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Why the Health Reform Wars Have Only Just Begun

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Abstract: *If the health care legislation passed in 2010 is implemented fully and on schedule, public attention will turn to features of the legislation that were perhaps less obvious during the debate. For example, who ultimately controls the new health exchanges—the states or the federal government? Resolution of this issue could determine the nature of health insurance in America. The so-called OPM alternative will soon be seen as an end-run for the public option and, if it remains on the statute book, could lead to a far stronger public option than anyone thought possible. Employers and employees will soon wake up to the fact that the legislation will accelerate the erosion of employer-based insurance. And rosy projections that health spending will taper down will most likely prove to be an illusion—forcing choices about price controls and budgets. However Congress responds to these decisions, it will mean big changes in access to services and control of the system.*

Whenever major bills are enacted, they create a dynamic that causes the programs or system they reform to evolve in often unanticipated ways, frequently requiring important additional decisions down the road. The recent health legislation is a classic example. If it does indeed go into effect as scheduled over the next several years, it will trigger profound changes that will force big decisions over the next several years, implying huge changes for insured Americans.

With a bill this large, and with so many of its provisions intertwined, it is impossible to predict its

Talking Points

- The health care legislation passed in 2010 will have profound implications well beyond the high-profile elements that attracted most public attention during the debate.
- Who ultimately controls the new health exchanges—the states or the federal government? How that is resolved could determine the nature of health insurance in this country.
- The "OPM alternative" to the public option, if it remains on the statute book, could lead to a far stronger public option than anyone thought possible.
- Employers and employees will soon wake up to the fact that the legislation will speed up the erosion of employer-based insurance.
- Rosy projections that health spending will taper down will prove to be an illusion. How Congress responds to that will mean big changes in access to services and control of the system.

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effects with certainty. As Henry Aaron and Robert Reischauer explained in a recent article, just the timetable for implementation is a political and technical minefield fraught with uncertainty.[1] As the authors point out, the long phase-in of provisions means that there will be many opportunities for Congress to alter or reverse some of the key provisions. Moreover, the administrative changes and ambiguities in the legislation mean that controversial aspects of the legislation will have to be revisited. Thus, many obstacles still confront this legislation, and many Americans believe strongly that the legislation should be substantially changed, cut back, or repealed entirely.

As Americans begin to digest the legislation, they will indeed find many aspects of the law that surprise them and discover also that major decisions have yet to be made.

A Flawed Strategy: Avoid Discussing Details with the Public

To be sure, the scale of the bill itself made it very difficult during passage for anybody, including those who wrote it, to be fully aware of all its features and implications. But proponents of the legislation generally decided *as a strategy* not to conduct a detailed conversation with Americans about the long-term changes the legislation would trigger.

Why? Because that strategy was the conventional wisdom among health reformers in the years running up to the reform effort. After the demise of President Bill Clinton's reform effort, a theory took hold that major health reform could be enacted only if proponents avoided a detailed conversation with the public about its likely impacts. The line of argument was that health care is so complex that people would necessarily be confused by the conversation. That confusion would lead to anxiety and then to opposition stoked up by health industry interest groups.

So, the theory went, health reform must be portrayed to Americans in positive generalities. Furthermore, the legislative action must be conducted quickly in order to avoid the public getting lost in the weeds and then becoming confused and anxious and increasingly resistant to change.

The flaws with this operational theory quickly began to appear when President Barack Obama started to advocate health reform. We live in the age of the Internet, Twitter, and blogs, so details of each phase of the legislation leaked out of Washington in seconds and within days were featured in rowdy town hall meetings. The new media rendered the "Keep it simple, stupid" theory impractical. Worse still, once Americans discovered specific items in the legislation that they had not been told about or that seemed to contradict rosy assurances that little would change for the insured, they became increasingly distrustful and angry, and opposition became more intense.

This public reaction does not augur well for the future stages of the reform legislation's rollout. The distrust and anger that built up during the legislative phase will have new targets as decision points are reached in the timetable for implementation. It increases the probability that strong opposition will develop against core elements of the reform measure, perhaps even the entire legislation, as the public focuses on them and when important decisions have to be made—such as when Congress has to decide on future recommendations for savings by the new Medicare commission. This strong undertow of public distrust and anger may be sufficient to block, delay, or transform major features of the statute that have yet to go into effect.

Four Critical Areas of Contention

Consider just four aspects that will mean profound changes and critical decisions in the years to come. Each underscores both the degree of change that the public will encounter and likely future battles.

1. Who will control the health exchanges?

The concept of a health exchange is to provide the equivalent of a farmers market or shopping mall through which individuals and families can choose the health plan that is best for them and retain it from job to job. In principle, such exchanges are a

1. Henry Aaron and Robert Reischauer, "The War Isn't Over," *New England Journal of Medicine*, Vol. 362, No. 14 (April 8, 2010), pp. 1259–1261, at *http://content.nejm.org/cgi/content/full/362/14/1259* (June 25, 2010).

very welcome improvement on the current employer-based system because they make it possible for families to exercise choice and effective ownership of their health coverage. They also facilitate portability. So the generic idea of an exchange has had broad support among analysts and lawmakers.

Unfortunately, the version enacted by Congress is not generic. It places sweeping requirements on plans that can offer coverage through an exchange. The legislation will also ignite a struggle between the federal government and the states over who will have effective control of the exchanges.

On the face of it, the states "won" the initial skirmish because Congress chose to go with the state-led exchange approach of the Senate version rather than the House's much more centralized national exchange approach. That decision might seem to open the way for a variety of state exchanges, which would encourage innovation and exchanges that more closely reflect the circumstances and political decisions of individual states.

This is the case today, with wide diversity in the exchanges already implemented or being considered. For example, the Massachusetts "Connector" is a highly regulated exchange with considerable additional powers given to the exchange management so that it is one integral component of the state's entire strategy for health coverage and budgeting. Meanwhile, Utah has opted instead for a far more "hands-off" approach—in effect a lightly regulated *Expedia.com* for health insurance.

Under the new legislation, however, states like Utah will face considerable federal intrusion into their exchange structure when this part of the legislation goes fully into effect in 2014. Health plans in the exchange will have to conform to very tight federal requirements. Moreover, this could be just the beginning of increasing federal control. In all probability, some of the committees in Congress that are responsible for the federal components of the exchange will seek to strengthen the federal role. Also, the Obama Administration's preference for a more uniform exchange system means the rulemaking and administrative decisions accompanying the legislation will seek to push the envelope on federal control.

There was a similar pattern after the State Children's Health Insurance Program (SCHIP) was enacted in 1997. The legislation gave states wide flexibility to choose methods of covering children, but states needed to obtain federal approval for their method, and the Clinton Administration used the approval process to push states to use its preferred methods of coverage. It seems likely that the Obama Administration will adopt a similar strategy.

So the design and control of health exchanges is likely to become one of the federal–state battlegrounds that will play out over the next months and years. And right now, given the language in the legislation, the federal government has the upper hand. If indeed the federal government succeeds in molding the exchanges to the full extent that would be possible under the legislation, the result will be a system that differs little from a national exchange with strong federal control. That, in turn, will mean that health plans will evolve into a more standardized industry with tight premium regulation and benefit design. If that proves to be the case, health insurance in the future will look much more like a regulated public utility than a variety of products offered through a farmers market for insurance.[2]

2. Why the "OPM alternative" could develop into a strong public plan.

Proponents of a public option were said to have suffered a severe setback when Congress dropped the House's proposal and instead chose a Senate proposal to create a selection of private national plans to be managed by the Office of Personnel Management (OPM), the agency that currently runs the Federal Employees Health Benefits Program (FEHBP). However, in reality, this decision by Congress may actually open up the path to a much tougher public plan option than even House advocates imagined.[3]

The first reason for this is that OPM already has considerable powers to regulate FEHBP's private

2. See Stuart M. Butler, "Risking Big Changes with Small Reforms," *New England Journal of Medicine*, Vol. 362, No. 8 (February 25, 2010), pp. 673–675, at *http://content.nejm.org/cgi/content/full/362/8/673* (June 25, 2010).

3. *Ibid.*

plans, including national plans through Blue Cross and other carriers. But today, OPM does not choose to use these powers fully. In part, this is because the culture of OPM is to be a fairly traditional benefits manager for employees. This contrasts strongly with the regulatory culture at the Centers for Medicare and Medicaid Services (CMS) and the current White House.

However, if a bureau is set up within OPM to operate the new private national plans and this is staffed by officials who share the CMS perspective, the private national plans that are offered are likely to operate as private entities in name only. In fact, the OPM bureau running the new program could so regulate the plans under OPM's current rules that they would effectively be administrators of a public option.

Second, the legislation would give even more powers to the new government managers housed at OPM.[4] The act requires OPM to negotiate medical-loss ratios, minimum benefits, premiums, profit margins, and "such other terms and conditions of coverage as are in the interests of enrollees in such plans." So the provision in the legislation to create a network of national private plans is likely to become another battleground as it becomes clearer that the "private" national plans will be so regulated and administered that they are virtually indistinguishable from a public option—and arguably an option managed with more executive branch discretion than even the House's version.

3. How reform could mean the end of employer-sponsored insurance.

Despite all the talk of avoiding any disruption of the current system of employer-sponsored insurance, the legislation actually seems destined to accelerate the steady decline of that form of coverage. To be sure, there are many good reasons to move away from the current employer-based system, but that is plainly not what Americans have been told the legislation will accomplish.

The reason for this prognosis is that the statute creates several new incentives for employers to move away from providing coverage. For instance, mandates and "pay or play" provisions might seem to be a tool to prop up the current system in the short term. But over time, the combination of regulations, new taxes on insurance products, and limitations on employers' flexibility to design benefits will induce many firms to drop coverage and most new firms to decide not to offer it.

Moreover, the erosion is likely to increase sharply once employers and their employees focus on the huge subsidy differential for families between exchange-based plans and employer-based plans. Modest-income families who obtain their coverage through the exchange will be able to receive subsidies in the range of $10,000 or more to offset the cost of their coverage—which will be portable from job to job. On the other hand, families with roughly the same income who obtain coverage through their place of work will receive a subsidy in the form of tax relief (from income and payroll taxes) for the employer's contribution to the health plan—in the range of $1,000 for non-portable coverage. In addition, certain employers will face "fines" of $3,000 for any low-income employee who exercises a new legal right to drop the employer's coverage in order to enroll in a subsidized exchange plan.

These numbers mean that many employers who currently provide coverage—and their employees—will have an enormous financial incentive to cash out their existing health benefits and distribute the value as extra cash income, after which the employees can obtain heavily subsidized coverage through the exchange and essentially receive thousands of dollars in additional compensation. Congressional staff were aware of this potential problem and sought to avoid this potential trend by creating various "firewalls" designed to make it very difficult for individual employees to move from employer-sponsored insurance to coverage provided through the exchange.

But the huge inequity in subsidy levels between the two sectors is likely to spark great anger when it becomes evident to Americans. Some lawmakers may try to "fix" the problem by adding new subsidies to employer-sponsored coverage so that the differential is not so great. Doing that was considered in the

4. *Ibid.*

early days of the legislation. However, creating large new subsidies for employer-sponsored insurance to try to limit the erosion would be extremely expensive, which is why it was rejected when the legislation was formulated. There are modest and temporary subsidies to smaller employers in the legislation to encourage them to offer insurance, but these are unlikely to have much impact.

Alternatively, the differential could in principle be reduced by paring down the subsidies for families within the exchange, but that would encounter resistance since it would reduce the coverage levels in the exchanges and increase family costs. Or lawmakers presumably could stand back and allow the erosion of employer-sponsored coverage to accelerate.

Given these stark and controversial choices, it is likely that this feature of the new health system will become another major battleground.

4. Tackling the inevitable rise in government health spending.

The sponsors of the health legislation have promised a future in which coverage and quality will improve while the total spending "cost curve" will trend down. "Bending the cost curve" downwards was a dubious proposition at the outset.

The common argument was that improving the efficiency of delivery and services at the "street" level would inevitably lead to a reduction in total health spending, but this line of economic reasoning is fallacious. As we see in many sectors of the economy, from cell phones and computers to automobiles, there is no direct connection between greater efficiency and better pricing of individual goods and services and the total expenditure on these good and services in the economy: It depends. As the unit price of computers has declined sharply, for instance, total expenditures have climbed rapidly. Total spending on a product or service is related to how people value it compared with other potential uses of their money.

In health care, economists point out that most people are insulated from the direct costs of health services through insurance or public plans, such as Medicare, so the demand for health care is far less limited by underlying prices than, say, the demand for computers and automobiles—where most people face the full cost of the product. So if we continue to insulate patients from prices at the point of consumption, improved efficiency, quality, and availability of health care most likely will increase the trend-line of total spending over time, not reduce it.

That underlying economic reality about health care is likely to be exacerbated by the health legislation. Indeed, most authorities, including the Congressional Budget Office (CBO), have forecast that the spending trend-line will go up rather than go down. Even then, the CBO's forecast is likely to prove overly optimistic regarding future spending. There are several reasons for that. Among them:

- Limiting the tax exclusions has been seen by economists as a critical incentive to discourage excess demand for health care at the workplace, but the limits on the tax exclusion for employer-sponsored coverage, dubbed the "Cadillac tax," were watered down in the legislation and delayed until 2018. While the CBO adjusted its forecast accordingly, most Washington insiders are skeptical that a controversial tax delayed for that long will ever actually be implemented.
- The CBO projection assumes that physicians' fees in the Medicare program will be cut by about one-fifth this year and then kept on a lower trajectory, as the law prescribes. This fee cut is a major part of the savings to be achieved in Medicare spending. But this approach to reducing Medicare costs has been in place since 1997 and in recent years has been routinely "fixed" (i.e., reversed by Congress) each year. The ink was barely dry on the legislation before a major effort was mounted to "fix" the fee savings (i.e., repeal them) permanently. If, as seems probable, the fee cut is routinely postponed or permanently eliminated, this will add substantially to health spending in the future.
- The legislation creates a commission that will propose major savings in the Medicare program in the form of payment reductions—savings that were considered too controversial for lawmakers to specify in the legislation—and future Congresses will implement the commission's proposals or change them to achieve the equivalent

cuts. But if Congresses in the future prove to be no more courageous than the current one, these projected savings will prove illusory.

- The legislation includes a major new program for disability and long-term care services. Given that it is CBO practice only to provide estimates for legislation over the next 10 years, this new program, the Community Living Assistance Services and Support (CLASS) Act, is actually what one might call a "profit center." That's because it is projected, on net, to bring in revenue to the federal government over the next decade, because premium revenue precedes the large benefit payments in future years. While the law gives the Secretary of Health and Human Services (HHS) the power to raise premiums to keep up with benefit outlays, one would have to be an optimist to believe that Congress will go along with that. Indeed, after the first decade, expenditures will increase to such a degree that the chief actuary of HHS has declared the program unsustainable.

Given these features of the legislation and the lack of downward pressure on spending in the health system, the problem of ever-rising health expenditures as a proportion of the economy is likely to become acute within the next decade. The resulting strains on the federal budget and rising concerns from foreign lenders about America's soaring debt are likely to increase demands for new steps to try to slow down total health spending.

But while there will no doubt be much wishful thinking on how to do this painlessly, basically only three broad strategies have been advanced over the years as possible ways to keep the public cost of health spending within bounds. We can expect a vigorous debate in the years to come between proponents of each one, and whichever strategy prevails, Americans are going to experience significant changes in their access to health care services.

Strategy #1: Increase the direct regulation of prices and payments in the health care system.

This strategy would mean even tighter price and payment controls in the public programs, and many lawmakers would likely urge extending such controls throughout private health care in an effort to slow down general health cost. A problem with this approach is that the many centuries of world experience with price controls is hardly encouraging, including their attendant shortages, gaming, and inequities and poor results in controlling spending.

The political advantage is that, at the outset, direct price controls tend to be popular, as they probably would seem to be when applied to such areas as pharmaceutical prices and insurance premiums. But once the effects of the controls start to work through the system, leading to such things as restricted formularies, longer waiting lines, physicians withdrawing from Medicare, etc., public support is likely to ebb. Nonetheless, if health spending soars above the trajectory promised in the legislation, tighter price and payment controls are very likely to be proposed, and if they are implemented, there will be new limits on access to care.

Strategy #2: Give greater powers to bodies like the new Medicare commission to make decisions about the allocation and volume of health care resources and to place limits on access to those services.

An alternative to trying to limit spending levels by controlling prices is to directly allocate and restrict spending on services. This is a strategy undertaken in many other countries, most notably through the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom. It involves giving considerable powers to an administrative agency while reducing the powers of the public or the legislature to circumvent or block the agency's decisions.

The U.S. reform legislation takes a step in this direction by creating an Independent Payment Advisory Board (IPAB) to propose changes in Medicare to reach spending targets (though the board can only alter payments, not change such things as eligibility). Significantly, the board's proposal will be given "fast track" consideration by Congress and will go into effect unless Congress enacts alternative steps to achieve the same savings.

If spending is not curbed under the new law, there will likely be calls to strengthen the IPAB and widen the policy tools it can use. Some proponents of the commission strategy will probably also pro-

pose similar bodies for other aspects of the health system beyond Medicare in the same way that Britain's NICE is able to do. Indeed, Donald Berwick, nominated to be administrator of CMS, is a declared fan of NICE, describing it as a "global treasure."

If Americans were to pursue that approach, it would mean a shift in the locus of health decision-making power over access to care to an appointed board, with less ability for Americans directly or through their elected representatives to alter those decisions. It is worth noting that in the debate over the reform legislation, Americans appeared quite resistant to the idea of boards preempting decisions by their health providers or Congress.

Strategy #3: Place a direct limit on total public spending for health care.

A more direct way of controlling the growth of government spending on health care is to end the open-ended entitlement commitment to publicly supported health spending (in which the "budget" is really just a projection) and replace it with a real budget that limits the government's financial exposure. In effect, it would make the federal health budget a "defined contribution" rather than a "defined benefit."

Fixed budgets of this kind are quite familiar to managers of "discretionary" programs, such as defense, education, or highways, as they are to health program managers in most other countries. In addition to a budget for public funds, there could also be a budget for tax subsidies—principally the individual tax exclusion for employer-sponsored insurance—which would imply an adjustable cap on tax relief.

A bipartisan group of budget analysts (including this author) have proposed applying long-term (perhaps 30-year) budgets to entitlement programs such as Social Security, Medicare, and Medicaid.[5] Their proposal would allow the budget for these programs to be reassessed every five years, but it would end the "auto-pilot" status of public funds for major health care programs and make the 30-year budget the default.

If public funds for health care were subject to a real budget in this way, it would clearly have a direct impact on the future spending trend-line. It would also raise critical issues that would have to be settled in the future. For one thing, the long-term budget would have to be designed in such a way that it balanced the reduced taxpayer financial risk associated with a defined contribution budget and the increased financial risk for Medicare enrollees and other beneficiaries of programs. That said, one of the key objectives of a defined contribution budget is to use greater cost-consciousness to encourage beneficiaries to seek better value for money and so temper the growth in health care costs and hence the future cost of the programs.

If such a limited budget were put into place, it could be allocated using two approaches, or a combination of the two.

- **A budget for service providers.** One approach would be for the government to allocate funds directed to facilities and institutions (as, say, Canada and Britain do). The major decisions over the availability and type of resources would lie with the government and providers.

  In this case, the beneficiary's services would depend on those decision-makers. So Americans would have to ponder whether the agency, board, or legislature would distribute budgeted funds in a manner they believed to be fair and effective, and whether their particular needs or concerns would be appropriately considered.
- **An "individual" budget, or voucher.** The other approach would be to distribute the budget to program beneficiaries for them to use to choose the plans or services that they thought would best meet their needs. This could be accomplished though some form of income- and risk-adjusted "voucher" for purchasing coverage—sometimes called "premium-support." Federal

5. See, for example, Joseph Antos, Robert Bixby, Stuart Butler, Paul Cullinan, Alison Fraser, William Galston, Ron Haskins, Julia Isaacs, Maya MacGuineas, Will Marshall, Pietro Nivola, Rudolph Penner, Robert Reischauer, Alice M. Rivlin, Isabel Sawhill, and C. Eugene Steuerle, "Taking Back Our Fiscal Future," The Brookings Institution and The Heritage Foundation, April 2008, at *http://s3.amazonaws.com/thf_media/2008/pdf/wp0408.pdf* (June 25, 2010).

employees have a version of this system, since the government pays a percentage of their premiums up to a limit, and they are responsible for the remainder of the plan they choose.

In this case, the beneficiaries' own decisions would determine how the budget was distributed. So Americans would have to consider whether the formula for calculating their voucher properly reflected their income and medical needs and whether they had the information to make good choices.

Conclusion: Big Decisions Still Lie Ahead

The health care legislation passed in 2010 will have profound implications well beyond the high-profile elements that attracted most public attention during the debate. Attention will turn to each of these less obvious features if the legislation is fully implemented on schedule.

For example, a struggle will ensue over who ultimately controls the new health exchanges—the states or the federal government. How that is resolved could determine the nature of health insurance in this country. The so-called OPM alternative to the seemingly deep-sized public option will soon be seen to be an end-run for that option. If that remains on the statute book, we could see a far stronger public option than anyone thought possible. Employers and employees will wake up to the fact—indeed, many already are doing so—that the legislation will speed up the erosion of employer-based insurance. Will that be allowed to happen? And rosy projections that health spending will taper down will most likely quickly prove to be an illusion. If—and however—Congress responds to all this, it will mean big changes in access to services and control over the system.

As these and other features become clearer to more and more Americans, they will have a lot to say about what should happen. The health reform battle is far from over.

*—**Stuart M. Butler, Ph.D.**, is Vice President for Domestic and Economic Policy Studies at The Heritage Foundation. These remarks are a revised version of an address to the Cancer Quality Alliance on May 6, 2010.*