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The Health Care Challenge Facing America's Governments

Richard P. Nathan

Introduction By Thomas L. Gais, Director, The Rockefeller Institute of Government

This is the third paper written by Senior Fellow Richard P. Nathan on the financial challenge of health care in the United States. Nathan's perspective on health care costs is special in several ways. Although he's writing about markets, his approach is inductive and institutional rather than the typical theoretical perspective. He looks at the different ways in which markets already operate in our health care system, including exchanges in the public and private sectors, health savings accounts, and "advance directives" — which he insightfully notes are instruments for strengthening markets through informed consumer choice.

Nathan is also a pragmatist. He has no reservations about borrowing and combining ideas from different sources to fashion a health care system that controls costs. Although this paper focuses on the consumer-choice approach for promoting cost consciousness, he calls for its reconciliation with the provider-value approach — a reconciliation I hope he explores in greater detail in future papers.

As a political scientist, Nathan correctly notes that policies don't just happen. They have to be refined, enacted, implemented, monitored, and adjusted through political processes — and those processes should be designed as carefully as the policies themselves. As he says, institutional inventions should not be "one-time arrangements." They should include "machinery, not just for overseeing and expediting near-term planning and implementation processes, but also for adjusting the new policy bargain as necessary." Many will disagree with his procedural and institutional recommendations, but it is hard to dispute the need for a more careful consideration of health care governance than we have seen thus far.

Finally, Nathan brings a long-term view that makes clear the potential bipartisan appeal of attacking the problem of health care costs. In 1969, when Nathan began working as assistant director of the U.S. Bureau of the Budget (soon to become the Office of Management and Budget), health care spending accounted for only 6.9 percent of the federal budget. In the same year, over twice as much — to be precise, 15.5 percent — of total federal budget outlays were spent on science,

space, and technology; natural resources and environment; energy; transportation; and education, training, employment, and social services.

But how things have changed. In 2011, health spending accounted for 21.6 percent of the federal budget, while outlays for science, environment, transportation, education, social services, and all the other items listed above summed to only 9.8 percent of the federal budget. Conservatives may consider growing health care costs to be an extreme case of run-away government spending. But liberals have to consider too whether this enormous shift in what the federal government does is tolerable, particularly in light of its implications for who benefits from health care spending and who is hurt by a shrinking pie for nearly all other domestic priorities.

As of this writing, we do not know how the Supreme Court's decision or the 2012 elections will affect federal health care reforms or prospects for additional changes. But Nathan's eclectic, institutionalist, and long-term perspective on the cost issue is well worth considering if and when national policymaking is once again feasible.

T*his paper focuses on the fiscal challenge to America's governments of rising health care costs. Based on a review of the literature and an analysis of current policies and programs, the paper argues that three types of reforms are needed: (1) strengthen market incentives, (2) place greater emphasis on income-testing, and (3) give priority to meeting catastrophic health care needs. The paper describes theories of management change and the activities of health insurance exchanges. It considers the role of the federal tax exclusion for employer contributions for employee health benefits in relation to the controversy about whether benefits should be provided on a defined-contribution (fiscally closed-ended) basis or a more open-ended defined-benefit basis (that guarantees a basket of health services). The aim of the paper is to provide an in-depth substantive and institutional explanation of changes that could be made consistent with the three types of reforms listed above by converting Medicare (the biggest source of cost pressures) to a defined-contribution (premium-support) program with stronger income testing, revising the Affordable Care Act, and establishing a course-correction system for making and implementing policy changes that enables the president and the Congress to adjust to new developments and changed conditions in the implementation of new policies.*

The Fiscal Imperative

Experts on health policy and public finances on both sides of the aisle politically believe reforms of entitlement programs, specifically and particularly health care programs, should be a major

component of the response to the deleveraging/deficit reduction challenge facing America's governments.

Princeton economist Alan Blinder, formerly vice president of the Federal Reserve and a member of the Council of Economic Advisors, wrote in the *Wall Street Journal* in December 2010 that health care is the key to the nation's long-term deficit challenge. Said Blinder, "It is a myth that America has a generalized problem of runaway spending. No. The truth is that we have a huge problem of exploding health-care costs, part of which shows up in Medicare and Medicaid."¹

Richard Kogan of the Committee on Budget and Policy Priorities has written: "To be sure, in subsequent decades as the population continues to age and health care costs continue to rise, federal non-interest spending will climb significantly higher.... In addition, if the debt continues to rise faster than GDP, interest will continue to swell. We will have to tackle these issues."²

Citing per capita spending for health care (\$8,000 per person), Ezekiel J. Emanuel, who worked in the White House on President Obama's 2010 national health reform law, summed up a recent article on health care costs by saying, "If you have heard it once you have heard it a hundred times. 'The United States spends too much on health care.' This is not a partisan point."³

In a similar vein, Peter Orszag, who directed both the Congressional Budget Office and the President's Office of Management and Budget, came away from his experience as the point person for finance in the 2010 health care debate with a pessimistic outlook. Said Orszag, "It is no exaggeration to say that the United States' standing in the world depends on its success in constraining this health care-cost explosion; unless it does, the country will eventually face a severe fiscal crisis of crippling inability to invest in other areas."⁴

Editorially, the *Wall Street Journal* has highlighted Medicare spending as "the main driver of the fiscal crisis ... growing about three percentage points faster every year than the overall economy for the last quarter century."⁵

The 2011 annual report of the Medicare Trustees is pessimistic about the country's ability to deal with cost pressures facing the system. Based on past experience, the Trustees urge readers to recognize the "great uncertainty" associated with achieving scheduled reductions in physician's fees and cost-reducing measures in the Affordable Care Act. In a similar vein, but even more emphatically, the Actuary's analysis says that cost estimates under current law should be viewed cautiously because of "the degree to which current-law projections understate actual future costs."⁶

For Medicaid, a recent study published in *Health Affairs* is entitled, "Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs and Needs for Physicians under Health Reform." The authors estimate that the number of additional people enrolling in Medicaid under health reform may vary

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by more than 10 million with a base-case estimate of 13.4 million and a possible range of 8.5 million to 22.4 million, with estimated costs and physician needs reflecting a similar very large range.⁷

The annual increase in Medicaid spending from 2000 to 2011 was 7.1 percent, driven by annual enrollment growth of 4.6 percent and medical price inflation and benefit increases estimated at 2.5 percent. This is 3.2 percentage points greater than the total annual growth in this period (3.9%) in state tax revenues.⁸

This challenge of bending the health care cost curve affects both the federal government and state governments and, according to one study, hits home for individual taxpayers. RAND health care analysts wrote in September 2011 in *Health Affairs*, "A Decade of Health Care Cost Growth Has Wiped out Real Income Gains for An Average Family." They said that from 1999 to 2009 if the rate of health care cost growth had not exceeded inflation the average family would have had income growth of \$545 per month instead of \$95, a difference that adds up to \$5,400 a year. The authors added, "Even the \$95 gain was artificial, because tax collections in 2009 were insufficient to cover actual increases in federal health spending. As a result, we argue, the burdens imposed on all payers by steadily rising health care spending can no longer be ignored."⁹

My judgment is that structural reform of the nation's health care programs is necessary and unavoidable. We cannot sit back and hope economic forces now in play will produce a steady state condition in which everyone who needs care receives all the care they need under existing policies and programs. Politicians have a hard job. Their role is to balance out entrepreneurs (business and private interests) and bureaucrats (the government's role) in modern democracies. This paper presents suggestions for performing this balance-wheel function for U.S. health policy, a challenge that has been the center of intense political and legislative debate for fifty years from the enactment of Medicare in 1965 to the Patient Protection and Affordable Care Act in 2010.

Two Management Theories

There are two principal theories of public management about how to reform government's role in health care. One is the provider-value theory, which emphasizes government action. Central to this theory is integrating ("bundling") services to increase the productivity and quality of care through the enhanced application of information technology, increased transparency about treatment results, and evidence-based rules and guidelines as techniques for curtailing unnecessary and inefficient procedures.

A second theory is the consumer-directed or consumer-choice theory. It resists governmental activism; its aim is to induce and empower patients to make wise choices in the marketplace. There is imbedded in this position a considerable and deep skepticism about the capacity of government and the American political system to micromanage American health care.

Of the two theories, the consumer-choice theory is not treated and discussed as extensively in the literature on health care as the provider-value approach. I decided I should emphasize this theory, although not to the exclusion of the provider-value approach. *On political and substantive grounds, I believe the two theories should be reconciled and pursued together.*¹⁰

The Consumer-Choice Theory

I view the consumer-choice theory as having three parts:

- **Increasing competition through health insurance exchanges.** While often not well explained, much of what happens in the provision of health care in the United States happens through health insurance exchanges, that is, market places in which consumers choose the insurance or network plan that, in their view, best fits their conditions, needs, and pocket book. Most such choices are provided under systems for Employer Sponsored Insurance (ESI) in both the private and public sector.
- **Savings plans that empower consumers.** Increasingly on health insurance exchanges employers are offering Health Savings Accounts (HSAs). They assign consumers responsibility for using up-front tax-deductible savings earmarked for health care in deciding, at least initially, what are the most appropriate and efficient services and treatments. Health Savings Accounts by law must be linked to health insurance plans.
- **“Advance Directives” under which people express their preferences for care at times of their most serious need.** While these legal instruments involving end-of-life treatment preferences expressed in “Living Wills” and grants of power to health care surrogates typically are not described in these terms (that is, as consumers making choices), that is what they are — choices made for those awful times when death is believed to be near. Most such choices are for the provision of comfort and loving support while at the same time (although some may take umbrage to saying it this way) constraining costs. They do this by reducing the application of the relentlessly advancing tools of modern medicine when, according to the expressed wishes and preferences of the patient and the views of his or her surrogate, they are determined to be futile.

In all three areas, these policies and instruments already operate on a substantial scale. Could they be expanded? Should they be?

The Role of Health Insurance Exchanges

Economists tend to like the idea of exchanges as a method for enabling consumers to select the insurance coverage they want and, in the process, pooling risks and incentivizing insurers and providers to compete. Other countries, notably the Netherlands,

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Switzerland, and Germany, place reliance in similar ways on the marketplace to induce competition on the part of for-profit and nonprofit nongovernmental entities that either are or operate like insurance companies.¹¹

The biggest American health insurance exchange is the Federal Employee Health Benefit program (FEHB) for U.S. government employees, including both executive branch and Congressional employees.¹² Nine million people (federal employees, former workers, and their dependents) arrange for and obtain health insurance benefits and care through this exchange, relying on a subsidy from their employer that covers around 70 percent of their costs. Management of this program is the responsibility of the U.S. Office of Personnel Management (OPM). The FEHBP has been around for fifty years and is well regarded.¹³ Other governmental systems that operate as exchanges provide valuable experience for managing competition, for example Part C (Medicare Advantage) and Part D (prescription drug coverage) under Medicare and systems for managing competition for health insurance for state and local government employees.

State and local governments provide health benefits to their workers the same way FEHB does. They have exchanges on which employees choose their health care plan. Most such choices are for health insurance policies provided by for-profit and nonprofit insurance companies. State and local employer-sponsored systems also offer managed care options. On an even larger scale, private employers offer choices to their employees on employer-sponsored health insurance exchanges.

As opposed to the way employer-sponsored coverage works, there are unanswered questions for new government-operated health insurance exchanges, whether under the 2010 Affordable Care Act or newly proposed for Medicare: How to avoid offering too many choices and confusing customers? How best to inform and assist customers? How to select the plans that are offered? How to risk adjust? How to prevent undue politicization, and what is the right economy of scale?

To sum up, private and public employer-sponsored health insurance, which covers approximately 150 million people, is the main way the United States provides health care. This is likely to continue to be so for the foreseeable future. My research found growing and strong concern on the part of both for-profit and nonprofit employers (private and public, large and small) about rising health care costs.¹⁴ As a result, employers are adopting cost-cutting measures for the plans they offer, either single plans or choices on employer-sponsored health insurance exchanges. Many are doing this (i.e., scaling back) reluctantly. There is a consensus among employers that they have a responsibility to provide health benefits for their workers.

Operationally, the big challenge for health insurance exchanges does not involve the way employer-sponsored health insurance is provided. Rather, it is the convoluted situation that

exists for the new subsidized coverage to be provided under the Affordable Care Act with each state responsible for setting up its own individual-market and small business-market exchanges. As discussed further on, it is unfortunate that this administrative challenge, which is now being dealt with (although not easily or smoothly) under the ACA law and the similar challenges that would have to be dealt with in setting up a federal exchange for Medicare premium-support, tend to be put on the back burner in health reform decision making, vis-à-vis debates about levels and types of coverage and care.

The Federal Tax Exclusion

One of the trickiest questions for efforts to enhance health care markets is how to view and whether to change the current situation under which employer contributions for health insurance are excluded from the federal taxable income of recipients. This is the granddaddy of all tax expenditures, accounting for an estimated \$180 billion in 2013 and over \$1 trillion dollars over the five-year period 2013-17. The pluses and minuses of this arrangement are beguiling.¹⁵

On the plus side, by incentivizing employer-provided coverage the exclusion increases coverage and provides opportunities for risk pooling. On the minus side, there are questions of horizontal equity (some people aren't covered by their employer and thus don't obtain the exclusion) and vertical equity (the argument that the exclusion disproportionately aids better-off taxpayers).¹⁶ Without going into particulars, I come out on the side of keeping, but capping, the exclusion. I see the benefits as outweighing the costs because the exclusion encourages competition and choice, which in turn can stimulate cost awareness.

There is another and related subject and debate to which I turn next, a growing movement in the country to cap employer health insurance benefits, not just for tax purposes, but generally. The two subjects are related, but should be treated separately, i.e., capping the tax treatment of benefits, which I favor,¹⁷ and the capping of benefits, which is now widely known by the term "*defined-contribution*" health insurance as opposed to "*defined-benefit*" health insurance.¹⁸

Defined-Contribution Versus Defined-Benefit Health Insurance

The U.S. Agency for Healthcare Research and Quality stated as one of its main findings: "Employers may lower costs by offering employees multiple insurance plans and making the same contribution to each."¹⁹ This last point about making "the same contribution" to each plan is crucial. Much of the recent literature on health reform that compares liberal and conservative views of health reform hinges on this question: Should health benefits (private and public) move further (they are already moving this way) towards the provision of defined contributions (a fixed amount of money) rather than defined benefits?

In the economy as a whole, this conversion is happening for pension benefits. Increasingly, private- and public-sector pensions are being converted from guaranteed-benefit to guaranteed-contribution programs.

In a 2011 article, Peter Orszag predicted that this will happen to health benefits as well. "Over the next decade, we are likely to see a shift in health insurance in the U.S.: So-called defined-contribution plans will gradually take over the market, shifting the residual risk of incurring high health-care costs from employers to workers." Orszag noted that in 1985 only ten out of the top Fortune 100 companies offered their employees a defined-contribution plan. By contrast he added, "Today [i.e., 2011], only 13 of the top 100 Fortune companies offer a traditional defined-benefit plan, and 70 offer *only* a defined-contribution plan."²⁰

One way this shift to defined contribution is occurring is that employers do this by offering what are known as "High Deductible Health Insurance" policies, although this phrasing, "High Deductible," is something of a misnomer. Deductibles can be affordable, by which I mean they can vary, for example, for hourly and salaried workers in a way that reflects ability to pay. Such plans often are combined with Health Savings Accounts as discussed in the section below on "Health Savings Options."

Orszag in his article said he is willing to bet \$1 on his prediction that defined-contribution health insurance will take over the market for employer health care in the next decade. And at the end of the article he asks: "Any takers?" I wouldn't bet against him, and even if I did it would be hard to prove him wrong.

Go back to the description of "High Deductible Health Insurance" (HDHI). If employers facing rising premiums for health care benefits want to cut costs, one strategy is to "close the end" (budget-speak for converting an open-ended financial commitment into one that is closed-ended or fixed); this can be done by switching from defined-benefit coverage to HDHI coverage.

Take an example: Let's say an HDHI policy costs an employer \$4,000, either a large employer who self-insures or an employer who purchases a HDHI policy for an employee from a private or nonprofit insurance company. Effectively this would not be a guaranteed benefit since the employer can adjust the terms of an HDHI policy to maintain its cost at a particular level (as above \$4,000). If insurance costs increase, this can be accomplished by requiring the employee to pay a larger share of the premium, raising the deductible or co-pay or out-of-pocket maximum the employee faces, or some combination of these measures. This is harder to do under a traditional health insurance policy that highlights a package of covered health-care benefits. Such plans have a services orientation as opposed to HDHI policies which tend to be described and treated as financial arrangements that have as an important purpose encouraging cost awareness and cost restraint.

Opponents of this strategy don't like it because they see the protection as insufficient and/or because they oppose shifting

costs in this way to individual employees and families. But like it or not this choice between defined-contribution and defined-benefit health insurance (hard as it is to pin down operationally) is the challenge presented by the debate on health care between liberals and conservatives and also, as described earlier, between advocates of the two theories of health reform, provider-value and consumer-choice.

This observation reflects a larger point about the way the American political system works. It is often the case when great policy debates are occurring that change is already happening at the same time the public is busily, and sometimes hotly, debating what should be done. This is what Peter Orszag says is happening to health care right now. Should the society provide a defined amount of resources for health care or guarantee defined benefits? Whether people regard defined-contribution policies as desirable or undesirable, good or bad, fair or unfair is a central health reform issue.

This goes back to the earlier juxtaposition of the two theories of health reform, provider-value and consumer-choice. Change is happening for both theories. Just as insurance companies are changing their policies, governments are adopting new ways to support delivery system reforms, hospitals and provider organizations are adopting new integrative approaches and improved information systems, emergi-centers are growing, and pharmacies are expanding their minute-clinics. The theme stated earlier needs to be reinforced here: Both strategies are needed, strategies that reform the management of provider systems *and* strategies that encourage market behavior on the part of consumers. The efficiency challenge is bigger than what either of them acting alone can accomplish.

In studying the “how-could-it work” dimensions of health reform, I have come to a better understanding of what is happening and also to a view of my own about how to regard these changes. Other advanced democracies provide care for everyone, yet the U.S. has nearly 50 million people (16 percent of the population) who do not have coverage. Germany adopted its universal system in 1883 under Bismarck; the United Kingdom did so seventy years ago at the end of World War II. The dilemma for the United States is that we face this challenge at a time and under conditions where fundamental forces are against us. The unrelenting advance of modern medicine has sent costs soaring. In turn, this has extended longevity; and demographic changes are rapidly and substantially adding to the nation's older population.

The Affordable Care Act is/was a typically multifaceted American political bargain that tries/tried to balance out substantive political and economic issues and interests.²¹ Many actors put their fingerprints on its 2,000-plus pages. The law is incremental as opposed to being a radical overhaul of the health care industry; it takes months to understand and even then there are many unanswered questions about how it will operate. Despite this, the ACA

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Medicare: The Push for Premium-Support

In contrast to the role of private companies in providing employer-sponsored coverage, Medicare is predominantly a direct government program, although since 1997 Medicare has had an exchange-type (Part C, "Advantage") option, which currently has a 25 percent take-up under a user-friendly exchange system administratively and operationally similar to that for Federal Employee Health Benefits.

Overall, Medicare serves 50 million people who for the most part are no longer employed. Generous as the program is, it presents the biggest public health-care cost-push pressure. In 1970, five years after Medicare was enacted, it accounted for 4 percent of the federal budget. Now it accounts for three times that share — 15 percent. And it is projected to keep on growing as baby boomers retire and modern medicine continues its relentless advance.²²

According to MIT economist Jonathan Gruber, "Just to finance the Medicare program, to put it on a solid footing for the foreseeable future, would require a 15 percent payroll tax. [The current rate is 2.45%.] Every person in America would have to pay 15 percent of their wages to the government, basically doubling the [total] tax burden of most American families. This is a huge long-run problem."²³

Under the leadership of Budget Committee chair Paul Ryan, the U.S. House of Representatives in 2010 and 2011 adopted a pro-choice overhaul of Medicare. Ryan's "new" Medicare would provide eligible seniors with a fixed amount of money to make their consumer choice by purchasing their health insurance or network care on a national Medicare health insurance exchange, which, like that for federal employees, would have regionally-based offerings. (For the FEHBP system, you can go online, enter your ZIP code, and see a good demonstration of how this system works.)

The critical point for the Ryan plan is *fiscal*. Unlike the Federal Employees Health Plan and many other private and public employer-sponsored systems, the Ryan plan is closed ended. Being a former budget official, this difference jumps off the page. Although it is subtle, I detect a softening in attitude among health experts on the need at least to countenance closed-ended premium-support for Medicare. When I began working on health finances I often received a knee-jerk reaction even to mentioning this idea. Now I detect a willingness (although often reluctant) to take a look at the arguments and methods for converting health benefits to a defined-contribution system. This is true of a few Democratic politicians (notably Senator Ron Wyden of Oregon) and public policy experts (notably Alice Rivlin) and writers and journalists, not just on the right, but increasingly in the liberal press.

Still, even if the politics and math could be worked out, a “reality check” is needed. Competition could change the mindset and marketing of health services, but not suddenly. Under the best of conditions, increasing cost consciousness will take time.

Advocates of premium-support for Medicare envision, as does Ryan, establishing a national health insurance exchange for the new Medicare to stimulate competition, help people make choices, and moderate Medicare cost push.

Such exchanges already exist for many employees and will exist (if it is implemented) under the Affordable Care Act. Their purpose is to offer choices so private insurers and providers compete for business. It is argued that doing this will reduce governmental intrusiveness, which health expert Harry Cain has characterized as “the micro-management of Medicare.” According to Cain, “the scale and complexity of the health care industry are beyond the grasp of 500 politicians sitting in Washington.”²⁴

Supporters of a Ryan-type overhaul of Medicare also favor transferring a larger share of Medicare costs to better-off beneficiaries through income testing, although there are formidable political barriers to doing this.²⁵ The rhetoric is hot and heavy. In conversations I have had, I often receive this response: “Medicare is insurance, you paid for it, whereas Medicaid is an entitlement.”

But that’s not quite right.

An analysis by Eugene Steuerle of the Urban Institute shows that the share that Medicare taxes and premiums cover “of the care provided to the average recipient ranges from 51 to 58 percent over time.” Steuerle says “[for] the rest we borrow from China and elsewhere, and we use up ever-larger shares of income tax revenue, leaving ever-smaller shares for the government functions. Bottom line: without reform, current workers would continue to shunt many of their Medicare costs onto younger generations.”²⁶

Warren Buffet should pay for a larger share of the cost for his care and so should I. Our children and grandchildren shouldn’t be saddled with half of these costs. But you have to ask, could income-testing under a Medicare premium-support system make a big enough difference? Could it appreciably reduce government health care spending?

I think it would be a good thing if actuaries could devise a smooth system to have better-off beneficiaries under the “new” Medicare pay their full (or nearly full) share of the costs while at the same time subsidizing seniors and the disabled who aren’t so fortunate. However, not only are the political barriers involved formidable, one has to be dubious about whether the math could be worked out smoothly.²⁷

Still, even if the politics and math could be worked out, a “reality check” is needed. Competition could change the mindset and marketing of health services, but not suddenly. Under the best of conditions, increasing cost consciousness will take time. I say this even though I have come to the conclusion that the Medicare premium-support approach should be adopted and that it should be linked with the subject treated next in this paper, the expansion of health savings options.

Health Savings Options

Health savings options have two parts, a Health Savings Account (or similar account)²⁸ and a High Deductible Health Insurance (HDHI) policy or sometimes called “catastrophic” insurance policy.²⁹ Like premium support for Medicare, the aim of the dual HSA-HDHI approach is to promote more of a marketplace mindset on the part of both health care consumers and service providers.

In reading and in interviews conducted with employers and insurers, I found growing concern about health care costs and commensurately increased interest in HSA-HDHI plans on the part of private as well as public employers. Many employers who have adopted these plans have instituted measures to educate workers about this strategy.

Linked HSA-HDHI plans are currently offered by one-third of all large private employers (those with over 500 workers) covering 11.4 million people; 13 percent of all employer-sponsored insurance (ESI) covered private workers. This is a five-fold increase from 3 percent five years ago.³⁰

Following is an overview of how these plans work. I rely here on published information from three sources, General Electric's plan, the University of Pennsylvania's, and the State of Indiana's. (All three are available online.)³¹

Each employer offers multiple plans, sometimes with one or two savings options as well as a preferred provider and/or point-of-service plan. Up to the level of the annual deductible, health care costs are the responsibility of the employee, with the assistance of funds from a savings account to which the employer (and in some cases the employee) contributes. If all of the funds in the employee's individual account are not spent in one year, they may be carried forward to reduce the deduction in future years, which gives the employee a direct interest in controlling spending. The higher the HDHI deductible, the lower the health insurance premium. Deductibles vary among plans. Deductibles, co-pays, and the ceiling for out-of-pocket costs can be set at levels appropriate to the pay and salary levels of workers so they are big enough to cause cost awareness while at the same time they are achievable in relation to the income of the persons or family insured.³²

Employers cite as reasons for adopting savings strategies like this that they increase transparency, encourage workers to be cost conscious, and reduce health care costs. One major insurer, Aetna, has publicized data based on the company's experience providing savings plans indicating that under these plans consumers tend to ask more questions, select services and treatments in ways that avoid duplication, and keep closer track of what they receive.³³

It is hard to put numbers to how widespread savings plans are likely to become. While annual data are available for large private employers, I could not find comparable data for small employers and public sector employers. On the basis of the information that is available, I believe it is reasonable to expect that in the relatively

near future as many as a third of workers, particularly younger and healthier workers, will be enrolled in or be “exposed” to the rationale and workings of savings options.

It is instructive to compare the effect of a Health Savings Account with supplemental health insurance, which particularly for Medicare beneficiaries means that they don't face appreciable up-front personal costs because they have a “Medigap” guarantee. The HSA-HDHI option provides back-end protection, whereas Medigap coverage puts the guarantee at the front end. Health Savings Accounts put consumers in the position *initially* of having to spend their own “saved” funds in an HSA account. Payments made with these funds are scored so they can apply to the required deductible and co-payments of the linked High Deductible Health Insurance policy. Medigap policies are not needed. In fact they are prohibited by law under the health savings HSA-HDHI approach.

It is contended by advocates of consumer-choice health reforms, and I agree with this position, that one benefit of increased reliance on the twin approach of exchanges and savings plans is that it would help bring health care cost data out of its mystery-land. As matters now stand, for many medical procedures the complicated and often multiple bills specifying the amount the patient has to pay, how much insurers cover, and how much providers are allowed to charge patients produce an indecipherable transactional mishmash for patients.

There are good theoretical grounds for simplifying health care finances. Economist Martin Feldstein warned in *Health Affairs* in 2006 of the danger of “excessive spending, because patients do not face the full cost of care at the time that decisions on health care are made.”³⁴ Feldstein probably didn't have Health Savings Accounts in mind. Their use has grown since 2006. Recently, *The Economist* highlighted the need for Health Savings Accounts in strong terms: “For most Americans buying a procedure is akin to choosing a house blindfolded, signing a mortgage in Aramaic, then discovering the price later.”³⁵

These are not just conceptual changes. They also involve institutional change. Administratively, both a new Medicare premium-support system (if enacted) and the ACA law (if implemented) would place greater reliance on exchanges to certify the insurance or network-care options eligible for subsidization. So, here's the question: Could such exchanges as part of next-step health reforms (in the case of the ACA, they are already on the books) be operated in such a way as also to promote consumer direction through the greater utilization of Health Savings Accounts?

As matters now stand, most Medicare recipients do not have Health Savings Accounts.³⁶ Consumer-directed reform could change this by encouraging new Medicare recipients who have Health Savings Accounts to carry them over into Medicare. This could reduce their premiums and perhaps also copays for the coverage package they choose on a new Medicare health insurance exchange.

To sum up, the suggestions made here would result in expanding the use of Health Savings Accounts for three groups – seniors under Medicare, middle-income workers covered under the Affordable Care Act, and workers in the private sector.

Operationally, the effect for Medicare of adopting a combined premium-support and savings strategy is that it would facilitate managing competition. Each year in “open season,” when beneficiaries update their income status and can consider changing their health plan, they could also make a decision to modify their Health Savings Account.³⁷ Although most current Medicare current beneficiaries wouldn’t have savings plans to carry over, this is likely to change over time as their use increases.

Going along with the promotion and expansion of measures like these to change the mindset and behavior of consumers to encourage cost awareness, Health Savings Account-HDHI options could be provided under the Affordable Care Act – not for all of the newly covered population, but for middle-income people, for example, over 200 percent of the federal poverty level.

Over time people are bound to move in and out of ACA health-insurance subsidization and as a result will be likely to be covered by (or exposed to) HSA-HDHI options. Along with strategic reasons for promoting a savings option to this population, there are practical “need-to-know” considerations. Consumers need to understand and be able to deal with the health insurance savings options they are likely to face.

Parallel policy changes to expand and facilitate Health Savings Accounts in the private sector are advocated in a book by George P. Shultz and John B. Shoven. Its theme is that consumers should become “empowered financial players”³⁸ in the health care marketplace.

To sum up, the suggestions made here would result in expanding the use of Health Savings Accounts for three groups – seniors under Medicare, middle-income workers covered under the Affordable Care Act, and workers in the private sector.

There are many ways such health financing arrangements can be structured. Currently there are exemptions under employer-sponsored health insurance plans where preventive care and wellness services are covered up front so that the costs of these services are not subtracted from Health Savings Accounts. This can be thought of as a “wrap-around” approach. Your employer covers certain prevention and related types of good practices up front (they are free) and you use your “saved” money for other health care expenses until your back-up HDHI health insurance plan comes into effect. Under the Affordable Care Act, such savings plans make sense for younger and healthier people.³⁹

The system for modifying and monitoring Health Savings Accounts is in place. The Internal Revenue Service sets rules for Health Savings Accounts on how much can be contributed and how these funds can be used. Current limits for annual contributions are \$3,000 for individuals and \$6,000 for families. The minimum allowable deductible for HDHI policies are \$1,200 for self-only coverage and \$2,400 for families. The IRS also sets maximum levels for the combined value of deductibles and out-of-pocket expenses under HSA-HDHI plans, now \$6,000 for an individual and \$12,000 for a family.

“Advance Directives” and End-of-Life Care

The third component of consumer-directed health care is often not included in this way, but I think it should be. Under even the best of circumstances, consumer-choice measures like a premium-support system for Medicare and health savings options can't be expected to get at a critical dimension of America's health care conundrum. I refer to the end-of-life expenses people incur as they age, when they face a serious or chronic illness or disability, or when they experience a life-threatening accident.⁴⁰ The challenges involved are chilling. This is notably the case for seniors as more and more baby boomers age into Medicare and as modern medicine continues its advance.

Estimates are that about a quarter of the total Medicare budget is spent on services for beneficiaries in their last year of life, with 40 percent of that in the last 30 days. Though dated, a study by the Medicare Payment Advisory Commission (MedPAC) for 1997 showed that the program paid an average of \$26,000 per person in the last year of life, or six times the cost to survivors who are on the rolls. This 6:1 relationship was found to be “remarkably stable” over time.⁴¹ For seniors, there is no question that Health Savings Accounts would be used up quickly under these conditions, even if Medicare recipients had accumulated them for a considerable time over the course of their life beforehand.

For end-of-life care decisions, much has changed in the past thirty years as a result of the growth of palliative care and hospice services. However, even with these services, decisions about the care that is provided are emotional and highly charged.

While many people have “Advance directives” and other legal documents in place, they often are not carefully read, updated regularly, discussed with family members or other surrogates — and, most unfortunate of all, research indicates they tend not to be read and respected when they are needed.⁴² The form of such documents varies by state. They include, for example, Living Wills, Powers of Attorney, and the Designation of a Health Care Surrogate. They are a relatively new development. California passed the first law authorizing them in 1976. Now all states have similar laws. It is mostly at the state level that these matters are dealt with.⁴³

There is an important conceptual way the subject of this section fits into this paper. Going back to the two theories of health care management (provider-value and consumer-choice), it is the provider-value approach that comes into play most strongly for end-of-life care. Among the options people should have on a new Medicare exchange should be network options that emphasize integrating and interlocking services and information about the care people receive when they are very ill. Remember, under an exchange people can change their plans annually. In such an annual review period, if a person is experiencing or newly fearful of accumulated chronic conditions, the selection of an integrated care system is not only humane but efficient.

In recognition of changes in the health care industry and marketplace that are occurring or are expected to occur under the Affordable Care Act, many of the nation's biggest insurance companies (and this is an industry dominated by big firms) are working on instituting new products for service integration that provide network care and enhanced information sharing.

A Compromise

My purpose in writing this paper was two-fold, to consider the health care fiscal challenge facing America's governments and in doing so to focus on the consumer-choice theory for health reform. Based on what I have learned, I present five proposals for bending the health care cost curve as part of the next round of fiscal grand bargaining.

1. **Reconciling the provider-value and consumer-choice approaches.** The new order should not be based on an either/or choice. I believe the consumer-choice approach for promoting cost consciousness on the part of patients and providers should be included in the next round of health reforms, but as noted above it will take time to take hold, and for that reason alone, it cannot provide the full solution. I don't think it is an exaggeration to compare doing this to the long period of public education to ban smoking. The consumer-choice approach is most appropriate for a Medicare overhaul and a policy of encouraging health savings options. At the same time, and as part and parcel of these reforms, every effort should be made on health insurance exchanges, including those newly authorized under the Affordable Care Act, to incentivize insurers and providers to integrate services. The two approaches (enhancing choice and incentivizing service integration and related reforms) should be advanced together; they should be viewed (not as competitive) but as complementary.
2. **Medicare premium-support.** The conversion of Medicare from being a fiscally open-ended program to premium support should be modeled on the Federal Employer Health Benefit Program and other existing health insurance exchanges. Decisions about how insurers and networks compete (involving, for example, subsidies, premiums, types of plans, deductibles, cost sharing, reinsurance, and risk adjustment) should be made on the basis of decision and planning processes as suggested in the next section of this paper. I should note that the FEHB program is not a closed ended (defined-contribution) system although the Bowles-Simpson deficit reduction commission suggested that this be tried out on FEHB for a pilot basis. My view is that we do not have the luxury of time to do this.
3. **Enhanced savings options.** Next-step health reforms should embrace as a major purpose the enhancement of savings options. Now widely available, they should be

further encouraged. Consideration should be given to requiring all employers who provide health insurance to their employees to offer a Health Savings Account as a condition of continuing to receive the tax exclusion. Although savings options are best suited for active workers, carrying them over into Medicare would enable Medicare beneficiaries (particularly new recipients) to make what for them could be favorable choices on a Medicare health insurance exchange by selecting plans with terms that reflect the status of their Health Savings Account. Such choices could include lower deductibles and co-pays and even an add-on benefit for a certain number of days of long-term home and institutional care.

4. **A national exchange for newly covered lower- and middle-income people added to coverage under the Affordable Care Act.** State governments are supposed to set up health insurance exchanges by 2014 for the newly covered 15 million-plus lower- and middle-income people who will become eligible for subsidized care. Initially, the House of Representatives opted for a national health insurance exchange. However, as matters played out (with the election of Scott Brown to succeed Ted Kennedy in the Senate), the final version of the law instead assigned this role individually to the 50 states. At the outset of the implementation process, the Obama administration appeared to want to finesse this requirement by relying on the authority of the secretary of Health and Human Services to prescribe the levels of covered care for the added ACA newly subsidized population. But in the heat of the 2011-12 primary campaign, a surprise occurred when the administration delegated to the states the responsibility for determining the "essential" benefits required for "Qualified Health Plans" under the ACA law. This situation, while still unsettled, has to be viewed as administratively convoluted and conceptually confused. The biggest health insurance companies are national. People move around a lot from state to state. In theory as well as in practice, the income-transfer function of government is generally regarded as appropriately assigned to central governments. It is hard to argue for as much policy and managerial reliance on the 50 states for new health insurance exchanges as appears to be envisioned by the Obama administration. Responsibility for the ACA new health insurance exchanges should be national.⁴⁴
5. **An interconnected system of health insurance exchanges.** The net effect of these recommendations should be an interconnected system of nationally administered health insurance exchanges. This could include a new Medicare health insurance exchange, an ACA exchange for newly covered individuals and families, an ACA exchange for small businesses, and the Federal Employees Health Benefits exchange. The exchanges should be operated separately, but

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in linked and similar ways that take advantage of compatible organizational approaches and information systems that enable people to find out about their eligibility from any one of the systems and in appropriate cases to transfer from one exchange to another.

The trade off of this compromise is that it would enable conservatives (Republicans) to go down the Ryan road and liberals (Democrats) to preserve (with modifications) the expanded coverage of the Affordable Care Act. Over time, the outcome of such a blended and income-tested compromise could have the effect of shifting government subsidies for health care from older to younger people.

The exigencies of a \$1.2 trillion budget sequester plus the need to raise the nation's debt limit next year and the expiration of the Bush tax cuts occurring simultaneously could produce a crisis and a moment for a fiscal grand bargain that includes health reform.

In their 2012 joint proposal for overhauling Medicare, Representative Ryan and Senator Wyden (D, Oregon) set as the goal for containing costs under their new Medicare premium-support system that they would increase at a rate equal to the growth rate of the gross domestic product plus one percent. Taking this or a similar goal as a base, following is a possible approach for a blended compromise for health care reforms that hinges on timing.

A law could be passed in two phases. The first phase would set out the principles, goals, and administrative structure for operating the new system. At the same time, the law could authorize a phase-two process to work out the devilish details. At the end of phase-two, the group charged with doing this could be required to submit a plan to the president and the Congress in the form of proposed legislation with built-in provisions for a legislative process where the president and the Congress, within an allotted period of time, could approve the plan or send it back to be revised.

Such a second-phase planning process would require time and involve tense and intense negotiations on the part of experts and stakeholders. Crucial decisions would have to be made about how the process would work: What would be the composition of the group that develops the phase-two plan, its leadership, and organizational location? How would it function and be financed?

Hard as it would be to create something like this, I believe an argument can be made that this is just the kind of institutional invention the country needs for course corrections on matters as fundamentally controversial as next-step health reform. If a three-part plan of (1) Medicare premium-support, (2) expansion of health savings options, and (3) implementation and fiscal and substantive changes in the Affordable Care Act were to be considered in 2012 or 2013, a phased planning and implementation process would provide time, discipline, and expertise for its execution.

If it took a year or even two years to work out and set up such a new deal for health reform as part of a multiyear deficit-reduction package, it would be better to do it under accountable multistep decision and planning processes rather than trying to rush through full-blown new legislation all at once for all time.

Institutional inventions like this should not be one-time arrangements. Phased, accountable implementation measures should include machinery, not just for overseeing and expediting near-term planning and implementation processes, but also for adjusting the new policy bargain as necessary. There are precedents for doing this in the role played by independent agencies. For example, a Health Care Review and Adjustment Commission could be created to look across the operations of multiple national health insurance exchanges, monitor their performance, and, as conditions warrant, present proposals to the president and the Congress for modifying policy goals and management systems.

This should be more than a fiscal response mechanism, although its fiscal-adjustment role should be clearly stated and well and widely understood. Each component health insurance exchange should have policy goals and fiscal targets that are embodied in the law establishing the new health reform system and are subject to periodic review. Having such a law in place would provide responsive oversight capability to deal with changing conditions, inaccurate cost projections, and new challenges. In doing so, it would give recognition to two realities, the huge management tasks involved and the impossible-to-predict conditions sure to arise in carrying out fundamental and systemic next-step health reforms. Staffing for implementation should include a broad array of administrative, actuarial, economic, and substantive policy experts.

Concluding Comment – Let's Make a Deal

Health reform is a metaphor for what's wrong with American government in the information age of global competition. Agonizingly slow Madisonian incremental decision making needs to be tempered in inventive ways. Not always, but at least some of the time. In the case of health policy, stakeholder views are deeply held and fiercely guarded. There are pronounced differences in between liberals and conservatives and between proponents of the provider-value and consumer-choice approaches to reform.

It is a lot to wish for that there would be a moment when the principal players could come together. Nevertheless, this is where I come out. It is partly a reflection of my political values, partly just plain wishful thinking, and partly an effort to find a political middle way. The approach proposed is incremental. It is like a dinner menu that asks you to pick some things from column "A" and some from column "B." If it took a year or even two years to work out and set up such a new deal for health reform as part of a multiyear deficit-reduction package, it would be better to do it under accountable multistep decision and planning processes rather than trying to rush through full-blown new legislation all at once for all time.

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- 28 Most of the time, I use the term Health Savings Accounts (HSA) in this paper although there also are other forms of accounts. Some employers provide a more limited option (a Health Reimbursement Account, HRA) where the funds involved are not transferred to the employee. These accounts are also known by other names. They can be used by the employee for eligible health expenses, but if they are not used in a given year they do not carry over to future years. HSA funds, on the other hand, are owned by the individual account holder.
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- 44 This could be done in collaboration with regional sub-exchanges based on arrangements with individual states and groups of states that have systems capacity and with a national Web-based information system that uses ZIP code reference points like that of the Office of Personnel Management for the Federal Employees Health Benefits program.

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