

Chapter Twenty-four

Designing Ideal Health Insurance

The modern era has inherited two models of health insurance: the fee-for-service model and the HMO model. Neither is appropriate to the Information Age.

Both models assume that (1) the amount of sickness is limited and largely outside the control of the insureds, (2) methods of treating illness are limited and well defined, and (3) because of patient ignorance and asymmetry of information, treatment decisions will always be filtered by physicians, based on their own knowledge and experience or clinical practice guidelines.

However, an explosion of technological innovation and the rapid diffusion of knowledge about the potential of medical science to diagnose and treat disease have rendered these assumptions obsolete. In this chapter, we briefly outline the type of insurance we believe would emerge if we rely on markets, rather than regulators, to solve our problems.

WHY TECHNOLOGICAL CHANGE AND THE DIFFUSION OF KNOWLEDGE HAVE MADE TRADITIONAL HEALTH INSURANCE MODELS OBSOLETE

Although the HMO model is often viewed as the more contemporary, it is actually the less compatible with the changes the medical marketplace is undergoing. The traditional HMO model is fundamentally based on patient ignorance. The basic idea is a simple one: make health care free at the point of consumption and control costs by having physicians ration care, eliminating options that are judged “unnecessary” or at least not “cost-effective.”

But this model works only as long as patients are willing to accept their doctor's opinion. And that only works as long as patients are unaware of other (possibly more expensive) options.

As we argued in the Introduction, we could spend our entire gross domestic product on health care in useful ways. In fact, we could probably spend the entire GDP on diagnostic tests alone—without ever treating a real disease. The information reality is that patients are becoming as informed as their doctors—not about how to practice medicine, but about how the practice of medicine can benefit them. Combine the potential of modern medicine to benefit patients with a general awareness of these benefits and zero out-of-pocket payments, and the HMO model is simply courting disaster. The fee-for-service model is only a slight improvement. It tries to control demand by introducing deductibles and copays. But even it offers strong incentives for patients to overconsume health care.

Some believe that managed care can solve these problems. They are wrong. Imagine grocery insurance that allows you to buy all the groceries you need; but as you stroll down the supermarket aisle, you are confronted with a team of bureaucrats, prepared to argue over your every purchase. Would anyone want to buy such a policy? Traditional health insurance isn't designed to work much better.

Accordingly, we propose a new approach. It combines an old concept, casualty insurance, with two relatively new concepts: universal HSAs (to control demand) and a proliferation of focused factories (to control supply).

DESIGNING AN IDEAL HEALTH INSURANCE PLAN

Let's begin by wiping the slate clean. Imagine you could get together with 999 other people and create an insurance plan just for 1,000 people. The 1,000 people are not alike. Some are old; some are young. Some are male; some are female. Some are in good health; some are not. Given these and other differences, how can you design a plan that all would want to join?

In answering this question, forget the normal insurance industry bureaucracy. Forget state and federal regulations. Forget federal tax law. Forget everything else that would pose an artificial impediment to achieving the ideal. You're on your own. You must design a plan that will come closest to meeting your needs and those of your colleagues. What follows is a discussion of some inevitable problems and some proposed solutions. We hope this thought experiment will point to how insurance markets would evolve if left free to do so.¹

Terms of Entry

One of the first decisions you must make is: what premiums should be charged to people when they join the insurance pool? No matter what benefits you decide to include in the plan, you have to collect enough premiums to cover all the costs. So how much should each person pay? We have a suggestion that not only will solve this problem, but also will avoid many others. In fact, failure to follow our suggestion on this issue will virtually guarantee that your group will not agree on anything else. Our suggestion is this: each person should pay a premium equal to the expected health care costs he or she adds to the 1,000-person pool. If individual A will add \$1,000, the right premium for A is \$1,000. If B's expected costs are \$5,000, B should pay \$5,000. If C's expected costs are \$10,000, C should pay \$10,000.

What if the premium is so high for some people that they cannot afford to pay it? Then either they will be left out of the pool or others must make a charitable contribution on their behalf. Since all agreements are voluntary in this imagined scenario, coercion is not an option. Politicians usually try to "solve" the problem by keeping the premium artificially low for people with high health care costs. But if some people are undercharged, others must be overcharged.

People who are overcharged will want less coverage than they otherwise would, and those who are undercharged will want more. If we want people to make economically rational decisions, they must be charged a premium that makes the expected benefit of their additional coverage equal to its expected cost.

Terms of Renewal

At the end of an insurance period of, say, one year, on what terms should people be allowed to renew? Should those whose health has deteriorated be charged more? Should people whose health has improved be charged less?

Insurance can be compared to gambling. Our decision to charge each entrant in the pool a premium equal to his or her expected costs makes the gamble a "fair" bet for all. But changing premiums based on changes in health status would be like changing the rules after throwing the dice. It would defeat the purpose of insurance, which is to transfer risk to others. Therefore, a reasonable rule is to raise or lower everyone's premium at renewal time, based on whether the whole group's costs have been more or less than expected. Those who got sick and generated high medical costs after joining the pool would not be penalized and would get the full value of the insurance.

Such a rule is broadly characteristic of the market for individual insurance. At the time of initial enrollment, people may be charged different premiums,

based on age, sex and perhaps health status. But once in a plan, no one can be expelled from it or charged an extra premium because his or her health deteriorates. Renewal is guaranteed, and if premiums are increased, they must be increased proportionately for everyone.

The small group market now operates quite differently in most states. A firm's premiums are readjusted annually, based not on the experience of the larger group with which the firm's employees have been pooled, but on the firm's employees' own experience over the previous year. In effect, it's as though every firm's employees were kicked out of the pool at the end of the year and allowed to reenter only if they pay new premiums based on the changes in their expected health costs. Subject to regulatory constraints, in the small group market people can buy insurance only one year at a time. If this practice applied to life insurance, everyone's premium would be reassessed annually, and rates for those diagnosed with cancer or AIDS during the previous year would be astronomical. Such a practice would virtually destroy the market for life insurance.² Small wonder that small group health insurance markets are in perpetual crisis.

The features of the individual market described above come closest to emulating what most economists would consider a free market for health insurance, although the market is far from perfect. By contrast, the features of the small group market are almost totally the product of unwise public policies—federal tax law, federal regulations and state regulations. Not surprisingly, this market has generated the most frequent complaints, particularly from small business owners. Unfortunately most states try to deal with the problem by piling on more regulations rather than by confronting its cause.

Third-Party Insurance versus Self-Insurance

The decision about what services to cover is closely related to the decision about how to allocate financial responsibility. For reasons that will become clear, the latter question needs to be addressed first. As noted above, recent changes in federal law allow deposits to HSAs to receive the same tax advantage as employer-paid premiums. Prior to that change, federal tax law encouraged people to give all their health dollars to third-party payers. But under neutral federal tax law, which services would we choose to pay directly and which would we insure for? That is, what medical costs would we want the pool to pay for, and which ones would we want to pay from our own resources?

Any time people transfer their resources to an insurance pool, there are two negative consequences (increased cost, at least for the group as a whole, and decreased autonomy) and one positive (reduced risk). The problem is to as-

sure that the reduction in risk is worth the extra premium we must pay to obtain it. Our imaginary insurance pool faces the same problems as every other insurance scheme. Any time insurance pays a medical bill, the incentives of the patient are distorted. All of us tend to overconsume when someone else is paying the bill, and this tendency, which economists call the problem of “moral hazard,” raises costs. To counteract the tendency, we will want to consider some of the techniques of managed care. But these techniques will restrict our choices, reduce our autonomy and perhaps reduce the quality of the care we get. Even if the quality is not diminished, administering the techniques will be costly.

Thus, no matter how well the plan is designed, for the group as a whole the cost of medical care will be higher than it would be if individuals simply purchased the same care on their own. Presumably, the higher costs are worthwhile if we enjoy enough reduction in risk. But at what point does the price we’re paying for risk reduction become too high? Specifically, when is it worthwhile to transfer risk to a pool and when does it make better sense to self-insure by putting funds into an account we own and control? Three general questions can help us arrive at an answer:

1. Is the medical service to be purchased prompted by a risky event or by an individual preference?
2. Is the price of transferring risk to a third party high or low?
3. Does the failure to obtain a service or the purchase of an inappropriate service potentially create costs for others in the pool?

The first question relates to the terms under which people obtain health care services. People differ in their attitudes toward medical care. They also differ in their levels of aversion to risk. Take diagnostic tests for the detection of cancer. As noted above, the more frequent the tests, the higher the cost. But medical science cannot tell us how frequent such exams should be.³ That is largely a value judgment, and people’s values differ. In general, such exams are not prompted by a risky event; they are influenced by individual preferences.

As a general rule, the more expenditures depend on personal choices rather than external events, the greater will be the problem of moral hazard. This consideration suggests we should encourage individuals to purchase directly most diagnostic tests and most forms of preventive medicine.

The second question reinforces this conclusion. Transferring the risk of cancer treatment to an insurance pool is relatively low-cost. For each dollar of exposure transferred, the extra premium is only a few pennies. On the other hand, transferring diagnostic testing to an insurance pool is relatively high-cost. For

each dollar of exposure transferred, the extra premium is a large part of that dollar. So the payoff for using insurance to cover cancer treatment is high, while the payoff for covering cancer detection is low.

The third question is whether the medical consequences of one's decision will generate costs for other members of the pool. Take immunization for childhood diseases for example. Studies show that these procedures pay for themselves by avoiding future health care costs that are greater than the costs of the vaccinations.⁴ This implies that members of an insurance pool have an economic self-interest in seeing that all children covered by the pool are vaccinated. It may make economic sense for the pool to pay for vaccinations, thereby incurring more cost than self-pay would generate, or to require that members obtain them, thereby reducing autonomy.

Closely related to the problem created by the failure to obtain a desirable service is the problem created by the purchase of the wrong service. Suppose our plan has a \$3,000 deductible and a member is diagnosed with cancer. Under this arrangement, the patient would pay the first \$3,000 of treatment costs and presumably would make his or her own decisions about how to spend the \$3,000. But that \$3,000 of decision making could have a large impact on later treatment costs, and bad decisions early on could generate larger subsequent costs for the group. Such considerations may create a presumption in favor of paying for all treatment costs from the pool in cases where the entire treatment regime promises to be expensive.⁵

Table 24.1 summarizes the case for a division between individual payment for medical services and third-party payment. Third-party payment for every medical service is potentially very wasteful. Such waste can be controlled only by invasive, expensive third-party oversight of individual medical care consumption. Such control necessarily interferes in the doctor-patient relationship. Some people may prefer this sacrifice of autonomy, and that may explain why there has always been a market for the traditional HMO. But many people will prefer self-pay and self-control, especially where no real reduction in financial risk is achieved by transferring control to a third-party payer.

Figure 24.1 shows that even after taking into account each of the general rules in table 24.1, some health services may not neatly fit into unambiguous "self-pay" or "third-party pay" categories. Ideal health plans might have considerable discretion, therefore, and how they exercise it would depend on their members' preferences. What is important is to recognize that in the ideal insurance arrangement, some decisions will be individual while others will be collective.

TABLE 24-1

General Rules*Individual Choice*

1. No risky medical event.
2. Price of third-party insurance is high.
3. Exercise of choice creates no externalities.

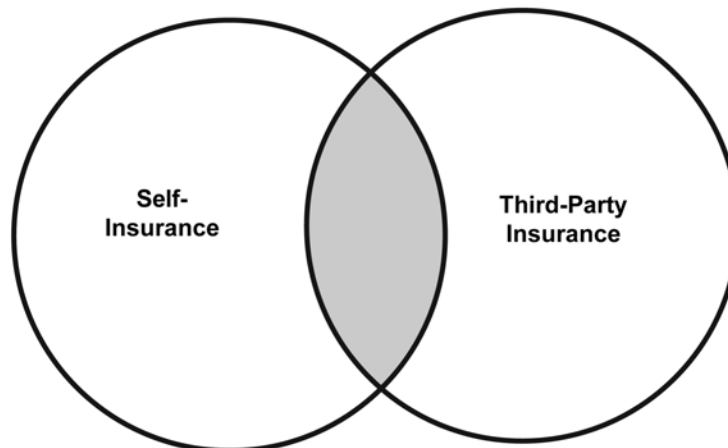
Collective Choice

1. Risky medical event.
2. Price of third-party insurance is low.
3. Exercise of choice creates risks for others.

Financing Mechanism for Self-Insurance: HSAs

A common objection to individual control is that people will not always make wise decisions. But in our imaginary pool, everyone must voluntarily agree to the design of the plan, so we cannot entirely escape individual choice and preference. In addition, even with the most comprehensive coverage, indi-

FIGURE 24-1

Appropriate Division of Financial Responsibility

viduals must make decisions about when to see a doctor and whether to purchase nonprescription drugs. So even if a patient wanted to turn all decisions over to someone else, that would be impossible. A more sophisticated objection is that most medical expenditures tend to be irregular, and are hard for people living from paycheck-to-paycheck to incorporate into a budget.

One answer to this objection is the HSA. As described above, many employers make monthly deposits to accounts from which their employees can pay expenses not covered by the employer's health plan.⁶ Money not spent for medical care must remain in the account until the end of the insurance period, usually one year, after which the employee can withdraw it and use it for other purposes.⁷ HSAs make individual self-insurance workable for families who otherwise might find direct payment too burdensome. But how should such accounts be designed in conjunction with third-party insurance coverage?

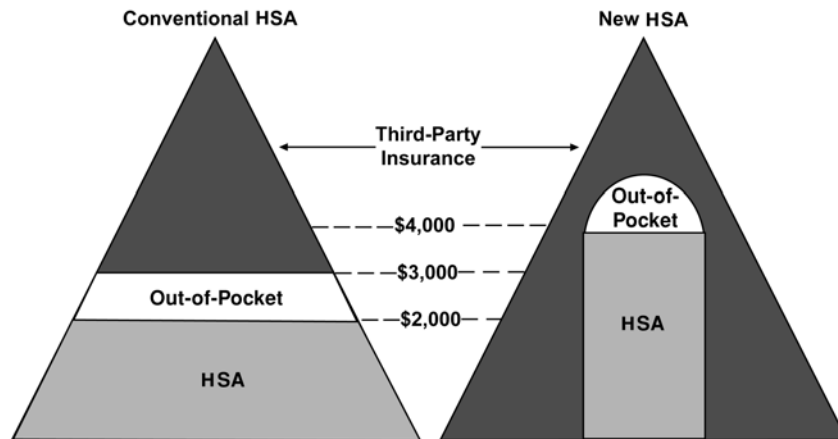
Implications for HSA Design

The left side of figure 24.2 illustrates the most common design of HSAs in employer plans. The plan pays all costs above a deductible of, say, \$3,000. The HSA deposit in this example is \$2,000. Thus, the employee pays the first \$2,000 of medical expenses from the HSA and the next \$1,000 is paid out of pocket. Any remaining costs are paid by the plan.⁸ Note that with freedom comes added responsibility. In current employer plans, individuals are usually free to use their HSA funds to purchase noncovered services. So, an employee might spend all of his or her HSA account on chiropractor services—even if these services are not covered by the plan and the payments do not count toward the deductible. An employee could exhaust the HSA funds on noncovered services and risk having to pay the entire deductible out of pocket.

However, HSAs designed in this way are not necessarily ideal. The above considerations imply that the design pictured on the right side of figure 24.2 is preferable. Under this design, the plan pays the first dollar for some treatments, while leaving the insured free to pay even higher amounts for some services than in the illustration on the left. Indeed, one way to think about the diagram at left is to see it as a special case of the diagram at right—one which would be voluntarily chosen only if all the considerations in table 24.1 were appropriately resolved by an across-the-board deductible.

The diagram on the right has a further advantage: it can fit into existing managed care plans. One problem these plans have in maintaining member satisfaction was summarized by Alain Enthoven in a well-publicized letter to then governor Pete Wilson of California.⁹ Enthoven described a woman who

FIGURE 24-2



was angry at her HMO doctor because he refused her a “medically unnecessary” sonogram. Enthoven surmised that if she’d had to pay fifty dollars out of her own pocket for the service, she would have thanked her doctor for saving her the expense. This and other incidents have convinced Enthoven, who has been wedded for years to the concept of the first-dollar coverage, that patient out-of-pocket pay is essential to make managed care work.

Interestingly, there is one place in the world where the diagram on the right has become a reality—South Africa. Since 1993 virtually all major forms of insurance have been competing on a level playing field (HMOs, PPOs and MSAs) partly due to liberal insurance regulations and partly due to a favorable ruling from the South African equivalent of the IRS. Anyone with an idea on how to design a better health insurance plan has been free to try. And during the decade of the 1990s MSA plans have captured more than half of the market for private health insurance. Under federal law, a tax-free HSA for Americans must have at least a \$1,000 deductible for individuals and \$2,000 for families and applies to all services—drugs, physician care, hospital care, and so forth. South African HSAs are more flexible. The typical plan has the first-dollar insurance coverage for most hospital procedures—on the theory that within hospitals patients have little opportunity to exercise choices. On the other hand, a high deductible (about \$1,200) applies to “discretionary expenses,” including most services delivered in doctors’ offices.¹⁰

South Africa’s more flexible approach also allows more sensible drug coverage. While the high deductible applies to most drugs for ordinary patients, a

typical plan pays from the first dollar for drugs for diabetes, asthma and other chronic conditions. The theory: it's not smart to encourage patients to skimp on drugs that prevent more-expensive-to-treat conditions from developing.

The Design of Third-Party Payment

One of the fastest-growing health insurance products toward the close of the last decade was the point-of-service (POS) option. This option has been popular because employees complained about the restrictiveness of closed networks. Yet, analysts say that POS options can raise the cost of health insurance by 11 percent or more.¹¹ It's as though people flock to managed care plans to take advantage of their low premiums, then demand options that undermine the ability of the plans to keep costs down.

The approach summarized in table 24.1 points to a partial solution. The reason out-of-network doctors cost more, even when paid the same fees as in-network physicians, is that they are likely to order more tests and generate the use of more ancillary services. But this would be of much less concern if third-party payment were restricted largely to curative services and patients paid with their HSA funds for diagnostic services.

The problem of how to control curative costs without unduly restricting patient choice or endangering quality remains. A possible solution is a variant on an old idea: a fee schedule. From time to time, the insurance industry has flirted with plans that pay doctors a set fee for various services. If patients selected doctors who charge more, they paid the difference out of pocket. In modern medicine, we know that the doctor's fee is only one part of a complex array of costs a doctor can generate. So controlling the physician's fee isn't enough. But why not fix the plan's cost for an entire treatment regime? Suppose a patient is diagnosed with cancer, and the health plan normally would contract to pay a fixed fee to a medical facility to cover all costs.¹² If the plan could be assured that this fixed fee were its maximum exposure, the plan would have no economic interest in restricting the patient's choices. It could, for example, allow the patient to go to an alternative provider and pay more, if needed, out of pocket or from an HSA. In this way, the plan controls its costs and patients still exercise choice; the exercise of choice puts pressure on the plan to maintain quality in its own preferred medical facility.

The decision to take the plan's money and seek treatment elsewhere need not be made once and for all. For chronic conditions, it could be reaffirmed annually. Take diabetes. Because traditional care for diabetes has been less than optimal,¹³ many patients and doctors have long maintained that patients (with the help of a physician) can manage diabetes more efficiently than managed care can.¹⁴ Why not let them try? The health plan might make an annual

deposit to the patient's HSA and shift the entire year's financial responsibility to the patient. If there were concern that the funds might be wasted, the health plan could hold the account and monitor it. An example of the range of possibilities is again provided by South Africa. Discovery Health (one of the largest sellers of MSA plans there) allows its diabetic patients the opportunity to enroll in a special diabetes management program. Under the arrangement, Discovery pays the program about seventy-five dollars per month, while patients pay another twenty-five dollars from their MSA accounts. Discovery is considering handling many other chronic diseases in the same way.

The Casualty Insurance Model

To appreciate where this line of thinking might lead, compare casualty insurance with traditional health insurance. After an automobile accident, a claims adjuster inspects the damage, agrees on a price and writes the car owner a check. Hail damage to a home's roof is handled in the same way under a homeowner's policy. In both cases, the insured is free to make his or her own decisions about paying for damage repair. In contrast, traditional health insurance is based on the idea that insurers should pay not for conditions, but for medical care. That health insurers rejected the casualty model is not surprising. After all, Blue Cross was started by hospitals for the purpose of insuring that hospital bills would be paid. Blue Shield was started by doctors to ensure that doctor fees would be paid.¹⁵ Had auto insurance been developed by auto repair shops, they also would have rejected the casualty model.

We are not suggesting that we give the insured complete freedom of choice. Paying people for a condition and allowing them to forego health care and spend the money on pleasure may not be in the self-interest of a health insurance pool, because an untreated condition today could develop into a new and more expensive-to-treat condition later on.¹⁶ We are suggesting that if people were largely free to make their own treatment choices and the market were free to meet their needs, health insurance would take a major step in the direction of the casualty model.

Covered Services

One of the most contentious issues in health politics today concerns the services health insurers must cover. Special interests have persuaded state legislatures to require insurers to cover a vast array of costly services, whether or not those buying the insurance want to pay for coverage for those services.¹⁷ In our hypothetical plan, however, these special interests get no voice. Only the 1,000 enrollees count. That said, traditional insurance has made a lot of

arbitrary distinctions that an ideal plan need not make. For example, traditional insurance paid for treatment of back problems by an M. D., but not a chiropractor. It paid for mental health services provided by a psychiatrist, but not a psychologist. The rationale was partly a misplaced attempt to save money, but it also reflected the physicians' interest in promoting insurance that pays for the services of medical doctors rather than the individuals' interest in protection against catastrophic costs.

The casualty model of insurance helps solve this problem. Health plans could control costs and give patients greater freedom to choose among competing providers at the same time. Coupled with the idea that people should pay their full cost when entering a health plan and that medical consumption decisions not arising from a risky event should be paid by the individual from an MSA, our ideal health plan should make coverage decisions a lot easier.

Terms of Exit

Recall that insurance contracts in the individual market are almost always guaranteed renewable. Once in an insurance pool, people are entitled to remain there indefinitely and pay the same premiums others pay, regardless of changes in their health status. That commitment is completely one-sided, however. The insurer makes an indefinite commitment to the members, but the members are free to leave the pool at any time.

This one-way commitment creates the following problem. New insurance pools attract mainly healthy people because insurers tend to deny coverage, or attach exclusions and riders limiting the coverage of persons who are already sick (a process known as "medical underwriting"). As time passes, some enrollees get sick and the premium paid by all must be increased to cover the cost of their care. Thus, mature insurance pools will almost always charge higher premiums than young pools. This gives healthy people an incentive to leave the mature pool. By switching to a young pool, healthy people can escape high premiums. But this option is not open to the sick members of the mature pool. If they try to switch, the new pool will either deny them coverage or charge them a higher premium because of their medical condition. As a result, it is not unusual in the individual market to find an insurer providing the same coverage, but charging vastly different premiums, depending on the age of the pool. Members of a mature pool, for example, might pay \$1,000 a month or more for their coverage, while entrants into a young pool might pay only a few hundred dollars. Clearly, these are not the features of an ideal insurance system.

A possible solution is to make the long-term commitment apply both ways. In return for an indefinite commitment on the part of the insurer, members

would commit to the pool for a period of, say, three, four or five years. This does not mean that people would remain stuck in a plan they wished to leave. It does mean that leaving the pool would require the consent of the pool. For example, if a healthy member left high-cost plan A to join low-cost plan B, B would compensate A for its loss. Conversely, if a sick member left A to join B, A would compensate B to take the member and pay for the higher expected cost of care.¹⁸ In this model, recontracting is always possible, but only the type of recontracting that leaves everybody better off.¹⁹

Moreover, in the ideal system described here, people would have far less reason to switch insurers because their pool would be providing mainly financial (insurance) services rather than health care. A member would not need to switch from plan A to plan B to see a particular doctor or gain a higher quality of care.

Can Markets Develop Ideal Health Insurance Plans?

The ideas outlined here are merely suggestive. We do not expect individuals to develop their own health plans. That's what competition and markets are supposed to do. Entrepreneurs are supposed to innovate and experiment to find the products people want to buy. But intrusive regulations aside, can we rely on the market to achieve the best result?

Patients as Buyers of Health Care

As we saw in chapter 13, one objection to individuals paying directly for most diagnostic and preventive services is that they would not get the lowest price or find the highest quality. But anecdotal evidence suggests that uninsured individuals, spending their own money, get as good a discount as do large buyers.²⁰ Even if this were not true, there's no reason why the health plan itself cannot negotiate discounts for its members, even if the members spend their own money when they receive the services.

The issue of quality is a bit more difficult. But the solution is not the first-dollar managed care for every service. Suppose that as part of its HMO network, Blue Cross set up primary care clinics for its members. Blue Cross asserts that these clinics deliver high-quality, cost-effective care. If the assertion is true, why limit the care to the HMO members? Why not allow anyone to enter the clinic and pay out of pocket for the same services? This has already happened in cities across the country—proving that fee-for-service payment and cost-effective care are not inconsistent, provided incentives are not distorted in other ways. There's no reason why a health plan should object to patients directly contracting for their health care as long as the plan's own costs

do not go up. Indeed, the plan itself could provide consulting and other buying services to help patients make wise choices.

Centers of Excellence and Focused Factories

Can there be a workable market for expensive, curative services—with patients paying the bill? In some places there already is. Managed care advocates often point to the Mayo clinic as an example of cost-effective medicine. They ignore the fact that most of Mayo's customers are fee-for-service patients. What Harvard University professor Regina Herzlinger calls “focused factories,” providing highly efficient, specialized care, are becoming a reality.²¹ These health care businesses deliver lower prices, lower mortality rates, shorter stays and higher patient satisfaction.

For example, the Johns Hopkins Breast Center is a focused factory for mastectomies. The Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire, is a focused factory for heart surgery. The Pediatrix Medical Group, which manages neonatal units and provides pediatric services in twenty-one states, is another example.²² Focused factories also are cropping up around the country to provide cancer, gynecological and orthopedic services. One spectacular success story is Dr. Bernard Salick, a kidney specialist who has become a millionaire by pioneering a national chain of round-the-clock cancer clinics.

Patients on their own can already take advantage of these emerging markets. Indeed, some focused factories are advertising directly to patients. In a *New York Times Magazine* advertisement, Memorial Sloan-Kettering Cancer Center boasted “the best cancer care anywhere” and described how its specialists saved a life after doctors at other hospitals had given up hope.²³

The Role of Employers

In the absence of federal tax law, why would employers become involved in their employees' health insurance. There are two reasons why employers might become involved, even with neutral government policies. One is the economies of group buying. Signing one contract for all employees involves less overhead than having agents sell individual insurance household by household. There may be some merit to this argument, but it is a rationale exaggerated by people who focus only on the first-year cost. Under current practice, employer group plans are renegotiated every year, whereas individuals usually stay in their plans for several years. Taking into account all costs over several years, the difference in cost is much less. This, presumably, is why employers rarely get involved in their employees' purchase of automo-

bile or homeowners insurance and play only a minor role in the purchase of life insurance.

A second reason for employers' involvement relates to the adverse selection problem. Medical underwriting—attempting to determine everyone's health status at the point of entry into a plan—is costly. Employer-sponsored group insurance avoids this cost by enrolling everyone—the sick as well as the healthy—at once. Further, group contracts are written in ways that discourage individuals from “gaming” the system by remaining out of the pool while they are healthy and then joining the pool once they get sick. Since in the typical arrangement the employer pays a large share of the premium, employees don't save much by remaining uninsured. In addition, new employees have to make the decision to join the pool on a specified date. Thus, the timing of the decision to insure does not coincide with the timing of illness.

Having acknowledged that there may be good reasons for employers to play a role independent of government policies designed to encourage them to do so, let us also acknowledge that the appropriate role of the employer does not have to be settled by armchair theorists. We can let the market decide. Increasingly, employers are moving away from a defined benefit approach and toward a defined contribution approach. This means that employers make a commitment of x dollars to each employee and their employees make their own insurance choices. Remember, this is the approach taken by the federal government for its employees, by most state and local governments for their employees and by some large private employers, although note the problems with these systems discussed in chapter 22. There is no reason in principle why employers cannot help employees reap the economies of group purchase and avoid the costs of medical underwriting, while at the same time acquiring personal and portable individual coverage.²⁴

THE BENEFITS OF IDEAL HEALTH INSURANCE

Three features of ideal health insurance would make it especially superior to the health insurance arrangements that prevail today.

Ideal Health Insurance Is Patient Centered

A large portion of our health care dollars would be placed in accounts that we individually own and control. Patients would pay for the vast majority of medical services from these accounts, and doctors would be free to act as agents for their patients rather than for third-party payers. But because patients would be spending their own money in the medical marketplace, physicians would be

encouraged to become financial advisers as well as health advisers. Doctors would compete not just on the basis of quality, but on the basis of value for money.

Ideal health insurance in the treatment of expensive conditions would be patient centered. Rather than have a third party pay every medical bill, insurers would make regular deposits to the HSAs of patients with chronic conditions, leaving them free to choose among competing focused factories for ongoing treatment. Rather than have a third party dictate terms and conditions for the delivery of expensive acute care, patients would be able to draw on a fixed sum of money and get their health needs met at a center of excellence or a focused factory of their own choosing.

Ideal Health Insurance Allows Insurers to Specialize in the Business of Insurance

One of the consequences of the managed care revolution is that insurers have been turned into providers of care. That is, the entity that pays our medical bills is the same entity that delivers our medical care. This development has had three negative consequences.

First, when the businesses of insurance and health care merge, health plans have perverse incentives to deny care. The rash of news stories reporting on the tragic consequences of underprovision of care are testimony to what can go wrong.

Second, when the choice of insurer is also effectively a choice of provider networks, consumers must make decisions that are humanly impossible. Ideally, one should not have to choose a cardiologist until one has a heart problem. One should not have to choose an oncologist until one gets cancer. But in today's market, when you choose your insurer you are at the same time choosing your heart specialist and your cancer specialist, whether you are aware of it or not.

Third, the managed care revolution has delegated to those on the buyers' side of the market (insurers) the responsibility of forcing those on the sellers' side of the market (doctors, hospital administrators, etc.) to deliver care efficiently. In no other market do we depend upon buyers to tell sellers how to produce their product. Undoubtedly, there are good reasons why other markets are not organized this way.

Ideal health insurance, by contrast, allows insurers to specialize in what they do best: manage risk. The supply side of the market would be encouraged to organize into focused factories and adopt other efficient techniques in order to produce high quality for low cost. The market would still be free to combine insurance and health care delivery where the combination makes

sense. It may turn out that for such specialized services as cancer care, efficiency warrants specialized insurance products. Ideal health insurance would allow those market developments by providing a mechanism for people to leave one insurance pool and join another (without extra cost) when their health condition changes.

Ideal Health Insurance Is Improved by the Free Flow of Information

Under the current system, consumer information is a threat to the stability and peace of mind of typical HMO personnel. The more patients learn, the more they are likely to demand. Under ideal health insurance, by contrast, accurate consumer information is a positive. The reason is that the insurer and the insured are on the same team, with a similar interest and objective: acquiring good value in a competitive market.

Needless to say, the changes outlined here will require appropriate changes in public policy. Of these, three are particularly important.²⁵

First, federal tax law must create a level playing field between third-party insurance and individual self-insurance through HSAs. As noted, the United States has already made a major step in that direction. Individual preference and market competition, not the peculiarities of the tax law, should determine the appropriate division.

Second, federal tax law must create a level playing field between employer purchase and individual purchase of health insurance. Although employers can purchase employee health insurance with before-tax dollars, people who purchase their own insurance get virtually no tax relief and must pay with after-tax dollars. (An exception to this generalization is the self-employed, who get partial tax relief.) Employers may have an important role to play in helping people obtain health insurance, but this role should be determined by the marketplace, not by tax law.

A third important change needs to be implemented at the state level. Many employers would like to move to a defined-contribution approach to employee health insurance. As a result, employees could enter a health insurance pool and stay there—taking their insurance coverage with them as they travel from job to job. Personal and portable health insurance is an idea whose time has come. Yet, virtually every state has made this approach (technically known as “list billing”) either illegal or prohibitively impractical.

These changes will not solve our most important health insurance problems. They will create a legal environment in which individuals, their employers and their insurers—pursuing their own interests—are likely to create the institutions they need.

NOTES

1. Although we confine our analysis to health insurance, people in an ideal world would probably be inclined to combine health insurance with other forms of insurance. That is, in an ideal insurance world, coverage probably would include health insurance, disability insurance, long-term care and life insurance.
2. The market would collapse to a market for one-year term insurance; and people with terminal illnesses would essentially become uninsurable.
3. Tammy O. Tengs et al., "Five Hundred Lifesaving Interventions and Their Cost-Effectiveness," *Risk Analysis* 15, no. 3 (June 1995), 369; David M. Eddy, ed., *Common Screening Tests* (Philadelphia: American College of Physicians, 1991).
4. Tengs, "Five-Hundred Lifesaving Interventions," 379.
5. Of course, the plan could then require a second opinion, retesting, and so forth.
6. John C. Goodman, "Medical Savings Accounts: The Private Sector Already Has Them," National Center for Policy Analysis, Brief Analysis No. 105, April 20, 1994.
7. Prior to 2004, such deposits were subject to payroll taxes and income taxes. The exceptions were tax-free MSAs allowed under a federal pilot program for the self-employed and employees of small businesses. However, under the pilot program, year-end withdrawals used for nonmedical purposes faced regular income taxes and a 15 percent penalty. As of 2004, HSAs in principle became available to all nonelderly Americans and withdrawals for nonmedical purposes prior to age sixty-five face income taxes plus a 10 percent penalty. Withdrawals after age sixty-five face no penalty.
8. This structure was actually required by law under the federal pilot program that made MSA deposits tax free for the self-employed and employees of small businesses. See Merrill Matthews, "Medical Savings Account Legislation: The Good, the Bad and the Ugly," National Center for Policy Analysis, Brief Analysis No. 211, August 19, 1996.
9. Letter from Alain Enthoven to Gov. Pete Wilson et al., January 6, 1998.
10. Of course, without some oversight, this reimbursement formula encourages discretionary procedures to relocate to a hospital setting.
11. A mandatory point of service option when combined with a requirement to reimburse at the same rates in and out of the network can raise the cost of health insurance by as much as 11.3 percent. Estimates of M&R for the National Center for Policy Analysis. Cited in Merrill Matthews, "Can We Afford Consumer Protection? An Analysis of the PARCA Bill," National Center for Policy Analysis, NCPA Brief Analysis No. 249, November 24, 1997.
12. Some insurers currently pay providers based on the patient's diagnostic related group (DRG). Medicare pays the same way.
13. Regina E. Herzlinger, *Market Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* (Reading, Mass.: Addison-Wesley, 1997), 173.
14. For a survey of the efficacy of self-monitoring, see A. Faas, F. G. Schellevis and J. T. Van Eijk, "The Efficacy of Self-Monitoring of Blood Glucose in NIDDM Subjects: A Criteria-Based Literature Review," *Diabetes Care* 20, no. 9: 1482-86.

15. See Goodman, *Regulation of Medical Care: Is the Price Too High?*
16. Although for the terminally ill, this is an idea worth considering.
17. Gail A. Jensen and Michael A. Morrissey, "Mandated Benefit Laws and Employer-Sponsored Health Insurance," *Health Insurance Association of America*, January 1999.
18. There is a growing literature on how to design such arrangements. See John H. Cochrane, "Time-Consistent Health Insurance," *Journal of Political Economy* 103, no. 3 (June 1995): 445–73; Mark V. Pauly, Howard Kunreuther and Richard Hirth, "Guaranteed Renewability in Insurance," *Journal of Risk and Uncertainty* 10 (March 1995): 143–56. See also Bradley Herrick and Mark Pauly, "Incentive-Compatible Guaranteed Renewable Health Insurance" NBER Working Paper 9888, National Bureau of Economic Research, July 2003; and Vip Patel and Mark V. Pauly, "Guaranteed Renewability and the Problem of Risk Variation in Individual Health Insurance Markets," *Health Affairs* (August 28, 2002) (Web exclusive).
19. What is envisioned here is a market for individual patients. For those who doubt that such a market could develop, recall that the same objection was once raised against a reinsurance market for residential housing.
20. The reason is that sellers have an incentive to charge marginal cost when no third party is involved.
21. Regina E. Herzlinger, *Market Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* (Reading, Mass.: Addison-Wesley, 1997), 173.
22. Harris Meyer, "Are You Ready for the Competition?" *Hospitals and Health Networks* 72, no. 7 (April 5, 1998): 25–30.
23. *New York Times Magazine*, May 3, 1998.
24. There may, however, be a legal obstacle. To our knowledge, every state government prohibits employers from buying individually owned insurance for their employees (see the discussion below) and some legal experts are convinced this practice is also outlawed under HIPAA.
25. For a fuller discussion, see John C. Goodman and Merrill Matthews, "Reforming the U.S. Health Care System," National Center for Policy Analysis, *NCPA Policy Backgrounder*, no. 149 (April 26, 1999); Pauly and Goodman, "Incremental Steps toward Health System Reform," and John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, D.C.: Cato Institute, 1992), ch. 20.

