



**Public Policy Forum**  
**Health Savings Accounts:**  
**Are They a Good Idea?**  
**Presented by**  
**Peter D. Salins and**  
**James W. Fossett**

*May 10, 2006*

*Richard P. Nathan:*

My name is Dick Nathan. I'm proud to be the co-director of Rockefeller Institute of Government, the public policy research arm of the State University of New York. We have many important and close dealings with both of our speakers, the provost of the State University and Professor James Fossett. I have been looking forward to this. I am very interested to hear what our speakers are going to say on a subject that I have been thinking hard about and lots of people are talking about and looking at in ways we're going to hear about.

I organized this to be an exchange of conversation. The ground rules are that Provost Salins will speak first. Provost Salins is saying that he thinks that Health Savings Accounts (HSAs) are a good idea and Professor Fossett is saying he doesn't think so. I will then give them each five minutes to respond to each other. I will then probably have a couple of questions that I want to ask and then I will open it up to the audience for questions from all of you. I won't say much about the topic because they will tell you what health savings accounts are and develop ideas about them.

Peter Salins has been here ten years as provost. I've come to know him well. He is a good friend. Peter is the vice chancellor for academic affairs and chief academic officer of the State University of New York, which is a far-flung enterprise in which he has done innovative, important work in a challenging and important position in our state. He is a scholar, well known for his work on urban policy in New York City and in the country on American cities in the fields of housing, urban development, economic planning, and immigration policy. His most recent book is called *Assimilation American Style*, published by Basic Books. A previous book I will mention is *Scarcity by Design*, published by Harvard University Press. So he has been a leading thinker on urban and domestic economic issues at CUNY before he came to assume his degrees, including his Ph.D. from Syracuse University.

Our second speaker is the person who I have known longest in this whole room, Jim Fossett. Jim worked with me when he was wearing knickers, or anyway he was just a kid. I was at the Brookings Institution and that is way back. He came here shortly after I did, as a faculty member at the Rockefeller College in public administration, and he has since then been a leading researcher and expert, particularly in health policy, at the Rockefeller Institute. He is currently doing new work on bioethics, working with Albany Med. He is the director of our program of studies at the Rockefeller Institute on health policy and particularly Medicaid, working with Courtney Burke. His political science training is from Vanderbilt University and the University of Michigan. A lot of his work on Medicaid and Medicaid managed care and health policy in general is on our web site. So these are two well-informed, expert, thoughtful people who are going to share with us now their ideas on a subject that I'm sure we'll enjoy hearing about, health savings accounts.

*Peter D. Salins:*

Thank you, Dick. First of all, some caveats. First, today, I'm taking off my provost hat and reverting to my earlier, more scholarly interests. Second, with respect to the issue here today, Dick mentioned the various issues that I've worked on and healthcare has not been a major part of that; but public policy has, and so I'm essentially bringing my public

policy and analytical perspective to an important domestic policy issue. The third caveat concerns the title of our panel and what I am supposed to be talking about. I think that it's unfortunate that some very important ideas in terms of social welfare policy that are being advanced by this administration in Washington are marketed under absolutely absurd names or titles, creating totally distorted views of their concepts. The administration's Social Security reform is not about "privatization," as everybody calls it. I'm not going to talk about that issue today, except to just make the point that it wasn't about privatization. It was about moving from a defined benefit to a defined contribution program, which could be public or private or any kind of a mix. Likewise, the "health savings account" proposal has nothing to do with savings accounts. And so again, I think it's unfortunate that whether out of a lack of marketing savvy or even a lack of understanding, an important concept has been marketed in absolutely the wrong way.

So I am not really talking about "health savings accounts;" I am talking about what I call "the smart path to universal healthcare." First of all, let me begin by defining the problem.

The United States has the most advanced healthcare system in the world in terms of health technology and the capability of dealing with adverse health events. At the same time, the United States has the most primitive healthcare finance system among the advanced countries of the world. The United States spends more than any other country, yet 45.8 million U.S. households are uninsured and health outcomes on the whole, at least compared to our advanced peers, range from mediocre to poor. And finally, the present finance model is economically unsustainable over the long haul. Just to document what you probably already know, but I think this puts the issue in bold relief — the United States spends 15.2 percent of its Gross Domestic Product (GDP) on health expenditures. Japan spends 7.9 percent, Australia 9.5 percent, Canada 9.9 percent, and France 10.1 percent. There is hardly an advanced country that spends much more than 10 percent of its GDP on healthcare and, of course, our GDP is the highest in the world, so we're spending a higher percentage of a higher GDP.

As for health outcomes, our life expectancy for the latest year for which I was able to get the data (it might have inched up a little bit since then), which I think it is 2004-05 is 77.3, Japan's is 80.8, Australia's 79.9, Canada's 79.6, and France's is 78.9. These aren't huge differences, but they show that even with our large expenditure we're not anywhere near the top. It looks worse when it comes to infant mortality, another important indicator of health outcomes. The American infant mortality rate per thousand live births is 6.9, Japan's is 3.2 (remember this is a place that spends about half as much per GDP as we do), Australia's 5.2, Canada's 5.3, and France's 4.5. I could have added 12 other countries but I'll stop here because this gives you the idea. Why do we have the problem? What is wrong with the U.S. finance paradigm? That's what I want to talk about; not "savings accounts," but the finance paradigm and how we might change that.



First, the original sin is our reliance on employer-based insurance. It's a terrible idea, and we are long past the time when we should have scrapped as much of that as possible. Regarding employer-based insurance, some of the points are obvious. It's not portable, so in a smoothly functioning labor market, coverage is enormously uneven. It all depends on who you're working for, so we have employers with great coverage like SUNY, employers with lousy coverage, and employers with no coverage. But even for the employers with good coverage, like my employer and the employer of some of the other people in this room, the State University of New York, the coverage has eroded because costs are rising rapidly and it is one of the areas where employers need to make savings.

The second major original sin is that there are no real incentives for health consumers to behave intelligently regarding the cost of healthcare. One of the two major components of that failure is the third-party insurance system, whether the third party is

an employer or the government. There is practically no, or a very minimal, tradition in the United States of first-party insurance coverage. Everybody expects somebody else to pick up the cost of their health insurance. And then the other component is the expectation that every health event needs to be covered by insurance. It's very unusual in any set of insurance-covered contingencies that all the contingencies would be covered. When we have homeowners insurance, if a tree falls on our house, *that* would be covered. But mowing the lawn, or routine maintenance, or painting of the house would not be. But when it comes to health insurance, all health events, whether they are serious or minor, expensive or cheap, are expected to be covered. Now, we do have deductibles, and other features that erode that principle, but the concept that the average American health consumer has is that all health events, all health treatment, is supposed to be covered, and if it is not, that represents a failure of the system.

In any case, a point that I am going to come to repeatedly in my talk is this system cannot be sustained. What should be our goals be in changing the system? First, we have to encourage health consumers to engage in a more market-oriented behavior or perspective when they purchase treatment for health events. That is the only way that we get the reasonably intelligent operation of any of our markets. By essentially not asking our health consumers to behave intelligently as purchasers of a service, we create many of the problems that we face. The second major goal? We have got to wean Americans off the employer-based system. Third, we have to control the growth in healthcare spending naturally, rather than through some kind of an institutional mechanism. And finally (I feel very strongly about this), we *do* need universal coverage.

If I am advocating universal coverage, what's wrong with single-payer? I don't know what my fellow panelist is going to be saying, but my guess is that single-payer may be one of the things that he promotes, and it is a major alternative to the direction in which I think we should go. I think the problems with a single-payer approach are quite evident if we look at the single-payer systems of other countries. To begin with, you have a lack of market responsiveness, which results in unsustainable rising costs and/or the rationing of healthcare, and these two things are in a kind of trade-off. If you want to

minimize the rationing, you sustain higher costs. If you want to minimize the growth rate of the costs, then you resort to rationing. In either case the government gets deeply involved in healthcare decisions. Increasingly, single-payer means, essentially, that the government is the single payer. I think that when we say single-payer, we invariably mean *publicly financed single-payer*, so the government becomes increasingly involved in the micromanagement of the healthcare delivery system. And, of course, you have an ever-growing reduction of consumer choice. So, what I'm encouraging is an entirely different approach, which I think is embedded in what is mistakenly called the "health savings account" idea.

I don't want to use the "health savings account" language, but these are the things that are in the new paradigm, First, Americans would be encouraged or, perhaps, required, to purchase their own health insurance; and what Massachusetts has just legislated is a very interesting experiment in that direction. Not everything Massachusetts is doing is right, and not everything that Massachusetts is doing is consistent with the paradigm that I'm advocating, but the concept that we should be encouraging individuals or households to purchase their own insurance is an important and critical first step. Second, we want to encourage low-cost health delivery options for minor healthcare events. The routine monthly or bimonthly visits to the pediatrician, the scrapes and minor burns and other routine health issues that people have, don't have to be treated by highly trained and expensive physicians. The extent to which such a system will have to be subsidized — and I do agree that there has to be subsidy embedded in any healthcare delivery system — we would shift the subsidies from employers and government plans to consumers. And, finally, we should reward good health behavior. So these are all the key ingredients we want to embed in the new paradigm.

What would be the basic features of the new paradigm? I would start with one that would probably be politically the easiest to do; and that is that all individual health insurance purchases would receive a generous tax benefit. Secondly, we would have to couple that with some format for better regulation — or at least vetting — of the health insurance industry, and health insurance plans.

The third point is that the tax treatment of employer-based plans cannot be more generous than the tax treatment of individual consumer-purchased plans. So, while we would probably not be able to prevent the continuation of the employer-based system, by making the tax subsidy as generous on the consumer side as it is on the employer side, my hope would be that that would cause a gradual shift toward consumer-financed insurance, and employers could guiltlessly start moving themselves from the old system because all of those tax benefits would automatically transfer to their employees as consumers. There also would have to be incentives for more strategic and intelligent utilization of healthcare, especially the insured component.

And, significantly, we *need* community rating. That's one of the areas where I probably depart most extremely from most of the people who would otherwise advocate health savings accounts. I think that without community rating none of these systems will work.

Here are some details that can be added to the basic paradigm that I'm presenting: Good health behavior should result in lower health insurance premiums. So rather than have health insurance cover preventive care, which is what happens or is demanded now, what should happen instead is that preventive care and testing would result in the reduction of premiums; very much as in the automobile insurance environment, where good motorist behavior — taking defensive driving courses and other things — results in lower premiums for automobile insurance. The out-of-pocket purchase of routine and recurring treatment should be encouraged mainly by discouraging their inclusion in health insurance plans.

And let me raise another important issue that has never been discussed by anybody as far as I know, but I'm very much aware of as the provost of a system with four medical schools. The high drug cost problem is largely a *high drug research cost* problem. It is not the manufacturing of pharmaceuticals that is really expensive; it is the research to create the pharmaceuticals that is expensive. We have a very sophisticated, high-quality, academic medical industry in America that could actually do drug research much more cheaply, or at least with less risk, than the pharmaceutical industry. So I

would recommend that we start moving most of the cost of drug development to the higher education academic medical centers of the country — with government support, essentially by either expanding the scope of the National Institutes of Health or by creating a new institute specifically for that purpose, because the cost of drugs is going to be an increasingly important part of the healthcare finance issue.

Now, the so-called health savings account model has a number of problems aside from its unfortunate naming. The tax treatment that is envisioned is not nearly as generous as that of the employer-based plans so it wouldn't create a natural incentive to move from employer-based plans to individual plans. As presently constructed, it would be unaffordable for most lower-income households. Further, there is absolutely nothing in there that would guide or regulate insurance plans that individuals would purchase. And there is the absence of community rating, which would invite adverse selection, which is, I think, the most common complaint that the critics of HSAs present.

Let me just conclude. The current American healthcare finance system needs radical revision. The single-payer solution is neither politically nor economically viable. The HSAs have gotten a bad rap mainly because their design has been careless, and their advocacy far too ideological. Massachusetts, at least, is beginning to show an alternative direction that might lead the way to a fairly substantial rethinking of the whole system nationally. Thank you.

*James W. Fossett:*

H. L. Mencken, the acerbic American critic of just about everything, is often credited with the observation that for every complex problem of human affairs there is a solution that is simple, neat, and wrong. What I want to argue is that the simple, neat, and wrong solution for the complex problems of health access, quality, and cost that we face as a country is to try to turn the healthcare system into something that looks like a market. HSAs are only the latest manifestation of the idea that our healthcare problems would be solved if we could make the market for healthcare look like the market for cars, flat screen TVs, or hotel rooms. If you make patients see the true cost of healthcare and pay

at least some of it out of their own pocket, give them information about quality of care and the like, the market will be turned loose somehow to do its magic. Now this is not a generically new argument. Economists have been making versions of it for years. But HSA proposals — and I think we have to stick with what's on the table rather than a more idealized version of it — envision much more extreme institutional change than earlier ideas and have the potential to effect changes not all to the good for people who don't enroll in HSAs. We've got at least some experience with this form of financing healthcare. HSAs have been around since 2003 and enrollment in them is well over 2 million by now. This experience, together with a lot of research we've gone over for close to the last 20 years, suggests that HSAs are neither simple nor neat but they're still wrong in a variety of different ways. One is that they don't help and may hurt low- and moderate-income families and may make access to insurance harder to get for a lot of people. Part of the point of this way of doing things is to move insurance coverage out of the heavily regulated group market in which you buy group coverage through your employer and into the individual market, which in most states is much less significantly regulated. Now, remember there are two parts to these things. One is the HSA itself, which is some kind of tax-advantaged savings arrangement that employees can contribute to directly without involving their employer at all. The second part is a high-deductible insurance policy. The idea is as health bills come in, you first draw down the balance that's in your HSA, then you're stuck with whatever other bills you have and pay for it with after-tax income until you hit that deductible. Then, if you have bills on top of that, you still have to pay a pretty healthy copay — frequently in the neighborhood of 20 to 30 percent — until you hit an annual out-of-pocket maximum and that's the point at which this high-deductible insurance policy kicks in. Now the way these pieces fit together make HSAs in general not a very good deal for low- and moderate-income people and particularly for the uninsured.

One is that most of these products that are on the market have a relatively high deductible. So you are responsible for a fairly good-size slug of spending before the insurance policy kicks in. The most commonly subscribed plan in the private market as of last year had a deductible for families of \$5,200. That means that a family with the

average median income of \$54,000 has to give up almost 10 percent of its pretax income to contribute enough to cover the deductible. I'll bet there are a lot of families that simply are not going to be able to afford that.



Second, the tax subsidy as currently constituted is simply not worth that much for people in this income range. Three-fourths of U.S. households are in the bottom two income brackets that don't pay any tax at all. That means that the maximum tax benefit that people are in a position to realize from an HSA is 15

percent, which is a margin that a lot of work suggests is simply not going to be enough to make it attractive. For people without insurance, the overwhelming bulk who don't pay any tax at all, there is no help at all from this particular thing.

Third, the out-of-pocket costs, what you have to pay with regular after-tax income, may be high. If you can't afford to save the entire deductible, and there are going to be a lot of people who are going to conclude that they can't, and your out-of-pocket maximum, the point at which your insurance policy kicks in is relatively high, then there are going to be a lot of families winding up with substantial out-of-pocket, after-tax costs. The precise numbers are going to vary according to where the plan puts the deductible, the out-of-pocket maximum, and what you have to contribute. But the point is, it's very easy for participants to wind up paying more from after-tax income for healthcare than from the subsidized savings that's supposed to make this easier to get.

Finally, in most states, the individual market is just not really very well regulated and it's entirely possible that people in poor health are going to be subject to underwriting, which means they're going to pay very large premiums and, in some states, it's perfectly legal for an insurance company to refuse to cover them at all. So what that's going to mean — this combination of potentially high costs, both out-of-pocket, and a

minimum tax subsidy — is that a lot of people are going to forego care that it's generally considered to be a pretty good idea for them to get. Raising costs to patients, a lot of work has found, may reduce medical expenditures but it doesn't do it in a good way. The way people reduce medical expenditures is by foregoing preventive care that "you don't really need." These are things like Pap smears, breast cancer screening, drugs, rather than looking around for high-quality care. So HSAs really aren't a very good deal for the overwhelming bulk of the population. Who they are a very good deal for is the so-called wealthy healthy. Upper-income taxpayers get a much bigger tax break, 35 percent, for enrolling in the current versions of HSAs and that deduction is simply worth a lot more to the better-off than it is to the less well-off. In fact, the current version of these programs is a better deal for tax-advantaged savings than any form of individual retirement accounts (IRA) that is currently available. Because with HSAs you don't have to pay taxes on either the money before you put it in or when you spend it. Those of you who are trying to juggle your IRAs with other kinds of tax-advantaged savings, you at least have to pay tax on it once. And there is no income limit typically on these kinds of proposals, so this has the potential, anyway, to turn into a major tax shelter for those who have maxed out on their IRA contributions or are above the income limit to claim the tax break. The Bush administration has proposed to double those contribution limits, which makes that deal even better.

So what this is going to do is, I think, dramatically increase the federal deficit by losing all the tax revenue that could be collected on these investments without making it cheaper or easier for anybody who currently doesn't have it to have any insurance. So it helps the wealthy in the upper tax bracket a lot. It doesn't help those in lower tax brackets very much, if at all. My economics professors taught me to call arrangements like that regressive.

Finally, I think healthcare simply doesn't work like a market, at least not in any simple way, and market competition is not a very effective way to hold costs down. The underlying theory of HSAs and a lot of other reform plans that have been on the market is that somehow we can turn patients into consumers who can make somebody compete for

the healthcare dollar on the basis of cost and quality. This is a theological issue for economists. Every system of organized interaction either is a market or should be made to look like one. But if you're not an economist, however, there are a couple of problems. One is that the competition doesn't address the primary problem. HSAs, in theory, make providers compete for cheaper services: Amoxicillin for the kids' earaches and colds, mammograms, Pap smears, and other things that are relatively inexpensive. This doesn't begin to address the big healthcare spending problem, which is disproportionately slung into a relatively small number of people who incur relatively big healthcare bills. Ten percent of the population in any given year accounts for over 70 percent of healthcare spending. These are people frequently older and toward the end of their lives with serious conditions, various kinds of cancers, heart disease, AIDS, major strokes, and other serious diseases that are scary to have and expensive to treat.

Second, there are a lot of data that suggest people just can't judge quality all that well. They've proven to be very sensitive to cost but not that sensitive to quality. It's a bit easier to do for primary care. But where quality is typically taken to mean some kind of interpersonal success, if you ask somebody, "Do you like Dr. X?" and they say "Yes" and you ask them why, the answer you will almost invariably get is something like, "He spent a lot of time with me, he answered my questions, he didn't talk down to me, and he didn't condescend." Now certainly that is a part of healthcare, but it doesn't necessarily have anything to do with how good the guy is as a clinician. I've heard arguments that say physicians are nicer when they've done a lousy job because they're scared they're going to get sued. But if you or somebody close to you has a serious and scary disease, the idea that somehow you're going to pump an oncologist or cardiologist for the cost effectiveness of the treatment program that he or she has proposed is just not reasonable.

Finally, there has been a lot of effort expended in trying to get people quality information. There is a lot of research that has been done. The review article that I assign on this question to my healthcare finance class has seven single-spaced pages of references but what they suggest is that people don't like numbers, don't understand them, and don't pay attention to quality measures even if they can get them. A survey

report last year in the *New England Journal of Medicine* said that only about 20 percent of people even look at quality information and, typically, less than 2 percent have ever changed their minds on the basis of it.

So, I repeat, this deal fits H. L. Mencken's criteria only it's not simple, it's not neat, but it is wrong.

*Richard P. Nathan:*

Thank you. Now we'll give each person a chance to respond to the other. First, Peter Salins.

*Peter D. Salins:*

Thank you. Two basic points. First, and I don't blame Jim for this, because he didn't know what I was going to say, but essentially we're talking past each other because what he was attacking was not what I was proposing. Now you can say Dick told us to only talk about health savings accounts so I had no right to offer my own particular variant on that. But the truth of the matter is that I don't think anybody in Washington takes the present design all that seriously, including its promoters, so I think the real issue is: Can we take some of the fundamental ideas that are in the concept, forget about all of the specific parameters — where Jim probably had some good points to make — and can that idea be recast into something that *would* be a major alternative both to the present hodgepodge, and to a single-payer system? I feel strongly that it can. I just want to recap the major points.

Clearly, the subsidy does have to be large enough so that the low-income households that Jim was referring to — many of whom, by the way, have no insurance at all right now — can be covered. The aggregate cost to the government will not be greater because we would essentially be moving that subsidy from the employer system to the consumer system. Clearly, you do want to design it in a way to urge intelligent health behavior. As I said, the kind of insurance plans I envision, which would be vetted and

regulated, would have premiums contingent on preventive care, screening, and that kind of thing. Finally, the high-deductible catastrophic idea is intrinsic both to the HSA concept and to what I propose because, essentially, what you want to do is to not have individuals necessarily expect to be insured for all minor and routine health events.

But let me go to what is really the nub of the philosophical disagreement between Jim's (and anyone else who agrees with Jim's point of view) and my view. In that disagreement, perhaps I do share a perspective with the proponents in Washington and elsewhere of health savings accounts. I think that this notion that healthcare is somehow exempt from normal economic rules is absurd. And I have heard that belief expressed in so many policy areas. Actually, since I have done work in many different public policy areas, in every one I hear the same allegation. *Housing* is not subject to market forces. How can you expect housing to be subject to the market? Land use, another area that I've worked in, is also supposed to be immune from the normal dynamics of the market. But I think that healthcare, like the other policy arenas I cited, is *absolutely* market responsive.

Let me mention two of the dynamics in healthcare that would very quickly adjust to a more market-oriented system. There is no magic to why health costs so much. Most of the cost of healthcare in America is the cost of the healthcare providers, most specifically the physicians. I don't want physicians to starve but essentially their pay, like the pay of lawyers and teachers and college professors — and even university administrators — will respond to normal supply and demand incentives. There is no automatic entitlement of anybody in the healthcare delivery system to a particular level of compensation.

The other point touches on this very patronizing assumption that the opponents of health savings accounts — or any kind of market-oriented system — keep on making. We educated people in this room can make intelligent healthcare decisions, but ordinary people can't possibly do that. First of all, there is plenty of healthcare decision making to be made even in a single-payer system or the current system. Many people neglect their healthcare needs. Many people make poor choices of physicians even if they have excellent coverage from their employer or from Medicare or some other kind of system.

So rather than taking this patronizing view that says we have to have a highly paternalistic, centralized system, I say that healthcare consumers, like consumers of food, clothing, housing, entertainment, and all the other goods that people buy, can make decisions as intelligently in a regular consumer marketplace in healthcare as in the other consumer areas.

*James W. Fossett:*

I want to thank Peter for admitting his limited sympathy with the version of this proposal that is now on the table in Washington. The Bush administration has reintroduced it several times and is even proposing to accentuate those features that both Peter and I find objectionable and I don't see anybody proposing the very sensible things that Peter is advocating. So the proposal on the table is the one that we've got. What I do want to spend a little time responding to, however, is this notion about whether or not healthcare is or is not a market good. Now, I'm still having some trouble getting this. When a board-certified physician who has been to school for a number of years and has a lot of experience with very complicated cases, recommends a course of treatment, anybody in this room no matter how well-educated they are, is going to have a lot of trouble arguing with that particular call no matter what other education or intelligence they have. The fact is that there is a fundamental information asymmetry between physicians and patients. It's not unlike the information asymmetry between my mechanic and me when I take my car in. I am very much dependent on my mechanic to tell me what's wrong with my car and I am in no position to second-guess the guy.

If you look at the way people historically have responded in market-like settings, because of this information asymmetry, whether the patient is a Ph.D. or anybody else, you find that they tend to respond behaviorally, and I don't think this is patronizing at all, it's just the way it is, by doing things that the same physician would not want them to do. They tend to drop preventive services that that physician would want to tell them are things they ought to get. And they have a lot of trouble figuring out quality. Now, I belong to an HMO and I know how to get this stuff. I can go online, I can read this stuff, I teach this stuff. But trying to get from that to whether or not a particular course of

treatment that my oncologist is prescribing for me or somebody close to me is a much different kind of proposition. If you go, in fact, to the oncology literature, you'll find that the profession itself is frequently at odds with each other about how to treat particular kinds of fairly complex diseases. If you happen to have one of those conditions, the notion that you can somehow pick when the medical specialist themselves haven't been able to arrive at a consistent definition of what quality treatment is, is more than absurd. It assumes that you've got an S on your chest under your suit somewhere that somehow the medical profession doesn't have. So, while it's true that physicians' salaries adjust to supply and demand, it's not really true that somebody going to the doctor is in the same position as somebody going to Best Buy and trying to find the best big-screen TV. There's no *Consumer Reports*. There's simply not the kind of information that's available to consumers of other things. And there's still this fundamental asymmetry between a board-certified physician who spent 12 years of his or her life worrying about cancer and somebody who has it. I don't know any way to reform the medical encounter to get rid of that.

*Richard P. Nathan:*

Thank you both. I thought both speakers were direct and informative and smart in dealing with a good topic, which did have HSA letters on it. Now I'm going to ask a question. I'll start with Jim and then Peter. One question for me and then I'm going to open it up to you.

Jim, when you talk about the fundamental information asymmetry, and then you use the car analogy and say, I don't know how to fix my car and indeed I don't, I think maybe we need a government program for universal car repair because I'm unable to function as a rational consumer. I've often thought and wondered that when you talk about consumers responding, sometimes we leave out the physicians. Our physician talks to us. I respect him. We go back to him. We like him and I think he likes us. And I think if he or she knew that we were exposed to some personal cost, the providers, and I don't mean just physicians, would behave differently. The market would behave differently.

So, Jim, I would like you to address that with a brief answer and then I have a question for Peter.

*James W. Fossett:*

You know, I think the same way about my physician, certainly. But it is true that physicians are the ones who control access to the market and access to services just the way in which your mechanic does. Now I think the advice that I get from my physicians is the best they can give me. But I'm in no position to do the kinds of things that the market model requires me to do as a consumer. I can believe in my physician's intelligence. I can believe in his or her competence. I can believe in his or her determination to give me the best possible advice. But I'm still dependent on them and I have no basis on which to say, "You're telling me," and I quote here from a recently published article by two of my colleagues, for example, "that you need a CT scan after your MRI was negative." Peter will answer all questions about the clinical import of that but the idea is what he or she tells me to do, I'm more than likely going to do.

*Richard P. Nathan:*

Peter, would you like to comment on his answer? Then I'll ask my question of you.

*Peter D. Salins:*

Yes. I think that one of the problems is a lack of imagination in what a new universe might look like. And maybe I'll be accused of being too idealistic or whatever, but I anticipate three cultural shifts. The first, which I think has been totally ignored in Jim's presentation, is that under the scheme that I envision *everybody would have insurance*. Right now there are 45.8 million households that don't have health insurance at all, so to talk about them in any way benefiting from the present system is meaningless. So first, we're talking about everybody having insurance. The second cultural shift anticipates everybody buying their own health insurance. Now, when they buy the insurance they

will have to factor in the issue of the subsidy; the subsidy is going to be limited so they have to decide what they can buy within the subsidy frame.

The third big cultural shift is the idea that a lot of the routine healthcare expenditures should not even be expected to be covered. Now, if you look at why the health-related expenses in these other countries that I have on that table are so much less than ours, it is not because of the difference in the expense between countries of open heart surgery and cancer and that kind of thing. There and here, those kinds of health events are treated reasonably effectively. The differences in aggregate healthcare expenditures among countries are related to expenditures for the smaller, minor healthcare events, which are much more frequent. Years ago, I did a study of healthcare in Nassau and Suffolk County. The overwhelming majority of visits to physicians or health facilities of one kind or another, and the resulting cost, was for relatively minor events. Those can be treated cheaply, as at the local storefront walk-in medical center, where there is a physician in attendance, but most of the work is done by other health practitioners and they do that work very effectively. So I think that with some imagination we can see how the system can be made more market responsive. In any case, the current system right now has a combination of very high costs and very mediocre health outcomes.

*Richard P. Nathan:*

I'm going to ask my question of Peter Salins and Jim can have a go at it. Then I'll open it up to everyone. You crossed me up on focusing on HSAs in the title of this talk and you suggested, and I'm fascinated and interested by where you're going with this, that this is not what you think ought to be the articulation of the new strong interest towards some kind of reform system that brings about universal coverage on a basis that introduces stronger incentives for market behavior. So would you comment more on what is it going to look like when you finish?

*Peter D. Salins:*

That's very important. Let me reiterate the key points. I'm not saying my concepts are necessarily contradictory with what the Bush administration has been promoting. But either out of an excess of caution, or lack of imagination, or bowing to what they consider to be the political constraints that they have to deal with, the administration proposals differ from mine, first of all, in not recognizing that we do have to have universal insurance coverage. That is the one area where I think I probably agree with Jim and a lot of people. Everybody should be insured. I just don't think everybody should be insured by the government and I don't think they should be insured by their employer. I think everybody should be insured, at least residually for those that aren't insured by government or their employers, by buying insurance themselves. Massachusetts is moving in that direction.

The second point is that the extent to which the current system plows enormous subsidies into these third-party insurance plans, you could actually shift that subsidy into first-party insurance plans. So, if an employer, for example, decided to get out of the health insurance business, that entire tax benefit, which is quite considerable, would shift essentially to the employees of that corporation. And the final point is that the health industry itself has to change. The assumption is that these high costs are just intrinsic to modern healthcare. They're not. There is equipment that is expensive intrinsically. The MRIs and the other screening devices and some of the implements and surgery and so forth are expensive. Pharmaceuticals are expensive, but I mentioned the reason for that is because we've shoved the entire cost of drug discovery to the drug companies, and actually we would be better off shifting the cost of that to government-subsidized work done at the academic medical centers. But the largest part of the cost of healthcare is the cost of the healthcare specialists. There is no fixed income or compensation that they are entitled to. And, interestingly, there isn't nearly the variation in the compensation as you have in many other industries. Look at law. Lawyers all do pretty well. I don't know how many lawyers are in the room, but I think most lawyers do reasonably well. But the range of pay for lawyers is enormous and it's much greater than the range of pay for

cardiologists or any other specialist. I think we would get, actually, a much more variable cost structure in a more market-oriented system.

*James W. Fossett:*

I guess I would have to disagree on several counts. One is where this difference between us and other countries comes from. Note first that a lot of these other countries, particularly in Europe, pay for care roughly the same way we do, by payroll taxes. So there is still this kind of framework that they do better than we do. But I think that there is an increasing amount of evidence that says the thing that's different is the expensive stuff and not the cheap stuff. If you look at how many MRIs, how many ultrasound machines, how many fancy expensive machines we have compared to Canada, Britain, France, or Germany, we have somewhere between two and three times as many of those things compared to population as most of our developed brethren do. Second, and the problem that's kind of particularly difficult to deal with, I think, when you're talking about the difference between making people buy insurance and giving them something that they can afford is some of those big-bucks solutions actually work. The way we treat cardiac care now is enormously more expensive for all the reasons that both Peter and I have talked about than it was 50 years ago. It's much more capital intensive. It's much more sophisticated. But the point is, according to several very sophisticated evaluations, in terms of better and longer life, it's worth it. So we don't want to reduce access to those kinds of procedures for reasons of economics. We've kind of made a commitment as a society that healthcare is one of the things that we want to distribute more equally than the market would let us.

Finally, we've already shifted the subsidy for drugs. Dole-Bayh and the significant amount of NIH money that goes into university-based drug research really is very heavily subsidized. But it's given universities the same incentive to behave in this kind of rapacious, patent-seeking, high-return kind of way that the pharmaceutical companies do. So we need to do something else. There are high costs, or at least intrinsic to the way we do business in this, whether it's through the drug companies or through universities.

*Richard P. Nathan:*

I have another comment/question. I'm going to not make it a question for them to respond to because I want to give you time, but I'm going to put it on the table and maybe we'll come back to it. This is the comment I'm making. In my lifetime, the most profound things that have happened around me in the country are the civil rights revolution, the change in the role of women in the economy, and how we die. And so what is involved here in part and underlying what a controlled or market-oriented controlling system might be is that the 10 percent of people who are sick and dying is where we spend so much of our healthcare money. Indeed, there is literature about this, the British have, that changed what we will do with miraculous treatments that modern medicine can provide. I'm just going to put it on the table. Maybe I can ask it at the end. Maybe somebody will want to ask the speakers to talk about this dimension of our subject matter but, as promised, I now open it up to your questions.

*Shadi Saleh:*

I'm with the Center for Public Health Preparedness at the University at Albany. I like Jim's point on comparing physicians to mechanics with the whole asymmetry of information, but it's even more severe with physicians because with mechanics you can always say, "Hey, how much is this thing going to cost me?" They'll say, "\$2,000." You say, "Well, the heck with it. I'll buy a new car." With physicians, you go to a surgeon and say, "Hey, how much is it going to cost me to have bypass surgery?" They say, "\$15,000." You say, "I'll get the new heart." It doesn't work that way. So with physicians, there is even a more severe asymmetry of information, which makes sort of the market theory even more challenging. Regarding your point on trusting your physician and what your physician says, well, the fact of the matter is that a significant proportion of the population, or at least the 46 million who are uninsured, don't have a primary source of care. So they don't even have a physician to trust their judgment. I think that the main macro effect of HSAs is the whole principle of risk and cost shifting. In the beginning of healthcare, it was a direct patient-to-provider relationship. You, as a patient, go to the provider, the provider will provide the care, and you pay. So the risk

was at the patient. Then it went to health insurance companies and employers and the government. So the government now must pay. Then, more recently, it moved again. Then afterward it moved to the provider with the whole withholding and I think the whole thing with the HSA is they try to move it now back to the patient.

*Richard P. Nathan:*

I'm going to stir up some questions. So both of you kind of listen and decide to comment on comments and try to get some diversity in the audience opinion.

*Tom Hilliard:*

I'm with the Schuyler Center for Analysis and Advocacy. I have two questions, one about individual insurance and the other about high-deductible health coverage plans. I certainly like the idea of doing away with employer-based health coverage, but I'm just curious about some of the known issue with individual insurance coverage and how you grapple with those. One is that the administrative costs are extremely high, you know, up in the neighborhood of 30 percent, and, of course, administrative costs are already one reason why the U.S. is more expensive than European countries. Second, there is medical underwriting. People with conditions as mild as hay fever have been excluded from individual health insurance and high-risk pools have been found to be pretty poor substitutes.

*Peter D. Salins:*

What about community rating, remember?

*Tom Hilliard:*

Yeah, although that does seem less politically salable than single payer in the U.S. But certainly that would be one answer. Maybe I should just let you address that before I go on.

*Peter D. Salins:*

The administrative issue I haven't got an answer to. I'm sure we could do some more detailed analysis of how this kind of thing would work. But as far as the strawman that has been erected against that system: first of all, even with a high deductible system, the assumption would be that precisely the things where these auto-mechanic-like physicians and their expertise come into play, are the events that would be covered by these kinds of policies. As far as the adverse selection of the high-risk pools, clearly the concept would not work without community rating.

*James W. Fossett:*

Like I said, the places that we've tried to introduce community rating has been a very hard political sell. We like segmented insurance markets and I don't think you can just wave your hands and say community rating will fix it if we think we stand no chance whatever of getting the community rating. Second, my guess is that trying to do away with underwriting the individual market would be an equally difficult kind of sell and if you're sick and you can't get covered because you're sick, you're kind of stuck. The high-risk pools, I agree with you, work better in theory than they have in practice.

*Bob Megna:*

I'm with the New York State Division of the Budget. I just have a comment. I understand that you want a good mechanic, you could go to a poor person in your neighborhood and they'll tell you where to find one. So I think sometimes you do underestimate markets from that kind of point of view. Also, just a comment but I would like your reaction. I think the idea of a market is not to say that heart surgery would be cheap. I think we're confusing two different things. It would still be very expensive, just like a Mercedes is very expensive. And I think what we want to make sure is that you have access so that people can get access to that heart surgery if they need it and have some insurance policy that will help them pay for that. I'm not sure what the right way to do that is but I think that it's a mistake to say the market doesn't work because something is expensive.

*Peter D. Salins:*

Exactly, I agree.

*James W. Fossett:*

Well, the market works. It certainly works and has expensive things in it. That's not the problem. I mean the rub comes in when you want to distribute things in a different kind of manner. Now, we don't have it as a matter of social policy that anybody who wants a Mercedes gets one. We do have it as a society that somebody who needs expensive surgery ought to have access to it regardless of their ability to pay for it.

*Bob Megna:*

The market sometimes is a good indicator of the kinds of things that you do have to pay for. I do believe that there are information asymmetries and I kind of agree with your point. But we know what the market would tell us about pricing unless we had a more market-driven system, which is why I think the auto mechanic system does work on the profit side even though we don't necessarily know how a car engine works because pricing tells us a lot of information about how to make a judgment about what to buy and what not to buy.

*James W. Fossett:*

Well, pricing is also supposed to be responsive in a market-driven system to certain kinds of incentives itself. And if you look at the way innovative medical procedures have diffused over the last years, you ought to be able to see that if you've got a dozen major medical centers who offer access to the same sets of services with surgeons who are roughly of equal talent, over time those prices ought to come down. There ought to be competition. And you don't see it. In fact, they go up.

*Tim Orcott:*

I'm with the Research Foundation of the State University of New York. I think the big problem is we don't know whether it would work as a market environment because we have no price transparency. So I think, though, there are physicians who price gouge, and I've seen it happen before, four times reasonable and customary, but people don't know that unless you work in the human resources office. So what would make sense to me would be some kind of index. If you're going to price gouge, you're going to price gouge on everything and maybe compare what the range of charges someone charges to a reasonable and customary standard and whether you're 99th percentile or 79th percentile, at least someone would have an idea. Those 46 million people who don't have a doctor yet, can at least say, "Oh, he's charging a lot more than this guy. I'll give him a try before I'm stuck trusting someone that I don't know."

*Peter Levin:*

Yeah, I think the whole HSA thing that Peter Salins sidestepped is the issue of that by creating health savings accounts people will be price sensitive and those of you who are enamored of markets this will appeal to very much. The fact of the matter is you really can't shop. And I use the example, if anybody needs an operation, how many of us have shopped the price of the anesthesiologist? It's totally unreasonable to expect this in our system. You would get the information that if maybe somebody has an office visit for \$50 and somebody else has it for \$65 and somehow you're going to shop the system and be a smart shopper. As opposed to the car thing; you go to the dealer and they want \$2,000 to fix it and you go to your mechanic on the corner and he says, "I can do it for \$1,500 or I'll just tighten this up and you're going to be OK for another six months," it just doesn't fit with healthcare. And those of us, I mean this was a big thing when I was in Washington to try to get the health savings accounts going and it's an idea that appeals to people, but there's no substance that it's going to bring down the cost of anything or make you able to buy healthcare in a better way. Plus, we've decided we want our healthcare administered by a financial services industry that talks about medical loss ratio of never going without 80 percent, and apparently we're very content to take this 20

percent and pay it out in dividends. So the other side of that is what's been going on in Albany with a group of physicians who have been pushing for single payer. You know, we're going to have to pick our way through this. Both sides have pluses and minuses but we can't have it both ways. We can't be smart shoppers because the market doesn't exist to be a smart shopper.

*David Shaffer:*

I'm with the Business Council of New York State. I have three quick observations, only one of which may be worth replying to. First, on the tax thing, they'll never swing a tax treatment of HSA and the treatment that a rich person gets now. The employer buys health insurance for you and that purchase of the goods for you is exempt from taxation. You get the 35 percent either way. The second thing, in this state at least, the individual market is more heavily regulated than the large group market. The third thing is I don't believe the market model people are talking about is the individual deciding what kind of surgery they're going to have. It's the individual deciding who's the aggregator of their healthcare services, exactly as you decide whether you're going to buy a Toyota or a Hyundai or a Ford. You don't decide, "I want this kind of timing system for the engine but I want that kind of radio and I want a radiator from this other place over here." That's the way that a healthcare market for the elderly and working is going to work that way, not by people saying, you know, "That's the wrong side of the brain to go in on my own particular case. I know better than the doctor." Nobody's going to get into that.

*Richard P. Nathan:*

Final comments. Jim, you go first, and then Peter.

*James W. Fossett:*

I guess in response, when I hear about aggregators of health preferences, I think about things like HMOs or other kinds of organizations that have some capacity to look at all these data on health quality and come to some reasoned understanding about it, we're

going to steer our business here or there, or wherever. And that strikes me as a much better arrangement and it gets rid of more of that information asymmetry than relying on individuals to do it. As far as a question about price transparency, the problem that I've seen, anyway, is that people are acutely sensitive to changes in price. I mean, the last elasticity I've seen for HMO premiums is somewhere upwards of 2, which is by economic standards, enormous. The thing that's harder to get a handle on, though, that's worrisome, is figuring out on an individual basis whether or not what you're buying is worth it. That's the harder thing to get a handle on. If you just say your health insurance bill is going to triple unless you change to this lower-cost plan, most people are going to do it. But if you don't tell them, you know, you don't have any access to hospital care, there are going to be all kinds of caps on how many prescriptions you can have and all that kind of stuff, that's the thing that people have some trouble figuring out how to relate to the price.

*Peter D. Salins:*

First of all, it's a complex area but also both sides of the debate probably erect strawmen and I think David hit the nail on the head. Nobody expects individuals to make a decision about what kind of heart surgery they're going to get. The two forms of market behavior that would be encouraged under what I envision are, first of all, that the individual buys the insurance policy. Now, the insurance policy may have features that may make some kinds of interventions more difficult than others, but most of these insurance policies will leave it to the physicians to decide what kind of heart operation or transplant or whatever is taking place. So the health insurance marketplace is not the same thing as talking to your mechanic and deciding what to do with your car.

The other kind of market behavior that has really been kind of a strawman by neglect is the failure to recognize the irrationality of general American health consumer behavior regarding the little things. The little things do matter. As a matter of fact, if you take care of the little things long enough, you don't have as much of a likelihood of the big things. The reason we have this enormous differential by class and education and income in health outcomes is partly because the better-educated population, most of

which does have health insurance, is able to make intelligent small decisions. Having a universal healthcare system, even if it's privately insured, will start spreading those benefits. I think that the other sort of strawman is the assumption that these costs are hardwired into the firmament. They're not. We have customs; we have practices; but as a matter of fact there is enormous variability in the cost of these things and if you look at the international data, not just the outcomes data, but if you look at the input data, that a lot of these things cost very different amounts of money in different countries, even modern countries with roughly comparable standards of living as the United States. Those will be pretty much my closing thoughts.

*Richard P. Nathan:*

I think this is terrific. Both the speakers did a very good job. I thank them and I thank you for coming.