CED
Committee for Economic Development

Adjusting the Prescription

COMMITTEE FOR ECONOMIC DEVELOPMENT
RECOMMENDATIONS FOR HEALTH CARE REFORM

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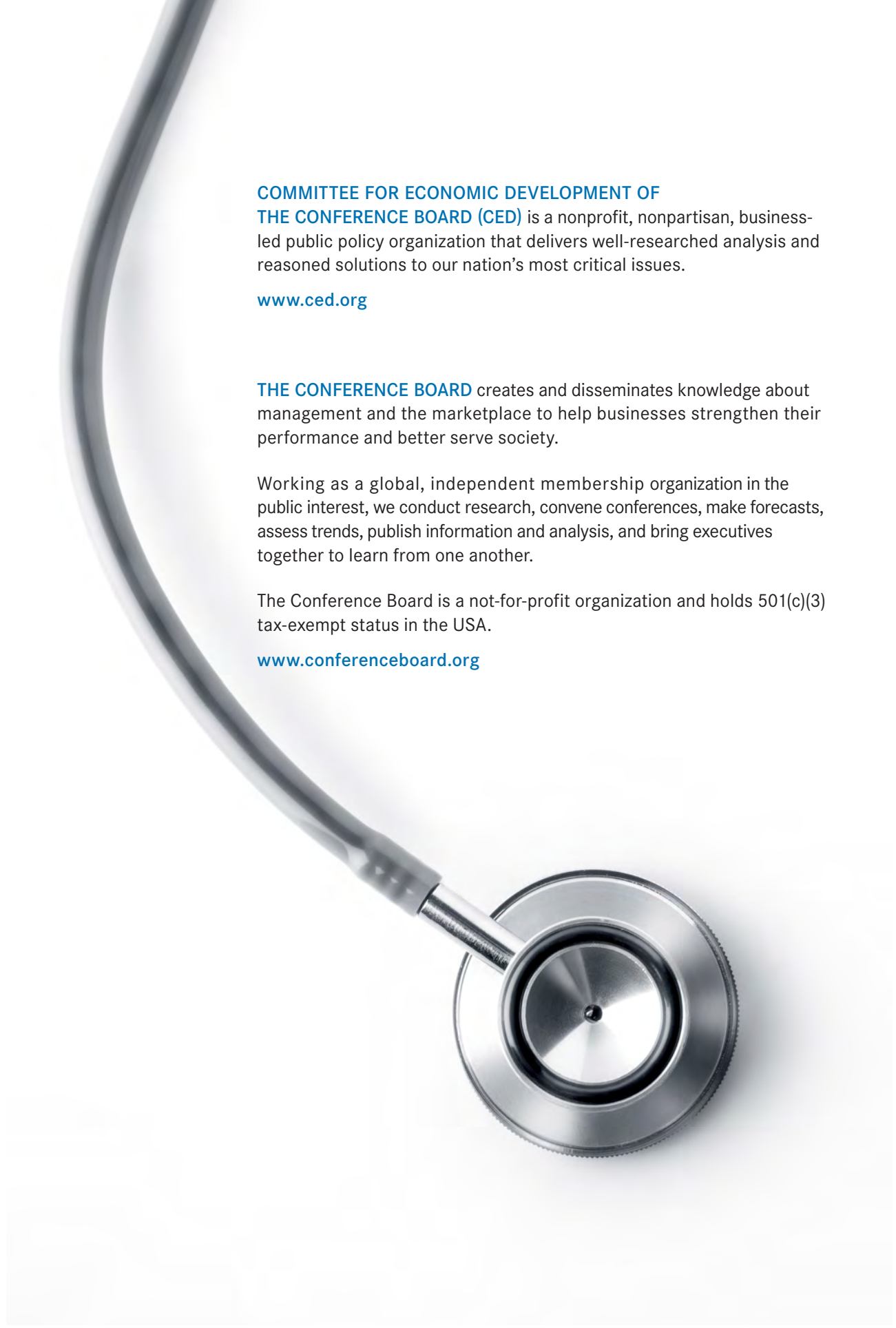

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Adjusting the Prescription

Committe for Economic Development
Recommendations for Health Care Reform

Letter from the Co-Chairs

The Patient Protection and Affordable Care Act of 2010 (ACA) made some important strides forward in the US health care system in terms of access to coverage—notably, for low-income working families and for those with pre-existing conditions—and took positive steps on cost and quality. But we can do better, and the Committee for Economic Development of The Conference Board (CED) believes that further action on health care reform is both necessary and inevitable.

CED believes that long-term improvement in quality, affordability, and access requires the right balance between the roles of government and the market. CED believes this balance would be achieved through a market-driven system, based on private-sector competition and cost-conscious consumer choice. Our vision builds on the ACA's advances by strengthening and broadening the new law's use of those market incentives to drive innovation for higher quality and lower cost, while maintaining an appropriate role for government to facilitate access and ensure that markets work. We believe that this truly would be the achievement of all three objectives of *quality, affordability,* and *access* that policymakers have sought for many years.

CED's 2007 policy report, *Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health-Insurance System*, detailed CED's comprehensive proposal for market-based universal health insurance. This new policy statement, *Adjusting the Prescription: Committee for Economic Development Recommendations for Health Care Reform*, shows how to transform the ACA into a system driven by market incentives that decrease costs, improve quality, and promote innovation—while increasing access to coverage. This statement also explains the need to reform Medicare, which is projected to be the strongest cost driver in the federal budget, and sets the stage for future CED research to do so.

We would like to thank all of the CED members who served on the Health Care Reform Subcommittee, which prepared this report; the members of the CED Policy and Impact Committee, who provided time and effort in its careful review; and all of the members of the CED staff, especially Joe Minarik, senior vice president and director of research, and Courtney Baird, research associate, for their work in support of the subcommittee's efforts.

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Executive Summary

Today, in Washington, health care policy is at a standoff. The nub of the dispute over health care is the relative roles of government and the market. In this policy statement, the Committee for Economic Development of The Conference Board (CED) puts forward a proposal that we believe strikes the best balance between these roles—that takes the best of both perspectives and builds a system that achieves the objectives of both.

The Patient Protection and Affordable Care Act of 2010 (ACA) took some important strides forward in terms of access to coverage, notably for low-income working families and for those with pre-existing conditions, and took positive steps on cost and quality. But we believe our vision would build on the ACA's advances by strengthening and broadening the new law's use of market incentives to drive innovation for higher quality and lower costs, while maintaining an appropriate role for government in facilitating access and making markets work. We believe that this truly would be the achievement of all three objectives of *quality, affordability,* and *access* that policymakers have sought for many years.

It has been clear for several decades that the cost of health care in the United States—for families, for businesses, and for government—has been spiraling out of control. At the same time, the nation has not received fair value for the sums that it has paid—and many Americans have not had insurance coverage at all. These failures of *affordability*, *quality*, and *access* led CED to develop our own ideas for market-based universal health insurance, using competition among private insurance plans driven by cost-conscious consumer choice to motivate improvements in quality at lower cost. Our most recent policy statement, released in 2007, provided highly detailed policy prescriptions.[1]

In 2010, the US Congress and the president responded to this slow-moving health care crisis by enacting the ACA. The new law sought to address the same concerns that CED recognized in our policy statement of 2007. However, relative to our vision, we believe that the ACA does both too little and too much. It leaves the deficient core of the health care system—based on fee-for-service medicine, with all of its long-recognized perverse incentives—substantially intact and increases government involvement in the delivery of health care, injecting remote, one-size-fits-all rules into what we believe should be the individualized physician–patient relationship. We believe that this combination will not deliver all of the innovation and process improvement that the nation needs to achieve higher-quality, more affordable care. We recommend a different approach, more in line with a market-driven system, but with an appropriate, though smaller, role for the federal government to ensure healthy private-sector competition as fertile ground for quality and efficiency to grow.

1 *Quality, Affordable Health Care for All*, Committee for Economic Development, 2007 (www.ced.org/reports/single/quality-affordable-health-care-for-all-moving-beyond-the-employer-base).

Specifically:

- We would replace the ACA's complex subsidy mechanism, which puts a heavy compliance burden on and may mislead families with modest incomes and has proved difficult to administer accurately.
- We would restructure the ACA exchange system to align more closely with cohesive geographic health care market areas, and to provide better information and decision support.
- We would broaden the exchange populations to increase the numbers of enrollees and also the risk diversity, especially in small geographic areas.
- We would expand the ACA's increase in consumer choice of insurance plans—which is the key to competition and innovation. Under the ACA, much of the population will receive insurance in exactly the same way—with limited choice—as before the new law's enactment.
- We would further challenge fee-for-service medicine. Under the ACA, the perverse incentives of fee-for-service medicine will continue to shackle competition and process improvement to almost the same unfortunate degree as under the prior system.
- We would render unnecessary the ACA's unpopular mandates—and their complex exemptions—to compel the purchase of insurance.
- We would go further than the ACA in the promotion of potentially valuable disruptive care-delivery models and of tort reform.
- We would reorient the ACA's Independent Payment Advisory Board (IPAB) to provide information for, rather than inject remote government judgment into, the physician–patient relationship. We would expand data gathering and research to inform physicians and patients in their own decision making.
- We would reduce the ACA's reliance on a system of state regulation that inhibits essential competition and market entry.

Recognizing the downside of fee-for-service health care, but without requiring a fundamental change to the system that imposes it, the ACA superimposes a series of add-on government-driven pseudo-market devices upon that system. The result has been some improvement, but we fear that the progress will remain limited and be temporary. True markets motivate all possible improvement in every aspect of the enterprise at all times. Government regulation, at best, mimics the effect of true markets, and it will always be inferior. Regulations specify areas for improvement—excluding all others—and create "check-the-box" compliance standards that may not represent the best avenues for improvement, and limit both the required improvement and the reward. The end product of the ACA's artificial devices and mandates, such as the IPAB, accountable care organizations (ACOs), and "bundling" of treatments into a single reimbursement for an episode of care, will be a cat-and-mouse game between providers and regulators, resulting in regulation, counteracting manipulation, and re-regulation and new forms of manipulation in a never-ending cycle. Simple and true markets would work much better, and that is what we seek.

As is explained in detail in the body of this policy statement, we recommend a series of steps that would transform the ACA into a more competitive and innovative system:

- Replace the ACA's income-conditioned premium subsidies with a "fixed-dollar" refundable tax credit, usable only to purchase insurance. The credit should cover the low-priced insurance plan available in the geographic region (and meeting standards, to avoid a "race to the bottom" on coverage and premiums).
- With premium credits available to all, eliminate the unnecessary individual and employer mandates.
- Risk-adjust premium revenue. Plans would accept consumers at uniform premiums regardless of preexisting conditions, and those plans that care for more-costly risks, on average, would be rewarded for doing so.
- Offer a broad variety of insurance plans. Encourage all existing and new plan business models by making them available to all consumers through the exchange and on a level playing field, with sound consumer protection and full information. Recognize that the diversity of consumer preferences and needs will lead to a corresponding diversity of plans and providers in the marketplace, but that innovation and disruption of the traditional plan and provider business models will be essential to increase quality and control cost.
- Encourage innovative practices while supporting routine necessary services. Ensure that innovations add genuine value, rather than merely cannibalizing revenue from essential services elsewhere. A shift from fee-for-service to capitated (or even bundled) reimbursement would go a long way in this direction.
- Private exchanges and insurance brokers can compete with public exchanges to serve all individuals who choose to use them—not the ACA's restricted populations—and can price on the basis of cohesive market areas, which may be parts of states or multiple adjoining states each with small populations, or may cross state lines around large integrated metropolitan areas. Single administrative and back-office operations can capture economies of scale in the exchange system by managing multiple pricing and market areas.
- Utilize multiple access points through which consumers may purchase insurance. Private exchanges or individual insurance brokers offer service to those consumers who would prefer to build such relationships. The market determines the kinds of information and guidance that consumers want (with protection against price discrimination based on health status).
- Establish an alternative national regulatory approval under which plans market across state lines to facilitate competition, market entry, and the expansion of the most-efficient systems.
- Redefine the employer role. Firms can offer plans to their employees, in competition with the other options available to their employees on the exchange. Alternatively, firms can serve as exchanges to their employees, join private multiemployer exchanges, or merely provide advice to their employees. All such options would include risk-adjustment of plan revenue, and all employees and plans would be treated equally regardless of employees' choices of plans.
- Emphasize data creation and analysis to inform the doctor–patient relationship, rather than government rule-making to co-opt it.

- Reform the tort system, using new data and analysis to formulate rebuttable standards of sound practice. Create specialized expert courts to facilitate more timely and less costly decisions.

The above steps would, in our judgment, much improve the health care and health insurance systems for the working-age population and their dependents. We believe that an essential remaining step in health reform would be to restructure the Medicare program. Medicare's costs have been growing more rapidly than the nation's collective income, out of which those costs must be paid. The margin between costs and revenues is so large that Medicare is the single most powerful force behind the projected future growth of the public debt (even after the recent cost slowdown, which was driven in part by the economic recession rather than any system improvements, is taken into account). Considering the demographic pressures of baby-boomer retirements and longer-term increases in longevity and reductions in fertility, fundamental reform is essential. Simple reductions in reimbursement rates will not suffice; they will drive providers out of the program and erode Medicare into a lower-tier health care system, which is not acceptable. Instead, CED will research the potential of the model for reform that we discuss in this statement to be applied to the Medicare Advantage program.

Health care is deeply personal. Those with existing medical conditions fear the loss of their existing care relationships. Everyone fears some development that will lead to a loss of good insurance or of coverage entirely and, with it, the ability to pay for their family's care. The ACA has eased those fears in some respects, but it has exacerbated them in others; and the American people surely do not relish the prospect of going through such an uncertainty- and anxiety-inducing legislative process again.

Still, even some of the ACA's strongest advocates recognize that there is far more to be done. Even the ACA's primary apparent objective—access—could be met more fully; quality remains at issue, and cost, despite all recent progress, still is beyond our ability to pay in the long run. The US health care system is so large—larger than the total economy of France, for example—and so dependent upon long-lived assets (even human skills and training), that regardless of the "health care fatigue" American citizens and their elected policymakers may feel, there is no time to waste in seeking a sustainable course.

As always, the temptation is to take political advantage of a crisis—to paint the other side as somehow ill-willed or uncaring and to refuse compromise. But health care is critical to the well-being of every citizen and to the financial health of the entire nation. Changing the law will require bipartisanship. Compromise is essential.

We at CED call on our elected policymakers to recognize the urgency of reform and take advantage of a brief respite from budgetary pressure to allow market forces and consumer choice to begin to reshape our health care industry. We stand ready to work with others in the public and private sectors to set our health care system—and all that depends on it—on sound footing for the nation's future.

Introduction

In 2002, the Committee for Economic Development (CED) issued a policy statement on how employers, working both individually and cooperatively, could improve health care quality and affordability. We believed those recommendations were sound, yet we observed few firms putting our recommendations into practice. These firms were leaders in introducing significant innovation in health benefits on behalf of their employees, but, in general, firms were slow to respond to the need for change. As a result, health care costs continued to rise, while quality continued to lag below any level commensurate with what society spent.

Three years later, CED, anticipating the need for fundamental change, undertook a new research project on our nation's health care system. Our subsequent policy statement, released in October 2007, found that the United States would need to take collective action to achieve greater quality of care at lower cost. Our policy statement explained our vision, in which greater consumer choice among competing private health insurance plans would motivate greater efficiency and higher quality on the part of both plans and providers. We proved to be right that dissatisfaction with the health care system would lead to early legislative action, and there are reflections of our vision for consumer choice and competition in the subsequent Patient Protection and Affordable Care Act of 2010, often referred to as the ACA or "Obamacare."

The ACA took some important strides forward in terms of access to coverage, notably for low-income working families and for those with pre-existing conditions, and took positive steps on cost and quality. But we believe that our vision builds on the ACA's advances and would strengthen and broaden the new law's use of market incentives to drive innovation for higher quality and lower costs, while maintaining an appropriate role for government in facilitating access and making markets work. We believe this truly would achieve all three objectives—*quality, affordability,* and *access*—that policymakers have sought for many years.

Relative to our vision, we believe that the ACA does both too little and too much: It leaves substantially intact the deficient core of the health care system—fee-for-service medicine, with all of its long-recognized perverse incentives. And it also involves government to a greater degree in the delivery of health care, injecting remote, one-size-fits-all rules into what we believe should be the individualized physician–patient relationship. We believe that this too little/too much combination will not deliver all of the innovation and process improvement that the nation needs to achieve higher-quality, more-affordable care.

In short, the ACA's central tendency is toward a lead role for the federal government to increase access, control costs, and improve quality—for government as the prime mover in health care. CED, in contrast, favors a fundamentally market-driven approach to control costs, increase access, and improve quality—along the broad lines of CED's vision, as expressed in 2007, but with some refinements, based on the experience of the ACA's enactment and implementation. The objective of this policy statement is to explain to people of all political orientations why we believe our vision will be more effective at improving the health care system.

As much as CED would prefer a fundamentally different alternative that would reflect our vision, the task now is to find a way forward to a better end point. We believe that the basic framework of the Affordable Care Act can be transformed from a government-led system into one that is driven by market-based consumer choices made in the context of the doctor–patient relationship.

CED's Vision for Health Care

Although we have revised our proposal for health care reform over the years, our vision for the health care system has remained substantially the same, based on these fundamental principles:

We believe that:

1. every American should have access to health care,
2. care should be of high quality, and
3. care should be affordable.

Achievement of any one of these goals (for example, access) without the others will not suffice. If care is not affordable, for example, today's access will prove only temporary.

We believe that, to reach these three goals, health care must be driven by cost-conscious market-based competition—the same force that motivates producers to provide the best possible quality at the lowest possible cost in virtually every other industry. We have cited examples of successful private and public health insurance systems that follow our vision in several regions across the United States.

To achieve these goals, consumers must make cost-responsible choices. We propose cost-conscious choice among competing insurance plans of all types, which people can undertake with deliberation when they are well. People should be able to save money—dollar-for-dollar—if they choose less-expensive, more-efficient plans that meet full quality standards. And they should be responsible for the incremental cost if they choose a more expensive plan.

With every individual assured access to a quality insurance plan and able to pocket the full savings from choosing a low-cost plan, insurers would, for the first time, have an incentive to organize with health providers to offer quality, affordable care that individual consumers want. Every consumer would have insurance and an incentive to choose the plan that provides what he or she believes to be the best combination of quality and value for money, knowing that he or she would be responsible for costs beyond the fixed-dollar contribution. Consumers could change plans freely at annual open seasons, if dissatisfied. Therefore, to attract and to keep customers, plans would need to be adaptive to pursue efficiency and quality, which would create meaningful competition in the health care marketplace, driven by fair rules that reward quality and cost-effectiveness—rather than denial of care and selection of risks.

This design would focus competition on value for money in the informed best judgment of consumers and would not, in any way, pick winners and losers in advance. The competitive market would do that, over time. The system should encourage differing delivery modes to foster competition and innovation. In the end, some existing models might be winners in the competitive marketplace, or the winners might be entirely new, as-yet-unimagined models. One thing would be certain: the outcome would be better than what preceded it because the incentives and opportunities for consumers to make economizing choices—and the need for insurers and providers to seek improvement to satisfy consumers—would be enormously increased.

The world has changed since CED last enunciated this vision for health care. Today, we hold to that vision, and we seek to refine the specific steps that would make it real.

Why We Are Not Satisfied with the Affordable Care Act

The ACA sought to address the same concerns that CED recognized in our policy statement of 2007. Why is CED dissatisfied with the health care system under the ACA?

Five years ago, CED's trustees and ACA advocates shared the same general assessment of the US health care system and of the need for change. Both groups believed that allowing large segments of the US population to go without insurance coverage was unacceptable. Both groups understood that the nation—public and private sector—could not long afford the continued rise of health care prices, even without expanded insurance coverage and certainly not with it. And both groups knew that, for all of its strengths, the US health care system could and should deliver a higher quality of care, with uniformly better outcomes—especially given how much of our collective income we spend on that care.[2]

Despite these shared concerns, however, the ACA wound up in a different place from CED's vision for health care reform. To be fair, some of this divergence surely arose because the real-world legislative process included compromise among numerous interests that were not heard in the CED subcommittee's deliberations. Still, those compromises degraded the final product, and we cannot help but believe that the ACA could have stayed better on course to a simpler, but fairer and more-efficient structure that more closely would have achieved the ideals of access, affordability, and quality. The vision was lost, rather than held continually in front of the legislators as a guide to the ultimate practical goal.

We conclude that the ACA does both too little and too much. It leaves the deficient core of coverage under employer-based insurance, and even Medicare, substantially unchanged, and it also imposes what we believe is excessive government control of health care. We fear that this combination will yield insufficient innovation and process improvement to achieve higher-quality, more affordable care that the nation needs. We recommend a different approach, one more in line with a market-driven system but with an appropriate (though smaller) role for the federal government to ensure healthy, private-sector competition as fertile ground to grow quality and efficiency.

These differences of belief should not be subject to caricature. The vast majorities of advocates of a central role for government (such as those who favor the ACA) and of advocates of a market-driven approach (including the CED) agree that everyone should have access to health care and that no one should be denied care because of lack of ability to pay. This might fairly be characterized as a shared American value. And, again, to be sure, CED's vision requires government rule-setting—such as is essential in many other industries—to ensure that the market is fair and that there is true and effective competition. Likewise, most exponents of both schools of thought recognize that costs under the current system of delivery of care are rising unsustainably and are highly motivated to find ways to slow the growth of cost. So there is considerable overlap between the two views, perhaps on

2 In 2011 (latest data available), the United States spent, in total, an estimated 17.7 percent of GDP on health care. This is the highest spending, by a wide margin, among the 34 member countries of the OECD (plus six emerging countries for which the OECD maintains statistics). It is frequently reported that US health care outcomes are not on a par with other countries that spend far less. For example, of 34 OECD countries, the United States ranks twenty-sixth for life expectancy at birth; thirty-first on infant mortality; last on obesity; and twenty-second on ischemic heart disease mortality. (See OECD, *Health at a Glance 2013: OECD Indicators*, OECD Publishing, 2013 (http://dx.doi.org/10.1787/health_glance-2013-en)). Such rankings are subject to criticism. For example, on infant mortality, there is international variation in the standard for counting live births, and it is alleged that the United States includes in its statistics at-risk births that some other countries would not. On life expectancy, the diverse US population and mechanized society disproportionately yield many violent and accident-related deaths that arguably should not be attributed to some failure by our health care system. On obesity, the United States has far more affordable food than many other nations. (For that matter, the pejorative meaning of high health care spending itself is challenged on the ground that the wealthiest nation logically might choose to spend a disproportionate share of its greater wealth on its health.) Defenders of US health care argue that our country is sought by persons with serious illnesses because we deliver the best care in such circumstances. The counterarguments are that the richest nation's excellence in acute care, while enjoying mortality statistics that are mediocre at best, arises precisely because our system rewards heroic measures but ignores the day-to-day task of maintaining health, and that fundamental reform is needed to add excellent routine care to our excellent acute care.

the questions that are most important to most Americans, and the remaining differences in basic, even philosophical, approach are highly nuanced.

The fundamental disagreement, however, is whether health care resources are best allocated through mechanisms put in place by the federal government or through market-based mechanisms. In the end, under CED's vision, many more decisions would be made by consumers, care providers, and insurance plans than is likely to be the case under the ACA.

Advocates of the ACA shared CED's principles of *access* to *quality*, *affordable* care, yet diverged in practice from the path that we would advocate. Following are the major components of what we believe would be a sound, workable, and potentially enduring health care reform, and how we believe the ACA departed from them.

PROVIDE REFUNDABLE TAX CREDITS TO BUY INSURANCE WITH OPPORTUNITY FOR PREMIUM SAVINGS

CED proposed a system of universal refundable income tax credits, financed with broadly based taxes and usable only for health insurance. These tax credits would be in the amount of the premium of the low-priced insurance plan or would be representative of a small number of the lowest-priced plans—meeting standards (to prevent a "race to the bottom" on plan coverage and quality) and available in the geographic region of the consumer. Taxing to finance health care might seem undesirable to some, but taxation merely recognizes a reality that has been lost on many participants in a system of employer provision and third-party payment: all health care must be paid for, and there is a cost to adding millions of people to the system. The previous system and the ACA might make the payment less transparent, but they cannot wish it away—however desirable the ideal of universal coverage might be. (A more detailed explanation of our proposal is presented on pages 35 and 36.)

In contrast, the ACA provides support only to low-income individuals via either expanded eligibility for Medicaid (for those with the lowest incomes) or subsidies (on a sliding scale for families with incomes above the Medicaid eligibility level). Medicaid coverage is provided to those with incomes up to 133 percent of the poverty-income standard.[3] Subsidies begin for households at 133 percent of the poverty-income level, such that their premium cost is 2 percent of their gross income. The highest income beneficiaries (households with incomes at 400 percent of the poverty-income level) pay premiums equal to 9.5 percent of income. Households with incomes above 400 percent of the poverty standard receive no subsidy.

Therefore, the ACA must include a complete income measurement and tracking process that is irrelevant to CED's vision. The ACA's subsidy structure is highly complex and likely bears significant responsibility for the early troubles seen with the various exchange or "marketplace" websites.

Measuring the relevant income concepts for subsidy eligibility is highly complicated. Applicants need to find documentation for various sources of income. For people with relatively low incomes, often with episodic work histories and sometimes not legally required to file tax returns, obtaining this documentation can be much more complicated than for a typical wage or salary earner with continuous work at a steady pay rate. But if the income measure is not accurate from the very beginning of the application process, the applicant cannot know what the actual price (net of subsidies) of insurance will be—hence, the frustration of many applicants who received an initial estimate of their cost of coverage that exceeded their prior expectation. Other inherent complexities include incomes that fluctuate. Relatively low-income enrollees may be asked to forecast their future income. If they underestimate, they would be required to return any excess subsidy—a potentially difficult task.[4] In addition, the subsidy formula has "notches," such that a small increase in income can cause a large decrease in subsidy. This complexity is required because of the subsidy structure the ACA uses.

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3 Pursuant to the US Supreme Court decision (*National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.*) that upheld the constitutionality of the ACA, some states have chosen not to expand their Medicaid coverage. In those states, very-low-income households that are not already eligible for Medicaid receive no support whatever.

4 "How to estimate your income for the Marketplace," Health Insurance Marketplace (www.healthcarehealthcare.gov/income-and-household-information/); ConsumersUnion, "Reporting Your Income When Buying Health Insurance on Your State's Marketplace," January 2014 (http://consumersunion.org/wp-content/uploads/2014/01/Reporting_your_income_2014.pdf).

Furthermore, and most important in the long term, many (perhaps, most) individuals, including those still covered by many employer plans or traditional Medicare, have little incentive to be cost-conscious under the ACA—ominously, no more incentive than under the current system that has yielded runaway costs for decades.

OFFER A BROAD VARIETY OF ACCESS CHOICES (THE INDIVIDUAL MARKET, PUBLIC EXCHANGES, PRIVATE EXCHANGES, EMPLOYER-BASED INSURANCE), LETTING CONSUMER PREFERENCE AND MARKET FORCES DETERMINE WHICH WILL PREDOMINATE

CED advocates the use of health insurance exchanges. In our original policy statement, CED pointed out the difficulty that many consumers would have initially when "shopping" for health insurance. Health insurance is among the most complex products or services, with the typical insurance policy containing many pages of legal language. The typical consumer does not try to read his or her insurance policy and is not equipped to comprehend it if he or she did read it. Yet economists count on educated choice by consumers to drive the market outcomes that force all firms to improve their performance. Without informed consumer choice today, it is no wonder that our health care system has extraordinarily rapid cost increases, which make it impossible to broaden access to affordable coverage.

A health insurance exchange can facilitate informed consumer choice by enforcing consumer protections and by providing impartial information and guidance and a simple enrollment mechanism to enroll in any of a wide variety of quality plans. The exchange would hold the plans at arm's length from the consumers; plans would accept every applicant and would charge uniform premiums, regardless of medical conditions.

Consumer protections would specify coverage standards for plans and craft and enforce standardized plan language to meet those coverage standards. That relieves consumers of the need to do detailed research to ensure that plans do not have exclusions in the contract language that would not become apparent until an expensive health crisis arises.

Information and guidance provided by an exchange can highlight comparative provisions through which plans make legitimate choices of where to add value to attract consumers and where to reduce benefits or increase deductibles or co-payments to hold regular premiums down. Experience indicates that, in the absence of information in an easily usable form, consumers will often fall back on the specious rule of thumb that the most-expensive health insurance policy must be the best. Well prepared comparative information potentially can break through that preconception by showing clearly what the coverage differences are between competing plans—perhaps highlighting that the team approach among physicians chosen by an integrated delivery system can be more efficient than the wide access offered in an old-fashioned, uncoordinated fee-for-service plan. Such information can be an essential building block for a successful market-driven system, and many consumers can benefit from one-stop shopping.

One positive aspect of the ACA was its creation of health insurance exchanges, but the ACA's implementation of its exchange system is far from perfect in several respects. One fundamental problem is that single exchanges are not predisposed to be truly responsive to market forces. Different consumers will want and need different kinds of assistance, and multiple vehicles will be more likely to evolve quickly and find the best designs if there is competition from the private sector. It is conceivable that, with competition, one selection mechanism will succeed at providing all the services its population needs, and that, for many or even all people, such selection assistance could even be offered for free. On the other hand, some consumers may be willing to pay for advice from insurance brokers or private exchanges if that payment yields demonstrably unbiased advice aimed at the consumer's interest. Thus, in our judgment, it is premature to rely on a single selection mechanism from the very beginning.

The early experience with the ACA "marketplaces" shows the downside of putting all of our proverbial eggs in one basket. Some exchanges failed even to function. Beyond that, there is a real question whether the exchanges are providing the information and decision support that consumers need.[5] On the basis of this experience, CED

5 For example, the ACA's health exchanges have not produced a calculator, as promised in the law, to help consumers estimate their out-of-pocket costs. Ferdous Al-Faruque, "Defending Big Pharma," *The Hill*, July 22, 2014 (http://thehill.com/business-a-lobbying/business-a-lobbying/212894-defending-big-pharma).

sees the benefit of alternative vehicles marketing health insurance to consumers. (A detailed explanation of our proposal is presented on pages 36 and 37.)

That said, this issue must be put in the proper perspective. The ultimate value to the consumer comes from the insurance plan itself, not from the point of purchase. The value of the marketing vehicle comes solely from connecting the consumer in the most efficient possible way to the right plan—the one that meets his or her individual needs. We believe that it is too much to assume that any predetermined marketing method is the best, but we do believe that success will be demonstrated through experience in the marketplace.

NEUTRALIZE RISK SEGMENTATION IN HEALTH INSURANCE EXCHANGES

Under the ACA, populations within some exchanges likely are smaller than they should be for the best risk-sharing. The ACA began by separating the population unnecessarily. For all of the widely acknowledged problems of the current health insurance system, the ACA tries to maintain that system's cornerstone—specifically, employer-based coverage. To the extent that this effort, especially the employer mandate, is successful, it immediately cuts the potential number of exchange participants within each state (an issue which we will discuss below) substantially. (Prior to the ACA, roughly half of the total population, which is about 60 percent of the insured population, received their coverage through employers.)

The ACA divides the potential population participating in the exchanges still further, by providing one exchange in each state for individuals to purchase insurance and a second exchange for employers to choose plans to purchase for their employees. Not only does this render the exchanges smaller and therefore potentially less attractive to insurers and consumer participants, it also reduces consumer choice for employees of comparatively small firms that choose to use the exchange as a vehicle to comply with the employer mandate. That defeats the very purpose of the exchange system—at least to those who believe in the value of competition among insurance plans and providers. Especially with risk adjustment of premium revenue to compensate plans that cover persons with costly conditions, these changes will encourage plans to participate in the exchanges.

OFFER A BROAD VARIETY OF PLAN CHOICES, LETTING CONSUMER PREFERENCE AND MARKET FORCES DETERMINE WHICH WILL PREDOMINATE

At the end of the day, the insurance plans and the health care that people receive are the bottom line of our system. Outcomes are key.

We seek a system under which, in the long run, many more consumers make their own choices of private health insurance plans, without restrictions imposed by anyone. We believe that from choice will flow a richer variety of plans, with more vigorous competition among them. As a result, there would be greater innovation, higher quality, and lower costs. Such a system would elicit greater satisfaction from consumers, yield more stable government budgets, and make private businesses more competitive by reducing the now-crushing and rapidly growing costs of providing care. (A detailed explanation of our proposal is presented on pages 41 and 42.)

We do not believe that the ACA achieves our vision. The relatively narrow individual exchanges in the ACA, the small-business exchanges, which can impose on an employee a single plan chosen by his or her employer,[6] and the continuation of much of the employer-based system under which consumers often have limited choice, suggest that, when the ACA is fully up and running, the health-insurance system will remain short of the CED vision of vigorous competition and choice. And ironically, as limited as it is, the broadening of the scope for choice of insurance plans to drive innovation is limited to those individuals sent to the exchanges—disproportionately, people with modest incomes, and therefore having comparatively limited scope for choice.

MOVE AWAY FROM FEE-FOR-SERVICE INCENTIVES

Thus, for all the political firestorm associated with its enactment, the ACA was *not* intended to change the fundamental structure of the US health care system: fee-for-service care. Most people, pre-ACA, received their care through either employer-provided insurance or the

6 Employee choice under the SHOP (Small Business Health Options Program) marketplace has been postponed. Amy Goldstein, "Bumps for New Health Exchange," *Washington Post*, December 1, 2014, p. 1 (www.washingtonpost.com/national/health-science/healthcaregovs-insurance-marketplace-for-small-businesses-gets-off-to-a-slow-start/2014/11/30/9f83c8ee-74ca-11e4-a755-e32227229e7b_story.html).

largest government program, Medicare. And, in fact, at its core, the ACA is little different from the system that preceded it in terms of fundamental incentives. Though both employer-provided insurance and Medicare have widely recognized basic flaws, and the ACA has struggled to change how they deliver care, both remain driven by fee-for-service delivery—to the extent that all of the ACA's well-intentioned appendages or add-ons cannot deflect the fundamental forces that ultimately determine outcomes of inadequate quality and excessive cost.

The problems inherent in fee-for-service reimbursement are fundamental and well known. CED does not question the good intentions of health care providers, who, after all, chose careers of caring for the sick. The question is not intentions, good or ill. It is, rather, that the reimbursement *system* provides constant rewards to the most expansive view of the patients' needs. Any service or treatment that provides any potential benefit to the patient may be paid for—and often on essentially a cost-plus basis. Cost-plus reimbursement means that every service adds to the provider's profit margins. As has been demonstrated, time and again, in contracting in other fields, such incentives are clearly perverse.

But the problem extends beyond incentives of commission; it includes incentives of omission, as well. Providers under fee-for-service reimbursement have less reason to adopt cost-saving practices—even purely business practices, such as personnel optimization or back-office management, that could cut costs, often with no possible effect on the quality of care. Elsewhere in the economy, producers seek every opportunity to cut any and all costs without reducing the quality of their product or service. This contrary predisposition in health care is caused by the absence of pressures toward efficiency that are felt in true market systems.

The ACA puts considerable emphasis on imposing standards on health insurance plans. And, to be sure, there is a need for standards. They are essential to prevent abuse of complex contractual language that the typical consumer is not equipped to judge. It was such language that resulted in practices relating to preexisting conditions, rescissions, and the like that have been dealt with by the ACA to broad consensus approval among the American people.

However, there also is a need for innovation in the marketplace and for consumers to have choices that suit their own unique preferences. The relatively narrow exchanges in the ACA and the continuation of much of the employer-based system under which consumers often have limited choice, suggest that, even when the ACA is fully up and running, the health insurance system will remain short of the CED vision of vigorous competition and choice.

WITH OUR VISION OF REFUNDABLE TAX CREDITS, REMOVE THE INDIVIDUAL MANDATE

CED's suggested alternative would not require an individual mandate. An individual who did not use his or her refundable credit to apply for, at minimum, the least-expensive plan would be forgoing cost-free health insurance.

Instead, the ACA has no alternative but to impose an individual mandate to maintain a viable insurance market. The highly popular provisions of the law—notably, the prohibition of disqualification or adverse underwriting on the basis of preexisting conditions—would cause moral hazard and a death spiral for insurance plans if not supported by very broad, if not universal, coverage. In the extreme, the fully rational individual in a system of guaranteed issue with no purchase requirement would fill out an insurance application in the ambulance on the way to the emergency room, and then fill out the withdrawal form in the taxicab on the way home. No one would pay insurance premiums, except when they were sick, and providing insurance would not be financially viable. While this account might seem a caricature of reality, there is evidence of such behavior in the similar system in Massachusetts, where rational individuals—known as "jumpers and dumpers"—tested the boundaries of law and regulation to get the most health care protection at the lowest personal cost.[7]

The ACA's policy to address these problems is the individual mandate. Individuals are required to purchase insurance, unless it is "unaffordable." Although this makes perfect sense to maintain viability of insurance, it adds further complexity to a system that already suffers from the need to calculate the very complicated subsidy

7 Josh Hicks, "Rick Santorum's Claims about Massachusetts Health Reforms," *Washington Post*, January 31, 2012 (www.washingtonpost.com/blogs/fact-checker/post/rick-santorums-claims-about-massachusetts-health-reforms/2012/01/29/gIQArcCecQ_blog.html).

mechanism described above. It speaks ill of a supposedly "reformed" health care system that insurance is considered "unaffordable" for some individuals.[8] And it leaves some of the worst aspects of our current system (notably, uncompensated care) in place.

Given that the individual mandate has proved to be one of the most divisive (though essential) elements of the ACA, and that creating the affordability exception to the mandate has proved predictably complex, eliminating the need for a mandate under the CED approach would be a significant advantage.

FACILITATE THE SHIFT TOWARD INDIVIDUAL CONSUMER CHOICE BY ELIMINATING THE EMPLOYER MANDATES

Among CED's major concerns have been the lack of access of many employees of smaller and even medium-sized businesses to quality health care and the lack of cost-consciousness in the designs of some plans of even larger employers. As a result, we believe that the current employer system must evolve to increase employee choice and sharpen incentives for higher quality and greater efficiency in the delivery of care. So we believe that our alternative vision, under which the current employer system competes with the exchange-based model, is far superior.

In contrast, despite all of the obvious failings of the prior system, the ACA was designed to maintain its most fundamental component; it did not take the leap toward structural change for greater choice and competition. Thus, by the estimates of the Congressional Budget Office, the number of persons with employer-provided coverage under the ACA will decline by only about 5 percent by 2025, which is only about 3 percent of the total population.[9] Again, we believe that all employers seek to provide the best possible coverage for their employees, and many succeed in achieving good coverage. But, in the long run, we need consumer choice in a competitive market, based on cost visibility, consumer cost-consciousness, and clear communication about efficient care delivery, to motivate plans to drive cost down and quality up.

And so, the ACA has been distorted by the prior system's tension between the perception of an employer obligation to provide coverage and the reality that many firms are not well suited to do so. Generally speaking, large employers in the United States have provided health insurance coverage, which they often found to be a recruitment and retention advantage over smaller firms. Smaller firms often lack enough employees to present a stable risk pool, just as they similarly lack the economies of scale to provide the administrative base for such a complex endeavor as delivering health care. Thus, although they have sought to provide high-quality health plans, some small firms can offer only inferior coverage at a greater cost share for the employee, and some have been unable to offer coverage at all. Therefore, there is a systematic difference in the United States in access to quality health care—surely, a necessity of life—between those who happen to work for larger firms and those who happen to work for smaller firms, compounded by the further accident of whether one's co-workers happen to be healthier or sicker than average. Arguably, given this nation's standards of fairness, that historical accident would, upon full consideration, leave many Americans feeling uneasy.

The ACA, however, could not find its way toward a robust alternative to reliance on employer coverage. Accordingly, the law imposed a mandate on employers under certain circumstances, including the size of the firm in terms of full-time employees. If one were to accept the premise that employers have an obligation, ethical or otherwise, to provide coverage, then the employment size of the firm could be a logical measure of that obligation, on grounds of the stability of the risk pool or administrative economies of scale. But the ACA's binary, on-off standard at 50 full-time (30 hours per week) employees has created a "notch" effect with anxiety costs that could well be in excess of the benefits of the program. The anxiety has arisen partly because of a perception that the alternative to employer coverage—the health insurance exchange

8 See, for example, John Ydstie, "Obamacare 'Glitch' Puts Subsidies out of Reach for Many Families," Morning Edition, National Public Radio, December 2, 2014 (www.npr.org/blogs/health/2014/12/02/367837115/obamacare-glitch-puts-subsidies-out-of-reach-for-many-families), which explains how a spouse in a single-earner family might be judged ineligible for a subsidy that would make family coverage affordable because of having income too high for a subsidy for worker-only coverage.

9 Author's calculations from Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's January 2015 Baseline" (www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-01-ACAtables.pdf).

or marketplace—does not provide an attractive source of coverage. If the true alternative is the prior individual insurance market, then that criticism of the ACA may well be unfair, and only time will tell the true performance level of each of the ACA's state exchanges (speaking more about the quality and cost of the insurance coverage than of the website experience). But the fundamental question is whether the particular employer of each particular individual is an appropriate determinant of the quality and affordability of health care.

LOWER THE BARRIERS TO NEW DISRUPTIVE BUSINESS MODELS TO INCREASE THE LEVEL OF PROVIDER COMPETITION, AND SOLIDIFY THE FINANCES OF 24/7 COMMUNITY SERVICES

CED's proposal implicitly encourages the voluntary formation of permanent team relationships among providers, simply because it would be the most advantageous way to practice medicine. Plans that are willing and able to overcome current institutional barriers (such as scope-of-practice restrictions)—raised by both some provider professions and government—can take advantage of innovative new business models to offer better care at lower prices, and be more attractive to consumers.[10]

Under the CED vision, all consumers choose the health insurance plans that they want on the basis of the value to them, including quality and price. Multiple plans following multiple models would succeed because needs and preferences differ from one consumer to another. However, we can expect that all plans would be driven toward greater cost-efficiency and greater quality because plans that fail on any single score can be superseded by others that use the same general model but avoid any particular shortcoming. Providers will recognize what is needed for success. They most likely will see that structures of multiple providers that can deliver coordinated care in a cost-effective way can offer consumers overall plans that are both lower in cost and conducive to higher quality. Thus, those providers will want to team up with one another—not because there is some statutory reward or penalty, but because it is the path most likely to lead to professional success, by the criteria of quality and price. In so doing, they will seek any other innovative tools, such as retail-store clinics or specialty hospitals, that will help them to fulfill their mission. Appropriate standards that ensure enrollees have access to 24/7 care will both create incentives for efficient, quality care delivery and ensure that such services are adequately funded. We advocate appropriate easing of scope-of-practice restrictions, plan restrictions of coverage of retail-clinic visits, and the like, as improvements of technology and organization facilitate utilization of these new business models.

Furthermore, those providers will aim their own personal performance toward delivering quality care at low cost. They will not be diverted by other criteria established in law or regulation, such as involvement of some minimum or maximum number of physicians. They will not be driven to "check the box" on any particular reporting form. If competitive markets are maintained, their objective will be precisely society's objective: quality, affordable care.[11]

The language of the ACA's statute and regulations will face a real challenge to come anywhere close to defining those objectives. For example, the ACA will drive the formation of accountable care organizations (ACOs, networks of doctors and hospitals that share financial and medical responsibility for providing coordinated care to patients) because of a statutory or regulatory reward

10 Resistance to specialty hospitals has arisen because of some instances of self-referrals by physician-owners of such facilities. See Lawrence P. Casalino, "Physician Self-Referral and Physician-Owned Specialty Facilities," Robert Wood Johnson Foundation, June, 2008 (www.rwjf.org/content/dam/farm/reports/issue_briefs/2008/rwjf28861/subassets/rwjf28861_1). Any such instances of abuse do not speak to the potential efficiency of the care-delivery model in a setting other than fee-for-service reimbursement. Under capitated prepayment, for example, specialty facilities would be created only when they provided genuine efficiencies. Retail clinics can be resisted by existing, competing full-care facilities because of the potential loss of patients and by some medical professions that fear a challenge from lesser-credentialed personnel in those settings. In a fully competitive health care system, in the long run, and especially outside of fee-for-service reimbursement, specialty hospitals and retail clinics could be built into the overall business model of integrated systems to obviate such issues.

11 There have been allegations of accumulations of market power by providers through mergers of hospitals and other intensive-care facilities. See Victoria Colliver, "Power Play on Health Care / Sutter Health, CalPERS Face Critical Decisions," SFGate, May 13, 2004 (www.sfgate.com/business/article/Power-play-on-health-care-Sutter-Health-2759676.php); Bleys W. Rose, "CalPERS Shuns Sutter Hospitals," *The Press Democrat*, August 10, 2004; Tanya Perez, "CalPERS Members Can Choose Sutter after 10-Year Gap," *The Davis Enterprise*, October 1, 2014 (www.davisenterprise.com/local-news/calpers-members-can-choose-sutter-after-10-year-gap/); and Avik Roy, "Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About," *Forbes*, August 22, 2011. Anti-trust enforcement will be a continuing challenge in local health care markets.

or mandate to do so.[12] Such an artificial incentive will be less effective than actual market forces because providers without any inherent reason to form an ACO will fulfill only the letter of the law without going the extra mile to fulfill its spirit (which also would pursue their own self-interest if the market is competitive). The ACO that they form will be designed to satisfy the law, not to succeed in a marketplace of unrestricted competition; it will be an unlikely regulatory triumph if the two turn out to be the same thing.

This distinction between regulatory and market objectives is a central reason why we believe that CED's vision for health care will achieve far better outcomes than will the ACA.

CREATE A CLEARING HOUSE FOR STUDIES, EVIDENCE-BASED MEDICINE, AND RECOMMENDED TREATMENTS TO PROVIDE A FREE FLOW OF INFORMATION TO PATIENTS AND PHYSICIANS, THUS EMPOWERING THEIR DECISION MAKING

The health care system needs an accumulation of data for research on medical outcomes for different treatments. CED's vision therefore includes a research and data-sharing organization (what we arbitrarily called the Institute for Medical Outcomes and Technology Assessment, or IMOTA), which would perform and enable research on what works in health care. Information can be difficult to price and sell at a profit or even to recoup costs, and the societal benefits can be great enough to merit subsidization. Furthermore, health care data can be private and sensitive, which can raise conflicts of interest, as there could be a profit motive to the exploitation of identifying information on such data. We therefore recognize the complexities in the organization of such an entity, but we believe that the potential return justifies the effort.

This stance is in contrast to the ACA's Medicare Independent Payment Advisory Board (IPAB), which is held by some to be health care reform's trump card in the cost-reduction game.[13] The IPAB would be composed of 15 full-time members (federal government employees who could not hold any other employment), appointed by the president and confirmed by the US Senate. If Medicare cost growth exceeds rates specified in the law, the IPAB will be required to recommend changes in some reimbursement rates (some specified reimbursement rates are off-limits until 2020) and other policies (beneficiary eligibility and premium amounts are off-limits) that are estimated to bring growth down to below those rates. The earliest cost-growth measurement period that possibly could trigger action by the IPAB did not end until this year; however, no IPAB nominees have been named yet. (In the absence of triggered recommendations from the IPAB, the secretary of US Health and Human Services is required to submit recommendations in its place; but, because of the recent cost slowdown, action would not have been triggered.) So in practical terms, the IPAB is still at the starting blocks, with no track record to assess.

The IPAB has been the object of considerable and contentious debate. Though we believe that the most vociferous attacks on the IPAB have missed the point, CED still finds its overall concept ill-founded. We discuss the IPAB's limitations in more detail below (in the context of other ACA government interventions into health care delivery that we find excessive). However, in this context, we will emphasize only that we believe that the IPAB, as empowered by the ACA, is an ill-advised intrusion into the doctor–patient relationship, potentially interfering with the delivery of care that is necessary under particular circumstances that a remote administrative panel cannot possibly foresee. We believe that there are other, better ways to address the causes of unnecessary care. For example, we foresee better results from a data-gathering and research function, rather than the overt direction of the IPAB, and believe that the ACA would have done better to have put its emphasis in that direction—providing information for doctors and patients to use in their own decision making.

12 According the Centers for Medicare and Medicaid Services (CMS), which is the federal government agency responsible for administration of Medicare, "Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients" (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/). Although the formation of an ACO is technically voluntary, as the CMS indicates, Kaiser Health News (run by the Kaiser Family Foundation) notes that Medicare uses "a carrot-and-stick approach" to encourage the formation of ACOs, and offers as its own definition, "An ACO is a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending" (http://kaiserhealthnews.org/news/aco-accountable-care-organization-faq/). ACO-like organizations also have been created in the practice of private medicine, outside of Medicare.

13 A detailed description of the IPAB is available at "The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending,"Kaiser Family Foundation, April 13, 2011 (http://kff.org/health-reform/issue-brief/the-independent-payment-advisory-board-a-new/).

There are entities within the federal government today that play some role in health care outcomes research. The newest is the Patient-Centered Outcomes Research Institute (PCORI), created by the ACA. PCORI has an unusual structure as a government-created nonprofit entity, funded with tax revenue. Other public research is undertaken by the National Institutes of Health, the Food and Drug Administration, and other agencies. The division of responsibility upon which the new and curiously organized PCORI was superimposed gives a sense that government has no coordinated and aggressive research agenda. We believe that a more serious approach to building a knowledge base upon which to formulate spending decisions (totaling about 18 percent of our GDP) is essential.

ENACT TORT REFORM, KEEPING THE ABILITY TO ACHIEVE MALPRACTICE REDRESS BUT USING DATA FROM THE HEALTH CARE RESEARCH INSTITUTION TO ESTABLISH SAFE-HARBOR CARE STANDARDS TO LIMIT LIABILITY

The US system of redress for those injured by the practice of health care is unsuccessful. It is slow, it is excessively costly in its consumed resources that do not go to the victims, and it can motivate unnecessary care ("defensive medicine") as protection against a potential speculative lawsuit. We believe that much can be done to improve the system. The research entity that we recommend (IMOTA) or a redirected IPAB could codify its findings on best practices into a "safe harbor" for providers, under which those who could document that they followed best practices would have a rebuttable presumption against related malpractice. Specialized courts (that could deal with health cases from an accumulated expertise) and carefully designed procedures for expert arbitration could simplify dispute resolution. The reforms that we suggest would in no way reduce the protections available for those who truly are harmed because of inadequate treatment or cure. However, we believe that these reforms would remove overuse of unproductive care in "defensive medicine" and make it easier for competent and careful providers to obtain affordable insurance and to practice. We are not satisfied by the ACA's limited steps toward tort reform.[14]

SUPPORT COMPETITION BY FACILITATING MOVEMENT OF PLANS AND INSURERS ACROSS STATE LINES; PROVIDE AN ALTERNATIVE TO STATE INSURANCE REGULATION

There are disadvantages to the key role of states in the ACA exchange system (as there were in the health care system that preceded it). Insurance regulation historically has been the responsibility of the states. This has numerous and conflicting consequences. On the one hand, we Americans value our "laboratories of democracy," and we are quick to argue that government closer to the people knows better their problems and is better able to respond effectively to them. On the other hand, even some who are most closely ideologically aligned with the concept of states' rights argue that some state health insurance regulatory systems suffer capture by providers of particular health care services or supplies, sometimes based on the location of manufacture. Thus, state regulations might provide that a home-grown medical appliance must be covered by all health insurance policies in the state, even if its efficacy is subject to question.

Although we, as a nation, do value more-local government's responsiveness to local issues, some might question the degree of that value's relevance to health care. Thus, regional differences might affect the relative prevalence of certain cancers and other diseases associated with smoking. But those differences in prevalence would not alter the desirability (indeed, the necessity) that all insurance plans everywhere cover treatment of such diseases. Nor would those differences in prevalence or the state of residence affect the appropriate treatment of such diseases when they occur. Ultimately, one might make a persuasive argument that health care is much more of a national- than state-based commodity or service. (This is not to denigrate the importance of differences in delivery of care, say, in rural versus urban settings. But many states have both urban and rural areas and already deal with such differences; there is no reason why an alternative federal regulatory system could not do so, too.)

The ACA did not take on the political task of addressing any adverse aspects of the state role in health insurance. CED recognizes the difficult politics surrounding this issue, but we do not believe that the health care system can be fully successful without significant reform in this respect. We discuss our specific recommendations on pages 42 and 43.

14 The ACA's action is limited to five-year demonstration grants to states; there is no nationwide, permanent action on this issue.

Counterproductive Government Involvement in Health Care under the ACA

Ironically, while the ACA leaves in place the fundamental structure of a fee-for-service system, it also attempts to influence behavior through a series of micromanaging rules and procedures. This is why we see far greater promise in CED's fundamentally changed market-based approach.

The previous section of this statement pointed out a few instances of such counterproductive government involvement, including the IPAB and the ACOs; below, we provide a broader and more-detailed analysis.

CARE-DELIVERY SYSTEM INNOVATION: "BUNDLING"

Perhaps not surprising, some actors in health care policy—including, most recently, the authors of the ACA—have attempted to simulate market forces within the current system. As an example, Medicare's central planners pre-ACA have tried to restrain pure fee-for-service reimbursement with "bundling"—providing a single payment for all of the care involved in one episode of the treatment of a single condition. The reasoning behind bundling is that providers will have no incentive to provide more than care that is justified because they will not be reimbursed for any additional services. Thus, it is argued, bundling would lead to more economical care. The use of bundling has been expanded under the ACA. It is one way in which government direction supersedes market forces.

CARE-DELIVERY SYSTEM INNOVATION: INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

A second example is the Medicare Independent Payment Advisory Board, or IPAB (described on page 23). Again, the IPAB is intended to provide expert, unbiased direction in the delivery of health care from 15 presidentially appointed and Senate confirmed full-time board members. In practical terms, the IPAB is still in the starting blocks, with no track record to assess; but we have fundamental concerns, discussed below.

CARE-DELIVERY SYSTEM INNOVATION: ACCOUNTABLE CARE ORGANIZATION (ACO)

The ACA also puts a heavy reliance on the creation of ACOs (as described on page 24). The premise behind the ACO concept is that all involved physicians should share a financial interest in the treatment of a patient with multiple complex conditions.[15] Thus, there would be a single payment for the patient's care, and the physicians involved with the various conditions would have to agree to share that payment. If they work together efficiently and complete the treatment using fewer resources, then more of the payment will be leftover as their "profit." The payment would not be increased simply because of the delivery of more services, so there would be none of the adverse incentives inherent in the fee-for-service system.

CARE-DELIVERY SYSTEM INNOVATION: GOVERNMENT DIRECTION VERSUS MARKETS

This institutional approach of the ACA, manifest in these three examples above—creating government-driven "pseudo markets" rather than channeling real market forces to achieve better results—follows directly from its philosophical underpinnings. Advocates of a leading role for government in the provision of health care begin from the premise that health care is a public good, largely financed by government, and that government should cap the amount spent on health care through global budgeting. It follows that the government should play a central role in deciding what health care is appropriate to provide. Otherwise, government could not carry out its task of allocating equitably the limited resources across competing demands. The underlying assumption is that capable and knowledgeable people with centralized authority can design a comprehensive approach to health care that will make these resource allocation decisions in an optimal manner. This underlying assumption leads to attempts (such as in the ACA) to drive the entire system through add-on devices, such as bundling or the IPAB.

15 "Bundling" could involve a condition that would involve only one provider, and thus might not require the cooperation of multiple providers in an ACO.

The issue is, who decides what procedures and technologies are made available—a government panel or the doctor and patient? Market-economy advocates, such as CED, come down on the side of the doctor and patient. The underlying assumption of those who advocate a market-driven approach is that health care and its delivery system are far too complex and rapidly changing for any group, no matter how knowledgeable or expert, to manage from the top down. The belief is that the sum of many, many individual doctor and patient decisions will provide outcomes that are superior to top-down management. And, thus, perhaps surprising to some, this market approach that is so motivated by concern about the effects of decentralized choice under fee-for-service incentives nonetheless would maintain provider and patient choice more than would the centralized-control philosophy of the ACA and its simulated market add-ons.

ACA advocates have used market rhetoric to justify devices such as bundling, the IPAB, and ACOs. For some, this rhetoric seems to cloak the reality of government direction and the suppression (or at least the limit on the effectiveness) of market forces. However, CED remains skeptical of the merit of these pseudo-market devices.

We acknowledge that the past and current attempts at simulated market discipline in our fee-for-service world, like bundling and ACOs, have, in some measure, improved cost and quality performance. But we fear that the limited rate of improvement we have seen will wane and that prospects for the longer term are less favorable. The examples of simulated markets have either failed or fallen far short of their promise (bundling)—or can reasonably be expected to fall short (the IPAB, and ACOs). This is not surprising on two main counts. First, simulated markets typically underperform real markets. Conditions and incentives are not the same. Second, health care providers respond to incentives to circumvent the confines of the pseudo-market systems.

BUNDLING

Bundling has provided some benefit, but it ultimately has failed to meet its full stated objectives, as would be predicted by these principles. For example, instead of choosing simple diagnoses and conditions and working to the bundled-payment budgets, some providers have used computer technology to find the most lucrative possible diagnoses and payment codes or search for multiple diagnoses and payment codes to maximize their reimbursements under the law or to order more procedures than they otherwise would.[16] In one notable example, facilities that provide acute care have handed off patients at the end of their acute treatment to their own rehabilitation facilities, which can provide follow-up care under a new payment cycle for separate and additional fees.[17] In sum (and ironically), health information technology—which was supposed to reduce health care costs—is being used with some frequency to maximize reimbursements (and therefore costs) for any given ailment, thereby defeating its own avowed purpose.

And, in addition to sometimes allowing too much unnecessary care (or at least billing), bundling sometimes can reimburse too little. The list of services for which providers are reimbursed may not include all commonsense interventions that would save money. For example, an experiment has shown that emphysema patients could be kept well with air conditioning to result in a net budgetary savings from avoided emergency room visits.[18] A patient who cannot afford a taxicab to obtain routine preventive care from the primary physician might eventually call an ambulance for far-more-costly treatment in an emergency room. Medicare covers amputations made necessary by diabetes, but might not cover preventive care that would make amputations unnecessary.[19]

16 In addition to these legal but unfortunate behaviors, there have been allegations of outright fraud, such as computer generation of results for tests and other treatments that are billed but not delivered. Steve Lohr, "Digital Records May Not Cut Health Costs, Study Cautions," *New York Times*, March 5, 2012; Reed Abelson, Julie Creswell and Griff Palmer, "Medicare Bills Rise as Records Turn Electronic," *New York Times*, September 21, 2012; Reed Abelson and Julie Creswell, "In Second Look, Few Savings from Digital Health Records," *New York Times*, January 10, 2013; Danny McCormick, David H. Bor, Stephanie Woolhandler, and David U. Himmelstein, "Giving Office-Based Physicians Electronic Access to Patients' Prior Imaging and Lab Results Did Not Deter Ordering of Tests," *Health Affairs,* 31 no. 3, March 2012, pp. 3488–3496.

17 Jordan Rau, "Medicare Seeks to Curb Spending on Post-Hospital Care," *Kaiser Health News*, December 1, 2013 (http://kaiserhealthnews.org/news/post-acute-care-medicare-cost-quality/).

18 Tommy G. Thompson and Donald H. Crane, "Medicare Debate Can't Only Be about Cuts," Huffington Post, May 4, 2011 (updated July 4, 2011) (www.huffingtonpost.com/tommy-g-thompson/post_2003_b_857504.html).

19 Jane Gross, "How Medicare Fails the Elderly," *New York Times*, October 15, 2011 (www.nytimes.com/2011/10/16/opinion/sunday/how-medicare-fails-the-elderly.html).

All of these problems, and many more, can result from gaps around and between bundled diagnostic codes. The predisposition of our Medicare system toward fee-for-service reimbursement—even if "bundled" as described above—results in such inefficient and suboptimal care. The inherent flaw is that bundling is an attempt to create a pseudo-market for part of health care; but real-life health care actors cannot be confined to such artificial subareas of their work and have every incentive to work around them and no reason to find sources of savings that are not within them. These problems could be avoided if bundling were made perfectly broad, such as through comprehensive capitated prepayment. "Bundling" is a poor cousin public-sector imitation of capitated prepayment, which was invented in the private sector under forces closer to a true market. Thus, system-wide reform must resolve these problems if health care is to attain the highest quality yet remain affordable.

The authors of the ACA have observed past limited successes with bundling and have responded with bigger versions of old bundles (such as including rehabilitation in a bundle with acute care) and some new bundles as well. But all partial bundles have boundaries and gaps. This merely creates an endless process of creating new bundles and revising old ones, with providers responding by constantly revising their billing practices to manipulate the system in new ways. We believe that the nation would do much better to rely on real markets instead, which would not be vulnerable to such manipulation.

There is a further, more fundamental problem with artificial market incentives, and it is difficult to resolve. The ACA today is beginning to impose standards and restrictions on the practice of medicine in the interest of reducing cost. Providers are beginning to use those revised practices. However, in many instances, providers still are reimbursed according to what amounts to fee-for-service standards. Thus, to the extent that providers are meeting new targets (such as reducing hospital readmissions) but still are being reimbursed by fee for service (under which they would have been paid for readmissions), they can find that they are doing good, doing what they are told to do, and are running losses as a result. This is partly a transition issue; it can be difficult to adopt a new business model while the old business model is paying the bills. But it also reflects inevitable internal contradictions when pseudo-market incentives are grafted onto a command-and-control, third-party-payer fee-for-service system.

IPAB

It is not likely that the IPAB will fare much better than bundling. First and most obviously, the IPAB's statutory authority is constrained, with its own built-in gaps (enumerated above). Second, the IPAB is one group of people reporting from one point of view. Markets drive process and productivity improvement because they evoke the widest possible range of ideas—some relating to the primary line of business, others relating to generic back-office business practice, covering basically all relevant areas—which gives managers the incentive, the methods, and the tools to beat the competition. The IPAB will not represent that broad perspective, and, given the deficient structure of the health care system itself, there is no motivation from the existence of the IPAB (or from anything else) for providers and plans to pursue vigorously such essential process improvement. The IPAB will provide one more figurative set of eyeballs and pair of hands to consider options to improve the quality and cost-efficiency of care, which, at one level, is unexceptionable. But in a truly market-driven system, *every* provider and plan would perform that function, looking at *every* part of the health care system; there is no reason to expect the IPAB, composed of a small number of additional experts in Washington, to do any better or to add unique value.[20]

Beyond those weaknesses, the dictates of the IPAB will provide only yes/no, check-the-box incentives, rather than the open-ended motivations created by the market. Market-driven enterprises earn rewards for every degree of additional improvement. There is never enough improvement because greater reward always can be had from any measure of additional improvement, however small the improvement and however satisfying the previous performance level might have seemed. By contrast, declarations from the IPAB almost certainly will be closed-ended; if you can check the box, you can avoid the penalty or pocket the incentive payment. The box may not constitute one of

20 The IPAB is empowered to issue directives for Medicare only. Its advocates argue that process improvements in Medicare will diffuse to improve the practice of all medicine. That may well be true, but using IPAB alone as a source of innovation clearly is inferior to creating incentives for process improvement in all of medicine in the first place.

the most important areas of potential improvement, and checking it may or may not denote the greatest possible degree of improvement, but once the box is checked, the game is over. Thus, the IPAB is most likely to be a poor substitute for real-market forces.

The savings targets that the IPAB must hit are set by arbitrary formulas in the law. If all other sources of savings should fail to suffice, the IPAB will likely turn to reductions in reimbursement rates, which, for some years, have been the tool of last resort for extracting savings from Medicare. Reimbursement rate reductions, given that many services already are reimbursed at or below cost, would lead to withdrawals of physicians from the program (and therefore problems of access) and an increasing sense of Medicare as a second-class, rationed source of health care for seniors and the disabled who depend upon it.

We believe that the IPAB is an excessive intrusion into private and personal decision making in health care. We place greater value in the doctor–patient relationship. We see government's role as the provider of information that doctors and patients can use to make their own decisions. We believe that consumer preferences should motivate the creation of health plans, which will use information to develop standards of practice for physicians and guidance for patients. Government's role in that process is to provide essential support, but not to control it.

ACOs

The ACO, at a simple level, also seems to be an admirable concept. The problem is that it is an artificial one. It attempts to gather together, for one or a few particular cases, physicians or other providers who have no preexisting professional relationship with one another. With no prior professional relationship and no certainty of any future one, many such ACOs will be rough-and-ready partnerships (in contrast to comprehensive integrated delivery systems, which cooperate on all cases, all of the time). There is no established rule for how the revenues from a particular case should be shared. In fact, as currently structured under Medicare, there is no reason to be sure that patients will know they are being treated by an ACO; so, to the extent that it is important, patient behavior cannot be counted upon. Thus, while the ACO may be a good idea in principle, it will be both more difficult to arrange and of limited efficacy in practice.

ACOs, both those dictated by the ACA within Medicare and similar structures created by providers within private medicine, have had some short-term favorable results. Advocates of ACOs argue that they address problems caused by poorly set reimbursement rates. The administered prices handed down chiefly by Medicare, but to some degree used by other numerous private payers (sometimes mimicking Medicare), cannot possibly correlate with the cost of providing those services (just as they may not correlate with their value to any particular patient). The result is that some services become "profit centers," and the providers of those services feel market pressure to break off from larger integrated institutions (such as hospitals) to set up specialty practices to enjoy their "profitability"—which exists only because, at this particular moment and with this particular set of reimbursement rates, their specialty service is overcompensated.

However, integrated providers of multiple services (like hospitals) are under contrary pressure to keep the overcompensated profit-center services. Just as some services are over-reimbursed, other necessary and beneficial services are under-reimbursed, so providers of comprehensive services are forced to engage in cross-subsidization so that over-reimbursed services pay for under-reimbursed services.

This arrangement is subject to further tension because some over-reimbursed services that the broader-based providers would like to keep could be delivered more efficiently in specialty hospitals. There is value in gathering a critical mass of specialists in one field to learn from one another and practice their specialty more continuously and intensively. To be fully successful, such facilities might need to be so large that they would have to draw patients from several surrounding comprehensive-service hospitals, which would then lose the "subsidy" earned by providing the over-reimbursed service. Thus, there might be multiple losers from this tug-of-war in a fee-for-service—or even a "bundled"—system.

Meanwhile, any given group of providers can be subject to strongly perverse incentives. A particular service might be overcompensated in one setting (say, in outpatient treatment) but undercompensated in another (perhaps in in-patient treatment). A comprehensive-service provider that is so whipsawed will face incentives

to build outpatient facilities, which could be very expensive and long-lived, only because, at this moment, outpatient provision is compensated too generously. Thus, the long-term investment in health care might become lopsided solely because of the accident of poor administered pricing, which could (and should) be altered at any time.

Putting all of these distortions together, providers believe that they are caught in a Catch-22. They are being asked by society to cut health care costs by reducing the volume of unnecessary services that they provide, and they believe that they are doing so, yet they are reimbursed on a fee-for-service basis. Therefore, by cutting the volume of services delivered, they are reducing their own incomes and increasing their payers' margins—and they are not being rewarded for their good behavior.

So current providers see favorable aspects to ACOs, which can free them from antitrust constraints. Those providers can share revenues to circumvent inaccurate pricing of different services (although that can require outright forbearance, even generosity, from overcompensated providers, who could be better off financially on their own). Some ACOs have outperformed prior attempts by unaffiliated providers who tried to organize loose integrated systems without the benefit of the ACO framework. Payers, too, recognize the value of ACOs, which can help improve the incentives for efficient utilization and quality improvement. Private payers are using ACO-like arrangements with providers to overcome limitations in fee-for-service payment in places where existing market dynamics, such as provider organization, integration, and technology infrastructure, make collaboration impossible.

These ACO successes are encouraging. However, CED continues to believe that a more market-oriented system could do better than ACOs. An important function—perhaps, the most important function—of ACOs is coping with a more fundamental problem, which is inaccurate reimbursement. Rather than coping mechanisms, a better way forward might be to deal with the underlying fundamental problem. The intent of CED's vision is not to pick winners; rather, market forces identify the best solutions. But, as just one possible example of the potential benefit of more comprehensive, market-driven reform, if providers were reimbursed by capitation, many of the problems that ACOs are intended to solve would just melt away. So, for example, a choice between in-patient and outpatient service delivery would not be dictated by relative reimbursement rates because there would be none. Instead, providers would decide according to clinical factors balanced by cost. The ACA's answer is to continue micromanaging, constantly resetting and re-resetting masses of reimbursement rates relative to one another, while the underlying technology and marketplace are constantly changing. This merely perpetuates a process of providers making decisions based on inexact relative reimbursement rates, rather than on medical considerations and overall efficiency. A true market system would halt that self-destructive process in its tracks.

Furthermore, forming an effective ACO is not easy, as noted earlier. Otherwise unaffiliated providers have to exert considerable effort to achieve agreement on whether and how to share both responsibility and revenue. There is the question of whether there will be enough future collaborations to justify the expenditure of organizational overhead. Meanwhile, the patient may not have a clear understanding of which provider is responsible for treating him or her. A simpler structure, such as a health maintenance organization that sells comprehensive care coverage at capitated rates, would not need to deal with such complexities and would achieve all of the same benefits, 24/7, with all of its enrollees in all of its services.

Again, CED's vision does not aim to pick winners. In fact, we hope for innovations that will surpass every provider structure that now operates. But we cannot ignore the strengths and weaknesses of those structures currently on the table. In generic terms, the objective is now commonly referred to as "clinically integrated networks," of which ACOs and comprehensive integrated delivery systems would be just two examples. The particulars may well change as thinking and technology evolve, but the principal characteristics, which appear enduring, are cooperation and sharing of information among providers across specialties, with care decisions based on the well-being of the patient—not on incremental payments for additional services or relative reimbursement rates for any particular services. We advocate the pursuit of better outcomes and consumer–physician interaction rather than any particular model for the delivery of care. To our very best judgment, our proposed system would yield to the market its rightful primacy on this point.

In sum, the ACA grafts command-and-control pseudo-market incentives onto a deficient underlying fee-for-service system. The track record of existing artificial market incentives is not inspiring. It should not be surprising that CED and many other observers remain skeptical and seek a better alternative.

On all of these scores, we believe that the ACA—for all of its good intentions and its partial steps in the right direction—falls short of what the nation needs now. There is no doubt that we can and must do better.

Enabling Conditions for Market-Based Reform

It is no surprise that market-based health care reform is a challenge. Health care long has been cited as one of the least-effective markets in the US economy.

The weakness of the health care market probably most cited by economists is third-party payment. Markets work because customers try to get the most from their limited numbers of spendable dollars and, in making their choices, send vivid signals to suppliers about exactly what they prefer. But if someone else is paying the bill, the consumer's number of available dollars is, as far as he or she is concerned, *not* limited—to the point where consumers rarely think to ask the cost of a therapy, and providers do not bother to state it.

It is not reflexively absurd in this society to think in terms of an unlimited number of dollars to spend on health care. Most Americans implicitly, even explicitly, think of life as having infinite value, and we rarely consider the possibility of limiting the efforts that we will undertake to save a life. At the street level, of course, resources *are* scarce and must be allocated. For example, the number of organs available for transplant is limited, which frequently raises ethical issues. But we generally assume that any feasible effort to safeguard a patient's life will be undertaken, regardless of monetary cost. To the extent that we act on that presumption, the market for health care will not drive the allocation of resources in the manner that economists believe is optimal and that we expect in the markets for other goods and services.

Although third-party payment hobbles markets, the solution is not to end it. If all Americans were wealthy and health care were cheap, (and, ideally, if health care became simple) we all could set out on our own. But none of those conditions is met in reality, and we Americans do value life, even the lives of others who are not capable of managing their own health care and whom we do not even know. So, realistically speaking, we need to find ways to live with third-party payment.

Another confounding aspect of the market for health care is the asymmetrical information between sellers and consumers. The amounts of information on the two sides are rarely precisely equal in any particular good or service market. However, given the complexity of the discipline of medicine and the length of time required to study it to the point of proficiency, health care may be the extreme of information asymmetry among all US markets. As a result, consumers are far less likely to bargain successfully toe-to-toe with health care providers than they are with sellers of other goods and services.

Furthermore, there may be relatively more instances in which consumers of health care have restricted choices of providers than there are with respect to other goods and services. Very roughly, one person in seven receives his or her health care through Medicare (counting the elderly only; some disabled and survivors also are covered by Medicare). Those persons have fewer choices of insurance plans (sometimes no choice—abstracting from Medicare Advantage, which we will discuss later) than do random consumers of general goods and services. In some instances, beneficiaries of traditional Medicare have some difficulty finding *any* physician who participates in the program; choosing among nonparticipating physicians might leave beneficiaries with far greater costs.

Another half of Americans are covered by employer insurance. Many of them—the number is uncertain—receive a health insurance plan chosen by their employer, with no choice of their own; others have too little choice to drive real competition. The list of physicians participating in those plans might also be restrictive. Perhaps one person in 12 is covered through the individual insurance market. By definition, those people have choices—they can choose among what offers they get—but pre-ACA, the problem often was whether they would get any offer at all, so choice could be purely academic. (This count of people also includes the relatively small number of nonelderly persons covered by Medicare.) Yet another one in eight or so is covered by the federal–state Medicaid program. This is only one plan in any given state, of course, and the roster of physicians participating in the program, with its comparatively low reimbursement rates, also is restrictive (including in those states that have put all Medicaid beneficiaries into managed-care arrangements).

Our point is not that these restrictions of choice are somehow necessarily wrong. Private plans can make their own judgments about provider quality or can limit the number of participating physicians as a necessary first step to require those physicians to share information and function as a coordinated team. Public programs with at least a soft budget constraint likely must enforce maximum reimbursement rates and refuse to deal with providers that will not comply. The point, rather, is that the market for health care is quite different from, say, a class of product sold in a supermarket, where each consumer is free to choose from among all alternatives, constrained only by his or her preferences and personal standards for quality and price. There is no realistic option to send health care consumers out to fend for themselves, assuming that fully competitive options will arise. Rather, we need to work to make this problematic market more competitive.

Competition can be restricted further in health care because its services must be delivered locally. That is true generally of services, but the urgency of some health care services can impose somewhat greater restrictions than in other instances. This can be particularly significant in rural parts of the country, where the lack of population density can reduce both the choice of and the access to providers.

In sum, we start from a market of particular ineffectiveness in driving the kinds of competitive outcomes that economists seek or even take for granted. "Market-driven reform" is, thus, both an obvious goal and a serious challenge, looking forward. So what would be needed to reach that undeniably attractive, but surely distant goal? We would cite the following factors.

A FREE FLOW OF INFORMATION FROM A VARIETY OF RELIABLE SOURCES

If consumers are to make sound choices, and to make a functioning market in health care, they need sound information on which to base those choices. Because of the complexity of health care, this entails collecting and processing massive amounts of data. In our view, the emphasis of the IPAB, as created by the ACA, is misplaced. Rather than providing dictates regarding the practice of medicine, an impartial data and research organization should collect and disseminate information—including safeguarding privacy while aggregating clinical results—so that doctors and patients can make better judgments about what treatments are likely to provide positive outcomes.

Once data are made available in a way that is consistent with individual privacy, research organizations—public and private—then can estimate the effectiveness of various treatments in particular circumstances. Having multiple perspectives would facilitate the development and validation of new ideas. We believe that a data-and-research entity could provide data, analyze those data, and aggregate the findings of other researchers in a fashion that would be more productive than the ACA's IPAB.

REGULATION THAT FOSTERS COMPETITION AND ENSURES PRODUCT INTEGRITY; LOW BARRIERS TO NEW ENTRANTS AND CLOSE SUBSTITUTES

Regulation can err in two opposite directions. On the one hand, it can fail to protect consumers from unsafe treatments and unqualified providers. On the other hand, it can be overly restrictive and fail to give consumers access to new and beneficial treatments and to providers who deliver care more efficiently and at lower costs. Either error would reduce consumer well-being, including with respect to cost. Excessive regulatory permissiveness can allow the use of expensive new treatments that yield no advantage over cheaper existing ones. Excessive restrictiveness can prevent the adoption and use of valuable new treatments or business models.

Although the costs of inadequate consumer protection are obvious, some may not understand that the unsustainable cost growth in health care has resulted, in part, from excessive market power in the hands of some providers. Such market power not only encourages higher prices in the short run, but it also dulls the incentive to pursue the process improvements that would allow lower prices in the long run. Without competitive pressure, markets do not work (as the economist's textbook would assume) to reduce price and increase value. The impediments to competitive pressure in health care that were described above are troublesome enough; compounding them with pricing power on the part of providers and even plans only renders those impediments far worse.

Market power and barriers to entry can result from multiple causes. Regulation can prevent, or make more costly, the entry of new providers. This can occur if regulations intentionally or unintentionally inhibit the entry of potential competitors from across state lines—which can happen because of unique requirements that might be incompatible or inconsistent with those of other states.

A similar, but separate issue could be prohibitions on potentially disruptive technologies or business models (such as specialty hospitals or retail-store clinics) that could prevent even in-state innovators from introducing better ways of delivering care. Excessive licensing requirements can go beyond consumer protection and inhibit investment.

Large required investments might erect barriers to entry. For example, an incumbent hospital provider could retain market power merely by refusing to allow access to its hospital beds, thereby forcing any potential competitor to build costly, possibly excessive, new hospital facilities to enter the market.[21] (This concern may be commonly pertinent, given the rise in outpatient procedures and shorter inpatient stays—making hospital construction less necessary and attractive. Population aging and increasing demand for hospital beds might cut the other way.) Thus, incumbents may be able to protect their positions and earn excessive returns not because of merit, but through many potential regulatory and natural market barriers. And, again, these factors operate in addition to the inherent impediments to competition in health care that do not operate in most markets for other private goods and services. Any action taken against these market barriers must not expose consumers to unsafe or incompetent care.

Remedies to market power are never simple—in health care or any other market. Is a particular provider or plan abusive and monopolistic or merely superior and successful? And even if the case is demonstrably the former, what is the remedy that injects competition but does not interrupt necessary and competent care? Antitrust remedies can be more art than science (which, some might argue, is a lot like medicine itself), and there are few (if any) generally applicable answers. But both regulations and antitrust policies will be keys to any market-based health care reform.

21 Colliver, "Power Play on Health Care / Sutter Health, CalPERS Face Critical Decisions," SFGate, 2004; Rose, "CalPERS Shuns Sutter Hospitals," *The Press Democrat,* 2004; Perez, "CalPERS members can choose Sutter after 10-year gap," *The Davis Enterprise*, 2014; and Roy, "Hospital Monopolies," *Forbes,* 2011.

RESPECT THE VALIDITY OF THE PHYSICIAN–PATIENT RELATIONSHIP; PROTECT THAT RELATIONSHIP, AND SUPPORT INFORMATION FLOW TO PATIENTS

We at CED, along with many in the fields of public policy and health care, believe that fee-for-service medicine presents perverse incentives and can lead to undesirable outcomes. However, we do not believe that this recognition is an indictment of health care providers or a denigration of the relationship between physicians and patients. Physicians join their profession because they seek to heal the sick. And although there are regularities in the practice of sound medicine, there is also uniqueness in every individual such that the physician–patient relationship cannot be replaced by a computer attached to a network with expert-system software and a database.

We believe that physicians empowered with the best support and motivation to provide efficient care—the nation's resources ***are*** scarce, and so the best possible care for all *requires* efficiency—will bring us as close as possible to the ideals of quality, access, and affordability. We also believe that our vision for the health care system provides the greatest prospect of achieving that goal.

RESPECT THE CONTRIBUTION OF NEW DRUGS AND MEDICAL DEVICES; THIS IS NOT AN EFFECTIVENESS QUESTION, BUT AN ISSUE OF INCENTIVES AND OVERUSE DRIVEN, BY DEFENSIVE MEDICINE

Similarly, we believe that pressures toward overuse of pharmaceuticals and devices are the result of perverse incentives that arise from both fee-for-service medicine and a malpractice system under which heroic measures can be seen as a necessary defense against a prospective lawsuit. Under the current system, information regarding efficacy can be irrelevant to the interests of the provider, whose best intentions must yield to the maintenance of insurability and avoidance of legal action.

Projections through the kind of regime change that we propose are highly inexact. However, we believe that the greater consumer pressure in a cost-responsible system would direct more medical innovation into cost-saving opportunities. And we believe that well-chosen reforms can ensure that patients harmed by malpractice receive prompt and appropriate compensation, while protecting

providers who seek the patient's best interest through the conscientious delivery of appropriate care and discouraging unproductive spending on "defensive medicine."

MAKE CONSUMERS AND PATIENTS PART OF THE SOLUTION

No model of reform will be successful unless and until we succeed in making consumers and patients integral partners in making good decisions about their health, both in terms of investing more in being healthy and making informed decisions about the health care they use. To reduce costs and improve health, individuals must be informed and empowered consumers, not simply patients passively receiving care.

In the current system, individuals are highly disconnected from, and insensitive to, the underlying cost of health care and the role that individual choice plays as a key driver of those costs. This is manifest in two main ways: lifestyle choices that contribute to costlier care and uninformed purchases of, and frequent noncompliance with, valuable health care services.

Appropriate consumer-focused incentive programs can address these different, but related issues. Consumer-focused incentive programs directed at lifestyle or behavioral changes, such as wellness programs, can have a significant and positive impact on health care costs. Evidence shows that well-designed programs can be cost-effective. There could be considerable improvements in health, and perhaps cost-savings, too, if patients took their prescription medications as instructed.

Additionally, cost-conscious choice among competing insurance plans, value-based insurance design, and consumer-directed health plans (CDHPs) all have the potential to educate consumers about cost and value as part of their health care purchases and bring greater awareness of the importance of prevention in controlling their health care costs.

We should motivate employers to utilize fully the incentives they have and encourage them to go further. Employers can be well situated to drive "positive disruption" through their existing communications platform with employees and their ability to encourage healthier behaviors; aggressive adoption of preventive and chronic care programs; and use of the highest-performing, value-based physician networks. The public health care information and analysis agency that we contemplate could serve as a clearinghouse for best practices, tools, and other resources for employers to use. And, although there already is (as there should be) a high bar for additional uses of public funds, the nation should consider tax credits for startup costs for wellness programs that deliver real results. Public policies should recognize the link between health status and socioeconomic status by allowing plans sufficient flexibility to offer wellness programs across payment systems and markets. These same incentives can be applied to the Medicare and Medicaid populations.

If all of these prerequisites could be put in place, we believe that the rewards would be crucial for the achievement of access to quality, affordable care.

HIGH RATES OF PRODUCT AND BUSINESS-MODEL INNOVATION

Business competition in the United States is known to yield innovation. Improvement is found not only in products and services, but also in their delivery. For many years, manufacturing was thought to be the epicenter of innovation and product improvement, and it still may be so. But, even in service delivery, US firms have found ways to improve customer satisfaction while reducing cost. The lowly haircut—traditionally cited as an activity where productivity growth was impossible[22]—has been a hotbed of innovation, largely in the business model.

There is no reason why health care should be any different. Innovation in health care and its delivery must respect the safety of the consumer. Innovation in the manufacture of automobiles (and countless other products) must respect the safety of the consumer. The responsibility is no less in either case. In both cases, there are issues of equitable treatment of persons of different means with respect to safety issues. Those issues must be recognized and dealt with.

The reward of process improvement in health care, as in other markets, arrives through more efficient use of resources. Under the pressure of competition, plans will seek ways to deliver the health care services that

22 Arthur M. Okun, "The Invisible Handshake and the Inflationary Process," *Challenge*, January-February 1970, p. 7.

consumers want at the lowest possible cost. If they do not compete successfully, consumers, empowered by choice, will move to other plans and providers at the next open-enrollment date. Cutting premiums by cutting essential services will not suffice because plans will lose enrollees just as surely as failing to deliver services efficiently. Furthermore, government regulation, just as it does today, will disqualify firms from selling insurance if they cannot demonstrate the ability to perform across a range of potential health care problems. This is one of the essential regulatory functions of government that must be performed well to provide essential protection to the consumer. It includes both a defined list of conditions that must be covered and the services required to remedy those conditions. This is not a function that can be left solely to the market because each individual consumer cannot be counted on to have the expertise, time, and energy to perform such research and verification. It will require input from all segments of the health care system and will be controversial.

As is true with other industries, the precise form of future innovation is unknown and unknowable. If industry actors knew what future innovations would be, they would have accomplished them already. What can be said is that innovation will extend across the entire health care enterprise, including both care itself and back-office support activities. Notable past innovations have been diverse. Providers that have attained sufficient scale have reorganized operations to assign as many tasks as possible to support staff, so that physicians can devote more of their time to high-value tasks that demand their skills. The tasks that can be assigned to non-physician personnel include numerous non-medical clerical responsibilities. But they also can include less skill-intensive medical tasks, such as routine diagnostic testing and even simple procedures surrounding surgery. Specialized personnel, non-physician and physician, can perform high-value services, such as reviewing clinical trials or codifying best practices based on clinical indications in expert-systems guides. The potential for such specialized human resource practices can change the optimal size of a medical system and lead toward larger integrated delivery systems, rather than (at the other extreme) solo or small practices—with an ultimate payoff of both lower-cost and higher-quality medical care.

But for some kinds of care, organizational advantages might come from different directions. People with urgent but non-skill-intensive needs while out of reach of a large integrated facility might be served best by a small, easily accessible retail-store clinic. The technological frontier for making such facilities cost-effective would include staffing decisions to provide the right kind of personnel, plus information technology to provide the necessary substantive support for the onsite staff and to record the clinic experience in the patient's central medical record, even if the clinic might not be solely associated with the patient's own health plan. Technologies such as these will be keys to providing affordable, quality care in rural areas, where large, integrated systems could not possibly be cost-effective.

An innovation similar in spirit is the specialty hospital. Experience indicates that physicians perform better when they can hone their skills through continued practice. Creating institutions that concentrate on particular ailments would seem to facilitate such skill-building through frequent practice and shared experience. They also could reduce costs through capturing economies of scale with respect to those particular procedures. Such innovation would be productive, but also would require the sharing of sufficient economies of scale to support both the specialty hospital itself and other institutions that must deliver treatment for other ailments, as well as 24/7 urgent services, in an efficient manner.

These are examples of past innovations, which may play into future process and productivity improvement. But, again, future innovation cannot be known. What we do know is that competition motivates economic actors to seek process improvement; the record without vigorous competition is poor—witness the cost dilemma for the current health care system. But, even though instances of competition in health care today are isolated, there is some evidence of success.

EXAMPLES OF SUCCESSFUL EXISTING INCENTIVE BASED SYSTEMS

True continuous process improvement in US health care will require competitive pressure across the country, in every market segment—care for the working-age population and their dependents, the elderly, and the low-income population as well. So long as segments of the market are sheltered from competition, some providers

will prefer to work comfortably there rather than to compete. The sheltered industry always will lag behind the possible, and its lack of dynamism will dull the competitive pressures, even in the segments of the health care market that nominally are forced to compete. Still, even today, there are segments of the health care system that are exposed to some measure of competition and perform measurably better than their less-competitive peers. The following are some examples.

The **Federal Employees Health Benefits Plan** (FEHBP) is designed along the general lines of CED's 2007 policy recommendations. Federal government employees (including, until recently, members of Congress and their staffs) are given a fixed-dollar employer contribution, which they take to what functions like an exchange or marketplace in an annual open season to choose from a list of alternative health insurance plans. The minimum number of choices (the number of "national plans," which are not necessarily accepted by physicians everywhere in the country) is about 10; in major urban areas, there usually are several more plans, including integrated delivery systems that operate in specific geographic areas. This is more choice than is afforded by many private plans. According to the federal Office of Personnel Management (OPM), which runs the plan, about 81 percent of total FEHBP enrollment is in fee-for-service plans, and 19 percent is in health maintenance organization (HMO) plans. Federal employees are concentrated in the Washington, D.C., area, and there are some concentrations elsewhere in the United States, but otherwise they are dispersed relatively broadly. Therefore, the incentives of cost-conscious consumer choice inherent in the FEHBP understandably have not been felt in the performance of the US health care system as a whole.

Furthermore, the FEHBP design has been relatively static in changing circumstances. It could encourage competition more effectively by encouraging entry by new delivery models. It has maintained national pricing, which can be problematic. And it has not implemented risk adjustment to reward plans that care for populations that have relatively more expensive conditions.

Nonetheless, there are indications that the FEHBP has been successful.[23] Federal employee satisfaction is generally high. Cost performance among the plans is somewhat better than it is for the nation as a whole. There have been proposals to open up the FEHBP to the population at large, as a mechanism to achieve universal coverage. Federal employee unions have tended to resist such proposals, however. They fear that, like any voluntary risk pool, an FEHBP opened to the public would tend to attract worse medical risks than the current federal workforce population, with the result that costs and premiums would increase for them. (Generally, any population of employed and insured people and their families would tend to be a more favorable risk pool than the population at large, which includes all people who cannot work or cannot qualify for insurance because of health problems. Self-selections from the population at large seeking insurance would tend to be worse health risks still, on average.)

Other similar systems are smaller, but have shown equivalent signs of success. The **state employee systems in California (CalPERS) and Wisconsin,** like the federal employee system, offer a fixed-dollar employer contribution. The employee can choose a plan during an annual open season. If the employee prefers a low-cost plan, the contribution might cover the entire premium; if he or she prefers a more-expensive plan, he or she is responsible for the incremental cost above the fixed-dollar employer contribution.

CalPERS covers many local government employees in addition to all state government employees. As a result, CalPERS has some leverage over the delivery of health care statewide. It is noteworthy, therefore, that health care generally is cheaper in California than it is elsewhere in the United States, and the cost has been increasing somewhat more slowly in California over recent years. How much of that result is the influence of competition injected by CalPERS enrollees is impossible to say, but the pattern suggests that competition works.

23 Testimony of Walton Francis before the Subcommittee on Federal Workforce, U.S. Postal Service and the Census of the Committee on Oversight and Government Reform, U.S. House of Representatives, April 11, 2013.

The performance of the Wisconsin state employees system has been followed in some detail. There is a large concentration of state government employees in Dane County because both the state capital (Madison) and the largest branch of the state university (University of Wisconsin–Madison) are there. More than 20 percent of the population of Dane County is eligible for the state-employee health insurance system. As a result, the cost-conscious state system customers have significant leverage over the overall market for health insurance in Dane County—much more so than in the rest of the state.

And from that follows a natural experiment. All of Wisconsin is governed by the same health insurance regulatory system. The population demographic across Wisconsin is probably more uniform than that among other states. But in Wisconsin, insurers market insurance and price by county, with the greatest concentration of cost-conscious consumers residing in Dane County. During recent years, premium costs increased less in Dane County than in the rest of the state and, as a result, are significantly cheaper for the same insurance coverage. In addition, Dane County has spawned several high-quality, low-cost integrated care-delivery systems. The greatest likelihood is that the competitive market in Dane County, where each individual provider associated with an integrated system seeks to deliver quality care so that his or her system can be successful, has led to these favorable outcomes. (Changes introduced by the state government most recently have not yet altered the basic structure and incentives of the system. Unfortunately, further changes that would dull incentives are now under consideration.)

Another example is **Stanford University**, which, on a smaller scale, provides a system similar to that of the federal government, Wisconsin, and the California state system. Stanford provides its employees with several choices, including two different integrated delivery systems. Stanford reports that about 80 percent of its employees choose an integrated delivery system, and the vast majority of university employees report that they are satisfied with their health care coverage.

Businesses have engaged in vigorous efforts to rein in their own health care costs, while also providing quality care for their employees. As one example, **Safeway** has invested heavily in encouraging wellness and healthy behavior.[24] However, the most prominent corporation to follow something that approximates the CED model is **Wells Fargo Bank** in California. Its experience is perhaps a lesson in why real improvement in health care cost and quality requires systemic change through public policy, not first movers that attempt to turn around the entire health care sector of the economy. Wells Fargo offers competing alternative private insurance plans: Kaiser, Health Net, more- and less-rich CDHPs, a health savings account (HSA)-eligible high-deductible plan, and also a broad-access PPO. The PPO costs a lot more than the others, but it is preserved by inertia—many employees are simply reluctant to change. Wells Fargo HR personnel reported that "Competition at the retail level just doesn't happen"; the system's attempt at introducing competition among health plans is producing some competition, but too little.[25] The failure of employees to move to less-costly, more-efficient plans is not encouraging—though HR personnel acknowledged that an important part of the problem is that providers face so few employers like Wells Fargo, CalPERS, and Stanford, whose employees are cost-conscious. As was suggested above, if competition occurs in just a small part of the market, some plans and providers will ignore that part and live comfortably in the noncompetitive segment. It is when competition reaches a critical mass that providers feel the pressure to perform.

The Wells Fargo CDHP has produced a little more value, but at the lower end of the cost spectrum—for generic drugs and the like. The result has been perhaps a 4 to 6 percent real reduction in cost, risk adjusted. People are making rational decisions at the lower end, but not yet asking "Who is the best doctor?" because there is no information on the quality of individual doctors, especially at the specialist level. Medicare does collect information on individual doctors, but it is not publicly available. Some doctors resist transparency. The website Yelp lets people review anything, including doctors and

24 Steven A. Burd, "How Safeway Is Cutting Health-Care Costs," *Wall Street Journal*, June 12, 2009 (http://online.wsj.com/articles/SB124476804026308603); and Laree Renda, "Focusing on What Matters Most – Health Behavior and Accountability," Institute for Health Care Accountability (www.theihcc.com/en/communities/employee_communication_education/focusing-on-what-matters-most-%E2%80%93-healthy-behavior-a_gqk6ur59.html).

25 Alain C. Enthoven and Joseph J. Minarik, *Health Care in California and National Health Reform*, Committee for Economic Development, June 2010 (www.ced.org/reports/single/health-care-in-california-and-national-health-reform).

hairdressers. A doctor in San Francisco brought suit to stop it, apparently on the ground that the responses were used to seed speculative malpractice lawsuits.

Wells Fargo's efforts are stymied also because of a concentration of hospital ownership in northern California, which has inhibited the efforts to create a high-value network plan that would be narrowed to low-cost, efficient providers. Even the most efficient integrated systems were perceived by Wells Fargo HR personnel to be pricing just below the other plans to maintain a narrow competitive advantage. Thus, the fruits of competition are limited because the segment of the market that is competitive is itself too limited. CED takes this as a call to action for serious, comprehensive market-based reform, rather than an argument against it.

In sum, the real-life examples strongly suggest that choice is constructive in a health insurance system. Consumers respond to the incentives in cost-responsible choices among insurance plans, and health care providers respond to those incentives embodied in the choices of individuals among alternative insurance plans. The result is both higher-quality and lower-cost care, with consumers choosing the best plans for their needs, not restricted to those that meet the preferences of their employers. Meanwhile, providers find it in their interest to deliver high-quality, low-cost care because it is the best way to ensure their health plans—that is, they and their employers—succeed. Incentives are aligned, which lies in stark contrast to the current system of third-party payment and fee-for-service medicine.

The ambitions for the ACA may have been broadly similar while the law was being negotiated, but those ambitions were not universally shared and seem to have been lost along the way. It will take a new roadmap to get from this new starting point (the ACA) to the destination we seek. The next section of this policy statement will update our vision and draw that new roadmap, and explain the changes that must be made along the way.

Where We Are, and Where We Want to Go: How to Close the Gap between the ACA and Our Market-Based Approach

In what respects does the CED vision need revision, especially in light of the ACA's enactment? What changes might make CED's proposal work better or come closer to political acceptability, or both?

We continue to believe in market-based universal health insurance, as articulated in the CED statement, *Quality, Affordable Health Care for All*, released in October 2007. We believe that our proposal, with improvements made with the benefit of the experience of the last five years, can significantly improve on the ACA. Following is our roadmap to arrive at our vision from today's starting place—the Affordable Care Act.

Several provisions of the ACA are unexceptionable and highly popular with the public: preventing denial of coverage or renewal, or underwriting higher premiums on the ground of preexisting conditions; preventing rescissions on the ground of immaterial omissions on applications; preventing lifetime cost limits; limiting the duration of waiting periods; requiring standardized and simplified enrollment and paperwork; and requiring coverage of children until age 26. However, we believe that the ACA could improve other provisions, which would align more closely with CED's vision:

REPLACE INCOME-CONDITIONED PREMIUM SUBSIDIES WITH A "FIXED-DOLLAR" REFUNDABLE TAX CREDIT

CED's vision is that all health care consumers make cost-conscious choices among competing private health insurance plans. Such competition will drive all plans and their health care providers to offer the highest possible quality at the lowest possible cost. With such competition, we believe that health care will become a dynamic, innovative industry. Without such competition, we believe that health care will continue adrift, with rising costs that society ultimately cannot afford.

Without financial support, many households cannot afford to make cost-conscious choices. We believe that the best way to ensure that every family has health care and contributes fairly to meet society's health care risk—both American values—is to provide each consumer with a refundable tax credit, usable only to purchase health insurance, financed with fair, broadly based taxes. The amount of the tax credit should equal the cost of the low-priced insurance plan—meeting quality and coverage standards—available in that consumer's region. Consumers who wish to choose a more expensive plan may use the tax credit toward the cost, but will be personally responsible for the excess of the premium over the amount of the tax credit. This design reconciles our value of health care for all with the imperative of cost-conscious competition.

Because all consumers will have paid (directly or indirectly) the broadly based taxes that finance the tax credits, all consumers will have contributed their fair shares toward society's health care risk. Therefore, all consumers will be entitled to coverage financed by these programs.

The tax credits would not be phased out for households with higher incomes, making administration simple and the pricing of insurance plans fully transparent. The amount of the premium credit in any given market area should be set equal to either the lowest single premium or the average or maximum of a small number of plans in the lowest tier of premiums available in that market. All insurance plans must be held to minimum quality and coverage standards, lest there be a "race to the bottom" on the true value of plans as they seek to state the lowest possible premium—with likely copays and deductibles

out of sight and out of mind.[26] And because the objective of this structure is consumer cost-consciousness, the premium credit should not be set on the basis of the overall average of all plans. That would increase the credit in response to every premium increase by every plan—even the least efficient—and would reduce both consumer cost-consciousness and competitive pressure on plans.

Low-income consumers will need some additional accommodation. Many health care plans impose at least modest copays or deductibles on various services to make their enrollees more cost-conscious. However, below some income levels, even minimal out-of-pocket costs can become burdensome and morph from inducements of cost-consciousness into rationing of care altogether. We expect that implementation of our vision would entail partial or even full coverage of copays and deductibles for consumers who now are Medicaid-eligible.

RISK-ADJUST PREMIUM REVENUE; ELIMINATE THE "CADILLAC TAX"

Health care plans that earn a reputation for providing the highest-quality care for persons with expensive conditions (e.g., diabetes or heart disease) and, as a result, attract more enrollees with such conditions should be rewarded, not punished with the disproportionately high cost of those cases. Conversely, plans should see no prospect of reward for finding subtle ways to encourage persons with expensive conditions to seek care elsewhere. The way to meet these concerns is through risk adjustment of premium revenue. All premiums would be paid into a central fund rather than to individual plans, and the fund would be distributed among the plans according to their stated premiums. adjusted for the relative riskiness of their enrollees compared with the population at large. Risk adjustment currently is practiced broadly, including, for example, in the Medicare Part D prescription drug plan, as well as in the exchanges under the ACA. It generally is calculated based upon prescription drug usage, which is well documented for the population at large. Risk adjustment, coupled with refundable tax credits, would render irrelevant and unnecessary the ACA's so-called "Cadillac tax" on high-value insurance plans, which has proven poorly targeted in many instances. (In fact, the eligibility and finance rules of our proposal should limit the role of the revenue authorities to collect the broadly based taxes to finance premium credits.)

RESTRUCTURE THE ACA's EXCHANGES

The exchange system under the ACA is organized by state. States are not necessarily the appropriate geographic units within which to market and price health insurance. Natural markets for the delivery of health care might be either larger or smaller than states and might well cross state lines. And there are states that encompass localities with wide variations in the cost of doing business. CED's paper on the experiences of providers and systems in California[27] explained that the state and local government employees health insurance system, run by CalPERS, found that it needed to price its insurance policies separately for five different markets within the state to remain competitive with plans that sought to compete by operating and pricing for only the low-cost, more rural markets, where the cost of doing business was less. There are numerous employment centers (New York City; Philadelphia; St. Louis, Missouri; Kansas City, Kansas or Missouri; Portland, Oregon; Memphis; Cincinnati) that draw residents from two or even three states. Residents of New York State, New Jersey, and Connecticut who work in New York City might wish to get their health care there and probably face similar costs of care. On the other hand, some rural states have sufficiently dispersed and small populations that they might not, by themselves, be complete health care markets. In other words, each individual state, as the ACA mandates, is not necessarily an appropriate universe within which to operate a health insurance system at unvarying prices. The objective, we

26 At the simplest level, this will require adjustments for plans with high deductibles, especially consumer-directed health plans (CDHPs), as discussed elsewhere in this statement. The extreme instance is some plans that achieved inclusion under the ACA, even though they provided no benefits for hospitalization. See Jay Hancock, "Debate Grows over Employer Plans with No Hospital Benefits," *Kaiser Health News*, September 26, 2014 (http://kaiserhealthnews.org/news/employee-insurance-hospitalization-coverage/). See also Tara Siegel Bernard, "High Health Plan Deductibles Weigh Down More Employees," *New York Times*, September 2, 2014, p. B1 (www.nytimes.com/2014/09/02/business/increasingly-high-deductible-health-plans-weigh-down-employees.html).

27 Alain C. Enthoven and Joseph J. Minarik, *Health Care in California and National Health Reform*, Committee for Economic Development, June 2010 (www.ced.org/reports/single/health-care-in-california-and-national-health-reform).

believe, should be to define areas within which health care is practiced and marketed on a relatively uniform basis, rather than to follow particular political jurisdictions.

Therefore, we would enable exchanges to be structured by market areas, following the experience of CalPERS in California, which divided the state into five separate markets. But, like CalPERS, we would capitalize on opportunities to have one operational unit serve several market areas. A single exchange operation that worked across multiple market areas, even if they had different pricing, still could achieve substantial administrative economies of scale. It also could encourage creative plan offerings that could take advantage of collaboration across market-area lines. For example, a plan could contract for some highly specialized treatments from a "center of excellence" in another market area, and so could achieve economies of scale along with the benefits of greater specialization and higher utilization in that specialty. It is conceivable that, with the diffusion of best practices among providers, the system could need far fewer separate market areas or that, in the extreme, there could be uniform pricing across the entire United States. Until that time, determining market areas will require considerable judgment and creativity; it will not be pure quantitative, deterministic science. However, the choice of market areas, which we would charge the exchange system to perform, will be an important contributor to the vigorous competition that is essential to attain quality, affordable care. In this respect, we believe that CED's vision has far more potential than the ACA.

And the most fundamental change from the ACA will be that every consumer may, at his or her option, take his or her tax credit to the exchange and buy coverage. Under the ACA, only persons not offered plans by their employers may go to the *individual exchange*. This leaves the exchange with a narrow population and raises the concern that the exchange is disproportionately populated by people who are bad risks and that premium prices there will be correspondingly high. The population in the ACA exchanges is further narrowed because employers can choose to fulfill their obligations under the employer mandate by going to the (separate) *employer exchange* to choose a single plan to impose upon their employees (until such time as the now-delayed employee choice provision is finally made active). The individual exchanges would be more attractive to private plans if those consumers participated.

Under CED's vision, instead, all consumers would use their refundable tax credits to access insurance through the exchange. Furthermore, each policy would be required to be sold at the same price to anyone who chose it within a market region. Therefore, no one ever could gain or lose by associating him- or herself with a different employer group; all individuals within a market area would be offered the same price for each particular insurance plan. (Of course, a plan (call it Plan A) with more elaborate coverage would be costlier than another plan (call it Plan B) with higher copays and deductibles, but every consumer would be offered the same higher price for Plan A and the same lower price for Plan B. Risk adjustment would compensate insurers that absorbed greater-than-average risk.) Therefore, there would be no "job lock"—a stated objective of the ACA, which it achieved only partially.

TAKE ADVANTAGE OF THE NEWLY ACCESSIBLE EXCHANGES TO ELIMINATE THE CONTENTIOUS EMPLOYER MANDATE

Under the CED vision, every consumer would have a refundable tax credit that would pay in full for the low-priced health care plan—meeting quality standards—in his or her geographic area. And every consumer would have the right to take that tax credit to a health insurance exchange to purchase insurance. The exchange would offer every available plan (see below), and every consumer, wherever employed (or if unemployed), would be charged the same price as every other consumer for any particular plan. Therefore, no consumer would be advantaged or disadvantaged by the accident of the terms of his or her employment, and there would be no *need* for every single employer to offer health insurance. Under the ACA (just as under the prior system), many employers are poorly situated to offer health insurance, leaving their employees at a disadvantage with respect to obtaining a necessity of life based on the accident of where they are employed. Accordingly, under the CED vision, it would make perfect sense to repeal the ACA employer mandate, which has raised fears of unfair treatment and burdens on business and created a distorting "notch" at the firm size of 50 employees at full-time (30 weekly hours) employment.

TAKE ADVANTAGE OF THE REFUNDABLE TAX CREDITS TO ELIMINATE THE INDIVIDUAL MANDATE

As explained above, CED's proposed refundable income-tax credits will allow every person to obtain health care coverage through, at least, the most-efficient, least-expensive plan at no out-of-pocket cost. Directly or indirectly paying the broadly based taxes that finance the credits would meet every person's responsibility to share in society's health care risk according to ability to pay. That is enough to justify that individual's health care coverage, even without any kind of mandate. In other words, under CED's system, individuals would not need the compulsion of a mandate and instead could enroll for insurance through the incentive of having the refundable tax credit. And if some individuals delayed enrolling for insurance, they still would have paid (directly or indirectly) the broadly based taxes that finance the system, so their failure to enroll would in no way reduce the system's financial viability.[28] Holding the tax credit unused would not reduce the resources available to the system. Therefore, there would no longer be any need to impose an individual mandate to purchase health insurance. We would recommend an aggressive program of outreach to inform people of their options and encourage them to take advantage of the opportunity to enroll in a timely manner.

SUPPORT A MORE CONSTRUCTIVE EMPLOYER ROLE IN PROVIDING HEALTH CARE TO EMPLOYEES

Under the CED vision, efficient marketplaces would be available to consumers and the exchange risk pool would be large and random, not heavily weighted toward poor risks. With such alternatives, many modest-sized employers could serve their employees best, with clear consciences, by ridding themselves of the administrative burden of providing insurance and allowing their employees to pick their own coverage, at competitive prices, by accessing the exchange system. By offloading the responsibility of providing health insurance, those employers could redirect their compensation dollars in ways that would provide greater value to their employees.

However, some employers surely will wish to remain involved in their employees' health care. CED has observed that employers understand that health care is an important contributor to their employees' well-being. Therefore, even if employees have the right to take their tax credits to a health insurance exchange and to have a broad range of choices at the same prices available anywhere, some employers will want to provide additional support.

Such employer help might take several different forms. An employer might offer onsite exercise facilities, wellness programs, or even an onsite physician or dietician who could coordinate with the staff of whatever insurance plan the employee has chosen. Many employers take such steps already, and they may wish to continue for the benefit of their employees.

An employer might go further and provide active support in its employees' choices of health care plans. The employer's human resources department could investigate the various plans' contracts and terms, help to interpret quality statistics, and generally try to match each particular employee's preferences to the particular plans that are available. Employees who have found their employers to be helpful sources of insurance would likely welcome such support in an important decision-making process.

Going yet another step, an employer might be large enough to function efficiently as an exchange for its employees. We believe that this function could add value. Such employers might believe that they can help their employees to make the best choices, given their particular circumstances, and to see those choices through to enrollment. Again, firms could use their expertise to provide guidance to their employees. However, employees would remain free to take their tax credits to the exchange system or to other vehicles of plan choice. Because people have differing preferences for health care and because, in expressing those preferences through plan choice, they send valuable market signals to plan sellers and organizers—and, through them, to health care providers—restricting that choice would be counterproductive. It sends plans and providers off with a determination to deliver care in ways that people do not really want. Ultimately, everyone loses in such a market.

28 Persons who fail to sign up for coverage at the outset of the new system could be enrolled when they first subsequently seek care.

EMPLOYERS WILL CONTINUE (OR BEGIN) TO OFFER PLANS FOR THEIR EMPLOYEES

CED's vision, as stated in 2007, was that all employer provision of health insurance and health care should be handed over to the exchanges. However, we have observed that some employer plans have been the source of numerous innovations, including the advancement of wellness programs and better health-related behavior on the part of employees and their families. Accordingly, we believe that those investments should not be lost, but rather should be encouraged, understanding that, for many employers, offering plans would not be the best choice, and so other means of delivering high-quality, affordable care (such as the exchange) must be available. We do not believe that such a level of care quality should be restricted, either absolutely or disproportionately, to those with the good fortune of working for large employers.

Accordingly, we recommend (in a measured change from our 2007 policy statement) that employers be permitted—not required, as under the ACA—to provide health insurance plans to their employees. Under our vision, if employers choose to offer plans, their employees should use their refundable tax credits to purchase those plans, in whole or in part (if necessary, supplemented by employee payments, perhaps through payroll deduction). (Such employers would pay, directly or indirectly, the same share of the broadly based taxes to finance the government-provided premium credit as all other employers; as the providers of coverage for their employees, they would have the same right as any insurer to receive the refundable tax credits in payment for coverage.) On the other side of the coin, the employer should submit to the same risk adjustment that is required of every insurer, just to protect those plans that take on the burden of populations that are disproportionately sick. Other employers may choose to benefit their employees by forming (or joining with other firms) their own private exchanges to help each employee find the right insured plan, that should be permitted as well, although it might prove to be cheaper in the long run if those employers merely provide information and counseling and leave the administrative infrastructure to the exchanges themselves.

The tax treatment of employer insurance must be on a level playing field with the tax treatment of insurance purchased on the exchange. The typical consumer would use the fixed-dollar refundable tax credit to buy the low-cost insurance plan in his or her market area—hence, there would be universal coverage. If he or she preferred a more expensive plan, he or she would be responsible for the incremental cost out of after-tax income (noting that there likely would be a tax deduction for extraordinarily large medical expenses—like the current law's deduction for expenses in excess of 10 percent of income—which could apply to insurance premiums). An employee choosing his or her employer's plan should be treated in exactly the same way. He or she should be required to surrender his or her tax credit in payment for the health coverage, as a first step. If the firm chose to spend more than those resources on delivering health coverage, then the excess should be attributed to the employees as taxable income to attain equal treatment of employer versus exchange plans.

Employees should be able to exercise their choices by instead taking their refundable tax credits to an exchange. We do not believe that substantial exits of employees will occur. Employers, especially large employers, have tremendous advantages in delivering health insurance and health care to their own employees. For example, having economies of scale and employees onsite enables the delivery of services, such as routine physician care, exercise, and advice on diet and other matters. Risk adjustment of premium revenues will neutralize any effects on the viability of employer risk pools. Still, we do believe, as a matter of policy and principle, all plans must be subject to full competitive pressure if their performance is to maintain the necessary high standards for quality and affordability.

Insurance is a major commitment on the part of employers, and we expect that insurance through the exchanges, which will itself become simpler and cheaper relative to employer-administered insurance, will be an attractive option. Employees sent to the exchange system should be treated equally to employees covered by employers and, likewise, that the employer decision whether to offer plans or to send employees to the exchange is driven by business and health care criteria, rather than by the pursuit of some tax advantage, for

example. And employees must continually put market pressure on their employers' health insurance and health care systems.

Therefore, under the CED vision, employers that have developed successful plans can continue them. And they can continue to use those successful plans for recruiting and retaining employees. But, unlike under the ACA, a broad risk pool in the exchanges will encourage numerous quality plan offerings at affordable prices for everyone, including employees of smaller firms, who today are disadvantaged in purchasing health care purely by the accident of where they work. Furthermore, the breadth of choice will mean that consumers with different preferences will be more likely to find plans that provide the health care that they want.

FACILITATE ADDITIONAL CONSUMER ACCESS POINTS TO THE COMPETITIVE MARKET FOR HEALTH CARE

The problems with the debut of the ACA's internet marketplaces strongly suggest that providing access is not mere routine, and there are likely more lessons yet to be learned. The most important task of the access system is to communicate with consumers to help them to choose the plans that provide the greatest value—that is, the best relationship of quality with cost for them. And because consumer preferences differ widely, different consumers will want different plans. Furthermore, different consumers quite possibly will find different modes of communication to be easier or harder to navigate.

For these reasons, we believe that consumers should have alternative access points to the process of plan choice. As noted, employers might choose to provide decision support or even to serve as actual exchanges for their employees.

An additional option would be for firms to band together in private exchanges to achieve economies of scale in plan selection, as many firms currently do under the ACA. That could give smaller firms the same option of providing full-service support to their employees, just as larger firms could do on their own. Thus, all of the functions of employee support—background research, responding to questions, enrollment, and more—could be cheaper on a per-employee basis. Such private exchanges may continue to add value. We recognize that private exchanges now fulfill some ACA functions that would be unnecessary under CED's vision. So, for example, firms that do not want to pay the penalty under the employer mandate might find a private exchange to be the best way to go, but there is no employer mandate and no penalty under the CED vision. Similarly, firms that are compelled by the ACA to offer a plan need to choose one or several, but the exchange open to the general public under the CED vision fulfills that function and, unlike under the ACA, every individual could use that exchange. Furthermore, because the ACA continues to allow separate risk pools, some employers might seek a private exchange to keep their employees out of what they fear would be a risky and therefore expensive public-exchange risk pool. That function, too, is irrelevant under the CED vision. Thus, some benefits of the private exchange today would become obsolete, but we believe that some employers still might want to join in a private exchange to provide the best-quality service to their employees.

For that matter, we would not rule out the continued operation of private insurance brokers and the individual market. Consumers who want and need decision support should be able to get it in the forms that they find most useful. Individual insurers that comply with the same consumer protections that apply in a public exchange could sell their products in a reformed version of the individual market. The recent success of some private exchanges suggests that they add value. Insurance brokers could serve those consumers who would be willing to pay for personalized advice. Consumers would decide which plan-selection vehicle(s) would be successful. With appropriate safeguards, all actors in this market will need to focus their energies on providing the greatest value to the consumer, including the highest possible quality of care at the lowest possible cost. Consumers will judge which channels of access provide that value, and those channels will grow.

Although we believe that multiple access channels should be made available, we do not know what the ultimate market judgment among those channels will be. It is possible that one or more access channels will succeed and some will fail. It is possible that, in the end, after current "teething" problems are resolved, a single public channel will provide all the information and support that consumers need, but it is possible that a critical mass of consumers always will want a private-sector perspective on their insurance and care choices. We welcome and are

willing to accept whatever judgment the market may hand down. We, of course, would not accept (and do not expect) any monopoly or oligopoly imposition of access charges on health care choice; the existence of a free exchange open to the general public should preclude that. We do believe that some consumers may be willing to pay for expert decision advice, if they believe that the advice is honest and unbiased. But, ultimately, we believe that the consumers' collective judgment of value will be correct and will prevail.

OFFER A BROAD VARIETY OF INSURANCE PLANS

Fulfilling the broad objective of CED's vision requires innovation and process improvement by providers and plans. That means that there must be a steady flow of new provider-competitors and new insurance plans. We believe that individual consumers choosing their own health plans in a cost-conscious way is precisely the best path to encourage such innovation and entry. Under the ACA, entry and innovation still require (as they did pre-ACA) that employers choose the new plan and impose it on their employees. Such marked change inevitably dissatisfies some people, so employers are predisposed to keep what they have, even if it is inefficient and promises rising costs down the road. In contrast, if individual consumers can choose their own plans, it is possible that a new and innovative plan, which might have failed to sign up 10 employers to provide coverage to all their employees, still could be chosen by 10 percent of the employees of each of those 10 firms and, in so doing, might achieve the necessary critical mass to take root and grow.

Specifically, CED's policy recommendation is that all consumers have access to a choice among several alternative private health insurance plans. Those plans should include all conceivable alternative modes of delivering care that consumers support in the marketplace: wide-access fee-for-service plans, consumer-directed health plans, integrated delivery systems, everything in between, and, in time, as-yet-unimagined models. Access to these alternative insurance plans should be as simple and easy as possible, with alternative mechanisms—a public exchange, private exchanges, and direct contact with individual plans—tested by the marketplace. Market entry by new and innovative types of plans should be encouraged. In this way, every consumer should have the opportunity to choose the type of plan that he or she prefers, so that the market decides which plans should succeed and expand and which plans need to "up their games" to succeed.

Beyond our fundamental vision of market-based competition, we believe that there are other things that the health care system could do to encourage innovation, entry, and a broad variety of plans. One is to set fair, uniform standards for plans, where necessary, while allowing variety and innovation whenever possible. For an obvious example, every insurance plan must offer coverage for serious and common ailments. It would make no sense to allow offering of insurance that did not cover diabetes or heart disease; once down that road, the end quickly would be health insurance for people who are not sick, which would be highly affordable but totally worthless. And because most non-attorneys (probably most attorneys, too) are not in the habit of reading and critiquing alternative insurance policies, there is a need for consumer protections regarding exclusions from health plans. Current regulation deals with such obvious issues. But the question then becomes, where should regulation stop to allow innovation to begin? Differences in current state regulation show that this question is far from trivial. Controversy over the ACA's implementing regulations has centered on long-festering social issues (like abortion coverage), but has extended more broadly to allegations of micromanagement on medical provisions that are not nearly so controversial. It will be challenging to decide where to draw the regulatory line, but drawing it skillfully will allow different health care plans to compete on a level playing field, focusing innovation where it adds value in the marketplace.

Apart from that challenge will be levels of copays and deductibles in insurance policies. With all else equal, insurance premiums can be cheaper if copays and deductibles are higher—insurance pays for less of the cost and the insured pays for more. But there can be an issue if an insurance plan with extremely large copays and deductibles attracts relatively low-income consumers on the basis of a low monthly premium. The consumer out-of-pocket share may turn out to be so large that providers wind up with a recurrence of uncompensated care, which we all thought near-universal insurance coverage would end. Thus, the reformed health care system that we envision strikes a balance; we need copays

and deductibles to make people cost-conscious, but the cost share must not be so large as to make consumer affordability a problem once again.

The extreme of this continuum is consumer-directed health plans (CDHPs), which feature larger-than-normal copays and deductibles but with tax-favored medical savings accounts (MSAs) or health savings accounts (HSAs) that are intended to help consumers to cover those out-of-pocket costs when they are sick. Such plans can work for some consumers, but they can be misused by others who take advantage of the very low monthly premiums (because their out-of-pocket cost share is so high) but do not fund their MSAs, and so wind up with medical bills that they cannot afford to pay. Some employers offer CDHPs to their employees and also fully fund their employees' MSAs. In these instances, funding for the MSA effectually becomes a part of the premium cost. We believe that this model is the most appropriate within the context of the CED vision, and so we believe that the premium costs of CDHPs should include full funding of the associated MSAs. However, this potential problem extends to all plans with high copays and deductibles, and consumers with modest resources should be fully informed when they exercise their choices.

But, to make clear and emphasize, we believe that competition among private insurance plans for the cost-conscious choice of consumers is the best driving force for innovation and process improvement and that copays and deductibles within an insurance plan are less effective and less important in driving fundamental change in health care.

We believe that our suggested policy combines the best that is available from each sector of the economy. Large employers that want to devote the resources to provide quality health plans for their employees will be free to do so. Those plans will be subject to a market test and, if they are successful, will be rewarded with employee loyalty through recruitment and retention. But other firms—both smaller firms that lack the necessary economies of scale to pursue such a complex enterprise as health care and larger firms that choose to focus all of their energies on their core lines of business—will be able to rely on the market to provide quality, affordable care to their employees. With a large share of the population having access to a well-designed exchange or marketplace system, the entire population will be able to choose quality, affordable care.

CREATE AN ALTERNATIVE FEDERAL REGULATORY PATH TO NATIONWIDE PLAN APPROVAL

Today, because state regulatory requirements or standards can differ significantly, health insurance cannot be sold across state lines—with the result that market entry is more difficult, competition is blunted, and incumbent plans (and even providers) can charge higher prices and ignore the need for process improvements that might both reduce costs and increase quality. This is one of the most significant barriers to competition and innovation and a broad variety of insurance and health care plans. Obtaining new and additional regulatory clearances inhibits even the most effective plans from expanding across the country.

We believe that insurers should have an alternative path to federal certification to sell policies across state lines. An alternative federal regulatory approval would be an enormous boon to competition and innovation. With such regulatory certainty, the finest health care systems could more easily market their expertise all around the country. This could make it far more likely that consumers would choose to enroll in efficient integrated systems (which typically have created closed networks of closely affiliated specialty physicians working as a team), for example. If there is only one integrated system in a geographic area, any consumer who, for whatever reason, did not want to restrict him- or herself to that particular physician network would refuse to join. However, if there were two or more such systems in that area (assuming that the geographic area had sufficient population density to support them), then that consumer would have a greater chance of being satisfied with at least one system's network. And, with several integrated systems competing, each system would face greater competitive pressure to achieve further efficiencies and even higher quality to attract enrollment. Without the ability of such systems to expand across state lines, it is far more likely that each will settle into a comfortable semi-monopoly position as the only integrated system in its jurisdiction. Each might be more efficient than the competing wide-access fee-for-service plans, but each also will lose the dynamism and the continuous improvement that comes only from true competition.

Offering insurance across state lines is not a panacea. A New York consumer, for example, could not buy today's insurance policy at small-town rates and then carry it into a physician's office in midtown Manhattan. There are geographic differences in costs of doing business (specifically in practicing medicine) that cannot be waved away with a piece of paper. And, for that matter, there are geographic differences in patterns of practice that lead some parts of the country to be far more efficient in delivering care, apart from generic cost-of-doing-business issues like rent.

The bad news is that competition is hard work. The good news is that the differences in performance across the country are so wide that the efficiency savings that we could achieve merely from bringing today's lowest performance standards up to today's state of the art would be enormous. Once achieved, there is still more to be gained, but it will come through the day-to-day slog of finding entirely new and better ways of doing things. It is the difference between playing catchup by copying the best existing practices (comparatively easy) and innovating by improving the best existing practices (comparatively hard). But every American would enjoy better health care at a lower cost if reform could bring our system to today's performance frontier and then innovate from there. We believe that plan competition across state lines is one of the most important ways to pursue that goal.

ENCOURAGE INNOVATIVE PRACTICES WHILE SUPPORTING ROUTINE NECESSARY SERVICES

Certain new health care institutions, as described above, appear to achieve significant efficiencies and deliver care in ways that people want. So-called "retail clinics" in convenient locations are one example. Retail clinics do not pretend to offer complete health care. They do not include specialists and may not even provide a physician; for some purposes, trained nurses suffice. Retail clinics can provide affordable care to the uninsured. It is a model often discussed for rural areas, where complete health care facilities within short traveling distances of all members of widely dispersed populations is not economically feasible. Even in urban and suburban settings, retail clinics can provide timely and easier access for many people. Technology can connect a retail clinic's non-specialist personnel with the expertise that they might need and can preserve and convey medical records for the patient's primary physician.

Another example is the specialty hospital. On many scores, it makes sense to consolidate many practitioners of a particular specialty in one location. Those specialists can learn from one another and hone their skills by dealing with more cases in their particular fields. Expensive and highly specialized equipment and facilities might achieve an economical rate of utilization in such a specialized facility, which may not be the case at a comprehensive care facility.

If ideas such as these improve the delivery of health care, they must be used. However, when added to an imperfect system, even good ideas can have bad side effects, so we need to adapt these ideas appropriately. For example, to serve some needs, a retail clinic need not provide complete medical care. However, all consumers need complete medical care (or at least the facility to provide such care, when needed). Under fee-for-service reimbursement, a retail clinic can collect fees for simple cases, taking revenue from a nearby comprehensive care facility that must continue to operate if consumers are to have available the comprehensive care that they need. The retail clinic adds value by providing convenient care that people want. However, because of the flawed reimbursement system, the retail clinic is, in effect, also obtaining value from the nearby comprehensive care facility. Any patient whom the retail clinic is not competent to serve is simply bumped to the comprehensive care facility, without the retail clinic paying for this essential backstop.

Under a more rational overall health care system that did not implicitly mandate fee-for-service reimbursement, every plan would be required to provide comprehensive care—thus, every plan would be required to pay for this essential service, supporting the comprehensive care facility. An integrated delivery system could operate both retail clinic outposts and central comprehensive care facilities. It could connect the two electronically and could size its comprehensive care capacity, taking account of the tasks that would be performed by the retail clinics. Because the reimbursement would be by capitation, the workload could be allocated efficiently between the retail clinics and the central facility without adverse monetary side effects.

Fee-for-service reimbursement, often at inefficient reimbursement rates or through imperfect bundling, also can create adverse side effects of even otherwise-efficient specialty hospitals. If the reimbursement of a specialty procedure is inefficiently high, it can make business sense for the specialists to strike out on their own, even though, in a true market, that same decision might be uneconomic. That decision might even involve investing in a new building and other long-lived facilities and equipment, which could give that uneconomic decision a 30-year (un)useful life. Advocates of government economic management of health care delivery would urge us all to "chill" because the inefficient reimbursement rates could be revised and the bundles could be broadened or narrowed. But such corrections, followed by technological and consumer preference changes that lead to new and different distortions that must later be re-corrected, would be a never-ending waste of resources. And because the inefficiencies are discovered only after they emerge (or else why would they have been created in the first place?), then the kinds of inefficient investment described above would be made all the time, forever. There is a reason why central planning has fallen out of fashion in every other industry all around the world.

Instead, we believe that a more market-based approach will consolidate those different health care functions that are delivered most efficiently in a comprehensive facility. When separate specialty hospitals make sense, they will be created and shared by multiple systems that will pay for services by contract at efficient market-clearing prices. Central planning authorities constantly groping for appropriate reimbursement rates will be unnecessary.

Markets work. A market for health care would work as well. The system underlying the ACA, which fundamentally is little changed from the prior system, clearly does not.

CREATE A NEW DATA AND RESEARCH INSTITUTION TO REPLACE THE FUNCTION OF THE IPAB

As explained above, CED's vision includes a research and data-sharing organization that would facilitate studies of effectiveness in health care. This information would help doctors and patients to make better decisions. We call it the Institute for Medical Outcomes and Technology Assessment (IMOTA).

In contrast, we see the proclaimed role of the ACA's Independent Payment Advisory Board (IPAB) to be making decisions for doctors and patients. We do not believe that this is appropriate or conducive to the best practice of medicine.

We leave open the question of whether the IPAB should be retained as a purely advisory body. However, we wonder whether existing entities, such as the Medicare Payment Advisory Commission (MedPAC), already fulfill the IPAB's function in every way, other than making binding decisions that we believe should better be left to the discretion of doctors and patients.

ENACT MORE AGGRESSIVE TORT REFORM

We believe that our current malpractice system spends too much money and takes too much time to deliver compensation inaccurately to victims of health care errors. We believe that our proposed IMOTA will provide the information base upon which good-practice guidelines could be formulated to provide a safe harbor for purposes of protection from accusations of malpractice. We also recommend the use of expert courts and arbitration to cut the time taken to resolve such disputes. We believe that progress on tort reform will make insurance more readily available, and will reduce costs by making the practice of so-called "defensive medicine" unnecessary, while providing timely compensation to victims of true malpractice.

How CED's Vision Uses the Best of Both Perspectives on Health Care

Today in Washington, health care policy is at a standoff. As we suggested at the outset, we see the nub of the dispute over health care as the relative roles of government and the market. We believe that our vision strikes the best balance between these roles—taking the best of both perspectives and building a system that achieves the objectives of both sides. We see our vision as an improvement that builds upon a foundation of the best of the Affordable Care Act (ACA). And we believe that our nation has important and widely shared principles and goals, which our vision advances in the most effective, possible way.

The ACA took some important strides forward in terms of access and made positive steps on cost and quality. But we believe that our vision builds on the ACA's advances by strengthening and broadening the new law's use of market incentives to drive innovation for higher quality and lower costs, while maintaining an appropriate role for government in facilitating access and making markets work. We believe that this truly would be the achievement of all three objectives of *quality, affordability* and *access* that policymakers have sought for many years.

Here is why we see CED's vision as the best embodiment of the principles of both the market-oriented and government perspectives of the health care system.

MARKETS WORK AND ARE ACCEPTED BROADLY…

Most basically, economists are nearly unanimous in their support for competitive markets. Markets create incentives for producers to innovate continuously so that they can both improve quality and hold down costs, so they can underbid the competition and attract more customers. The opportunity for profit in markets encourages other producers to enter, giving consumers more choices and increasing competitive pressure on all sellers to raise quality and hold down costs. CED believes that markets will be at the core of any successful health care system.

Many participants in the health care debate stand firm on the primacy of markets. In fact, the ACA explicitly injects several important market-oriented devices into the health care system.

The ACA extended the policy innovation of "bundling" to more medical conditions.[29] What is bundling at the end of the day? It provides a fixed payment for complete treatment of a patient's particular condition, so that if providers can treat the condition more efficiently—that is, with fewer resources—they can increase their "profit" (that word is used in some arguments for bundling and the ACA). In other words, it is applying market forces and the profit incentive to medical care.

Similarly, the ACA promulgates the use of accountable care organizations (ACOs). ACOs take a fixed fee for the treatment of a complex condition requiring multiple specialties and organize the specialists to work together and share the payment. So, again, if they cooperate efficiently and use fewer resources to treat the condition, they increase their collective "profit." This is simply applying market and profit incentives to the particular conditions for which the ACA "prescribes" ACOs.

And then there is the Independent Payment Advisory Board (IPAB). We expressed our concerns about the IPAB's potential centralized prohibition of some treatments that should be considered on the basis of individual circumstances by physicians and patients. However, other aspects of the IPAB's mission are affirmations of the valid role of market incentives in health care. How? The IPAB is directed by the ACA to impose penalties for falling short of designated performance targets or rewards for meeting them. Thus, the IPAB explicitly endorses the use of financial incentives to drive provider behavior. This function is, in effect, like a health care provider (subject to market competition) who observes a cost-drain in his or her own

29 "Bundling" was an innovation for public policy in that it adapted and applied the prior private-sector device of capitated prepayment.

operations (perhaps by a more successful competitor).[30] In this particular respect, it relies on market principles and profit incentives to improve health care delivery.

We believe that our vision improves upon and extends the ACA's attempts to apply market forces to health care. In effect, the incentives under our vision facilitate bundling, ACOs, and the problem-identification processes of the IPAB and make their operation broader and stronger. The ACA's bundling does not cover all conditions; ACOs do not extend to all providers and all treatments; and the IPAB does not use all available input (only a limited number of "experts") to uncover all cost-increasing weaknesses in health care delivery. In contrast, the CED proposal creates strong incentives for insurance plans to extend bundling to all of an enrollee's conditions, treated by all of the plan's providers, acting as a single ACO covering all conditions 24/7, and with all providers, in effect, recruited to be members of their own IPAB, identifying and remedying all weaknesses they can find in their own practice. Thus, we believe that our vision builds on the best of the ACA. Our vision strengthens and broadens the same market-based incentives used by the ACA to motivate providers to work together to deliver high-quality health care more efficiently. In other words, we believe that our vision follows on—and improves—some of the key devices in the ACA.

...BUT AN UNFETTERED MARKET CANNOT SOLVE ALL HEALTH CARE PROBLEMS–GOVERNMENT MUST PLAY A ROLE

CED's vision puts market incentives to work in addressing health care's problems of excessive cost and insufficient quality. But we believe that the market, alone, cannot solve all of those problems and the way in which market forces are used must be carefully designed. Although we do not choose the path toward a market-driven system that is preferred by many of the prominent advocates of markets in health care, we believe that this group would recognize that we employ the market in a sound and constructive way.

Markets are essential in health care, but their potential is limited in two key respects. First, much of the population cannot afford market-clearing prices for health care, and so, just as there is today, there will need to be a public role in ensuring access to care. The vast majority of Americans believe that everyone should have access to care; it is a true shared American value. Under our vision, however, we believe there truly is no need for an individual mandate. Taking into account our vision's refundable tax credits, which would purchase a comprehensive plan, and the exceptions in the ACA's mandate, there is no doubt that CED's proposal would cover more Americans – and cover them better—than does the ACA.

Second, health care is one of the least-efficient markets in the economy, in our judgment, for unavoidable reasons. One of the most important (in addition to the prevalence of third-party payment) is the extreme inequality of information among participants—and this, too, motivates a public role to moderate market outcomes. Health care is extraordinarily complex. Insurance is extraordinarily complex. Insurance for health care is, quite logically, doubly complex. The complexity of all forms of insurance has led the nation to accept regulation, and there seems little doubt that the nation will continue to accept regulation of health insurance, given the extreme popularity of some of the ACA's provisions—including prohibition of discrimination based on preexisting conditions, prohibition of rescissions of coverage for immaterial errors in applications, and mandatory coverage on family policies of children up to age 26. So this is one more reason why pure market outcomes will be asked to yield to some public influence.

Another often-forgotten role of government regulation in health care is antitrust. Health care services are local; people have geographically limited choices in times of acute need. Compared to other industries, it is easier for health care providers to achieve geographic monopolies (such as through hospital space or specialty practices) and use that market power to charge higher fees.[31] Carefully crafted policy is necessary to prevent acquisition of such market power. Should such market power be accumulated, it can be especially difficult to undo any ill effects without destabilizing the delivery of care. So, once again, there will be a public role in moderating market outcomes.

30 We believe that open-ended market forces would be more effective incentives than the regulatory function of the IPAB, which most likely will set capped rewards (or capped penalties) if a health care provider meets (or fails to meet) a target.

31 See the discussion in Enthoven and Minarik, *Health Care in California and National Health Reform*, p. 20.

Additionally, consumers need decision support in the highly complex world of health insurance, as they do with other insurance and financial services. Especially given health care's own native complexity and role in preserving life, most people need help in understanding what matters. This is particularly true when the nation seeks to harness market forces to drive better outcomes in health care. Many individuals are accustomed to having their health care coverage decisions made for them: An employee might be handed one plan for insurance coverage by an employer. An elderly person might simply take the traditional Medicare option upon turning 65. A low-income person takes what the Medicaid program gives him or her. This may work to an extent for some, but the market receives no signals from such non-choices.

Instead, as health care has evolved—even before the ACA (and certainly after it) —typical consumers are given greater power of choice. It is the necessary path, as people learn that many personal decisions far beyond the traditional purview of health care have enormous consequences for their health. Choosing health care providers and modes of coverage and care are now a part of personal responsibility. But many people will not be comfortable in that new role and will seek support.

There is always a danger that such newly responsible consumers will find themselves on a tilted playing field. They will need apples-to-apples comparative information about plans. Sound information standards will be necessary to prevent a "race to the bottom" in promotion of plans, taking advantage of consumers in the early learning phase and lacking experience in health plan choices.[32] Government, at least in part, will likely need to perform that function of disseminating or setting standards for information. Some would argue that such decision support under the ACA needs improvement.

We recognize that there is a proper role for government in providing health care coverage. Still, there is a crying need for competitive forces to drive innovation and cost savings in health care, and we have concerns about how that is best accomplished. In particular, many advocates of a free market for health care coverage support consumer directed health plans (CDHPs), which have high deductibles,[33] perhaps with funds in a health savings account (HSA) to help cover those deductible expenses. Advocates of CDHPs believe that they encourage cost-consciousness because consumers who are covered by CDHPs must spend their own money (including the balances in their HSAs, which earn interest tax-free) on health care, subject to the deductible.

CDHPs do engender cost-consciousness and are good choices for some, such as healthy, young single persons who need to save on premiums.[34] However, we are skeptical about the long-term efficacy of CDHPs as the tip of the reform "spear" in controlling health care costs. Where CDHPs have their greatest effect is in deterring "preference-sensitive," comparatively small-dollar expenses that are cumulatively less than the amount of the annual deductible. But this nation does not face a health care cost crisis because of small-dollar expenses; our problem is not that people go *en masse* to the doctor to seek relief from common colds. Rather, most health care dollars are spent on a comparatively small number of people who incur very large bills for multiple chronic conditions or catastrophic acute episodes. Those individuals know, from the outset of their treatments, that they will far exceed any CDHP deductible and have no incentive to limit their health care spending. Advocates of CDHPs say that incentives matter, and they are right; but the bulk of health care spending is undertaken by people who have no incentive to limit that spending, even if they are in CDHPs.[35]

32 An example would be enticing consumers with lower monthly premiums, achieved only through more onerous, but inadequately explained and disclosed, copays and deductibles.

33 Averaging annually between $4,391 and $4,909 for family plans, and $2,205 and $2,265 for single plans. Kaiser Family Foundation and Health Research Education Trust, *2014 Employer Health Benefits Survey*, September 2014 (http://kff.org/health-costs/report/2014-employer-health-benefits-survey/).

34 However, such persons must be fully informed of and prepared for the high-deductible expenses that could become a factor if illness or injury should strike. For this reason, we believe that HSA funding should be built into the CDHP premiums.

35 But this numerical analysis understates the limits on CDHP effectiveness. Individuals with costly conditions generally face severe impairment or even loss of life. Such persons are highly unlikely to practice economizing behavior with no financial incentive, even if they have learned habits of economizing on low-dollar care. Many such situations are urgent, allowing little time for cost-saving market research with respect to alternative providers and treatments. Such conditions also can be highly complex, and most non-physicians would be unlikely to succeed at a crash course in medicine when their lives are on the line and hours may count. For that matter, many individuals with highly complex conditions may not even be physically capable of making such decisions, much less undertaking specialized research.

For this reason, we are skeptical about the long-term benefit of CDHPs as a primary policy instrument to control health care costs. We believe that CDHPs will help many people to save comparatively modest amounts on care and, perhaps more important, will encourage those people to begin to make their own health care decisions. But we believe that we have a better way to provide incentives for efficient care and cost control over the long term and in all aspects of care delivery.

We believe that market forces are essential and that our approach of a refundable tax credit to finance the low-cost comprehensive plan in the consumer's geographic region, with consumer responsibility for the incremental cost of a more expensive plan, would provide even greater and more effective market forces for innovation, higher quality, and cost control. Under our approach, consumers would have market incentives as they made the key, significant choices among health care plans and providers in a considered way during an insurance open season, rather than under stress and in haste when a serious illness or injury has occurred. Non-physician consumers still could work with their doctors to choose specialists and make the best choices of treatments, but they would not have total responsibility over such decisions they are not equipped to bear. And our formulation focuses the consumer to choose based on the quality and cost-efficiency, which are the key variables in long-term health care cost control.

Therefore, we believe that our vision truly does harness market incentives to drive improvement in health care. At the same time, we believe that our approach also aligns those market forces in the most reasonable way with the values, principles, and selected tools of the ACA, including specifically the bundling, ACOs, and the IPAB that are seen by many as the essential cost-reducing elements of the new law. Our approach increases health care coverage more than does the ACA. So we see our proposal as drawing on the best of both the market and the government perspectives, striking a reasonable—indeed, we believe, superior—balance between them, rather than repudiating either one.

Reforming Medicare: The Role of Medicare Advantage

Beyond reforming the health care system for the working-age population and their dependents, we must raise our sights to the major public health care programs.

Cost pressures in Medicare are a problem in their own right and cause further systemic problems. A number of policy analysts of differing political stripes have suggested a "premium support" model—under which beneficiaries receive a cash payment that they can use to purchase the insurance plan of their choice—to curb Medicare cost growth. Careful implementation of Medicare premium support is needed to achieve both political acceptance and policy success.[36] In future research, CED will investigate a particular stepping stone (or stumbling block, if mishandled) to the success of the premium support model: the Medicare Advantage program.

Most budget analysts agree that Medicare cost growth is the primary past and projected cost driver in the federal budget. Because the public debt will explode under current projections, this makes Medicare cost control a high priority. The current Medicare model has not proven amenable to cost control. Current law includes mandatory physician reimbursement cuts if cost growth exceeds set thresholds, but the policymaking system has proven incapable of allowing those reimbursement cuts to occur. In recent years, there has been some relief from Medicare cost growth. However, no one can explain why cost growth has slowed; some of this relief is likely because of the recent deep economic recession, which eventually will dissipate. Even with the recent cost slowdown, Medicare eventually will overflow the banks of the budget—the question is when, not if.

The problem of cost growth threatens both the quality of and access to the program. If the impending 21 percent cuts in physician reimbursements[37] were to take place, there is little doubt that some physicians would choose to cease serving Medicare beneficiaries, while those remaining would attempt to shift costs from Medicare to the private sector. Many beneficiaries could lose access altogether, while a growing sense (and reality) of Medicare as a "second-tier" health care system would emerge for others.

Current law also creates the Independent Payment Advisory Board (IPAB) to identify and mandate cost-saving measures, but we are skeptical. We believe that market forces could induce a number of competing insurance plans to identify potential cost savings better than a single independent and remote board. Market forces could be unleashed if individual Medicare beneficiaries could choose on the basis of quality and price among private plans and the traditional Medicare system, competing on a level playing field. This "premium support" model may emerge as a frequently chosen alternative to the current single-payer Medicare system. It has been advocated by, among others, the Bipartisan Policy Center's Debt Reduction (the "Domenici-Rivlin") Task Force.

There already is an element of competition in the Medicare program, through "Medicare Advantage" (MA). Under MA, beneficiaries can elect to receive their benefits from private plans rather than traditional Medicare. Almost all Medicare-eligible persons can choose from at least two MA plans in addition to traditional Medicare, and most have even more options; on average, beneficiaries have about 18 options. The total number of plans nationwide is 1,945.[38] Medicare Advantage now is chosen by

36 Some have criticized premium support on the ground that the cash payment will not be sufficient to purchase adequate coverage, but that problem goes away if the cash payment simply is made adequate.

37 Congressional Budget Office, *The Budget and Economic Outlook: 2015 to 2025*, January 2015 (www.cbo.gov/sites/default/files/cbofiles/attachments/49892-Outlook2015.pdf).

38 Kaiser Family Foundation, "Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes," December 2014 (http://files.kff.org/attachment/data-spotlight-medicare-advantage-2015-data-spotlight-overview-of-plan-changes).

approximately 30 percent of Medicare beneficiaries, and that proportion is rising—despite reimbursement cuts included in the ACA that many believed would drive beneficiaries away from the program.

Medicare Advantage should be a cornerstone of the premium support solution to the problem of Medicare cost growth. What is wrong today is that MA plans are paid on a formula that is based on traditional Medicare's fee-for-service costs. The current MA program structure encourages plans that are more efficient not to reduce prices, but to offer "supplemental benefits" – "bells and whistles," if you will—to increase enrollment. At the very best, MA is a much-attenuated, if not entirely lost, opportunity to use the workings of the marketplace to improve both quality and efficiency in the program that threatens to destabilize our nation's entire budget.

Changing the rules of MA could provide a real head start to any attempt to improve Medicare through premium support. In terms of the political environment, which many believe is toxic, it could build on a program that many elderly already know, use, and trust. Street-level implementation could leap ahead through the use of programs that already exist.

Although MA exists and operates today, Medicare has fallen short of meaningful cost control. To kick-start a true alternative, we need to find a way to cut MA loose from fee-for-service costs—a way in which MA programs can compete on price and give the beneficiaries who choose them a way to keep the financial savings. It would be destabilizing simply to cut MA payments below the current cost of fee-for-service Medicare, and the day-to-day care of the elderly rides on the implementation.

Transition to a fundamentally reformed Medicare program will not be simple, and it must be gradual. Current Medicare beneficiaries, especially those who are older, already have medical conditions and relationships with physicians who treat them. Packing up and moving to a new health care plan is not an attractive—or even feasible—option for those people.

Beyond the issue of continuity of care is the matter of finance. If Medicare is not to overwhelm the federal budget—which, by current trends, it will do, even with the recent cost-growth slowdown—the federal government must spend less (simply put). Some consider Medicare spending to be a zero-sum game—to them, if the federal government spends less, beneficiaries must spend more. To the elderly living on social security plus small, eroding retirement nest eggs, who have no realistic options for supplementing their incomes, this prospect is terrifying. Some with political agendas exploit these preconceptions and fears and make a serious national conversation about solidifying Medicare's finances almost impossible.

The path forward must respect the financial vulnerability of the current elderly and their need for continuity of care. This means that budgetary savings from Medicare reform necessarily will flow slowly (which also means that progress on reform is urgent). The population most likely to choose newly restructured or newly created Medicare Advantage plans is not the older current beneficiaries, but the younger ones, especially new enrollees over time. Some argue that, to maintain the stability of care for the current elderly population, who already have medical conditions and programs of care with physicians they know and trust, Medicare must remain unchanged in perpetuity. That is a formula for fiscal disaster and it misjudges reality. It misses the fundamental point: the vast majority of *new* Medicare beneficiaries *must* change their health care arrangements upon enrollment. An intelligent reform program would take advantage of that reality and see to it that new enrollees (and any older beneficiaries who can consider changing plans) have an array of more cost-efficient, higher-quality plans from which to choose. And if the MA market becomes attractive to enrollees, it will likewise become attractive to insurers and integrated plans, which may offer new 65-year-olds the option of continuing with the same kinds of plans that they chose while in their working years. Thus, for many, reform of the Medicare system may offer *more* stability and continuity, not less. But as Medicare Advantage expands, the federal government must use risk adjustment and other tools to ensure that care of the current elderly through traditional Medicare remains stable as well.

CED will investigate policy options to provide a step-by-step transition from the current MA system to full premium support, so that the many existing MA plans can continue to operate but shift to different rules that will give the incentive and opportunity to reduce costs while fulfilling responsibility to beneficiaries. Our work will explain this process in terms that will both inform the public and give elected policymakers the background they need to move

beyond the logjam in today's unsustainable system. This is perhaps the most important—and most difficult—task in setting the federal budget right, while also protecting the health of the nation's vulnerable elderly population.

A further issue is the joint federal–state Medicaid program. Medicaid serves both the low-income population broadly and the indigent disabled (including many institutionalized elderly).

We believe that the improved efficiency that our reform program will achieve in the care of the working-age population is the most productive step that could be taken to control the cost of caring for the non-disabled Medicaid population. States should be able to enroll Medicaid beneficiaries in the same efficient systems that we contemplate for all working-age Americans and their dependents. Care for the indigent disabled is a topic beyond the scope of this project. However, we recognize the importance of this issue—for both patient quality of life and the ability of governments to meet the cost of care and fulfill other priority obligations. We look forward to research that will provide guidance on the best ways to achieve quality, affordable care for the disabled.

Conclusion and Prospects: A Plea to Surmount Partisanship in the Nation's Interest

Despite every effort and every recent scrap of good news, health care continues to be an economic weight on both the public and private sector.

The Affordable Care Act (ACA) was crafted to be a net zero for the federal budget. It contains cost-saving provisions, but it spends those savings on expanded coverage. Some of its savings provisions are highly ambitious, especially in the long run.

Taking account of all savings claimed by the ACA and all of the recent good news regarding slower-than-anticipated growth in health care costs, the Congressional Budget Office (CBO) projects in their baseline that, by 2089, the federal deficit will increase by 9.9 percent of GDP. In these projections, spending on Medicare increases by 6.3 percent of GDP and interest on the public debt increases by 8.7 percent of GDP.[39] Taken together, all other components of the budget on net *reduce* the deficit; therefore, the entire increase in interest on the debt can fairly be attributed to the increase in Medicare spending. Thus, despite any and all recent good news, health care is the root cause of our future federal budgetary problems. At the same time, growing Medicaid costs are a major burden on state government budgets and, in the private sector, health care costs are a large and growing weight on both business and household budgets. The health care burden for businesses inhibits investment and therefore stunts future growth of both total output and wages. In fact, there is substantial evidence that the slow growth of cash wages over the last several decades has been largely or totally caused by the impingement of growing employer payments for health insurance on cash compensation for employees.[40] There is little or no reason to assume that cost pressure on the private sector will be relieved by the ACA or any other visible development.

Thus, as tired as official Washington is of the health care issue, there is little time to waste before our elected policymakers take it up again.

The temporary release of the pressure of health care cost growth on the budget provides an unfortunate excuse for inaction. It is easy to avoid the difficult task of reform and merely hope that the problem goes away. But, in this unfortunate reality, our few years of budgetary peace are the perfect time to address the issue. Now, policy can be made in comparative quiet and stability. Eventually, otherwise, decisions will need to be made in crisis.

The approach that we recommend is bipartisan and non-ideological. It has elements that would appeal to both political parties. We see it as a reasonable compromise, if the representatives we elected would choose to put the nation's interest—indeed, its needs—first.

We hope that these ideas will trigger a principled debate on one of the most urgent issues facing our nation and that its debate will begin soon, before the eventual, inevitable crisis.

39 Congressional Budget Office, *The 2014 Long-Term Budget Outlook*, July 25, 2014 (www.cbo.gov/publication/45308). The figures quoted in the text ignore Medicare offsetting receipts, which would not affect the conclusion.

40 Mark J. Warshawsky, "Can the Rapid Growth in the Cost of Employer-Provided Health Benefits Explain the Observed Increase in Income Inequality?" September 22, 2001 (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1932381).

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