DRAFT -- NOT FOR QUOTATION

BRINGING OUT THE WORST IN PEOPLE:

The Corrosive Effects of American Health Insurance

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ABSTRACT

According to a number of recent opinion surveys, the American public finds itself increasingly disenchanted with the American health system. In a recent ten-country survey, only Italy matched the United States in the respondents' unhappiness with their health system.

Dissatisfaction with the American health system does not appear to originate in misgivings over the health-care *delivery* system. Rather, it seems to reflect misgivings over the manner in which American health-care is *financed*. Calls for a "fundamental reform or complete rebuilding " of the "American health system" are thus likely to refer mainly to the nation's *health-insurance* system.

Countries whose citizens rate their health-system relatively highly provide those citizens with secure health-insurance coverage that is portable between jobs and localities and whose premium is divorced from the individual citizen's health status. Furthermore, the insurance systems in these countries tend to be administratively simple from the viewpoint of both patients and providers. Finally, they minimize or avoid cost shifting among third-party payers.

The American health-insurance system lacks these apparently desired features. By international standards, that system is administratively cumbersome, and it encourages cost-shifting among payers. Private health insurance policies are bewildering, are not portable and are priced to reflect the health status of individuals in even small firms or families. Many private insurers will not sell health insurance policies to individuals at all. Others blacklist entire industries whose employees are deemed "high-risk." Public health insurance programs provide notoriously incomplete coverage. The Medicare program for the aged subsidizes health-care for the well-to-do elderly, but its benefits are limited and it still leaves millions of low-income elderly to spend large proportions of their meager incomes on health care. The Medicaid program for the poor has more comprehensive benefits; but it covers fewer than half of American families below the federal poverty level. Jointly, the public-private American health-insurance system leaves millions of low-income Americans without any insurance protection whatsoever, among them about 10 million children. The system seems increasingly moribund.

Among the many current proposals to reform this moribund system, government-mandated, employer-provided health insurance, coupled with an expansion of the Medicaid program, seems to be the politically most viable option at this time. That approach, however, is likely to be acceptable to the business community only if the mandate is coupled with heavy additional regulation of the nation's private health-insurance industry. In the end, private health insurance in this country is likely to be based upon (1) *mandatory open-enrollment*, (2) *community-rated premiums* and (3) an *all-payer* system for reimbursing the providers of health care with given regions, i.e., a system under which every payer pays the same provider the same fee for the same service.

I. MALAISE IN AMERICAN HEALTH CARE

Leaders of America's health industry regularly remind the American people that theirs is "*the* best health system in the world." Although that claim may seem self-serving, there is something to it.

While large segments of American industry lag further and further behind their foreign competitors, America's medical industry remains a magnet for both students and patients from all over the world. American physicians and their allied health personnel are generally acknowledged to be highly trained--both academically and clinically. Finally, in no other country are hospitals and medical practices consistently closer to the latest technological frontier, nor could any other nation claim to provide the bulk of its population with quicker access to beneficial medical innovations, most of which emerge from the nation's first-rate medical research.

Yet, for all of its strength, the American health system is now thought to be in a state of crisis. Governments at all levels wring their hands over the system's inroads into public budgets. The business sector laments that government shifts health-care costs into the private sector and that the seemingly uncontrollable outlays by business on employer-paid health insurance saps the ability of America to compete in the international market place. Year after year, the nation's physicians and hospitals feel threatened by incessant talk cost control that never comes, but seems just around the corner. In the meantime, these providers are suffocating under an ever growing mountain of paper rained down upon them for purposes of reimbursement and [largely ineffectual] utilization review. Patients, for their part, are bewildered by that same paper war, as they are forced to choose among ever novel forms of health-insurance options and as they fill in their forms to seek reimbursement, wondering what costs their particular insurance policy will and will not cover and how secure that coverage really is. Finally, in the richest country on earth, the media bombard the public with the worrisome question: "Can You afford to be Sick?"

Table 1, taken from a recent, ten-country survey on public attitudes towards health care[1], suggests that only Italy now matches the United States in the degree of popular dissatisfaction with the nation's health system. Respondents elsewhere in Europe and in Canada generally

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[1] Robert J. Blendon, Robert Leitman, Ian Morrison, and Karen Donelan, "Satisfaction With Health Systems In Ten Nations," *Health Affairs*, Summer, 1980; pp. 187-92.

TABLE 1

THE PUBLIC'S VIEW OF THEIR HEALTH CARE SYSTEM IN TEN NATIONS, 1990

	Minor changes needed[a]	Fundamental changes needed[b]	Completely rebuild system[c]	Per capita health expenditure (U.S. dollars)
Canada	56%	38%	5%	$1,483
Netherlands	47	46	5	1,041
West Germany	41	35	13	1,093
France	41	42	10	1,105
Australia	34	43	17	939
Sweden	32	58	6	1,233
Japan	29	47	6	915
United Kingdom	27	52	17	758
Italy	12	46	40	841
United States	10	60	29	2,051

Source: Harvard-Harris-ITF, 1990 Ten-Nation Survey.

[a] On the survey, the question was worded as follows: "On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better."

[b] "There are some good things in our health care system, but fundamental changes are needed to make it work better."

[c] "Our health care system has so much wrong with it that we need to completely rebuild it."

SOURCE: Robert J. Blendon et al.; Exhibit 2.

rated their health systems much more favorably than did Americans, who evidently did not regard their health system as the "best in the world."

[Table 1]

The dismal Italian score may be explained by the tight resource-constraints that are implicit in the low per-capita health expenditures under that nation's government-run National Health Service. Tight resource constraints, however, cannot explain the low American score. The United States spends *more* than any other nation on health care, per capita, and as a percentage of the Gross National Product, and its health system is marked by excess capacity in most regions of the country. *If one assesses economic systems by their ultimate effect upon people's satisfaction--as economists are inclined to do--then the American health system now can be said to minimize the proverbial bang for the buck.*

It may be thought the low American score reflects popular misgivings over the excess capacity of the American health system and over the high cost it begets. In fact, however, these problems appear to bother mainly health policy analysts and the policymakers whom they advise. The general American public has never expressed much concern over either excess capacity or the percentage of the GNP devoted to health care. On the contrary, most recent surveys suggest that the public would like to see even *more* resources devoted to health care[2], whether privately or publicly financed.

Among policymakers there is growing concern over the *quality* of American health care. Research has revealed that the per-capita utilization rate for many expensive medical procedures varies by factors of two or three among regions without any discernible linkage to health status[3] and without clinical explanation other than "preferred practice style." Furthermore, upon review by clinical experts of actual practice patterns in the United States, it has been found that many medical interventions actually applied to patients appear to have been inappropriate[4].

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[2] See Robert J. Blendon et al., *op. cit.*, pp. 190-1.

[3] See John H. Wennberg and Alan Gittelsohn, "Small Area Variations in Health Care Delivery," *Scientific American*, vol. 246, No. 4, April, 1982.

[4] See, for example, Robert H. Brook and Mary E. Vaiana, *Appropriateness of Care*. Washington, D.C.: The National Health Policy Forum of George Washington University; June, 1989.

These findings cast some doubt onto the medical theories that now guide American physician's in their practice decisions[5]. They also cast doubt on the notion there exists a tight, positive linkage between health spending and the quality of care received by patients. So far, however, these findings also have raised eyebrows mainly among the *cognoscenti* in health policy. Survey after survey has shown that American patients are still highly satisfied with the clinical quality of the care they receive, and also with the amenities of the setting in which that care is rendered.[6]

If neither the overall cost of American health care nor its quality are the source of American dissatisfaction with the health care system, that dissatisfaction must have its roots in the only remaining facet of the system: *the insurance system by which American health care is financed*. Upon closer examination, that system comes across as an brittle patchwork that increasingly fails American society because it no longer serves widely shared social objectives. Thus, when Americans call for a "fundamental reform or complete rebuilding" of the American "health system," they are unlikely to call for a restructuring of their doctor's practice or of their neighborhood hospital. More probably, they have in mind chiefly the nation's moribund *health-insurance* system.

II. SHORTCOMINGS OF AMERICAN HEALTH-INSURANCE

Countries whose citizens rate their health system relatively high vary quite significantly in their approach to health-care financing. Their approaches, however, exhibit certain common features that seem to be important to people and that are lacking in American health insurance. These features can be classified under the following rubrics.

A. Social Equity

All of the countries with highly-rated health systems divorce the individual household's (or business firm's) contribution to the financing of health care from the health status of that household's (or business firm's) insured members. That common feature reflects a widely shared social ethic.

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[5] It can be doubted, however, that physicians in other countries practice on superior medical theories.

[6] Blendon *et al.*, *op. cit.*

Europeans and Canadians, for example, would view it as morally reprehensible to extract from someone struck with diabetes, hemophilia or cancer a higher health-insurance premium than from an otherwise equally positioned individual fortunate enough to be healthy. They would find it just as reprehensible to charge a sickly and poor person the same health-insurance premium as a sickly but wealthy person. Finally, they would find it completely revolting to deny someone the protection of health-insurance altogether, just because that person is or is likely to be afflicted with poor health (a practice increasingly common in the United States).

Instead, these nations typically base the individual's financial contribution to health care on ability to pay. That tends to be automatically so where health insurance systems income-tax financed (as tends to be the case in the Canadian provinces). Where health insurance is payroll-tax financed (as tends to be the case in the Social-Insurance systems of continental Europe), the individual's or the firm's contribution is not a flat amount per employee, because such a head-tax would impose too heavy a financial toll on low-wage industries. Instead, the Social-Insurance systems levy health-insurance premiums as a flat percentage of the payroll, which automatically bases these premiums on the employee's and the firm's ability to pay.

In poll after poll, the American public professes allegiance to a similar social ethic. The American health insurance system, however, marches to a different drummer. According to an advertisement widely published about two years ago in the popular media by "America's Life and Health Insurance Companies," the industry apparently considers it "unfair"[7] for low-risk [*speak: healthy*] persons to subsidize high-risk [*speak: sick*] persons through their health-insurance premiums. In their underwriting and pricing policies, many private health insurers--although not all[8]--follow precisely the social ethic proposed in that advertisement.

For individually sold policies, the industry's so-called "actuarially fair" insurance premiums are based strictly on the individual's projected health status, which tends to put those premiums beyond the financial reach of sickly persons with low incomes and can impose a heavy financial burden even on middle-class families. For group policies sold to business firms, the premiums tend to be "experience-rated" over the firm's employees. While that

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[7] The advertisement explicitly states that such cross-subsidies would be *unfair*, which makes it a normative statement on preferred social ethics.

[8] Some Blue-Cross and Blue-Shield plans still try to sell community-rated health-insurance policies to the general public.

approach borders on community-rating for very large companies, it can imply enormously high insurance premiums for small companies with one or two sickly employees.

To illustrate the plight of small business firms under this insurance system, there is attached hereto as Appendix A a letter recently sent by a small business firm in Ohio to a Member of Congress. In that letter, the firm reports being advised by its insurance carrier that henceforth the firm's health-insurance premium per employee will be $ 792 *per month*, which works out to almost $ 10,000 per year, or $ 4.55 per hour of work. It should surprise no one that this employer now asks the Congressman for a federal health-insurance program for the "middle-income citizen." Such pleas take on added urgency as some private insurance carriers have begun to blacklist entire industries whose employees are judged to be "high risk" and to whom these insurers therefore will not sell health insurance at any price.[9]

If the health-insurance premiums for a small business firm are experience-rated over that firm's employees, the firm is given a powerful financial incentive to discriminate in its hiring policies on the basis of a candidate's projected health-care status, even if that health status will not otherwise impair the employee's productivity. That incentive can work against other important social objectives, because it tends to work against older employees, against women and against other groups thought to be high risk.

The categorical, federal Medicare program ostensibly divorces the individual aged's contribution to health-care financing from his or her health status. It does so incompletely, however, because it excludes from coverage many needed health services and products, and it still leaves the aged to finance an average of close to a third of their health-care out-of-pocket at point of service, or through private Medigap policies. Worse still, with the exception of very poor elderly who are entitled to Medicaid coverage in addition to their Medicare policy, the individual aged's own contribution to financing his or her health care is not scaled to his or her income and wealth. It has been estimated that for some low-income aged, their own share of health expenditures can absorb an average of slightly over 20 percent of their

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[9] See, for example, Yondorf and Associates, *The Medically Uninsurable*. Report to the Colorado Legislature from the Colorado Division of Insurance, Denver, CO., January 10, 1990; p. 24.

already meager income[10]. *Few if any other nations now visit such hardship upon their low-income aged. It seems to be a uniquely American phenomenon.*

On the surface, the federal-state Medicaid program for the poor is much more comprehensive in coverage than is the Medicare program. In principle, it seems closely tailored to the egalitarian social ethic professed elsewhere in the world and by the American public. In fact, however, the program now covers only half of the population officially designated as poor, and even these more fortunate citizens often cannot find physicians willing to treat them at the relatively low Medicaid fees. Furthermore, in many states, the eligibility standards even for women and children are so low as to eclipse from the program the bulk of families falling below the official, federal poverty line--hence the large number of poor Americans without health insurance of any kind.

Uninsured poor Americans frequently do obtain critically needed care on a charity basis. But they do so in the undignified status as health-care beggars, and even then they are typically hounded by bills they could honor only by absorbing a heavy financial burden. *The United States is now the only country in the industrialized world where families can literally go bankrupt over medical bills.*

About 30 to 37 million Americans are now without health insurance. About two thirds of them are the families of full-time, low-income workers whose employers (usually small firms) do not offer employees health insurance. About a third of the uninsured (over 10 million) are children, and many of the uninsured are working women in female-headed households with children. To let millions of mothers and their children go without any health-insurance protection is unheard of elsewhere in the industrialized world. It makes a mockery of the adage that "Americans worship Apple Pie and Motherhood." *In fact, it can fairly be asserted that no nation in the industrialized world now shows as much callous disrespect for mothers and their children as does the United States of the late twentieth century*[11]. The nation's spotty health-insurance system is a clear manifestation of that disrespect.

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[10] Data cited in John Holahan and John L. Palmer, "MEDICARE'S FISCAL PROBLEMS: AN IMPERATIVE FOR REFORM," The Urban Institute, Washington, D.C., February, 1987, Table 6.

[11] For a second opinion on this bold assertion, see the eminent American pediatrician T. Berry Brazelton's "Why Is America Failing Its Children?" *The New York Times Magazine*, September 9, 1990; p. 40 ff.

B. Portability

In all of the countries with highly-rated health systems, insurance coverage is effectively portable, in the sense that individuals do not lose their health-insurance coverage when they move from one location or one job to another.

By contrast, in the United States the bulk of private health-insurance coverage is tied to a job with a particular firm. If an American changes jobs, he or she also must change their health-insurance policy. At the new job, some pre-existing medical conditions may be screened out as uninsurable for various length of time. This uniquely American approach obviously serves to decrease labor mobility, which is economically inefficient. Furthermore, as already noted, if a firm's premium is experience-rated over its own employees, the approach can trigger subtle forms of discrimination against employees thought to have poor health prospects.

When Americans lose their job altogether, they lose with it their and their family's health insurance as well. While they now have a right to purchase their old firm's policy at existing group rates for a year, eventually that coverage ceases altogether. *No other industrialized country now visits upon persons unfortunate enough to lose their job the added hardship of losing also their health-insurance coverage for themselves and their families.* Europeans and Canadians would consider such a policy morally reprehensible as, apparently, does a growing segment of the American public.

C. Administrative Simplicity

Countries with highly-rated health system typically go to great length to reduce the administrative complexity of their health-care financing from the viewpoint of both patients and the providers of care.

Canadians and Europeans, for example, are not asked to pour annually over the bewildering literature published by dozens or more competing health-insurance plans that advertise their products with varying degrees of clarity. Furthermore, they either are not at all involved in claiming reimbursement from the insurance carrier (e.g., in Canada, West Germany or England) or that process is made very simple (e.g., in France).

Relative to the typical Canadian physician, his or her American counterpart employs at least one and often more additional staff just to process claims under our unwieldy insurance

system. Similarly, Canadian and European hospitals use only a fraction of the staff used by the typical American hospital for claims processing.

It is now generally acknowledged that the complex paper war our health-insurance system visits upon patients and providers alike is not productive and has grown beyond reasonable limits[12]. The precise magnitude of this administrative burden, in monetary terms, remains a matter of speculation. It *is* known that, during the 1980s, the cost of administration has been among the fastest-growing components of total national health expenditures in the United States. According to one estimate somewhere between 8 to 10 percent of total national health spending in the United States goes for the added administrative complexity of the American system, relative to the much simpler Canadian system[13]. Finally, it is well known that many Medigap policies sold by commercial insurance carriers to the aged entail "loss ratios" in the low 60 percent, which means that about 40 cents of every premium dollar paid by the aged for such policies is absorbed by administrative overhead and profits[14]. Loss ratios of this magnitude are simply unheard of in other health-insurance systems. They can hardly be a source of American pride.

Only those who derive their income from administering our complex health-insurance system can possibly derive a net advantage from its administrative complexity. It may safely be assumed that patients and the providers of health care find that complexity disenchanting, as the polls suggest, and one must wonder how much longer they will be willing to carry this needless burden.

D. Fairness among Third-Party Payers (and their Clients)

At any point in time, a substantial fraction of the total costs borne by health care providers are fixed overhead costs. Payers with market muscle (for example, Medicare,

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[12] See, for example, the American Society for Internal Medicine, *The Hassle Factor: America's Health Care System Strangling in Red Tape*, Washiongton, D.C., 1990.

[13] David U. Himmelstein and Steffie Woolhandler, "Costs without Benefit: Administrative Waste in U.S. Healthcare," *New England Journal of Medicine*, vol. 314, February 13, 1986; pp.441-5.

[14] It may be noted that, on average, the Blue Cross-Blue Shield plans appear to achieve loss ratios over 90 percent, while the Prudential Insurance Company achieves a loss ratio in the mid 80 percent.

Medicaid or large insurance firms) can exploit that circumstance by seeking fees and charges below fully allocated total unit costs. As long as the discounted prices cover truly variable unit costs, providers with excess capacity will still find it profitable to serve the patients at the discounted prices, even if these do not cover full costs.

It is well known that Medicaid in many states pays providers fees and charges much below fully allocated unit costs. There is evidence that Medicare, too, now pays many hospitals less than fully allocated unit costs. Finally, the uninsured often receive care from hospitals free of charge or at revenues below even truly variable costs. Faced with these fiscal pressures from large payers and from the uninsured, the providers of health care naturally seek to recover their fixed overhead costs and profits disproportionately from smaller payers with less market muscle, who therefore end up paying charges much above fully allocated unit costs. This phenomenon is now known in the trade literature as "cost shifting. It is technically known as "price discrimination," i.e., the practice of charging different customers different prices for the same service.

Cost shifting of this sort is bound to be part of the factors driving the high insurance premiums now charged small employers (see Appendix A). In any event, it is generally thought to explain why the health insurance premiums of small business firms have tended to rise so much more rapidly in recent years than have the premiums of larger business firms[15] who can resist such cost shifts through Preferred Provider Networks (PPO)[16].

Most other industrialized nations consider price discrimination in health care inequitable, because it tends to shift the burden of financing health care to payers least able to resist high charges--either small insurance carriers and business firms, or very sick patients themselves. Most nations seek to avoid this practice either by having only one public insurance carrier (as is the case in Canada), or by collecting multiple private payers into regional associations that must, by statute, negotiate common and binding fee schedules with corresponding, regional associations of providers--the so-called *all-payer* reimbursement systems (as is the case in West Germany). Under an *all-payer* system, every payer within a given market area pays the same provider of health care the same fee for the same service.

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[15] See, for example, *Meeting the Health Care Crisis*, report on a survey by the National Association of Manufacturers and Foster Higgins, 1989.

[16] In a PPO, providers offer a firm price discounts in return for incentives that drive the firm's employees (as patients) to the discount-granting providers in the network).

As will be argued below, it can be expected that America's hard pressed small-business sector, which now picks up a disproportionate share of the providers' overhead, will before long lobby government for a similar all-payer approach. Most probably, the state governments will be asked to organize such arrangements.

III. WHITHER AMERICAN HEALTH INSURANCE?

This nation's job-based health-insurance system originally grew out of a clever attempt, during World War II, to evade wage controls through the conversion of wages into novel fringe benefits that were exempt from wage controls and from income taxation as well. The system developed further during a period when the rest of the world was still digging itself out of the ashes of World War II, when American industry therefore reigned supreme, when productivity gains and economic growth were rapid, when employment relationships were relatively stable and when the cost of health care was relatively low, even for serious illness. It may have been plausible at that time to suppose that this job-tied insurance system could serve as a stable basis for financing American health care, and that whatever gaps it might leave could easily be filled with appropriate government programs.

Much has changed in the meantime. Just as productivity growth abated during the 1970s and 1980s, technical breakthroughs in medicine have made even routine health care ever more expensive. Industry in the rest of the world has recovered and, in substantial segments, overtaken American industry. Jobs in America are now subject to managerial decisions made on distant shores by foreign competitors or by the foreign owners of American companies. And when foreign competitors do not threaten an American's job security, it may nevertheless be threatened by a global capital market that may subject one's company, at any moment, to a takeover and restructuring, which in turn may threaten one's job. In such a world, a hitherto secure American middle class must fear the possible loss of health-insurance coverage even during good times. As one pundit has put it, job-tied health-insurance in that context has become *health-unsurance*.

At this time, Americans must therefore ask themselves whether their traditional, job-tied private health insurance system can continue to serve this country adequately during the next several decades. In its current form, the system passes around patients and costs like so many hot potatoes. Through clever risk selection and actuarially "fair" pricing, insurance carriers seek to pass potentially high-risk clients from one private carrier to the other, and

thence to the pool of uninsured. Through screening of various sorts, to protect their beleaguered bottom lines, the providers of health care increasingly dump uninsured patients from one to another, and thence to the pool of unattended. Finally, every third-party payer now tries to save money by having other payers pick up disproportionate shares of the provider's fixed overhead charges and profits.

It is a system that creates suspicion and rancor all around and tends to bring out the worst in a people that otherwise likes to think of itself as the most generous people on earth. Through its perennial game of hot potatoes and the gaps it leaves, the system exposes millions of Americans to anxiety, to genuine health risks and to the prospect of financial ruin. *Anyone who proposes to build further upon such a system advocates building on shifting sand.*

It is at least conceivable that the private insurance sector will see the handwriting on the wall and, even without government prodding, preemptively develop new health-insurance products that are (a) portable between jobs and (b) community rated within broad regions, so that large and small employers pay the same insurance premium *per employee*. But even such new products might not be suitable for the nation's growing low-wage sector. Eventually, that sector will find it ever harder to cope with flat premiums *per employee*, as per-capita health spending continues to escalate far in excess of wages. In the longer run, an employment-based health-care financing system probably will have to levy premiums as a flat percentage of payroll, as is the custom in other nations that rely on payroll financed health care.

Unfortunately, the track record of the private health-insurance industry does not encourage one to expect swift, constructive reactions to the social problems outlined above. In the absence of government intervention, that sector is likely to continue to segment the population into ever finer risk classes and to exclude ever larger numbers of high-risk Americans from its rolls, thus processing less and less of the cash flow going into health care. As the industry proceeds on this torturous path of self-destruction, government will be drawn ever more heavily into the health-insurance sector simply by the private sector's default.

Let us examine some of the options for such government interventions.

A. "Access" versus "Cost Control"

The business community and government legislators have come to view the cost of American health care as excessively high and out of control. Therefore, they frequently insist

that cost must be controlled first, before health-insurance coverage can be extended to all Americans.

Such a strategy has political appeal, because it furnishes a seemingly legitimate rationale for avoiding society's moral obligations. Indeed, because there has never been any benchmark for judging when health-care costs are under or out of control, the strategy already has served for two decades as an excuse for leaving millions of Americans without health insurance. It is a rather cynical approach to health policy, one that not only exposes millions of Americans to unwarranted health- and financial risk, but also threatens the financial viability of many important health-care institutions, especially those located in low-income areas.

It maybe thought that, since most other nations provide their citizens with universal health-insurance coverage at lower cost, it ought to be possible to legislate both "access" and "cost control" (speak lower cost growth) at the same time. In principle that may be so. In practice, however, most other nations--notably neighboring Canada--have followed a strategy of "access first, cost control later," presumably in order to gain for their access-proposals the political support of health-care providers who naturally translate the words "cost control" into "reductions in provider incomes."

Although American governments at all levels now favor budget-neutral policy changes, that arbitrary constraint is apt to stand in the way of bringing all Americans quickly under the protection of health insurance. At some point, America's political leadership, *if it sincerely desires to protect all Americans against the financial cost of illness*, will have to come clean before the public and admit that, in the short run at least, better access to mainstream American medicine for added millions of Americans will increase total national health expenditures (by probably about $ 25 to $ 35 billion) and that such a policy would imply some added tax money.

B. Options for Added Access

Very broadly speaking, the millions of currently uninsured--and yet to be uninsured--Americans could be granted access to needed health care either through (A) publicly provided health-insurance, or (B) publicly owned and operated health clinics and hospitals. Figures 1 and Table 2 lay out these options schematically.

[Figure 1 and Table 2]

FIGURE 1

OPTIONS FOR PROVIDING UNIVERSAL ACCESS TO HEALTH CARE

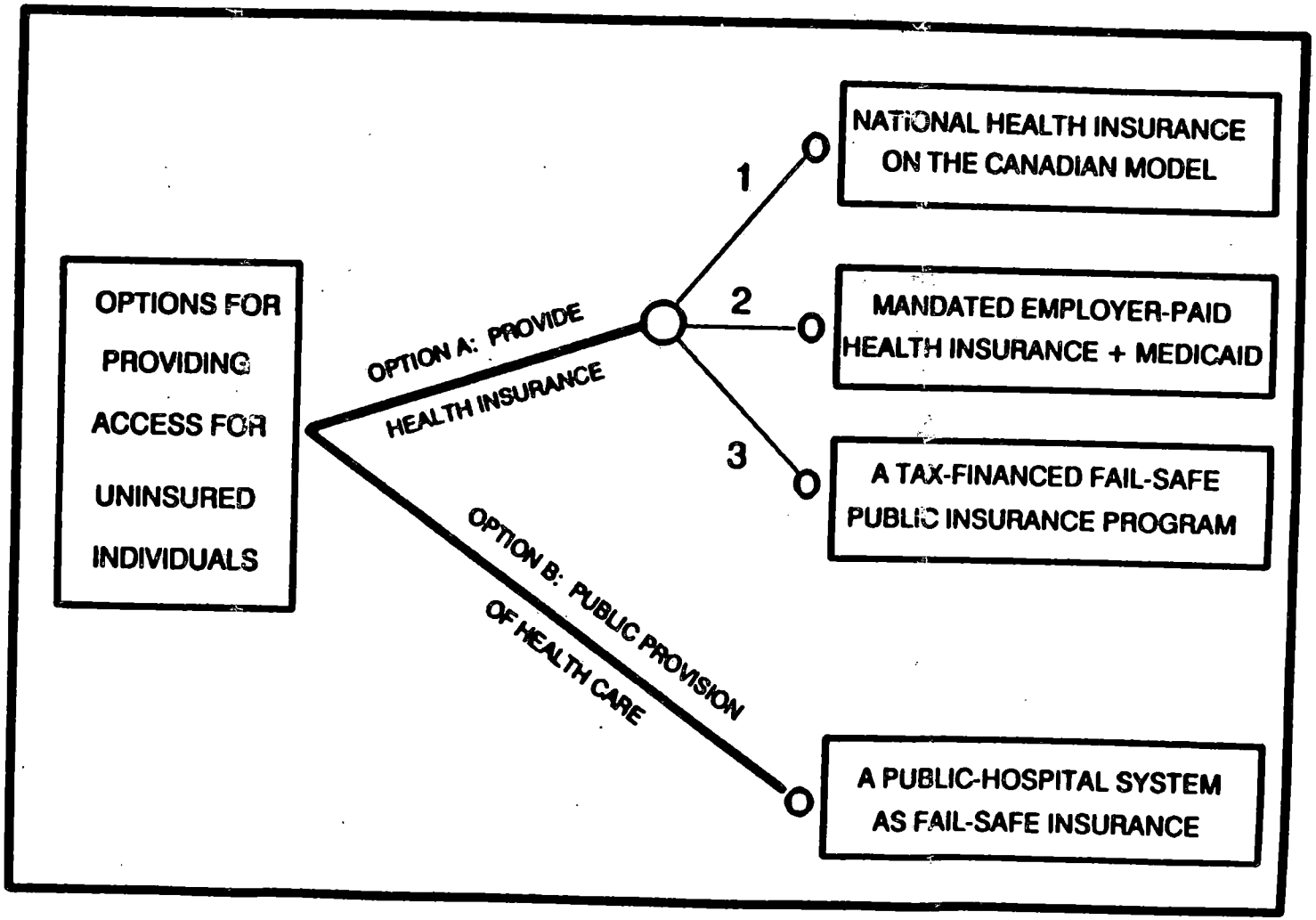

TABLE 2

ALTERNATIVE MIXES OF HEALTH-INSURANCE AND HEALTH CARE DELIVERY

PRODUCTION AND DELIVERY	COLLECTIVIZED (SOCIALIZED) FINANCING OF HEALTH CARE.			DIRECT FINANCING
	Government Financed Insurance	Private Health Insurance[a]		Out of Pocket by Patients at point of Service
		within a statutory framework	within an unregulated market	
Purely Government Owned	A	D	G	J
Private Not-for-Profit Entities	B	E	H	K
Private For-Profit Entities	C	F	I	L

The Canadian Health System — The West German Health System

[a] Note: Technically, whenever the receipt of health care is paid for by a third party rather than by the recipient at point of service, it is financed out of a collective pool and is thus "socialized" financing. In this sense, private health insurance is just as much "collectivist" or "socialized" as is government-provided health insurance. Both forms of financing destroy the normal workings of a market, because both eliminate the individual benefit-cost calculus that is the sine-qua-non of a proper market.

1. Option A--Public Provision of Health Insurance

Government at either the federal or the state levels can extend comprehensive health-insurance to all citizens through three broadly distinct approaches.

National Health Insurance: First they can, as Canada has done, act as the sole provider of basic health insurance (cells A, B and C in Table 1). As is evident from Table 1 above, Canada does appear to have demonstrated its ability to operate such a system to the relatively high satisfaction of its populace. Alas, it is unlikely that the approach could easily be grafted onto the United States any time soon, if ever. The strategy implies the virtual dismantling of the private health-insurance sector and, as is well known, would be likely to trigger the staunch opposition of the entire provider community as well. Nation's with parliaments, in which the reigning administration can count on party discipline, may be able to overcome such powerful political obstacles. Canada obviously did. But this nation's much weaker system of governance would be unlikely to produce a coherent and *workable* health insurance plan on the Canadian model, even if the public at large wanted it, as some surveys suggest it does[17].

Mandated, Employer-Provided, Private Insurance: An alternative to the Canadian approach would be to *mandate* all private employers to offer their employees a specified, comprehensive, private health-insurance package. It is the second insurance option shown in Figure 1. Because over two-thirds of all uninsured are full-time workers and their dependents, that approach would sweep the bulk of the currently uninsured into the private health-insurance system, leaving the remainder to be picked up by the public Medicaid program for the poor, or by some other public risk-pool.

Mandated employer-provided insurance is, of course, a pseudo tax upon the private sector, but one that does not flow through public budgets and thus may not be perceived by the general public as a tax increase. Therein lies its considerable political appeal. Its main drawback is that it is a head-tax upon employment, rather than a flat percentage of payroll. As such, the strategy may be burdensome to low-wage industries.

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[17] See, for example, Robert J. Blendon, "Three Systems: A Comparative Survey," *Health Management Quarterly*, vol. XI, No. 1, First Quarter, 1989; pp. 2-7.

Voluntary Private Insurance with a Public Fail-Safe Program: As a third option, one could leave the matter of employer-based health insurance a private matter to be negotiated *voluntarily* in the labor market and simply capture anyone not privately insured in a tax-financed, public Fail-Safe health insurance system--for example, a substantially enlarged and upgraded Medicaid program, albeit one with uniform national standards and substantial federal financing. Part of the requisite financing could come from a regular payroll tax, part from income taxes, and part from sales taxes. An illustration of such a plan is attached hereto as Appendix B.

Coupled with a tax-financed Fail-Safe option could be strong financial inducements (e.g., subsidies or taxes) for private employers to offer their employees health insurance "voluntarily." Such schemes are now known as "Pay-or-Play" plans. Depending upon the strength of the fiscal inducements, a "Pay-or-Play" plan may border either on a purely *mandated* health insurance or on the pure Fail-Safe approach. In Figure 1, these "Pay-or-Play" plans fall somewhere between the second and third insurance branches.

In principle, the third insurance option, a tax-financed Fail-Safe system, ought to have greater political appeal in a country that loathes government *mandates* of any kind. It ought to have appeal particularly to the business community, as it offers the individual firm and its workers the option to free their labor contract from the burden of health-insurance altogether.

In affording the business sector that choice, however, the approach might deprive the private insurance industry of some potential clients. It would thereby evoke that industry's traditionally powerful political opposition. Furthermore, the plan clearly would call for a sizeable increase in the government's health-care budget, as more Americans would gain access to care and as at least some business firms would move their hitherto insured employees into the public Fail-Safe system. It would take strong political leadership to raise the requisite taxes for the scheme.

2. Option B--Public Clinics and Hospitals

Health-insurance contracts typically represent ill defined, open-ended promises whose costs are not easily controlled *ex ante*. Instead of providing such open-ended contracts, the public sector might simply provide the needed care itself in publicly owned and operated facilities. Although that approach (cell A in Table 2) represents the much dreaded "socialized

medicine" in its purest form, it does have considerable political appeal and, not surprisingly, has long been used in many places in the United States.

First, a public health system enables legislators to set fixed budgets for their health programs at the beginning of the year, and to avoid the surprises of the open-ended insurance programs, such as Medicaid and Medicare. Second, a public health system allows politicians to delegate to the administrators of the system many morally troubling and politically sensitive chores, such as defining, on the spot, eligibility and benefit packages. It is a perfect device for politicians severely to ration health care without seeming to do so. Indeed, should a financially hard-pressed administrator of a public clinic or hospital evoke a public outcry by withholding needed care, the budget-slashing politicians could have their cake and eat it too: they could demonstrate their concern for the health of the poor by holding public hearings on the administrator's alleged failings.

Finally, of course, like any government-operated institution, a publicly owned health system affords politicians numerous means of granting political favors, either to job seekers, or to contractors and other suppliers of the system.

The shortcomings of a public health system are implicit in its political appeal. First, such systems have not generally been known to be cheap per unit of output. Second, they afford their clients little choice and market power. What the client receives is, in effect, the system's tax-financed *noblesse oblige*, which may range from excellent to awful, depending upon the social ethic of the employees working within the system. Third, publicly owned systems tend to avoid accountability. They seldom produce reliable financial reports, especially reliable statistics on unit costs. Finally, as noted, such systems tend to spare the politician public accountability for a legislating a potentially offensive, second-class health system.

IV. A PROBABLE SCENARIO

At this time, probably the politically most viable option would be the second of the insurance options shown in Figure 1, i.e., *government-mandated* employer-provided health insurance, coupled with an enlarged Medicaid program.

Credit for the basic idea goes all the way back to former President Richard Nixon who proposed it in his *Health Message to Congress* on February 18, 1971 and later had it fleshed out as the Community Health Insurance Partnership (CHIP). Numerous close mutants of that

proposal now lie before legislative chambers at both the federal and state levels. The approach has been openly endorsed by the American Medical Association, and it is likely to be endorsed by the American Hospital Association as well.[18]

The option to *mandate* employer-provided health insurance would be feasible at either the federal or the state level. If only some states were to implement it, however, the approach might beget a beggar-my-neighbor policy under which lean and mean states without such a mandate would be able to attract business firms from the more generous states with the mandate and, at the same time, export to the more generous states their sick and poor, many of whom might migrate to the more generous states in search of access to care.

It is easy to imagine a scenario involving the adoption of *mandated*, employer provided insurance, at either the state or the federal level.

In that scenario, the Medicare and Medicaid programs will continue to shift health-care costs to private payers, as the federal deficit mounts in the years ahead. The larger among the private payers will seek to resist these cost-shifts through more vigorous pursuit of Preferred Provider Arrangements and Health Maintenance Organizations, both of which are able to extract price discounts from providers. Thus fiscally besieged, these providers will be even more tenacious than they have hitherto been in seeking revenues from payers with less market power, prominent among them small insurance plans and the small business firms they insure. Unable effectively to resist these higher charges, many small business firms may be driven to cancel their health-insurance programs (if they have one) or not establish one in the first place. A concerned federal or state government is likely to respond to this practice by legislating a mandate upon all employers to provide their employees health insurance.

If that scenario came true, however, the small-business sector probably would acquiesce to the *mandate* only if the underwriting practices of private health insurers were appropriately regulated. Among these new regulations would likely to be mandatory open enrollment and community-rated premiums. Ultimately, these stricture would lead to an *all-payer* reimbursement system, at least within broad regions, such as the state.

There would therefore have to be developed a new mechanism under which regional associations of payers could negotiate *binding* fee schedules with counterpart associations of providers. Associations endowed with such powers do not yet exist in the United States,

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[18] See "McCarthy keeps critics at bay," *Health Week*, September 10, 1990; p. 41.

although they have long functioned in many other countries[19]. Provision of the legislative authorities for such associations would presumably fall to the state governments, perhaps with federal guidance and technical assistance. In terms of Table 1 above, the American health system would be concentrated in the second column of the table--cells D, E and F.

[19] West Germany operates a system falling into this generic category of health-insurance systems. For more detail on West Germany's system, see the author's "West Germany's Health-Insurance and Health-Delivery System: Providing Access with Cost Control." Paper written for the Bi-Partisan Commission on Health Care, August, 1989.