HEALTH CARE FOR US ALL: GETTING MORE FOR OUR INVESTMENT

Health Care for Us All challenges the common belief that health care problems in the United States are difficult and possibly insoluble. Americans want to get more for their health care spending, including insurance coverage for everyone that is patient-centered, portable, and permanent. In addition to these two goals, they want a system that respects incentives for high-quality care, exhibits a responsible approach to the budget, and is sustainable. *Health Care for Us All* adopts these five objectives and applies an efficiency filter to identify the virtually unique framework that meets all objectives. Impediments to achieving Americans' goals can be summarized under the rubrics of too little insurance, too little income, and too little properly functioning market. The efficient remedy for each is the subject of the book. Related philosophical as well as economic issues, such as why there should be government involvement in health care, are analyzed.

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Health Care for Us All

Getting More for Our Investment

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For Shelly, Chris, Kimberly, Tom, Lindsay, Josh, and Daniel,
and Luke, Lisa, and Jesse

Help, or at least, do no harm.

Hippocrates (460–377 B.C.)

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Preface

We wrote this book for two reasons. The first is that well-meaning but uninformed proposals to reform the health care system can harm people – *really hurt* those who trust the government experts and politicians to do their public job of selecting health care policy that prevents predictably harmful consequences as conscientiously and as well as they, not in government, do their private ones. People have died because their diseases became untreatable while they waited to be seen by their government health care plan. Others face financial ruin because they encountered medical catastrophes without adequate insurance. People deserve better. Openness, respect, and deference to the individual and the household must be evident in the social institutions and structures involving health care. Professed good intentions are not enough: health care arrangements must be uniformly compassionate, consistently effective, persistently efficient, and financially sound. Creating a system that tends naturally and organically in that direction does not happen by accident. It must be inculcated with sound principles and nurtured by their thoughtful application, coupled with the avoidance of bad principles, before so large and vital a sector as health care can be further affected by political action.

The second reason is that – contrary to widespread belief – it is eminently possible to implement a health care framework for the United States that meets the fivefold requirements of universal access, patient-centered personally responsive portable coverage, respect for incentives for high-quality care, fail-safe cost containment by government of its injections into the health care sector, and sustainability – and to do so efficiently. For the most part, the answers to Americans' health care concerns have been available for a long time. We have tried to be adept in illustrating for the first time the appropriate design of the entire system using components that minds smarter than ours have made available. At the same time, the endeavor is not entirely a simple project of assembling pre-made parts; we also

address features that have not received widespread attention, yet are the key to success.

If the answers to America's health care issues are already known in principle, why have they not been acted upon? We think the answer is that the health care debate has been dominated by two groups that are unable to hear each other. Group A consists of academics, health care experts, and economists who have provided suggestion after suggestion in article after article, in testimony after testimony, of what should be done. Some of the finest minds in the nation and world, including Mark Pauly, Peter Zweifel, Alan Enthoven, Patricia Danzon, Regina Herzlinger, John Goodman, Jonathan Gruber, and David Cutler, have clearly illustrated how health care and health care insurance should operate.

Group B consists of individuals who lack the background and tools to make knowledgeable decisions about health care alternatives. Emperor Diocletian is remembered for noticing that wherever the Roman legions marched, the prices of food rose. He determined to put a stop to exploitation of the army, declaring by edict that prices should not rise and there was to be cheapness. He thought that he had taken a necessary and laudable action. How much about supply and demand did he really know?

Many proponents of health care reform from legal disciplines, from medicine, from various nooks and crannies of government, and from the not-for-profit sector have admirable intentions, but they do not understand what they are being told. Like Diocletian, they wish to decree that there be plenty. They do not see why the goodness of their intentions cannot cut through the hazards and obstacles that impede the poor from receiving the health care desired for them. Not truly comprehending the fatal defects in their plans, they ascribe the opposition to their proposals to meanness and selfishness of the opposing political party, the "rich," or various other scapegoats. The resulting public discussions of health care are often characterized by political posturing and so are unproductive – void of learning and the necessary discourse required to move to workable solutions. In this environment, even those who understand the issues are unable to achieve consensus to make forward progress.

A third group, Group C, consists of laypersons in all walks of life who, rightly, want their elected officials to do what they are elected to do: consult the experts, think through the issues, and select the wisest course of action. Our goal is to produce a book that draws the three groups together by explaining in as compelling a way as we can why Group A says what it says, addresses Group B's difficulty in understanding what it hears, and explains

what efficiency says about the way health care and health care insurance should be reformed.

How do we propose to move the groups together and fix health care, without creating new problems in the attempt to solve the old? The answer is found in *identifying the precise goals*, *applying principles that most effectively lead to those goals*, and *being aware of policy triage*.

It is not necessary to re-invent the wheel when very good wheels addressing the purpose already exist. Engineers have known for years that innovations in one field or application get used over and over as the solution to problems in other fields and applications. The repetition of problems and solutions, repeated patterns of technical evolution, and the re-use of existing innovations caused them to think about "how to solve the problem of how to solve problems." *TIPS* is the acronym for "Theory of Inventive Problem Solving."[1] According to the TIPS process, once the essential elements of a problem are identified and isolated, available solutions should be accessed and applied to the solution in the new context. We follow the TIPS principle in this book by applying standard economic solutions – what we call "off-the-shelf" parts – to the objectives laid out in Chapter 2, "Goals," and fill in the gaps with our own chinking and mortar. This protects us from misguided and often overly complicated policy solutions that derive from incremental adjustments to the very structures that do not work now.

Policy triage is another important consideration. On the battlefield, initial medical care is made more effective by giving priority to lifesaving measures. A similar understanding applies to health care policy. In health care there are problems that result from various false structures now in place. Health care policy should not be directed to these problems because they will disappear when the underlying structures causing them are replaced. A second group consists of problems in health care that, while unfortunate, may be intrinsic and not susceptible to policy. Health care policy should not be directed to them either. The problems to which health care policy can and must give priority relate only to features that determine system-wide incentives and behavior. The health care sector (we hesitate to say "market" for reasons discussed in Chapter 10, "Preserving Prices") needs rationalization (in this book we use the term to refer to removal of unreasonable and counterproductive features) and correction to allow it to function as a market. These issues are the battlefield wounded to whom medical attention is

[1] Developed in the former USSR beginning in 1946 and now being practiced throughout the world (Mann, 2002), *TRIZ* is the acronym for the same phrase in Russian, where the concept originated. http://www.trizjournal.com/whatistriz_org.htm [accessed 9 January 2007].

devoted. One implication of policy triage is that the reader will not see in this book countless institutionalized details regarding the current (failed) health care market (non-market is a better description). Much of American health care is the result of years of misguided government intervention and tax policy.[2] Fixing the system does not consist of making adjustments to failed structures, but of replacing them with sound ones.

Recall the man who came upon his friend one night diligently searching underneath a street lamp and asked, "What are you looking for?" "My wallet," the friend replied. "Where did you lose it?" he asked. "Over there," the friend said. "Then why are you looking for it here when you lost it over there?" the man asked. "Because I can see better here."

The story is amusing because we know how easy it is to fall into the comfortable trap of pursuing an easy-to-see, though fruitless, remedy when common sense says something else is needed. Health care is like that. Consider 1885 and the desire to improve transportation. The internal combustion engine was already invented, long known to experts, but not widely understood at large. The "experts" would not be serving the needs of progress in transportation if they had devoted themselves to describing the details of leather harnesses and whips, and changes to buggy and horse-drawn wagons that might make marginal improvements. Devising ways to deal with three ruts in dirt roads caused by horse-drawn conveyances may have sounded helpful but, in fact, would represent time poorly spent. No matter how voluminous their treatises or how knowledgeable these experts might be, their knowledge was about to become irrelevant when the way of life that horse and carriage represented was replaced with a more effective mode of transport. In this book we want to reference the fundamentals to see what they imply: the goal is to discover the best way to meet a given list of objectives that we all agree on and, in so doing, to get the most from our investment.

Conclusion

It was tempting to produce a longer treatise filled with theoretical innovations and novel insights. Ignoring whether we would have been capable of the needed profundity, our time and the reader's can be better spent because the main task for the United States is ensuring that everyone has access to needed health care through health care insurance. It turns out that this requires little profundity and is easily accomplished by moving to the

[2] Goodman (2007) traces a number of ways that government policy perversely encourages people to make socially undesirable decisions with respect to health care.

fore a few economic principles that accomplish the objective efficiently and lead to a virtually unique framework. *Health Care for Us All* is not intended to be a lengthy review of institutional details, but the description of a sustainable, cost-effective response to the health care dilemma of the uninsured. We have provided only material that we considered necessary to that objective.

In the 1930s Baylor University Hospital instituted a program for Dallas area schoolteachers that provided specific inpatient services for a set monthly premium. The idea was conceptually sound, grew with time, and became the basis of Blue Cross insurance. Today we need a "New Baylor Plan" that has the potential for the success and longevity of the first. We name the plan described in this book the "Targeted Intervention Plan" but speak only for ourselves and implicate no others in the book's content.

The Executive Summary and Chapter 12, "Summary," detail the elements of the Targeted Intervention Plan in short, direct fashion for those who wish to see the end from the beginning. The rest of the book justifies how we got there.

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Executive Summary of the Targeted Intervention Plan

Universal health care implies that everyone have health insurance and enough income to buy it. The intervention and incentive symmetry principles determine the efficient way to extend coverage. Patient-centered care and respect for the patient require that the patient be the center of the financial arrangements for health care. Health care is a private good, except for relatively limited public health aspects (e.g., epidemics and spread of disease). Standard welfare economics applied to economies with private and public goods[1] suggests that healthy markets are the efficient mechanism for distributing private goods. Health care markets and health insurance markets have correctible problems that are part of the fix. Next, incentive compatibility for efficient income transfers so all can afford insurance suggests the need to distinguish between the capable and incapable needy. A modification of the Earned Income Tax Credit has desirable features for income transfers. With individuals all having enough income to buy health insurance, and being efficiently incentivized to do so, there remains only the issue of government budget management and framework sustainability. These are delivered by a provider revenue tax and the fact that consumers buy their insurance on an actuarially fair basis and buy their health care at competitive prices. These arrangements are indefinitely sustainable and treat all individuals fairly and alike. For most consumers, who surveys show are happy with their insurance and health care arrangements, nothing changes. The framework merely intervenes at the minimal number of points to accomplish all of its selected objectives efficiently.

[1] We use the terms "private good" and "public good" in their technical sense. A "private good" provides benefits only to the one consuming. Consumption of a private good by one individual prevents it from being consumed by another. "Public goods" provide benefits to everyone, because public goods can be simultaneously consumed by many. National defense is a public good because the service of "safety" provided to one can be consumed by many at the same time.

1. Every American voluntarily buys adequate, basic health insurance.
2. Everyone can afford insurance and everyone receives an economic benefit for its purchase.
3. Government defines the basic policy. Risk groups are defined by age, sex, and geographic location.
4. Participants can change health plans at any time.
5. Health insurance policies:
    (a) Are priced on the basis of actuarial fairness and competition.
    (b) Cover insurance events plus the risk of reclassification into a higher risk status.
    (c) Guarantee renewability at the same price for all in one's risk group.
6. Government budget outlays are predictable and sustainable and contain no unlimited entitlements or uncontrolled net expenditures.
7. Pro-competitive policies reform the health care and health insurance markets, including the following:
    (a) Incentives for high-quality care are present.
    (b) Health care providers post prices.
    (c) Prices for identical service must be offered by a health care provider on the identical terms it offers to all buyers.
    (d) Insurers have freedom to underwrite and compete in insurance markets.
    (e) Insurance users are protected from unfair practices.
8. Those with satisfactory insurance through place of employment or self-purchase may continue current arrangements. Medicare, Medicaid, and State Children's Health Insurance Programs may be replaced by the program if desired.

The Targeted Intervention Plan takes an efficiency perspective. Efficiency means selecting methods to accomplish a given objective at least cost, or, equivalently, with the highest possible citizen well-being. An efficient outcome is one for which it is impossible to improve one individual's well-being without harming another's. Efficiency rules out certain ways of doing things and accepts others.

I. Universal Coverage. Individuals who buy health insurance meeting the minimum standard are rewarded in the form of lower prices for their non-health-insurance purchases.

- The price advantage conferred by health insurance is an efficient inducement to buy insurance. This means that other means to the same objective have higher social costs (or, at best, the same costs).
- Using the incentive symmetry principle (see Section 3.2, Principle 2: Incentive Symmetry), there are different ways that an efficient incentive to buy insurance can be implemented. We find attractive the one that requires no program budget outlays to support the price differential and impacts *only* those who do not buy insurance. See discussion of the *Subsidy Version* in Section 8.1, The Plan. Because no one needs to pay any tax related to the program, the price differential can be made as high as needed. When it accomplishes its objective, it is a self-erasing intervention that collects no revenue and necessitates no budget outlays.
- It is wastefully inefficient to subsidize everyone's health insurance purchases – creating tax deadweight loss and distortions – just to affect a few who do not now buy coverage.[2] Were everyone's insurance purchase to be subsidized as in a refundable tax credit (contrary to the proposal here), it would no longer be possible in future periods to distinguish those who would buy insurance without government help from others. In the Targeted Intervention Plan, the incentivized noncompliers self-identify.
- If efficiently inducing the uninsured to buy health insurance is dropped as an objective, then the price-differential-incentive intervention described here can also be dropped.

II. Income Support. To address equity issues, everyone will have enough income to buy health insurance, made available in a separate, efficient, and incentive-compatible way.

- Many of the perceived "problems" of health care are not health care problems, but problems of too little income that can be better addressed through dedicated income programs. Separate problems require separate solutions.
- Income of the capable needy is augmented by an amount that, combined with their other income, is sufficient for them to buy health insurance. A modification of the Earned Income Tax Credit is consistent with proper work incentives.

[2] There must be special reasons for government to take money not needed for government functions and give it to others. Government charity creates false incentives (see Section 5.3, Summary on Public Provision of Private Goods and Charity). However, if one posits that everyone must have health insurance, then the most efficient means to enable people to have enough income to do so must be used.

- The incapable needy are not susceptible to work incentives and so may be provided direct income aid.

III. Market Rationalization. Key changes to the way health care is bought and sold and to the way health insurance is bought and sold are critical. It is not possible to expand health insurance coverage beneficially if the insurance market and health care sectors are not also adequately reformed. Imposing expensive, unaffordable insurance through a badly designed plan and unreformed market can be worse than no plan at all (see Appendix B, "Badly Done Insurance Programs Can be Worse Than No Insurance").

Enhanced competition means that insurance will be patient centered and personal. Other proposed changes make it portable and permanent (see Section 8.1, The Plan).

- The Basic Health Insurance Policy
  - **Freedom to Underwrite.** A national framework for health insurance cannot depend for its success on insurance companies acting against their own interests. Entry and exit are critical to market contestability and competition. Underwriting freedom allows competition to improve service, deal effectively with moral hazard, and lower administrative overhead costs.
  - **The Base Policy.** The base insurance policy coverages must be allowed to vary by age and sex to keep prices low and fair. The base policy is sold by an insurance company to all members of the same risk class (age, sex, location) at the same price, eliminating adverse selection issues for base insurance.
  - **Gurauranteed Renewability.** Guaranteed renewability at standard rates is enforced for all health insurance policies. A national re-insurance mechanism (see the discussion of guaranteed renewability in Section 7.2, Time and the Uninsurable, and Section 8.1, The Plan) allows individuals to change providers consistently with guaranteed renewability.
  - **Homogeneous Risk Pooling, Actuarially Fairly Based Premiums.** Homogeneous risk pooling and actuarially fairly based premiums are good insurance tenets. Competition keeps prices to the lowest feasible.
  - **No Utilization Gatekeeping.** No gatekeeping is a freedom-of-choice provision. If insured individuals wish to purchase a covered service and are willing to pay the required co-pay or co-insurance rate, then they may decide to do so. This rationalization will cause

the base insurance policies to be devised with moral hazard kept foremost in mind.

- **Source Tax Neutrality.** Tax neutrality implies that individual purchase of health insurance is kept on a tax basis comparable to insurance offered through place of employment.
- **Affordability Safeguards.** The base health insurance product is kept affordable several ways. The mandated base coverage (insurance meeting the minimum standard introduced in Section I, Universal Coverage, of this summary) incorporates only features that are premium-reducing (such as selected preventive care) and needed. Pre-paid (routine) care is excluded from the base policy (unless such care is premium-reducing). Unwanted, unneeded, and purely elective benefits are excluded from the base policy. When individuals are appropriately insured in homogeneous risk pools (rated by age and sex), the problems of making insurance more expensive than it is worth to the insured largely disappears. For example, requiring 20-year-olds to pay for colonoscopies and heart bypasses of the elderly could easily make their policies too expensive relative to what they are worth because they are paying for procedures that they rarely use and do not benefit from. However, even if colonoscopies are included in basic plans for all age groups, they will become significant in pricing only for those in the older risk pools. Those in older pools, however, want such coverage because they use it with higher frequency.
- **Insurance Connector.** An "insurance connector" (see Section 9.2 for discussion of the Massachusetts connector) serves an efficiency function by facilitating information flows.
- **Other.** Price transparency, freedom of sourcing by the insured (see Section 8.1, The Plan, Step 4), and insurance portability by the insured (supported by a re-insurance mechanism; see discussion of Section 8.1, Table 8.1) are other safeguards to effective insurance (see Section 7.2, Essential Insurance).

- Health Care

  Efficiency-creating, pro-competitive rationalizations are desirable. We list here only two that taken by themselves would transform health care competition.

  - **Price Transparency.** In a rationalized market, providers have the freedom to set prices however and in whatever manner they choose. However, their prices must be transparent and posted.

- **Most Favored Customer Pricing.** Providers must charge one customer on the same terms that they charge to their most favored customer. The effect of a most favored customer clause in health care will be that concessionary prices negotiated in the market for one buyer will be made available to all buyers on the same terms. Competition and most favored customer pricing will result in prices near marginal cost, as a rational market should have. Because government has ability to impose prices that the marketplace does not, Medicare and Medicaid prices would need to be treated differently.

IV. Sustainability and Government Budget Control

- **Provider Revenue Tax.** A provider revenue tax is essential to access cost-shifting dollars already in the health care system and re-direct them to a more efficient means of covering the "top-off costs" (see Chapter 1, Introduction, and Glossary and Definitions) of universal coverage.
- **Budget Control.** Government support enters the health care and health insurance sectors through income transfers, A. If B is *removed* from the health care sector and is a program choice, then government net expenditure, $(A-B)$, is a program choice. Since B subtracts from the sectoral revenue stream, it must be implemented as a revenue tax on health care providers and insurers.
- **Sustainability.** When government provides income support in an amount that covers top-off costs, it fully pays for the additional health care usage of the newly covered population. With everyone paying actuarially fair prices for health insurance and the health care sector receiving revenues sufficient to cover its costs of health care provision, the program does not depend for its success on agents acting against their own interests. Moreover, by separating efficient inducement to buy health insurance from income support, the program sits on its own base (see Section 3.3, Principle 3, Every Pot Sits on Its Own Base), does not governmentalize (see Section 3.5, Principle 5, No Governmentalizing), and is not a Ponzi scheme (see Section 3.6, Principle 6, No Ponzi Schemes). Such a program is indefinitely sustainable (see Section 2.5, Goal 5, Sustainability).