



**THE NELSON A.
ROCKEFELLER
INSTITUTE
OF GOVERNMENT**

UNIVERSITY AT ALBANY
State University of New York

Richard P. Nathan has a Ph.D. in political economy and government from Harvard University, taught at Princeton, worked as a federal budget official, and as a policy researcher at the Brookings Institution and the Nelson A. Rockefeller Institute of Government. He headed the Institute from 1989 to 2009 and is currently an Institute Senior Fellow.

ROCKEFELLER INSTITUTE BRIEF

WWW.ROCKINST.ORG

MARCH 2013

America's Health Care Cost Crisis and What to Do About It

Richard P. Nathan

Introduction By Thomas L. Gais, Director, The Rockefeller Institute of Government

For the past three years, Dick Nathan, an expert on public management and budgeting, has been digging into how government health programs work and how decisions are made about them. His particular concern is the constant, frenetic, politicized way federal budget issues have been decided lately in a steady-state crisis mode. Over the last thirty years, the federal government has enacted only three budgets.

Nathan brings a political science and management focus to bear. In this paper, he presents his analysis of the five major players in the health care economy. His emphasis is on governance. And his principal concern is the lack of both the time and expert input on health programs and finances in the fast and often furious hard bargaining that goes into budget deal making.

He advocates, and spells out further in this paper, what he believes should be "*invented*" as institutional machinery that will provide knowledge-based, more measured, and contemplative inputs into health care budgeting, which has been so central to current debates about government finances. His proposals for new institutional capacities to adjust health care policies and programs are especially important now as the Affordable Care Act is being put in place and the Congress shows some signs of moving toward a regular budgeting process.

Nathan's recommendations do not take politics out of process. They are modeled on the Simpson-Bowles deficit reduction commission to bring research and expertise to bear on ways of adjusting government policies and program, but always with the ultimate decisions subject to presidential and congressional action.

In this paper Nathan says that whatever you think is going to happen to health care programs and finances (some experts predict increased budget pressure; others are more optimistic that costs will moderate), there should be a central place in government to monitor and adjust health policies.

Nathan presents his own ideas about the kinds of health policy changes he thinks may be necessary, but stresses that there are large unknowns, which is why he believes there is a need for a better way to analyze and track developments in this field and to make frequent policy adjustments. The positions and proposals in this paper are his own ideas and do not represent the views of the Rockefeller Institute, which is grateful for having him continue in service as a senior fellow.

When I stepped down as director of the Rockefeller Institute of Government in 2009, I decided to pick a new subject to learn about and write about. I picked health insurance and the costs of health care, which for me is a familiar subject but not one I had studied in depth. The choice was fortuitous. The subject is fascinating. I formed a view of current conditions and what I think needs to be done that surprised me and wrote several policy papers for the Institute.

This paper does three things. It presents a summary assessment of the seriousness of the long-term fiscal challenge presented by rising health care costs. It discusses my substantive conclusions about the kinds of policy changes that should be considered.

But most important of all, the paper proposes the invention of an institutional mechanism to monitor and react to changing conditions in a way that recognizes this basic fact: As the Affordable Care Act is implemented, there are bound to be big and important unknowns about how it will play out. It is not possible from a standing start today to know how large and serious the resulting challenges will be for American health care and the nation's public finances. There should be in place a way in government — gradually, iteratively, and seriously — to assess changing health care conditions and needs and propose to the president and the Congress what are determined to be necessary legislative changes.

There are two possible scenarios. One is that health care costs are moderating and that the Affordable Care Act will work to enable the country to limit the growth of health care spending. The other is that health care costs will continue to grow and that the Affordable Care Act will add, rather than control, costs. I believe the second scenario is the right one and that modest reform will not be enough. America has a health care cost crisis that will take at least one more round of health reform to fix it.

Underlying this conclusion is a central economic fact: The U.S. economy is not experiencing strong, steady growth. The combination of global economic changes and the revolution in information technology do not portend the kind of economic buoyancy that has been America's trademark. Projected growth is not promising; job creation has been tepid. Most of the jobs created since 2008 have been low-wage and often part-time, jobs. The challenge this poses for government spending and particularly the need to control health care finances is not just a fiscal challenge. It is a

Whatever the reader thinks of my policy ideas (and there are plenty of alternatives to choose from), this should be President Obama's trip to China. It is not what we expect him to do, but it is what he should do, formulate, recommend, and strongly back a way to make sure the country controls the growth of health care costs as part of long-term fiscal grand bargaining.

governance challenge. It requires changes in governmental institutions to assess and respond to hard issues like this that cannot be resolved by politics as usual. We cannot sit back and hope economic forces now in play eventually will produce a steady state condition in which everyone who needs medical care receives all the care they need under existing policies and programs.

In the American political system, the politics of health care are such that a new institutional mechanism empowered to monitor and propose adjustments to government health care policies and programs should have two key features. It should be insulated from day-to-day politics and it should have leverage by being explicitly and intrinsically linked to long-term budget targets for controlling the growth of health care costs, either in nominal terms or in relation to the gross domestic product.

Whatever the reader thinks of my policy ideas (and there are plenty of alternatives to choose from), this should be President Obama's trip to China. It is not what we expect him to do, but it is what he should do, formulate, recommend, and strongly back a way to make sure the country controls the growth of health care costs as part of long-term fiscal grand bargaining.

In his 2013 State of the Union, the president said, "Yes, the biggest driver of our long-term debt is the rising cost of health care for an aging population." He emphasized Medicare as central to this fiscal challenge, "And those of us who care deeply about programs like Medicare must embrace the need for modest reform — otherwise, our retirement programs will crowd out the investments we need for our children, and jeopardize the promise of a secure retirement for future generations."

It is a chastening reality of American government that responding to major challenges like this requires the build-up of a crisis mentality. This is not a desirable, tidy, or necessarily agreeable way to do business. Still, I think it is likely to be the case that health care costs pressures will be action-forcing.

The Fiscal Imperative

Nate Silver in his data-blog series in *The New York Times* reported "Health Care Drives Increase in Government Spending." Silver based his analysis on entitlement spending in the four decades since 1972.¹ If entitlement spending, said Silver, had grown at the same rate as the gross domestic product, it would have risen in this period from \$500 billion to \$1.4 trillion. Instead, entitlement spending today (as of 2011) is \$2.9 billion. This is lightly larger than the overall increase in government spending relative to gross domestic product in this period. It results from "the fact that all spending on all other categories has been essentially flat relative to G.D.P." I believe this situation is only going to get worse.

Governments at all levels pay for half of all health spending; employers, individuals, and charitable contributions account for the rest. On the broadest basis (including both private and public

Economist Kenneth Arrow showed fifty years ago that what he called the “uncertainty” of medical care makes it incompatible with the classical economic model for the allocation of goods.

health care spending) the rate of increase in health spending slowed down in 2009 and 2010. Still, the Centers for Medicare & Medicaid Services (CMS), which provides the official data, reported an annual increase of 3.9 percent each year, which was over twice the rate of growth of the economy in the period. Moreover, CMS projects the rate will speed up in 2013 to an annual rate of 5.5 percent.

Currently, the health care industry accounts for 17.9 percent of America's gross domestic product. This ratio is forecast to continue to rise and exceed 20 percent by 2018. Compared to other countries, this is a very high ratio. On the basis of the data provided by the Organization of Economic Cooperation and Development (OECD), the European average share of national health spending in relation to GDP was 7.9 percent, compared to 12.9 percent for the United States (using the OECD definition for making these comparisons). This situation exists despite the fact that European countries have universal, or near universal, health care coverage, while in the United States private insurance and government programs leave one-sixth of the population uninsured and many others underinsured.

The Kaiser Family Foundation reported in September that the average annual family premium for employer-sponsored health coverage reached this big number — **\$15,745**,² a number that is likely to keep growing. My opinion, writing early in 2013, is that we don't need to panic right away about looming federal deficits, but that over the long run the United States has to do something about the possibility of further high and rising health care costs.

Theoretical Problems

This dilemma for government health programs is a function of the nature of medical care. There is a widespread view politically that health care is a right, that it should be provided to everyone. Unfortunately, the decision on whether to do this is not susceptible to a yes or no answer. The devil is in the details. What is meant by health care? Should it cover a full and wide range of needs — cosmetic surgery, acupuncture, eye and dental care, nursing care, home care, all medications and devices — cradle to grave, fully and for everyone? And should it be free regardless of one's economic circumstances?

Economist Kenneth Arrow showed fifty years ago that what he called the “uncertainty” of medical care makes it incompatible with the classical economic model for the allocation of goods.³ Most people who use medical care do not consume the same kind of care on a frequent basis. Recommended treatments tend to be unfamiliar. Moreover, it often isn't clear what is needed. You can't return an operation if it doesn't work.⁴

Economist William Baumol added a related attribute of the special character of medical care. A story about the debate on the failed Clinton health reform plan helps to make his point. In the course of the Clinton administration's work in 1993 on its health

In the long run, history would appear to be on Moynihan's side. There is reason to be skeptical about government efforts to promote efficiency in health care programs due to the uncertain character of medical services.

reform plan, U.S. Senator Daniel Patrick Moynihan talked about the problem of "Baumol's disease," by which he meant "the inevitable escalation of costs under labor-intensive social programs."⁵ Moynihan was so impressed with Princeton economist William Baumol's research on the difficulty of public agencies to prevent "the spiraling of costs" under government programs that he arranged a luncheon for Baumol and Hillary Clinton to talk about this theory.

Sometimes called the "cost disease," Baumol's theory originated in the mid-1960s in research he conducted with Princeton economist William Bowen showing that the way classical economic theory ties wages to labor productivity doesn't always work. Their original study was on the performing arts. An example given is that the number of musicians needed to play a Beethoven string quartet is the same today as it always been.⁶

Baumol argued that much of the cost involved in providing medical services is attributable to one-on-one interactions between caregivers (physicians, nurses, and support personnel) and patients. Moynihan made this point to Hillary Clinton. She wasn't impressed. However, to placate the senator, an influential member of the Finance Committee and expert on social policy, she arranged a meeting for Baumol with White House aides. They didn't buy Baumol's argument either.

In their book on the abortive Clinton plan, Haynes Johnson and David Broder said of Moynihan: "He wouldn't say so aloud, but he clearly thought the Clinton's naïve in their approach, especially when they claimed that their reforms would produce great savings that would enable coverage to be expanded."⁷

Moynihan told Johnson and Broder that he based his doubt that the Clinton health reform plan could control health care costs on what was happening to the Medicaid program in New York State. His problem was with the politics of health care as well as economics, referring to the roles of interest-groups, politicians, and bureaucrats in government.

Moynihan embellished the point. "Here I have it, sir, handing over charts and statistical analyses. Data. Documents for you. Medicaid doubled in eight years of the Reagan administration, then doubled again in four years of the Bush administration." Johnson and Broder described Moynihan as adopting his professorial role. They said he "arched his eyebrows, peered owlishly over his spectacles" and said: "Assuming geometric progression, sir, what day is the day on which we reach the point when Medicaid doubles in one day?"

In the long run, history would appear to be on Moynihan's side. There is reason to be skeptical about government efforts to promote efficiency in health care programs due to the uncertain character of medical services, their labor intensity, the political activism and heft of health care organized interests, and the intrinsic and growing complexity of the health services. Up-coding of services, ordering more tests (some of them in self-owned facilities),

excess consulting, and overly frequent appointments undergird this skepticism about internal supply-side efforts of governments to constrain health care costs.

Expert Opinion

Ezekiel J. Emanuel, who worked in the White House on President Obama's 2010 national health reform law, said, "If you have heard it once you have heard it a hundred times. 'The United States spends too much on health care.' This is not a partisan point."⁸ Similarly, Peter Orszag who directed both the Congressional Budget Office and later the Office of Management and Budget during the formation of President Obama's health reform plan, said, "It is no exaggeration to say that the United States' standing in the world depends on its success in constraining this health care-cost explosion; unless it does, the country will eventually face a severe fiscal crisis of crippling inability to invest in other areas."⁹

According to the Simpson-Bowles commission on deficit reduction, "Federal health care spending represents our single largest fiscal challenge over the long run."¹⁰

Princeton economist Alan Blinder, formerly vice president of the Federal Reserve and a member of the Council of Economic Advisors, put it this way: "The myth is that America has a generalized problem of runaway spending. No. The truth is that we have a huge problem of exploding health-care costs, part of which shows up in Medicare and Medicaid."¹¹ Taken together, Medicare and Medicaid account for 25 percent of federal spending; they are projected to account for one-third in 2021.

Focusing on Medicare, Jonathan Gruber estimates that in order "to put the program on a solid footing for the foreseeable future would require imposing a 15 percent payroll tax. Every person in America would have to pay 15 percent of their wages to the government, basically doubling the tax burden on American families."¹²

Likewise, the 2011 annual report of the Medicare Trustees was pessimistic about the country's ability to deal with cost pressures. Based on past experience, the Trustees urged readers to recognize the "great uncertainty" associated with achieving scheduled reductions in physician's fees and cost-reducing measures in the 2010 national health reform law, the Patient Protection and Affordable Care Act.¹³

An analysis by Eugene Steuerle of the Urban Institute shows that the share that Medicare taxes and premiums cover "of the care provided to the average recipient ranges from 51 to 58 percent over time." Steuerle says "[for] the rest we borrow from China and elsewhere, and we use up ever-larger shares of income tax revenue, leaving ever-smaller shares for other government functions. Bottom line: without reform, current workers would continue to shunt many of their Medicare costs onto younger generations."¹⁴

As a political scientist, I look at health care in America differently from the way most economists and health experts do.... There are five major players in the health care economy.

An article on Medicaid published in *Health Affairs* focusing on cost estimation was entitled, "Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians Under Health Reform." The authors estimated that the number of additional people enrolling in Medicaid under the Affordable Care Act could range anywhere from 8.5 million to 22.4 million, with estimated costs and physician needs reflecting a similar very large range of uncertainty.¹⁵

Two Approaches for Next-Step Health Reforms

There are two theories for next-step health care reforms to address cost problems. One is the provider-value theory emphasizing government action to integrate services and in other ways increase the productivity, quality, and efficiency of care. It works primarily on the supply side of the economic, that is, to influence how providers behave.

The other theory is the consumer-directed or consumer-choice theory, which works on the demand side. It seeks to leverage the power of consumers in making decisions about what they buy and how and how much they pay. Its emphasis is on giving consumers "skin in the game" — giving them a tangible connection to the cost of their health care by empowering and aiding them to make wise choices in the health care marketplace.

In my opinion, provider-value approaches shouldn't and can't be the main strategy for dealing with the fiscal imperative of rising health care costs. Many leaders in government responsible for health care policies come to their jobs with a concern about and belief in programs they are responsible for. Government by itself does not have the necessary penetration, leverage, commitment, or clout needed to reform the huge health care industry. The provider-value approach, relying on initiatives and experiments by public agencies to reorganize health care, in my view, is the less promising of the two theories of change. In the long run, stimulating and managing competition in health care marketplaces is the better approach for achieving cost control on an equitable basis. I base this conclusion on an examination of the history and political economy of health care in American.

The Political Economy of Health Care

As a political scientist, I look at health care in America differently from the way most economists and health experts do. We have to consider what has happened to political power in the system.

There are five major players in the health care economy — providers of care, consumers, and three types of intermediary organizations. The three types of intermediary organizations are private employers, governments, and insurance companies. In recent years, all five of these players have seen their role and influence change.

Providers of Service

Paul Starr's seminal study of the two-century evolution of American medicine, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*, documented the distinctive characteristic of the political economy of health care. Writing in 1982, Starr foresaw "the growth of corporate medicine"¹⁶ as had Arnold Relman, editor of *The New England Journal of Medicine*, who coined the term "the new medical industrial complex."¹⁷

Today, what stands out for providers is the power of centralized health care systems, both nonprofit and for-profit. This has been accomplished through mergers and acquisitions, the establishment of chains of hospitals, the purchase by hospitals of medical practices (converting physicians and other providers to hospital employees¹⁸) and the establishment of specialized programs and clinics in hospital centers. The resulting race for market share by systems acquiring and promoting breakthrough technologies has resulted in problems of overbuilding and duplication that have raised concerns about proper utilization in many health care markets, especially in large urban regions.

Interest group politics are a big factor in causing and protecting this growth. Data from the Center for Responsive Politics show that, from 1998 to 2012, the U.S. Chamber of Commerce topped the list for lobbyist spending with a cumulative total of \$941 million. However, taken together, five health-related lobbying organizations (the American Medical Association, the American Hospital Association, Pharmaceutical Research and Manufacturers, AARP, and Blue Cross/Blue Shield) spent more. They were among the top ten spenders, ranking third through sixth and ninth with a combined total larger than the Chamber's — **\$1.172 billion**.¹⁹

Ironically, the application of information technology (IT) appears to have helped hospital systems expand. In a dramatic turn of events, the RAND Corporation recently shifted its position from advocating IT as a technique for enhancing efficiency as it did in 2005 to now concluding that IT facilitates service expansion on the part of providers.²⁰

Hospital growth and consolidation spurted in the later 1990s and there is evidence that a recent similar upturn is occurring currently.²¹ Hospital-center operations reflect the dynamic entrepreneurial character of American capitalism in the varying ways they are organized, what they include, and what they acquire. Salaries for hospital CEOs (both nonprofit and for-profit) are large and competitive. A listing of the salaries of the CEOs of the "top-grossing hospitals" in 2010 showed the nonprofit hospital ranking twentieth in gross receipts with the highest salary for its CEO at \$9.72 million. Seventeen of the hospitals studied had CEOs salaries exceeding \$1 million, thirteen exceeding \$2 million. The highest grossing hospital (the University of Pittsburgh Medical Center) paid its CEO \$5.97 million.²² This is not an anomaly, for example,

**I focus on the
middleman role of
“intermediary”
organizations.**

when one considers similar markets for top leadership of public and private universities and often also their sports teams.

Economically, the incentives of centralized health care systems to focus on patients, at best, can be described as “blurred.” Many hospitals rely on external funding where the standard applied is whether a particular loan or investment will produce a projected amount of added income. Resulting economic pressures can exacerbate situations in which hospital administrators, already saddled with appreciable sunk costs, see themselves as faced with pressure to make business decisions to control and limit costs, for example, for maintenance, cleaning and supplies, and most importantly for the amount of time spent with patients by hospital-based practitioners and other personnel. All of this, in the view of hospital administrators, occurs in an environment in which they regard many allowable reimbursements received for treatment (often with justification) as insufficient.

This is not intended to impugn motives or judgment of hospital administrators and health care business managers, only to make the point that many health care service providers do not have an incentive to do what as a society we need to do — rein in health care costs that in the U.S. are already the highest in the world. This is so, despite the fact that we have yet to extend care to a large segments of the population, coverage that is scheduled to go into effect soon and will strain the capacity of the nation's health care system.

Three Types of Intermediary Organizations

I focus on the middleman role of “intermediary” organizations. They perform their intermediation role by managing competition on exchanges — the marketplaces for the health care options available to consumers.

The three main types of intermediary organizations are private employers; governments and their agents, i.e., insurance companies; and direct provider networks. In their role managing competition, these intermediaries do have a cost-effectiveness incentive. It operates through the choices they make of provider organizations, in negotiating on services and rates with provider organizations, and in reviewing their utilization of services.

My aim is to give a new meaning to the term “managing competition” for health care. In the past, the term has been associated with the movement in the 1980s to stimulate health maintenance organizations (HMOs, i.e., capitated local provider systems) that have an incentive to integrate services and control costs. Prominent health care systems that play this role are still cited as models, but in the 1980s the movement petered out as a broad-scale solution to rising costs. What I observe is that as hospitals have increased their market dominance, the power balance has shifted strongly in their favor, so much so that managing competition in health care should now be viewed in terms of the need for a countervailing role in the health economy. Add to this the corporate

power of hospital systems and the similar political and lobbying clout of prescription drug companies and medical device manufacturers; it is evident that consumers need friends.

They need institutions that can assist them to make wise choices for their coverage and the services they use. In different ways and with different stakes in the health care economy, private businesses, government agencies, and insurance companies do this by operating exchanges. This is the key point. Such exchanges can — and *should* — help represent the consumers' and the society's interest in achieving greater efficiency in health care market-places.

Health insurance exchanges are not new. It's like the title character in Moliere's play, *The Bourgeois Gentleman*, who was surprised to discover that he was speaking prose. Examples of existing health insurance exchange arrangements include thousands of large and small private employers, Medicare Advantage (Part C), and the Medicare prescription drugs program (Part D). Other examples are the exchange for federal employees and retirees²³ and similar exchanges for the employees and retirees of many state and local governments. For lower-income citizens, Massachusetts has led the way in setting up new health insurance exchange systems (California and Vermont are close behind). Large number of similar state-level exchanges will be coming on-line soon under the Affordable Care Act.

Health insurance exchanges have different forms, approaches, and priorities both among and within the three categories of intermediary organizations, each of which is discussed in sections that follow.

Private Employers²⁴ — It is customary to speak of employer-sponsored insurance (ESI) as a "benefit," although from the workers' perspective it has to be noted that ESI is a form of compensation. How employers provide coverage is in substantial part a function of federal law pertaining to the tax treatment of employer-sponsored insurance. In addition to tax laws, the Affordable Care Act introduces new rules that will materially affect employer-sponsored health insurance.

Several motivations affect employer decisions about health benefits. This is a big subject. Still, it is useful to sketch out some of the types of factors that come into play. Depending on the industry they are in, employers may want their health benefits to be generous and comprehensive in order to attract and retain employees. However, in other settings this may not be a strong motivation. At the same time that health benefits can help employers obtain and retain valued workers, it is also another cost that enters the bottom line. How these calculations are made in deciding on the character and cost of options for employer-sponsored health insurance often depends on the industry a company is engaged in and the type of work its employees perform. If their work is skill intensive and high priced, the employer is likely to want to have attractive health benefits. If on the other hand, the

industry employs a large number of low-skilled workers (restaurants, hotels, discount stores) the incentives are likely to be very different.

Where the latter labor force pattern is pronounced (i.e., the predominance of lower-skilled employees), the Affordable Care Act could affect the health insurance market in a strong way. The law's coverage requirement could lead to a preference on the part of employers to hire more part time (less than thirty-hours per week) workers. It also could lead some employers (particularly those with a labor force with mixed skill levels) to adopt such a high-cost benefit package that most of the company's full-time workers would be eligible for subsidized coverage under the Affordable Care Act.

Whatever their policy (extensive benefits or limited), if health insurance premiums continue to grow rapidly employers will have an increasing incentive to control costs. Rising premiums for health insurance have already pushed many employers to adopt new strategies. In recent years, for example, this cost pressure produced a surge in the adoption of health savings accounts (HSAs), which are required by law to be tied to a catastrophic health insurance policy. Typically, these linked health savings accounts and catastrophic health insurance policies are less expensive than conventional health insurance. They come in various forms that put workers in the position (at least for their initial and routine health care expenses) of using their "saved" funds for health care purposes, hence being exposed to the prices of these services in a way that it is assumed will help to control spending.²⁵

It is difficult to generalize about the types, costs, and effects of private-employer health insurance; it will be even harder to do so as the Affordable Care Act is implemented.²⁶ The law does not require private employers to offer the same benefits as those that are required for newly covered, subsidized low- and middle-income citizens.²⁷ Still, it does require large (more than fifty workers) employers to provide coverage or face a penalty that, while modest in the initial years, increases after that.

The Affordable Care Act could also encourage changed personal behavior, e.g., not to marry or even to get divorced in order to maximize subsidy benefits. Likewise, it could especially affect the behavior of small employers, for example, by causing them to hire fewer workers; rely more on part-time workers; and, under certain conditions, to self-insure in order to evade requirements of the new law.²⁸

Governments — Like private employers, governments (national, state, and local) already play an intermediary role in the sense meant here by operating health insurance exchanges for their workers and retirees. The Federal Employees Health Benefit Plan (FEHBP) supervises the coverage for nine million workers and retirees; state and local governments have similar exchange systems for their workers and retirees.

Moreover, governments will soon have a substantially expanded role in offering choices on health insurance exchanges to low- and middle-income citizens and small businesses under the Affordable Care Act.²⁹ How this occurs will be dependent on what the take up is (both the total number and the types of plans selected), on the policies adopted by different states and the federal government, and on the way these policies are implemented. This is a big unknown that has to be factored into any consideration of next-step health reforms.

In an intriguing (and I think good) way, there is growing interest in the turbulent current processes underway for developing Affordable Care Act health insurance exchanges in what is called “*active purchasing*.”³⁰ The term refers to strategies to assure that the new coverage options offered are understandable, accessible — and affordable. Indeed, active marketing strategies are fundamentally important for health insurance exchanges not just under the new law but across the board for both governments and private employers.

In addition to the operation of health insurance exchanges for the provision of employee health benefits, the federal government is engaged in health insurance intermediation under Medicare in large and major ways, for “Medicare Advantage” plans (Part C³¹) and for Medicare prescription drug benefits (Part D). Both programs offer opportunities for insurers to compete for customers under exchange-type arrangements that operate at the regional level on the basis of ZIP code area designations.

Indeed, under Medicare Advantage there is active (sometimes overactive) competition to gain customers. In the annual Open Season period for selecting Medicare Advantage plans, eligible recipients are barraged with letters, phone calls, and emails advertising competing plans. The decision whether to purchase a particular Medicare Advantage plan is aided by a CMS (Centers for Medicare and Medicaid) five-star rating system for eligible Medicare recipients. Navigators also play a critical role in helping eligible recipients make their decisions, both at the time of their initial eligibility as to whether to select “original” fee-for-service Medicare or a Medicare Advantage plan and for decisions about switching plans already chosen.

There are indications that the arrangements made between the government and insurers on the prices paid by the federal government to subsidize Medicare Advantage plans are too generous. They involve a complex formula system to set the “benchmarked” levels of payments to insurance companies for playing this role. These rates need to be “managed” better (i.e., adjusted). Fairness should entail that profit margins are reasonable — but not out of line. In summary, my view is not that Medicare Advantage is operated the way it should be, but rather that this approach is important in considering how governments can manage competition as a way to rein in health care costs.

The most critical financial question is whether the subsidies provided are open-ended or closed-ended. Medicare Advantage has a fixed (though changeable) total value, while “original” (or traditional) fee-for-service Medicare and the FEHBP system are open-ended in budgetary terms.

This, of course, is the fundamental question raised by Rep. Paul Ryan in advocating the conversion of all of Medicare to a premium-support system, rather than operating under an open-ended financing arrangement. I favor closing the end for all of Medicare, not because I like the idea, but because I think it is necessary and fair to do so. As a beneficiary of “original” Medicare, one is made aware of how generous this assistance is — indeed, to a fault. The estimate cited above, and in fact often mentioned in political debate, is that Medicare taxes and premiums cover only half its costs.³²

An important specific about the way health insurance works needs to be emphasized here. Most policies (and the Affordable Care Act require this) have out-of-pocket limits. The law also prohibits limitations on lifetime benefits. In my opinion, the way health insurance works should go further. These two policy provisions should replace “Medigap” health insurance, which covers first-dollar costs in a way that camouflages the costs of care. Doing this (eliminating Medigap, often called “supplemental” insurance policies) would shift health insurance protection away from its current overemphasis on first-dollar protection and towards more emphasis for more people on catastrophic coverage — that is, relieving the costs hopefully on an income-tested basis for people when they face major and large medical needs.

One needs to be careful about generalizing in discussing the role of government as an intermediary in the health care economy. Its role cuts two ways. On the one hand, governments have a “bottom-line” concern (their spending) and thus an incentive to hold down costs and assure that prices are favorable to them. On the other hand, governments (and this often involves different people inside government) have a historic and important role in providing health care. This can cut the other way in economic terms, by providing as an upside cost pressure

Insurers — Few people love their health insurance companies, but the fact of the matter is that their middleman role in health care marketplaces has been fundamentally changed. The Affordable Care Act struck a new bargain between health insurers and governments. In exchange for getting millions of new customers, the law restructures their role in many ways. For example, health insurers can no longer refuse applicants on the basis of previous conditions, limit total policy coverage, spend more than 20 percent on administration, and refuse to cover dependents under age twenty-six. To a considerable extent, insurers now are regulated by the federal government, whereas in the past state laws and policies have been dominant.

Institutional inventiveness is required. Although it would not be easy to accomplish, gradual, iterative multistep governance reform embodied in law could perform this role over time and be linked to deficit-reduction bargaining processes.

As in the two previous examples, the intermediation role of health insurers is likely to be affected by the Affordable Care Act. They will get more business, and at the same time they will be subject to more pressure to compete with other companies to get this business. The resulting effects on competition could have important cost-restraining effects. The extent to which, and the way in which, this occurs will depend on government policies and implementation of the Affordable Care Act. The key point, as stressed throughout this paper for all five players in the health care economy, is that there are big unknowns about both the operations and economic effects of existing program and the effects of the implementation of the Affordable Care Act.

The Consequences for Consumers

To cut to the quick, I believe next-step health reforms should focus on the role of intermediaries in managing competition on exchanges in order to provide countervailing power for consumers to the growing power of providers. There are three reasons why this intermediation-exchange role is so important. One is that exchanges are the instrument for selecting, bundling, and presenting the options available to different groups of consumers. The second and related reason is to assist consumers in making choices among what are often complicated coverage options made under personally stressful conditions.

But the biggest reason why intermediators are necessary is *economic* — to perform the middleman/countervailing/balancing role as the bargaining agents with providers on behalf of consumers.

So, What Should be Done?

Institutional inventiveness is required. Although it would not be easy to accomplish, gradual, iterative multistep governance reform embodied in law could perform this role over time and be linked to deficit-reduction bargaining processes.

As a first step, such a law could establish an entity like the Simpson-Bowles National Commission on Fiscal Responsibility and Reform. Its charge should be to recommend principles, goals, and an implementation system for next-step health reforms. Similar to Simpson-Bowles, such a commission could have ten members — four appointed by the president (including the chair and co-chairs) and three each appointed by the leaders of the House and Senate. Members should not be government officials or representatives of organizations or stakeholder groups. No more than two of the president's appointees should be of the same political party.

Taking into account the reactions to the initial plan and the need for a long-term time frame for deficit reduction, the authorizing law should provide for and lead to further action to produce legislative proposals that would be considered on an expedited basis whereby the president and the Congress need

either to approve them or send them back to the commission to be revised.

Such a law should be explicitly and intrinsically linked to the budget process. This should be done by setting a goal or goals for constraining the growth of national and/or government health care spending over the decade following enactment — for example, cumulatively according to a specific target of savings, such as \$800 billion over ten years, or targets linked to a ratio of health spending to gross domestic product (GDP).

The commission should be required to report annually to the Congress. Beginning with its report on the second anniversary of the law establishing the commission, it could, for example, be directed each year to present a **“fiscal and policy analysis report”** in terms of whether national or government health expenditures are on a prescribed path to achieve the budget goals set in the law for constraining the growth of spending and, if not, to recommend legislative actions to achieve a specified goal (or goals).

The Centers for Medicare & Medicare Services produces annual and long-term data and projections on national health expenditures. The new commission could use these data as the base for its **“fiscal and policy analysis reports”** and the presentation of policy action or alternative policy actions for maintaining national and/or government health expenditures within a specified band of growth — again, by way of illustration, perhaps equivalent to the previous year's growth in GDP or, as in the Simpson-Bowles, Ryan-Wyden, and Domenici-Rivlin proposals, GDP plus one percent.

The devil is in the details. There are multiple “policy handles” the commission could consider — that is, the moveable parts of government health programs and medical services that could be candidates for policy change. Possibilities include the components of health insurance policies (premiums, deductibles, copays, out-of-pocket limits); income levels and lifetime earnings characteristics; health habits and prevention practices; and differentiated reimbursement levels for services provided at workplaces, neighborhood miniclinics, or emergency centers as opposed to hospital emergency rooms or physicians' offices.

In the Affordable Care Act, there is provision for an as-yet-unformed Independent Payment Advisory Board (IPAB) to recommend policy changes for Medicare, though **not** linked to budget targets. In addition, IPAB's charge does not include important program areas in which changes also could be considered — the Affordable Care Act, federal tax policy, and Medicaid — all domains with multiple and critical interconnections. In particular, I do not think that changes in Medicaid can or should be made without taking this larger context into account.

Based on the analysis in this paper of the challenge presented for health care spending, I conclude that four objectives should be highlighted: (1) to increase price awareness; (2) to adjust government subsidies so that they are income tested on a calibrated

basis; (3) to emphasize meeting catastrophic health care needs in a way that reduces what is currently an overemphasis on first-dollar coverage; and (4) to close the end on original fee-for-service Medicare.

Taken as a whole, such a strategy would rely more on market mechanisms — shifting less risk to government and more to better-off citizens as a strategy for constraining public costs and enhancing price awareness in health care marketplaces. This is a key principle. The idea of shifting more health care costs from governments to patients on a basis that stresses ability to pay is not shared by everyone. Politically, I see this as a middle way. Down the road I foresee the need for changes that include both modifications of the Affordable Care Act and comport with and reflect the Republican position about closing the end in the federal budget on original fee-for-service Medicare. I hope readers will regard my analysis and the conclusions reached as usefully illustrative of the kinds of ideas that could ultimately be considered to deal with the health care cost challenge.

However, as I said at the outset, what I most care about is not my policy conclusions about changes that should be considered to constrain the growth of health care spending. The recommendation I care about most is that new institutional capacity be established to assess and adjust to what is happening over time to America's health care economy. There are many moveable parts. The intellectual terrain is not susceptible (much as we might like it to be) to solutions that can be determined from our present vantage point. This is essentially a governance challenge. The institutional machinery needed to respond to health care cost pressures should reflect changing fiscal and economic conditions and scientific discoveries that we cannot now predict. Forecasts of the costs of government programs are notoriously uncertain; they are often subject to political and wishful thinking. Both the health of the nation and that of the national economy require the invention of in-depth, nimble, and more contemplative ways to make and, over time, gradually put into effect crucial national economic policy changes.

About The Nelson A. Rockefeller Institute of Government

The Nelson A. Rockefeller Institute of Government, at the University at Albany, is the public policy research arm of the State University of New York. The Institute was established in 1982 to bring the resources of the 64-campus SUNY system to bear on public policy issues. The Institute is active nationally in research and special projects on the role of state governments in American federalism and the management and finances of both state and local governments in major areas of domestic public affairs. Thomas Gais is director of the Institute. Richard P. Nathan, author of this paper, is a senior fellow at the Institute. Michael Cooper, the Institute's director of publications, was responsible for production of this report.

Endnotes

- 1 Nate Silver, "Health Care Drives Increase in Government Spending," *The New York Times*, January 17, 2013. See also Silver's longer blog posting, "What Is Driving Growth in Government Spending?" *The New York Times Politics Blog*, January 16, 2013, <http://fivethirtyeight.blogs.nytimes.com/2013/01/16/what-is-driving-growth-in-government-spending/>.
- 2 Kaiser Family Foundation, News Release, September 11, 2012, based on the report on results of the foundation's 2012 annual survey of employer health benefits, <http://www.kff.org/insurance/ehbs091112nr.cfm>.
- 3 Kenneth J. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *The American Economic Review* LIII, 5 (December 1963): 941-73, <http://www.aeaweb.org/aer/top20/53.5.941-973.pdf>.
- 4 This phrasing is from a provocative book on what is happening to American medicine by Maggie Mahar, *Money-Driven Medicine, The Real Reason Health Care Costs So Much* (New York: HarperCollins, 2006), 3.
- 5 Haynes Johnson and David S. Broder, *The System: The American Way of Politics at the Breaking Point* (New York: Little, Brown and Company, 1996).
- 6 William J. Baumol and William G. Bowen, *Performing Arts: The Economic Dilemma - A study of problems common to theater, opera, music and dance* (New York: Twentieth Century Fund, 1966). In 2012, Baumol updated his views on the cost disease in William J. Baumol with contributions by Monte Malach, Ariel Pablos-Méndez, and Lilian Gomory Wu, *The Cost Disease: Why Computers Get Cheaper and Health Care Doesn't* (New Haven, CT: Yale University Press, 2012).
- 7 As told by Johnson and Broder, *The System: The American Way of Politics at the Breaking Point*, 354-55.
- 8 Ezekiel J. Emanuel, "How Much Does Health Cost?" *The New York Times*, October 30, 2011, <http://query.nytimes.com/gst/fullpage.html?res=9E06E7D9143DF933A05753C1A9679D8B63>.
- 9 Peter R. Orszag, "How Health Care Can Save or Sink America," *Foreign Affairs* 90, 4 (July/August 2011): 42.
- 10 The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth: Report of the National Commission on Fiscal Responsibility and Reform* (Washington, DC: The White House, December 2010), 2, http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.
- 11 Alan S. Blinder, "Four Deficit Myths and a Frightening Fact," *The Wall Street Journal*, January 19, 2012, A19, <http://online.wsj.com/article/SB10001424052970204468004577164820504397092.html>.
- 12 Jonathan Gruber, "Universal Health Insurance Coverage: Progress & Issues" (Syracuse, NY: Center for Policy Research, Maxwell School of Citizenship and Public Affairs), 18, <http://surface.syr.edu/cgi/viewcontent.cgi?article=1001&context=cpr>. As of 2012 the payroll tax rate was 4.2 percent for Social Security and 1.45 percent for Medicare — a total of 6.5 percent.
- 13 Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2011 Annual Report of the Boards of Trustees" (Washington, DC: The Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 13, 2011, quotes are from pp. 2 and 44, http://heartland.org/sites/all/modules/custom/heartland_migration/files/pdfs/30102.pdf.
- 14 Eugene Steuerle, "Are You Paying Your Fair Share for Medicare?" *The Government We Deserve Column*, Urban Institute, January, 6, 2011, <http://www.urban.org/UploadedPDF/901397-are-you-paying.pdf>.
- 15 Benjamin Sommers, Katherine Swartz, and Arnold Epstein, "Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians Under Health Reform," *Health Affairs* 30, 11 (November 2011): 112186-93.
- 16 Paul Starr, *The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry* (New York: Basic Books, 1982). On the last page of his book, Starr wrote prophetically, "The failure to rationalize medical services under public control meant that sooner or later they would be rationalized under private control ... by corporate conglomerates whose interests will be determined by the rate of return on investments. That is the future toward which American medicine seems now to be headed." (p. 449). See also Mahar, *Money-Driven Medicine*, a provocative book that carries Paul Starr's thesis and story two decades further in time.

- 17 Arnold Relman, "The New Medical-Industrial Complex," *The New England Journal of Medicine* 303, 17 (October 23, 1980): 969-70.
- 18 Estimates are that 40 percent of physicians currently are hospital or other institutional employees.
- 19 OpenSecrets.org, Center for Responsive Politics, <http://www.opensecrets.org/>. The money dilemma in American politics has been commented on a lot. My favorite source is Mancur Olson, *The Rise and Decline of Nations: Economic Growth, Stagflation, and Social Rigidities* (New Haven, CT: Yale University Press, 1982). His argument is that as democratic societies age, vested interests (particularly what he called "distributional interests") become increasingly stronger.
- 20 Reed Abelson and Julie Creswell, "In Second Look, Few Savings From Digital Health Records," *The New York Times*, January 11, 2013, <http://www.nytimes.com/2013/01/11/business/electronic-records-systems-have-not-reduced-health-costs-report-says.html>, and Arthur L. Kellerman and Spencer S. Jones, "What It Will Take to Achieve the As-Yet-Unfulfilled Promises of Health Information Technology," *Health Affairs* 32, 1 (January 2013).
- 21 Allison Evans Cuellar and Paul J. Gertler, "Trends in Hospital Consolidation: The Formation of Local Systems," *Health Affairs* 22, 6 (November 2003).
- 22 Bob Herman, "CEO Compensation of the 25 Top-Grossing Non-Profit Hospitals," *Becker's Hospital Review*, September 26, 2012, <http://www.beckershospitalreview.com/compensation-issues/ceo-compensation-of-the-25-top-grossing-non-profit-hospitals.html>.
- 23 The Federal Employees Health Benefits Program (FEHBP).
- 24 The annual survey by the Kaiser Family Foundation and the Health Research Educational Trust provides extensive data on employer health benefits. The 2012 survey issued September 11, 2012 is the 14th in this series.
- 25 For a discussion of how health savings accounts work, see the section, "An Example of Consumer-Choice Reform" in Richard P. Nathan, "How to Rein in Health Care Costs: Empower Consumers," Rockefeller Institute Brief, December 2012, 14-6, http://www.rockinst.org/pdf/health_care/2012-12-Rein_In_Costs.pdf.
- 26 For an excellent discussion of how the ACA could affect business and personal behavior, see David Gamage, "Perverse Incentives Arising from the Tax Provisions of Healthcare Reform: Why Further Reforms are Needed to Prevent Avoidable Costs for Low- and Moderate-Income Workers," *Tax Law Review* 65 (June 4, 2012): 669-721, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2067138. The law, for example, requires employers to cover workers, but not their dependents. There could be cases in which, as noted, this could influence decisions to marry and divorce, and even in some cases for family members not to accept job offers that would mean their dependents are uncovered, compared to their receiving coverage if that worker is either unemployed or part-time employed and both the worker and the family have health coverage.
- 27 It does require them to provide preventive services and disallows lifetime limits.
- 28 Robert Pear, "Employers with Healthy Workers Could Opt Out of Insurance Mandate, Raising Others' Costs," *The New York Times*, February 18, 2013, <http://www.nytimes.com/2013/02/18/us/allure-of-self-insurance-draws-concern-over-costs.html>.
- 29 As of February 15, seventeen states are setting up an exchange, seven are partnering with the federal government to do so, and twenty-six have chosen the default position of having the federal government operate an exchange in their state.
- 30 See Nathan, "How to Rein in Health Care Costs: Empower Consumers" for a discussion of active purchasing on the part of state governments in planning for new ACA health insurance exchanges. The paper includes a table on p. 12 showing the seven states that as of August 2012 had opted for "active purchaser" contracting.
- 31 Medicare Advantage now accounts for 27 percent of all recipients.
- 32 Steuerle, "Are You Paying Your Fair Share for Medicare?" On February 17th this year, NBC on *Meet the Press* showed a chart saying that over their lifetime an average American wage earner pays \$122,000 for Medicare and receives \$287,000 in benefits.