CHAPTER 4

The Importance of Health and Health Care

The American health care system is an engine for innovation that develops and broadly disseminates advanced, life-enhancing treatments and offers a wide set of choices for consumers of health care. The current health care system provides enormous benefits, but there are substantial opportunities for reforms that would reduce costs, increase access, enhance quality, and improve the health of Americans.

An individual's health can be maintained or improved in many ways, including through changes in personal behavior and through the appropriate consumption of health care services. While there is substantial health care spending in the United States, the importance of health does provide a strong rationale for this level of spending. But because health care financing and delivery are often inefficient, there are opportunities to advance health and access to health care services without further growth in spending. To improve the efficiency of health care financing and delivery, the Administration has pursued policies that would increase incentives for individuals to purchase consumer-directed health insurance plans. The Administration has also worked to link provider payments to performance, thus rewarding efficient delivery of health care. In the President's State of the Union Address, he proposed changing the tax treatment of health insurance, offering all Americans a standard deduction for buying health insurance. Such a change could play an important role in increasing the efficiency of the American health care system and expanding health insurance coverage.

The key points in this chapter are:

- Health can be improved not only through the consumption of health care services, but also through individual behavior and lifestyle choices such as quitting smoking, eating more nutritious foods, and getting more exercise.
- Health care has enhanced the health of our population; greater efficiency in the health care system, however, could yield even greater health for Americans without increasing health care spending.
- Rapid growth in health care costs and limited access to health insurance continue to present challenges to the health care system.
- Administration policies focus on reducing cost growth, improving quality, and expanding access to health insurance through an emphasis on private sector and market-based solutions.

Health and the Demand for Health Care

The demand for health care is unlike the demand for most consumer products and services because while the desire for consumer products and services comes from direct consumption, the desire for health care is not derived directly from the consumption of the medical procedures themselves; rather, it comes from the direct value of improved health that is produced by health care. For example, demand for an MP3 player is based on the enjoyment that an MP3 player brings to a consumer, but few would choose to get a laparoscopic cholecystectomy for the same reason. Rather, a consumer's desire to have her gallbladder removed is directly related to the positive impact the operation is likely to have on her health. Understanding how health is produced, demanded, and valued is a useful starting point for evaluating the health care system and health care policy.

Demand for Health

People demand health because of its role in facilitating and providing happiness. Health can be defined along two dimensions: the length of life (longevity) and the quality of life. A person derives value from the quality of life directly and indirectly: directly because one's level of health affects the enjoyment of goods and leisure and indirectly because one's level of health enhances productivity (Box 4-1). Enhanced productivity can be rewarded in the labor market through higher wages. The indirect effect of health on productivity suggests that health is an important component of human capital investment. Consistent with the basic principle of our economic system, consumers exercise choice in purchasing health care and other goods and services.

The Production of Health

Health care is only one of the factors that determine health. Other factors include individual behaviors, environmental factors, social factors, education, income, and genetics. If we think of an individual as a producer of health, the key production inputs are the time and money spent on health-improving activities and health care. Health-improving activities can include individual choices regarding exercise, nutrition, and lifestyle. Health care can include hospital care, outpatient visits to medical providers, nursing home care, and medication. Because health can deteriorate from accidents, sudden disease, and the effects of aging, health care inputs are needed not only to maintain current levels of health but also possibly to restore health following an illness or injury.

Box 4-1: Health Effects on Job Productivity

Health can affect job productivity through absenteeism and presenteeism. *Absenteeism,* not being present at the place of work as a result of injury or illness, prevents an individual from contributing to output, and may also affect the ability of coworkers to be productive when tasks require collaboration. *Presenteeism* is the loss of at-work productivity caused by a lack of physical or mental energy needed to complete tasks, increased workplace accidents, and the possible spread of illness to fellow employees. There is evidence that both of these factors are costly. According to the Current Population Survey (CPS), 2.3 percent of workers will have an absence from work during a typical week due to injury or illness. Several studies estimating the extent to which presenteeism affects productivity indicate that, on average, the productivity loss caused by some of the most common conditions (such as allergies, depression, musculoskeletal pain, and respiratory disorders) is between 5 and 18 percent.

Investment in improving and managing health offers opportunities to mitigate some of these costs. An increasing number of employers are instituting at-work wellness programs that provide targeted health management. These programs range from monetary penalties for those with unhealthy lifestyles (such as smoking or uncontrolled diabetes) to subsidizing access to exercise facilities. The benefits are shared by the worker (higher earnings, better quality of life) and the employer (enhanced productivity and decreased health care expenditures). Evidence of the success of these programs, while incomplete and variable, suggests that at-work wellness programs can improve worker health outcomes and provide a positive return to employers. One long-term study of a particularly comprehensive wellness program shows that health care expenditures fell by an average of $225 per employee per year (mostly due to fewer doctor visits and hospital stays), but it took several years to realize these benefits.

Studies of trends in health-improving activities show a mixed picture on whether Americans are investing more in their health. A recent study finds that Americans are smoking less and controlling their cholesterol and blood pressure better (through a combination of health-improving activities and medical inputs). In contrast, there has been a dramatic increase in obesity in the United States in both adults and children during the past few decades. Obesity has more than doubled since the late 1970s, from 15 percent to 34 percent among adults. Among children ages 6 to 19, the incidence of

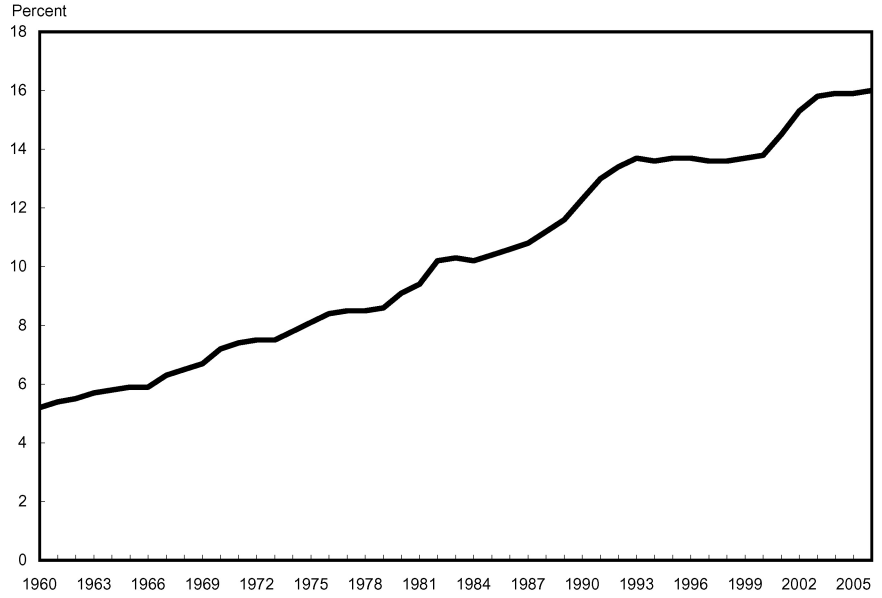
being overweight has tripled. Obesity is an indicator of unhealthy behavior because it often reflects a lack of exercise and overconsumption of unhealthy foods. Also, obesity is associated with a higher risk of many diseases and health conditions, including hypertension, Type 2 diabetes, coronary heart disease, and some cancers.

Trends in Health Spending

Americans are investing more in their health as measured by health care expenditure. In 2006, Americans spent over $7,000 per capita on health care, up from $2,400 in 1980 and $800 in 1960 (all in 2006 dollars). National health care spending has grown more rapidly than the economy as a whole, so health care accounts for an increasing share of the overall economy (Chart 4-1). National health care spending now accounts for about 16 percent of gross domestic product (GDP), up from 9.1 percent in 1980 and only 5.2 percent in 1960.

The primary factor that tends to drive health care expenditure growth is the development and diffusion of new technologies. Knowledge about health and health care conditions continues to expand over time, generating an expanding inventory of new or improved products, techniques, and services. Medical technology may account for about one-half or more of real long-term

Chart 4-1 **National Health Expenditures As a Share of Gross Domestic Product**
Health care expenditures have increased faster than GDP.



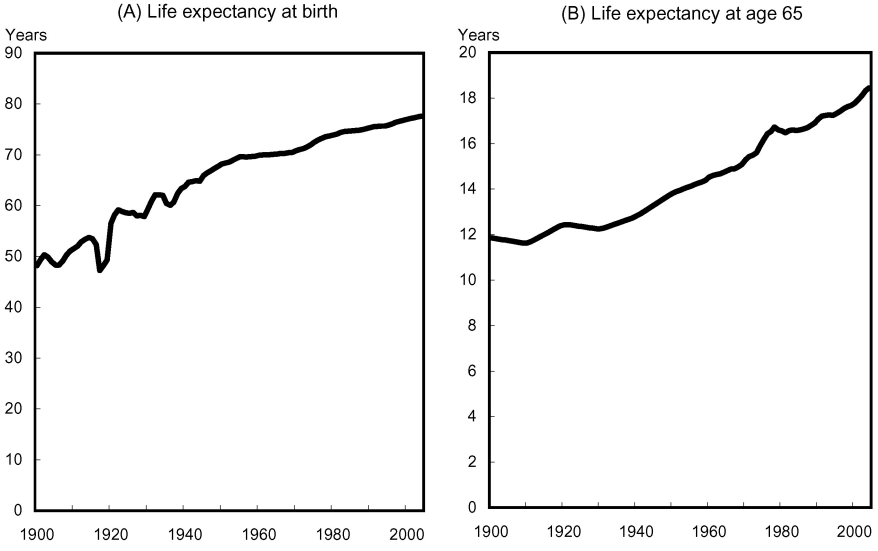
Source: Centers for Medicare and Medicaid Services.

health care spending growth. Rising incomes are a second important factor because as income increases, a greater proportion of income is typically spent on health care. The aging of the population and increasing disease prevalence is a third important factor contributing to expenditure growth in the United States. Other cited factors include more rapid wage growth in the health sector, greater insurance coverage supported by large government subsidies through both government-sponsored programs and tax subsidies, and the low share of health expenses paid out-of-pocket by health consumers.

Trends in Life Expectancy

Life expectancy is only one of many outcome measures for health, but because it has been reliably and consistently measured over time, it offers a unique historical view of trends in health. United States life expectancy trends since 1900 both from birth and from age 65 are shown in Chart 4-2. In the two panels of this chart, we see life expectancy gains throughout the century. Progress in life expectancy at birth was rapid in the first half of the century, growing from 48 to 68 years. Between 1950 and 1970, life expectancy at birth grew gradually, reaching only 71 by 1970. Progress picked up in the 1970s, with life expectancy reaching age 78 by 2004. There is a contrasting pattern for the life expectancy among those who live to age 65. Life expectancy at age

Chart 4-2 **Life Expectancy at Birth and at Age 65**
Life expectancy at birth increased rapidly in the first half of the century and life expectancy at age 65 increased most rapidly after 1970.



Source: Centers for Disease Control, National Center for Health Statistics, National Vital Statistics Reports, vol.54, No.14, April 19, 2006.

65 showed little progress until the 1930s; in the subsequent 4 decades, life expectancy at 65 rose 3 years to 15 (meaning that in 1930 a person who was 65 could expect to live to age 77, while in 1970 a 65-year-old person could expect to live to age 80). Starting in the 1970s, the pace of improvement accelerated. By 2004, life expectancy at age 65 was 18.5 additional years; a gain of 3.5 years of life over the past 3.5 decades.

Innovations in health and health care can explain the patterns in longevity. Changes in the first half of the 20th century came largely through progress in reducing malnutrition, improving sanitation, and containing infection through improved public health measures and the use of antibiotic agents such as penicillin. After about 20 years of gradual improvement in life expectancy, the rising longevity from 1970 reflects progress in treating life-threatening ailments prevalent among those over 50. As shown in Table 4-1, the largest single contributor to increased longevity has been reduced mortality from heart disease (3.6 years); reduced mortality from strokes added another 1.3 years to life expectancy. Reduced mortality from those two conditions has thus added nearly 5 years to the life expectancy of Americans.

Research suggests that the lower mortality from heart disease and strokes is primarily attributable to advances in intensive medical therapies, non-acute medications to manage high blood pressure and high cholesterol, and changes in individual behavior to reduce risk factors such as smoking and high-fat diets. Improvements in medical treatments alone are believed to account for at least 3 of the 5 years of the life expectancy gain that is attributable to reduced mortality from heart diseases and strokes.

To put these substantial benefits of extending life into a perspective that accounts for the increased spending on health care, it is useful to assess the tradeoff between the cost of the treatments and the benefits of longer life. An influential study has done this and found the benefits of increased spending on cardiovascular treatments to be about four times as large as the costs.

TABLE 4-1.—*Additional Life-Years Due to Reduced Mortality from Selected Causes, for US by Decade, 1950-2000 (years)*

	1950-1960	1960-1970	1970-1980	1980-1990	1990-2000	Total
Infant Mortality	0.47	0.35	0.67	0.22	0.16	1.87
Heart Disease	0.38	0.55	0.96	1.08	0.67	3.63
Cancer	0.01	-0.05	-0.09	-0.05	0.30	0.16
Stroke	0.15	0.24	0.52	0.31	0.07	1.29
Accidents	0.14	-0.09	0.27	0.27	0.09	0.66
Other	0.66	0.00	0.55	-0.28	0.40	1.33
Total	1.80	1.00	2.93	1.54	1.68	8.96

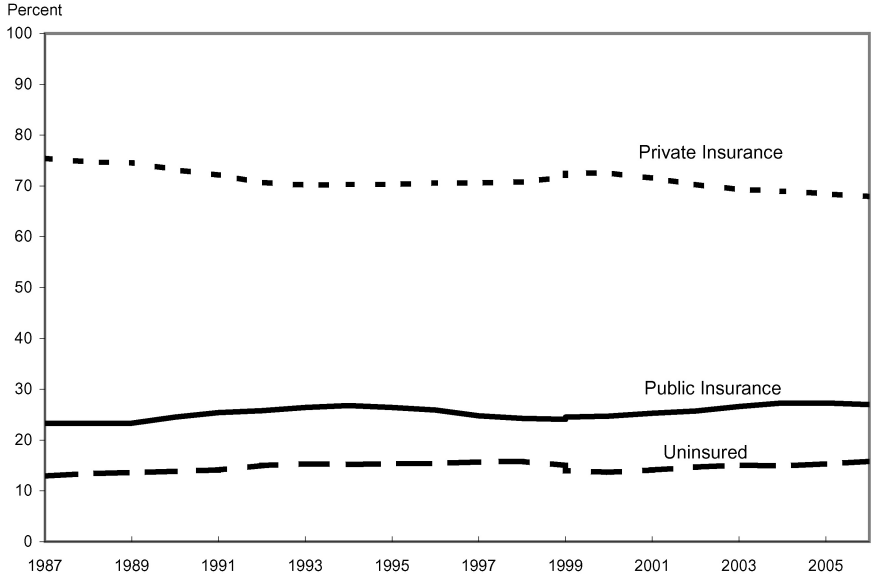
Source: Murphy, K.M., and Topel, R.H. The Value of Life and Longevity (2006). Journal of Political Economy, vol. 11, No. 5, 871-904.

While the study focused on spending on cardiovascular disease, the basic conclusion—aggregate health-spending increases have provided positive returns—is true more broadly. Using the same framework, the total increase in health care spending since 1950 can be justified, in monetary terms, by the life expectancy gains from cardiovascular treatment and neonatal care alone. Gains from other treatment advances (not to mention benefits other than life extension, such as a higher quality of life) thus imply that, over the past half-century, the benefits from greater health care spending in the United States have exceeded their costs. However, the benefits of greater health care spending in relation to costs have not been as favorable since 1980, suggesting potentially diminishing returns from health care spending.

Trends in Health Insurance Coverage

Health insurance helps shield families from the financial risk of the unanticipated health expenses of serious illness or injury, and facilitates access to the health care system, thereby improving health outcomes. Given those benefits, it is a major concern that at any given time, 16 percent of Americans report that they lack health insurance. The primary driver of declining enrollment in private insurance has been the increasing cost of health care and this decline contributes to the rising proportion of uninsured (Chart 4-3).

Chart 4-3 **Health Insurance Coverage by Source: 1987 to 2006**
Declining private insurance is associated with rising public insurance and uninsured.



Source: Department of Commerce (Bureau of Census), Current Population Survey, Annual Social and Economic Supplements, 2006.

Addressing Challenges in the Health Care System

The trends in the U.S. health care system suggest that the rapid growth in health care costs will persist. Health care costs will pose an increasing challenge for consumers of health care and health insurance as expenditures in this sector make up a greater share of household consumption. Taxpayers will also face an increasing challenge as the budgetary burden of Federal and State health care programs continues to expand. (See Box 4-2 for an overview of government health care programs.) Reducing health care cost growth and increasing access while improving health care quality are the goals of Federal health care policy. The Administration's objective has been to develop market-oriented policies to meet these goals by fostering the innovation, flexibility, and choice that are the best aspects of the American health care system. Market-oriented policies must address potential market failures that are at the root of the challenges in the health care system. These problems include insufficient information available to patients, health providers, and insurers; access barriers for lower-income or disadvantaged Americans; and two specific market failures that arise in insurance markets: moral hazard and adverse selection. *Moral hazard* is the tendency for individuals to overuse certain types of health care when insurance covers a sizable fraction of the costs; *adverse selection* is the tendency for insurance to be purchased by those persons who are most likely to need it (and who thus have higher costs). Policies aimed at mitigating these problems can enhance the ability of our market-oriented health care system to achieve the goals of controlled cost growth, improved access to health insurance coverage, and high-quality health care.

Box 4-2: Government Health Care Programs

About 46 percent of health care spending is funded by Federal and State Governments through various health programs. The main government-funded health programs are designed to serve specific populations and include Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and the Veterans Health Administration (VHA).

Medicare was enacted in 1965 and covers nearly all individuals aged 65 and older (as well as some younger individuals with disabilities or specific illnesses). Medicare today consists of three basic parts. Part A is hospital insurance, which covers stays in hospitals and nursing facilities. Part A is primarily funded by a 2.9 percent payroll tax (1.45 percent each for workers and employers). Part A is generally provided automatically

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Box 4-2 — continued

and without premiums for persons age 65 and older who are eligible for Social Security or Railroad Retirement benefits. Part B is supplementary medical insurance which covers doctor visits and other outpatient services. Part B is voluntary and enrollees pay a monthly premium, yet 94 percent of those eligible elect to enroll. Part D, Medicare's prescription drug benefit which started in 2006, is available on a voluntary basis to individuals who qualify for Medicare Part A, and requires a monthly premium for those beneficiaries who do not qualify for the low-income subsidy. Unlike other parts of Medicare, Part D is administered by a partnership between private insurers and Medicare officials to provide choice of prescription drug plans to beneficiaries and to allow for price competition. Part B and Part D are funded by a combination of premiums from beneficiaries and government revenues (Part D also receives some resources from the States). In 2007, there were 43.4 million beneficiaries enrolled in Part A, 40.6 million in Part B, and 24.4 million in Part D.

Under Fee-for-Service Medicare, health care providers are reimbursed by the Federal Government at predetermined rates for services provided. However, Medicare beneficiaries can opt to enroll in a private Medicare plan under Medicare Advantage through local coordinated care plans offered mostly by local health maintenance organizations (HMOs) and preferred provider organizations (PPOs), regional PPOs, and private fee-for-service providers. Local coordinated care plans make up 72 percent, regional PPO plans 3 percent, and private fee-for-service plans 21 percent of Medicare Advantage plans.

Medicaid was also established in 1965 as a health care program for low-income individuals, in particular those with children. Medicaid is administered by the States, and is funded by both the Federal Government and the States. Like traditional Medicare, Medicaid also reimburses private providers for services at predetermined rates and allows recipients to enroll in Medicaid managed care plans in many States. However, unlike Medicare, these predetermined rates are determined at the State level. In 2006, there were 45.7 million enrollees in Medicaid, of whom 65 percent were in managed care plans. The State Children's Health Insurance Program (SCHIP) was created in 1997 to cover children from low-income families who do not qualify for Medicaid. SCHIP is also administered by the States and funded by both Federal and State Governments, but the Federal contribution towards spending is higher for SCHIP than for Medicaid. In 2006, there were 6.6 million enrollees in SCHIP.

While Medicare, Medicaid, and SCHIP are publicly funded programs, most health care services are delivered by private providers not employed by the government. In contrast, the Veterans Health Administration

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Box 4-2 — continued

(VHA) delivers health care to veterans through a system that is run by the Department of Veterans Affairs. The VHA is a truly public health care system in the sense that the Federal Government owns the VHA hospitals and employs the health care providers.

Rising health care costs are creating budget pressures for government health care programs. Currently, Federal spending on Medicare and Medicaid totals about 4 percent of GDP, or about 20 percent of the Federal budget. Rising health care costs, however, will likely raise those figures in coming decades. If spending grows 1 percent per year faster than GDP (which is somewhat slower than the historical rate of growth over the past 40 years), for example, the Office of Management and Budget projects that in 25 years, spending on these two programs alone could reach 8 percent of GDP. Such spending growth, if it came to pass, would require either unprecedented levels of taxation or dramatic reductions in other government activities.

Moral Hazard and Cost Control

In most markets, consumers decide what to purchase by comparing the benefit of a good or service relative to its cost. In the health care sector, however, consumers often do not learn the prices of goods and services until bills are received weeks or months later. Because health insurance polices cover most health care costs, including the costs of routine, predictable health care services, consumers have little incentive to try to access and act on price information. This moral hazard effect encourages overuse of certain types of heath care, gives little incentive for consumers to consider costs in their search for a provider, and distorts incentives for technological change.

Overuse of health care can occur when the perceived cost of a service is less than the actual cost and, as a result, the service may be used even when its value is less than its cost. This happens, for example, with health insurance coverage that shields consumers from the true cost of a service by having them pay none or only a portion of its cost. To illustrate, consider a consumer's decision to purchase a migraine therapy that costs $100 to produce. If the symptoms are serious enough and would be relieved by the therapy, the consumer might be willing to pay more than $100 for the therapy. The consumer would thus purchase the therapy regardless of how much of the $100 cost was covered by insurance, and the purchase would not be overconsumption. If the customer had milder symptoms, however, insurance may induce overconsumption. Suppose, for example, that the consumer would only be willing to pay $25 to relieve the symptoms. If insurance covered the entire $100 cost, the consumer would purchase the therapy since the $25 benefit exceeds the consumer's

effective price of zero. Even if a $10 copayment was required by the insurance benefit, the purchase would still take place. Because the social cost of $100 exceeds the $25 benefit, this purchase would not be socially beneficial and would therefore be considered overconsumption.

Because consumers are less sensitive to the prices of the health care services they consume, the competitive forces that typically keep prices down are weakened. Imagine two hospitals that provide the same service, but hospital A charges $1,000 and is located in an older facility, while hospital B charges $2,000 but is located in an updated facility with a wide array of amenities and equipment on site. Given these choices, a consumer facing the actual price may prefer hospital A, but in a world where few costs are shared with the patient, most people would choose hospital B. This gives hospital B few incentives to control costs given that convenience or amenities have a greater influence on consumer choice than price.

New technological innovations enter a market in which consumers rarely pay more than 10 to 20 percent of the market price out-of-pocket. This influences the value of the innovations that are developed and marketed. If a new product is only slightly more effective than an existing product, for example, it may be highly demanded even if it is priced well above existing alternatives. Because there is a market for new technology with little additional benefit over existing treatments, innovators have sufficient incentive to create new technologies with little marginal value.

Health insurers and their sponsors (employers) recognize that insurance reduces consumer incentives to be responsive to costs. Insurers use a variety of cost-control mechanisms such as utilization review, pre-approval, and drug formularies to attempt to manage costs and, in part, counteract the lack of cost consciousness by consumers. But those mechanisms can only partly offset the problem. In addition, insurance benefits are designed to limit moral hazard by sharing the costs of services received with the beneficiary. Design features to accomplish this goal include deductibles, copayments, and coinsurance. *Deductibles,* the dollar amount that a consumer will have to pay before the insurer pays for any medical expenses, are often less than $500. *Copayments* are a fixed fee paid per visit or per prescription. *Coinsurance* is a percentage of the cost of the service that is the responsibility of the consumer.

These cost sharing mechanisms are underutilized because of a bias created by the tax code. The health insurance premium of employees paid by employers is exempt from income and payroll taxes, but individual spending through deductibles, copayments, and coinsurance is taxable. As a result, there is a tax incentive for employers to compensate employees through generous health insurance plans that limit cost sharing. Thus, the tax code reduces the incentive for optimal health insurance design and ultimately encourages individuals to purchase more health care services than they would otherwise. Health Savings Accounts (HSAs), enacted into law by this Administration

in 2004, and the standard deduction for health insurance first proposed by this Administration in 2007, both provide a mechanism for eliminating the tax bias against greater cost sharing. These policies are intended to offer the private sector more opportunities to control costs through greater consumer awareness of the cost of health insurance premiums and health care services.

Health Savings Accounts

Health Savings Accounts are savings accounts of pre-tax dollars, funded by individual or employer contributions, that can be used toward current and future out-of-pocket medical expenses. HSAs are designed to be used in conjunction with high-deductible health plans, reducing reliance on insurance for routine health expenses. The funds in the HSA can be used to pay these routine health expenses directly. Because unspent funds belong to the individual and can accumulate over time, HSAs lead the individual to play a more active role as a health care consumer. In January 2007, HSAs covered 4.5 million people, which is an increase of 1.3 million since January 2006, and 3.5 million since March 2005.

As the consumer plays a greater role and becomes more aware of routine health expenses, provision of inefficient care should be reduced; incentives for providers to adopt cost-effective therapies should increase; and possibly, some health care prices may decline, which may even benefit consumers in traditional insurance plans. Yet the benefit of moving to a high-deductible policy with an HSA will vary in that chronically ill individuals with persistently high spending may find these policies less desirable because their out-of-pocket spending would be consistently high. Consumers in lower tax brackets will derive a smaller tax benefit from HSAs because the value of tax exemption depends on a consumer's marginal tax rate (the tax paid on the next dollar a worker earns).

A Standard Deduction for Health Insurance to Replace the Tax Exemption

The lack of consumer sensitivity to health care prices occurs not just through the consumption of health care services, but through the consumption of health insurance as well. The tax exemption of employer-sponsored health insurance premiums is inefficient because, by providing a larger tax break to families with more-generous employer-sponsored health insurance policies, there is an incentive for health insurance to cover more services than employees would otherwise demand. This occurs because employees can increase after-tax compensation by accepting more of their compensation in the form of health insurance.

The President has proposed to replace the current open-ended tax exclusion for employment-based health insurance with a flat $15,000 standard

deduction for health insurance to all families (or $7,500 for individuals), whether that insurance was obtained through their employer or on their own. The amount of this standard deduction would be independent of the actual amount spent on the premium, so families who obtain insurance policies for less than $15,000 (but whose policy satisfies a set of minimum requirements for catastrophic coverage) would still have an exemption for the full $15,000 of compensation from income and payroll taxes. The annual increase in the standard deduction for health insurance would be linked to inflation as measured by the Consumer Price Index.

This policy has two key effects: 1) It would reduce the inefficiency of the current tax treatment of employment-based health insurance and would allow individual consumers to benefit from reducing the cost of their insurance; and 2) it would provide for equitable tax treatment for health insurance purchased inside and outside of employment. The first effect can be shown in the following example. Consider a family of four with an annual income of $50,000 and a health insurance policy worth $10,000 that is sponsored by an employer. Because the marginal tax rate of this family is roughly 30 percent, the current tax exemption for the cost of this insurance policy provides a $3,000 tax break to the family. Another family with the same income and an employer-sponsored health insurance policy worth $20,000 currently receives a tax break of $6,000. One advantage of the proposed standard deduction is that it provides the same tax treatment to all types of health insurance plans. Under the proposed plan, both families would qualify for the flat $15,000 standard deduction and receive the same tax savings of $4,500. The flat tax break provides a strong incentive to obtain health insurance coverage, and it would allow families to reap the tax benefits of health insurance policies with optimal cost-sharing features. Because the tax break is not more generous for those who choose expensive health insurance plans (unlike the tax exemption), consumers will become more conscious of cost when purchasing health insurance and health care.

Health insurance purchases by families and individuals with or without access to employment-based health insurance would receive the same tax benefits under this policy. Currently, tax treatment of health insurance premiums is inequitable because it does not offer the same tax break to families and individuals without access to employment-based insurance, who must instead purchase a private plan in the individual health insurance market. The family considered above with an annual income of $50,000 receives a $3,000 tax break for a health insurance policy worth $10,000 sponsored by an employer, but no tax break for a similar health insurance policy purchased through the individual insurance market. Under the Administration's proposal, those who are currently insured in the individual health insurance market would see a reduction in taxes commensurate with those insured in the group market. As

a result, those who are currently uninsured because they have no access to employment-based insurance, would be given a strong incentive to purchase coverage. An uninsured family of four earning $50,000, for example, would receive a tax benefit of $4,500 if they purchased health insurance in the individual market (the value of the $15,000 standard deduction if the family faces a 30 percent marginal tax rate). That tax break would cover nearly half the cost of a family health insurance plan costing $10,000.

The availability of a tax deduction for the purchase of health insurance for individuals and families who are not offered employer-sponsored coverage will make health insurance more affordable for millions of Americans. The Administration estimates that the standard deduction would provide 3 to 5 million individuals with health insurance who did not have it previously. Even with a standard deduction, challenges for affordable coverage remain for individuals with low incomes or with substantial risk of high health expenditures. The Administration's Affordable Choices Initiative addresses these remaining challenges. The initiative facilitates State efforts to make health insurance more affordable for individuals with persistently high medical expenses or limited incomes. Currently, subsidies and payments from the Federal Government are funneled through providers; the objective is to redirect funding toward individuals.

Controlling Costs Through Competitive Insurance Markets

The effective functioning of a competitive marketplace for health insurance requires addressing adverse selection. Adverse selection arises when insurance is most attractive to those persons most likely to need it. If the premium is based on the population average and the policy disproportionately attracts those who spend more than the average, the policy will lose money for the insurer. The policy will then either increase in price or not last in the market. In the extreme, some consumers do not purchase insurance because the only policy available to them is priced for the most expensive consumers.

The problems can be most severe in insurance markets involving small firms and individuals without access to group coverage, because large risk pools mitigate many of the forces that can lead to adverse selection. (However, adverse selection can arise in broad risk pools when competing health plan choices are made available.) To varying degrees, States can minimize adverse selection by permitting providers in the market for individual insurance to rate each individual on the basis of his or her medical risk and past health care expenditure. As a consequence, individuals with chronic illnesses have to pay higher premiums, be denied coverage altogether, or be denied coverage for the condition which is making them ill.

To reduce the extent to which high-risk individuals face higher premiums and to improve the availability of certain health insurance benefits, States have imposed a range of restrictions on insurance underwriting practices as well as coverage mandates on nongroup (and in many cases on group) health insurance plans. These regulations generally include guaranteed issue laws that require insurers to issue insurance to any eligible applicant without regard to current health status or other factors, and community rating laws that prohibit insurers from varying premium rates based on health status and restrict the amount by which insurers are allowed to vary rates based on characteristics such as age or gender. Although these regulations tend to reduce insurance premiums for high-risk individuals, they also increase premiums for lower risk individuals. Those premium increases can have the unintended consequence of encouraging people to wait until they have a health problem before enrolling. If such adverse selection reduces participation of healthier people, premiums will increase and the voluntary insurance market may cease to operate effectively. The result may be less insurance coverage and only limited premium reductions for those who are chronically ill, as those who are healthier choose to forgo coverage entirely rather than pay higher premiums.

The approach of the Administration is one that encourages lower premiums particularly in the individual and small group markets, where adverse selection poses the greatest challenges for competitive insurance markets. The Administration supports a national market for health insurance rather than State-specific markets. This would effectively make insurance available to individuals and small groups under conditions that resemble those now available to employees of many large corporations, which, by self-insuring, are exempt from State insurance regulations and instead operate under the Federal insurance law provisions of the Employee Retirement and Income Security Act (ERISA). Health insurance policies with lower premiums would be more readily available because health insurance policies would not be subject to costly State mandates and regulations. The Administration also supports Association Health Plans—plans that allow small groups to band together to purchase insurance subject to Federal rather than State regulations—because they would reduce adverse selection problems encountered by small employers, achieve economies of scale in negotiating lower rates with participating insurers, and allow for greater participation in a competitive choice system of health insurance plans.

Improving Quality and Costs Through Information and Reimbursement

Because of the complexities of medicine, patients must often rely on experts to determine their diagnosis and select treatments. If the incentives for the expert are different from those that would produce the greatest benefit for the

patient, however, the services delivered by the expert may not always be of the greatest benefit to the patient. For example, doctors may have incentives to overstate the value of expensive tests, and most patients lack the expertise to assess these claims.

Physicians determine needed services for patients. Because these decisions are in part subjective, diagnoses and treatments often differ across physicians, sometimes in ways that are not in the patient's or society's best interest. For example, the frequency of spinal surgery is almost eight times higher in some parts of the United States than in others, even though the percentage of people who have back problems does not vary widely between regions. These types of geographic variations in quantity of care exist across a wide range of treatments, yet few differences in outcomes can be detected. Overuse of health care services is one problem, and underuse is another. A classic study evaluated the rate at which clinicians followed processes of care widely recommended through national guidelines and the medical literature. When averaged across all phases of care for the most common or lethal conditions, it was determined that nearly half of patients who met conditions for effective clinical care failed to receive appropriate care.

There is great potential to improve quality and/or reduce costs through reforms that improve information on quality and costs, and align provider payments so that providers are rewarded for the health outcomes of the patients rather than just for the services they perform.

Information on Effectiveness

One of the key impediments to more effective health care delivery is a lack of relevant information—for patients, providers, and payers—on the comparative effectiveness and efficiency of health care options. Such information would be particularly useful for services that are in common practice, generate high costs, employ rapidly changing technologies for which multiple alternative therapies exist, and are in areas with substantial uncertainty. The wide geographic variations in the use of procedures suggest that better information on the effectiveness of different styles of medical practice could result in substantial cost savings.

Health Information Technology

Health information technology (health IT) allows comprehensive management of medical information and the secure exchange of medical information between health care consumers and providers. Broad use of health IT has the potential to help dramatically transform the delivery of health care, making it safer, more effective, and more efficient. While a number of large health care organizations have realized some of these gains through the implementation of multifunctional, interoperable health IT systems, to date, experimental evidence supporting the broad benefits from health IT is more limited. The

Administration supports broad adoption of health IT as a normal cost of doing business, including policies that will encourage physicians and others to adopt electronic health records and through furthering technologies for safe, secure health information exchange.

Value-based Purchasing

Pay for performance or *value-based purchasing* is a payment model that encourages health care providers to meet certain performance measures for quality and efficiency. A recent example is eliminating payments for negative consequences of care. The Centers for Medicare and Medicaid Services (CMS) implemented a provision of the Deficit Reduction Act of 2005, which prevents Medicare from giving hospitals higher payment for the additional costs of treating certain "hospital-acquired conditions"—conditions that result from medical errors or improper care and that can reasonably be expected to be averted. Now big insurers are following Medicare's lead and are moving to ban payments for care resulting from grave mistakes. These changes remove a perverse incentive for hospitals: improving patient safety could reduce revenues and profits. As a result, these reforms should trigger safety improvements and enhance the efficiency of the health care system.

Transparency of Price and Quality Information

Transparency of information on price and quality has been a priority of this Administration. Medicare has provided incentives to providers to submit performance information to CMS and many of these performance measures have been made available on the CMS website so that consumers can compare the quality of providers as they seek care. The administrators and sponsors of Medicare and other Federal health insurance programs have been directed to share with beneficiaries information about prices paid to health care providers and the quality of the services they deliver. The commitment is to transform Medicare by always seeking to improve the connection between expenditures and positive health outcomes without increasing Medicare spending.

Promoting Healthy Behavior

Encouraging healthy behaviors, such as exercising more, eating better, controlling weight gain, and quitting smoking, may be a cost-effective alternative to increased spending on health care. One way to encourage healthy behavior is through health education. For example, much of the beneficial effect of prenatal care is simply related to education about healthy behavior while pregnant. A better understanding of the risks of high cholesterol and blood pressure (and how to reduce those risks through healthy behavior) is credited with being a very highly efficient way to improve health outcomes. Administration policies that aim to increase consumer sensitivity to health

care costs have a positive indirect consequence in that they may induce an increase in healthy behaviors.

Conclusion

The health care system in the United States has helped improve the health and well-being of Americans. As health care costs continue to rise, enormous opportunities exist to increase the value of health care and improve health insurance coverage. Addressing these fundamental problems and fulfilling the potential of our health care system will require innovative polices to help Americans get the care that best meets their needs, and to create an environment that rewards high-quality, efficient care. While Federally sponsored health insurance for the most vulnerable Americans through Medicare, Medicaid, and SCHIP remains a priority, private markets offer the best opportunities for controlling costs and providing innovative policies to enhance efficiency, quality, and access. Efficiency of health spending would be improved if tax code reforms were enacted. Reforms could level the playing field between employer-provided and individual health insurance, thus boosting insurance coverage. At the same time, reforms could reward consumers for purchases of higher deductible plans with reasonable copayments that provide insurance for costly medical necessities, but do not encourage unwarranted procedures. By addressing concerns of adverse selection, insurance markets can become more competitive, thereby promoting innovation, choice, access, and efficiency. Finally, health care quality can be addressed by improving the transparency of health care information and by tying reimbursement to the performance of providers.