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Building Public Support for Slowing the Growth of Health Care Spending

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The task of moving from policy proposal to successful legislation means navigating the waters of public opinion that influences practical politics. This is true of all areas of policy, of course, but health care waters are especially turbulent. Health care is intensely personal and costly for families, and even small policy changes have potentially huge financial implications for them as well as other stakeholders. If successful ways of addressing the health spending challenge are to be devised, it is critical to reflect on the underlying values and moral choices associated with any policy approach. The wise policymaker will thus consider policy refinements or pursue policy options that might make proposals more compatible with the underlying values of Americans—or at least to pose initiatives in ways that force the public to consider the moral trade-offs involved.

The Challenge of Achieving Health Care Spending Reform

Achieving public policy goals in health care is particularly difficult because of the way in which Americans think about health policy proposals. As

Daniel Yankelovich has explained in his classic work on how people make policy decisions, people go through stages in deciding what should be done about an issue.¹ These stages range from focusing on the issue currently on the “radar screen” for most people and acquiring urgency, to weighing choices and trade-offs, and finally to making decisions about those choices. The problem with health care—more than most other major issues—is that while Americans certainly think of health care and health care costs (more precisely, the costs they face) as a critical issue, there is enormous confusion, wishful thinking, internal contradiction, and emotion entangled in the way people evaluate health policy proposals. People tend to look at health proposals from a personal and financial viewpoint but also in terms of basic values and perspectives—such as rights, fairness, risk, and obligation. These feelings are typically not well-articulated or often even understood by those who hold them, which is why traditional public opinion polling on health can be so contradictory and misleading. But because people are likely to react to health proposals in this way, careful consideration of the value choices triggered by approaches to the health spending challenge is critically important.

The chapters in this volume discuss three general goals, each of which has important practical implications for Americans and hence for the way they are likely to respond to specific proposals. One goal is to improve the efficiency with which Americans spend health dollars—getting better value for money. Improving efficiency might seem noncontroversial. But as discussed below, the meaning of “value” is often intensely subjective. For example, what seems like unnecessary small talk to a doctor may seem like caring, personal attention to the patient.² So what is deemed to be value in health care spending decisions, and who makes those decisions, is critical to public acceptance of those decisions.

A second goal is to limit expenditures, through incentives or controls. This goal enters the picture because even if society could agree on what constitutes efficiency, and on steps that would improve it, growth in spending would not necessarily moderate. For example, if people have a pent-up demand for medical services, and their spending is constrained only by their acceptable out-of-pocket cost, then improving value for money while retaining today’s subsidies and incentives would lead people

to increase total consumption of services for the same level of out-of-pocket spending, not to reduce their spending. More direct control of spending or changed incentives would still have to be introduced to cause a restraint in spending growth. The tools available to do that, such as market incentives or expenditure controls, each require tough decisions that raise deeper issues.

But there is a third goal, or perhaps a group of goals, that is interwoven in the other two—the goal of fairness, or equity. While important to the policymaker, of course, the idea of fairness is central to whether typical Americans will accept a policy. How people visualize “fairness” is associated with deeply held values and is often subjective, making broad public acceptance of a plan to improve efficiency or hold down costs all the more difficult. Many Americans see access to some level of health care as a right of citizenship and balk at any action that would seem to contradict that notion of right. Many also place great weight on the idea of equity in health care, leading them to resist steps that seem to treat similar people in different ways. Fairness affects the way people think about obligations and responsibilities involved in health care; how these should be distributed between individuals, employers, and different layers of society; and who should make these decisions. Fairness also affects the way people respond to the degree of economic risk they consider reasonable to expect a family—or the taxpayer—to shoulder. And fairness influences the degree to which Americans think government or employers should honor promises made long ago, even if those promises conflict with commercial viability or other urgent spending or tax goals.

Improving Efficiency while Achieving Equity

While everybody would agree with the general proposition that it is good to improve efficiency, there is intense debate about what constitutes efficiency in the case of health care. To an economist, efficiency in health care means allocating the level and combination of services in a way that produces the greatest medical benefits with the fewest economic resources.³ But while seeking to be efficient, policymakers also must seek to distribute health services in a way that maximizes the nation’s collective preferences, recognizing people’s notions of equity and fairness.

Several difficulties and conflicts arise when policymakers actually try to do this. There are what one might call technical arguments. Even if efficiency is considered simply as achieving a specific medical outcome (such as removing a kidney stone or curing a cancer) with the least economic resources, and even if all the externalities involved could be captured, Antos and Rivlin explain in chapter 2 that there are still uncertainties and disputes about what approach actually produces the best medical outcome.

Another difficulty is far more intractable. Even assuming that it is possible to agree that certain techniques will maximize efficiency in achieving specific medical outcomes, there is wide and subjective disagreement on what constitutes the “benefit” or “value” of a particular procedure for a particular patient. For example, is it good value for money to carry out a double knee replacement on an 85-year-old man? The answer depends on what is meant by “value” and who is doing the measuring. Putting aside for the moment the issue of who is paying the bill and comparing cost, different people will have very different assessments of value. The patient probably has a very different vision of benefit than an insurance benefits manager or the director of the Office of Management and Budget. And a lifelong walker likely will place a different value on the replacement than would a couch potato. So two seemingly identical patients with identical prognoses might envision very different benefits from the operation because value is highly subjective. Economist David Cutler points out that even though the perceived value of a health improvement is heavily subjective, some tools are available to help quantify people’s subjective valuations.⁴ For example, the additional years of active life typically associated with a procedure can be measured. But trying to design policies that take account of the wide variation of valuations is a daunting task. Imagine designing and enforcing a bureaucratic regulation to ensure that the 85-year-old walker got knee replacement and the couch potato did not. If the way cases are actually resolved and resource decisions made seems unjust to politically influential segments of the population, achieving reforms to rein in spending becomes extremely difficult.

Private versus Social Perceptions of Value and Efficiency

Some would argue that allowing markets to resolve these subjective value-for-money decisions is the most logical and value-neutral allocation system

because markets place the locus of control in the hands of the user of medical services. Surveys show that the personal choice in health that accompanies markets is a strongly held value. And when individuals have more responsibility for spending resources, the argument goes, they have a greater incentive to calculate whether a particular array of services, including new technologies, delivers the best value for the money they can spend. When Americans buy cars or computers out of their own resources, for instance, the purchasers weigh the cost of technologies to enhance performance or safety against the benefit they perceive they will receive—including unique, subjective value.

But some analysts raise cautions about reliance on markets. In a technologically complex area like health, one natural concern is that individuals are not well equipped to identify the goods and services that will most efficiently deliver the value they seek. As Wilensky emphasizes in chapter 3, good and available information about outcomes and costs, among other things, is essential if consumer-driven decisions are to be efficient. Moreover, in health as in other decisions involving significant and technically complex decisions, such as buying a house or picking a college for one's child, consumers often turn to "agents" to help them process information and make a decision. Agents not only have to be knowledgeable; the consumer must also trust the agent to offer advice or make a decision in line with the consumer's values.

Even putting aside these concerns, using markets as a policy tool to achieve economic efficiency in health care raises several additional issues. One is whether a market is transparent, in the sense of the patient decisionmaker taking into full account the cost of resources involved when comparing subjective benefits with costs. As Antos and Rivlin explain in chapter 2 and Ginsburg in chapter 6, that comparison is heavily skewed in favor of choosing more health service for millions of Americans in the private sector because of the tax treatment of health insurance when an employer organizes the insurance. Even though the insurance is in reality a cost to the employee, in the form of forgone cash income, the cost is veiled to the employee and so encourages inefficient decisions and higher expenditures than would occur if an individual compared (subjective) value with the true cost. Several proposals in earlier chapters that are designed to improve efficiency by sharpening market incentives raise these

issues of transparency and social goals. One aim of proposals to reform the tax treatment of health insurance, for example, is to improve transparency and present people with a clearer comparison of cost and perceived benefit when making a health decision.

SOCIAL VALUE. A deeper issue is whether improving an individual's perceived value for money would actually capture the full meaning of efficiency. In particular, it is open to question whether an individual's personal, subjective view of value for money should be the determinant of efficiency in all cases, even if the person were to have full information and complete control of resources and unerringly maximized medical outcomes. Can society allow people to fail to vaccinate their children against measles, for example, just because they personally do not value the protection?

The complication is social value. Let us say that as a national or state community we have concluded that there are broader social values related to health care that normal markets do not recognize and that encouraging more (or less) spending on health by certain people helps to achieve a social goal. For example, a social goal might be that as a "membership right" of society, all Americans should be able to obtain an adequate level of health care ("adequate" being a political decision, not an objective one); that access to good health care, like high rates of home ownership, is part of the American Dream. Such a goal could lead a community to decide collectively that subsidizing private spending on health care is a social good, and it might do so not just through spending programs but also by tax preferences (as the federal government does for both health care and home ownership).

But a decision to subsidize health care also raises the issue of whether the community is concerned about the type and volume of care that is purchased with the subsidy. If funds are transferred from the wider community to an individual so that society can achieve the social goal of a certain standard of health care for every person, it is reasonable for the community to have some say in the level and type of care the person receives with the transferred funds or tax preference.⁵ It is also reasonable to argue that the higher the proportion of spending on health that comes from this community funding, as opposed to the individual's own funds, the greater the case for the community to determine what constitutes value in the services provided. By this argument, the use of public funds

means the broader community's view of the efficiency of technology, services, and procedures (such as a knee replacement) can trump the individual's view of efficiency at least to some degree. This line of argument is used to justify some level of required benefit package when public funds are involved. The same logic for a benefit design applies to other services where public funds are used, either directly to pay providers or through vouchers, such as in housing or education.

VALUE IN PUBLIC AND PRIVATE COVERAGE. The case for the community having a voice in determining value and efficiency is perhaps strongest in Medicaid and other programs for low-income individuals, where all or almost all of the funding comes from the public. In these programs it is reasonable to argue for procedures to assign a value to a certain service based on the goals of social policy and to include or exclude the service from a benefit package. In a federal-state program like Medicaid, there is of course the complicating issue of who can speak for the wider community since different streams of public funds are involved. But there is also a strong case for a wider community's voice to be heard in Medicare. To be sure, the beneficiary contributes payroll contributions, premiums, and out-of-pocket spending. But the program also includes a huge contribution from the general taxpayer. It does this explicitly in Part B, which primarily covers physician costs and is not funded by the Medicare payroll tax. But it also does so implicitly for the whole program because of unfunded Medicare obligations.

Social objectives as a factor in measuring value and efficiency are not confined to public sector programs, however. To be sure, a compelling general case can be made for saying that when people spend their own money on health care, they should be the sole arbiters of value and efficiency (an example might be expensive Botox treatments for wrinkles). Yet to the extent that tax policy is specifically designed to alter decisions by transferring funds and subsidizing health services through focused tax relief and credits, the wider community can reasonably demand at least some say in how the transferred money is used. Consider proposals to limit or cap the tax exclusion for employer-sponsored insurance while creating a refundable tax credit for moderate and lower-income individuals. Proponents argue that this approach would directly increase economic efficiency by exposing upper-income individuals to more of the

true cost of coverage by reducing the tax subsidy from other taxpayers. In addition, a refundable credit would offset the cost of health care for lower-income workers and induce greater utilization of health care compared with unsubsidized goods and services. A community could decide that this result achieves a social goal of greater equity in access to health care. It could also conclude that the tax credit would lead to more efficient use of public finances, by reducing revenue loss in the tax system and by inducing lower-income households to seek timely care rather than ending up in emergency rooms with more severe health problems or in expensive public programs.

As noted in earlier chapters, the current tax system provides a large benefit to upper-income employees, because employer-sponsored health benefits are free of all taxes. So a tax credit/exclusion cap reform would even out the community-financed benefit. Moreover, since a tax exclusion or tax credit is intended to achieve a public purpose, the argument can be made that specific benefits and coverage requirements can and should be a condition of tax relief for private plans to achieve the public purpose of access to a particular level and type of health care. Some use this line of argument to propose that tax credits should be restricted in use to certain sources of plans, such as employer coverage or state pools. Still, even where the argument is accepted in principle, the acceptable degree of community control is fiercely debated.

Why Limit the Growth of Spending?

However one decides to resolve questions of value and efficiency, improving efficiency is not the same as reining in total spending. Society can have low or high efficiency at any amount of spending. And while efficiency improvements likely will moderate the growth of health spending—although the degree is disputed—the authors of various chapters note that the total amount of health care spending is heavily driven by the incentives and commitments built into the system. So if the growth of health spending is too slow, policymakers must revisit those incentives and commitments and ponder the implications of making any changes.

Should policymakers even be trying to reduce the growth of health care costs? It might be argued that if efficiency has been improved in an

agreeable way, then policymakers should not be concerned about the amount Americans spend on health care, either in dollar terms or as a proportion of the national economy. After all, society does not tend to worry about the proportion of the national output that is devoted to housing, cars, or movies. So is there really such a thing as a correct or ideal level of health spending? If a rising share of GDP for health care was no longer considered inherently troubling, at least a paradox would be resolved: faster rates of building and employment growth in family or commercial construction are trumpeted as good for the economy and the American future, yet announcements of faster hospital building or employment are greeted with alarm. Moreover, there might be sound reasons for health spending to be increasing as a proportion of GDP. For example, as the population ages, one would expect a service disproportionately consumed by older Americans to push up health spending. As average Americans become richer, one would also expect an increased preference for spending on improvements to health relative to other uses of money, leading to a higher proportion of national income devoted to health.

A distinction might be drawn between spending growth in the private sector and in the public sector. If people are spending their private resources on health care in ways that give them satisfaction, even if doctors and some economists say those ways are unnecessary and wasteful, should policymakers really be concerned? Provided that policymakers ensure that private markets are working fairly and regulated efficiently, it could be said that policymakers should not worry about the level and preferences of private health spending any more than spending levels on movies, vacations, or iPods. At the same time, one might argue that public spending on health reflects public preferences, and so policymakers would be right to focus on spending levels in the public sector.

As previous chapters indicate, even if this distinction is accepted in principle, there are public policy reasons to be concerned about two things when direct subsidies or tax preferences are involved: the level of public subsidy associated with the extra health spending induced, and the type of spending induced.

Certainly in the public sector, the government has an obligation to consider the costs of pursuing health policy goals. It must consider spending on health care objectives in relation to other, competing public goals, as

well as the cumulative economic effects of government spending. As discussed below, this raises the issue of how and whether long-term promises can be kept. Should the government modify public programs in which it has made promises that cannot be honored in the future without an unacceptable diversion of funds from other programs, future tax or debt burdens to finance the promises, or slower economic growth?

Consider once again spending in the private sector. It would be hard for most Americans to accept a general proposition that the government should seek to restrict people's ability in the private sector to spend their own money on their own health care—or their employer from doing so using part of their compensation. This would be true even if that money is spent on health services the vast majority would not choose. But when public funds are entwined with private dollars, or when a certain private expenditure is encouraged with tax relief, the equation changes and there is a reason for concern. The generous tax treatment of employer-sponsored health insurance artificially skews private preferences for health care compared with other goods and services, boosting health spending beyond the level that would otherwise occur. It becomes legitimate for the community to be concerned about private sector health spending when subsidies or tax relief is involved. The argument is not that the government should limit private spending on health care, but that the government should not subsidize artificially high private spending—at least by those with higher incomes.

Thinking about the Sanctity of Promises

The entitlement status in the federal budget of programs like Medicare and Medicaid conveys a critically important moral dimension. These entitlements represent long-term promises to deliver a defined benefit without the limitations of a normal budget. Hence proposals to reduce the scope of the benefits, or the eligibility or funding levels, are widely interpreted by Americans as renegeing on a solemn promise. So it is unlikely that proposals to curb spending on these programs will be politically successful unless proponents can reshape the understanding of health care promises in the minds of Americans.

Entitlements versus Discretionary Commitments

The challenge for policymakers seeking to curb health entitlement programs is to persuade Americans that it is reasonable and fair to balance these promises against the cost of other legitimate goals and implicit promises made to other worthy groups. For if the promises are seen in isolation, and the true cost hidden, Americans are not faced with a moral trade-off and resist proposals that seem to weaken a solemn commitment.

If people are even to consider a trade-off between health care commitments and other promises, they must first, of course, accept that circumstances require a trade-off. Surveys indicate that Americans today generally do not readily accept that premise.⁶ Beside the typical affliction of wishful thinking—that all goals and desires could be achieved if “waste” were eliminated—resistance to the idea of a trade-off also occurs because the budget process allows politicians to avoid discussing difficult long-term budget trade-offs. While the annual Medicare Trustees report lays great emphasis on the long-term unfunded obligations of Medicare, the federal budget considered by Congress ignores the present value of long-term commitments, considering only the five-year or at most ten-year spending scenarios. So lawmakers have little incentive to make difficult decisions to curb future spending obligations or to avoid politically attractive new programs with immediate benefits but costs that mushroom over time. The absence of long-term spending consequences in the budget helps explain why Congress in 2003 enacted a multitrillion dollar Medicare drug bill while claiming it was clamping down on spending.

Changing the Budget Process

A necessary condition for public discussion of moral and spending trade-offs is to make the budget trade-offs more transparent and public. One small but critical step would be to amend the budget process to include a present-value measure of long-term entitlement obligations and special tax preferences in the annual budget process and to incorporate changes in the present value into the annual budget resolution. Several proposals introduced in Congress would incorporate such a change.⁷ This change would at least bring long-term commitments into the limelight of the

annual budget. To be sure, there are legitimate disputes over the methodology and accuracy of estimating the present value of future health spending. But this is a case where even a crude estimate would sharply improve the nature of the public discussion.

Building on greater transparency, a more radical step would make the trade-offs between health programs and other goals even more visible and less avoidable by requiring annual federal budgets to comply with a long-term spending and financing plan. This step would convert Medicare and Medicaid from entitlements to discretionary programs and set a long-range budget. This would end the preferential entitlement status of the programs and force decisions to be made regularly and on a more equal footing between health promises and other promises (such as promises to protect the nation or to educate the young), and between the burden of these spending programs and the economic costs of taxation. Recognizing that planning for retirement requires some certainty over time, a discretionary budget for Medicare might be included prominently in the budget for, say, a thirty-year period, along with a financing budget that would adequately cover obligations. This long-term spending and financing plan would be adjusted regularly in light of such things as changes in technology and demographics. The five- or ten-year budgets enacted by Congress would have to comply with this longer-term budget plan. The long-term plan, as well as the shorter-term budgets, could be linked to some degree to underlying medical costs in order to provide a level of certainty and protection. Indeed an indexed or voucherized budget can be designed to set the financial risk at any point along a spectrum between the community holding the whole risk (a defined benefit entitlement) to the individual holding the entire risk (an “arbitrary” fixed budget). Whatever the fine-tuning, there would be a real, limited budget that could be revisited periodically and adjusted in light of economic conditions and new priorities.

Changing entitlement health programs such as Medicare into discretionary programs would effectively give these programs the same budget status as the SCHIP program. To keep spending within the budget limit, Congress would periodically have to take specific steps, such as changing eligibility rules, altering the covered benefits, implementing greater means-testing, or adjusting payments to providers. Some have suggested

a “trigger” mechanism that would implement automatic adjustments in eligibility or provider payments if the budget is exceeded.⁸ To be sure, designing and enforcing a health spending trigger is no easy task. Reducing payments in Medicare is a form of price control, for instance, and would cause providers to try to game the trigger by increasing volume or reclassifying procedures. And triggers based on fee payments to doctors or changes in eligibility can be so politically sensitive that they are reversed. Nonetheless, for the policymaking process the prospect of a trigger, much like Benjamin Franklin’s reflection on the prospect of hanging, can concentrate the mind—and lead to a program redesign to address the budget requirements.

Forcing Americans to confront a trade-off between health entitlement spending and other goals is a necessary condition for spending control, but it is not a sufficient condition. To agree to such a major change in spending, Americans also would have to be persuaded of at least two things. One is the proposition that it is unfair for promises made to current and future retirees to trump commitments to other worthy groups, such as children or soldiers, irrespective of the economic conditions or the accepted importance of those other needs. Another, in the case of the funding obligations for Medicare, is the proposition that it is unfair simply to expect future generations to have to fully honor commitments they were not necessarily even a party to making—or at least that intergenerational commitments are renegotiable.

Contemplating Risk

Making the case for limiting the growth in health care entitlement expenditures is especially difficult because risk is central to the discussion. Revisiting the implicit social contract between the generations and between health commitments and other social obligations means balancing financial risks associated with health.

When it comes to their health, Americans have shown in their voting patterns and insurance decisions that they want the financial risk associated with an accident or illness to be minimized. Yet their very concept of risk in health is different from that in other spheres, and it has been changing. In health, for instance, there seems to be a quest not only to avoid wide variations in personal spending but also to achieve the goal of

reducing one's personal spending while constantly increasing one's level of care. Detroit workers with pink slips, however, and looming obligations in Medicare, indicate how illusory that goal is becoming. Moreover, the term "risk" traditionally referred to things that might or might not happen—an accident, a dread disease, or falling into such poverty that one could not afford the minimum acceptable level of health care. These were the unexpected health concerns for which private and social insurance was intended. But today there is an additional form of risk that has shaped Americans' view of risk in health care and their attitude to health programs—the "risk" that in the future they might not be able to obtain the constantly improving health services associated with the good life. Things can be done in health care today—expensively—that were virtually unthinkable a few decades ago, and they can improve and extend life to a degree that most previous generations would not have even imagined, let alone thought of as a right to be guaranteed by society. The fear that in the future one may not share in this presumed right is at the heart of the risk of unfulfilled expectations; a product, says journalist Robert Samuelson, of the "postaffluent society."⁹

Americans plan for this expanded view of health risks either by reducing them (such as avoiding certain lifestyles), saving in advance, or insuring against them. The last strategy spreads the risk by sharing it in some collective fashion through private insurance, social insurance, or programs supported through general taxation. Private insurance spreads risk across a voluntary association of those people who choose to purchase insurance—although in tax-advantaged employer-sponsored insurance the employer effectively controls the purchase decision and the portion of the employee's compensation devoted to insurance, so the term "choose" is somewhat illusory.

By their very design, however, social insurance and direct spending programs do not distribute a random financial risk across a normal insurance group of individuals; they assign the risk to a community, usually the national community. But when the financial risk to one individual or small community is reduced in this way, the risk to another individual or community increases. Thus entitlements in the public sector, like defined benefit plans in private companies, do reduce the financial risk for the beneficiary, but they increase the financial risk to the wider community

that is obligated to finance the entitlement. So proposals to rein in spending in these programs force Americans to consider what constitutes a fair distribution of financial risk. In particular, policymakers must consider how Americans will react to policy changes that alter the relative risks shouldered by health beneficiaries and the beneficiaries of other programs, by the federal government and the states, and by different generations.

THE BALANCE OF RISK BETWEEN GROUPS. Health entitlements and other health spending reduce the financial risk for beneficiaries but increase the risk for groups with needs that must compete for funds and generally for groups that are dependent on discretionary programs. For example, Eugene Steuerle has drawn attention to the way in which middle-class entitlements, especially Medicare, are relentlessly crowding out funds for children's programs. This crowding out will accelerate as the baby boom generation retires.¹⁰ If Americans were asked explicitly if they found this trend acceptable they might consider spending reforms. But the budget process clouds the picture. As discussed earlier, if policymakers are to achieve policy decisions on health spending that reflect the balance that Americans want to achieve between competing social goals and the underlying values they represent, then the budget process must make such trade-offs much more transparent.

FEDERAL AND STATE RISK REDUCTION. A policy designed to reduce federal costs in health entitlements—that is, to reduce the financial risk to current and future taxpayers—also requires consideration of the financial risk to states and even lower levels of government that have a legal or moral obligation (under pressure from voters) to maintain acceptable levels of care. One suggested way to reduce the risk to states is to give them greater flexibility and incentives to find more efficient ways to design and deliver services, and the legal power to adjust eligibility or services for some categories of beneficiary. This can be done through waivers and block grants. However, advocates of Medicaid and other programs for low-income Americans understandably worry that retrenchment at the federal level means benefit and eligibility changes that may insulate state coffers while shifting the risk down to vulnerable beneficiaries of the programs. The complaint from advocates is that, all other things equal, this flexibility means higher out-of-pocket payments, reduced availability of

services, and even reduced eligibility for individuals whom average Americans generally want to help.

Is there a way to address risk-shifting between levels of government that might better address the concern that the financial risk and burden on the poor would be excessive? Perhaps this can be done by edging toward an acceptance of tiering in health care for those in need. Based on the pattern of federal and state legislation over the years, society does seem to be striving to assure all residents that they can count on some minimum level and scope of health care from the community if they cannot afford it themselves. But Americans also seem to take the view that beyond that minimum it is appropriate for states to vary the level of benefits and categories of beneficiaries as reflected in the resources and the social values of their citizens. So there seems to be a distinction drawn between a national community obligation and smaller communities in which preferences and capacities shape any additional obligation. This sense of tiered obligation is already enshrined in the mandatory and optional populations in Medicaid and SCHIP.

As we consider how states might adapt to the financial risk associated with reining in federal spending and the concern it raises for beneficiaries, perhaps the federal government's role should be clarified in light of the way Americans look at spreading risk and obligations between different levels of community. The approach might be to clarify in statute both the national goals of federal-state programs and the national protections that must apply to beneficiary groups, but give states much wider flexibility than today in how they organize health services to achieve those goals.¹¹ It is important to recognize, of course, that the principle of tiering means that beyond a minimum national set of benefits and eligibility for public programs in America, it has to be acceptable for needy individuals to receive different levels and types of care than do better-off Americans. These differences reflect not just local (that is, state) financial capacities, but also differing views of the proper balance among social commitments to health care and to other goals such as education or housing.

RISKS TO INDIVIDUALS. However society tries to sort out the financial risks to different communities associated with restraining total federal health spending, experience shows it is very difficult to get public support

unless Americans feel that ultimately the financial risks to individuals are handled reasonably and fairly.

That sense of fairness depends on the nature of the risk and the individuals at risk. For instance, Americans typically feel that those who “play by the rules” and have tried to plan for the future deserve more protection than those who have not. And most think it is especially unfair to change the rules on someone who has tried to plan but does not easily have the ability to adapt to changes in a program. The capacity of a person to plan for change or adapt to it is central to the public’s sense of fairness about spending controls. The pattern of legislation in recent years indicates a strong public resistance to budget reductions in Medicare that would significantly affect current retirees or those nearing retirement but some openness to higher costs, such as through income-testing, on more affluent seniors.

More ambivalence occurs in the case of the Medicaid population. A strong desire to help those who fall on hard times is balanced against a tendency to view many on Medicaid as having more generous health care protection than most who work and are modestly paid. Moreover, the recent pattern of state Medicaid changes suggests that the public’s commitment to low-income working-age people and their children who are needy is seen, rightly or wrongly, as more limited and temporary than its obligation, say, to the elderly. The Medicaid commitment is seen as dependent on the community’s available resources—with the obligation to children more strongly felt than to parents and especially to single adults without children. At the same time, the strong commitment to those who are reaching retirement is broadly perceived as a higher-order promise to repay those who have contributed to their health benefits—Americans think of Medicare benefits as something people earn and that reducing earned benefits is unfair.

Rationing

The discussion in the previous chapters points to two broad approaches intended to curb spending within the context of public perceptions of fairness. One is to place greater control of the allocation and pricing of health services in the hands of government. The aim in this case is to allocate resources according to a community-wide sense of fairness and

efficiency. The other approach is to invest control mainly in the hands of individual users of services, with markets as the tool to allocate resources. The aim in this case is to give individuals the ability to allocate resources in ways that maximize their own preferences. Both involve rationing, in the simple sense that total resources (private combined with public contributions) are less than the demand, and both raise issues about control in the context of risk.

Americans flinch from the term “rationing,” in the sense of government officials making decisions over who will or will not receive particular medical services. But then they also flinch from the idea that medical service decisions should be made on the basis of who can afford to pay a premium or out-of-pocket price. In fact, rationing in the sense of denying services according to some criterion (perhaps by price, perhaps by a formula to determine “need”) is implicit in every system of allocating any resource.

Each general rationing technique raises different values and ethical concerns in people’s minds. Rationing by explicit denial of access, for instance, raises the issue of who in the community should make these decisions and on what moral basis? Rationing by payment to service providers, either in the public or private sector, raises additional concerns. For example, should health providers be the ones who must make rationing decisions when their costs exceed their payments from the government or insurers?¹² Conversely, should the high salaries of doctors relative to other professions (compared with other countries) be considered sacrosanct? Furthermore, rationing by price at the point of consumption, through deductibles and co-payments, raises the general question of whether ability to pay should be the determinant of access to all care, or perhaps only to access for certain categories of care.

Devising successful policies to slow the growth of health expenditures actually requires policymakers to consider how people view these different forms of rationing—not just how mechanically efficient the forms are, but how they conform to people’s sense of values and fairness.

The public’s willingness to accept rationing in the form of government agencies deciding whether specific items are covered services depends in large part on whether people have confidence in the way the political process makes these decisions. One possible way of reducing

these concerns is to make coverage decisions as objective as possible, by reducing the perception that decisions are the result of provider lobbyists or other pressures. Oregon sought to resolve these concerns by ranking services according to the medical evidence on their cost-effectiveness and using public meetings and dialogs to build acceptance among Oregonians for eliminating less effective services in order to stay within the budget. Meanwhile Canada and the United Kingdom have procedures to regulate the introduction of new technology into their systems. In the United States, some have proposed a “Benefits Board” of medical experts to revise the Medicare package, in place of Congress legislating benefits in an atmosphere of lobbying and gridlock. The proposed board would periodically recommend the most cost-effective and modern benefits package for a budget, and Congress would have to enact or reject the package without amendment.¹³

However, these seemingly objective approaches trigger two general concerns. The first is the issue of subjective value raised earlier in the discussion of efficiency, namely, that the value judgments of a panel charged with assessing the benefit of a procedure necessarily will often differ sharply from those who are subject to its decisions. Ranking disputes in Oregon often centered on these value judgments. So in its Medicaid reform plan of the early 1990s, the state sought to address this by incorporating a series of public meetings to gauge opinion and refine its ranking of services.¹⁴ The second and related concern is the fear that a remote panel of “faceless” individuals will make mechanical decisions and cannot be reasoned with—the worry that lies at the heart of the widespread antipathy to insurance companies and particularly to managed care. Unless and until explicit rationing system procedures in public programs are perceived to engage those affected and to be flexible, it is likely that Americans will resist the idea of politicians or bureaucracies directly limiting their care.

To be sure, the more common form of rationing in the United States is not by directly allowing or disallowing access to care, but by regulating the payment for care. Private markets do this through pricing and provider-payment decisions, and so do most public agencies. Thus care is restricted by the willingness of providers to deliver care at the payment level and of the patient to pay out of pocket. For this reason, many worry

that tightening budgets for public programs or cutbacks on employer payment levels for health plans shifts the financial risk to the individual and implicitly rations according to the criteria of government or employers.

Proposals for voucher-style approaches (such as premium support proposals for Medicare and cash and counseling in Medicaid) or health savings accounts are said to respond to this concern by shifting greater control of the financial resources to the beneficiaries of public programs or private coverage. The aim in these approaches is to give beneficiaries greater opportunity to shape the allocation of services according to their own assessment of value and to remove it from government officials or employers. But there are issues to consider in this approach. The community is at greater risk if the individual makes bad decisions (one reason that HSAs are linked with catastrophic insurance). Moreover the resultant balance of financial risk between the individual and the community will depend on the way in which funds for the voucher or the savings account are determined. The more that funding is indexed in some way to the underlying cost of medical services, the less the risk is shifted to the individual—and the less tightly health costs will be constrained. Still, as discussed earlier, there remains under these approaches a tension between community visions of value when public funds are involved and the individual's preferences. This tension is reflected in the degree to which benefit requirements are attached to the use of funds by the individual.

Rethinking the Medicare Social Contract

While many steps could be taken that would have some impact on the explosive future growth in Medicare spending, it seems unlikely that dramatic savings can be achieved without redefining the Medicare promise. Politically, revisiting that promise is no easy task. Americans would have to agree on the nature of that promise as well as decide how sacrosanct that promise is in the face of other goals and limited resources.

The actual Medicare promise is open to question. At its inception in 1965, the program's benefits reflected the objective of providing coverage comparable to employment-based coverage at the time. If that objective is held to remain the basis of the promise today, then it is reasonable to modernize benefits, such as improving Medicare's catastrophic protection. It would also be in line with that view of the promise to alter

beneficiary costs to reflect the current trend toward greater cost-sharing in employment-based coverage. Alternatively, if the promise is to maintain the original approach to financial protection and the private-public balance of financial risk, it could seem reasonable to make significant adjustments today. For instance, the premium for Part B was originally set at 50 percent of costs. Today the beneficiary share is only 25 percent. Adjusting the premium percentage and the real value of deductibles to the original 1965 promise would mean substantial costs for seniors today and large savings to the program.

If it were possible to agree on what the promise is, would Americans be open to altering it to keep costs in check and free up resources for other social goals? Altering the promise would challenge deeply held values associated with the idea of social insurance. In particular, it would require Americans to alter the widespread view that Medicare is a sacrosanct social contract, a binding promise to deliver benefits based on an insurance agreement paid for not just with individual (subsidized) premiums and payroll taxes, but also collectively with general taxes. A step toward changing that view would be to correct the widespread misperception that promised benefits are financed entirely by payroll taxes and premiums and can be maintained by eliminating “waste” in Medicare itself and in other programs. To someone who holds this view, the solution to excessive costs is to improve efficiency, not renege on a promise. That person sees no trade-off between Medicare commitments and achieving other goals. To him or her, a proposal to reduce benefits or level of access to benefits is both unnecessary and unjust.

Thus if major changes are to be made in the benefits structure or financing of Medicare, Americans would have to think differently about the program and its underlying social values. That means redesigning the social insurance model. Of course, Medicare already departs significantly from the classic American social insurance model. Parts B and D are optional, premium-based insurance programs heavily subsidized by general revenue. Congress’s decision to income test Part B premiums is a further departure.

Americans might be willing to modify the Medicare social contract. After all, Americans typically will forgo a portion of something they are entitled to if they accept the need for them to do so to address a higher

need. Presenting more clearly in the budget process the scale of unfunded obligations and the growing role of general revenue in Medicare would help prepare the ground for a public discussion over the entitlement. That discussion would have to focus on the consequences for other national goals of honoring the letter of the Medicare promise, such as the crowding-out effect of the burgeoning general revenue commitment and the morality of passing on a huge financial burden to future generations.

Let us assume Americans were willing to contemplate a change in the Medicare social contract that would reduce the trajectory of costs and obligations in order to provide more resources for other goals and to reduce unfunded obligations. In what ways might the contract be reframed?

INCOME INSURANCE. One approach would be to turn Medicare into collective “income insurance” to enable retirees to afford adequate care if they lack sufficient income, rather than the traditional vision of social insurance. Income insurance would secure an individual’s ability to afford health care during retirement. Risk insurance would replace today’s program, which finances the delivery of medical benefits with little or no regard to income during retirement. Under this vision, today’s income-related payroll taxes would become in effect a premium for collective insurance that pays for services only to the degree that an individual’s retirement income falls below a certain level. In addition, upper-income retirees would pay an income-related premium for Part A services as well as Parts B and D or make payments in some other way. Individuals would in practice be paying income-adjusted premiums for a health program available to all retirees.

THE MEDICAID MODEL. Another approach would be to transform Medicare from a social insurance program into a more traditional income-based program. In effect Medicare would become a form of national Medicaid program for the elderly, with all benefits becoming income-related. Recent legislation to relate Part B premiums to income as well as unsuccessful proposals to make the drug benefit income-based assistance are consistent with this approach. Under this restructuring there would be a far weaker case for payroll tax financing, since the social insurance basis of Medicare would be replaced with a needs-based approach. To support this change, however, Americans would have to

accept a crucial change in the nature of the Medicare promise. The program could no longer be interpreted as a promise to return dedicated contributions made during a person's working life—arguably a higher-order promise to return resources that somehow belong to the individual. Instead it would reflect a much more limited promise by the wider community to help the low-income elderly afford health care—a commitment that would have to compete on more equal terms with promises to other groups and for other purposes.

A third, hybrid approach would be to shrink the social insurance element of Medicare to the level of a very basic safety-net program, while encouraging or even mandating individual private savings and insurance to supplement the basic program. While keeping a smaller social insurance commitment in place, with its higher-order promise by the community, this approach would shift choice and responsibility for additional services to individuals. It would link supplementary benefits during retirement to the ability of the private savings and insurance vehicles to finance them, with the attendant risk to the individual, rather than to an open-ended commitment and shouldering of risk by the community.

Revising Expectations

If the proposals in this book are to be enacted, Americans will have to think differently about their expectations for health care, about the meaning of risk and mutual obligation, and about retirement. That will require a serious and honest conversation.

Americans will have to consider which health services should be a “membership right” for U.S. residents and which are marginal preferences. And given the aging of the baby boom generation, the idea of retirement must be at the center of that conversation. Rising costs associated with increased longevity, demographic shifts, and the health care expectations of a modern society are the principal drivers behind the country's health spending predicament.

A contemplation of the risks and promises related to retirement, and their implications for other groups and generations, is central to a discussion about retirement health costs. But so is a frank conversation about the very concept of retirement. As Barbara Butrica and others at the Urban Institute have pointed out, increasing life expectancy has

changed expectations about retirement and fundamentally altered the economics of both private and public financing of retirement.¹⁵ During the 1930s, when America began in earnest to create social insurance structures for retirement security, the typical worker could expect a retirement of just a few years—assuming he or she even reached retirement age. Today each new cohort of working Americans grows accustomed to the idea of enjoying an ever-larger proportion of its life in active retirement, financed in large part by someone else.

Americans so far have not been willing to accept significant limits in their health care. They also have yet to accept the proposition that the cost of generous health care during a predictably long retirement is unsustainable and cannot be shifted constantly to someone else. Anxiety about the uncertainties of health leads Americans to resist proposals to raise the Medicare eligibility age in line with increasing life expectancies (in contrast to Social Security where age was raised without much controversy). They are also resistant to the idea of curbing their ever-expanding health care expectations. And they are resistant to shouldering more of the predictable cost themselves while reserving social programs primarily for the needy and for truly unexpected developments. Until policymakers engage in a serious discussion with Americans about these issues and values, it will be very difficult to generate strong public support for the necessary steps to rein in health care costs.

Notes

1. Daniel Yankelovich, *Coming to Public Judgment: Making Democracy Work in a Complex World* (Syracuse University Press, 1991).

2. Indeed Malcolm Gladwell in his book *Blink: The Power of Thinking without Thinking* (New York: Little, Brown, 2005) refers to studies indicating that physicians who spend more time in conversation with their patients, and also engage in “active listening,” are held in higher regard by patients and are far less likely to be sued. See Gladwell, pp. 39–43, referencing Wendy Levinson and others, “Physician-Patient Communication: The Relationship with Malpractice among Primary Care Physicians and Surgeons,” *Journal of the American Medical Association* 277, no. 7 (1997), pp. 553–59.

3. For a discussion of efficiency and the particular challenges in achieving efficiency in health care, see Henry J. Aaron and William B. Schwartz, with Melissa Cox, *Can We Say No?: The Challenge of Rationing Health Care* (Brookings, 2005), pp. 93–107.

4. David M. Cutler, *Your Money or Your Life: Strong Medicine for America's Health Care System* (Oxford University Press, 2004), pp. 10–21.

5. If the transference of funds is seen as moving toward a Rawlsian vision of social justice through income equality, however, the funds would be interpreted as truly belonging to the recipient rather than the community, giving the community a much weaker claim to determining how the money is used.

6. For example, see Robert J. Blendon and John M. Benson, “Americans’ Views on Health Policy: A Fifty-Year Historical Perspective,” *Health Affairs* 20, no. 2 (March/April 2001): 33–46.

7. For example, Senator Joseph Lieberman (D-Conn.) introduced a comprehensive overhaul of the budget process in 2003 containing provisions requiring that unfunded liabilities be included in the budget process (S 1915 108th Cong., 1st sess., Honest Government Accounting Act of 2003).

8. For example, Rudolph G. Penner and C. Eugene Steuerle, “A Radical Proposal for Escaping the Budget Vise,” *National Budget Issues* 3 (Washington: Urban Institute, June 2005) (urban.org/UploadedPDF/311192_NBI_3.pdf). The Medicare drug legislation of 2003 included a weak version of a trigger that would force consideration of a financing plan if general revenues were projected to rise above 45 percent of total Medicare costs—a proxy for the entitlement crowding out discretionary funds. Steuerle and Penner suggest a comprehensive trigger mechanism for retirement entitlements and for tax levels.

9. Robert J. Samuelson, “Affluence and Its Discontents,” *Washington Post*, May 10, 2006, p. A25. See also Robert J. Samuelson, *The Good Life and Its Discontents* (New York: Crown, 1995).

10. C. Eugene Steuerle, “The Incredible Shrinking Budget for Working Families and Children,” *National Budget Issues* 1 (Washington: Urban Institute, December 2003) (urban.org/UploadedPDF/310914_incredible_shrinking_budget.pdf).

11. For a proposal to combine national goals and policy parameters with wide state flexibility, see Henry J. Aaron and Stuart M. Butler, “How Federalism Could Spur Bipartisan Action on the Uninsured,” *Health Affairs* web exclusive, March 31, 2004: W4-168–W4-178.

12. See Stuart M. Butler, “Private Sector Incentives and Ethical Health Care,” in *Ethical Dimensions of Health Policy*, edited by Marion Danis, and Carolyn Clancy, and Larry R. Churchill (Oxford University Press, 2002), pp. 202–26.

13. For a description of the benefits board idea, see Stuart M. Butler, “Achieving Progress on Medicare,” *Backgrounder* 1627 (Washington: Heritage Foundation, 2003) (www.heritage.org/Research/HealthCare/bg1627.cfm).

14. See Michael J. Garland, “Rationing in Public: Oregon’s Priority-Setting Methodology,” in *Rationing America’s Medical Care: The Oregon Plan and Beyond*, edited by Martin A. Strosberg, Joshua M. Wiener, Robert Baker, and Alan Fein (Brookings, 1992), pp. 37–59.

15. Barbara A. Butrica, Karen E. Smith, and C. Eugene Steuerle, “Working for a Good Retirement,” Retirement Project Discussion Paper 06-03 (Washington: Urban Institute, May 2006) (urban.org/UploadedPDF/311333_good_retirement.pdf).

