

Discussant Comments on
Alice Rivlin's
"Transition to Comprehensive Health Care Reform"

David T. Ellwood
Harvard Kennedy School

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President and Hillary Clinton were certain that the nation could cover everyone, increase quality, and reduce the total costs of health care. After all, other industrialized countries were getting far more for far less than we were spending. The problem for the first lady who led the push for health reform and Ira Magaziner, her designated staff director of the effort, was that achieving all three involved transforming the insurance markets, shifting the delivery system, recapturing all the cross-subsidies and direct and indirect payments covering, reducing payments, and making hundreds of other changes large and small. Even then the numbers did not seem to quite add up. As one colleague confided in me, “Ira thinks he’s one computer run away from a miracle.”

Alice Rivlin rightly points to the same three objectives: universal coverage, more cost-effective care, and slowing the growth of health spending. But she doesn’t necessarily call for it all being done at once. I think that is a wise insight. Indeed I believe the only credible way to do health reform is to treat it as a journey, not an event.

When I was getting ready to join the Department of Health and Human Services at the beginning of the Clinton administration, my colleague Joe Newhouse took me aside and presented what I will call the Newhouse dilemma. “Health reform will fail unless you in the administration resolve the following conundrum: 80 percent of people think the health care system is broken, and 80 percent are happy with their own coverage.” The Clinton administration never found a resolution to the Newhouse dilemma. Indeed their proposal seemingly fell right into the trap. Harry and Louise told the nation that this extremely complex plan would screw up their own quite satisfactory plans.

To my eyes, the only state or federal level plan that has seemed to credibly cover nearly everyone without tripping over the Newhouse dilemma is the Massachusetts health plan which mostly keeps the existing employer system, includes an individual mandate that all persons get coverage (if it is “affordable”), and offers some expansion of government benefits and subsidies for those who otherwise cannot afford to buy private coverage. Its most popular feature may be the Connector that greatly simplifies the purchase of insurance for individuals and those in small businesses. It doesn’t “screw things up” for people with existing plans because it does not change things for most people.

Unfortunately it also fails to do anything about two of Alice Rivlin’s three vital goals: improve cost-effectiveness and control costs. So in reading and reflecting on Rivlin’s very wise and thoughtful paper, one is left to wonder: is now the moment when we can design a new radical reform plan that really tackles all three goals? If so, my own choice would be a variation on the Fuchs-Emanuel and Enthoven plans. But my pragmatic and sometimes cynical side, having been honed during battles over health and welfare reform, leaves me skeptical of the big bang in health reform. Very skeptical.

Three Lessons from Welfare Reform

My own area of expertise is more welfare than health. And thus my words as a discussant should be treated with an unusually high level of caution. While I was present at the beginning of the Clinton Administration, and peripherally involved in health

reform, my own time in Washington was mainly spent helping to lead Clinton's efforts on welfare reform. In retrospect, things turned out pretty well in that case. At the time, it did not always feel that way. But things really turned out better than expected.

I took away three lessons that might be important for health reform.

First, complex plans which require that several elements all be present often leave the Congress with the politically easy intact, and the politically difficult missing. Want welfare reform with time limits, but only if there is some sort of subsidized job program for those who reach the limits but can't find jobs (like right now!)? You'd better plan for time limits without the jobs. Want to hold states accountable for placing people into work and reducing caseloads? Expect accountability on caseloads (which is easy) but not job placement (which is hard).

The second lesson is that experimentation can really help shape effective policy. For years, states had the opportunity to get "waivers" from existing federal welfare rules if they conducted a serious and effective evaluation of the program. The results of these studies had a profound effect on the plans that emerged. For example, 5-10 years before welfare reform passed, nearly everyone had believed that education was the most important and powerful first step in getting people into a job and off of welfare. But state experiments consistently showed that placing people in jobs immediately was far more effective in both the short and long run. (Later research found that a combination could be even more effective.) As a result, nearly everyone agreed that a work first strategy made sense in welfare reform.

The third lesson reflects my analysis of why things turned out better than expected: a combination of changed incentives and highly visible, strong institutional signals can change behavior of both recipients and providers far more quickly and effectively than one might ever guess. Welfare reform signaled that welfare recipients should not stay on welfare forever by imposing time limits—this was the element most people focused on. But policy changes also sharply changed the economic rewards to working for low income parents by sharply increasing the Earned Income Tax Credit and expanding Medicaid coverage for working families. And welfare reform also strongly signaled to state and local administrators that the system should no longer be designed chiefly to write checks to needy people, it should focus on moving people into work. On top of all this, the economy was also incredibly strong. And so, long, long before anyone hit a time limit, behavior changed, low education mothers began working outside the home in vastly greater numbers, and both welfare and poverty fell. Nothing like this kind of response was predicted by any of the responsible analysts.

Recognizing that carefully crafted plans are due to be undone, I think the hope that we could create an ideal health reform is fleeting. When one adds the worries about Harry and Louise and the enormous moneyed interests who stand to lose in a plan that radically shifts the insurance and delivery systems and shrinks costs, I think the odds of full-scale reform that meets the three Rivlin criteria and that this group would applaud are miniscule.

So what is the nation to do? Should we could start with a variation on the Massachusetts plan, putting off quality and cost for another day. Or must we could fight hard for our ideals, with the likely expectation that we will be again defeated and hope that we have laid the groundwork for victory still further down the road.

I believe that if we can move toward universal coverage now, even if we have not acted effectively on quality and cost measure, we absolutely must do so. But I would argue that we need not abandon those vital elements. Welfare reform also suggests we can move more quickly toward an ideal system than many people suppose, if one puts in place the proper individual incentives and institutional messages. I would hope we could put in place a variation on the Massachusetts plan, as Obama seems to propose, but look toward a day when the other elements will emerge in force as well. If the current episode is a step in the longer process, then the real questions are these: Where do we want to be in 5-10 years? And what elements are vital seeds to ensure the system moves in the direction we want?

What Do We Want the Health Insurance and Delivery Market to Look Like in 5-10 Years?

Rivlin's paper, the responses, and the work of this project make clear that there is no overall consensus on where we want to be. Still several failures of the current market for health insurance and health care suggest critical elements. I am no health expert, but with trepidation let me note what strikes this outsider as vital.

I am an economist, and economists are trained from birth to like markets. And the markets we like best, the markets we call "perfect," are ones where small is beautiful and comparison shopping is easy. Very large numbers of well informed buyers purchase commodities provided by a multitude of producers, choosing the products based on quality and price. In such cases, great theorists such as Ken Arrow show that such markets are both efficient and socially appealing. No buyer or producer can dominate the market. Consumers select the most value for their money. Producer can profit only by creating positive goods for consumers and reducing their costs.

Almost no markets really work like that, but the markets for health care and health insurance flunk worse than almost any other. The worst feature is the skew of health care costs. The vast majority of health care dollars are spent on a small group of sick people. Private insurers can lower their costs most effectively not by offering a better product, but by finding ways to exclude people who will be expensive. When there is vast money to be made via "selection," the creativity of sellers will be focused there. The only real solution to this is to find some way to pool people in large enough numbers that risks are spread and insurers cannot cherry pick. I suspect employer insurance works and persists in large part because it solves the risk selection problem. Employed people are less likely to be sick. Employers can and usually do insist that everyone in the firm be eligible to buy the insurance. The bigger the employer, the more the risk is spread.

In part because of risk selection strategies, but mostly because it is a lot easier to sell and collect premiums for a policy that covers thousands of workers than one that covers a single individual or family, administrative costs are much lower for people covered in large groups. And individual consumers are in a terrible position to decide what features they really need in health coverage. Plans often seem purposely designed to obscure what is covered. Comparison shopping for an individual is nearly impossible in the market of today. Bigger is clearly better for insurance market buyers.

Micro-production in health care—essentially individual fee-for-service doctors—also seems inefficient and problematic. My impression is that the evidence is mounting that technologically interconnected, integrated multispecialty group practices (MSGPs) really can and often do deliver better care at a lower cost. Health systems can much more readily adjust their practices to changing medical knowledge. And it is far easier to control costs at a larger scale. Independent doctors have no incentives to reduce costs, use more efficient treatment methods, or substitute lower cost professionals. Mechanisms for accountability and comparison are far less effective at smaller scale than larger scale. It is a lot easier to decide whether a large group practice has better health outcomes than an individual doctor. Our current system provides neither the incentives nor the mechanisms to learn what works, to move people efficiently among providers, or to adjust practice based on evidence.

That said, fears remain that HMOs overly restrict access to certain physicians and practices and in so doing, might reduce rather than improve the quality of care. I believe MSGPs really can and often do deliver much better quality, but that ought to be something that the buyers of health coverage can judge. If such systems really deliver better value, the market should be able to work for consumers/buyers if they have the information and the choices are available. That would require information and technology and perhaps options that do not really exist today.

We should want the system to evolve into one where sellers could not readily select for risk and buyers could make reasonable choices among a limited number of dimensions. And it seems equally critical that pressure and capacity be created for consumers to actually choose the highest quality, highest value providers, making credible judgments on quality and price. And the system clearly needs mechanisms of accountability, quality and outcomes measurement, and a capacity to learn what works best.

These comments are neither novel nor particularly insightful, but as we consider what elements might be critical, I tried to keep them in mind.

What Role Should Employers Be Playing?

There are many reasons to be deeply concerned about an employer based health insurance system. The comments of Alain Enthoven detail these far better than I could. I would particularly highlight the fact that when coverage and employment is tied, risks to workers are dramatically heightened. Those who lose their jobs, lose their coverage. They then have no effective way to pay for illness and will be far more likely to be

pushed into bankruptcy. Workers may be unwilling to move from job to job for fear of losing coverage. Employers may not want to hire workers who are at high risk of medical expense for fear of pushing up their own premiums. And employers are not always very effective in selecting the plans that make the most sense for their employees.

I have always been adamant that the employer based system needs to go, but when we are thinking about health reform as a journey, where we want to radically expand coverage and new pressures for quality and cost must come to bear, I suspect we should be slow to walk away from employers.

Large employers and those who are part of the large group insurance market do significantly mitigate the risk selection problems of their members and they sharply reduce administrative costs. Note also that employers can do something that a large scale public system probably never can: they can severely limit choice. In health insurance, where comparisons are so hard, and selection is such a danger, more choice often is counterproductive. Employers should have the time, energy, and incentives to find, support, and promote higher value plans for their workers. They have rather strong incentives to control costs and improve quality. Until a well developed market for smaller buyers has moved far down the line of solving the selection, administrative cost, information and quality dilemmas facing individuals, employer and other large group buyers seem to be a rather vital force.

Economists have long argued for the removal or capping of the tax deduction provided to employers for health insurance. Rivlin echoes these sentiments here. Indeed, she describes Obama's decision to attack McCain for his proposal to reduce or remove the employer tax deduction as one of the President-elect's two greatest mistakes on this issue. In the long run, I tend to agree. But during the long transition period, I have started to rethink that view.

It is hard to dispute that the deduction encourages employers to offer excess health insurance benefits and makes them less sensitive to cost. Removing or capping the deduction would provide vital money to help pay for reform. At the same time, eliminating the deduction will certainly encourage employers to reduce and perhaps eliminate coverage and may heighten "crowd-out" whereby workers are shifted to the government or subsidized coverage. Most plans would levy a fine on employers that fail to cover their workers to help level the playing field. It seems challenging to find the right mix of pay-if-you-don't-play and reduced tax incentives for buying coverage that will make sense. In the near term, one might want to pay particular attention to how changes in tax policy will influence coverage behavior of employers. After an effective system is in place for individuals to evaluate, afford and select insurance, we clearly can use tax policy to discourage employer coverage if we want to do so. In the meantime, we might want to instead adjust it in ways designed to make employers more inclined to be cost and quality sensitive, more inclined to offer choices which include MSGP options, and more rather than less inclined to offer coverage.

What Role for the Individual and Small Group Market?

The current market for individuals and small groups is something of a disaster. Risk selection is rampant, even the wisest consumer cannot credibly compare alternative plans, administrative costs are sizable, and many consumers simply choose not to get coverage at all.

Massachusetts seems to have made real strides in improving the situation. An absolutely central element of the plan is the requirement that all consumers buy health insurance “if it is affordable.” Many of those not now buying coverage are actually young and healthy. Including them in a pool of new buyers lowers the effective cost of coverage. Personally I cannot see how any individual and small group coverage system can ever offer affordable insurance unless there is a mandate. A voluntary system inevitably will attract the sickest first, requiring both high subsidies and discouraging participation from many of the uninsured. In contrast to what Rivlin says, for my money, Obama’s attacks on Hilary Clinton’s individual mandate were probably the biggest health reform mistake of his campaign. I think that the right time, really the essential time to include a mandate is at day one. Without it universal coverage will never be in sight, and I suspect it will be very hard to add by itself at a later date. It works only as part of a larger package of reforms.

Massachusetts’s Connector also seems a major step forward in making the health insurance market work for individuals and small groups. The Connector reviewed and qualified a limited number of health plans in any area, insisted on no more than three levels of coverage options in each plan (bronze, silver, and gold), and created a web site which makes it easy to compare and select a health plan for themselves. Based on the enthusiastic response, users seem to find it very useable and appreciate its simplicity.

Some form of insurance exchange with a readily useable web site and limited, approved choices is another absolutely essential element of any initial reform. With it a more rational market can begin to develop. Without it risk selection and lack of information will prevent the individual and small group market from functioning.

Unfortunately the Massachusetts plan does very little to really control costs, monitor quality, or encourage best practice in medicine. Most critically, new technology, monitoring, and outcome measurement systems need to be created that will allow some system of rating quality and outcomes across plans as quickly as possible. Strong pressures for “exchanges” to include MSGPs when available would also make sense.

Advocates of a voucher system that ultimately eliminates the employer based system and puts control in the hands of individual consumers need to consider what other elements including information, choices, and incentives should be in place immediately to give this type of market a real chance to develop.

What is clear is that within a well structured system with limited choices, such as the Federal Employee Based Health System and certain large employers, consumers are

comfortable and reasonably effective in making choices. An exchange/connector coupled with an individual mandate seems like a place to start.

What Role for Government Administration and Coverage?

Government has shown that it can readily provide traditional fee-for-service coverage for well defined populations with Medicare and Medicaid. Its capacity to control costs in any way other than simply reducing reimbursements (and potentially shifting costs onto private sector buyers) is suspect. Its ability to improve outcomes and quality is even more questionable. In principle, as Rivlin notes, Medicare could serve as a very effective place to experiment with a wide range of quality and cost control strategies. The question for Medicare and for any public system is whether a system can be devised that effectively insulates the system from political pressure. Any innovation that changes behavior, especially those that reduce costs, create winners and losers. The losers have strong incentive to become politically active and undo the change.

In principle an independent, “Health Fed” could commission research on outcomes and effectiveness, help determine the minimum benefit package, conduct and evaluate coverage experiments, even explore Medicare reimbursement strategies. Rivlin expresses some skepticism about such an independent “Health Fed,” asking that it be more accountable and more democratic. I fear the opposite—that the Congress will be unwilling to cede control of important elements of the health system and prevent decisions based chiefly on science and analysis. I doubt Congress will ever cede power the way they have with the Fed. Too often members of Congress who have been unhappy with research results have forbidden further research on the topic. I think independence is nearly essential for serious reform of a system as complex as the health sector.

Some have called for all or some consumers to have an option of buying into Medicare as one of their choices. For some this is part of a not-so-secret plan of moving to a single payer system. Rivlin seems to dismiss single-payer systems almost out of hand. Medicare has done a lot to improve access, but its impacts on cost and quality are problematic. Other nations have been able to cap health care costs with single payer systems, but these nations typically have very different political systems.

A Medicare buy-in option need not push toward a single payer system. It might provide effective and important competition for private plans. Still, I think there are legitimate worries to allow buy-ins up front. First, there is real danger that prices will be set at such a low rate that consumers select Medicare, not because it is a better value, but because it is subsidized more. Thus far Medicare has done little to really provide information on quality or to shape practice in ways that are more effective. In addition, Medicare is so large that it can dictate such low reimbursements that it forces providers to charge higher prices to private plans. Finally, sick individuals may be more inclined to choose the Medicare option and this would give employers and other groups a strong incentive to dump their highest cost cases into the public sector, recreating a selection game.

I think the real question is whether a fair competition can be set up where consumers and even groups can properly compare and potentially choose public insurance over private. Absent a strong Fed-like independent agency, I am skeptical. And trying to tie Medicare buy in to an acceptably independent Health Fed runs the risk of violating my welfare reform lesson—be cautious of critical interdependencies in policies. One might get buy-in without the Fed. Still the logic of making plans compete for real value, including a public alternative should not be dismissed.

What Are the Critical Elements if Health Reform is a Journey Not an Event?

I for one am not certain where the health system should end up. But it is clear we need a far more functional market for health coverage and health services. And we need the system to evolve in ways that generate full coverage, and put genuine pressure on quality and cost, just as Rivlin instructs. From my admittedly limited perspective, I think the following elements are vital.

- Individual Mandate—Without a mandate, one cannot achieve universal coverage, and selection will play far too great a role in driving the evolution of the health insurance market.
- A Vastly More Functional Insurance Market—Some sort of exchange or connector must present consumers with a comprehensible number of readily comparable choices. At a minimum price and benefits must be easy to understand. In time, quality and outcome measures must be included to help consumers make wise choices.
- Work to Include Incentives to Make Employers (and Their Employees) More Cost and Quality Conscious—I think it is a mistake to try to push employers out of this market soon, but altering tax policy and benefit regulation in ways that focus these consumers on better choices, including offering MSGPs seems important. Small employers should have access to the exchange/connectors.
- Create an Effective Mechanism to Insulation From Key Decisions, Scientific Analysis, and Evaluation from Excessive Political Processes—Some form of Health Fed might really help.
- Invest Heavily in Effectiveness Measures, Outcomes Measurement, and Technological Integration—Without such an investment, quality and accountability are impossible.
- Ensure Real Choice and Create Fair Competition Between Plans--Ensure different types of plans are available and must compete (both MSGPs along with fee-for-service). Consider competition between private and public plans as well.
- Consider Structured Experimentation—A great deal was learned in welfare reform from state level waiver experiments.

The last point is the only one not discussed above, precisely because I do not know enough about ERISA and other features of the system to offer a sense of what is feasible. Rivlin dismisses the idea of state level experiments, but here I want to again remind that we learned so much from state level experimentation for welfare reform. We are learning a great deal from state level work now, notably in Massachusetts. I think there is a great

deal to learn about what sorts of insurance, quality, and choice structures really make a difference. It seems essential to find ways to experiment in some form. We simply do not know enough about where we want to be headed.

Rivlin has once again provided all of us with her great wisdom and invaluable insights. Like her I think it's vital to move ahead with the parts of health reform which we can, particularly on coverage. Like her I worry about cost and quality. I agree with most of what she highlights. But I would emphasize that this is a journey. We may not know where or when we might approach the top of the mountain. But as we begin, we ought to be able to put features in place that ensure that we keep moving uphill.