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We Should All Be Czars

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There are some lofty goals for those attempting to reform the health care market. We hear a lot about "bending the curve" of health care spending, increasing efficiency, rewarding quality, ensuring portability and insuring the uninsured. All the while, everyone should expect access to the best health care money can buy. Are these goals achievable or does pursuit of one exclude another? We suggest that all are achievable if we all become health czars.

Czarist allusions have become in vogue in recent years. We have drug, war, and pay czars, and though a health czar has not yet been named, there is a new proposal suggesting that the President empanel an Independent Medicare Advisory Council consisting of five members. This council would be charged with making annual recommendations on changing Medicare payments for covered services. The health czar solution fits well in a top-down planning world.

Just as other top-down planning endeavors, it is doomed to failure. But let's not give up on the czarist solution; rather let's just expand our horizon. Let's have bottom-up individual planning where our Health Care Advisory Council truly represents each and every American because it is composed of all Americans. In this world, all health care consumers are czars. Our panel would daily monitor health care spending, would diligently root out waste, and would definitely increase efficiency. Empowering this council will require a fundamental change in current government policies, but without fundamental change, the stated goals of health care reform won't be achieved.

Consider the largest chunk of the health care market – workers and their dependents covered by employer-based health insurance. Because of its size, this market segment determines our view of what is "normal" health insurance. There is an expectation that all Americans should have the same access to health care enjoyed by workers and their dependents regardless of work status. How this expectation arose is difficult to trace precisely, but much is due to the tax preference associated with health care consumed as part of workers' compensation packages.

The health consumption subsidy has produced a situation in which employer-based insurance has low deductibles and low copays. Generous employer-based health insurance coverage is a consequence of the requirement that firms provide the same insurance options for all employees combined with the incentives of different employee types. High income members of the group who face higher marginal tax rates receive a larger subsidy, while high cost members of the group receive a subsidy from the lower cost members. Both incentives help create a group preference for generous health care insurance plans. Apart from the employer-based groups, high cost individuals would have to pay higher premiums and lower cost individuals would pay lower premiums. Other forms of insurance are risk adjusted. No one decries the fact that teenage boys who drive sports cars have higher auto insurance premiums than do experienced safe drivers. Premiums for term-life insurance contracts rise with the age at which they are initiated and are adjusted for known health risks.

So why don't the low cost workers opt out their employers' health insurance package? The short answer is the tax subsidy is too generous for a low cost employee to forfeit. Further, it is difficult for firms to compensate employees with higher wages conditional on them opting out of the health insurance pool. These risk pools thus help overcome the problems associated with charging high health expenditure individuals higher premiums. It is also argued that without the tax subsidy, not enough health care would be consumed and the distribution across income classes and health types would be deemed socially inappropriate.

But do the benefits of providing the tax subsidy outweigh the costs? The cost of the tax subsidy is generous health

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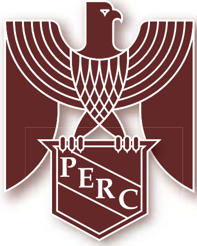

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insurance that results in consumers and providers alike having little concern about the price and the quantity of health care consumed. This distortion leads to higher spending than would exist in its absence and is largely responsible for the decades of rapid spending growth. The tax preference has clearly distorted the allocation of consumption and resources toward health care in the United States.

The health insurance enjoyed by employees has also become the measuring stick for Medicare and Medicaid beneficiaries, and in the current debate, the goal for the uninsured population. Because of these expectations, bending the health care curve must start with reforming employer-based health insurance. Indeed, limits on the tax exclusion have been part of the recent discussion. The first and most fundamental change we suggest would limit the tax exclusion to the price of a guaranteed renewable health insurance plan that has a comparatively high cost sharing. The price of this type of insurance would define the size of the tax exclusion each family receives. Families can purchase more insurance if they would like, but additional insurance purchases would not be tax preferred. This sort of insurance will change expectations about the type of coverage that is extended to Medicare and Medicaid patients and to the uninsured.

Imagine a health care market in which consumers evaluate the price of a service or product before they consume it. Such a market would emerge if consumers face higher cost sharing up to a higher deductible and maximum dollar expenditure. They would seek out the best deal they can find on their pharmaceutical purchases, and they would ask their doctors the implications of having one more test. Unnecessary expenditures would be reduced and efficiency would be improved. There would be no need for a health czar. Consumers would all be czars requiring that the health care they buy is worth the dollars they spend on it. The deductibles and then the copays up to the catastrophic limit would provide effective metering of spending. This discipline on the part of health care demanders will provoke responses on the supply side as well. Together these forces would thus "bend the curve."

Reducing the tax subsidy in this manner raises multiple questions: What will happen if people don't choose to purchase preventative lower cost interventions and screening given that they face more cost sharing? Won't this drive up costs when more serious conditions arise? Will the firm-based groups continue to form or will the market become more individualized? If the latter occurs how will higher risk individuals afford their insurance? These are all important questions, but we must remember that they arise in the context of a market that many have declared broken.

If individuals were responsible for a greater percentage of the up-front cost of the health care they consume, then the first two concerns would not be part of the public debate. However, since group members must currently pay for the consumption of other members and taxpayers must pay for the consumption of Medicare and Medicaid patients, these issues become matters of public policy. With higher cost sharing, individuals will have a greater incentive to make cost effective purchases of preventative measures. Further, the insurance can be designed in such a way that it insures against health status change. The guaranteed renewable aspect of such insurance would address the last two questions as well.

Insurance against health status change has not received the attention it is due in the current debate. This kind of insurance can be part of what we now call "health" insurance and can be thought of as being a combination of payment for current year medical expenses and a long-term contract that guarantees the beneficiary the right to future coverage independent of future health status at agreed upon terms. This ensures the ability to buy health insurance without concern for preexisting conditions.

Though this type of insurance does not currently exist there are examples like term life insurance. It is initially risk rated, but thereafter a constant premium is paid in support of a known payout. However, similar

contracts have not emerged in the health care market because it is highly regulated and subsidized.

How would Medicare and Medicaid be reformed? The previous discussion sets the stage, but similar changes to these programs would be met with considerable political opposition. Elsewhere we have discussed in detail the reforms we have in mind for Medicare. We suggest establishing a partial prepayment mechanism whereby workers make contributions to retirement health care accounts in proportion to their incomes. As a result, future high income retirees would face higher cost sharing through their health care account than would low income retirees, but all would begin to care about the cost of health care. The very low income retirees, currently dually eligible for Medicaid, and Medicaid patients in general, would receive a stipend in their health care account equal their catastrophic limit and would keep the unspent portion of the stipend at the end of the year. With these reforms retirees and Medicaid patients would care about health care costs.

Attempting to insure the uninsured requires an understanding of why individuals are uninsured. The most recent statistics indicates that 57 percent of the uninsured are less than 35 years of age and 21 percent are in households with family income topping $75,000. Thus, many of the uninsured are uninsured by choice because in the current health insurance market they are required to subsidize high cost consumers of health care.

However, if the reforms suggested above are in place for 85 percent of the population, insuring the uninsured becomes much more feasible. Access to affordable health care insurance will definitely be within reach for most of the folks who are counted as uninsured today. With the advent of insurance against bad health outcomes, the cost of insurance would be dramatically reduced and first dollar coverage would not be the default expectation.

Health care consumption will be allocated somehow. The current means of allocation through low cost sharing, tax subsidized private insurance and low cost sharing public insurance programs have produced a situation that almost all agree must be fixed. There are two paths to achieving the stated goals of health care reform. The path that has been making the rounds in Washington will lead to increasing bureaucratic allocation of health care but the other path relies on individuals and markets to identify the best allocation of health care.

We have outlined steps that if taken, would lead to the stated goals of health care reform. The first step is to reduce the tax subsidy given employer provided health insurance. Simply extending the tax subsidy to all individuals regardless of their employment status could reduce the number of uninsured, but would still lead to a distortion in the market since health care costs the consumer less than it costs to produce. Reducing the tax subsidy, such that a family can deduct the cost of guaranteed renewable higher cost sharing insurance for each family member, will bring about the a more efficient allocation of resources. When such a reform is enacted, those with greater health costs would receive a greater tax subsidy. The expectations of those who receive public insurance through Medicaid and Medicare would change and the cost of insurance for the uninsured would be lower in a market reformed along these lines.

The health care debate provides a tremendous opportunity to bring about substantial reform. Americans are concerned about the size of the health care sector and its growth because so much of the spending is either paid directly by government payers or though tax subsidized insurance. Government policies have produced the current politically charged environment and a market that is essentially devoid of incentives on the part of the consumers and providers to consider how much is spent on health care. Reducing the government's role rather than expanding it, by increasing the individual's role will lead to consumers directing where their health care dollars are spent. This is much preferred to the alternative. With every individual a health care czar, all will watch what health care costs since it will be their money on the line.