

LAW AND THE FOG OF HEALTHCARE: COMPLEXITY AND UNCERTAINTY IN THE STRUGGLE OVER HEALTH POLICY

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I. INTRODUCTION

In healthcare, as in any field of professional practice, uncertainty is an everyday fact of life. New research and information technology can reduce uncertainty insofar as its cause is limited knowledge, but scientific and technical advances cannot dispel uncertainties when they have another source: complex, variable, and opaque institutional arrangements that are ultimately political in origin. Compared to systems in the other major democracies, the American healthcare system stands out not only for its cost and inequities but also for its extraordinary complexity. That complexity — and the fog of uncertainty it creates for everyone involved in healthcare — is more than a nuisance; it is a problem with wide repercussions that deserves more analytical attention than it has thus far received.

Complexity is not an inherently bad thing. Our computers, smartphones, and the Internet are complex, but they are relatively easy to use, and they make other things easier and cheaper. Complexity becomes a problem, however, when it adds to cost and difficulty without yielding compensating benefits. In healthcare, patients and providers alike face that kind of gratuitous complexity. The complexity has economic effects: the administrative costs of healthcare are far higher in the United States than in other countries with more unified or standardized systems of healthcare finance.¹ The complexity also has a psychological impact: health insurance and the healthcare system are confusing and frustrating to many of the sick and their families, as well as to those who care for them. Not least of all, complexity has a political impact: health policy has become so intricate that proposals for change also seem too complicated to many people, lending plausibility to charges that “death panels” or other insidious schemes are

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1. See, e.g., Uwe Reinhardt, *Divide Et Impera: Protecting The Growth of Health Care Incomes (Costs)*, 21 HEALTH ECON. 41, 44 (2012); Steffie Woolhandler et al., *Costs of Health Care Administration in the United States and Canada*, 349 N. ENG. J. MED. 768, 772 (2003).

secretly hidden inside them.² In an era when American politics has become polarized on partisan and ideological lines, the fog of healthcare has become so thick as to make rational public discussion of health policy nearly impossible.

The United States worked its way into this fog step by step. Instead of enacting a comprehensive system of healthcare finance, as did the other rich democracies of the world, Congress created different programs for different groups — veterans, the employed, the elderly, some of the poor. Each of these programs was based on its own distinctive principles, which run the gamut of the public-private spectrum. For veterans, there was a federally owned and operated health system; for seniors, a federal insurance plan with private supplemental insurance; for the categorically eligible poor, a mixed federal-state program; for workers with employer-provided coverage, a tax subsidy for private insurance. As health costs rose, employers and private insurers adopted a myriad of different plans and rules in a largely unsuccessful effort to keep costs down. For similar reasons, programs and rules multiplied in the public sector as well. Many of the complexities in those programs stem from legislative compromises struck in Congress, which were then overlaid with further compromises in later additions and revisions. Private markets, federalism, and legislative compromise have their virtues, but transparent and streamlined arrangements are not necessarily among them. Ironically, some of the most highly prized features of America's political economy have produced one of the most reviled features of the American healthcare economy — its bewildering complexity.

When people discuss the primary objectives of health policy, they do not usually mention reducing the fog that envelops the system. In Donald Berwick's well-known formulation, for example, the "triple aim" of health policy should be "improving the experience of care, improving the health of populations, and reducing per capita costs of health care."³ Reduced complexity would contribute to two of those objectives: an improved experience of care and lower costs. But escaping from the fog will not be easy. Many people are comfortable in it, some earn their living from it, and the shock of entering the daylight of a simpler system would probably cause many people to believe at first that they were worse off even if they were not.

2. PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 237 (2011) [hereinafter REMEDY].

3. Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 759 (2008).

II. THE FOG OF THE HEALTHCARE MARKET

Consider first the fog that hangs thick and low in the healthcare market. The American healthcare system systematically obscures prices and costs. At crucial points of decision, most people have no idea of the true cost of their health insurance or healthcare.

The employment-based insurance system can be counted as a success in this respect: it conceals costs from those who ultimately bear them. Economists agree that the cost of health insurance, including the share nominally paid by the employer, is borne by the worker, who would otherwise receive higher wages.⁴ But most employees with health benefits do not see it that way; they see it as a burden shouldered by their employer. Most do not even know the total cost of their insurance coverage; until this year, their W-2 did not show the employer's contribution to their insurance.⁵ Pay stubs typically list only the employees' share, and their awareness of that amount is minimized because it is subtracted from their paychecks before they receive a dime. In addition, they do not see themselves as benefiting from a tax subsidy, although the exclusion of employer health insurance payments from taxable income is the third costliest federal health program (after Medicare and Medicaid).⁶ If Americans had to write a check every month to make a single lump-sum, after-tax payment for health insurance, the resistance to rising premiums would surely have been greater.

Prices for medical services are also enveloped in fog. Hospitals and other healthcare providers do not post their prices, much less offer any way of comparing how expensive they are. Depending on a patient's insurance coverage, providers charge different prices for the same service. Indeed, they regard prices charged to different insurers as a trade secret and often cannot give a simple, straight answer to a consumer's questions about the price for a service at the time it is being provided. It is as if, when you drove up to a gas station, there were no signs indicating how much the fuel would cost, the station would charge you a different price depending on the type of car you were driving, and the attendant refused to tell you the price even while you were at the pump.

The low visibility of prices for healthcare and insurance has been a major contributory factor in America's high medical costs. As Uwe Reinhardt has shown, prices for the same service vary wildly within the United States, with the average sharply higher than in the other rich democracies. In 2010,

4. Lawrence Summers, *Some Simple Economics of Mandated Benefits*, 79 AM. ECON. REV. 177, 178 (1989).

5. I.R.C. § 6051(a)(14) (2012).

6. Jonathan Gruber, *The Tax Exclusion for Employer-Sponsored Health Insurance* (Nat'l Bureau of Econ. Research, Working Paper No. 15766, 2010), available at <http://www.nber.org/papers/w15766>; see also REMEDY, *supra* note 2, at 75.

for example, private insurers in the United States paid from \$6,379 to nearly \$14,000 for a normal delivery, with an average price of \$8,435 compared with \$3,768 in France, \$2,667 in Canada, and \$2,147 in Germany.⁷ In a study conducted between May 2011 and July 2012, fewer than half of hospitals contacted could provide a price for a total hip replacement; among those that did, prices varied from \$11,100 to \$125,798.⁸ Moreover, price appears to be unrelated to quality; there is no evidence, for example, that the U.S. hospitals that charge more for a given service deliver a correspondingly superior quality of care.⁹ Americans may believe that they get more and better healthcare by spending more money on it, but mainly they pay a higher price per service without evidence of corresponding benefits.

To be sure, people know that healthcare is expensive, and especially if they are uninsured, the price of an initial visit to a physician may deter them from getting care. That may help explain why the annual number of physician visits among Americans aged 18 to 64 dropped from 4.8 to 3.9 between 2001 and 2010, a period when the proportion in that age group without health insurance rose from 17% to 21.8% and an increased proportion of the insured faced higher cost-sharing.¹⁰

Healthcare differs from other markets, however, in that the demand for services comes only in part from consumers. Once patients are in the midst of treatment, physicians and other providers make most of the decisions that determine how much that course of treatment costs. As a result, much of the demand is supplier-induced, especially for the most costly services. Unlike most other consumer spending, moreover, healthcare spending is highly concentrated among a small proportion of the population. In any given year, five percent of people typically account for about fifty percent of healthcare costs, while the top ten percent of people account for two-thirds of costs — and most of this spending takes place above the deductibles even in high-deductible plans.¹¹ But just as patients lack information about prices, so do physicians: it's no part of their training, and they ordinarily

7. Reinhardt, *supra* note 1, at 46.

8. Jaime A. Rosenthal et al., *Availability of Consumer Prices from US Hospitals for a Common Surgical Procedure*, JAMA INTERNAL MED. (Feb. 11, 2013), <http://archinte.jamanetwork.com/article.aspx?articleid=1569848>.

9. Reinhardt, *supra* note 1, at 46.

10. BRETT O'HARA & KYLE CASWELL, U.S. CENSUS BUREAU, HEALTH STATUS, HEALTH INSURANCE, AND MEDICAL SERVICES UTILIZATION: 2010, at 2 (2012), available at <http://www.census.gov/prod/2012pubs/p70-133.pdf>; Sabrina Tavernise, *Doctor Visits Dropping, New Census Figures Show*, N. Y. TIMES, Oct. 1, 2012, at A22.

11. NAT'L INST. FOR HEALTH CARE MGMT. FOUND., THE CONCENTRATION OF HEALTH CARE SPENDING 1, 2 (2012); Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, 20 HEALTH AFF., March/April 2001, at 9, 12.

have no reason to take an interest in what hospitals, laboratories, or medical-device and pharmaceutical companies charge.

Oscar Wilde defined a cynic as someone who knows “the price of everything and the value of nothing,”¹² but in healthcare, that is too rosy a view. A true cynic would say that neither doctor nor patient knows the price or the value of treatment, though they had best be convinced of its value so as to benefit from a placebo effect.

It is one of the ironies of the supposedly market-oriented American system that healthcare prices are much harder to discover in the United States than they are in many countries where prices for physicians’ services are negotiated annually, posted publicly, and easily available. In France, where the payment system is now electronic and nearly instantaneous, patients must nonetheless first pay their physician before receiving reimbursement.¹³ This system was adopted originally because the medical profession insisted that it continue to be paid directly by patients under the French insurance system, but it now serves as a way of maintaining public consciousness of prices.¹⁴

In the 1970s, a healthcare system with all-payer rates, annually negotiated and publicly posted, was imaginable in the United States. But since the 1980s, it has seemed inconceivable because of political opposition to price regulation and because private insurers, Medicare, and Medicaid pay such different rates that any move to a uniform standard would cause enormous financial disruptions. But even if Democrats and Republicans cannot agree on all-payer rates, why not insist that healthcare facilities at least post a uniform set of prices for people not covered by Medicare and Medicaid? As Michael Porter and Elizabeth Teisberg, two business school professors, point out: “The administrative complexity of dealing with multiple prices [for the same service] adds costs with no benefit. The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantages individual system participants gain from it, even for those participants who currently enjoy the biggest discounts.”¹⁵

Two possibilities suggest themselves. One would be to use Medicare’s relative values and let providers determine the multiple of Medicare rates that they prefer to charge. For example, one hospital might charge Medicare plus 25%, another Medicare plus 50%, enabling consumers to

12. OSCAR WILDE, *LADY WINDERMERE’S FAN* act 3, sc. 1.

13. T. R. REID, *THE HEALING OF AMERICA* 59 (2009).

14. *Id.* at 60–61; see also MARC A. RODWIN, *CONFLICTS OF INTEREST AND THE FUTURE OF MEDICINE* 35 (2011) (confirming that direct payment by the patient to the physician has been a core principle of the French insurance system since its inception).

15. MICHAEL E. PORTER & ELIZABETH O. TEISBERG, *REDEFINING HEALTH CARE* 66 (2006).

know instantly relative costs. A second possibility, without the use of Medicare's relative values, would be to require providers to adopt one set of prices for all private payers and to post those prices online in a uniform format. In that case, entrepreneurs could develop websites and apps to enable consumers to figure out how much care at different facilities would cost. Just as guides indicate how much restaurants cost on a simple scale with dollar signs, so an overall index could, at a glance, show how a doctor's or hospital's prices stood in relation to others. Some health plans have begun to offer online resources to compare prices, though at this point they appear to be of little practical value.¹⁶

Posted prices would be particularly helpful to the millions of people now moving into high-deductible plans. Advocates of the market want healthcare consumers to be more price-conscious, but how can they make price-conscious decisions without any way of knowing what prices are? Even more than liberals, market-oriented conservatives should want to adopt requirements for price transparency.

III. THE FOG OF HEALTHCARE PROGRAMS

Just as Americans have gotten used to the fog in the healthcare market as if it were normal for producers and consumers not to know the price of services, so they have gotten used to the fog that hangs over public programs for healthcare. The history of healthcare policy in the twentieth century is a story first of failure and then of piecemeal reform — the failure of general proposals for national health insurance, and the passage of piecemeal efforts to deal with the problems of groups that benefit from public sympathy and effective organization. The passage of these programs has often involved compromises of a particular kind. Compromise does not inherently lead to greater organizational complexity; for example, members of Congress may split the difference on the budget for an agency without complicating the agency's structure. The adoption of major health programs, however, has involved *ideological compromises* between left and right that have resulted in complex structures with hybrid operating principles. The passage of Medicare and Medicaid in 1965 and the

16. See Maribeth Shannon, *Turning Consumers into Shoppers*, HEALTH AFF. BLOG (October 18, 2012, 11:05 AM), <http://healthaffairs.org/blog/2012/10/18/turning-consumers-into-shoppers-using-high-deductible-plans-wisely/>. Shannon touts United HealthCare as an example, but its pricing tool seems only to be an illustration of the idea, without the necessary data that would make it useful to consumers. *Id.*

adoption of the State Children's Health Insurance Program in 1997 illustrate these patterns.¹⁷

The passage of Medicare and Medicaid at the zenith of Lyndon Johnson's Great Society is generally seen as a great victory of American liberalism, but the programs were compromised at their inception in ways that undermined their purposes and added to their complexity. The story has been told many times.¹⁸ In 1964, Lyndon Johnson and the Democrats won a landslide victory promising to enact a hospital insurance program for the elderly on the same basis as Social Security — that is, through a federal payroll tax. After the election, Republicans offered an alternative called "Bettercare," a subsidized, voluntary insurance plan that would also cover physicians' services, albeit through private insurers. As its alternative, the American Medical Association (AMA) proposed an expansion of existing federal grants to the states for healthcare of the elderly poor. Before the 1964 election, the key obstacle to passing the Democrats' hospital insurance program was the chairman of the House Ways and Means Committee Wilbur Mills. After Johnson's landslide, however, and with the president's encouragement, Mills not only agreed to go ahead with the hospital insurance plan but also added to it modified versions of the Republican and AMA proposals. The Democrats' hospital insurance proposal became Medicare Part A, the Republican proposal to cover physicians' bills became Medicare Part B, and the AMA proposal became Medicaid.

The trouble with Mills' three-layered cake was, first of all, that it had too much frosting on it; the desire to propitiate the doctors and hospitals led to absurdly generous provisions for paying them. Second, the legislation made healthcare finance much more complex. The other major democracies do not finance the healthcare of the elderly through a separate system, but the 1965 legislation resulted in the establishment of four different systems to pay for seniors' healthcare. Medicare's two parts worked on different principles: Part A was financed by an earmarked tax, Part B by a combination of general revenues and premiums paid by seniors. Part A and Part B each had its own deductibles, copays, and other rules. In addition, as a result of Medicare's limited benefit package, the majority of the elderly bought private supplemental insurance. Finally, Medicaid would cover seniors who

17. Medicare and Medicaid were established as a part of the Social Security Amendments of 1965. The State Children's Health Insurance Program (SCHIP) was established as a part of the Balanced Budget Act of 1997, § 4901, Pub. L. No. 105-33, 111 Stat. 251, 552 (codified as amended at 42 U.S.C. § 1397 (2006)) [hereinafter BBA].

18. The following discussion of Medicare draws on my account in *REMEDY*, *supra* note 2, at 41-50; see also PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 363-378 (1982).

had very low incomes or spent down their assets and ended up in a nursing home.

Medicare itself had lower administrative costs than private insurance, primarily because the government didn't do any marketing, medical underwriting, or even much questioning of claims — it just paid them. But like the multiplicity of private insurance plans for people under age 65, the multiplicity of government payment systems created under the 1965 legislation inflicted an enormous paperwork burden on patients and families and required providers to hire legions of administrative personnel. Critics of a single system of national health insurance had said it would be a bureaucratic nightmare, but the more unified or standardized systems in other advanced countries have much less bureaucracy. It was political compromise in America that made healthcare in the United States a bureaucratic nightmare.

Subsequent changes in Medicare have added to the complexity. Besides the four separate arrangements for paying for seniors' healthcare, Congress created a fifth in 2003 when it added a prescription-drug plan (Medicare Part D) on a different basis from all the other parts.¹⁹ Passed under a Republican president by a Republican Congress, the program provides prescription-drug coverage entirely through private insurers, just as Republicans would originally have preferred for other medical coverage of seniors in 1965. Unlike other Medicare benefits, drug coverage has a unique, donut-hole structure; as originally passed, after a \$250 deductible, the program covered 75% of costs up to \$2,250, nothing for expenses between \$2,250 and \$5,100 — that's the donut hole — and 95% of expenses above that level.²⁰ Also unlike other benefits, the list of covered items (that is, drugs eligible for reimbursement) varies depending on the private insurer. These features may account for the reaction of seniors after the law was passed. A November 2004 survey found that by a margin of 81% to 13%, seniors said the program was "too complicated."²¹ In November 2006, after Part D went into effect, the proportion agreeing that it was "too complicated" was still 71%.²²

Confronted with an average of about 40 prescription-drug plans in their area, how well do the elderly do in choosing plans? Not so well, it turns out.

19. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071-80 (codified as amended at 42 U.S.C. § 1305 (2011)).

20. *Id.* § 1860D-2(b)(1)-(3), (4)(B); see also Drew E. Altman, *The New Medicare Prescription-Drug Legislation*, 350 NEW ENG. J. MED. 1, 7 (2004) (providing a succinct summary of the Medicare Part D donut-hole).

21. Elizabeth C. Hamel et al., *Medicare and Medicaid*, in AMERICAN PUBLIC OPINION AND HEALTH CARE 187, 187 (Robert J. Blendon et al. eds., 2011).

22. *Id.*

A recent study from the National Bureau of Economic Research finds that fewer than ten percent of seniors choose a plan that would be the most cost-effective for them — that is, the plan that would minimize their costs, given their drug usage.²³ When faced with dozens of options, seniors tend to respond more to the premium than to the benefit package and consequently choose options with low premiums that do not provide them good coverage. Reporting on the first three years of Medicare Part D, the same researchers find that “variety in available levels of coverage has diminished sharply for individual buyers Offerings of plans with the most comprehensive coverage have collapsed, and plans with intermediate coverage are at risk of a death spiral of rising premiums and falling enrollment.”²⁴

The establishment of the State Children’s Health Insurance Program in 1997 added another layer to government finance of healthcare.²⁵ Congressional passage of the program followed a familiar sequence.²⁶ In the 1950s, after Democrats had failed to pass national health insurance under President Truman, they retreated to a proposal of a separate program for a sympathetic age group — seniors. Similarly, after the defeat of the Clinton health plan in 1994, Democrats retreated to another idea for a special program for a sympathetic age group — children. Already, during the 1980s, Democrats had been able to forge alliances with Republicans to extend Medicaid to low-income children and pregnant women.²⁷ Continuing that process would have been simpler administratively than creating a separate program, but political compromise once again resulted in a new layer of finance. Republicans did not want to expand the federal entitlement to the poor, but some of them were willing to support a program with limited grants to the states for children’s coverage; indeed, they saw a new State Children’s Health Insurance Program (SCHIP, later CHIP when the program was renamed) as establishing a model that could eventually become a more fiscally limited alternative to Medicaid. As a result, the final, compromise legislation had a hybrid quality, offering states a fixed amount of money but with the option of using it for a separate CHIP program, an

23. Florian Heiss et al., *Plan Selection in Medicare Part D: Evidence from Administrative Data 25* (Nat’l Bureau of Econ. Research, Working Paper No. 18166, 2012), available at <http://www.nber.org/papers/w18166>.

24. *Id.* at 3 n.3.

25. BBA § 4901; Jeanne M. Lambrew, *The State Children’s Health Insurance Program: Past, Present, and Future* 49 THE COMMONWEALTH FUND, Feb. 9, 2007, at 1.

26. CMS, TRACING THE HISTORY OF CMS PROGRAMS: FROM PRESIDENT THEODORE ROOSEVELT TO PRESIDENT GEORGE W. BUSH 2, available at <http://www.cms.gov/About-CMS/Agency-Information/History/downloads/presidentcmsmilestones.pdf>.

27. REMEDY, *supra* note 2, at 70-71.

expansion of Medicaid or a combination of the two — without, however, putting the federal share on an entitlement basis.²⁸

These examples point to the underlying forces that have produced the exceptional levels of complexity in healthcare programs. America's political institutions — the checks and balances in the Constitution, plus additional practices adopted by Congress — make the passage of large-scale reforms in any institutional sphere exceedingly difficult. In the case of healthcare, those obstacles were sufficient to block the adoption of national health insurance. For supporters of broadened insurance protection, the course of least resistance was to focus on specific, sympathetic groups in need and to use complex legislative compromises to build ideological and interest-group coalitions. I am not prepared to say that this was the wrong choice, given the political conditions. Thus far, however, the pattern has been to add layer upon layer to the financing system. Unfortunately, this same process has been evident in the recent history of efforts to achieve comprehensive reform.

IV. THE FOG OF COMPREHENSIVE REFORM

The healthcare bill proposed by President Clinton in 1993 and the Affordable Care Act (ACA) signed by President Obama in 2010 represent the two most ambitious recent efforts to achieve comprehensive reform of healthcare. In both cases, critics ridiculed the plans as too complicated. In 1993, when he was a Republican, the late Senator Arlen Specter displayed an elaborate chart with a maze of boxes and connecting lines showing all the parts of the Clinton health plan, ostensibly proving that it was so complex as to be unworkable.²⁹ Sixteen years later, opponents of "Obamacare" produced similar charts, though by that time Senator Specter was a Democrat and provided a crucial vote for the legislation.³⁰

No doubt healthcare legislation has become complicated, but complexity in law is not the same as complexity from the standpoint of the consumer. Computers, smartphones, and the Internet are again relevant comparisons. Not only are they technically complex; they also depend on complex laws regulating telecommunications, intellectual property, product liability, and other matters. But complex legal rules are often necessary to assure that our institutions and technologies work smoothly.

28. *Id.* at 141.

29. Ron Goldwyn, *GOP Rolls Out Specter's Chart to Attack Clinton Health Plan*, PHILADELPHIA INQUIRER (Jan. 28, 1994), http://articles.philly.com/1994-01-28/news/25825240_1_health-care-plan-chart-health-reform-plan.

30. *Understanding the Obamacare Chart*, JOINT ECON. COMM. REPUBLICANS (March 22, 2012), http://www.jec.senate.gov/republicans/public/?a=Files.Serve&File_id=96b779aa-6d2e-4c41-a719-24e865cac666.

To be sure, law should be no more complicated than the task requires. Critics of both the Clinton health plan and the ACA denounced them as “Rube Goldberg” contraptions.³¹ Goldberg was a sculptor and engineer who drew cartoons of intricate devices that performed simple tasks in convoluted ways. The implicit premise of the Rube Goldberg analogy was that healthcare reform was simple but made unnecessarily convoluted by the Democrats who concocted these proposals. But the legacies of the past rule out solutions that are simultaneously simple, effective, and popular. History cannot be unwound: the United States already has a legally complex healthcare system. If Senator Specter had displayed a chart of the existing system, it would also have had a maze of boxes and lines. Legislation cannot just erase all that accumulated law without causing severe repercussions. If we are going to improve the system — including measures that simplify it from the perspective of consumers and practitioners — we will have to do it through laws that carefully take existing complexities into account.

At the beginning of the healthcare reform effort in 1993, just after Bill Clinton asked her to lead it, Hillary Clinton wanted to keep things simple. In one of my first conversations with her in the White House — after a Sunday afternoon meeting of the National Economic Council in the Roosevelt Room in early February 1993 — she mentioned that she had heard that the legislation in Canada establishing universal coverage had been just a few pages long and only set out general principles for the Canadian provinces. Her question had nothing to do with single-payer. Still new to health policy, she was hoping that we could somehow develop a short, simple bill with general principles for the states. In the end, of course, that is not what happened.

But why couldn’t that have been the approach? Any responsible healthcare proposal, as I have just suggested, had to deal with interactions with existing programs and institutions. In addition, in the United States, a law that only set out general principles would probably be deemed unconstitutionally vague. Moreover, Congress would never pass such a law because it would effectively delegate so many critical decisions to the executive branch and the courts, and so vague a bill would die for lack of support from groups in both the industry and the public that would demand specific language to protect their interests.

The intricacies of the Clinton health plan also reflected its ambitions. Legislation that just aims to cut federal spending need not be that

31. See, e.g., Robert Pear, *Clinton’s Health Plan: Principles; Experts’ Grades: ‘A’ in Security, ‘C’ in Simplicity, ‘D+’ in Savings*, N.Y. TIMES (Sept. 24, 1993), <http://www.nytimes.com/1993/09/24/us/clinton-s-health-plan-principles-experts-grades-security-c-simplicity-d-savings.html> (describing Clinton’s healthcare plan as “a fragile Rube Goldberg contraption”).

complicated, but legislation that aims both to achieve universal coverage and to control national health expenditures (public and private) will necessarily deal with a wide range of issues. The Clinton plan also epitomized the tendency I mentioned earlier: it was a prime example of ideological compromise. It sought to discipline spending, as Clinton himself said in a campaign speech in September 1992, through “competition within a budget” — that is, a system of private health plans, competing under an overall, global budget for healthcare.³² That system required the establishment of a new institution that the Clinton plan called a “regional health alliance.” Like the insurance exchanges created under the ACA, the alliances were to offer coverage through private insurers. Unlike the exchanges, they were to offer coverage to nearly the entire population in a region under age 65, with the rate of increase in the average premium regulated by a federally set global budget.³³

I argued then, and I still believe, that the Clinton plan would have substantially simplified the health system from the standpoint of consumers. The proposal called for the alliances to offer three types of insurance coverage — traditional fee-for-service, preferred provider plans, and HMOs — each with standardized benefits and cost-sharing.³⁴ Enrollment, claims forms, and many other aspects of the system would also have been standardized. The basic idea was to maintain competition among private health plans, but to do it in a more structured environment that reduced complexity and administrative overhead and increased the salience of price comparisons. The Clinton plan would have substantially consolidated programs and plans. Medicaid beneficiaries would have received coverage through the alliances, the number of employer plans would have been radically reduced, and there never would have been any need for a separate children’s health insurance program.

From the beginning, however, the Clinton plan was pilloried for its complexity, partly as a result of the administration’s own ineptitude. The first announcement of the plan came through the unauthorized release in early September 1993 of a technical outline, without any explanation in plain English. As I note in my recent book, “When architects release plans for a

32. JACOB S. HACKER, *THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON’S PLAN FOR HEALTH SECURITY* 113 (1997). I helped to develop the idea that competition within a budget could be a basis for ideological compromise. See, e.g., Paul Starr, *Healthy Compromise: Universal Coverage and Managed Competition Under a Cap*, *THE AMERICAN PROSPECT* (Nov. 26, 2001), <http://prospect.org/article/healthy-compromise-universal-coverage-and-managed-competition-under-cap>.

33. WHITE HOUSE DOMESTIC POLICY COUNCIL, *THE PRESIDENT’S HEALTH SECURITY PLAN* 60-70 (1993).

34. See generally Starr, *supra* note 32 (arguing that Clinton’s proposal would have reduced administrative overhead and standardized benefits and cost-sharing).

building, they ordinarily present an artist's rendering or a physical model to the public. The Clinton White House released its health plan in the form of engineering specifications. The impression that the proposal was impossibly complicated was firmly established at that moment."³⁵

Moreover, the core ideas of the Clinton plan were unfamiliar, and unfamiliarity is often mistaken for complexity. The plan's hybrid approach, "competition within a budget," was a new idea. So was the concept of a regional health alliance. Those of us involved in the Clinton effort hoped to win over conservatives by preserving private insurance and competition and to win over liberals by achieving universal coverage and capping the growth of healthcare costs. Instead, right and left focused on the aspect of the proposal they hated, the healthcare industry was terrified by the prospect of global budgets, and many people were just confused.

Reflecting lessons learned from the early 1990s, the ACA is less ambitious than the Clinton plan. It includes no cap on the growth of insurance premiums or any other global budgeting mechanism. Instead of establishing insurance exchanges for the entire population under age 65, the law leaves in place all existing employment-based insurance, Medicaid, and CHIP and sets up the exchanges only for the individual and small-group markets, with voluntary enrollment.³⁶ During the 2008 campaign, trying to reassure people with good private coverage that they had nothing to lose from reform, first Hillary Clinton and then Barack Obama had used the same line: "If you like your insurance, you can keep it." But that reassurance meant preserving most of the complexity and administrative cost in the existing system. This is one of the contradictions of health politics: *Reforms that seem simpler because they maintain existing forms of coverage also maintain more complexity.*

Obama also benefited from the 16 years that elapsed from Clinton's proposal. By 2008, there was a working example of an insurance exchange in Massachusetts, so it was no longer a hypothetical idea. In addition, the development of online communication and business showed how an exchange could be organized cheaply and efficiently. In 1993, a regional health alliance was denounced as another bureaucracy; today, people can envision the insurance exchange as a website — an Expedia for health insurance.

The ACA contains a variety of measures specifically aimed at simplifying healthcare from the standpoint of consumers. The single most popular provision in the law has been the requirement for insurers to publish easy-to-

35. REMEDY, *supra* note 2, at 99.

36. BERNADETTE FERNANDEZ & ANNIE L. MACH, CONG. RESEARCH SERV., R42663, HEALTH INSURANCE EXCHANGES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) (2012).

understand benefit summaries. According to a November 2011 Kaiser poll, that provision receives the support of 88% of Democrats, 87% of Independents, and 76% of Republicans.³⁷ Under the law, the Department of Health and Human Services is also developing online resources for Medicare beneficiaries to compare the quality and cost of hospitals and physicians.³⁸ In addition, by 2015 states are supposed to provide a single entry point for people applying for coverage through the new insurance exchanges, Medicaid, or CHIP, instead of burdening individuals with figuring out where they should apply.³⁹ Online gateways can streamline eligibility determination, enrollment, and many other aspects of health insurance.

But the new insurance exchanges and affordability subsidies will represent yet another separate layer of healthcare finance, with complicated provisions regarding the subsidies, individual mandate, penalties for certain employers not offering qualified insurance, and other matters. Among the many uncertainties in implementation, two stand out as particularly troubling. The first concerns the insurance exchanges; the second concerns the Medicaid program.

The insurance exchanges are supposed to facilitate consumer choices among health plans. For example, they are to offer plans in four tiers, arranged according to actuarial value, from bronze plans at 60% actuarial value (which means consumers would pay an average of 40% of costs out of pocket) to silver plans at 70%, gold plans at 80%, and platinum plans at 90%.⁴⁰ But whether the exchanges clear away the fog or create more of it for consumers will depend on how states carry out the legislation — in particular, whether they act merely as clearinghouses, listing any and all plans insurers offer, or as selective bargainers, using their group-buying power as leverage to get the best deals for consumers and then framing the choices in a comprehensible way.

Studies in behavioral economics have repeatedly shown that offering consumers more options does not necessarily enable them to make choices in their own best interest. For example, in 401(k) plans, when employees face a large number of choices, they are often so bewildered that they make no choice at all and leave employee matching funds on the table — a

37. KAISER FAMILY FOUND., KAISER HEALTH TRACKING POLL: NOVEMBER 2011, at 5 (2011).

38. Anne Weiss, *Transforming Care Through Transparency*, HEALTH AFF. BLOG (Oct. 5, 2012), <http://healthaffairs.org/blog/2012/10/05/transforming-care-through-transparency/>.

39. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10202(c)(1)(A), 124 Stat. 119, 924 (2010) (codified at 42 U.S.C. § 1396(d) (2011)) [hereinafter ACA].

40. *Id.* § 1302(d)(1) (codified at 42 U.S.C. § 18022 (2011)).

decision clearly not in their interest.⁴¹ More generally, public policy inevitably faces choices about what Richard Thaler and Cass Sunstein call “choice architecture” — that is, how to present choices to consumers, preferably in a way that recognizes cognitive limitations and enables people to make decisions that reflect their own interests.⁴²

If a state establishes its exchange as a clearinghouse with a minimum of regulation, insurers will predictably structure their benefits, marketing, and other aspects of their business to sign up healthy, low-risk subscribers and avoid the sick. If allowed to do so, however, they will defeat the objective of spreading costs fairly and prevent the market from rewarding plans that provide good healthcare at a low cost. A plan that is wasteful and inefficient in its provision of healthcare may nonetheless be cheaper because it avoids high-risk enrollees, while a plan that provides good care efficiently but suffers from adverse selection may be driven out of business. Under the ACA, measures such as risk-adjusted payment to plans and standardized benefit packages are supposed to combat this tendency, but they are unlikely to be sufficient without active management of the market by the exchange and state regulation of coverage offered outside it. In Medicare Part D, adverse selection has undermined plans with broad coverage.⁴³ There is a distinct danger that the insurance exchanges will repeat this experience, creating a market in which more comprehensive plans disappear. Historically, the employer-based system has concealed the true cost of insurance, reducing sensitivity to costs and allowing the system to become inordinately expensive. But exactly the opposite process may unfold in the exchanges, where plans with more comprehensive coverage may be killed by adverse selection, leading to a race to the bottom.

As a result of the Supreme Court decision in *NFIB v. Sebelius*,⁴⁴ the implementation of the ACA’s Medicaid expansion is now even more uncertain than the implementation of the exchanges. If a state does not establish an exchange, the law at least gives the federal government back-up authority to establish one.⁴⁵ But if a state does not carry out the expansion of Medicaid, there is no back-up federal authority to cover people with the lowest incomes. Until the Court’s decision, a state could choose whether or not to establish a Medicaid program, but once it did so,

41. RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* 112 (rev. and expanded ed. 2009).

42. See *id.* at 81-100.

43. Florian Heiss et al., *Regulation of Private Health Insurance Markets: Enrollment, Plan Type Choice, and Adverse Selection in Medicare Part D* 26 (Nat’l Bureau of Econ. Research, Working Paper No. 15392, 2009), available at http://www.nber.org/papers/w15392.pdf?new_window=1.

44. 132 S. Ct. 2566 (2012).

45. ACA § 1321(c)(1) (codified at 42 U.S.C. § 18041 (2011)).

it had to comply with all the rules for the program set by Congress.⁴⁶ Now there are, in effect, two Medicaid programs: 1) the program as expanded and amended until 2010, which is still an all-or-nothing choice for the states; and 2) the new program created under the ACA, which states may decide to accept or reject independently. According to the administration's interpretation, states cannot pick and choose which people to cover among the newly eligible,⁴⁷ but a state that proceeds with the 2010 expansion of Medicaid can later reverse the decision and cut off eligibility for the new beneficiaries. The split between Medicaid I and Medicaid II promises to create legal complexities and conflict for years to come.

The Court's decision creates uncertainties not only about Medicaid's future but also about other proposals, such as raising the Medicare eligibility age to 67. Before the Court's decision, it appeared that low-income 65 and 66-year olds would at least have Medicaid to fall back on, but that can no longer be assumed.

President Obama's reelection has probably resolved whether the ACA will be carried out. But the deep ideological disagreements between the two major parties and among the justices of the Supreme Court ensure a continuing struggle over health policy that will continue to yield ambiguous and conflicting policies. There is no technical defogging equipment available to clear the air and make the healthcare system transparent. The root of the problem lies in our history. After a long period of adding layers to the financing system, we need a new era of consolidation and simplification, preferably on the basis of principles of fairness and transparency. If a solution lies in our future, however, it will not come about simply or easily, but only after wrenching political change.

46. 42 U.S.C. § 1396a(a); see also *NFIB*, 132 S. Ct. at 2581.

47. See Kathleen Sebelius, *Progress Continues in Setting up Health Insurance Marketplaces*, HEALTHCARE.GOV (Dec. 10, 2012), <http://www.healthcare.gov/blog/2012/12/marketplaces121012.html>.