Mesh,” *CQ Politics*, June 6, 2009, available at www.cqpolitics.com/wmspage.cfm?docID=news-000003136735 (accessed June 8, 2009).

8. 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.

9. Robert J. Blendon et al., “What Happened to Americans’ Support for the Clinton Health Plan?” *Health Affairs* 14, no. 2 (1995): 7–23.

10. Mark A. Hall, “Perspective: Of Magic Wands and Kaleidoscopes: Fixing Problems in the Individual Market,” *Health Affairs Web Exclusive*, October 23, 2002: w353–w358.

11. 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 these are generally not related to health status).

12. “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.

13. Scott Harrington and Tom Miller, “Perspective: Competitive Markets for Individual Health Insurance,” *Health Affairs Web Exclusive*, October 23, 2002: w359–w361.

14. Joint Committee on Taxation, “Background Materials for Senate Committee on Finance Roundtable on Health Care

Financing,” Report JCX-27-09, May 8, 2009, available at <http://finance.senate.gov/JCT.pdf> (accessed June 20, 2009).

15. 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.

16. Deborah Chollet, “Perspective: Expanding Individual Health Insurance Coverage: Are High-Risk Pools the Answer?” *Health Affairs Web Exclusive*, October 23, 2002: w349–w352.

17. Communicating important patient information is often difficult even within the same health facility. Hospitals typically have a variety of legacy computer systems that do not readily permit the transfer of information between departments. For an illustration of this problem, see Joseph Swedish, “Can Health IT Improve Medical Care? Yes, But . . .” (presentation, AEI, Washington, DC, March 18, 2009), available at www.aei.org/doclib/Joseph%20Swedish%20presentation.pdf.

18. Robert B. Helms, “Taxing Health Insurance: A Tax Designed to Be Avoided,” *Health Policy Outlook* no. 7 (June 2009), available at www.aei.org/outlook/100046.

19. Congressional Budget Office (CBO), *Designing a Premium Support System for Medicare* (Washington, DC: CBO, December 2006).

20. 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), available at www.ajmc.com/media/pdf/AJMC_06janFendrickEdit18to20.pdf (accessed June 13, 2009).

21. Louise B. Russell, “Preventing Chronic Disease: An Important Investment, but Don’t Count on Cost Savings,” *Health Affairs* 28, no. 1 (2009): 42–45.

22. The Dartmouth Institute for Health Policy and Clinical Practice, “The Dartmouth Atlas of Health Care,” available at www.dartmouthatlas.org (accessed September 7, 2009).

23. Elliott S. Fisher et al., “Fostering Accountable Health Care: Moving Forward in Medicare,” *Health Affairs* 28, no. 2 (2009): w219–w231.

24. 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* 28, no. 1 (2009): 37–41.

25. Steven A. Burd, “How Safeway Is Cutting Health-Care Costs,” *Wall Street Journal*, June 12, 2009.