



Committee for Economic Development

Quality, Affordable Health Care for All

Moving Beyond the Employer-Based Health-Insurance System

CED's Diagnosis

The U.S. employer-based health insurance system is failing. The *cost* of insurance is rising faster than wages, or total income in the economy – which is not sustainable. U.S. businesses' insurance costs make them less competitive in world markets and depress cash wages. The *quality* of care is much lower than it should be. Authoritative studies document numerous errors of prescription and treatment that cause unnecessary suffering, illness, injury and cost. Patients get only an estimated 55 percent of necessary and appropriate care. And *access* to care is deteriorating; 47 million Americans lack health insurance, and that number is rising.

The root causes of these problems lie deep within the structure of our health-care system. No one has an *incentive* to seek, or provide, quality, cost-efficient health care; there is no meaningful competition in our employer-based health insurance system.

Insurers usually insist on covering all of a firm's employees – to reduce per-employee overhead costs and to avoid the risk of enrolling only the sickest workers. Most *employees*, therefore, have no choice of health-insurance plan (if they are offered health care at all). But employees, understandably, insist on choosing their doctors. Therefore, to satisfy both insurers and employees, *employers* generally can offer only one plan that provides access to almost every doctor. The only way to reimburse any doctor an employee might choose is on a fee-for-service basis – a system that presents the worst incentives: the more services, the more fees.

Patients want all the services that might deliver any benefit, however small; doctors and hospitals are predisposed to provide those services, at least in part because they are paid for each service they provide. Providers actually make more money when they are slow to diagnose and treat a problem: they are paid for more “services” that way. There is little or no incentive to utilize cost-saving technology such as health information systems and electronic patient records. Indeed, in this “cost-unconscious” environment, there is little incentive to find a less-costly way to solve *any* health problem. On the contrary, costly new discoveries, though often highly beneficial, can be deployed at great expense and considerable risk even before they are fully evaluated.

Because workers change jobs frequently – and often must change insurers and even doctors when they do – insurers and doctors have little incentive to focus on insured patients' long-term health. Thus, persons are treated only when they already are sick, rather than guided to maintain their health. Insurers can make more money by avoiding enrolling sick persons than by finding better ways to treat them.

Thus, in a system with millions of dedicated care-givers – and arguably the best care in the world for people who are seriously ill and have insurance – we also have spiraling costs, growing tens of millions of people with no insurance at all, and even more people with often undiagnosed and untreated chronic conditions (such as obesity) that will lead to serious and costly preventable illnesses (such as diabetes). About 83 percent of total health spending treats people with at least one chronic condition.

CED's Policy Recommendations

The nation needs a new system to replace employer-provided health insurance. All past efforts by employers to reform health benefits have failed to provide affordable, quality health care. The market is flawed, leaving those most in need without coverage and driving costs ever higher. A government-run command-and-control system will not succeed; devolving complex medical decisions from doctors to patients will not lead to more affordable care. Instead, ending this vicious cycle will require a national policy to restructure the health-insurance market (and thus the health-delivery system) so that *all* Americans can afford and obtain quality coverage. *Health care can improve when incentives for employers, employees, and providers all encourage quality, affordable care.*

Individuals, not *employers*, should choose the health care plan that best meets their needs, from a range of options; no one should be forced into a particular type of plan. People also need access to clear information about costs, outcomes, and patient satisfaction. People should be able to keep their coverage when they move from employer to employer – there should be no more “job lock.” And importantly, people should be able to save money – dollar for dollar – if they choose a less-costly plan; their cost-consciousness would cause providers to minimize costs – while maintaining quality.

The nation can establish such a market for quality, affordable health care through two key steps.

In the first step, the federal government should establish independent regional “exchanges” that would provide a single point of entry for each individual to choose among competing private health plans. This system would improve on the current Federal Employees Health Benefits Plan (FEHBP), which covers members of Congress. Every individual would be guaranteed the right to choose one from a range of private insurance plans. Plans could charge no difference in premium for age or preexisting conditions (unlike the current individual insurance market). These exchanges, like the Securities and Exchange Commission for financial markets, would set standards for plans to ensure quality,

comprehensive coverage, and protect consumers through standardized “fine print.” Each exchange would provide side-by-side plan comparisons and would organize an annual open season at which individuals could change plans – introducing competition into the marketplace for health insurance and care. Each exchange would “risk-adjust” premium revenue to insurers – that is, pay more to insurers that cover relatively more people with expensive conditions – which would give insurers a greater incentive to cover, and less incentive to shun, sick people.

The exchanges would be supervised by a “Health Fed,” modeled on the independence and structure of the Federal Reserve. Independence is essential so that the Health Fed can adapt quickly to changes in health care practices and needs without distraction by politics. The Health Fed would build trust in the new exchange system among consumers, providers and insurers. It would set standards for reporting performance information by plans. It would collect data and estimate future costs, potential savings from reforms, and proper risk-adjustment for plans that enroll relatively more (or fewer) sick persons. It also would create an Institute for Medical Outcomes and Technology Assessment to evaluate the comparative costs and benefits of technologies and care practices, and report to health providers and the public. There would be an option of national (not just state) regulation of health insurance plans to facilitate competition and innovation.

In step two, subject to progress by the exchanges and the willingness of the public to provide the financing, every household would receive a fixed-dollar credit sufficient to purchase the low-priced quality health plan offered in its region. Every individual, therefore, would be able to buy quality health insurance at no out-of-pocket cost. Anyone could choose to purchase a more-expensive plan by paying only the additional cost. Under this approach, everyone could keep the kind of health-insurance plan and doctor that they now have and prefer. Such fixed-dollar contributions have been used successfully by employers such as Hewlett Packard, Wells Fargo, the University of California, Stanford University, and the states of Washington, Wisconsin, and California for their employees. The fixed-dollar credit would be financed by eliminating the current exclusion for employer-provided insurance, and by broadly based tax revenues, for example a payroll, value-added or environmental tax. In effect, every individual in the nation would contribute toward the health-insurance program, and every individual would be entitled to insurance – without costly “mandates” or means testing.

With every individual assured access to a quality insurance plan, and able to pocket the full savings from choosing a low-priced plan, insurers and health providers would for the first time have an incentive to offer quality, affordable care that people – not their employers – want. There would be competition in the health-care marketplace, driven by fair rules to reward quality and cost-effectiveness, rather than denying care and selecting risks. Rules-based competition has driven progress in every other industry in our economy and around the world, and competition shows the greatest promise of turning health care from its current path of unsustainable cost growth, mediocre quality, deteriorating health, and declining coverage.

With health plans competing to attract cost-conscious consumers, we can expect our health-care system to change for the better. Health providers would be accountable for quality and cost. To remain affordable while maintaining quality for their customers,

providers would need to adapt to new challenges and opportunities. They would move away from fee-for-service episodic treatment of symptoms to emphasizing primary care, health promotion, disease prevention, early detection and treatment, chronic disease management, and cost-reducing innovation and process improvement – including efficient use of technology, such as electronic medical records, knowledge management, and computerized caregiver support tools; better use of physicians’ time, in part through team practice with non-M.D. professionals; matching resources to the needs of the populations served; and regional concentration of complex care, to achieve expertise and economies of scale. To control costs, providers would need to avoid conflicts of interest, and use the best possible evaluation of the efficacy of treatments and therapies. This agenda is a challenge for existing insurers and providers – but it is a feasible task, and no more than we expect from successful firms in every other sector of the economy.

In our policy statement, CED recommends a transition path toward this restructured system in gradual, incremental steps that would be manageable for our political system and our economy. It would begin with the new exchanges providing access to health insurance for small businesses, which by itself would be a major improvement in the health-care marketplace – where small-business employees today often are on their own seeking coverage for themselves and their families.

Conclusion

We believe that this approach holds the greatest promise of providing the working-age population and their dependents with quality, affordable health-insurance coverage. We hope that this plan will stimulate constructive debate, and increase interest in a non-ideological, market-based system in which both government and the private sector play their most productive roles.

The full statement is available at www.CED.org

