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ECONOMIC PERSPECTIVES

The American Health Care System: Principles for Successful Reform

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An ideal health care system will provide better health to more people at lower cost on a continuous basis. This should be the ultimate goal of health care reform. Yet decades of legislative attempts have failed to achieve this aim. Why?

First, proposed and enacted reforms have tended to focus on the provision of services rather than on the outcomes of those services.

Second, reforms have tended to reinforce the weaknesses of the current system. Existing laws, regulations, institutions, and politics obstruct and discourage cost-cutting innovation. They unnecessarily constrain the supply of care, the means to improve it, and the capacity to lower costs. These problems predate the Affordable Care Act (ACA), but the ACA compounds them. Unfortunately, proponents of market-based solutions have mostly offered piecemeal fixes that have failed to convince broader constituencies.

Third, Washington has aimed far too low. We should not seek to “bend the cost curve,” but rather to break it to bits. Enabling more people to receive better care at lower cost on a continuous basis requires replicating the plunging costs and soaring quality in computing, transportation, agriculture, manufacturing, distribution, and communication. In the mid-1990s, simple cell phones were toys of the rich; 15 years later, smartphones dotted the world’s poorest villages. When American health care boasts the cost-cutting innovation we associate with a Steve Jobs or Henry Ford, we’ll be on the right track.

PRINCIPLES OF SUCCESSFUL HEALTH CARE REFORM

Achieving a successful health care system rests on the following principles:

Cost-cutting innovation is achievable. In recent times, health care technology’s miraculous leaps have been accompanied by dramatic cost increases. But this pattern is established by current laws, regulations, and institutions. Nothing intrinsic to health care dooms us to perpetually rising costs or, eventually, to centrally planned rationing.

Consumers (patients) are paramount. The health care system often protects established providers to the detriment of consumers. Federal and state laws should enable competitors to challenge established providers, thus making the interests of consumers paramount.

Providers need autonomy. Physicians, hospitals, and other providers face rigid government controls and red tape. Innovation cannot flourish in a system focused on stabilizing the status and livelihoods of well-established producers. Providers must have sufficient autonomy to focus on consumers’ wishes.

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Innovators need rewards. Current health care laws and regulations discourage or prohibit cost-cutting, quality-improving innovation. Markets must reward innovators who provide services that consumers value, and these innovators must not face arbitrary punishment for taking reasonable risks.

Consumers need choices. Since World War II, laws have arbitrarily separated Americans into rigidly segmented insurance markets—Medicare, Medicaid, CHIP, VA, ERISA, small-group, large-group, individual, high-risk. A unitary market would yield greater competition and more informed consumers.

Markets need prices. In the current system, prices bear little relation to underlying costs or consumers' preferences. So, neither consumers nor providers have adequate information to allocate resources efficiently. Innovation and efficiency require strong, reliable, and transparent price signals.

Finances must be stable and equitable. Medicare currently requires huge intergenerational wealth transfers to stay afloat, yet it still teeters on the edge of insolvency. The ACA will greatly expand these transfers. These laws demand that younger, healthier Americans overpay for insurance so that older, sicker (and often wealthier) Americans can underpay. Programs must be structured to assure long-term viability and must not impoverish the young to pay for the old.

Health insurance does not equal health care. It is important to remember that health insurance does not ensure health care. And health care is only one determinant of health. Ultimately, we must evaluate success on how healthy people are and not on how many procedures we do on them.

PUTTING PRINCIPLES INTO PRACTICE

The health-care system cannot adequately serve consumers and patients without cost-cutting (aka "disruptive") innovation that sends costs plummeting and quality of service rising. Disruptive innovation requires three conditions: 1) innovators must be allowed to innovate; 2) consumers must have choices; and 3) price and quality information must flow freely among consumers and producers.

Enable innovators. Disruptive innovation occurs when new entrants can challenge established producers on a level playing field. The government must not protect insiders from competitors, and all producers must be free to innovate, experiment, and take prudent risks. Reforms that enable innovators will:

- Eliminate state laws protecting established providers against competition. At present, certificate of need requirements block new hospitals from entering the market. Aggressive scope-of-practice limitations bar nurse practitioners, pharmacists, and others from undercutting physicians. State licensing requirements block entry by out-of-state newcomers. Hospital funding schemes protect established institutions from competitors. Benefit and provider mandates force consumers to purchase undesired coverage. State medical education policies can artificially limit the supply of providers.
- Rationalize the tort system so malpractice laws punish those who are guilty of malpractice and don't punish those who are innocent. The vast majority of malpractice incidents never reach trial or settlement. And evidence suggests that only a minority of doctors paying malpractice judgments or settlements are actually guilty of malpractice. The tort system's real damage may be that the threat of malpractice litigation stifles innovative treatments and delivery systems.
- Allow consumers and producers to tap foreign innovations. Domestic insurers should be able to cover visits to overseas facilities. American hospitals should be free to adopt successful management techniques from abroad. Hospitals in places like India, Costa Rica, and Thailand have developed remarkable delivery systems. Places like Singapore and Japan offer innovative insurance models.
- Reduce red tape and excessive restriction of practice patterns. Regulations create artificial economies of scale, making it difficult for physicians and others to operate small practices. Larger practices may be more risk-averse and, hence, less conducive to innovation.

Give consumers choices. For innovation to take root, informed consumers must be able to accept and reject options put forward by the market. Our current, fragmented insurance system deprives consumers of options and makes it difficult for them to vote with their feet. Successful reforms will:

- Move toward a seamless market. The fragmentation of the insurance market makes it impossible for neighbors, friends, and colleagues to share information in ways that enable competitive markets to function. Reduce the number of submarkets and separate government programs, and increase the mobility and portability among different insurance plans.
- Remove the tax-code bias that favors employer-based coverage over individual coverage. This is particularly important in moving to a seamless market. The current bias toward employer-sponsored insurance is a legacy of World War II–era price controls, compounded by taxation practices and labor regulation.
- Begin moving Medicaid enrollees into the private health insurance market. This, too, is a crucial part of establishing a seamless market, and it is also an ethical issue. Medicaid consigns lower-income Americans to substandard care and deprives them of choices. As enrollees' income fluctuates, they can churn back and forth between Medicaid and private insurance—sometimes sending family members into different markets and interrupting care. Block grants are an appealing half-way measure, but ideally, today's Medicaid enrollees ought to have access to the same coverage that wealthier Americans purchase—with financial assistance where needed.
- Allow standard insurance to accommodate people with pre-existing medical conditions. The ACA takes a heavy-handed approach by simply requiring insurers to accept all comers, regardless of their health status—an approach that previously wrecked the insurance systems in several states (notably New York and Kentucky). Better methods are available. High-risk pools are one possibility, but they are arguably a single-payer system for the sick. Alternatives include premium supports (subsidies) for purchasing standard policies and health-status-change insurance.
- Create a legal environment conducive to long-term health-insurance contracts. One can buy a life insurance or long-term care policy that specifies a schedule of premiums to pay over the next, say, 20 years, along with a promised payout schedule. Not so with health insurance. One reason is that what we call health insurance is hybrid health insurance plus a health care prepayment plan. Another reason is that insurers know that government may slap additional benefit mandates on the policies in future years, thus making it impossible to estimate future costs.

Strengthen information flows. Innovation requires informed, empowered consumers. Decisions should be made by patients, their families, and their medical providers. It is less desirable for these decisions to be imposed by, say, state officials, and even less so by distant federal officials in Washington. Contrary to elite opinion, patients and other laypeople are quite adept at making complex health care decisions. Furthermore, patients' medical decisions often depend on subjective and highly personal preferences, not on objective scientific criteria. Successful reforms will:

- Replace Medicare's reimbursement formula so prices reflect both the underlying costs and the preferences of consumers/patients. Medicare's reimbursement formula—based on a set of rigid price controls—severs the connections between prices and underlying costs, thereby misallocating resources. (The misallocation is worsened by the fact that the reimbursement rates for a particular specialty depend not on the interaction of supply and demand, but rather on the specialty's self-evaluation.) Medicare's formula drives prices and insurance contracts outside of Medicare. And poor administrative oversight of Medicare providers leads to staggering levels of waste and fraud. Medicare's pathologies comprise the single greatest challenge to America's fiscal stability and the single greatest obstacle to health care innovation.
- Make health care prices meaningful and transparent. Health care "prices" are largely accounting fictions that bear scant relationship to the underlying supply costs or patient preferences. To change this, the Medicare reimbursement formula must be addressed and, along with it, the largely derivative private insurance

and hospital prices. Only when patients and providers can see and feel the impact of costs—reflected in prices—will we begin moving toward efficient resource allocation.

- Minimize the reliance on centralized experts. The ACA greatly expands the role of self-designated experts to determine which treatments people receive, when they receive them, and at what cost. This drives health care further away from patients' desires and toward the preferences of a distant elite. Centralized allocation requires an excessive faith in data, modeling, the peer-review process, the permanence of scientific findings, the omniscience and impartiality of bureaucrats and politicians, and the power of centralized decision-makers to fine-tune the behavior of more than 300 million Americans. Innovation requires a healthy respect for science and strong doses of skepticism and humility.
- Allow Americans to purchase true health insurance. What currently passes for health insurance is part insurance but mostly a prepayment plan for health care services. This generates vast administrative costs for routine procedures and absolves consumers and providers of any need to consider the relative costs and benefits of treatments. The ACA worsens the problem by discouraging high-deductible plans, health savings accounts, and other elements of consumer choice.

Don't imperil economic opportunity. The current structure and financing of health insurance diminish individuals' life prospects by interfering with their access to employment and with their ability to save and accumulate wealth. Furthermore, the effects of employer-based health insurance on employment and wealth fall inequitably and arbitrarily on different groups.

- Separate health-insurance decisions from employment decisions. For more than 50 years, the tax system's bias toward employer-sponsored insurance and the rules governing those policies have created the phenomenon of "job lock"—employees tethered to employers for fear of losing insurance coverage. The ACA worsens matters by orders of magnitude. It is forcing employers to alter the structures of their businesses, to reduce the number of employees, and to cut employees' hours. As a general principle, the insurance market should not determine one's access to employment.
- Don't finance health insurance via intergenerational wealth transfers. Medicare is an unfunded liability with an on-paper trust fund consisting of congressional IOUs. As baby boomers grow old and sick, their Medicare costs will fall on their children and grandchildren, who will have to fund Medicare through their taxes. We know this scheme is not sustainable; yet the ACA amplifies the problem, as it requires millennials to greatly overpay for insurance beginning in 2014 so older people can greatly underpay for theirs. This arrangement threatens millennials' lifetime income prospects.

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