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POINT/COUNTERPOINT

Starting health reform from here

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No one is satisfied with the U.S. health system. In 2022, 26 million Americans were uninsured (Keisler-Starkey et al., 2023). In 2019, life expectancy at birth was 79 years, among the lowest in the Organisation of Economic Co-operation and Development (OECD), coming in a full 4 years below France (OECD, 2021). All of this is despite the United States devoting 17% of its economy to healthcare, the highest in the OECD and nearly double the average (OECD, 2021).

We are lucky that Liran Einav and Amy Finkelstein, two of their generation's leading health economists, have turned their attention squarely to these interrelated problems, thinking from first principles about how they would redo America's health system from scratch. Writing a counterpoint to their proposal is awkward on multiple levels: their book is excellent and should be required reading by specialists and non-specialists alike; I would be perfectly happy if their proposal were adopted; and, perhaps most importantly, they know vastly more about this topic than I do. As a result, many of the issues I raise are orthogonal to their arguments and some may well be wrong.

My own preference is for incremental health reform rather than the teardown they advocate. This is partly based on answering a different question than the one they pose—instead of a blue-sky health system without constraints, how do we actually make progress given the powerful vested interests and broad attraction of the status quo? But it is also partly based on a conservativism that mistrusts large changes and worries they could disrupt what is good and functional within the current system.

Perhaps more importantly, while ignoring the legislative constraint is welcome—and something that policy people do too little of—you cannot also ignore the constraint on how a plan will be implemented and developed over time and be received by actual people. I worry that the basic benefits they propose would either grow to be much more than basic, coming at high expense, or would be subject to serious backlash. Rather than rely on just that one instrument to control costs, I would also include broader cost sharing, something we know works.

Ultimately we do not just need a plan for a reformed health system but a plan for a process that will develop and change and improve over time. I am not sure what exactly that is, but giving more thought to the roles of competition, innovation, and delivery systems has to be part of the solution.

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WHAT HAS STOPPED HEALTH REFORMS IN THE PAST

Past attempts at health reform have run up against two interrelated obstacles: powerful vested interests and the powerful attraction of the status quo. Three examples illustrate the different ways these obstacles have operated in manners that will become relevant for thinking about some of the shortcomings of the Einav and Finkelstein proposal—and what an alternative could look like.

The first example is President Bill Clinton's failed attempt at health reform (Johnson & Broder, 1996). The Health Security Act, more commonly known as Hillarycare, was unveiled in September 1993. It was a complicated proposal that would have affected just about every American with private health insurance. The famous "Harry and Louise" ads were financed by the Health Insurance Association of America (HIAA), a concentrated interest, but the ads were successful because they appealed to a broader concern on the part of Americans who feared losing access to their health insurance plan and their doctors—people preferred the status quo. Within a year the plan was dead.

The second example is the addition of "catastrophic coverage" to Medicare, enacted in 1988 (Holstein & Minkler, 1991). It was exactly the type of blue-sky plan that would make sense to economists, filling what is still a major gap in Medicare's design—its failure to offer true insurance by placing a limit on out-of-pocket costs. The public, however, was less enamored of the plan—or at least of having to pay for the plan—so what might have been welfare-improving on paper led to a horde of senior citizens, at least some of whom would have directly benefited, confronting the plan's architect, Congressman Dan Rostenkowski, as part of a general opposition that led to the provision's repeal within 2 years of its initial passage.

Third, the issues confronting health changes are not just matters of public policy. A variety of ways to save households money have been implemented by insurance companies over the years but many of them have been rolled back due to their unpopularity. The emblematic example was HMOs, which attempted to control costs through steps like adopting closed networks and requiring preapproval for specialists. The evidence on their outcomes broadly shows that they saved money and did not result in worse health outcomes, but resulted in much less satisfied customers—perhaps the most famous dissatisfied customer being the fictional John Q portrayed by Denzel Washington in a film of the same name (Sacks, 2018). Echoes of this continue as more states and now the Federal Trade Commission (FTC) are making it increasingly more difficult for health insurance companies to impose prior authorization (Sable-Smith, 2024; Sausser, 2024).

HOW HEALTH REFORM HAS HAPPENED

The progress we have made in healthcare has come from understanding and respecting these constraints. And we have made a lot of progress in expanding health insurance coverage—which is central to the value that Einav and Finkelstein place at the center of their normative framework, the "enduring, if unwritten, social contract: access to essential health care, regardless of resources." In 1960, one quarter of the U.S. population was uninsured; today, as shown in Figure 1, it is less than one tenth—and many of those uninsured have access to insurance that they could get if they really needed it.

The progress has resulted from respecting the two major constraints that have interacted to stop reforms in the past: the disproportionate power of entrenched interests and a broader public unease with changes to the status quo. Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) were all created and expanded over time because they went to populations that largely did not already have health insurance (so did not have to address status quo bias issues) and helped existing interests by expanding the market and reducing providers' losses from uncompensated care.

The 2009 and 2010 efforts to reform health care faced a more daunting obstacle than these earlier efforts (Cohn, 2021). Medicare, Medicaid, and CHIP focused on the most politically sympathetic

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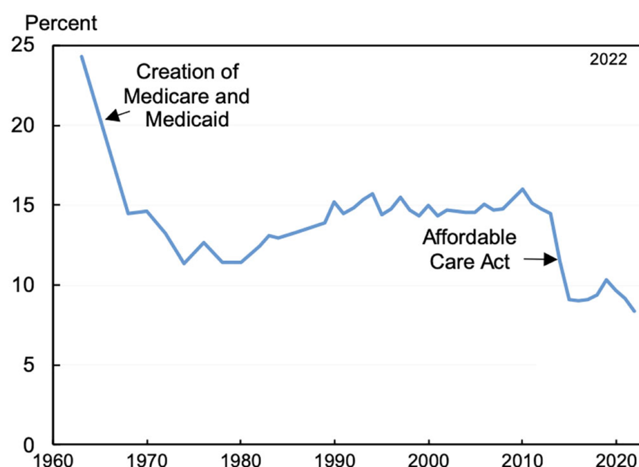

FIGURE 1 Uninsured rate, 1963–2022.
[Color figure can be viewed at wileyonlinelibrary.com]

groups, such as the elderly, pregnant women, and children. By 2009, the biggest need was to expand health coverage for less politically sympathetic populations, like childless adults and younger people. These populations were disproportionately less likely to vote, and in some cases, like some younger people, did not even necessarily place a high value on health insurance coverage.

The process of passing the Affordable Care Act (ACA) involved an extensive and ultimately successful effort to get the major medical industry associations for doctors, hospitals, and pharmaceuticals on board (the device manufacturers were just about the only concentrated interest to oppose the legislation). The status quo preference was addressed by designing the plan to build on and fill in gaps in the existing system rather than creating something new, which President Obama (2009) defended, saying "If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what." While he came to regret that statement when some plans were cancelled, it was a relatively accurate description of the overall approach in the Affordable Care Act, especially in contrast to other health reform approaches.

STARTING FROM SCRATCH IS AN IMPORTANT INTELLECTUAL EXERCISE

Every policy development is implicitly, or explicitly, maximizing an objective function subject to constraints. Einav and Finkelstein choose not to impose any constraints based on political feasibility, not trying to address the types of impediments that stopped the Clinton reform plan or single payer or the types of concessions that enabled the passage of Medicare and the ACA. Einav and Finkelstein justify this choice with an appeal to their comparative advantage as economists not political practitioners. This modesty is welcome but is perhaps overstated. After all, politics is closely related to the incidence of different policies—a topic where economists have a lot to offer, for example Finkelstein et al. (2019).

Regardless, it is a reasonable choice and in some ways is welcome. Most health policy proposals come from people steeped in Washington and are designed either subject to political constraints or to maximize a political outcome. A proposal from neither of these perspectives is refreshing. When Milton Friedman published *Capitalism and Freedom* in 1962, he did not worry very much about political feasibility, and since then some of his more radical ideas have become mainstream like floating exchange rates, school vouchers and negative income taxes. Friedman's book is still read

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today—which rarely happens with ephemera designed to maximize the ever-shifting constraints of the political system.

Less defensible, however, is that Einav and Finkelstein ignore the social constraints, the same ones that caused Medicare's catastrophic coverage to be reversed and eroded HMOs. Their plan is also not completely bereft of political constraints, which are smuggled in through their decision to unnecessarily rule out cost sharing.

ARE AMERICANS READY FOR BASIC COVERAGE?

Suppose the Einav and Finkelstein proposal succeeded in being enacted into law. What would happen next? The centerpiece of the plan is a basic benefits package. How would Americans respond to this? The answer is not clear because they intentionally eschew any definition of what a basic plan would consist of, arguing that this should be a social and political choice that people make together.

The problem is that "basic" is easy to say but hard to operationalize. During the development of the ACA, President Obama often told us he wanted us to design a Yugo of a plan, referring to a basic, inexpensive Yugoslavian car that was sold in the United States in the late 1980s and early 1990s. But just about every outside group and person engaged with the plan design took the opposite view, arguing that it should cover a very wide range of medical treatments and choices.

As Einav and Finkelstein discuss at length, much of what is provided by the health system is "amenities," which cost money and resources but do not contribute to better health outcomes. This distinction between the primary purpose and the amenities is rarely made in other spheres. For example, imagine a management consultant studying the $150 billion annually spent on hotel rooms in the United States. They might conclude that about $125 billion of that sum was wasted because hostels could have provided the same shelter, with a bed, access to toilet, and showers, at a much lower cost. But this recommendation would miss the point.

The social compact that leads our society to believe that no one should be denied critical health care does apply to the aspect that is extending health but not to everything else like the choice of doctor, speed of response, quality of hospital room, and the many other amenities that have little evidence-based link to health outcomes but are considered a fundamental part of healthcare by most people. If "basic" was truly as basic as they would make it, the public backlash could be intense.

The "basic" plan we have today is Medicaid and it covers just about everything including dental and vision, it just pays extremely low reimbursements for these services. Medicaid's prices would not work on the scale of the plan they envision but it is hard to imagine people being satisfied with less extensive benefits.

Einav and Finkelstein argue that people would need to collectively decide what should count as basic benefits consistent with their understanding of the social compact. The problem is this is a very hard choice to make if the decision is not linked to the cost. When people have options for multiple employer-sponsored plans, they can sometimes trade off premiums vs. generosity of amenities and coverage. How would this happen at the level of society when there was no direct link between the taxes that finance the universal basic benefit and the benefit itself? This is an issue in just about everything in public finance, but it is more severe given health care's large share of the economy and how important the "basic" aspect is to the universality of this plan and its claimed costs savings.

The financing of healthcare is already very opaque with a typical family of four spending about $32,000 annually but possibly only noticing the about $3,000 they pay out of pocket or maybe also the about $6,000 they contribute to the premium for their plan. The rest of the money is in the form of foregone wages (the incidence of the employer contribution for health insurance) and taxes for healthcare. This structure makes it hard for people individually or collectively to make decisions that tradeoff health amenities vs. the many other goods and services they desire; the Einav and Finkelstein plan would only compound this problem.

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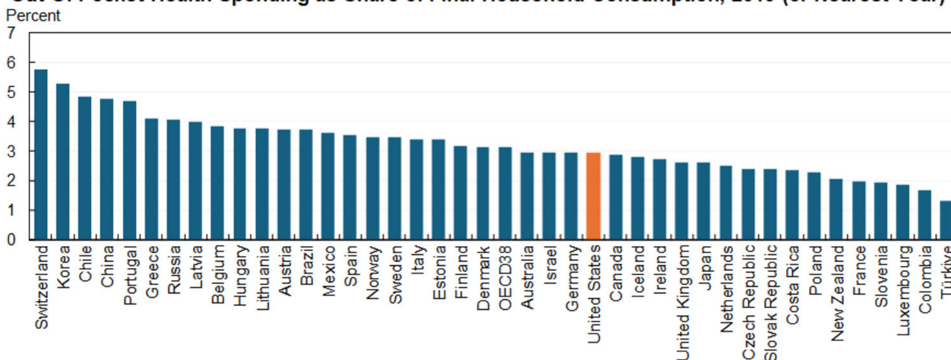

FIGURE 2 Out-of-pocket heatlh spending as share of final household consumption, 2021 (or nearest year). [Color figure can be viewed at wileyonlinelibrary.com]
Sources: OECD Health Statistics 2023 (see https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2023_7a7afb35-en); OECD National Accounts Database (see https://www.oecd.org/sdd/na/).

WHY SHOULD COST SHARING BE EITHER 0% OR 100%?

Perhaps most striking in the Einav and Finkelstein plan is their apostasy on cost sharing. The famous RAND Health Insurance experiment (Newhouse et al., 1993) found that cost sharing could reduce spending by 30% without any adverse impacts on health outcomes (notwithstanding the fact that people are not particularly rational about what care they cut back when they are faced with out-of-pocket payments). In various papers, together and separately, Einav and Finkelstein have confirmed these findings (e.g., Aron-Dine et al., 2013) and have increased the magnitudes because of the ways in which reduced exposure to health costs has affected the path of technological innovation and adoption (Finkelstein, 2007).

Einav and Finkelstein justify their shift as a consequence of designing a universal plan, noting that other countries with universal coverage do not have cost sharing or have complicated workarounds to avoid people who cannot afford it having to pay.

If I were completely convinced that their basic coverage approach would be sustainable and affordable, I might follow them to this same conclusion. But I would not want to drop any proven tools for reducing costs without worsening outcomes. Moreover, their discussions of the experience of other countries feels like adding a political constraint to their optimization exercise, something they eschew in developing their overall approach.

Cost sharing is, if anything, a slightly bigger part of the health system in other countries. Americans paid 2.8% of medical costs out of pocket in (or near) 2021, slightly below the median and mean for OECD countries, as shown in Figure 2. Much of the out-of-pocket payments in other countries were for spending that is not covered by the basic plan. But that is not a reasonable objection to including it in the basic plan they propose. It is hard to imagine that the optimally designed health plan would have 0% cost sharing for some items and 100% cost sharing for everything else without anything intermediate between the two. It is especially hard to imagine this makes sense if you think that it will be difficult or impossible to limit the scope of the 0% cost sharing components in the basic plan.

Of course, you cannot have cost sharing for essential health services for people that cannot afford it. But there is a well understood solution to that problem, income-related cost sharing as originally proposed by Feldstein (1971), which is to relate the magnitude of cost sharing to a household's income, something that is optimal given that under normal risk aversion the cost of the risk associated with a given amount of cost sharing goes down as incomes rise, making it more optimal to have lower premiums and higher cost sharing as incomes rise. Furman (2007) proposed a plan that limited cost sharing to 7.5% of income for typical households with no cost sharing for low-income households,

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finding that it "could reduce total health spending by 13 to 30 percent, reducing premiums by 22 to 34 percent without hurting health outcomes" (p. 2). There are administrative obstacles and complications to implementing this in practice, but the benefits are large enough that it is worth trying to address them. And, in fact, the ACA included Cost Sharing Reductions (CSR) for households with incomes between 100% and 250% of poverty that are enrolled in marketplace plans.

HEALTH REFORM AS A PROCESS NOT AN END POINT

One thing I learned from working on the ACA was that no one had all or even most of the answers, especially when it comes to delivery system reform—a topic that is beyond the scope of Einav and Finkelstein's book. The answer is to take more seriously how to put in place systems and processes that can discover better answers over time, not simply assume that one knows them in advance—let alone knowing whether they will be politically or socially sustainable.

The classic process is a market which in a very wide range of domains effectively ensures allocative and productive efficiency as well as innovation. A free market in healthcare will not work due to pervasive market failures including adverse selection, moral hazard, monopoly power, and many more issues.

But it is also wrong to ignore the fallibility of government or the people that implement its policies either. Medicare is a poorly designed insurance plan that would not even qualify as insurance under the ACA mandate because of its unlimited cost sharing (despite having first dollar coverage for many services), as a result it is basically unusable as a sole insurance plan—with 90% of beneficiaries supplementing it with something else. It took the federal government decades to add a prescription drug benefit to Medicare, an omission that would have driven any private insurer out of business. And even when government plans have come in under cost, like the prescription drug benefit, a big part was because of innovations that were unanticipated or underestimated by the creators of these plans, like tiered formularies for prescription drugs.

I do not know the answer, but it should involve some of what is best about markets while remedying what is worst about them, which is something the ACA tried to do with the marketplace and insurance reforms. It also needs to do what is best about the government while building in a process of innovation and change, something like the Center of Medicare and Medicaid Innovation Center. And the most vexing issues in healthcare are how to balance its cost against the many other desires and priorities people have—so a mechanism that makes costs and tradeoffs more transparent is essential to ensuring the competition and innovation process will lead to better results over time.

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