Committee for Economic Development

Adjusting the Prescription

Committee for Economic Development Recommendations for Health Care Reform

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

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).

March 2015

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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.

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.

See the full report for more insights, including:

Recommendations on how to improve innovation and competition through a wider variety of plans and more ways to purchase plans;

Suggestions for increasing the transparency of pricing, the success rates of medical procedures, and risk adjusted premiums;

Reforms for state regulatory and tort systems;

Insights into inefficiencies of current fee-for-service arrangements, bundling, the Independent Payment Advisory Board, and Accountable Care Organizations;

Examples of successful existing systems that are similar to CED's recommendations; and

Ideas on how to restructure Medicare (to be specified in detail in future CED research).

The full report can be downloaded at: http://ced.org/reports

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COMMITTEE FOR ECONOMIC DEVELOPMENT OF THE CONFERENCE BOARD | www.ced.org | +1 202 296 5860
THE CONFERENCE BOARD | www.conferenceboard.org
AMERICAS | +1 212 759 0900 | customer.service@conferenceboard.org
ASIA | +65 6325 3121 | service.ap@conferenceboard.org
EUROPE, MIDDLE EAST, AFRICA | +32 2 675 54 05 | brussels@conferenceboard.org
THE CONFERENCE BOARD OF CANADA | www.conferenceboard.ca | +1 613 526 3280

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