

# Health Care Reform: Design Principles for a Patient-Centered, Consumer-Based Market

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State and federal lawmakers are focusing increasingly on health care reform, and a growing number are expressing serious interest in "patient-focused" or "consumer-centered" approaches. This is certainly a positive development. Lawmakers of both parties are now more inclined to advocate making the patient the focus of America's health care system.

However, the vocabulary of health care policy is often elastic, and different people use the same terms to express significantly different concepts. This elasticity adds to the general confusion among the public and policymakers that seems to plague this area of public policy and often results in legislators and taxpayers talking at cross-purposes or past one another.

Consequently, clarifying the rationale, objectives, and principles of consumer-centered health care reform is important so that participants in the discussions, particularly the taxpayers, accurately comprehend the concepts and implications of this approach and are better equipped to evaluate the various proposed reforms at the federal and state levels.

## Key Principles

The fundamental objective of a patient-centered health care system is to maximize value for individuals and families so that they receive more benefit and better results for their health care dollars, both as patients and as consumers buying health insurance. Only when individuals choose and own their own health insurance will the other actors in the system—health plans and providers—have the right incentives to deliver better value in the form of improved results at lower prices.

If policymakers are serious about real patient-centered, consumer-driven health care reform, they should ensure that their legislative proposals embody six key principles:

- **Individuals are the key decision makers** in the health care system. This would be a major departure from conventional third-party payment arrangements that dominate today's health care financing in both the public and the private sectors. In a normal market based on personal choice and free-market competition, consumers drive the system.
- **Individuals buy and own their own health insurance coverage.** In a normal market, when individuals exchange money for a good or service, they acquire a property right in that good or service, but in today's system, individuals and families rarely have property rights in their health insurance coverage. The policy is owned and controlled by a third party, either their employers or government officials. In a reformed system, individuals would own their health insurance, just as they own virtually every other type of insurance in virtually every other sector of the economy.
- **Individuals choose their own health insurance coverage.** Individuals, not employers or government officials, would choose the health care coverage and level of coverage that they think best. In a normal market, the primacy of consumer choice is the rule, not the exception.
- **Individuals have a wide range of coverage choices.** Suppliers of medical goods and services, including health plans, could freely enter and exit the health care market.
- **Prices are transparent.** As in a normal market, individuals as consumers would actually know the prices of the health insurance plan or the medical goods and services that they are buying. This would help them to compare the value that they receive for their money.
- **Individuals have the periodic opportunity to change health coverage.** In a consumer-driven health insurance market, individuals would have the ability to pick a new health plan on predictable terms. They would not be locked into past decisions and deprived of the opportunity to make future choices.

## The Key Tests of Reform

Not all health care reform legislation that is labeled consumer-oriented is equally effective or significant. The key test is whether

or not it puts in place structural changes that maximize the ability of a large number of individuals to make basic choices about their own health insurance coverage and medical care.

Individuals are both consumers and patients. In a consumer-centered health system, individuals directly control the flow of dollars, buy and own their own health plans, pick the kinds of coverage that they want, and determine which plans offer them the best value.

In such a system, consumers expect transparent prices, and consumer choice stimulates competition among plans and providers to offer better value for money. That competition, in turn, drives innovation in both clinical practice and plan design. For individuals as patients and consumers, value for money is judged in terms of results: better medical outcomes, improvements in their health condition or status, cost-effective treatments, and health plans that save them money by helping them stay well and, when they do need care, by identifying the providers that offer the best results at the best price for their particular condition.

Thus, true consumer-centered health reform is system-focused reform, not product-focused reform. Its objective is to improve performance and results by changing the basic structure and incentives of health care markets so as to maximize value for money in health insurance and medical care. It is not simply an exercise in legislating new product designs or trying to plug gaps in coverage by crafting new programs for targeted subpopulations. Instead, true consumer-centered health reform focuses on making fundamental structural changes in the system, as opposed to merely expanding the existing system or micromanaging insurance plan designs or provider reimbursement methodologies.

Policymakers need to step out of the conventional mindset that accepts the basic structure of the present system as a given and attempts only to modify it around the edges. For example, legislative proposals to promote certain product types- e.g., health maintenance organizations (HMOs) and health savings accounts (HSAs)-may well have beneficial effects, but they do not fundamentally change how the system functions as long as someone else picks the health plan for the individual. Similarly, no amount of regulatory tinkering with provider reimbursement rates or payment methodologies can create more than marginal improvements in value as long as the system vests control over key decisions with employer and government "payers" who are not the ones receiving the medical care or using the health insurance policy.

Rather, consumer-centered health reform challenges policymakers to redesign the basic rules of the health care market to create new incentives for all of the actors in the system to put the interests of consumers and patients first.

Properly designed structural reforms will also produce a better framework and new incentives for addressing the current system's failings in cost, access, and quality more effectively. If responding to consumer needs and preferences is made the organizing principle of the system, then insurers and providers will have the right incentives to develop innovative ways to deliver better value to consumers and patients in the form of lower costs and improved outcomes.

In a reformed market, competition will produce new and better plan designs, clinical practices, and provider payment arrangements without lawmakers needing to micromanage the process. At the same time, it will generate new opportunities for lawmakers to focus public assistance more effectively to ensure that all Americans have access to the benefits of a system that offers better value.

The fundamental problem with the current system is that it encourages all participants (payers, insurers, providers, and patients) to engage in a giant game of cost-shifting, with each party trying to stick one or more of the others with a bigger share of the bill. Thus, while there may be plenty of competition in the present system, much of it is a zero-sum competition in which there is a loser for every winner. What America's health care system desperately needs are structural changes that create positive-sum competition in which all participants can "win" by working, often collaboratively, to improve the health care value proposition.<sup>[1]</sup>

#### The Consumer As Key Decision Maker

The place to start examining any economic or social system is with its basic organizing principle, which is identified by asking "Who is the key decision maker in the system?" In any economic or social system, the key decision maker is the one who sets the parameters for the other participants in the system. The other participants must act in response to the needs or preferences of the key decision makers.

Political science clarifies this process. For example, in a democratic system of representative government, the organizing principle is popular sovereignty, identified by the fact that voters are the key decision makers. Other participants (e.g., office holders, public employees, lobbyists, and interest groups) operate within the framework of the preferences periodically expressed by voters in elections. To advance his or her interests successfully, another participant must ultimately persuade voters either that they already want what the participant is proposing or that they should want it.

This creates a cascading chain of incentives throughout the system. For example, the most successful way for a lobbyist to persuade a politician to vote for what the lobbyist wants is to show the politician how such a vote would be popular with voters.

Other political systems (e.g., monarchies, aristocracies, and dictatorships) have different organizing principles, each of which can be determined by identifying the key decision makers in these systems.

The same holds true in economics. Most market economic systems are "consumer-driven" because the individual customer is the key decision maker. The other participants (e.g., producers, shippers, wholesalers, and retailers) must operate within the framework of the consumers' preferences as expressed through their purchases. To advance their own interests successfully, the other players must find ways to persuade customers either that they are offering what the customers already want or that the customers should want what they are offering.

Again, the result is a cascading chain of incentives. Thus, the surest way for a shipper to get a producer's business is to demonstrate that it can deliver goods to retailers or consumers more quickly and at less cost.

As in politics, alternative economic system designs can be recognized by identifying the key decision makers and, thus, the systems' organizing principles.

For example, the organizing principle of a monopoly is that the economic sector is "producer-driven." A monopoly exists (whether by accident or by design) when only one producer provides a particular product, thus making that producer the key decision maker. With no alternative producers available, other participants in the sector (e.g., consumers and retailers) are constrained by what the sole producer decides to produce and its quantity, timing, and price.

Likewise, when suppliers collude, such as through a guild or cartel, the resulting market can be described as "supplier-driven," reflecting the fact that suppliers hold the key decision-making power in that particular sector.

#### The Health Care Sector Anomaly

In health care, on the supply side of the supply and demand equation are physicians, hospitals, and other health care professionals and institutions. Collectively, they are commonly referred to as health care providers. On the demand side are the patients who are seeking or receiving medical treatment. The broader term "consumer" encompasses not only patients, but also individuals who, while not actively seeking or receiving medical care, purchase related products and services, most notably health insurance.

In the U.S. and many other countries, health care differs from most other economic sectors because government policies have sponsored, promoted, and maintained an anomaly in the sector—an additional set of participants known as third-party payers. While individuals always ultimately pay the costs of any health system, governments have instituted policies that effectively divert a portion of their incomes into the hands of others (the payers), who then make the basic or key decisions on how to spend the money on behalf of patients.

The simplest variant of this arrangement is the single-payer system, in which the government taxes its citizens and then pays medical providers for treating them. The U.S. and some other countries have developed multipayer variants of the same basic model.

In multipayer health systems, the government is almost always one of the payers, but its role is more limited than in single-payer systems, typically operating tax-funded medical care payment programs only for certain subgroups of the population. For example, in the U.S., the federal government runs a tax-funded single-payer system for the elderly called Medicare, while the state governments run a similar system for the poor called Medicaid.

However, for the majority of individuals in countries operating multipayer health systems, the relevant third-party payers are private entities such as employers, unions, or associations. These private payers divert a portion of their workers' or members' income either to buy health insurance or to pay medical bills directly on behalf of their employees or members. These arrangements can be either mandatory, as in Germany, or voluntary, as in the U.S.<sup>[2]</sup>

Yet, in a voluntary third-party payment system, individuals are unlikely to hand over large chunks of their income and the authority to spend it without something that makes the arrangement significantly more advantageous to them than buying the services directly. That is particularly true for something as personal and important as health insurance and medical care.

In the U.S., these arrangements exist largely because employee compensation that is diverted through employers to buy the employees' health insurance is exempt from federal income and payroll taxes. In contrast, if workers wanted their employers to divert part of their compensation for other purposes—such as buying groceries, paying for their housing, or leasing cars for their personal use—they would find that tax law treats such arrangements as income and taxes the workers accordingly. While the law does not prevent employers and workers from entering into third-party payment arrangements for food, housing, transportation, or anything else, such arrangements are uncommon because they offer no clear advantage (tax or otherwise) to workers over receiving their compensation in cash and then paying directly for the goods or services of their choice.

#### The Evolution of the Health Care System

Current health care systems are a relatively recent phenomenon. They evolved in response to advances in biology, chemistry, and physics since the end of the 19th century that transformed medicine into a scientific discipline and an expanding economic sector. Even though the purpose of medicine is to better the lives and health of patients, the health care financing arrangements that evolved over the past century have never been truly consumer-centered.

Through at least the first half of the 20th century, health systems were essentially provider-centered. Patients were expected to defer to the judgment of medical professionals and to pay what was charged. It was considered highly unprofessional for physicians to engage in explicit price competition. Hospitals granted admitting privileges to physicians, and physicians referred patients to the hospitals where they had such privileges. Thus, a hospital's real customers were the doctors who controlled the flow of paying patients, not the patients themselves.

This basic structure persisted even as third-party payers, whether governments or employers, were introduced into the equation. Third-party payers were expected to pay the usual and customary charges billed by physicians and hospitals for their services, but not to question the benefits, quality, or value of these services. This provider-centered focus can be seen in early health

insurance arrangements. For example, in the 1930s, hospitals organized Blue Cross and doctors organized Blue Shield to guarantee providers steady, predictable income streams by having patients—and later, their employers—effectively prepay for medical care on a subscription basis.

However, the resulting growth in the cost of medical care eventually spurred payers to start questioning the bills, beginning in the 1970s. At first, the focus was on the prices charged by providers. Payers, both government programs and private insurers working for the employers who were their customers, imposed payment limits on provider charges. Over time, those initial limits evolved into complex and comprehensive payer-imposed provider fee schedules.

However, as the payers soon discovered, prices constituted only half of the cost equation. Costs were still climbing thanks to steady increases in the volume and intensity of the medical care being provided. In recent decades, payers have tried to tackle this other half of the cost equation with a variety of restrictions on patient access to specific treatments or technologies.

The result is that today's health care financing systems, whether at home or abroad, are functionally payer-centered, with third-party payers having displaced providers as the key decision makers in the system.

In this specific sense, there is no qualitative difference between a single-payer system and a multipayer system. Both systems are payer-centered. Consequently, both systems generate the same incentives for other participants to respond to payers' demands and preferences rather than those of providers or patients. In a single-payer or a multipayer system, the payers decide whether or not to contract out to private insurers all or part of their role in managing the system, and they determine the terms and extent of such contracts. Private insurers therefore first serve the interests of the third-party payers who are their customers.

Thus, the relevant question is "For whom do the private insurers work?" not "Are private insurers part of the system?"

#### The Alternative: A Patient-Centered, Consumer-Based System

The obvious shortcoming of a provider-centered system is that it distorts the system in the direction of providing more, regardless of cost. The natural tendency of providers is to assume that increasing the volume and intensity of medical services will generate more benefit. Of course, this assumption is not consistently true. Depending on the circumstances, a particular test or therapy can be unnecessary or ineffective. Indeed, many medical interventions entail significant risks to the patient and can cause more harm than good. At other times, the modest benefits are not worth the costs.

In contrast, the shortcoming of a payer-centered system is that it distorts the system in the opposite direction by focusing on the cost side of the equation to the detriment of the benefit side. The most obvious, most effective, and simplest way to limit costs is by not spending money, but simply paying less or refusing to pay at all does not inherently produce more benefit or better value for the patient.

Furthermore, both a provider-centered system and a payer-centered system have an inherent bias to favor short-term considerations over long-term considerations. In a provider-centered system, the incentive is to do more now without adequately considering the possibility that such a course of action could produce a worse result later. In a payer-centered system, the incentive is to save money today without adequately considering the possibility that this could increase future costs.

Neither a provider-centered system nor a payer-centered system has the requisite incentives to maximize value systematically and consistently. Only consumers have a natural interest in a system that reduces costs while simultaneously improving results over the long term.

For any economic system to be value-maximizing, it must consistently and broadly reward consumers with lower cost and greater benefits if they seek the best value and must reward producers and suppliers with more business and higher incomes if they offer a better value than their competitors.

Thus, the foundational insight behind consumer-centered health care reform is that the only way to achieve better value in health care is to make the consumer the key decision maker in the system. Only when users and payers are the same will the incentives in the health care system properly align to seek and generate better value. Since third-party payers are never the users of the system—after all, doctors and hospitals treat people, they don't treat governments or companies—the only way to align the incentives to produce better value is to give those who use the system (patients and consumers) control over the funding and the associated spending decision. No other alternative arrangement can systematically and consistently produce more for less and secure value for the patient.

#### The Objectives of Patient-Centered, Consumer-Based Reform

The overarching objective of consumer-centered health care reform is to transform the health care market into one that maximizes value, meaning that the system's operational dynamic is competition among participants to produce better results at lower cost for patients and consumers. Once delivering better value to consumers becomes what enables other participants (e.g., doctors, hospitals, insurers, drug makers, and insurance agents) to "win" within the system, many of the current problems start to solve themselves. A consumer-centered system begins to control costs because it creates increased pressure to justify costs better in terms of demonstrated benefit. At the same time, a consumer-centered system generates pressure to improve results by demanding data showing that anticipated benefits are commensurate with expected costs.

Consumer choice also creates stronger incentives for measuring and reporting quality and performance because consumers need that information to make better decisions, thus producing improvements in those areas as well. Even a portion of the access problem begins to solve itself. When health insurance attaches to the person instead of to the job, fewer people

encounter circumstances in which they lose their health insurance coverage, and the size of the uninsured population is commensurately reduced.

A secondary objective is to provide lawmakers with a better foundation on which to build complementary public policies that more effectively address those access issues that competitive markets alone cannot solve. For example, the existence of a consumer-centered market for food makes it easier for policymakers to assist those who need help beyond what the market can provide through such means as subsidies in the form of food stamps or targeted incentives for grocery stores to operate in economically or geographically marginal, underserved areas. In a similar fashion, the presence of a consumer-centered, value-maximizing health system would allow lawmakers to focus tax dollars on helping those individuals who are financially or geographically disadvantaged to "buy into" a well-functioning system.

Another secondary objective is to encourage greater innovation. In this regard, health system innovation encompasses not only medical innovation to produce new and better treatments and therapies, but also innovation in organization and financing such as developing better clinical practices for treating patients, better provider payment arrangements, and better insurance plan designs.

This last point is particularly important. By putting the interests of patients and consumers first, a consumer-centered system forces other participants, particularly insurers and providers, to rethink their relationships and interactions. The current confrontational dynamic, in which providers try to force payers to spend more and payers try to force providers to charge less and do less, becomes an unproductive strategy for both sides because it does not produce the better value that consumers want. Instead, in a consumer-centered market, providers and insurers would find that they can both win (gain market share and increase income) if they collaborate to deliver better value (more benefits for less costs) to patients and consumers. This forces them to think more creatively and urgently about how providers can improve their quality, results, and efficiency and how insurers can restructure provider payment and contracting arrangements to capture newly created value and pass the savings and benefits on to their customers.<sup>[3]</sup>

#### The Key Principles of Real Reform

Lawmakers looking to design the right policy framework for enabling a consumer-centered, value-maximizing health system need to start with six key principles.

PRINCIPLE #1: Individual consumers are the key decision makers in the system.

In a consumer-centered health care system, individuals are the key decision makers with respect to medical treatments and health insurance. The current payers in the system (governments and employers) will still play an important role, but in a different fashion. They will no longer manage the details of the system, but will instead play supporting roles in assisting consumers, who become the system's primary decision makers. The role of employer will center on providing their employees as consumers with financial engineering and decision-support services.

The financial engineering aspect encompasses various employer strategies to help workers participate in the system more efficiently. For example, the workplace is a convenient location for distributing information and handling administrative tasks, such as workers choosing coverage from a menu of options during an annual open season. Similarly, employer participation in an automatic payroll deduction system for insurance premiums is an administrative efficiency that benefits workers at very little cost to employers.

Most important, as long as federal tax policy treats worker compensation for health care as tax-free to the worker if it is passed through the employer's hands, employers can leverage the tax code to ensure that their employees' spending on health insurance and medical care takes advantage of that favorable tax treatment. Doing so effectively lowers the cost of health insurance and medical care to workers by 15 percent to 50 percent because workers do not pay taxes on this compensation.<sup>[4]</sup>

Employers can also play a decision-support role by assisting their employees with information and guidance in making health care choices. Most often, this will take the form of the employer or an insurance broker under contract with the employer helping individual workers pick the insurance plans that best suit their personal circumstances and preferences. Employers can also offer their employees a range of related services, such as workplace clinics; health promotion programs; information on the costs, risks, and benefits of common treatments; and comparative data on the quality and results of health care providers. Employers inclined in this direction will find that numerous vendors already exist who are willing and able to bring these and similar programs into the workplace.

For governments, their role in a consumer-centered system shifts to financial assistance. Ultimately, the goal should be for the government to stop trying to design and operate public health insurance plans and instead focus on providing disadvantaged individuals with the necessary funds to buy into the same consumer-centered system that everyone else uses.

This will primarily take the form of steps to shift public assistance from a defined-benefit model to a premium-support model. In the current defined-benefit model, the government operates separate public health insurance plans for specified subsets of the population—something that government is poorly equipped to do competently. In a premium-support model, the government would operate programs to supplement the incomes of those who do not have sufficient funds to buy adequate health insurance and medical care in the market, just as the government now does with food stamps to help the poor buy groceries.

In some places, such as rural areas or economically distressed locations, governments might also provide assistance in the form of targeted subsidies or incentives to ensure that essential health services are available—for example, by funding clinics or offering inducements to health professionals to practice in those areas.

PRINCIPLE #2: Individuals buy and own their own health insurance coverage.

For a health system to be consumer-driven, health insurance coverage must be purchased and owned by individual consumers. In other words, the coverage contract must be an agreement between the insurer and the individual consumer. If the contract is between the insurer and some other party, such as an employer or a government, then the other party, not the individual consumer, is the insurer's real customer.

While at one level a coverage contract is a legal arrangement, it is primarily an economic arrangement. The legal aspects of the contract simply define the specifics of the underlying economic arrangement between the insurer as the supplier and the counterparty as the customer. As a supplier, the insurer is legally obligated and economically motivated to work in the interest of its customers. However, when the counterparty is an employer or government, that entity becomes the insurer's customer, and the counterparty's interests may differ from or be contrary to the individual's interests, even if the coverage is ostensibly purchased for the individual.

A simple analogy illustrates this key point. When a parent purchases breakfast cereal for a child, the customer is the parent, not the child. The parent and the child may have different opinions as to the best cereal to purchase. Indeed, these different opinions likely result from differences between the interests and preferences of the parent and the child. For example, the child likely prefers flavor over nutrition, while the parent will likely view nutrition as more important than flavor. Of course, the child's preferences likely influence, at least partially, the parent's decision, and cereal makers may even try to exploit this by pitching advertising to the child in the hope that he will influence his parents.

Ultimately, the buying decision rests with the parent, who is therefore the cereal maker's true customer. For the child to be the customer, the child must make the purchasing decision, using either his own money or money given him by a parent. Absent such a shift in decision-making authority, to sell more cereal, the cereal maker must first make its products attractive to the parents who will buy them, regardless of how attractive it makes the cereals to the children who will eat them. This means that the cereal maker must focus on the aspects that matter most to parents, such as nutritional content or pricing that gives them good value for their money.

While parents letting their children choose which breakfast cereal to buy is probably not a good idea, having individual consumers—not their employers or the government—choose their own health insurance plans is a good idea.

PRINCIPLE #3: Individual consumers choose their own health insurance coverage.

Individual ownership of coverage is an essential criterion for a consumer-driven market, but it is not the only criterion. A market characterized by individuals purchasing the product is still not a consumer-driven market if only one product is available, if there is only one supplier, or if the suppliers are organized in a cartel.

In such monopolistic circumstances, the lack of meaningful choice for consumers means that the key decision-making power still resides on the supply side of the economic equation. For the market-shaping power of the key decision maker to shift from the supply side to the demand side, consumers must have a choice of competing products and suppliers. Only then must suppliers respond to consumers instead of the other way around.

The linchpin of a consumer-centered health care market is the opportunity for individuals to choose the health insurance coverage that best suits their own preferences. While choice of health care providers is certainly essential to a well-functioning, consumer-centered market, the ability to choose among a diverse array of competing health insurance plans is the most important feature. This is true for two reasons.

*First*, health insurance is the principal mechanism for financing medical care. Indeed, this is true even when consumers opt for high-deductible plans and purchase much of their routine medical care directly from providers. For a health system to be truly consumer-centered, individual consumers must ultimately decide how the money in the system is spent. Thus, the first and most basic decision that consumers must be allowed to make is which health insurance plan to purchase.

*Second*, the choice of a health insurance plan of necessity incorporates a whole set of other implicit choices, such as what the plan will pay for versus what the consumer will purchase directly from providers, how and from whom the consumer will receive care, and how the plan will assist consumers in deciding among competing providers and treatment options. This last consideration is particularly important. Even the most sophisticated consumer may not have all of the relevant information available or have sufficient time to gather and analyze it when deciding among providers and treatments. However, health plans have—or should have—the information and expertise to assist consumers in making these decisions.

What consumers want is good value—meaning the best medical care at the best price. In a competitive market in which consumers choose their own health insurance, insurers succeed and prosper by offering consumers a better value proposition than their competitors offer. In other words, they apply their data and expertise to finding their customers the best medical care at the best price or, better yet, to finding ways to help their customers minimize their medical spending by staying or becoming healthy.

Thus, when individual consumers decide which insurance plan to purchase, insurers become the consumers' expert agents, helping them to navigate the health care system and obtain the best results at the lowest cost.

PRINCIPLE #4: Individuals have a wide range of coverage choices.

In any truly consumer-centered market, multiple suppliers compete to offer consumers better products at better prices. Yet for market competition to produce better value consistently—that is, by simultaneously increasing benefits while decreasing costs—consumers must be free to choose from a range of different options, and suppliers must have wide latitude to innovate in meeting consumer demands and preferences with new and better products. Thus, a precondition to any well-functioning, consumer-centered market is that lawmakers avoid unduly restricting either the options available to consumers or the scope for supplier innovation.

Government does need to set some basic rules for any well-functioning market. Much like establishing product safety standards or a uniform system of weights and measures, government can establish rules that facilitate well-functioning markets without unduly restricting supplier innovation or consumer choice. However, for a competitive market to function optimally, the basic rules need to permit wide scope for suppliers to innovate in developing new and better products and features to meet consumer needs and preferences.

Furthermore, lawmakers need to recognize that not all consumers have the same needs, preferences, or priorities. Suppliers must be free to innovate in offering different products to different subsets of consumers, targeting their different needs and preferences. This is particularly important in the health care sector where constantly expanding scientific knowledge and the resulting innovations in medical treatment force continual reassessment of what is “best” for individual patients and specific medical conditions.

For example, in health care, it is appropriate for government to limit the practice of medicine to those who demonstrate adequate knowledge and skill, but lawmakers should avoid inappropriately restricting provider competition with rules beyond those necessary to ensure basic provider competence and patient safety. Likewise, lawmakers should also take care to avoid imposing regulations that needlessly micromanage providers, stifle innovation in clinical practices, or favor one set of providers over another.<sup>[5]</sup>

In the same fashion, lawmakers need to set basic standards and rules for health insurance products and the companies that offer them. Yet they need to resist the temptation to substitute their judgment for the consumers’ judgment.

In setting health insurance market rules, lawmakers should focus on establishing the broad market parameters and allow market competition to work out the details. For example, in setting coverage standards, lawmakers should limit themselves to specifying basic coverage categories, such as physician services, hospital services, and prescription drugs. They should avoid micromanaging the market by, among other things, imposing coverage mandates for specific conditions or treatments or by stipulating how plans must contract with providers.

Similarly, lawmakers should not enact measures that favor one particular plan design over others. Government policy should treat all plan designs (e.g., HMO, preferred provider organization (PPO), indemnity insurance, and HSA with high-deductible insurance) equally. Such an approach not only permits beneficial competition and innovation, but just as importantly respects and accommodates differing personal preferences among consumers.

PRINCIPLE #5: Prices are transparent to consumers.

The same holds true in establishing rules for the price side of the price/benefit equation. In all cases, lawmakers should avoid direct “price setting” because such interventions inevitably distort the market in ways that end up harming both suppliers and consumers.

Yet government does play a legitimate role in ensuring that a market functions fairly and smoothly by establishing basic pricing rules, which enable consumers to comparison shop effectively by clearly informing them up front about the price of each option. For example, government requires grocers to include the unit price on the label of products sold by weight or volume and requires lenders to disclose the effective annual percentage rate (APR) of a loan when offering financing to prospective borrowers.

In a similar fashion, lawmakers will need to reach agreement with stakeholders on the appropriate standards for calculating and communicating prices to consumers in the health system. While enhanced price transparency at the provider level will certainly improve the functioning of the health system, the bigger issue will be the rules for how insurers price their health plan offerings.

Because insurance premiums can be calculated in a number of different ways, lawmakers need to establish rules for reporting those prices so that consumers can comparison shop among the different offerings. In other words, which factors and parameters will be used in reporting prices? Will prices (premiums) be reported on an age-adjusted basis? If so, will the competing plans produce rate tables priced in one-year age increments, or will five-year age increments be sufficient for insurers and simpler for consumers? Lawmakers will need to address similar questions about other possible rating factors, such as geography and family status.

Regardless of the specifics, lawmakers need to establish some set of basic rules on reporting premiums. Otherwise, if competing insurers priced their plans in different ways, or if insurers customized the premium charged to each individual customer, it would be difficult or even impossible for consumers to comparison shop among plans. Without some agreed convention on reporting prices, the balance of power in the market shifts back to the supplier because the answer to the consumer’s question “What is the price?” becomes “It depends.” This makes it difficult for consumers to weigh the relative costs and benefits of competing options accurately and makes the market supplier-driven instead of consumer-driven.

The specifics of the pricing convention are less important than making certain that some standard pricing convention is used. For example, for many years the standard convention on the New York Stock Exchange was to price stocks in eighths of a U.S. dollar, while the London Stock Exchange used hundredths of a British pound. Although they used different pricing conventions,

both markets worked equally smoothly. Indeed, when U.S. stock markets switched to using hundredths of a U.S. dollar, some market participants fared marginally better or worse than they had fared under the previous convention, but the markets continued to function smoothly. In contrast, a stock market would become less transparent and less efficient if each company was listed using its own choice of currency and fractional system.

In setting these and other market parameters, lawmakers should focus on ensuring that the resulting rules are transparent and equitable to consumers and that they provide insurers with a level playing field while accommodating their legitimate business concerns.

PRINCIPLE #6: Consumers have regular opportunities to make coverage choices on predictable terms.

For a market to be truly consumer-centered, individuals must be able, at least periodically, to reconsider past purchasing decisions and make different ones. A market that restricts consumer choice by unreasonably locking consumers into past decisions also has the effect of shifting the balance of power in the market back to suppliers.

For example, if a market rule locked consumers into buying new cars only from the manufacturers of their first cars, this would clearly shift market power from consumers back to suppliers and reduce producer competition and its resulting benefits. With much of its customer base locked into its product line, each producer would have significantly less incentive to respond to consumer demands for better products, more innovative features, and lower prices.

For the health insurance market to be truly consumer-driven, a clear set of rules must establish when and under what terms consumers can choose among competing options. Otherwise, adverse selection or constant churning could undermine the stability and viability of these markets. Nonetheless, these rules need to ensure that the market puts the interests of consumers firmly ahead of the interests of suppliers (the insurers) while still accommodating the legitimate business concerns of the suppliers.

This feature of consumer-centered health reform will likely be the most unsettling to many insurers because it will require them to adjust their business practices to accommodate a new market dynamic in which the customer picks the supplier. In the current dynamic, the supplier picks its customers through various strategies that focus on selling to some potential customers but not to others.

In setting this portion of the market rules for a consumer-centered system, lawmakers need to start from a clear understanding of both the product in question and the needs and behavior of consumers.

A significant portion of any health insurance plan is not insurance in the classic sense of financial protection against unpredictable risks or costs. All health insurance plans still retain some element of this protection, but it is no longer their primary feature. Rather, a large share of health insurance today consists of prepayment for medical care of varying cost and predictability. While the concept of using health insurance to pay for a full range of possible medical care was originally developed decades ago to serve the providers' interest in having more predictable income, that concept has since superseded its original intent.

Today, health insurance plans are a way for consumers to manage their need to finance medical care of varying predictability. In recent decades, advances in medical science have steadily made more medical services more predictable for more patients. Furthermore, the current trends in scientific discoveries and their practical applications in the clinical setting will make even more medical care more predictable for more patients in the future. This is an irreversible dynamic that is driven by steadily expanding knowledge in the basic sciences of biology, chemistry, and physics, closely followed by constant practical innovation in applying that knowledge to the development of new tests and therapies.

This ongoing scientific evolution has several practical implications for health insurance and health insurance markets.

*First*, it is no longer practical or desirable for policymakers to attempt to fight the rising tide of scientific knowledge by trying to restrict health insurance plans to paying only for the limited and ever-shrinking share of medical care that is genuinely unpredictable. Even the more consumer-directed plan designs that limit coverage by requiring subscribers to pay directly for more of their routine care will need to evolve to accommodate this new reality—for example, through mechanisms to ensure that incentives are properly aligned between the care that subscribers purchase directly and the care paid for by the plan—so that the totality of treatment is integrated and produces optimal results. While such plans will continue to attract a share of consumers, they will need to demonstrate in a competitive market that the total proposition offered—the combination of services paid directly by the consumer and services reimbursed by the plan—is a good value compared to other plan designs and produces a combined outcome for the consumer that is as good as or better than that offered by alternative, competing arrangements.

*Second*, plans will need to become more of the consumer's "expert agent" who works to identify for customers the best providers and treatment options available at the best prices. Some current business practices, such as negotiating provider contracts based mainly on price and then steering patients to those providers, will not compete adequately in a value-maximizing market.<sup>[6]</sup> Instead, plans will need to develop new strategies. For example, they might cover all providers in a given market but vary patient co-pays according to an analysis, which the plan makes available to its subscribers, of which providers offer the best results at the best prices. Pharmacy benefit managers have already pioneered such a business strategy in the form of tiered co-pays for different competing drugs.

*Third*, a consumer-centered system will need to curtail some current insurer underwriting practices that exclude, limit, or charge above-standard rates for coverage for certain individuals or certain medical conditions. While these traditional practices will need to be retained in a limited form as penalties against those who wait until they are sick to buy coverage, they cannot be applied when individuals with coverage choose a different plan if the new market is truly consumer-centered. One of the important



incentives for purchasing health insurance when an individual is healthy must be the assurance that future changes in health status will not disadvantage the individual when retaining existing coverage or choosing new coverage.<sup>[7]</sup>

*Fourth*, as science increasingly makes more medical care more predictable, health plans must recognize that they are increasingly less in the business of cross-subsidizing unpredictable risks and more in the business of cross-subsidizing health status. In this regard, cross-subsidizing health status is not only a horizontal exercise—commonly understood as the healthy paying for the sick—but also a longitudinal one in which a healthy person today will probably be in poorer health at some point in the future or even vice versa.

A competitive, consumer-centered system will force insurers to rethink some of their business practices in this area as well. For example, insurers might experiment with offering features such as multi-year contracting, premium discounts for participation in wellness or disease management programs, or cash rebates to subscribers who successfully meet agreed-upon health improvement goals. These and other novel plan designs can create powerful new incentives for consumers, providers, and insurers to work together to achieve better value by keeping or making consumers healthier at a lower cost.

*Fifth*, lawmakers must ensure that the market rules in this regard are fair to consumers, while also accommodating the legitimate business concerns of insurers. For example, if consumers are to be able to choose coverage at standard rates regardless of health status, it will be necessary to limit when consumers can make these choices to avoid confusion in the market. For instance, consumers could be limited to choosing or changing coverage only during an annual open season, or for some other fixed period of time, with exceptions for special circumstances such as loss of employment or loss of coverage under a spouse's plan.

Similarly, lawmakers will need to work closely and cooperatively with insurers to devise risk-adjustment mechanisms to give insurers incentives not to avoid subscribers with health problems, but rather to help them get better outcomes at better prices or even to specialize in identifying and organizing cost-effective treatments for patients with specific conditions, such as diabetes, cancer, and heart disease. The market will need risk-adjustment mechanisms that allow each insurer to accept all customers regardless of their individual health status and that permit all insurers to aggregate a portion of their large claims and equitably redistribute these costs across all consumers in the market.<sup>[8]</sup>

## Conclusion

The current debate over health care reform is usually framed in terms of addressing cost and access problems, accompanied by occasional discussions about the need to improve quality and outcomes in the system. Yet those issues are all manifestations of a more fundamental dissatisfaction with the status quo. Implicitly, both policymakers and the public are motivated by a sense that health care today is not living up to their expectations for value at either the individual level or the societal level.

While America's current health system has clear strengths, it also has significant weaknesses. For all the benefits that it provides in helping people to live longer and healthier lives, America's health care system seems too costly, confusing, inefficient, and uneven in its results, and it leaves too many people without adequate access to its benefits. Fundamentally, Americans as individuals and as a society intuitively recognize that the present health system could do a much better job of delivering value.

Put simply, Americans rightly sense that either they are paying too much for their present health system or the system should be delivering better results given what they are already paying.

The solution and the challenge for policymakers is to undertake the reforms needed to transform the present system into one that does a much better job of rewarding the seeking and creation of better value. As the experience of other economic sectors shows, health care need not be a zero-sum game in which costs can be controlled only by limiting benefits and benefits can be expanded only by increasing costs. Rather, a value-maximizing system will simultaneously demand and reward continuous improvements in benefits while continuously reducing costs.

Such a value-maximizing result can be achieved in health care only if the system is restructured to make the consumer the key decision maker. When individual consumers decide how the money is spent, either directly for medical care or indirectly through their health insurance choices, the incentives will be aligned throughout the system to generate better value—in other words, to produce more for less.

All Americans should be able to agree with the goal of creating a value-maximizing health care system. Consumer-centered health care market reforms are the only effective means for achieving that goal.

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