A BETTER PRESCRIPTION

AEI SCHOLARS ON REALISTIC HEALTH REFORM

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Special Report

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Months of congressional wrangling over health care reform produced massive bills that were deeply unpopular. And now President Barack Obama wants legislators to try again. We agree that the country needs an honest discussion about reforming our health care system. It is time to reframe the debate.

Health care reform cannot be accomplished by passing a single piece of legislation, no matter how comprehensive it might be. Nor can we select "core elements," as Obama put it, from existing bills and create new and better legislation. Reform will require major changes in incentives, outlook, and institutions, and it will take time.

For more than six decades, the government has taken greater control over the system, bringing us to the unsatisfactory situation we have today. The reforms debated last fall followed that model, creating a labyrinth of new mandates, regulations, subsidies, and taxes. As the public came to understand what the legislation included and what it would mean for them, support declined.

Instead of investing even more in political solutions and top-down controls, we must rely more on accountable and competitive markets. Instead of emulating Sisyphus in trying again to roll the huge boulder of national health reform for all up the steep slopes of Capitol Hill, we should empower individual consumers and patients to step up, reward advisers who help them, and ask would-be central planners to step back.

It is time to level with the American people about what is possible and what is necessary in terms of health care reforms. We need a better prescription.

A New Direction for Reform

There are real problems in the U.S. health care system. Health care is a $2.5 trillion industry. Its high cost and persistent rapid rate of growth threaten to outrun the ability of families to pay for their health care and meet their other obligations. Fiscal pressures also threaten to overwhelm the ability of federal and state governments to finance ever growing obligations in Medicare, Medicaid, and other health programs.

Americans need relief from rising health costs, but they also need a health system that works. Despite our unparalleled levels of health spending, tens of millions of Americans lack insurance coverage for extended periods of time. Millions more fear that the insurance they do have will fail to give them stable and secure access to health care when they need it. We are paying a great deal for medical services, but too often that care does not yield commensurate improvements in patient health and well-being.

Rather than minimizing the role of individuals, a new approach to reform would make them the focal point of health care decisions. Those decisions include not just what insurance to purchase or what doctor to see, but also lifestyle choices and personal behavior that can affect well-being. Individuals are not just patients in the health system, they are also consumers.

To make consumer-driven health care a reality and not a hollow slogan, we must have a realistic view of what consumers can do. We should not expect that people will make every health decision on their own. They need help to understand what their insurance and health care choices are. Good decisions cannot be made without better and more accessible information, but consumers also need trusted advisers or expert agents who can help them interpret how the choices they have would affect them personally. Such agents already exist—the family physician, for example, or the employer who offers a health plan to his workers—but they, too, need better information and stronger incentives to provide advice tailored to the needs of the individual. Consumers should become more active participants in the decisions that affect their lives and their wallets.

Rather than imposing top-down control over the health system, reform must allow the system to find its own solutions to problems. Unforeseen developments inevitably arise that do not fit neatly into even the most complex and comprehensive legislation. Rather than having to guess a second and third time how best to control the health market well after a problem has occurred, we should take advantage of the market's ability to adapt to changing conditions.

Taking a market-based approach does not mean that government should not have a role. Regulations are needed to promote effective competition and to deter the worst excesses and fraud that might otherwise occur, without imposing constraints that drive out innovation and entrepreneurship. Competitive markets can be self-correcting if we do not subsidize failure.

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A better prescription requires that we rethink both the goals and methods of health reform.

- We must set realistic priorities for reform. We have neither the resources nor the wisdom to solve every problem in the health system through one grand legislative act.

- We must take measured steps to reform the health care system, allowing for frequent midcourse corrections as we learn how the system reacts to policy changes. We cannot anticipate every contingency and prevent every adverse consequence, no matter how many experts we consult or pages of legislation we write.

- We must recognize that the success of health system reform depends crucially on the way individuals, health providers, employers, and others respond to changes in incentives. Government can act as a catalyst for reform without attempting to dictate the results.

- We must recognize that the ultimate objective is to help Americans achieve healthier, more productive lives. Much of the responsibility for accomplishing that goal will rest with individuals, and their actions can be taken with no changes in government policy.

The goal of reform should be to make the health sector more competitive and more responsive to consumers so it can ultimately satisfy Americans' demands for appropriate care at the lowest cost.

Three Principles for a Better-Functioning System

Problems in a social and political system as complex as the health sector are not easy to solve. The thousands of pages of reform legislation written in 2009 testify to that fact. But the details often get in the way of understanding both the problem and the solution. To gain a clearer perspective, we offer three core principles for realistic and sustainable health reform. We also discuss some examples of policy changes that could be adopted as part of a renewed effort to create a well-functioning and responsive health system.

Number One: Place the Money—and Greater Control—in Consumers' Hands. In well-functioning markets, producers compete for customers by offering lower prices or better products. In the health sector, however, individual consumers are at a disadvantage when buying insurance and seeking care. They generally do not make the key purchasing decisions about which insurance to buy and how much to pay, and they (and their doctors) rarely know the price they will pay for medical services. These factors blunt the

power of competition to rein in the cost of increasingly expensive health insurance.

From one perspective, it is not surprising that the consumer's voice is muffled in the health sector. Making a good decision about insurance or care requires weighing complex information against personal needs and preferences, which is challenging even in the best of circumstances. It is often difficult to understand which specific services are covered by insurance under what conditions. This complexity is one of the factors motivating public demand for reform. Similarly, few people outside the medical profession are equipped with the knowledge to decide on their own which treatment is best. We can build mechanisms that enable consumers to make their own decisions with expert assistance, but we need not force every person to make every decision regardless of their ability or willingness to do so.

Health Insurance Purchases. Over 60 percent of people under the age of sixty-five—about 166 million people—receive their health insurance through an employer. The dominance of employer-sponsored coverage is explained by two factors: workers with employer-sponsored coverage benefit from a federal tax break worth more than $250 billion a year, and it is easier for most people to accept an employer's coverage than to search for their own insurance plan.

The Internal Revenue Service does not count employer contributions to premiums as part of a worker's taxable income. Many workers can also pay their own share of premiums on a pretax basis. That saves the average worker 30 cents in federal income and Social Security taxes for every dollar spent on health. Most workers save even more by avoiding state and local income taxes on their health benefits.

The savings are not free, however. The price people pay includes:

- Little or no choice of health plans. Collective insurance purchasing means some workers are required to buy insurance that is more expensive and comprehensive than they would have chosen if they made the decision.

- Inefficient use of health services. The tax exclusion biases the employer's decision in favor of higher premium plans that offer nearly first-dollar coverage—since the tax break applies only to premium contributions and there is no limit on the value of the subsidy. Higher-premium plans generally require lower out-of-pocket payments for services, which many people prefer. However, low deductibles and copayments reduce the consumer's cost consciousness and promote greater use of health services that may not be worth their full cost.

- Lower wages. When premiums increase, higher employer contributions mean lower wage raises. Many workers are unaware that they, and not their employer, are paying for their generous health plan by accepting lower wages.

- Unfairness to people with greater need. The tax break is not available to those who do not have employer-sponsored coverage, which includes people who do not have jobs as well as many low-wage workers.

Replacing the tax exclusion with a tax credit would promote smarter insurance purchasing and give the consumer a stronger voice in the insurance market. Such a tax credit could be increased for lower-income families or those with greater health needs who need more help to purchase insurance. A first step could be to cap the value of the tax exclusion, channeling the additional revenue into tax credits for those most in need. The credits should be set to help the uninsured purchase basic coverage, with more generous assistance for people with lower incomes as well as for those who have greater health risks and would have to pay higher premiums.

Other actions must be taken to realize the full potential of placing consumers in charge of their insurance decisions. To be effective, people need a choice of health plans, and they need information about those plans to inform their buying decisions.

Without informed choice, dissatisfied customers effectively cannot have their voices heard.

Health insurance "exchanges" could expand consumer access to a variety of health plans by providing one-stop shopping and standardized information about benefits, provider networks, and cost. An example of a privately run insurance exchange is eHealth.com, which offers information and online applications without limiting what insurers can offer. The Federal Employees Health Benefit Plan (FEHBP), a health exchange with several plans and providers from which employees can choose, operates as an employer-sponsored benefit, negotiating with insurers over the benefits, costs, and other aspects of health insurance offered to federal employees.

A government-run exchange could have more or less regulatory power, but there would be a temptation to seek increasing control over the insurance market. Such an exchange could become a vehicle for excessive regulation that drives up costs and limits choices unnecessarily, a risk the FEHBP has avoided. Policymakers are not capable of determining the best design for health insurance and cannot anticipate innovations that will emerge in the market. For that reason, an exchange should facilitate insurance purchases and not abuse its power to limit the insurance options open to consumers.

Another proposal to increase health insurance choices and reduce costs is to allow insurers to sell their plans across state lines. Insurers could be permitted to offer coverage in any state, as long as they satisfied the requirements imposed in their home state. Adding a few more insurers to a market would increase competition. However, the real benefit derives from competition among state regulators to attract insurers willing to move their operations into the state. States would have an incentive to encourage insurers to relocate by lowering regulatory barriers (such as benefit mandates that increase costs but add little value for consumers). Although insurers could offer a wider mix of products with different brands of state regulation embedded in them, the ultimate choices of what is bought and sold would be determined by consumers in more competitive markets.

Effective competition does not require every person in the market to search for the best insurance option without assistance. Many people shop for appliances by consulting reports from consumer organizations comparing the options. This reduces the difficulty of finding information and simplifies the decision by allowing consumers to limit the options they seriously consider. Moreover, appliance manufacturers respond to even modest losses of market share by reconsidering how they can make their products more attractive to potential buyers.

We can expect the same kind of behavior in the health insurance market. Many, perhaps most, workers would remain with their employer's plan even with a tax credit that could be used to buy other kinds of coverage. People who feel that they need a different kind of policy would consult consumer guides or seek advice from insurance agents or other experts. Some consumers would do their own homework, but they likely would be in the minority. In any case, if the public is to accept after-the-fact results in health care, individuals must have before-the-fact opportunities to choose. Many consumers may not want to manage most details of their health care decisions personally, but they should be able to decide who will decide for them.

Health Care Purchases. Consumer decision making does not end with the purchase of insurance. Individuals also must make decisions about the health care they receive and who provides that care. Patients need to have reliable information about the treatment options before them (including both cost and medical effectiveness), and they need to be able to trust those who help guide them through what can be a complicated series of difficult considerations. Better decision-support tools could help inform diagnoses and selection of treatment. Better information on provider performance could help patients choose their physician or medical center. This is particularly important for patients with serious conditions requiring invasive treatment, where a provider's experience can be a significant determining factor in a patient's outcome.

Producing useable information tools requires access to detailed data on patients, their treatments, and their outcomes. Although that information is contained in patient records, it is not readily available and cannot be compared easily across physicians. Initiatives to promote the use of electronic health records could lower the paper barrier and make these data more accessible to researchers. Medicare could do more to make its information on patient outcomes and provider performance available to the public. Medicare claims data could be used to generate more meaningful information on physician performance if they were shared in a careful and responsible way with private-sector experts.

However, there are serious analytical challenges in measuring performance and the data can be difficult to interpret. For example, a top surgeon may have a higher rate of fatalities because he receives a much larger share of very difficult cases with prognoses that are poor under any circumstances. At present, neither the data nor the analytic methods are capable of reliably sorting out the physician contribution to health outcomes from other factors.

Despite the challenges, there is general agreement that we should make better use of information currently trapped inside the medical system. Additional federal support for data development and new methods of measuring performance would advance our knowledge in this area. Setting reasonable minimum thresholds for measurement validity, establishing baseline standards that provide sufficient consistency but do not stifle further innovation, and facilitating collaboration between payers and providers would help advance the field of performance measurement. We cannot measure provider performance perfectly, but information need not be perfect to be useful.

Because not all patients react in the same way to a given treatment, therapeutic options should not be arbitrarily limited without enabling patients and their doctors to consider how specific circumstances might affect treatment decisions. Research on the comparative effectiveness of alternative medical interventions can help inform these decisions, but ultimately patients and physicians must decide. Do the potential benefits outweigh the likely risks?

Is the patient willing to bear the financial and physical costs associated with the treatment? How will the patient and family deal with follow-up care after the procedure? Such questions cannot be answered in the abstract, and the answers can determine the best course of treatment to follow.

Number Two: Align Expectations with Reality. Political rhetoric tends to promise more than can be delivered. Many claims made about the health reform legislation do not stand up to scrutiny. So-called universal coverage in the major congressional bills considered last fall, for example, was universal except for some 20 million people, many of whom are noncitizens living in the United States. Families were supposed to save $2,500 on their insurance, except that many would be paying higher premiums and more taxes under health reform legislation. The legislation would have preserved Medicare benefits for seniors, but cutting $400 billion out of provider payments would almost certainly have made it more difficult to obtain care. Health reform is supposed to solve the long-term deficit problem, except that the legislation considered last year created a trillion-dollar entitlement without any certainty that federal costs will decline.

A skeptical public saw through some of these claims, but many people still have unrealistic expectations about what their government, their insurer, and their doctor can and should do for them. Everyone might expect to be covered for virtually everything, but only because it is so difficult for them to know what the full cost will be and how much they, rather than someone else, will have to pay. If everyone believes they will come out ahead, many are sure to be disappointed.

Contrary to political behavior (if not belief), resources are finite—even in the health system—and prices play an important role in matching consumer demand with producer supply. The expectation that everything can be paid for (by someone else) has created the financially unsustainable system we have today. Last year's reform legislation would have imposed even greater demands on the capacity limits of the current health care delivery

system. Providing an additional 30 million people with a new entitlement to services would result in shortages and longer delays for patients seeking care. To keep costs in check and reallocate a limited supply of health services, the most likely political response would be both price controls and rationing. But simply limiting the use of services and discouraging the development of new, expensive (but potentially more effective) interventions will not put us on a sustainable long-term path. We must change the incentives that drive spending and seek better value for our health dollars.

It will eventually be possible to expand coverage widely, but only if we pay for what we can pay for. With the current inefficiency, inappropriate incentives, and excess in the health system that inflate the cost of care and erode its value, it is not feasible to expand insurance to 30 million people quickly. The funds are not there, and the longer-term commitment would add financial burdens that could destabilize our economy. We can start off more slowly, expanding coverage to those most in need while working to reform the system.

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As part of that process, we must reevaluate the financial promises we have already made in Medicare, Medicaid, and the tax subsidies for employer-sponsored coverage. In each case, financial incentives encourage greater spending but not necessarily better value.

Medicare is an open-ended entitlement facing a $37 trillion unfunded liability over the next seventy-five years. Medicare's generous subsidy combined with a fee-for-service payment system

has reduced the price sensitivity of beneficiaries and providers alike, encouraging a rapid expansion in the use of more (and more costly) services.

Costs in Medicaid are shared between the federal and state governments, but Medicaid is also an open-ended entitlement; it is threatening to engulf state budgets in California and elsewhere. States have used various financing schemes to increase the federal government's payment without necessarily increasing the availability or quality of services to beneficiaries.

The tax treatment of employer-sponsored health insurance is another kind of open-ended entitlement. There is no limit on the amount of employer contributions to health insurance that can be sheltered from taxation, and the potential benefit of the tax exclusion is unlimited. As a result, we have seen employer plans grow more generous over time, which has increased both their premiums and the value of the tax subsidy.

The rising cost of Medicare and Medicaid represents a growing burden on the federal budget. The shift to higher-premium plans induced by the tax exclusion reduces the funds available to the federal government. Their combined effect accelerates the growth in health care spending that is a burden on everyone.

Shifting from potentially unlimited subsidies to a defined-contribution approach would establish some control over the health spending and revenue commitments that undermine the country's fiscal future. Also known as premium support or vouchers, defined contributions provide funding for a basic level of care through fixed payments or subsidies given to individuals.

Individuals who are given a defined contribution can use their own funds to buy a richer insurance benefit or improved access to care. The government's contribution could be quite generous, but there would be no commitment to unlimited generosity. Resource constraints have always been a reality, even if not fully recognized by those who make promises with other people's money. Employers obviously recognize the financial limitations they and their employees face when selecting an insurance plan to offer, and rising health costs have forced employers to tighten benefits over the last

few years. A defined-contribution approach would better align government programs with fiscal reality.

A tax credit for health insurance, discussed earlier, is an example of a defined contribution. With this form of subsidy, consumers would have strong incentives to shop wisely since they would pay the additional premium for more costly insurance. The tradeoff is higher premiums for lower deductibles and copayments, more comprehensive benefits, or broader access to providers and services. Subsidy amounts would have to be carefully calibrated to reflect the individual's income status and health risk without undercutting the cost-sharing incentives that promote efficiency.

The defined-contribution concept is used in parts of the Medicare program, notably in Medicare Advantage (MA), which offers private health plans as an alternative to traditional fee-for-service Medicare. Those plans are paid a monthly rate for each member—that is, a defined contribution that covers the government's share of the cost of covered services—with the amount determined through competitive bidding. However, the efficiency incentives of a fixed payment for a bundle of services are blunted by a flawed bidding process. Because the plans bid against artificially high benchmarks, federal payments average 14 percent more than the cost of providing standard Medicare benefits under the traditional program.

The solution is to retain the defined contribution concept and reform the bidding process to fund it. The Medicare drug benefit under Part D provides a successful model. Part D plans bid against each other without any preset payment benchmarks. Moreover, all Part D plans are required to bid the cost of a basic benefit package, but within limits they are allowed to vary their formularies, cost-sharing requirements, access through retail outlets and mail order, and other aspects of the benefit.

A similar approach, with all MA plans as well as traditional Medicare participating in the bid process, would allow the government to set payments based on the low bidder in each local area. More efficient plans have an advantage under this process, either because they can bid lower and reduce the premium enrollees pay or offer additional benefits at a higher premium. Over time, less

efficient plans would have to become more efficient if they wanted to retain their share of the market. Under this bidding process, there would be no need to limit the flexibility MA plans have to offer additional benefits, a simplified system of deductibles and copayments, specific networks of providers, and other aspects of health plan design.

The defined contribution principle would also help resolve perverse financial incentives in the Medicaid program. Under the current system, the federal government pays a percentage of the cost of Medicaid services. That percentage varies from state to state, with the federal share averaging 57 percent of state costs. Replacing those matching payments with a block grant to each state would place clear limits on federal funding. States would have an incentive to manage their programs better, to reduce fraudulent claims, and to eliminate questionable financial practices common in the current system.

It might be possible to convert portions of Medicaid into a cash subsidy program for the purchase of private insurance eventually; however, cashing out the program could be prohibitively expensive because private plans would not have Medicaid's authority to restrict access to care and dictate low reimbursement rates to providers. Many in the Medicaid population, particularly nursing home residents who can no longer live in the community and the developmentally disabled, would need considerable help selecting a private plan. Rather than fully cashing out the program, a long-term goal would be to give low-income families subsidies sufficient for them to obtain private insurance that covers basic services while retaining the ability to provide more advanced services for beneficiaries who need them.

Number Three: Create Accountability in the Health System. A central theme in the health reform debate is the demand for responsibility and accountability in the health system. The sharp disagreements about the role of government evident throughout the debate rest in large part on perceptions about the ability of a market system to hold individuals, insurers, providers, employers,

and others accountable if they fail to act responsibly, however that might be defined. Thus the legislation had a mandate for individuals to buy insurance and for insurers to sell it because too often they do not.

This kind of accountability flows only in one direction: individuals and insurers are accountable to the government for adhering to new rules, but the government is not directly accountable to those it regulates. This hierarchical approach to accountability seeks compliance with decisions that have already been made. It rarely permits feedback to improve the decision, except through cumbersome bureaucratic mechanisms and political influence, and it can be difficult to correct mistakes once a decision is promulgated in regulations.

Government accountability is as important as private-sector accountability, and the track record on this score is not a source of optimism. Mistaken decisions made in the political arena often persist for years because the process favors the status quo. The health legislation considered last fall was replete with payoffs to secure votes, despite obvious inequities created when some states are granted preferential treatment over others.

Mandates, regulations, and other tools of government enforcement might aim to produce desirable responses, but they breed resistance and evasion that reduce our success in meeting social objectives and raise the cost of health care. There is a tendency to add more layers of regulation over time to seal off avenues of escape as affected individuals and firms react to reduce the adverse consequences they would incur as a result of the initial policies. This makes the entire system more rigid and cumbersome and less able to withstand economic and political shocks.

In contrast to the top-down hierarchy of government control, market mechanisms depend on two-way accountability to improve decision making on the part of both consumers and producers. An overpriced or inferior product loses market share, which sends a clear signal that improvements must be made—and what constitutes an improvement is determined by the purchaser and not some external authority. Similarly, consumers are not guaranteed to be

perfectly satisfied with the decisions they make, but a market system does not require them to continue to buy something they may not want.

Regulation is needed to set the rules of the road, but results—where we are headed and how we get there—cannot be dictated by policymakers. Properly structured incentives, better information, a climate that promotes innovative solutions to difficult problems, and a legal system that provides reasonable redress are essential for achieving a high level of health system performance.

Insurance Regulation and Mandates. New federal regulations on private insurers that were proposed in the health legislation were intended to make generous coverage available and affordable for everyone. "Guaranteed issue" would have required insurers to offer coverage to all who apply, regardless of their state of health. To make the premiums affordable, insurers would have been subject to "adjusted community rating," which limits how much they may charge older or sicker individuals for coverage.

In addition, new federal standards essentially would have defined the insurance products that could be sold. Benefit mandates would have required insurers to cover a wide range of medical services as part of the minimum package, limits would have been placed on what consumers would have to pay in out-of-pocket costs and premiums, and other requirements would have been imposed on the level of premium increases and insurers' operating expenses.

The combination of guaranteed issue, rating restrictions, minimum loss ratios, and other dictates in the health legislation can be deadly, even with a mandate requiring everyone to buy the industry's product. The proposed regulations drive up the cost of coverage, particularly to young healthy people. The cost-saving decision for them is "just-in-time" coverage—insurance purchased to pay for a major medical expense and then dropped, saving thousands in premium payments. Heavier fines are not the answer; smarter regulation is.

Americans should be guaranteed access to insurance with premiums that do not unduly penalize them for developing health

conditions that raise their risk profile. But that guarantee should be granted only to those who maintain continuous coverage and do not attempt to exploit the system. Everyone could be given an initial opportunity to enroll freely in insurance. Failure to purchase initially or breaks in coverage would expose individuals to the risk of new medical underwriting, which could bump them into a higher premium class. The initial guarantee of coverage, coupled with the risk of higher premium payments for failing to act responsibly, would be a strong incentive for individuals to maintain coverage—without having to resort to a government mandate that is unenforceable in practical terms.

Before developing a system to guarantee access to insurance, we should provide a more secure safety net for medically uninsurable individuals who cannot buy coverage for their specific health problem or who may be unable to buy insurance at all. State high-risk pools could fill that role, but substantially more federal support and better operating rules are needed before they will be effective.

Payment and Delivery Systems. The way we pay for services is a major reason our health system fails to give full value for the money. Fee-for-service payment, commonly relied on by private insurers and public programs, provides compensation to providers whether the patient gets better or not. Payments are made if the services provided are considered part of the normal standard of care, even if other services might have yielded equal or better results for the patient at a lower cost.

Because the outcome of a treatment depends on many factors outside the direct control of the physician, this is often unavoidable. However, payments can be structured to promote more appropriate treatment and better coordination of care among providers and to discourage the unnecessary use of services.

Instead of paying on a service-by-service basis, a single "bundled" payment could be made to cover a range of services likely to be needed to treat a patient for a particular condition. For example, Medicare pays hospitals for inpatient care based on the patient's diagnosis rather than on the specific set of services provided to treat that

condition. Because hospitals can keep any savings from operating more efficiently, Medicare's inpatient prospective payment system has contributed to lower lengths of stay and reduced inpatient costs.

However, these shorter lengths of hospital stay have increased the demand for postacute care, provided to patients who do not need to remain in the hospital but are not ready to return home. For that reason, experts are exploring the expansion to broader bundles, such as paying for an entire episode of care, to more fully capture the savings from improved management of patient care.

Although bundled payments promote efficiency in fee-for-service medicine, they are not a panacea. Bundling does not necessarily reward providers for delivering more appropriate or effective care if the bundle considers only the cost and not the outcome of care. Consequently, the bundled-payment methods currently available provide no guarantee that health spending growth will slow or that the value we get for that spending will increase.

"Pay for performance" is intended to promote more effective care. Medicare pays a bonus to providers who meet certain medical criteria. Current payment methods typically focus on "process" measures of performance—that is, whether the provider followed some treatment protocol—rather than whether the patient's health improved markedly as a result of the care. Such indicators are at least measurable, but they do not reflect the end product of medical treatment.

Research is continuing on payment methods that might allow fee-for-service Medicare to reward providers for superior performance in terms of both the outcomes and cost of care. Past experience demonstrates that payment incentives can exert a powerful influence on the way health care is delivered, and Medicare has proven to be a good laboratory for developing new payment methods.

Policymakers also have begun to examine how they can intervene in the market and promote new business organizations that could deliver quality care in a more cost-effective way. This will prove to be a far more challenging task.

This approach is inspired by world-famous health systems—the Mayo Clinic, Geisinger Health System, Kaiser Permanente, to name

a few—which are models of superior performance. Such systems are not necessarily low cost, but many experts and consumers believe they provide better value than traditional insurance.

These health systems deliver care in an organized way; they coordinate the activities of providers, monitor their performance, promote two-way feedback with their patients, and make adjustments to improve their operation whenever they see the opportunity. They rely on a continuous learning process that promotes incremental improvements in business practice and patient management.

The health legislation seeks to promote a variety of new medical models, including accountable care organizations, medical homes, and other approaches that offer more coordinated patient-centered care. Policymakers should not casually assume they can legislate new business enterprises into existence to produce better patient outcomes or lower cost. It is difficult to transplant the medical culture and business models of successful health systems to new markets. Differences in the receptivity of patients and physicians to new approaches of delivering care can mean that success in one place does not translate easily into success somewhere else. A wiser course would rely on private sector initiative to develop new models of care delivery, allowing the market to determine what works and what does not work.

To encourage delivery system reform, we should not leave patients out of the process. One of the most promising avenues for improving care would be to develop better information for both patients and their physicians. To develop relevant and reliable information, we need better access to data on what actually happens to different patients in the course of their treatment, better methods to determine what the data mean, and better ways to make that information understandable and accessible to consumers and medical professionals. Analytic methods that reliably indicate how a provider's decisions and practices contributed to the health of the patient and the cost of care must be refined to account for variations in the patient's initial condition, compliance with medical advice, and other factors that are outside the physician's control. In addition,

privacy concerns must be addressed, and decisions must be made about who should have access to patient data and how those data can be used.

Malpractice Reform. If a serious and avoidable error is made in the treatment of a patient, we might expect that wrongdoers would end up in court, and we might hope they would be appropriately punished while victims would be appropriately compensated. But it rarely works this way. An effective medical-liability system would reliably distinguish between good care and bad care. Instead, ours distinguishes between good cases and bad cases.

Patients who have suffered real harm are often unable to seek redress in the courts because the legal process is arcane and expensive. Others with less serious injuries may be heard in court because they have a better chance to obtain larger judgments, at least from the economic perspective of contingent-fee legal counsel. Settlements and jury awards can be out of proportion to the injury sustained. Moreover, the legal process may not always distinguish between truly negligent care and bad health outcomes that were unavoidable. Consequently, the medical malpractice system can be arbitrary and unfair to patients and providers alike.

This has a chilling effect on medical practice that extends well beyond the narrow confines of the cases that are filed and brought to court. An adversarial atmosphere promotes defensive medicine and discourages honest communication between physicians and patients. It adds up to worse care and higher cost. In short, many people who have reason to sue do not. Yet many of those who bring claims (and often receive damage awards) should not. Our expensive medical tort system fails both to deter negligent care and to improve access to necessary services.

A new system is needed. Limits on awards provide some crude malpractice premium relief to medical providers, but they do not fundamentally change the defects in our medical-liability system. Specialized health courts could provide the expertise to adjudicate claims more quickly and accurately. Incentives for prompt consideration of a patient's claim should be strengthened.

Personal Responsibility. Going to court imposes accountability at the back end of the health system, after the illness has been contracted and the medical services have been rendered. We should be at least as concerned about accountability at the front end of the process. Individual behavior plays a central role in determining our state of health, our need for care, and the effectiveness of treatment. Lifestyle choices, risky behaviors, and failure to heed sound medical advice can result in the use of services that could have been avoided, poorer health outcomes, and greater expense for the individual and the broader community.

Preventive health services—including immunization, medical screening, and medications for chronic conditions—are frequently touted as cost-effective ways to improve population health. However, research has shown that most preventive services fail to reduce medical cost. Moreover, as the recent controversy over mammogram guidelines issued by the U.S. Preventive Services Task Force illustrates, the scientific evidence on the effectiveness and appropriateness of some prevention services is often unclear and subject to dispute.

Individuals can be encouraged to take personal responsibility for their own actions to prevent disease. The obesity epidemic among younger people is a case in point. Obesity is associated with high cholesterol levels and blood pressure (which increase the chance of a heart attack or stroke). We can treat these conditions with regular visits to the physician and medications. But many patients can avoid these conditions in the first place by adhering to a good diet and exercising regularly. The medical treatments add to the cost of care, and they often are no more effective in preventing the onset of serious disease than a change in personal behavior.

Employers and insurers can work together to promote healthier lifestyles and better adherence to treatment recommendations. Some employer plans operate wellness programs and lower the premiums paid by their employees if they reach certain goals, such as stopping smoking or maintaining healthy weight, blood pressure, and cholesterol levels. This is not purely altruistic; if this approach is successful over the long term, the company could benefit from lower absenteeism and disability rates.

Insurers do not have the same latitude as employers to reward beneficiaries who attain important health goals, but they can structure their coverage to promote better patient behavior. Value-based insurance designs use financial incentives to encourage patients with treatable chronic conditions to remain faithful to their doctor's recommendations. For example, some employer plans lower the copayment on drugs or other treatments for workers who have hypertension or diabetes.

Market-based health reform is no panacea. It would not produce an instant cure for every problem facing the health system, but it does not claim to do that. Instead, a market approach provides the tools by which the health system can become more effective, more efficient, and more responsive to patient needs.

People who have high-deductible health plans rather than conventional coverage also have an incentive to make careful health care and lifestyle decisions. Such plans typically include health savings accounts (HSAs), which allow workers (often with contributions from their employers) to cover their out-of-pocket costs with pretax dollars. Such plans could promote healthy behavior more effectively if they incorporated elements of value-based design, such as requiring lower copayments on treatments that are effective in managing chronic disease. Better decision making could pay off in lower costs and higher HSA balances over the long term.

More could be done to promote a healthier population. Currently, employers may reward employees participating in wellness programs by returning to them as much as 20 percent of their insurance premium. That limit could be increased. In addition, financial incentives could be targeted more directly to plan beneficiaries who face high health risks that could be reduced through lifestyle or other changes. We could also provide greater flexibility in the design of high-deductible health plans and HSA plans to direct better incentives in such plans.

Conclusion

Policymakers have a problem. Americans made it clear last fall that they will not tolerate a top-down health reform that further centralizes power and decision making in Washington. They distrust the promises of lower costs and more secure coverage, and they fear losing what they have now. It is time for a new approach to health reform; it is time for a better prescription. Rather than making promises that cannot be delivered, it is better to level with the American people about what is possible and what is necessary.

Market-based health reform is no panacea. It would not produce an instant cure for every problem facing the health system, but it does not claim to do that. Instead, a market approach provides the tools by which the health system can become more effective, more efficient, and more responsive to patient needs. Instead of a cookie-cutter approach, market-based reform offers rewards for innovation, excellence, and responsible behavior but recognizes that not all people have the same needs, preferences, and ability to pay.

We should strengthen effective competition that rewards initiative and 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 Congress enacts are sustainable over the long term.

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AEI's Health Policy Studies program is one of the most active centers at AEI. For decades it has provided the intellectual and practical underpinnings for health care debates. The team has analyzed issues and concerns critical to the future of America's health system, spanning subjects as varied as health coverage for the uninsured, Medicare and Medicaid reform, the role of the Food and Drug Administration, the effects of price controls on pharmaceutical research and development, drug reimportation, global health and drug provision, and the role of private-sector solutions to public health problems. A list of the scholars in the program appears below.

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