Journal of Law and Health

Volume 23 | Issue 2 Symposium

2010

Form & Reform: The Economic Realities of the United States Healthcare System

Mark Votruba
Case Western Reserve University

FORM & REFORM: THE ECONOMIC REALITIES OF THE UNITED STATES HEALTHCARE SYSTEM

MR. STEIGER:

Good afternoon, everybody. My name is Eric Steiger, I'm one of the editors-in-chief from the Journal of Law and Health. And I'm happy to welcome all of you to the second speaker event in the 2009/2010 Journal of Law and Health Speaker Series. Thank you all for coming.

Now, I know that the news last week was dominated by the story of Sandra Bullock's breakup; however, some of you might have noticed that a small piece of minor legislation also got passed through Congress last week And you also might have noticed that it wasn't quite as full of bipartisan support as it otherwise might have been. And so, the real question: Could it have been? What would such legislation have looked like? And what's the real difference between that and what we have now? And in order to help us answer that question, we have Professor Mark Votruba from Case Western Reserve's Weatherhead School of Management with us.

Professor Votruba has written on the allocation of medical resources, incentives for care, insurance markets, the effects of plant closings on communities, parental job loss and the link between divorced non-resident fathers' proximity and children's long-run outcomes. He has a Ph.D from Princeton University, and we're proud to have him here today. Everybody please give a warm welcome to Professor Mark Votruba.

PROFESSOR VOTRUBA:

I'll start by echoing Eric's sentiment that I was as surprised as anybody to see how quickly the healthcare reform debate came to a conclusion. Certainly, when Eric and I started exchanging e-mails about what I might talk about today, this wasn't the anticipated title for my talk. I originally thought the title of my talk was going to be "*Is* There a Bipartisan Solution for Healthcare Reform?" not "*Was* There a Bipartisan Solution for Healthcare Reform?" Given everything that happened in the weeks preceding the resolution – the Democrats losing their 60-seat super-majority in the Senate and the apparent lack of trust between House and Senate Democrats – the Democrats appeared unable to resolve the differences between the House and Senate versions of legislation. I assumed we would still be discussing the *possibility* of large-scale reform. Then, suddenly, the Democrats agreed to resolve their

differences and found a legal means for passing the legislation without any Republican support. And here we are.

But I still think it is worth asking the question: was a bipartisan solution possible? I think the question is still relevant because understanding how a bipartisan solution might have been achieved might help us focus on issues that are going to get in the way of having productive public conversations in the future. And so, I hope that you will still find some value in this talk.

What I want to talk about is not necessarily the positives or the negatives of what happened, but instead I'd like to reflect on the way that it happened, and especially the fact that reform was passed without any support from Republicans. This was a major piece of legislation, where we normally would have expected the kind of bipartisan compromises represented in other landmark pieces of social legislation. In the last century of U.S. history, all major pieces of social legislation have been passed with broad bipartisan support, including Medicare and Medicaid, the Social Security Act, and the Civil Rights Act. Shouldn't this have been the case for healthcare reform? Shouldn't a bipartisan compromise of some sort been possible?

Certainly many people believe so. For instance, the following quote is from William Pewen, a former senior health policy advisor to Republican Olympia Snowe:

> Three in four Americans say the health care system needs to be overhauled, and many provisions in the pending legislation have strong support. What's more, the core of the Senate's legislation closely resembles the very bill the Republicans offered in 1993 as an alternative to the Clinton plan. This makes clear that bipartisan reform was achievable, and indicts Congress for its failure to realize that goal with broad public support.[1]

I think this is an especially interesting comment coming from a Republican, who states plainly that the current reform legislation was essentially a modified version of the counter-proposal the Republicans offered in 1993. It also indicts Congress for not being able to achieve a broad bipartisan consensus on reform legislation.

This is another quote along the same lines from Republican David Frum. Some of you might have seen this since it's gotten a lot of attention in the press. This was from his article entitled "Waterloo," which was very critical of the Republicans for the way they handled themselves in the legislation process.

> Could a deal have been reached? Who knows? But we do know that the gap between this plan and traditional Republican ideas is not very big. The Obama plan has a broad family resemblance to Mitt Romney's Massachusetts plan. It builds on ideas developed at the Heritage Foundation in the early 1990s that formed the basis for Republican counter-proposals to Clintoncare in 1993-1994.[2]

---

[1] William F. Pewen, Op-Ed, *The Healthcare Letdown*, N.Y. TIMES, March 16, 2010, *available at:* http://www.nytimes.com /2010/03/16/opinion/16pewen/html (last visited May 13, 2010).

[2] David Frum, Waterloo, http://www.frumforum.com/waterloo (last visited May 13, 2010).

This reflects the same sort of sentiment as the earlier quote. Obama put it more succinctly when he held his healthcare reform summit a couple weeks ago. He said: "We agree on 80% of the issues."[3] This might be an exaggeration, but in light of the earlier quotes from Republicans, I don't think it exaggerates by much. A little later, I'll be more precise about why I don't think this is much of an exaggeration.

Before turning to that, I want to briefly address the issue about whether the lack of bipartisanship should really matter to us. I hope that most people will agree that it does matter because I'm not going to argue the point for very long. I tend to believe that both parties suffer from their own deficiencies as far as promoting extreme opinions and ignoring concerns from the other side. The legislative process is almost certainly improved when Congressmen of different political parties, with different priorities and perspectives, are able to work together.

A second quote from William Pewen, who's the adviser to Ms. Snowe, captures the potential problem when only one party is forwarding a piece of legislation and is trying to do it with a very slim majority. "Ultimately, Democrats decided to pass their bill with no Republican support, sacrificing bipartisanship and empowering every Democratic senator to seek inappropriate concessions."[4] We saw the fallout from this sort of behavior in things like the Cornhusker Kickback, where the Senator from Nebraska was able to cut a special deal for his state. It's not surprising to an economist that these things happen when a vote is going to be close and you're a Senator who represents a key vote on a piece of legislation. You're obviously going to be able to demand special concessions for your constituents, and a lot of senators will do just that.

A similar quote comes from David Frum again:

> "Barack Obama badly wanted Republican votes for his plan. Would we have leveraged his desire to align the plan more closely with conservative views? To finance it without redistributive taxes on productive enterprise - without weighing so heavily on small business - without expanding Medicaid? Too late now. They are all the law."[5]

What he's suggesting here is that there was a possibility the Republicans could have engaged in the process a little more and perhaps turned the legislation into something better.

The second thing that concerns me about the lack of bipartisanship is that it certainly led to an ugly and combative legislation process. As a result, it may have significantly undermined prospects for future compromises on other types of legislation that we need to enact in the future.

The first point I would make about this is that healthcare reform is not ending with this bill; it's rather the start of something, and it's going to be an evolutionary process, especially as far as cost containment goes. I suspect we'll be talking about cost containment in healthcare for as long as we're all alive because the cost of healthcare is inevitably going to rise and we're constantly going to face difficult

---

[3] Barack Obama, President, United States of America, Speech to joint session of Congress addressing Health Care Reform Plans, September 9, 2009.

[4] Pewen, *supra* note 1.

[5] Frum, *supra* note 2.

social questions about how we finance that care, and especially how we finance it for people who can't afford to finance it for themselves.

The second point I would make is that, going forward, it's hard to imagine Congress forging the type of bipartisan consensus that will be necessary to address the long-term fiscal problems facing the federal government. Most people are probably aware that the budgetary outlook for the federal government looks terrible. Taxes are going to go up, and spending is going to get cut, and we're going to have to make tough decisions about how those things are going to happen. I tend to believe that we're going to make smarter decisions with respect to those questions if we're all working together -- if we don't shell ourselves off into our ideological cocoons and if political opponents can discuss these problems with one another in an honest way.

I. GENERAL PROBLEMS WITH U.S. HEALTHCARE

Now I'd like to turn to some "general consensus" issues – problems in the U.S. health care system that most everyone is aware of. First, everyone basically knows about our excessive health care spending. We spend about two times more per capita than what is spent in other developed countries. There's also widespread overuse of care that sometimes has questionable value for producing better outcomes. This is well-documented in medical literature: the over-use of angioplasty and stents, back surgeries on people that shouldn't have them, too many orthopedic surgeries, and we probably use advanced technologies for scanning to a much higher degree than we need to.

A second problem is that Medicare and Medicaid are financially unstable because healthcare costs are rising faster than the rate of productivity growth. As a result, the increase in tax revenues can't keep up with the increased spending on these programs. So something has to be done to contain those costs.

We also know the system is plagued by uneven quality, and not just across regions of the country, but within regions as well. There's dramatic differences in the quality of care patients receive from different practices. Quality problems are especially pronounced for people who suffer from chronic illnesses, who might see seven or eight different specialists on a regular basis. These patients are facing a system where the doctors who treat them probably have little or no relationship with each other, they don't share electronic medical records, and they don't have any way to coordinate their activities. It's the worst way we could possibly care for people who have chronic illnesses, but it's become embedded in our healthcare system.

The last "general consensus" problem has to do with affordability and access issues, especially in the non-group market where individuals who don't have coverage through their employer have to search for coverage on their own. I will especially focus on problems in the non-group market because this is where a large part of the healthcare reforms actually apply.

Those suffering the greatest disadvantage in the non-group market are persons with pre-existing conditions (PECs). Insurers have no interest in covering people for a premium that is less that the expected cost of covering them. It should be no surprise that insurers will charge higher premiums to persons with pre-existing conditions, or deny them coverage altogether. They are not running charities. A consequence of this it that persons most in need of care are often unable to afford coverage.

Directly related to this, premiums in the non-group market will rise dramatically, or insurers will discontinue coverage, if a policyholder develops a problem that

increases costs over the long term. As a result, insurance in the non-group market does not provide very good insurance against health-related costs, except for the *short-term* costs. For instance, it doesn't provide much insurance against the risk of having cancer and becoming a cancer survivor because cancer survivors have higher expected costs. The insurers are going to want to charge cancer survivors much higher premiums for their higher expected costs going forward. Insurance in this market can provide protection against the short-term costs associated with getting cancer, but doesn't provide protection against the long-term costs of being a cancer survivor. This is a deficient form of insurance, which is intended to shield us from the cost of being afflicted with health problems, but is only able to shield us from the short-term cost.

Now people are concerned about high premiums throughout the insurance market, and not just in the non-group market. Everyone is opposed to high premiums, but these mostly reflect the fact that healthcare spending is so high. Insurers much charge a premium that's going to be sufficient to cover the costs that they eventually incur on behalf of their policyholders. As health care spending rises, so does health insurance premiums, and we shouldn't expect otherwise.

But the non-group market is also special in this regard since premiums in this market are also inflated by excessive overhead -- all the dollars that get eaten up in administrative costs and profits and the various other things that insurers have to spend money on other than financing health care. In the non-group market, about 70 cents of every premium dollar actually goes to finance care, with the rest absorbed as "insurance overhead." Looking at why premiums so high, this is something we ought to focus on -- it suggests that up to 30 cents of every premium dollar might be shifted from overhead expenses towards lower premiums or better care.[6]

I want to break these numbers down a bit because this is the type of data that I think should matter a great deal but probably had no influence on the healthcare

[6] Milliman Consulting Group (2006) for the *Council for Affordable Health Insurance*

	Nongroup Market	**Large Group Market**
Total Overhead	30%	12.5%
Eligibility, enrollment, claims	10.5%	7%
Marketing, total	14.5%	2%
Commissions	12.5%	1%
Profit	3%	2.5%

reform debate. The following table breaks down the overhead costs for different types of insurance plans. The first column reports average overhead costs in the non-group market, where individuals are out there shopping for insurance for themselves, not obtaining it through an employer. The second column reports averages for the large group market – the setting where workers obtain insurance that's offered through their employer. You'll notice big differences here. First, in terms of total overhead, 30 percent of every premium dollar goes to overheard in the non-group market compared to 12 and a half percent in the large group market.

Where does this difference come from? From the political rhetoric, you might expect it comes from differences in profit, and that's absolutely wrong. If you look at the bottom line, the profits in both of these markets are actually quite slim; they're about what you see in the rest of the financial industry. In the non-group market, profits are in the margin of 3 percent or so; in the large group market, they're about 2 and a half percent. Even if you got rid of these profits altogether, you're barely cutting the premiums, right? You're only cutting premiums by 3 percent.

Where do the differences lie? To a small extent, they lie in the fact that the non-group market has much more turnover, so there's constantly people flowing in and out of plans, which imposes a cost on insurers who have to keep track of who's enrolling and who's dis-enrolling from their plans. That's part of what's going on.

The biggest part of the difference in overhead, though, has to do with marketing expenses, especially commissioner fees to insurance brokers. If you look at the numbers, commissions jump out as the most noticeable difference where 12 and a half percent of the premium dollars are spent on commissions in the non-group market, and only 1 percent in the large group market. So, I just want to reflect on these numbers for a bit because most of you probably haven't seen them and because they received virtually no attention in the political debate.

First, I want to say something about the Republicans. Some Republicans suggest that the problem of too-high premiums in the non-group market could be fixed through interstate insurance competition. This argument has an economic logic to it and it fits a standard economic model that Congress is comfortable with, which is the monopoly pricing model. If an insurer has monopoly power, it allows the insurer to raise premiums without losing much business to competitors. We expect insurers will take advantage of monopoly power by raising premiums in order to increase profits.

Theoretically, this story sounds sensible, right? It just doesn't match up with the data. Because if the problem was that insurers were taking huge profits by exploiting monopoly power, it ought to show up in these profit numbers. But it doesn't.

On the Democratic side, the Democrats primarily marketed reform by railing against evil insurers. But again, if you look at the numbers and ask what contributes to higher premiums, it's not coming from excessive profits. I'm not here as a spokesperson for the insurance agency. I just want to say that, when I look at these numbers, it doesn't occur to me that the problem is that insurers are taking too much in profits. What does occur to me, as a economist who looks at these kinds of numbers, is that higher premiums in the non-group market primarily reflect higher marketing expenses, especially commissions; not higher profits. And excessive marketing for an economist indicates a different sort of problem than the standard "market power" argument.

When you see high commissions like this in a market, what it reflects to an economist is a market where people have great difficulty shopping for health plans;

and most of us can imagine that this is probably true. Health policies are very complicated things. Insurance contracts run for hundreds of pages. There are all these differences across plans in terms of what's covered, what are the deductibles and co-pays, what is the composition of the network, how are drugs covered, is there a possibility that certain claims are going to be denied by my insurer, et cetera. The list goes on and on. These are complicated products which means it's hard for individuals to compare the value that they receive from different insurance options.

This is the type of market where economists expect people to have a hard time finding the right policy -- what's the policy that's best for me? Economists have a term that we use to describe these kinds of problems; we refer to it as "search frictions." "Search frictions" are just a shorthanded way of saying we don't expect consumers in this market to have an easy time finding the policy that's best for them. As a result, they are going to be more heavily influenced by how plans are marketed, and they are also going to rely heavily on other people. They're going to rely on intermediaries to help them make their decision about what health plan to buy; these intermediaries are insurance brokers. At the same time, brokers have to worry about where their money is coming from, and they're receiving commissions from the insurers in order to promote their policies.

So, in this sort of market, we have a very hard time believing that people are always going to find their way to the highest-valued plan. And instead of competing on value – since insurers know consumers can't measure the value of different plant very well -- they're going to compete on their marketing efforts; their going to compete by jacking up the commissions that they offer brokers to sell their policies. Now, that's a story that actually fits with the data; not the stories about evil insurers, but the fact that the marketing expenses are being driven by search frictions in this market.

II. TWO PROPOSITIONS ABOUT THE PLAN

That was intended to give you one example where I'm concerned that the policy debate got disconnected from reality and where some fairly simple numbers might have helped inform the discussion in a positive way. For the rest of my talk, I want to concentrate on two propositions. I'm not sure everyone is going to agree with these propositions, but I'm going to try and convince you of them anyway.

The first proposition is this. Despite Republican rhetoric about the *entirety* of the Democratic legislation -- the fiscal concerns and the "government takeover" sort of arguments – I would argue that most of the individual components are not very controversial; at least not controversial to health policy experts, including conservative health policy experts.

The true disagreement – and this is my second proposition -- the true disagreement was over the extent of redistribution that was embodied in the legislation and the mechanism that the Democrats designed to ensure that persons with pre-existing conditions were treated with parity in the insurance market, meaning that persons with a pre-existing conditions couldn't be denied coverage and would be charged the same premiums as everybody else.

I'm going to now discuss the different components in the reform legislation, but only very broadly, because we don't have time to go into detail about all the components of the legislation. As the opponents like to say, the legislation is 2,400 pages long, and I'm happy to take questions about the specifics at the end. But I do want to focus on the broad components of the legislation to identify where I think

there is broad agreement, at least agreement in terms of what the legislation is intended to do. And then, I want to focus on where I think the real disagreements lie.

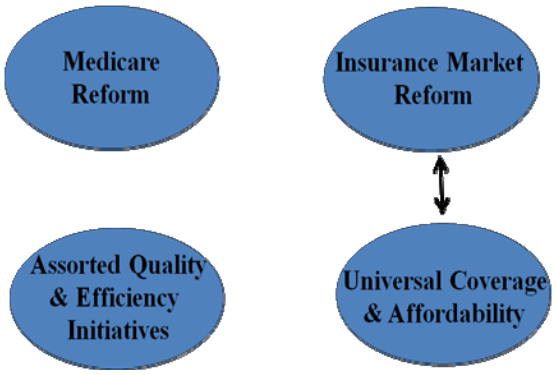
And the disagreements lie over on this (right) side of the picture,[7] not on this (left) side of the picture. This side of the picture involves things like Medicare reforms. What are we going to do to constrain spending in Medicare? What are ways that we can improve the benefits for Medicare beneficiaries? And then, there were an assortment of quality and efficiency initiatives that didn't get a whole lot of attention in the public debate, but actually most people who study these issues think are probably pretty good ideas.

On the other side is the whole set of things that have to do with the remaking of the insurance market, but really the remaking of the individual insurance market. These things have been tied together because the steps that the Democrats take in order to improve the universality of coverage and to improve affordability are really tied into the measures they have for reforming the non-group health insurance market.

Now, you notice I only put arrows on the right side on this figure. The Obama administration and the Democrats are fond of saying that all these pieces fit together. I think that's a little bit of a sleight of hand. The pieces pertaining to affordability and insurance market reform do fit together. The pieces pertaining to Medicare reforms and the assorted quality and efficiency initiatives could each have been plucked out if one wanted. You'll see that when I show you what some of these pieces are. (I would also say that this discussion is not intended to be entirely comprehensive. This is just a summary of some of the major components in the legislation.)

---

[7] Main Components of Healthcare Reform (slide):



First, consider the Medicare changes.[8] There are some ways in which Medicare coverage will change. Eliminating the drug coverage donut hole for prescription drugs; everyone seems to be in favor of that. Another coverage item was to eliminate co-pays for preventative services; most Republicans could probably find a reason to support that as well.

On the payment side, there's going to be a change in the way that we pay for different sorts of services. Specifically, we're probably going to increase the relative payments for primary care services relative to specialty care services. That's based on the notion that, by over-paying for specialty care, we're actually encouraging doctors to do too much expensive, specialty care. I think most people would agree with that, including most Republicans. There's also a plan to reduce payments for potentially avoidable hospital re-admissions; I would say most everyone would agree with that. Why should we pay for hospitals more that do a bad job at making people well?

The next category of items is a bunch of things which don't get much attention, but are actually probably the most valuable things in the whole bill, which is a whole set of pilot programs that are going to be run by Medicare and Medicaid to test alternative pay mechanisms for how we pay doctors for the things that they do. These alternative payment mechanisms are the sorts of things that academics have been talking about for a long time but haven't found their way into actual policy.

8

Democratic Provisions: **Medicare Reforms**	**Republicans' position**
Coverage: eliminate drug coverage "donut hole"	Universal support
Coverage: eliminate copays for preventive services	Most support
Payments: increase relative payments for primary care vs. specialist care	Most support
Payments: reduce payments for potentially avoidable hospital re-admissions	Most support
Pilot programs: experiments testing alternative payment mechanisms (quality/efficiency incentives; "bundled" payments; reimbursing "medical homes")	Most support
Phase out subsidies for Medicare Advantage plans	Some support
Reduce fraud	Universal support
To extent reform increases insurance rates, can reduce DISPRO payments to providers	Universal support

And one of the reasons they haven't found their way into policy is because it's hard to know how to implement them. Let me give you one example. The best example I can give has to do with the bundling of services.

Currently, a diabetic, for instance, sees maybe seven or eight different specialists, as well as his primary care doctor. And all of those doctors who are involved in the patient's care are each separately getting paid for what they do for the patient on a fee-for-service basis. These fee-for-service payments encourage all the doctors to do as much as they can. It does not encourage them to coordinate that care, or to try to produce care that's more efficient in order to lower the cost. Why would they care about that? Well, they probably do care about making their patients healthier, but they also care about making money, and they make money from the services that they provide. Producing health more efficiently usually means making *less* money in a fee-for-service system.

So the idea behind bundling payments is that, instead of paying all these doctors individually for the individual things they do, the payments for diabetes care would be bundled so that the team of doctors involved in a patient's care would receive a single ("bundled") payment. And the team of doctors would be told, "Go and do the best that you can to take care of this patient. We're not going to pay you for each individual thing you do. You're going to get this fixed payment, and you're going to take care of this patient, and if you can find ways to do it at a lower cost, that's great, you can keep the savings." So, it's reversing the incentive from providing inefficient higher-cost care to providing efficient lower-cost care.

This is a great idea by economic standards; most economists would like to see the system move in this sort of direction. The problem is, we don't know how to get there. We don't exactly know how to define these bundles. And we don't always know if there's going to be somebody on the receiving end to accept these bundled payments because right now most doctors are operating in offices where they don't have arrangements with other doctors that would allow them to manage these kinds of bundled payments. So, we have to get there, and these pilot projects are a way of experimenting with this, to figure out how we can do it. So, hopefully these experiments will allow us to move in the right direction.

There's another part of Medicare reform, which is somewhat controversial, that has to do with the phasing out of the subsidies for Medicare Advantage plans. Some of these things – let me just go through some of these things and not talk about all of them in detail. Some Republicans would probably support reducing Medicare Advantage plan subsidiaries as a means of controlling Medicare costs since, currently, Medicare pays about 15 percent more to enroll someone in Medicare Advantage than when they remain in traditional Medicare. Maybe they wouldn't support eliminating the subsidies altogether, but this is the type of thing where there's obvious room for compromise.

Then there are things that policymakers always say they're going to do, like reducing fraud. So, there's a bunch of stuff about reducing fraud in the bill, and I was glad to see in the healthcare summit that everyone seemed to think that was a good idea. Of course, if reducing fraud is so easy and universally supported, one wonders why no one has done it before.

And the last thing where there's universal support is this: If we are able to reduce the amount of uninsured, then Medicare shouldn't have to pay as much in the way of DISPRO payments. DISPRO refers to "disproportionate share" payments. These are essentially special side payments that get paid to hospitals who care for a lot of

Medicaid and indigent patients. The reason why Medicare does this is because we know that there are some hospitals that have to provide a lot of charity care, and we don't want to finance that charity care directly, so instead we finance it indirectly by making these side payments to hospitals that have to take on a lot of these patients. If we increase the insurance rates, we should be able to reduce these payments.

On the quality and efficiency side,[9] I'll just discuss a couple of these, but I think you'll get the gist of it. For the most part, these things are not particularly controversial. I'd especially highlight the first one – the Center for Comparative Effectiveness -- because I think this one is the most important. It's also the one where it's most questionable whether Republicans would support it given their rhetoric during the debate.

The Center for Comparative Effectiveness is intended to serve as a clearinghouse for information related to the effectiveness of different kinds of treatments. It would exist basically as a body to provide information to doctors, insurers and patients about what treatments work best for which conditions.

Now, a very popular idea in policy circles is the idea of "value-based purchasing" – that we should pay more for things that work and pay less for things that we know don't work. It's hard to imagine how you get to world with value-based purchasing without having something like a Center for Comparative Effectiveness. It doesn't

---

9

Democratic Provisions: **Quality and Efficiency Initiatives**	**Republicans' position**
Center for Comparative Effectiveness: to conduct, support and synthesize research on outcomes, effectiveness and appropriateness of HC services	Some support
Center for Quality Improvement: to identify, evaluate, develop and implement best practices in HC delivery; develop quality metrics	Some support
Quality Reporting requirements (for nursing homes, hospitals, surgical centers)	Most support
Disclosure of financial arrangements between providers and technology developers	Most support
Develop national strategy to improve population health through evidence-based prevention/wellness programs	Most support
Reform GME funding to increase training of PCPs	Most support
Create standards for financial transactions to reduce administrative complexities	Most support

have to be this exactly, but you have to have some entity which everybody respects that's providing unbiased information about what works and what doesn't work. Otherwise, insurers are not going to be able to make judgments about what they should or should not pay for on the basis of how much value different sorts of treatments provide.

I think that the hard part about something like this is that when you think about how legislation gets scored – meaning the CBO has to figure out how much all this is going to cost -- something like the Center for Comparative Effectiveness is only going to show up as a cost when the CBO considers how expensive legislation is. When, in fact, a Center for Comparative Effectiveness could be a cost-saver, but we just don't know whether it will be a cost-saver, or how much. If done right, the Center ought to be delivering information to the market which allows the market to finance healthcare more rationally and hopefully claw back spending that doesn't contribute to better health outcomes.

I won't go into much detail about other things in the table due to the amount of time we have. But I would say that most of these things, perhaps with some tweaking, could have potentially drawn some Republican support.

So, my personal opinion on these sets of reforms is simply this. Even in today's strange political climate, I think reform legislation that only focused on these components (the Medicare reforms and quality/efficiency initiatives) should have been amendable to compromises that yielded broad bipartisan support. The costs of these items are relatively modest. They could have been trimmed if Republicans wanted; for instance, a smaller version of some of these things could have been negotiated. Beyond that, *not* doing some of these things, like the Medicare pilot projects and the Center for Comparative Effectiveness, it just seems to me would have been incredibly shortsighted, even if we can't predict the eventual cost savings.

If the Republicans had engaged in the process they might have even improved the legislation along these dimensions. For a while, there was some talk about replacing the Payment Advisory Commission in Medicare with an independent commission that would have had the power to implement value-based pricing for Medicare services. I think the Democrats weren't willing to go out on a limb on their own with this idea because it would probably take a lot of heat from the doctors and because it would have fed the rhetoric about "rationing." And so, this was pulled from legislation.

Another place where the Republicans might have improved the legislation has to do with the Medicare Advantage subsidies. Republicans have supported these subsidies because they like the idea that traditional Medicare should face some amount of competition from private insurers in that market. As an economist, I like that idea as well. The difficulty in this is that competition in the Medicare market doesn't work very well because traditional Medicare is able to pay very low prices relative to what private insurers have to pay to providers. And so, the playing field really isn't level between those two. This is the Republicans' main opposition for getting rid of the Medicare Advantage subsidies. They think the Medicare advantage subsidies are helping level the playing field.

Well, another solution to this problem is to get rid of the subsidies while leveling the playing field another way, which would be to create "price parity" so that Advantage plans don't have to pay higher prices than traditional Medicare. I think this have would have been a very productive direction for the debate about Medicare and Medicare Advantage, and about healthcare prices in general. If we had had

discussion, I think we might have ended up with a different piece of legislation since currently – and this is not necessarily well-known -- different insurers often pay vastly different prices to the exact same providers for the exact same services. This makes no economic sense at all, raises administrative costs dramatically and has equity implications as well.

Regardless, though, even if we did just these things, and if the GOP had engaged and improved the legislation along these lines that I'm suggesting, doing these things wouldn't have done much to address insurance affordability problems, especially not in the near term, and wouldn't have addressed the access problems in the poorly-functioning non-group market, which is where the other provisions come in. And this is where I think the major disagreement starts.

III. WHERE THE MAJOR DISAGREEMENT STARTS

The major disagreement, I believe, starts with the provisions that address shortcomings in the private insurance market, and this is where I think the potential for compromise got stymied. The objections that the Republicans offered are partly fiscal. And I don't want to diminish these concerns at all. We obviously face a serious budget shortfall in the federal government, and the legislation is probably going to worsen that situation despite the creative accounting by Democrats where they presume certain future cuts are going to happen to Medicare payment rates, which likely will not happen. But I'll recite what some of these concerns are.

Obviously these are the provisions which are the most expensive in the bill. The provisions that address insurance affordability and reform the insurance market comprise about 70 percent of the total cost of the bill. And the cost of these provisions -- in case anyone is surprised to find this out, they shouldn't be -- the cost of these provisions is directly tied to the magnitude of the help the Democratic legislation provides to the families with trouble affording premiums and to persons who have pre-existing conditions. Regardless of how it's done, providing meaningful help to these groups is going to be expensive because insurance is expensive.

When we started this process, I don't think we ever had an honest discussion about this, that if we want to achieve anything approaching universal coverage, it's going to cost a lot of money because insurance costs a lot of money. And a large section of the group, roughly a third of the group that doesn't have insurance, are people that have pre-existing conditions, and it's going to be even more costly to extend coverage to them.

Here is where the Democratic provisions lie in these sorts of issues, and the Republicans' position as I see it.[10] The first thing that the Democrats were shooting for -- because they didn't want to scare the hell out of everybody -- is they wanted to leave the group insurance market largely unaffected. That's because 90 percent of the people with private insurance get it through their employer, and those people didn't want their existing situation to be threatened.

I'd judge the Republicans to be schizophrenic on the question of whether to leave the employer group market largely unchanged. At some points in the debate, they've been critical of reform legislation as changing too much, too fast. But how could reform be "too big" of a change if you're leaving 90 percent of the market untouched? On the other hand, many of the proposals that Republicans have suggested would actually lead to a gradual undoing of the employer-based market, by de-coupling employment for insurance. This would be a far more radical change than what the Democrats were proposing, at least as far as how many people would be affected. The Democrats didn't want to run into that problem, so they tried to avoid affecting the group insurance market as much as possible.

A big part of the costs have to do with the Medicaid eligibility expansion. Currently, a family's income has to be under the federal poverty line (FPL) to be eligible for Medicaid, and that threshold is going to be raised to 133 percent of the

---

10

Democratic Provisions: Access/Affordability/Market Reforms	**Republicans' position**
Group insurance market would be largely unaffected	Schizophrenic
Medicaid eligibility expansions	Oppose on cost grounds, potential compromise
Establishment of state-run "Health Insurance Exchanges" to replace current individual insurance market	Most support
Subsidies for lower income persons in the Exchange	Oppose on cost grounds, potential compromise
Prohibit Exchange insurers from charging higher premiums, denying coverage for PECs	Schizophrenic
Regulate minimum coverage standards for policies offered on Exchange	Oppose, "government takeover"
Individual mandates: penalties for non-coverage; individual coverage *must* be bought on Exchange	Oppose, "government takeover"

FPL. Republicans, for the most part, oppose this on cost grounds, but I think there was probably a potential compromise here. Many Republicans probably would have accepted some expansion of Medicaid; probably not the expansion of the size that the Democrats went after, but something.

The third major component of reform in this area is the establishment of the Health Insurance Exchanges, which would replace the current individual insurance market. You might not know from the dialogue that we've had, but most Republicans support the idea of Health Insurance Exchanges, based on previous Republican proposals. Republicans also supported the Exchange concept as the basis for the Medicare prescription drug bill. So, the idea of an Exchange is not radical, and most people know it's a good idea. It makes it easier for consumers to find the policy that's best for them.

The fourth component has to do with subsidies for lower income persons in the Exchange. Again, we have a problem with the cost of this because this is, again, a very costly part of the legislation. But I think it's also a part where compromises were possible. So, the Democrats might want a little more help with the poor, the Republicans might want a little bit less. Let them fight over it and come to some solution in middle.

Then there's the provision to prohibit Exchange insurers from charging higher premiums or denying coverage for people with pre-existing conditions. Here again, I think Republicans are a little bit schizophrenic. Early in the debate, everyone was saying that insurers should treat everybody "fairly" regardless of pre-existing conditions. By the end of the debate, Republicans were not saying that much. So, I think their tone on this changed, though I do think Republicans share the concern that there needs to be better equity as far as the affordability of insurance for different sorts of people, though perhaps to a weaker extent than the Democrats.

From here, we move into the territory where the party differences get harder to bridge. For instance, regulating minimum coverage standards for policies offered on Exchange. This is generally opposed by Republicans on the notion that this is a government takeover. Why do we need the government intruding on what sorts of insurance that we buy? And then, we have the mandates -- penalties for individuals who don't obtain coverage. Individuals who do buy coverage on their own are also forced to but that coverage through the government's Exchange. This also feels like a government takeover in some sense because it's basically shutting down the private, independent market for individual insurance and saying everybody without employer group coverage now has to buy their insurance through a state-run market. So, if you're concerned about extensive government influence in the market, as many Republicans are, certainly this would be the type of thing that would bother you.

Unlike the other provisions that we discussed earlier -- things having to do with Medicare and the efficiency and quality initiatives -- once we get into these areas, it's harder to imagine bipartisan compromises where we could find some sort of agreement across the two parties. The Republicans and Democrats *could* conceivably compromise on the cost aspect of these provisions. For instance: How much help do we really want the federal government to provide to people who have low income and have trouble affording insurance? This is a question that we could debate, but is also the type of question where compromises should be possible.

IV. PRE-EXISTING CONDITIONS

However, the way the Democratic plan aims to help people with pre-existing conditions, by prohibiting insurers from charging them more or denying them coverage, stymied possible compromises because it necessitated the other provisions the Republicans find most objectionable.

Let me tell you how this works by way of a quote that Peggy Noonan provided in a column she wrote for the *New York Times.* Peggy Noonan is someone you probably know as a speechwriter for President Reagan and President Bush. I'd suggest here that she should stick to writing speeches for reasons that will become clear. This is a quote from her column:

> The public in 2009 would have been happy to see a simple bill that mandated insurance companies offer coverage without respect to previous medical conditions. The administration could have had that, and the victory of it, last winter.[11]

If the administration had followed this advice, maybe they could have passed the legislation, but it would have been a disaster because it would have led to what economists call a "premium death spiral," and it would have led to higher uninsurance rates. Here's how that would work out:

First, if you tell insurers that they can't deny coverage to people with pre-existing conditions, the risk pool of people with insurance coverage has to worsen. You're bringing everybody with pre-existing conditions into the marketplace, and you're giving them deeply-discounted premiums, so they're going to want to buy insurance in that market. As premiums rise, people who don't have pre-existing conditions are going to find insurance less desirable because their coverage is no better than it was before. That means healthy policyholders are going to have an incentive to drop their coverage in order to avoid paying high premiums that indirectly subsidize the premiums for people with pre-existing conditions.

On top of that, healthy people have another incentive to forego coverage because they know that, if a health problem does emerge, they'll be able to receive the same sorts of benefits that other people with pre-existing conditions have. They'll be able to enter the market whenever they want at the same fixed rates that everybody else is receiving.

So, the distributional implications for this kind of policy is that persons with pre-existing conditions would be better off, with better access to insurance at lower prices than the market is currently giving them. But the cost to healthy people in the individual market would have been very high, and many of them would have ended up foregoing insurance as a result.

If you start with the notion that insurers have to charge the same premiums to everybody, the only way to avoid a premium death spiral is to layer on additional provisions. And that's what the legislation does – it layers on additional provisions. If the goal is to have insurers charge everyone the same rates, these provisions make sense. If you don't think that's the right goal, of course, then none of these provisions make sense. But in the context of that goal, they do make sense.

---

[11] Peggy Noonan, Op-Ed, *The Risk of Catastrophic Victory*, N.Y. TIMES, January 7, 2010, *available at*: http://online.wsj.com/article/SB10001424052748704130904574644701673362182.html (last visited May 15, 2010).

If you're going to make insurers charge everybody the same rates and you're worried about healthy people dropping out of the market, then one of things you end up doing is having a mandate for individuals to obtain coverage because you want to do something to induce healthy people to remain in coverage. And so, you end up having penalties for individuals who decide to forego coverage.

If you're going to have mandates for individuals to have coverage, there's no way to avoid the fact that you have to define what you mean by "coverage." That means, you have to define what the minimal level of coverage is going to be. There's no avoiding this.

If you're going to have these mandates for individual coverage and you're trying to make these cross-subsidies occur through the Exchange, then you can't let the healthy consumers obtain their coverage outside of the Exchange. If healthy consumers can leave the Exchange, they will want to buy insurance from someone outside of the Exchange who only sells policies to healthy people. Again, the whole object here was to get healthy people to cross-subsidize premiums for people with pre-existing conditions, so you have to force them in the same insurance pools. That means forcing everyone to purchase insurance through the Exchange.

Now, you can't just force everybody to buy coverage. There's also the problem that some people are going to have trouble affording coverage. Affordability is already a problem, and it's going to become an even bigger problem as premiums rise. And so, in order to address this concern, whatever subsidies you might have intended for low-income consumers now have to be even larger to make the individual mandate politically palatable to everyone.

So now we're in a market where there is an individual mandate and individual subsidies (that are quite large) in the non-group market. Well, if individuals can get rather large subsidies in the non-group market, then employers begin to scratch their heads and say, "Why are we bothering to offer insurance? Our employees might do better if we let them go to the private insurance market where the government is going to give them these subsidies." Now we've created this incentive where employers might not want to keep offering insurance, and one of the goals of the Democrats was not to disrupt the employer provision of insurance too much.

In response to that, we then have to layer on the employer mandate provisions -- penalties for employers who don’t contribute to the healthcare of their employees to offset the fact that employers now feel less compelled to offer coverage.

Now we have these employer mandates, which raises a concern because some firms are small, they can't afford to offer coverage, and we don't want to penalize these firms too much or drive them out of business. So what do we do? We end up needing more subsidies, targeted to the small employers because we're worried about the economic impact of the employer mandate.

In light of the Democratic objectives, which was increasing insurance rates and achieving premium parity for people with pre-existing conditions, this set of provisions, while complicated, makes sense because they all hang together in a certain way. And they hang together in a way that seems to be attractive to a lot of people, as experts on both sides of the political spectrum have written favorably about other systems that employ this configuration of provisions.

There are similar types of systems that work well, in Switzerland and the Netherlands, for instance. The conservative professor at Harvard Business School, Regina Herzlinger, has written very affectionately about these kinds of systems as models that the U.S. should perhaps try to emulate. A similar system was

implemented through bipartisan compromise in Massachusetts with the support of Republican Mitt Romney, who was the governor at the time. Robert Moffitt of the Heritage Foundation is a conservative economist who has advocated a similar set of ideas. And then, as I mentioned earlier, a similar system was proposed by Republicans to counter Clinton's earlier healthcare reform proposal. Which is all just to say that these are not radical provisions out of left field.

But the provisions also leave little room for compromise, and among these provisions are ones the GOP finds most objectionable. It's hard to compromise on an individual mandate, an employer mandate, the government takeover of the non-group insurance market and the high cost associated with high subsidies because these pieces are all hanging together.

V. CONCLUSION

The last question I want to pose is whether there was a way out. And I think there was a way out, but it would have required Democrats to reconsider what it really was that they were hoping to achieve. Was their goal to have insurers offer everyone insurance at the same premium regardless of pre-existing conditions? Was that *really* their goal? Or was the *real* goal to have a system where insurance was equally affordable regardless of someone's pre-existing conditions.

These might sound like the same thing, but they're not, because the first one suggests that we want to tell insurers to operate against their self-interest. We want to tell insurers that they have to offer policies at money-losing rates when somebody with a pre-existing condition approaches them for coverage. The second one says: We can let insurers charge whatever they like. We don't have to intervene in how the market prices insurance for different individuals. But if we don't like the outcome, if we don't like the fact that people with pre-existing conditions are being charged more, then we have another option, which is to help them out by subsidizing their premiums directly with government subsidies. This is the other approach. This is the potential compromise I think existed but the Democrats never offered. It is a compromise that might have left some room for both sides to find their way to a middle ground.

When I think about the compromises that might have been possible, I want to start with a counter-proposal, specifically, the counter-proposal that was embodied in the Boehner amendment offered in the House.[12] What Boehner proposed was that we would help people with pre-existing conditions by expanding the use of high-risk insurance pools with a modest increase in federal funding for those pools.

So what are these high-risk pools? Some of you have probably heard of these before. We don't have a high-risk pool in Ohio, but most states do. High-risk pools currently exist in 34 states. They serve about 200,000 people. These are insurance exchanges -- yes, exchanges -- set up by states to specifically serve people denied coverage because they have pre-existing conditions. Private insurers offer plans on these exchanges; participants get to choose which of the plans they want; and the state partly subsidizes their premiums. Some states also provide additional income-based subsidies. And the consensus about these high-risk pools is that, for what they're designed to do, they work reasonably well, but are severely under-funded.

---

[12] *See* H.AMDT.510 to H.R.3962, 111th Congress (2009).

This matters because the amount of help that a high-risk pool can provide to persons with pre-existing conditions is going to be limited by the level of financing they receive. Due to the financial constraints on high-risk pools, several states have had to temporarily or permanently close their pools to new applicants. Even with the subsidies, many people have access to high-risk pools still can't afford the premiums. And the coverage that's available through these pools is generally much less than what people receive in other parts of the insurance market.

Here's some data that Hall and Moore put together from their analysis of high-risk pools in the State of Kansas.[13] If you look at the deductibles and co-pays that people in the high-risk pool face versus people in other types of plans, they're dramatically higher. For instance, the average deductible for people in Kansas's high-risk pool is $3,400.

As an economist, I'm not necessarily opposed to high-deductible policies. In fact, a lot of economists think that having people pay higher deductibles might be a good way of getting healthy consumers to be smarter consumers of health care and not consume things that have low value. On the other hand, I don't think you want people with pre-existing conditions to pay $3,400 deductibles since it's usually important for them to receive regular care, and a high deductible can prevent them from doing that. On top of that, even though the coverage is not very good, the premiums for plans in the high-risk pools are very high. In Kansas, they average $6,000 a year for a single individual, and this is for coverage that includes, on average, a $3,400 deductible.

So, what did the Boehner amendment aim to do with respect to this? First, it mandated that all states would run a high-risk pool. And the second thing that it would do is dedicate additional federal spending towards the premium subsidies in these pools; $15 billion over ten years. Plus, they included a provision that premiums would not exceed 150 percent of the average market premium.

The policy message of this proposal is pretty clear… I'm not saying this to be critical, I'm just stating a fact because the policy message here is clear. What the Republicans were saying is: We want to help people with pre-existing conditions, just not that much. They are certainly not talking about parity. They're not saying that people with pre-existing conditions should have equal affordability for insurance. They're okay with persons paying more, 50 percent more to be exact, than healthy policyholders for less complete coverage than healthy policyholders usually have. And, even then, the financing ensures that help will not be available for everybody who presumably qualifies.

---

[13] Jean Hall, Janice Moore, *Does High-Risk Pool Coverage Meet the Needs of People at Risk for Disability?* 45 INQUIRY 340, 348 (2008). Professor Vortruba referred to a slide highlighting that this study found:

> -mean deductible for plans obtained through Kansas's high-risk pool exceed $3400, compared with $250 for FEHBP plans
>
> -coinsurance rate for PPO (traditional) plans is 30% (50%), compared with 10% (25%) for FEHBP plans
>
> -mean premium (single-coverage) = $6000/year

The CBO estimates that expanding high-risk pools along these lines would reduce the number of insured by about 3 million people. Andrew Wilper, in prior research, estimates that around 11 million Americans without insurance have a chronic illness.[14] So, the GOP strategy would provide some degree of help to about 30 percent of them.

A. Areas for Possible Compromise

So, where could the Democrats have compromised? If they had stepped back and taken this proposal of Boehner's and said: You know what? Let's use this as a starting place; and see where can we work from here? And I think there are places that they could have done that. And they might have even ended up in a place that perhaps was not so far from their eventual bill. Though I think it would probably have provided less help to people with pre-existing conditions and people with low incomes.

The first compromise is: If an exchange is such a good idea and everyone agrees on it, there's no reason to just have an exchange jut for the high-risk pool. We ought to have an exchange for everyone and let insurers charge whatever they like to different people, and let market competition serve its usual role at constraining premiums. And then, we're going to provide subsidies to persons who have pre-existing conditions in order to achieve some level of equity as far as the affordability of insurance for people.

A second compromise the Democrats could have made, is they could have argued that the help they provided to people with pre-existing conditions with the Boehner amendment is too stingy. They could have said that the subsidies to persons with pre-existing conditions should be high enough to offset -- fully, not partly -- fully offset the higher premiums they face and those subsidies should be available to all persons with pre-existing conditions, not just 30 percent of them. This would obviously make the bill more expensive. But it was a potential compromise, and they could have argued over the exact details and seen where they ended up.

A third compromise the Democrats would have wanted to make had to do with the affordability problem for low-income workers who don't have group coverage, and who also are going to need some assistance if we're going to improve insurance rates among that population. So, they could have negotiated with the Republicans over the size of income-based subsidies, they could have negotiated over the size of expansions of Medicaid. These are places where people are expecting compromises to occur.

Then the fourth compromise is that the subsidies would also apply to employer coverage. One of the problems in the Democratic plan is that the income-based subsidy is only available in the non-group market, not if you get insurance through your employer. What that does is create this problem where some employers are going to find that it's in their interest to discontinue offering coverage. If the subsidies actually followed the workers so that they would still apply for employer-based coverage, they could have undone this problem.

---

[14]Andrew Wilper, *A National Study of Chronic Disease Prevalence and Access to Care in Uninsured U.S. Adults*, 149 ANNALS of INTERNAL MED. 170 (2008).

So, how would this compromise play out in the non-group market? Part of it we can't say, because we really don't know how the compromises would have turned out. But this is, roughly speaking, how I think we would have ended up.

The group market would still be largely unaffected. The non-group market would still benefit from the creation of an Exchange. Premiums in the non-group market would be higher for people with pre-existing conditions, but would be partially or fully offset by subsidies. There would be no requirement necessary for people to buy insurance through the Exchange. Everybody who was eligible for the subsidies would want to use the Exchange to obtain their subsidy. And everybody who's not eligible for subsidies would want to use the Exchange anyway because the rest of the non-group market functions terribly. And then, we could forego the individual mandate without creating a premium death spiral because we're not asking healthy policy holders to indirectly subsidize the policy holders with pre-existing conditions through higher premiums. And then, we could also forego the employer mandates because the individual subsidies would follow the workers who obtain their insurance through their employer.

In short, we would have still ended up providing substantial help to the same groups that the Democrats were trying to help. In theory, the amount of help could have been just as great as the Democrats actually achieved. It just would come at a higher federal cost because, unlike the Democratic plan where there are hidden taxes in the form of mandates, instead the government would instead be taking on those costs more fully themselves.

B. Final Thoughts

So, I'll just end with some final thoughts -- my impression of what just happened. I'm looking forward to seeing what questions come up on this. This is my interpretation of what happened, and I'm still trying to digest it.

First, I think the Democrats went for broke, and they nearly lost. They went for broke to establish insurance parity for people with pre-existing conditions, and to provide substantial assistance for low-income persons so they could afford to obtain insurance.

In response, the Republicans also went for broke because they don't deem these goals as being worth the cost -- not to the extent that the Democrats were trying to achieve there. These costs are ultimately borne by healthy and higher-earning taxpayers, and the Republicans tend to be less interested in this form of redistribution. But neither side was very honest about what the policy differences were really about.

And this is probably what bothers me the most in reflecting on what's happened over the last year. It’s that the policy disagreements here were mostly over the extent of redistribution, and we never really came to grips with that. The ideologues in both parties would rather talk about government takeovers or they'd rather talk about evil insurance companies instead of acknowledging that there are tradeoffs.

As a nation, I think we have an interest in trying to do our best for people at the bottom of the ladder, and we don't like to acknowledge that there are tradeoffs. If we're going to try to improve affordability for insurance for the poor, if we're going to try to increase insurance equity for people with pre-existing conditions, then it's going to cost the rest of us, and we need to be honest about that. And I don't think politicians are willing to be honest about that.

And the thing that worries me about that is that it doesn't bode well for the government being able to solve the long-term fiscal problems that we're still having. That's my reflection on things and I look forward to the conversation.

C. Questions From the Audience

MR. STEIGER:

Thank you, Professor. We now do have time for a few questions. Afterwards we will have a short reception.

MALE 1:

On the whole, I thought you gave an outstanding lecture and I wanted to congratulate you. I thought most of your points were really outstanding in an exceptionally complicated area. And I thought you simplified it as well as it could be out of the whatever -- 2,000 or whatever pages.

But I had a point to make that I think is what everybody -- they sometimes talk about it. But in my mind, since I ran emergency rooms for years and other healthcare centers, what is really going on here, when you talk about people with pre-existing conditions who do not have healthcare and the other "30 million people" in the United States who do not have health insurance/healthcare; and then, we talk about the cost associated with giving them health insurance and everybody is talking about a billion dollars here or 100 billion a year or a trillion, and they say, "Oh, woe is me. This country cannot afford it," and -- they do not understand at all what they're talking about. Because these people have, for years, gone to these emergency rooms at inappropriate times for inappropriate care that cost all of us in the United States much more than a trillion dollars.

And it's such foolishness the way Congress talks. A billion dollars to give these people health care so they can get pre-existing care so that they may be healthy at one time so they don't come into the emergency room with a stroke that costs -- or a heart attack that costs them a couple 100,000 or a million when they could have been taking the pills.

Can you just comment on that?

PROFESSOR VOTRUBA:

I agree with what you're saying. There's no doubt that the lack of insurance causes lots of people with pre-existing conditions to consume health care in the least efficient way.

MALE 1:

And much more expensively.

PROFESSOR VOTRUBA:

I don't disagree with that at all.

I wouldn't say that people don't talk about that at all. I think most people know that there's quite a bit of charity care that occurs in the system. And charity care is

ultimately financed by the rest of us. It amounts to somewhere around $3000 per uninsured person.

MALE 1:

Yeah, but it happens every day.

PROFESSOR VOTRUBA:

It happens every day. And that does reduce the cost. And actually, the extent that that reduces the cost of reform is in the reform to some extent. One of the ways that we're financing that charity care is through these DISPRO payments. Obviously, those are going to come down and those end up getting reflected in the savings in the bill.

MALE 1:

But it's pre-existing care. They give pre-existing conditions –

PROFESSOR VOTRUBA:

Ideally they'd be getting better care in better settings, hopefully improving the quality of the care they receive and lower costs. Absolutely.

MALE 2:

What was this public option and why was that such a bad idea?

PROFESSOR VOTRUBA:

So, the public option was the idea that the government would create a -- basically would be a generic policy that would exist in all insurance -- in all exchanges. All the state exchanges would have this generic public option, which would probably be fashioned after Medicare, and would just give everybody at least one additional option to what they already have.

Now, it's kind of an interesting thing, the failure of that. The Democrats were promoting the idea as increasing competition of the insurance market. And the one thing I'd say is that they didn't sell that idea to any economist because economists just recognize that as being bunk. Because you look at these numbers, and it doesn't strike any economist, these numbers here, as saying: "Oh yeah, adding another insurer is going to cut that profit by what? Maybe by a tiny amount, but this isn't where the savings lie." And so, throwing one more insurer into the market can't possibly have a big effect when the profits that are being taken are that low.

On the other hand, they really missed the boat on two sides. Because if the Democrats understood the notion of search frictions, they could have potentially sold the idea of the public option. Because one attractive idea of public option is that it wouldn't have to be public. It could be publically defined, but where primary insurers could run it. The point is that if there was one plan that everybody perfectly understands, if there was some benchmark option that everyone knows they have and

they understand its characteristics, then it reduces the search friction problem that I was referring to. The benefit of having this benchmark option for everyone is that plan with higher premiums would really have to justify to the consumer what additional value their plan provides. In a market that's plagued by search friction, having a benchmark option is really a smart economic solution to that problem. And nobody ever talks about that because it gets into sort of complicated issues about how markets actually function.

The bottom line is that there was an economic story to justify having a public option. The Democrats never even told that story, and instead told the story about evil insurers, and that story actually didn't sell, and it also sort of contributed to more of the "government takeover" kinds of concerns.

MR. STEIGER:

Thank you, Professor. And there's going to be a reception now. We're done. Thank you very much. A few other people we can thank are Laura Ray, our advisor for the Journal of Law and Health; David Genzen in the automation staff; and the entire staff of editors and associates at the Journal, without whom we couldn't have done this. Thank you all very much for coming.