



# La Follette Policy Report

ROBERT M. LA FOLLETTE SCHOOL OF PUBLIC AFFAIRS

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## DIRECTOR'S PERSPECTIVE

If you had to choose between the following two alternatives, which would you take? 1) A world where you were restricted to the health care treatments used in 1950, but otherwise had today's standard of living; or 2) a world where you benefited from today's levels of  
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**Editor's Note:** *In this La Follette Policy Report, we are breaking with tradition and devoting the entire issue to a single topic. This year nearly 45 million Americans lack health insurance coverage. In late October 2003, the La Follette School sponsored a symposium dedicated to exploring alternative public policies for reducing the number of uninsured. La Follette faculty member Barbara Wolfe organized the symposium and invited two nationally known health care economists to present their solutions to the problem of the uninsured. The two were Rashi Fein, an emeritus professor of the Harvard Medical School, who favors single-payer, government financed insurance, and Mark Pauly, the chair of the Department of Health Care Systems, in the Wharton School at the University of Pennsylvania, who supports a market-oriented approach that relies on private insurance augmented by government financed vouchers or tax credits for the needy. The symposium, which was entitled "Facing Health Care Tradeoffs: Costs, Risks and the Uninsured," was made possible by the generous financial support of Mark Stone.*

*This issue includes edited versions of the talks given by professors Fein and Pauly along with brief commentaries presented at the symposium by Professor Wolfe, and by Thomas Hefty, retired chair of the Cobalt Corporation, whose subsidiaries include Blue Cross Blue Shield United of Wisconsin and United Government Services, the country's largest Medicare intermediary. These four articles are supplemented by sidebars that provide background on the problem of the uninsured, a primer on the types of insurance used by most Americans, and a glossary of terms frequently used in the discussion of the uninsured.*

## Universal Health Care: Moving Toward a Single-Payer Approach

**By Rashi Fein**

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## Conflict and Compromise over Tradeoffs in Universal Health Insurance Plans

**By Mark V. Pauly**

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# PROVIDING HEALTH INSURANCE FOR THE UNINSURED

## The Problem: A Large Number of Americans Have No Health Insurance Coverage

According to the latest data from the U.S. Census Bureau, 43.6 million U.S. residents lacked health care insurance coverage in 2002. This number represents 15.2 percent of all Americans. Although the number of uninsured varies from year to year, in 2002 nearly 8 million more Americans were without health insurance than a decade earlier.

### What are the Consequences of Being Uninsured?

The uninsured are generally more likely to face health and financial problems than the insured. According to a report published in 2002 by the Alliance for Health Reform, the uninsured are three times as likely as the insured to have a medical need that goes unmet (15 percent vs. 4.4 percent). Also, the uninsured are twice as likely as the insured to delay

needed medical care (15.7 percent vs. 8.6 percent). The Urban Institute reports that mortality rates of the uninsured are 5 to 25 percent higher than the insured.

After seeking medical care, the uninsured often face significant financial burdens. The Alliance for Health Reform reported that the majority (70 percent) of the uninsured with medical bills exhausted their savings to pay medical expenses, and, in 1999, 40 percent of all personal bankruptcies were due to large medical bills.

### Who are the Uninsured?

It is not easy to characterize the uninsured. Although low-income individuals and the young are more likely to be without health insurance, the uninsured can be found at every income level and among all age groups. While some individuals, especially those who are young and healthy, choose to go without health insurance, accepting jobs with higher wages in lieu of insurance coverage, others can not find jobs that offer health insurance and can not afford to purchase individual coverage. Most spells of uninsurance are short, less than a year. However, most of the uninsured at any point in time have been uninsured for the previous 12 months.

### Employment Status

In 2002, the vast majority of the uninsured were in households with a head who worked full or part time—60 percent of non-elderly uninsured were members of households with a head who worked full time for the entire year, while an additional 22 percent lived in households where the head worked less than full time. Not surprisingly, in households where the head was not employed, the probability of being without health insurance coverage was much higher than in households with a full or part-time worker. Not all workers work for firms that offer health benefits, and among those who do, some are not eligible because they work insufficient hours or are contract or temporary workers. Even among those with offers of employer-sponsored health insurance, some workers decline the coverage and go without coverage. These persons most often cite cost as the reason for not taking up coverage.

### Age

As illustrated in Figure 1, in 2002, young adults, ages 18–24 were most likely to be uninsured. Because individuals in this age range tend to be quite healthy, they are less likely to purchase health insurance or seek out jobs that offer health insurance coverage. While the elderly, those age 65 and over,

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are almost all covered by the government's Medicare program, older working-age adults are often uninsured, not by choice, but because they are unable to find jobs that offer employer-sponsored health insurance and because they can not afford independent, non-group coverage. For those with pre-existing health conditions, or a history of health problems, the problem of obtaining health insurance coverage is particularly severe.

### Race and Ethnicity

As shown in Figure 2, Hispanics are much more likely to be without health insurance than individuals in other racial and ethnic groups. While blacks and Asians were more likely than whites to be uninsured, their rates of uninsurance were substantially lower than the rate for Hispanics. Research being conducted at the Center for Studying Health System Change reveals that among Hispanics, those who were unable to speak English were much more likely to be without health insurance coverage than English-speaking Hispanics. Non-English-speaking Hispanics are less likely to qualify for government-sponsored insurance and more likely to work in low-paying jobs that provide no health insurance benefits.

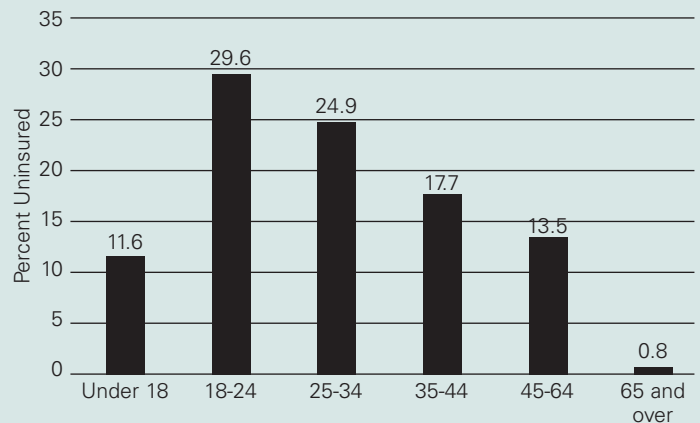
### Income

Non-elderly individuals with relatively low income are much more likely to be uninsured than those with higher incomes. Figure 3 shows how the uninsurance rates and the number of non-elderly individuals without health insurance vary by family income. Over one-third of individuals living in families with 2002 incomes under \$10,000 were without health insurance coverage. The rate of uninsurance declined to 16 percent for those with family incomes between \$40,000 and \$50,000, and to 8 percent for those with incomes over \$50,000.

The data in Figure 3 also show that nearly a quarter of the 43.3 million non-elderly individuals without health insurance for all of 2002 lived in families with incomes over \$50,000. Although a number of people in this top-income category may not be able to afford health insurance, especially if they are unable to obtain a job which offers employer-sponsored insurance, others may consciously forgo health insurance because they believe there is little chance they will need medical care. A substantial number of individuals assigned to the \$50,000 and above family-income category are in fact single, young adults who are either unemployed or hold low-paying jobs that do not offer health insurance benefits. These individuals still live with their parents (and thus are classified according to their parents' income), but are too old to qualify for their parents' health insurance policy.

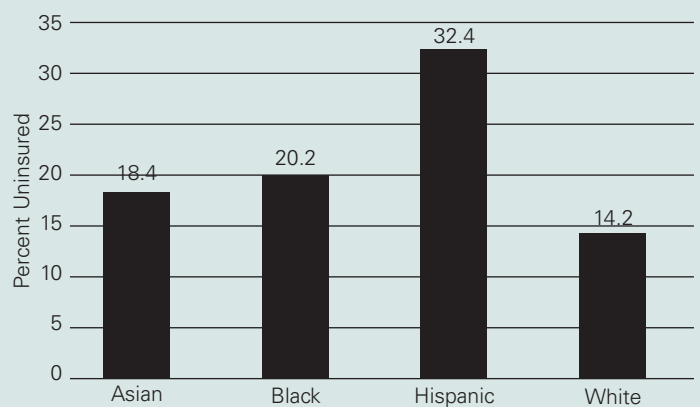
**FIGURE 1**

**Percent Uninsured by Age**



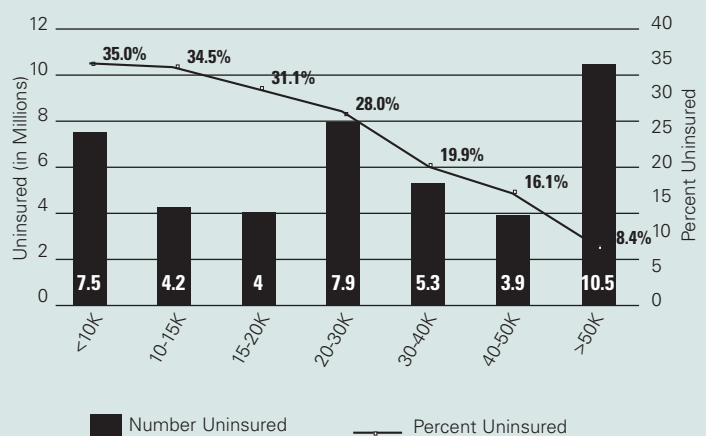
**FIGURE 2**

**Percent Uninsured by Race or Ethnicity**



**FIGURE 3**

**Number and Percent Uninsured by Income**



Note: Figures 1 through 3 are based on data from the U.S. Census Bureau.

## Universal Health Care: Moving Toward a Single-Payer Approach

I will address three topics in this article. I would like to set forth some of the economic and non-economic factors that lead me to favor what has come to be called a “single-payer” approach to universal health insurance—though for purposes of understanding I would prefer to say a “social insurance” approach or “Medicare, albeit an improved and more comprehensive Medicare, for all.” In the second and briefer section, I will discuss some of the economic and non-economic difficulties that such an approach would entail. While these various “problems” do not lead me to abandon the social insurance approach, they must be noted and, to the extent possible, dealt with or mitigated. Finally, I would like very briefly to take note of some possible “compromises” that would enable us to attain the goal of universal coverage while preserving the social cohesion, progressivity, and efficiency that I believe can be attained in a social insurance program.

I note that I will not present data on the dimensions of the problem of the uninsured in the United States. I choose not to, in part, because it is reasonable to assume that these data are well known. Furthermore, in a sense the data are misleading because they almost imply that if one has insurance all is well. That simply is not the case, and not only because many persons have inadequate insurance coverage. Rather, it is that a focus on the uninsured may lead us to overlook the fact that Americans who have insurance fear that their benefits will prove insufficient and that, though insured today, they might become uninsured tomorrow. In a May/June 2003 Kaiser Health Poll, 26 percent of those interviewed said that at the personal level their biggest concern about the economy was losing their jobs. A full 24 percent stated that their biggest concern was not being able to pay for health care.

### A Social Insurance Approach to Universal Health Insurance

Why do I believe in a social insurance approach to universal health insurance? On what does my argument rest? What assumptions am I making that lead me to prefer that policy option?

First is a set of what might be termed “values.” While I do not believe these values are idiosyncratic, I cannot

and do not claim that they are universally held, or even that they are held by a majority of Americans. I suspect that the number of persons who would subscribe to these values and how deeply they would hold them depends on the level of specificity with which their implications are elaborated. Broad principles and values of the kind that are described in sermons and are subject to individual interpretation are likely to elicit more support than legislative proposals designed to translate values into operating programs.

Nevertheless, because social policy is the product of more than economics, I cannot ignore the subjective value system embedded in the social insurance approach. Policy proposals have multiple impacts and effects of different dimensions. There is no formula by which we can assign weights to these various impacts. The weights we accord, the trade offs we make, are an expression of our values. It is appropriate for social scientists to refer to values, and it is important to recognize that my belief in universal insurance and my policy prescriptions to get there derive from my values.

My value system stresses equity. I do not believe that the state of an individual’s purse or expectations about its future state should determine the quantity and/or quality of the health care one receives. That view reflects the influence that health care has on pain, discomfiture, and even length of life. The support for universal access and for equity in health care resource distribution in almost all industrial countries and the support in the United States for Medicare, Medicaid, and child health programs (and, in the abstract, for universal insurance) derive from the fact that medical care has certain unique qualities that evokes emotional responses.

### Government’s Role in Reducing “Unfairness”

The distribution of illness supports the notion that “life is unfair” and leads me to quickly add that one of government’s roles is to help make up for or reduce that unfairness. Voluntary action by individuals and groups is useful, but alone it cannot accomplish the redistribution required to treat all at a level appropriate to a civilized society. Thus, universality implies some form of collective action by that instrument of collective action, government.

Government action, of course, can take many forms. It may set the “rules of the game” within which markets would operate, rules that can range from complex regulation to “simple” enforcement of anti-trust measures. It may provide general cash assistance or specific forms of aid such as Medicaid to persons and families below some threshold income. It may enroll all individuals re-

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**Focusing only on the uninsured may lead us to overlook the fact that Americans who have insurance fear that their benefits will prove insufficient and that, though insured today, they might become uninsured tomorrow.**

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regardless of income in a social insurance program that pays for services (Medicare). Or, government may provide the services in government-owned facilities such as Veterans and state mental hospitals.

In general Americans have tended to favor market production and distribution and have relied on government to compensate for market failures and to keep markets competitive. Nevertheless, in health care we have developed insurance and support systems like Medicare and Medicaid, both of which involve a public/private mix: We use public dollars to buy services produced in and by the private sector. It is evident that support for government underwriting of universal access does not imply rejection of the various roles that the private sector and free markets can play.

I should be clear: I do not hold the view that government is always wise, trustworthy, honest, and always especially concerned with those at the bottom of the income ladder. But where voluntary redistribution fails and proves insufficient, coercive redistribution by government via the tax system is required. The virtues of the market are many, but it is not an engine of redistribution. That role and other roles required to deal with market failures involve government.

To say “government redistribution” is to say much, but it is not to say enough. Government redistribution policy can take many forms. To state that one believes health care is of such importance that one favors providing more of it to individuals who lack resources to acquire as much of it as would benefit them does not imply a single payer solution to the problem of redistribution. As noted, one could give people more money even while recognizing it would not be all spent on health care. One could provide a form of scrip that could be spent only for health care services, just as we do with food stamps. One could give or provide subsidies or tax credits for insurance policies to persons with low income and insufficient care. One could increase Medicaid coverage and benefits, or one could provide everyone regardless of age and income with expanded Medicare-like benefits. Furthermore, these and other approaches could be combined.

If we were concerned only with redistribution, it would seem clear that tax credits for the purchase of health insurance and/or Medicaid would have considerable merit. Medicaid can be targeted to provide assistance or services only to those who need them. Ten dollars worth of redistributive services or of tax credit for insurance purchase can be provided with a budget expenditure of ten dollars (though it should be clear that such subsidies would have to be targeted in a very sophisticated manner: Gruber and Washington have found that the existing subsidies for Federal employees cost between \$31,000 and \$83,000 for each newly insured person).

In contrast, a Medicare-like program that pays for ten

dollars of services for those who otherwise would not receive these services would have to raise sufficient funds to offer those same ten dollars worth of services to those who do not need the full (or perhaps, any) government assistance. Therefore, one must ask what virtue is there in having everyone receive insurance through the same government program if that requires a much larger program than would be needed for a targeted approach. Why Medicare or Social Security rather than a program for the uninsured or poor elderly? Why enroll everyone in a social insurance program when you are most concerned with a subset of the population?

There are a number of reasons that one might favor a social insurance universal approach, that is, one in which all of us are part of the same program and have the same benefits. Let me group

these into categories, beginning with the political. It is not unreasonable to argue that when, as is the case today, most people already have insurance, achieving universality by enacting a new program that would replace already existing insurance may appear threatening rather than comforting and may make enactment more difficult.

Nevertheless, support for universality even among those with insurance may be greater than the body politic assumes. As noted earlier, many individuals and families with insurance feel threatened: they are not certain whether they or their dependents will continue to have insurance, whether their deductibles and co-insurance will continue to increase, whether their benefits will be reduced, whether they will have to contribute increasing amounts and percentages to premium costs. Furthermore, medical care costs have increased to a level that has made an increasing number of employers and employees aware of the impact that these costs have on wages and salaries. It is possible that over time an increasing number of employees and employers will support health insurance reforms that would break the link between employment and insurance, a link that generates animosity, difficulties, and ill will around the collective bargaining table. Breaking that employment link does not require that it be replaced by social insurance. Yet, if—as I would hope—the link is broken and needs to be replaced, then the threat of a new and unknown program is reduced.

Even so, the single-payer approach, entailing a need for new taxes, which in large measure may substitute for existing payments, hardly has a bright political future in the short term. I would like to think that education, leadership, and patience would help tip the scales, but these are in short supply. No, the political advantages of a single payer universal approach lie in another direction. The advantage does not lie in making it easier to enact such legislation, but in making it more difficult to weaken the legislation once it is enacted. The political

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**The political advantage lies in the phenomenon of universality and the fact that “we are all in the same boat.”**

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advantage lies in the phenomenon of universality and the fact that “we are all in the same boat.” There is no way to hurt low-income beneficiaries without hurting all beneficiaries.

I believe that Medicare and Social Security have fared better than Medicaid and welfare, because of universality. I know that some would argue that the explanatory variable is the age variable: that programs for the aged are likely to receive more favored treatment than programs for the poor. What merit this argument may have is somewhat weakened when we examine the way we deal with long-term care in general and with Medicaid nursing home financing in particular. Age does count, but I believe that universality plays a significant role in protecting Medicare and Social Security and, similarly, would play an important role in preserving a Medicare-for-all program if it were enacted.

I leave the non-economic discussion of universality with two additional comments. In a society which appears increasingly fragmented, I believe there is an important side-benefit associated with the creation of social programs and institutions that are seen as universal and that contribute to social cohesion. The intersection of beneficiaries around Medicare and Social Security surely is not the same as the intersection that requires that we rub shoulders together. Nevertheless, it should not be

dismissed lightly. Since, the analysis of “social cohesion” and of its potential contribution lies beyond the confines of even a broad definition of “economics,” and most assuredly beyond my competence, I rely on persons from other disciplines (psychology, political science, and sociology) to explore this matter.

My second comment is even briefer: Equity involves more than simply receiving an appropriate set of services or sum of money; it also requires that services be received under conditions that do not destroy one’s dignity. The IRS is better at preserving dignity in providing tax credits than welfare offices in providing their benefits; Medicare uses the language of “beneficiaries” while Medicaid speaks of “recipients.” Can dignity be preserved in a targeted approach? The answer is “yes,” but only if we are exceedingly sensitive to the issues involved and structure the program accordingly.

### Economic Features of a Social Insurance Program

Discussion of the economic features of a Medicare-like social insurance program must begin with the fact that any such program has to be financed by taxes. It is patently obvious that there are many different kinds of taxes: some more progressive, some less; some causing

## WHAT ARE THE MAJOR POLICY PROPOSALS TO ADDRESS THE PROBLEM OF THE UNINSURED?

Currently there are a number of policy proposals that address the issue of health insurance coverage within the United States. Some of the more popular policies include a single-payer system, incremental expansion to public programs, vouchers, tax credits, and “pay or play” requirements. The details of these policies vary greatly from proposal to proposal and are often used in combination to provide insurance coverage. Also, in some cases, proposals may combine policies with private insurance, such as a single-payer system and the option to purchase supplemental private insurance.

Here are brief descriptions of some of the major policy proposals:

**Single-payer health care**—A single-payer health care system would designate one entity (presumably the Federal government) to function as the primary purchaser of health care services. All individuals would be covered under the health care system, regardless of income. Individuals would have the option to purchase supplemental insurance that would provide services not covered by the program under some proposals. The system would be financed through a combination of individual income and employer taxes.

#### Incremental expansions of public insurance programs—

As few believe a single-payer plan is politically feasible, some advocate for more modest expansions in public insurance programs such as Medicaid or SCHIP. This might involve expanding eligibility to higher-income groups or parents of SCHIP-eligible children.

**Tax credits**—A tax credit is an amount that can be subtracted from actual income taxes owed. Some health care reform proposals provide tax credits to low- and moderate-income persons to help them free up money for health insurance. Because tax deductions help persons in higher income tax brackets more than those with lower incomes, tax credits are better in focusing benefits to low- and moderate-income persons. Refundable tax credits provide benefits to individuals that may exceed their actual tax liability.

**Vouchers**—A voucher is a government-issued certificate given to a low-income or moderate-income individual that can be used to pay all or part of the cost of health insurance coverage. It is similar to a refundable tax credit.

**“Pay or play”**—A “pay or play” program imposes a tax on employers (public as well as private) who do not provide health insurance to their employees and uses the revenue to finance a public health insurance program for those lacking access to employer coverage.

significant economic distortions, some more trivial in nature. While recognizing that the way the dollars are raised for universal health insurance has to be an important part of the discussion about specific legislative initiatives, today's discussion will abstract from that topic. Suffice it to note that when I state that I favor a Medicare-like approach, I do not imply that I find every characteristic of the existing Medicare program (including the existing payroll tax) desirable.

The heart of a Medicare-like proposal is neither the way the necessary funds are raised, nor the cost-sharing characteristics of the various deductibles and co-insurance, nor the structure of and limits on benefits. The heart of the proposal is that everyone has the same insurance coverage, that the insurance is provided by the government, and that government bears the underwriting risks. Of course, that is not all that the active proponents of single-payer are interested in. The recent proposal by The Physicians' Working Group for Single-Payer National Health Insurance, for example, would—among other things—eliminate all cost-sharing via deductibles and co-payments, pay all hospitals an annual budget, include coverage for all long term care, cover all prescription medications and supplies, and convert all investor-owned hospitals and long term care institutions to nonprofit status. Though I believe that many of these changes would be desirable, a number of them can be compromised without violating what I would consider the heart of the single-payer approach.

As suggested, the critical aspects of the expanded and improved Medicare/social insurance approach are that everyone has the same health insurance policy and that it be provided by a governmental entity. The accompanying advantages, even aside from the assurance that we would achieve universality, would impact in three areas: physicians and other care deliverers, employers and employees, and administrative costs.

It goes without saying that one of the problems that physicians, other caregivers, and hospitals have at the present time relates to their interaction with multiple insurers and multiple policies. Of course, we could do better than we are in standardizing benefit packages, rules, regulations, and forms, even while retaining the present system of multiple insurers and multiple benefit packages. The fact, however, is that we have not done better. Thus a single payer approach that has less variation, is simpler, and requires less administrative staff would benefit all those who receive reimbursement.

The benefits to employees and employers also are readily apparent. For employees it lies in the removal of fear and in the development of a consistent benefit package that is more likely to be understood because it is more stable than is true today when employees move to new employers or face a renegotiated health benefits package with the same employer. For employees and employers the benefit lies in the removal of health benefits from the collective bargaining agenda. This, after all, has been the most fractious issue on the table in recent

years, and for good reason. There is little reason to imagine that these dynamics will change under current arrangements.

The final benefit, I believe, lies in the area of administrative efficiency and administrative costs. With payments to providers coming from a single source, there would be a significant reduction in the costs of marketing, advertising, and administration and consequent gains for the rest of the economy and/or the health sector. Payments to providers from a single source would simplify enrollment, eliminate insurers from the picture, and eliminate a whole cadre of employees (e.g., health insurance brokers, health benefits managers) whose work involves being as efficient as possible at tasks that are required only because they are imbedded in an inherently inefficient system. One can debate how large the savings would be, but surely we can agree that they would be considerable. In a recent editorial in *The New England Journal of Medicine* Henry Aaron criticized the methodology used by Woolhandler et al. to arrive at the estimate of \$209 billion of "excess spending on health care administration" in the United States as compared with Canada. But Aaron's "conservative" estimate is \$159 billion, still a rather considerable sum.

## Problems Facing a Social Insurance Approach

So what is the problem? What are the issues that one might raise as an objection to Medicare for all? The first problem, of course, is political. Even though over half of those 65 and over were uninsured in the late 1950s, it took close to a decade to enact Medicare. Given the fact that today the vast majority of Americans already have insurance, the task of moving a social insurance proposal through the legislative process would be much more difficult. As a supporter of a single-payer approach I have often been asked, "What will it cost?" The response, "Less than we are now paying," has generally been viewed with a high degree of skepticism. I suspect that, in spite of Medicare's efficiencies, the statement that a single payer government program would provide better and cheaper insurance than most persons now have would be treated with much suspicion. Nor is there any current evidence to suggest that today's political span of attention is great enough to support the sustained effort at education, organization, and legislation that would be required.

The political problem is not the only one that would inhibit progress. Let me mention two others. The first relates to the fact that this kind of a non-incremental program would require a massive shift in the flow of funds. Since most estimates of the expenditure increase required to cover everyone have been in the order of five percent of current personal health care expenditures, it is not the increase in real resources that is the problem. Rather it is the shift in money flows. Funds that now move from employers and employees to insurers would have to be redirected into tax coffers. Clearly, this would

impact on labor negotiations and collective bargaining, wages and salaries, and employment. Furthermore, such a change would involve significant differential distributional impacts on individual employer and employee and the associated benefits and losses might be substantial. This consideration has implications for the very structure of the program and the speed with which it is implemented.

The final matter that I would mention on the minus side of the ledger is that the kind of a program that I describe, as is already the case with Medicare, puts very substantial power in the hands of government. Even with the best of motivations that power can be abused and history suggests that we cannot presume the best of motivations will always prevail. That, perhaps, is especially the case when regulations must be developed and implemented and acts must be administered by individuals who oppose, or at the

minimum do not believe in, the very program they must manage. Administering an insurance system means more than simply paying bills. The preamble to Medicare states,

“The bill specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities.” We know those words are empty. In terms of the federal deficit, I may be encouraged by the belief that it is more likely that government will be parsimonious than that it will be profligate, but as a prospective patient, I am discouraged. A greater role for government means more power in the hands of government. To accept this one has to believe that government will be committed to transparency and that it can be effectively constrained by the electorate.

### **Sensible Compromises to Minimize Problems with Social Insurance**

That brings me to my last section: a very brief comment on “compromises” that might minimize some of the problems that enactment and implementation of a Medicare-for-all program would entail. I call them “compromises” because that is how many single-payer advocates would view them. Nevertheless, I believe that some of these so-called “compromises” are sensible and do not destroy the central advantages of the universal model put forward.

The first compromise tries to address the issues inherent in transition from existing money flows. It does so by phasing in universality in a series of predetermined steps over a limited period of time. One could choose the steps so that the fiscal impact of each step would be

comparable. Thus, one might begin with all children 18 and under, move to the age group 19 through 28, and so forth. Alternatively, one could reduce the age for Medicare in a series of successive steps. Though such a program would involve complexities that would not be present in doing it all in “one fell swoop,” I believe it would solve many more problems than it would create. A phasing proposal is certainly a better form of “incrementalism” than the somewhat incoherent approach we have used in which legislative initiatives need not and do not contribute to a total plan.

A second “compromise” tries to deal with the power of the federal government. There is no easy way to do so, given that we are all Americans and that there is merit in having comparable benefits and similar arrangements across the various states. Even so, I would suggest that serious consideration should be given to permitting

states to “do it their way” as long as they can certify that all residents are covered for a federally specified set of benefits. This kind of arrangement has merit even beyond that of reducing the power of central

government. Different states might choose alternative arrangements and we might learn from those differences. Indeed, such an experiment could begin quite soon if the federal government were willing to provide financial assistance and set national standards and definitions of universality; if it assisted in finding ways to reduce the administrative costs involved in having national employers deal with multiple programs in the various states; and if it enabled “forward looking” states to adopt meritorious but costly experiments that others might shun and thus help avoid a “race to the bottom.” I do not suggest that a state-by-state approach would be simple to administer. Nor do I suggest that it would achieve horizontal equity between all Americans, but it would move us along. In time, perhaps, the various state systems would gravitate into only a few patterns; in more time, perhaps, they would develop into a national system.

Finally, compromise is possible if we keep in mind that the ultimate objective is that *all of the population be covered* and that this be done in a manner that—within political constraints—is funded in a progressive fashion, is structured to stimulate cost containment and to enhance administrative efficiencies. That is no trivial statement of objectives: it does not call for *maximizing* administrative efficiency or for *eliminating* insurance companies or for *denying* any role for market competition and patient concerns in enhancing cost containment. I believe that if we emphasized the objectives listed and really kept in mind the central objective of universal coverage, persons of good will could find effective and reasonable compromises.

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**Different states might choose alternative arrangements and we might learn from those differences.**

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## WHO PROVIDES HEALTH INSURANCE?

Of the 242 million Americans covered by some type of health insurance, 72 percent are covered by employer-sponsored policies. Most employees receive health care through health maintenance organizations (HMOs) or some other form of managed care such as Preferred Provider Organizations (PPOs). Most employers allow their employees some choice among health care providers. Although, on average, large employers pay for about 80 percent of the cost of health insurance, some employers pick up the entire cost, while others place the burden mainly on employees. In addition to a share of the premium cost, employees are sometimes required to pay the first few hundred dollars (or more) of annual health care expenditures (referred to as deductibles) as well as a set amount or percentage of charges for services used after the deductible is paid (referred to as *copayments* or *coinsurance*, respectively).

Under current law, employment-sponsored health insurance receives very favorable tax treatment. For employers, payment of employee health insurance premiums are considered a deductible business expense. For employees, employer-paid health insurance premiums are not considered income for purposes of calculating federal or state income taxes or Social Security or Medicare payroll taxes. In addition, for those who itemize their deductions, premiums paid by employees are deductible for income tax purposes if the sum of premiums plus other out-of-pocket medical expenses exceed 7.5 percent of adjusted gross income (AGI). Since 2002, self-employed individuals can deduct for income and payroll tax purposes, 100 percent of their health insurance premiums. Many employers also offer their employees access to flexible spending accounts. These accounts allow employees to pay the cost of their portion of the employer-sponsored premiums plus other non-covered medical expenses with pre-tax dollars. By reducing employees' income and social security tax liabilities, these accounts provide an additional tax subsidy to employee' health insurance expenditures.

Approximately 11 percent of insured individuals rely on privately purchased non-group health insurance (also referred to as individual insurance). This insurance is often quite expensive and frequently provides the purchaser with quite limited insurance coverage. For individuals who are not self-employed, health insurance premiums must be paid out of after-tax income, and are only deductible if the premiums plus other unreimbursed medical expenses exceeds 7.5 percent of AGI.

About one-quarter of all Americans receive some sort of government-provided health insurance coverage. Some of these individuals also receive insurance coverage through private health insurance. In addition to government insurance provided for members of the military, the three major government programs that provide health insurance are *Medicare*, *Medicaid*, and the *State Children's Health Insurance Program (CHIP)*.

**Medicare** is a federal health insurance program for virtually all persons age 65 and older and some severely disabled persons under age 65. The program provides insurance for hospital stays as well as regular doctor visits. To receive Medicare coverage, individuals are required to pay premiums of \$66 per month (higher premiums are required for individuals who had 30 or fewer quarters of Medicare-covered employment). In addition, Medicare recipients are responsible for deductibles and some coinsurance costs.

**Medicaid** provides health insurance coverage for some low-income persons and families. Specific eligibility rules vary by states, subject to federal regulation. Eligibility rules can be based on income and assets standards, receipt of certain income assistance programs, and the size of medical expenses relative to income. Medicaid is the primary public payer of long-term care and supplements Medicare benefits for low-income elderly persons. It is financed by state and federal funds (the federal government pays at least 50 percent of the total cost in each state), and is administered by states within broad federal guidelines. Under federal guidelines, states are required to provide Medicaid beneficiaries certain mandated medical services such as hospital stays, x-rays, and doctor visits. Other services such as dental care, physical therapy, and vision services are optional, and individual states can decide whether these services will be covered by Medicaid.

**SCHIP** provides federal matching funds for states to spend on health coverage for uninsured children. The program is designed to reach uninsured children whose families earn too much money to qualify for Medicaid but are too poor to afford private health coverage. Some states reached these children by expanding their Medicaid programs while others set up separate programs using private insurers.

## Conflict and Compromise over Tradeoffs in Universal Health Insurance Plans

The proportion of the population without health insurance has remained roughly stable over the past decade, in the face of both a large government program State Children's Health Insurance Plan (SCHIP) to cover uninsured children and a period of high prosperity. Given current trends in health insurance premiums and macroeconomic activity, the uninsured percentage is widely predicted to increase.

Why is such a significant minority of the population uninsured? And why doesn't the political system do something about this situation?

I will argue that there are some differences in values and beliefs, which have impeded policy action. But my main point is that the primary problem is related to political strategy and bargaining (or the lack thereof). In fact, a majority of citizens and a majority of participants in the debate share core values in terms of objectives, but differ both on how to get to those objectives and which tradeoffs they are willing to make among them. I will argue that the key element in breaking the logjam would be for those whose first preference is universal single-payer coverage to compromise and accept a voucher-based multiple payer approach. Success cannot be guaranteed even with this compromise, given the current state of the federal budget. But, without it, we will be condemned to more years of fruitless debate and inaction.

I will also discuss key design issues in voucher/credit programs, and conclude with a proposal for a phased introduction of a variety of options that deals with important fears on all sides and integrates well with what currently exists.

### Policy Preferences

A majority of Americans would prefer to institute programs that would significantly reduce the ranks of the uninsured. A recent poll conducted by Robert Blendon and his colleagues at Harvard found that a majority (74 percent) of voting age respondents favor a program to provide coverage to the uninsured. Why then, in a majoritarian democracy, do we fail to see action?

Although there are a number of reasons, I believe the strongest reason has been identified by Stuart Altman, a former government official and dean at Brandeis University. I call his argument "Altman's Conundrum": Simply put, Altman argues that the various groups in society advocating different approaches to achieving the goal of providing insurance coverage for the uninsured do indeed represent a majority of the nation's population. Blendon's study in fact shows that several different pol-

icy alternatives receive equally strong support, with the only option not garnering a majority being single-payer plans. The problem is that, for each group, the next best alternative to its preferred solution is to do nothing, and no single group constitutes a majority. Informally, Altman argues that the various groups advocating for the uninsured kill each other off politically. The uninsured remain as they are.

In what follows, I will present a simple model of Altman's Conundrum. This model shows that compromise is needed for those who favor universal governmental tax-financed single-payer reforms. This group, which I reluctantly (given the political overtones) label "liberals," needs to compromise with those who favor the other major alternative: vouchers usable for private insurance. I borrow a term suggested by Sherry Glied and label those people "marketists." I will also consider employer mandates of the "pay or play" variety and argue that they represent the worst of both worlds and so are even less likely to emerge as a majority rule winner.

### Altman's Conundrum Semi-Formalized

We assume that there are three groups of voters or decision makers. There are *liberals* who prefer governmental action but who do not represent a majority of decision makers. There are *marketists*, who are concerned about the uninsured but who want to use private markets to furnish coverage to many (though not necessarily all) of the uninsured. This group is also a minority, but the liberals and marketists together constitute a decisive majority. Finally, there is a third group (26 percent of respondents in Blendon's study) who are *negativists*; they do not at present favor any plan to reduce the number of uninsured, presumably because they feel that problems caused by the absence of insurance are not severe enough to justify action that may impose some negative effects on them, such as higher taxes or more restrictions on their health insurance and health care choices. No one of these three groups is a majority, but together, any two groups constitute a majority. Voting is by *sequential binary choice*. This means that a series of referenda are held in which each proposal for solving the problem of the uninsured is considered by the voters relative to a single alternative policy. Any proposal that gains a majority of votes against all other proposals is accepted and becomes law.

Table 1 shows a "voting matrix," which displays Altman's conundrum. The three proposals are: universal tax financed single-payer *government* insurance, tax-financed partial *vouchers* for private insurance coverage, the *status quo*. The columns display preference orderings; the entry at the top of each group's column represents its most preferred option and the entry at the bottom its least-preferred option.

As it is set up, Table 1 indicates that liberals most prefer *government*, marketists most prefer *vouchers*, and negativists most prefer *status quo*. I also assume, I think

**TABLE 1**  
**Voting Matrix of Altman’s Conundrum**

Liberalists	Marketists	Negativists
Government	Vouchers	Status Quo
Status Quo	Status Quo	Vouchers
Vouchers	Government	Government

The top entry represents the most preferred option; the bottom entry the least preferred option.

quite realistically, that the negativists, whose first choice is the status quo, would prefer a system of vouchers to a single-payer solution. If I assume that the second choice for both liberals and marketists is the status quo, then it is easy to see that the majority-rule winner is *status quo*. It defeats both *government* and *vouchers*, by a 2–1 margin.

Now we explore what happens if either the liberals or the marketists agree to compromise. Table 2 shows the same “voting matrix,” altered to reflect this possibility. I assume that each group’s compromise involves switching its second and third place preferences. Thus liberals’ second choice would be vouchers, and third choice the status quo, while marketists’ second choice would now be single-payer insurance followed by the status quo. If the liberals compromise, the majority outcome now changes from *status quo* to *vouchers*; vouchers win over the status quo. If, in contrast, the marketists compromise, there is no majority-rule winner. Policy alternative *government* defeats *status quo*, *vouchers* defeats *government*, but then *status quo* defeats *vouchers*. Put slightly differently, even if the marketists compromise, the only way that the electoral process would choose a single-payer solution (*government*) would be if the negativists—those who most prefer the status quo—would also prefer government single-payer insurance to vouchers.

Making the leap from theory to practice, I therefore

**TABLE 2**  
**Exploration of Compromises**

**Liberals Switch**

Liberalists	Marketists	Negativists
Government	Vouchers	Status Quo
Vouchers	Status Quo	Vouchers
Status Quo	Government	Government

**Marketists Switch**

Liberalists	Marketists	Negativists
Government	Vouchers	Status Quo
Status Quo	Government	Vouchers
Vouchers	Status Quo	Government

The top entry represents the most preferred option; the bottom entry the least preferred option.

conclude that a good way to make a plan to reduce the number of uninsured a politically viable and stable alternative to the status quo would be for liberals to compromise and support vouchers, not as their first choice, but as their second choice. I next discuss in detail what changes in values among liberals or compromises on strategy among marketists would be needed to make this more likely to occur.

**Moving Liberals toward a Compromise**

According to the surveys analyzed by Blendon et al., slightly less than half of survey respondents favor single-payer national health insurance as a mechanism for eliminating the uninsured. What ideas will these people need to give up in order to develop a compromise with the marketists that will move the country towards adoption of policies that would solve the problem of the uninsured?

There are several tenets associated with the liberal position that will need to be sacrificed. One is the high priority placed on eliminating inequalities in the use of medical services and medical spending. Many supporters of a single-payer system believe that access to health care services should not depend in any way on one’s income, wealth, ethnic or racial background, or place of residence. This contrasts with the view of many voucher advocates, who believe that the highest priority should be to get highly effective care to those who need it. At the same time, voucher advocates believe that individuals with the will and the means to spend their own resources on additional care should not be prevented from doing so. Voucher advocates also want to build on the common-sense perception that in order to achieve greater (though not necessarily perfect) equality in *health outcome* in a world where resources, education in how to work the system, and contacts are unequally distributed and correlated with unequal incomes, one needs to have unequal *insurance*, with *greater* benefits for the less able than for the more able. An unyielding devotion to nominal uniformity in health insurance in a world where incomes and wealth are and will remain unequally distributed can only prevent any forward movement towards a solution to the problem of the uninsured.

A second tenet of liberal thought that will need to be relaxed is the belief held by many liberals that government will nearly always do a very good job in producing goods and services, especially when compared with private profit-seeking firms. Setting aside baser motives for favoring government control, such as providing jobs or favoring allies, for example unions, there certainly are some people who believe that they will get a better deal in transactions with civil servants or institutions controlled by non-profit organizations or community activists, than from private enterprise. There are, of course, others who read both history and their personal experiences to come to exactly the opposite conclusion.

A final core belief for many liberals has to do with

means testing. It is beyond question that both insurance coverage and spending on medical care for those with insurance coverage is higher for higher-income people at any given level of health. If the social problem raised by the lack of insurance is inadequate use of medical care and/or inadequate financial protection from medical bills, then it seems logical that programs to affect insurance purchasing need not touch higher-income households except to collect tax revenues. And yet one of the articles of faith for many liberals is that insurance coverage take the form of social insurance with coverage uniform for almost all. (It is noteworthy that the prototype for social insurance, the German sickness fund system, exempts individuals with incomes above about \$80,000 from the obligation to take the social insurance.) The usual argument against means testing is political: it is felt that if the upper middle class is not included in the socialized insurance system, that politically influential group will not support generous insurance for lower-income people.

I do not believe that this political prediction is necessarily true. But, even if it is, this “ends justify the means” political argument is difficult to fit into any respectable normative model of the democratic process. One would hope that, facing transparent political choice institutions, the non-poor would be willing to support the poor. If they are not, what rationale can be advanced for creating a more complex process that traps them into doing more good than they would like? Moreover, it is by no means obvious that requiring uniformity will induce middle class support. If the burden of transfers becomes large enough, and the possibility of private alternatives exists, the middle class may bail out altogether on helping low-income uninsured just as they have bailed out on helping poor children in many inner city public school systems. Finally, and to my mind most decisively, one of the things voucher supporters explicitly dislike is the idea of being trapped in a single public system, not so much because they oppose transfers they have been tricked into accepting, but because they dislike the uniformity of final product that necessarily accompanies that system.

## Moving Marketists toward a Compromise

The single most important feature of competitive markets that marketists seek to preserve is the ability for citizens to choose their own insurance, in multiple dimensions. However, it seems likely that there will have to be some restrictions on insurance choices, for three reasons. The first is simply economy. To offer a low-priced decent plan to the currently uninsured, some way of reducing administrative costs for private and public insurers will need to be found. Settling on a rel-

atively small number of plans is a way to economize that will not do much harm if the plans do indeed span the full spectrum of options. The second reason for restricting the range of choices is the need to avoid *adverse selection*. One way to deal with this is to prohibit plans so generous that they would only be chosen by people with high risk of illness, and in a similar fashion avoid very skimpy plans that no one would choose if they were priced in ways properly reflective of risk. Finally, some people will not be able to

**Adverse Selection** can occur when a group of people knows more about their health status and health histories than their health insurance provider. This “information asymmetry” may lead a large number of persons in poorer than average health to enroll in health insurance plans with generous benefits, thereby driving up costs and eventually the premiums of those plans.

make reasonable choices. They need to have their choices restricted.

A second compromise is to permit there to be a publicly-administered insurance option available to people. This option would presumably be chosen by people who trust public management rather than private management.

Such a government option would also be a good candidate for fallback insurance. To a considerable extent, this is the current model on the table for Medicare reform. Existing proposals permit alternative health insurance plans—private for-profit, private non-profit, or run by state governments—to compete directly with the traditional government-managed Medicare.

To make competition work properly all plans must abide by the same rules in terms of accepting higher risks. That task will be eased if a reasonably good method of risk adjustment of the government contribution can occur. Observable variables can at present provide a serviceable method for measuring high risks. It would also be possible, and probably desirable, to “overshoot” with risk adjustment—to overpay modestly for apparent higher risks—to provide plans with incentives to recruit and retain those with high risks of illness as members, and perhaps compete by enhancing the quality of care for high-risk members a little. To some extent I believe that we should be willing to risk a little more risk in order to have a much wider set of options, and to use market rather than political discipline to incentivize efficient and sensitive plan performance.

## Convincing the Skeptics

The primary task in convincing negativist skeptics should be to develop *persuasive* information. There are some skeptics who believe that the uninsured have

some access to care, and conclude that additional access furnished by insurance will not do enough good to cover the extra cost they (or “society”) will have to pay. What we know is that some of the uninsured have worse health status than the otherwise apparently similar insured, but what we do not know is the contribution of “uninsurance” to that difference.

The National Academy of Sciences’ Institute of Medicine (IOM) recently conducted a large scale, expensive project on the uninsured that is, in my view, a failure precisely because it directed its arguments and analysis toward those already convinced of the need to cover the uninsured—the aforementioned liberals and marketists—and did not seriously address what the skeptics are skeptical about. The literature the IOM relied upon largely consisted of correlations between insurance status and process measures (like “person reports not being able to get needed care”) and outcome measures like self-reported health status or hospital admission for avoidable causes, while controlling for some observable characteristics. While this correlation would be persuasive to an advocate such as myself who is predisposed to believe that insurance is good for medical care and medical care is good for people, it may well not convince a skeptic who is not willing to give insurance and medical care the benefit of the doubt.

Skeptics are likely to point out two flaws to the arguments about the importance of insurance coverage. The first, already suggested, is that correlation is not causation. By not delving seriously into why the uninsured fail to obtain the insurance that the great bulk of Americans are somehow able to afford, the analysis cannot refute the alternative hypothesis that the same thing that causes a minority of people to choose not to get insurance also causes them to choose activities which reduce health and to avoid activities which could improve health. The one randomized trial we have, the RAND health insurance experiment, did not include a comparison with people totally without health insurance; everyone in the experiment at least had income-conditioned catastrophic coverage. According to the economists who managed the RAND experiment, it failed to show that more insurance coverage (than catastrophic) had any appreciable effect on health except for low-income people at initially high risk.

There is other evidence, primarily from natural experiments in the form of Medicaid cutbacks, that shows quite clearly that not having insurance is quite harmful to the health of poor sick people. The skeptic’s response, however, is to note that the great bulk of the uninsured are neither poor, nor sick. If all we wanted to do was to get “insurance” to poor people who are already sick, we would only need to cover a tiny fraction of the currently uninsured population. To justify a policy of substantial reductions in the number of uninsured, the real question is how much of a difference insurance would make to the health status of people who are initially well and young, with lower- or middle-class incomes, or of people living

in households with above-average incomes.

So far our country has been unwilling to subsidize insurance of poor able-bodied adults without dependents. Evidence that coverage would make a difference to their future health would matter, and we do not have the evidence. The difference could never be as large as the difference for sick people, but these able-bodied adults are much cheaper to cover. The cost effectiveness of coverage for them might well be higher than it is for those with chronic illnesses who already are high risks.

There also is considerable skepticism among the middle class about the cost of doing something about the uninsured. As I pointed out years ago, the real resource cost of covering the uninsured, is actually quite small—precisely because the uninsured are a small minority of the population and because they already use substantial amounts of care. The rest of us currently pay for that care primarily in the form of higher charges by health care providers who choose to or are obliged to treat the uninsured. The idea is that if you will agree to pay higher taxes to cover the uninsured, you will get about two thirds of that back in lower prices charged by hospitals who now will no longer need to cover charity care and bad debt, and then your insurer will translate those lower charges into lower premiums. The gap in this argument is painfully obvious—how can anyone guarantee that hospitals will cut their prices, rather than finding some other uses for the excess funds, such as support of medical education or research?

To sum up, the typical uninsured person is not poor, sick, and miserable. The most precise statement is that there is no typical uninsured person today. There is no analogous “objective” characteristic of the uninsured that is a good predictor of being uninsured or that is not subject to manipulation in response to subsidies. Being uninsured, or even not being offered job-based insurance, is eminently manipulable, as the substantial *crowd out* from expansion in Medicaid coverage has shown. A poor person is likely to be uninsured, but an uninsured person is not likely to be poor. So poverty is not a good predictor of being uninsured. All of this means that it will be hard to construct tidy programs well targeted at the uninsured, and therefore hard to provide simple designs that will convince skeptics. I will return to the question of targeting later.

**Crowd Out** is said to occur if new public health insurance programs or the expansion of existing programs to extend coverage to the uninsured either prompts some employers to drop employee health coverage or results in some employees substituting public coverage for employer-sponsored coverage.

## Why Not Make Employers Pay?

Probably the most frequently discussed method for covering the uninsured is the one that makes the least sense in terms of economic logic or political trans-

parency. The argument goes as follows: the great bulk of private insurance is obtained in connection with the job of one or more wage earners in the household. While employees are explicitly charged some premiums for this coverage, most employers pay the bulk of the premium. There are some employers, however, who are not willing to give their employees this benefit, especially small employers. Even though those employers assert that they cannot afford to pay for such coverage, it is only fair that they too should be required to pay, either for coverage they choose or toward coverage provided by a government-managed source of fallback coverage. This mandated employer health insurance coverage has been called “pay or play.” To many people it seems like a fair and reasonable policy response to the problem of the uninsured. Fair, because it addresses inequities between those employers that choose to help finance health insurance coverage for their employees and those that choose not to. Reasonable, because it provides coverage that the great bulk of the non-poor are used to. So isn’t this an approach that provides a compromise between public regulation and private production, that makes sense, and that has bright political prospects?

I think the answer is likely to be no. The important and confusing question is: who really pays the “employer’s share” of the health insurance premium? Or, more precisely, how will a firm’s profits be affected if employers are required to turn over money for health insurance premiums? Economic theory and some strong empirical work suggest that the great bulk of this cost will fall, not on profits or employer net incomes, but on workers’ wages and other benefits. The depressive effect on wages could come about if employers lay off workers they now find more costly. But it is actually in employers’ interest to reduce money wages relative to what they would have been, rather than to lay off workers and experience lost output. Requiring employers to provide health insurance will not necessarily lead to an immediate reduction in wages. As employers are often reluctant to cut wages, they will tend to wait until the next time wages are set, and then raise wages less than they otherwise would have. Employers whose workers did not value health insurance enough to warrant offering it in the first place, may not be able to capture quite all of the increase in health insurance costs in the form of lower wages.

If everyone understood these economic principles, the opposition to “pay or play” should come from those workers who prefer to receive their compensation in the form of take-home pay rather than benefits. In effect, an obligation on employers to “pay or play” is, in its simplest version, like obligating employers to be tax collectors. Employers must either impose a head tax on workers, or a mandate that workers sacrifice some cash wages in order to obtain health insurance that they presumably did not value enough to hold out for when seeking work. It is not at all clear that the impact of mandat-

ing employer-provided health insurance is well understood. And even if uninsured workers understood the impacts of the mandate on their wages, it is unlikely that as a group they are politically powerful enough to have much impact on the policy outcome.

What is likely to produce more effective opposition to a health insurance mandate is opposition from employers not currently offering coverage—almost entirely small firms. The Clinton health reform plan included an employer mandate that was strongly opposed by small businesses. Because these employers apparently feel that they (not their workers) pay for health insurance, and because they think they cannot “afford” to pay more, the opposition to any new “pay or play” proposal is likely to be as fierce as it was to previous proposals.

But most fundamentally, I think requiring small business either to play or to pay is likely to be a third rail issue. Given the perception that small businesses create jobs, given the effectiveness of their lobbies, and given that large firms really don’t have a stake in this game, insisting on “pay or play” seems like an unnecessarily provocative act. It might be possible to use this method if employers were explicitly permitted to reduce wages by the amount of the mandated cost or, less aggressively, if employer “contributions” across the board were accounted for on employee pay stubs and treated for tax purposes as the wages they are. But “taxing benefits” raises issues of its own. There is a rationale in permitting employers to arrange insurance if that is what employees prefer. On balance, however, making clear that an employer option exists and making workers who arrange their coverage that way eligible for the same subsidy as those who prefer the individual market would seem to be the best way to go, far preferable to requiring people to let their boss arrange their health insurance whether their employer is up to that task or not.

## Variation Among the Uninsured

If these broad plans cannot receive high levels of political approval, can we at least identify some subset among the uninsured for whom the benefits to all from a particular type of coverage would be large relative to the cost? To answer this question we are forced again to confront the issue of the extent and form of heterogeneity among the uninsured. Table 3, taken from recent Current Population Survey data, shows that on the whole the uninsured are neither poor nor rich. In the three broad household income categories described, no single category contains a majority of the uninsured. Indeed, my main conclusion from this data is that there are three reasonably distinct levels of “need” among the uninsured, that divide the adult population roughly into thirds.

To begin at the top of the income distribution, a little less than a third of uninsured adults are in households with incomes at or above the median income for the country as a whole. At the other extreme, about a third of the

TABLE 3

**Non-elderly Individuals without Health Insurance,  
by Income as Percent of  
the Federal Poverty Line, 1999**

Family Income as Percent of Poverty Line	Percent of the Uninsured	
Less than 100	25.1	} 32.6
100–124	7.5	
125–149	8.1	} 39.9
150–174	7.5	
175–199	6.0	
200–249	10.4	
250–299	7.9	
300–399	10.0	} 27.6
400–499	6.5	
500 and more	11.1	
<b>Total</b>	<b>100.0</b>	

Note: Based on data from the Current Population Survey.

uninsured have household incomes at or within hailing distance of the official poverty line. Finally, a little less than a third of the uninsured are “tweeners,” with incomes between an augmented poverty line and the median income.

Table 4 cuts the data slightly differently, exploring whether income is a very good way of predicting both being uninsured and the absence of private insurance. The data suggest that over a fairly wide range of income, most but by no means all households are privately insured. There is no obvious threshold income at which the great bulk of households switch from being unin-

TABLE 4

**Percent of Non-elderly Individuals with  
Non-government Health Insurance by Income  
as a Percent of the Federal Poverty Line, 1999**

Family Income as Percent of Poverty Line	Percent with Non-government Health Insurance
Less than 100	26.3
100–124	45.7
125–149	51.8
150–174	58.0
175–199	66.2
200–249	73.2
250–299	80.1
300–399	85.8
400–499	89.1
500 and more	92.4
<b>Total</b>	<b>74.2</b>

Note: Based on data from the Current Population Survey. The term “Non-government health insurance” includes insurance for military personnel, veterans, and government workers.

sured to being insured. Put slightly differently, most of the uninsured are a minority in their own socioeconomic stratum. They are unusual, in not choosing to devote the resources to insurance that most people like them choose. What would really help is a better understanding of why these people are unusual. Do they face usually high prices for insurance or for other things? Are they heavily in debt? Do they behave in risky ways with regard to other aspects of their behavior?

Research suggests that one reason why some non-poor are uninsured is a high price for insurance (but not necessarily a high premium payment). Young people face much lower premiums in the individual insurance market than middle-aged people, and yet lower-middle-income young people not offered employment-based coverage are significantly less likely to choose individual insurance than lower-middle-income middle-aged people. I think that the reason the young avoid health insurance is the perception, and in some states the reality, that health insurance is not particularly a good deal for the young. Middle-aged people also apparently search more aggressively for lower premiums than do younger people. Beyond this, we are left to speculate about tastes, decision processes, and the like. What we do know, however, is that many more of these “tweeners” would be willing to spend their own money on health insurance if a decent subsidy made insurance a deal too good to refuse.

## The Way Forward

Any program to cover a significant number of the uninsured will require major new government funding to be devoted to this purpose. With the substantial deficit currently at the federal level, and with the substantial limits on state spending power, is there any point in talking about a large new program at the present time? I do not see any realistic reason to have a serious discussion of short-run strategies. However, it may be possible, most realistic, and perhaps most hopeful, to begin now preparing for a program to be implemented gradually at some time in the future.

We already have a mini-program in place, in the form of credits for coverage under the Trade Assistance Act. For workers who were adversely affected by imports, the option of an advanceable and refundable credit for a flat 65 percent of health care premiums is now available, as long as the insurance is offered by anyone *except* a private individual insurer. Plans offered by former employers, trade associations or unions or state governments all qualify individuals for the credit.

I think it is also desirable to treat the subpopulations of the uninsured differently by devising a first-round fallback or default plan for them that is similar to what is most common among their otherwise similar insured brethren. For poor and near-poor people, the default option should be Medicaid. As is the case with the current Medicaid system, beneficiaries would not be expected to

make premium payments. The default plan for lower-middle-income and middle-income young adults and their children would be private insurance combined with the offer of reasonably generous tax credits (say, in the range of \$1,500 per year per person, adjusted for future increases in premiums). These individuals would be expected to purchase either group or non-group health insurance, and pay the difference between the value of the tax credit and the insurance premium.

For uninsured adults with incomes above median income—a quarter to a fifth of total uninsured—it is less clear what should be done. My most preferred strategy would simply be to mandate that they have insurance (enforced by a heavy tax penalty if they do not), and let them figure out the best way to obtain coverage. If we need to sweeten the deal with a modest subsidy, then offer everyone a tax credit equal to the average tax benefit a person with median income currently receives due to the tax-free status of employer-provided health insurance. Those with incomes above the median will find a better deal in group insurance, while those who prefer individual coverage will at least get some financial help from the government.

The final group (the smallest) that might be helped by something a little different is the non-young, non-poor, non-rich uninsured. Think of the people over age 55 with household incomes below the median but well above the poverty line. If offered a tax credit like younger workers and turned loose to find their own insurance, this group will face more of a challenge. Getting a job that carries coverage may be harder than for younger people. Relatively modest tax credits, around \$1,500, will still leave them paying thousands of dollars out of their own pockets for coverage supplied by often-reluctant insurers. I hasten to add that I am not certain that there is a real problem for this group. Non-elderly individuals over 55 are now the most likely group to buy individual health insurance entirely with their own after-tax dollars when they don't have a job that provides insurance. Presumably, the reason they purchase their own health insurance is that the financial burden of purchasing coverage is easier for them to bear than the risk associated with big medical bills.

However, one possible alternative for this group might be called “Medicare for Some.” The notion would be to permit people over 55 to enter the Medicare program, with a partial subsidy. They could choose the same benefits in the government-run Medicare program as today's elderly and disabled do. This would not, however, be their only option. They could also choose among a variety of private plans that Medicare approves, possibly with a supplementary premium for additional benefits.

In all cases, these target plans, Medicaid, neutral private insurance vouchers, Medicare for Some, and

slightly sweetened deals for the upper-income individuals, would only be put in place temporarily. Careful and timely monitoring of performance and behavior would occur, and, if any given plan worked reasonably well, it would be made available to those outside of the target group. Thus the poor could receive 100 percent vouchers for private coverage, and the non-poor (whether young or old) could sign up for Medicaid or Medicare. All plans would, in this situation, be in direct competition with each other. There would be no special favors for Medicaid, traditional Medicare, Medical Savings Account plans, or private HMOs.

## Designing Credits and Vouchers

Considerable progress has been made in researching and thinking about how to design credit and voucher programs, even though legislative action has so far been on a small scale. Some questions, such as exactly how people will respond to programs which require

them to add their own private payment to credits in order to use the credits to obtain insurance, can only be answered definitively by experience. Others, such as how the private insurance market in which credits are used might be reconfigured are necessarily speculative. I

am going to give these programs the “benefit of the doubt” where the evidence is mixed, but my conclusion is that we have a good basis for expecting positive outcomes from such programs when they are well designed and used by the right populations.

There are, first of all, some administrative issues which seem fairly well settled among policymakers interested in such programs. The proposed designs envision *advanceable, refundable credits with prospective income conditioning*. These terms can be explained by reference to the problems they are supposed to solve. The first problem is that many individuals will not be able to afford to pay for health insurance unless they have the credit in hand before their health insurance premium is due. A tax credit will not help the millions who pay sales and payroll taxes but no income taxes. The solution to this problem is to reverse the timing and make credits available before a person buys health insurance. A credit can be prospective and advanceable, administered to pay toward a person's monthly insurance premium as that premium comes due. Either the credit can offset tax withholding, or there can be direct payments from the government to the insurer of choice.

The second problem is that an income tax credit will not help millions of families who currently owe no income taxes, yet must pay substantial amounts of payroll, sales, and property taxes. The obvious solution to this problem is to make the credits refundable. With a re-

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**We have a good basis for expecting positive outcomes from credit and voucher programs when they are well designed and used by the right populations.**

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fundable credit, if the value of the credit is greater than the person's income tax liability, the excess is refunded as a positive payment. Finally, a way to administer any income-based credit is to base eligibility for credits on a person's income in the previous year. Small errors from doing so may be judged to be a much less serious problem than the benefit from assured payment to people who need to plan ahead.

A less easily solved question is determining the minimum set of services that the insurance eligible for the credit must cover. There is a tradeoff here. For any given level of tax credit, the more costly the premium, the greater the chance that a person will not use the credit at all. At the same time, a decision to cover a broader range of health care services will result in a higher premium. My own preference is to have minimum coverage requirements set low even though that may run the risk of incomplete coverage. I make this choice because I view some coverage for many of the formerly uninsured to be preferable to really good coverage for a very small fraction of the uninsured.

Finally, the most serious design and policy question is how to treat variations in risk, either in designing the credits or in regulating the private insurance for which credits will be used. Basic economic logic tells us that if insurers are to be able and willing to cover people whose expected expenses for a given nominal insurance policy are higher than average, the best design is one that provides more revenue when an insurer sells to a higher-risk person. Even if total revenues could cover average costs, any process in which everyone pays the same net premium will discourage insurers from seeking to cover the more expensive customers. It is administratively difficult, however, to adjust for risk perfectly in the subsidy program, and complex even to adjust for it imperfectly.

If low-income person A has higher expected medical expenses (risk) than person B, there are three subsidy options: (1) Adopt the simplest policy of paying the same subsidy, and hope that person A will be willing to pay a higher insurance premium than person B. (2) Adjust the size of the credit or subsidy on a person-specific basis to account for each person's higher risk. (3) Make larger subsidy payments to insurers who cover people known to be higher risk, either in the form of an assigned high-risk pool or by reinsuring some portion of each insurer's high expected risks.

The great bulk of the uninsured are not high risk, although the proportion of those who are high risks is somewhat greater than among the privately insured. However, among people in families that include a full time worker, there is much less difference in risk between the insured and the uninsured. In any case, probably because they are on average relatively young, the

great majority of the uninsured report their health as "good" or better. Thus focusing on high-risk uninsured is guaranteed to have a small effect on the total head count of the uninsured. At a minimum, introducing a public program for those with costly *and* chronic illness should be able to take the few tragic cases off the table. That leaves people who are initially not severe risks, but who will in the future incur a majority of medical costs, both for minor illness and for serious, expensive, but unforeseen illness.

For reasons already discussed, I do not think it is necessary to make special adjustments to the portion of the variation in health insurance premiums that is due to something highly predictable: older age. The question is what to do about variations due to the initially unpredictable onset of high-cost chronic conditions. The simplest approach, which I am inclined to favor, is to require insurers to adopt "adjusted community rating bands" for new insureds and guaranteed renewability for those who are currently covered. Guaranteed renewability is in fact

already in effect for individual insurance. If I buy individual insurance, my insurer is required to renew my coverage and is forbidden from singling me out for additional premium increases based on my experience. If I get my coverage through my employer, I have this protection

if I remain in the same job, but I do not have this protection if I change jobs.

For a person who is applying for coverage for the first time to any given insurance company, there is a strong incentive for the insurance company to determine if that person is high risk or has high-risk dependents. Because individual insurance is so expensive, insurers correctly fear that someone who wants to buy it knows something secret about their future use of medical care. I allow for "bands" or some kind of penalty to deal with the egregious case of someone who waits to seek coverage until he is really sick. Although these individuals could face a penalty for waiting to get coverage, that event should be rare if the insurance subsidy is generous and the program is well marketed. Of course, if we set up a system of subsidies we think is fair, there is no obvious reason not to take the final step and make insurance purchase an obligation rather than a choice. However, I do not think the electorate is ready for such control yet.

Compared to a mandate, it is obviously more complicated to create incentives for individuals to buy coverage. It is also more complicated to permit choice of coverage, since any opportunity for choice also is an opportunity for those with higher risks to take advantage of insurers. If I thought that there was a single insurance plan that all Americans could agree was close to best for each and every one of them, and a single management that would do a good, honest, and waste-free job without

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**The most serious question is how to treat variations in risk, either in designing the credits or in regulating the private insurance for which credits will be used.**

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the pressure of competition, I would go for a single system. Unfortunately, I don't think there is a single-payer plan that Americans would agree to, and neither do I have confidence that the government would always do a good job administering any such plan. I think there is irrefutable evidence that Americans value choice in health insurance. Some want to be free to select costly insurance that allows them a wide choice of medical providers and treatments. They also value the freedom to select health insurance plans of different degrees of permissiveness matched with different costs. I also think it unlikely that even the best motivated managers, whether public servants or private employees, will always be motivated to do the right thing or even to know what the right thing is. So, at least initially, I would think it appropriate to offer choice to people (the non-poor) who are used to choice.

## Conclusion

There is no free and painless way to get nearer to universal health insurance coverage in the United States. If we want to make something—anything serious—happen, people are going to have to compromise. My preferred approach, though magnanimous in its tolerance for public programs, still has a steel spine. It postulates that Americans can and should ultimately and individually be given the power to choose in health insurance. But the first choice I see adults making for themselves is a choice of whether to choose, or whether alternatively to hand over this complex issue to some other entity. The alternative, of making a collective choice of a single-payer system binding on all is still a potential political choice, and might still come about. My judgment is that such a degree of uniformity is not needed, and is not likely to lead in any case to unanimity. Even though we are “all in this together,” that does not mean that we cannot be clever and creative in allowing those of us who want to have different outcomes be able to express those differences, with “solidarity” expressed primarily in the form of transfers to others rather than uniform consumption of health insurance.

Is the time ripe for action? I hope so, but it may be that things will have to get worse before they get better. Perhaps the middle class will have to feel threatened with loss of health insurance coverage. Rising medical spending alone will not be sufficient motivation. Alternatively, and more hopefully, we research types may be able to do what we should have done long ago—assemble information on the value and effects of insurance for the non-poor, non-sick that will be sufficient to convince a skeptic. Perhaps we can dig a set of channels for old transfers to drain off, and new transfers to flow, that will allow the middle-class taxpayer to feel that spending serious money on this problem is, at long last, a worthwhile thing to do.

## DIRECTOR'S PERSPECTIVE

*continued from page 1*

health care treatment, but in all other aspects of life faced the 1950 standard of living?

People differ in their answers to this question. This tells us that for many people, health care may be worth as much as all the other things we consume. Longevity is increasing, and in my view, living longer while in good health is worth more than all the other benefits of a growing economy combined. Increased longevity is the most visible payoff we receive from university research and from science in general.

As health technology develops, however, health costs rise, and our historical way of paying for health care—a complicated mix of payments from business, government and households—is being challenged by these rising costs. In particular, it is challenged by the question of who is to pay for the health care of the large number of Americans who have no health insurance.

This issue of the *Policy Report* summarizes the proceedings of a recent La Follette School symposium on health care finance that confronted the question of the uninsured.

The symposium was made possible through a generous gift from Mark Stone. Over 100 attended to hear talks from several of the nation's leading experts on the financing of health care. The audience came from all over campus and reflected a wide-range of backgrounds. A vigorous discussion took place on a number of issues raised by the four symposium speakers. Mark Stone and members of his family attended the symposium, and participated actively in the discussions. We are grateful for his financial support and his intellectual curiosity.

In the coming decades, health costs are expected to grow in relative importance, and to take an increasing share of the nation's income. Health policy issues will grow in importance as well. The large role of government in paying for and administering health programs, combined with the growing share of health-related expenditures in public budgets tells us that schools of public policy and public affairs will devote increasing shares of their attention to health care issues in coming years. The La Follette School, with its existing strength in health economics, social policy, and science policy, will continue to play an important role in the ongoing public policy debates concerning both the delivery and financing of health care in the United States.

*Donald A. Nichols*

# Facing Health Care Tradeoffs—Costs, Risks, and the Uninsured

By Thomas R. Hefty

*Thomas Hefty has retired as chair of the Cobalt Corporation, whose subsidiaries include Blue Cross Blue Shield United of Wisconsin and United Government Services, the country's largest Medicare intermediary. He is co-chair of Wisconsin Governor Doyle's Economic Growth Council and is Of Counsel at Reinhart Boerner Van Deuren s.c.*

The debate on health care tradeoffs continues with free-market voucher advocates on one side and the loyal opposition, advocates for single-payer government-financed insurance, on the other side. In the nearly 40 years since I first stepped onto the University of Wisconsin Madison campus, surprisingly little has changed in the debate despite the extensive changes in how health care is delivered, in industry costs, information systems technology, and health care technology. Health care costs have skyrocketed. The baby boom generation has aged and is approaching Medicare eligibility. Internet technology has dramatically reduced the costs of providing consumer choice in health care, and health care technology has advanced in its ability to both prolong life and to improve the quality of life.

One missing alternative in the current debate between free-market and single-payer advocates is a third alternative—better government. This alternative includes better, more intelligent regulation of the private health insurance market and better, more efficient enrollment practices for existing government programs. Intelligent regulation is not an oxymoron. Neither is efficient government. Yet in health care we continue the debate about economic policy without clear economic analysis, and we debate public policy without a clear look at what we have learned in 30 years of administering Medicare and Medicaid.

The traditional analysis of the health care tradeoffs in addressing the uninsured looks at annual changes in the national average rate of uninsurance, and in differences in insurance coverage rates by income level in any given year. Important lessons can be learned by looking in detail at the policies that are in place in the states with the smallest proportion of uninsured. These states include Iowa, Minnesota, Rhode Island and Wisconsin. Each of these states had an uninsured rate of approximately 8 percent, roughly one-half the national average and less than a third of the rate of uninsurance in states with the highest uninsurance rates. These low rates of uninsured were achieved with different mixes of insurance regulation, state risk pools, and outreach policies for Medicaid and SCHIP programs.

The success of this third health care policy option, combining intelligent regulation and better government, is evident in states with low uninsured levels. A 1998 study conducted by the Urban Institute showed that the

variations across states' uninsurance rate could be explained in part by insurance regulatory reforms. States that adopted *guaranteed issue regulations* plus new regulation of premium rates increased their uninsured rates—clearly not the intended result.

Within Wisconsin, the uninsured rate among counties varied from 4 percent to 17 percent. These wide differences in the incidence of uninsurance occurred despite the existence of a common insurance regulatory environment and Medicaid benefit levels. The differences in the rates of uninsurance reflect sharply different economic conditions in different counties, differences in health care costs, and county efforts to encourage Medicaid enrollment.

Differences across states in the percentage of population who are not insured depend in part on the share of population who have employer-sponsored health insurance, privately purchased insurance, and government-provided insurance. The differences across states are quite large. The level of employer-sponsored coverage varies from a low of 50 percent of the population to a high of over 80 percent. The rate of privately purchased individual health insurance coverage ranges from a low of 5 percent to a high of 17 percent of a statewide population. The percentage of a statewide population enrolled in Medicaid ranges from 6 percent to 18 percent.

A considerable amount can be learned about the tradeoffs in health insurance policy by looking at another line of insurance—auto insurance. Although little research is done on the comparison between health insurance and auto insurance, there are many similarities. For example, there is a clear public interest in having universal auto insurance coverage. Also, there are substantial external third-party costs incurred due to individuals' failure to purchase coverage. Lastly, like health care insurance, auto insurance is expensive for low-income families. In response to these social concerns, many states have a policy mandating auto insurance. This policy is similar to the "pay or play" model of health care regulation. In examining the effectiveness of compulsory auto

**Guaranteed issue regulations** are state government policies that require insurance companies to issue policies to all people who apply. Such policies do not necessarily regulate the premium cost of the policies issued by insurance companies.

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# Increasing and Equalizing Coverage: Views from the Symposium's Organizer and Presidential Candidates

By **Barbara L. Wolfe**

*Barbara Wolfe is a professor of economics, population health sciences, and public affairs at the University of Wisconsin-Madison. She is also a faculty affiliate and former director of the Institute for Research on Poverty.*

I enjoyed both of these presentations immensely and think they offer two quite accurate assessments of the gains from increasing health insurance coverage and the impediments to significant changes to the current system of health care coverage in the United States. There are many individuals and groups with vested interests, and thus it is difficult to devise any single plan that is viewed as an improvement by most of them, even if most will agree that they dislike the current combined public-private system of coverage and the consequences of our system in terms of the costs of care and the resulting distribution of burdens. Both professors Fein and Pauly recognize this and provide insight into various dimensions of the dilemma.

In my brief comments I will attempt to do two things. First, I will address several additional issues that I believe could be important in shifting to a broader based system of coverage in this country, and second I will survey the plans of presidential candidates for the 2004 election to get some flavor of what politicians think may be politically attractive options that appeal to a large portion of the populace.

## **Issues to Consider in Reforming our Health Insurance Policies**

I start by raising the issue of the desirability of constraining the tax subsidies that currently flow to recipients of employer-funded health insurance benefits. (For any eligible employee, the subsidy rate is their combined marginal income tax rates (federal and state) plus the social security payroll tax rate.) Currently there are no caps in place on such subsidies. Employers can offer coverage for routine care including preventive dental care and coverage for eye exams and corrective lenses. Due to their predictability and costliness, these services are traditionally not insurable items. Some employers also offer health insurance packages that include regular coverage of private hospital rooms and cosmetic surgery. The consequence of the lack of restrictions on coverage is that the government foregoes tax revenue that could be redirected to subsidize more urgent care for low-income individuals who currently have little or no coverage. The current tax-based subsidy is very regressive and provides the largest subsidies to those facing the highest marginal tax brackets, namely, taxpayers with the highest incomes. A reasonable reform might involve capping these subsidies, reducing their

regressive nature, and using the resulting tax savings to partially fund new coverage for those who are currently uninsured.

I also want to ask whether it is desirable to place mandates on employers to offer coverage to their employees? As Pauly suggests, economic analysis and some recent empirical evidence suggest that mandates may reduce employment opportunities. Consistent with this analysis, the experiences of Hawaii and California provide evidence that employer mandates appear to change the incentives facing employers in a way that reduces employment. Employees with family members who have a long-term health condition may be at particular risk under employer mandates. Reform proposals that avoid such mandates or at least are designed to minimize the negative employment consequences would improve the chance of success of employer oriented plans.

Finally, I would like to raise the issue of coverage design and the implications for equalizing access to care. First, if there are substantial differences in coverage or supplementary coverage is available and purchased by those with higher income, those with higher incomes (and better coverage) will tend to demand and use more and better care. Second, persons with lower incomes tend to be more sensitive to cost sharing requirements (co-payments) than those with higher incomes. So if there is cost sharing or cost sharing for those with more limited coverage, access will be unequal. Third, if there are significant differences in level of payments for care by insurers, these differences may influence both provider location decisions and their willingness to serve particular patients. Such choices may result in less care available in neighborhoods with lower income families, less access to specialists, and possibly higher time and transportation costs for persons living in lower income areas. And if change in work status or employers is associated with a change in coverage, there may be consequences in terms of spells without coverage, replication or omission of preventive care and differential use of care.

These points suggest that we might wish to carefully consider placing a cap on the tax subsidy to employer provided coverage to finance any public expansion of coverage or subsidies (including tax credits) for the private purchase of insurance and that co-payment schedules should consider income conditioning. One approach that I find appealing on a number of grounds would be to provide universal coverage to all children, financed at least in part by the tax savings from capping

the subsidy to employer based coverage. The choice between single-payer coverage and more limited initiatives, such as tax credits, has been carefully laid out already by Professors Fein and Pauly.

## Health Policy Plans of the Presidential Candidates

What plans for health insurance coverage are the candidates for President proposing? The accompanying tables lay out these plans for a number of the candidates including those who have received the most attention. President Bush proposes income conditioned tax credits to encourage lower income families to purchase health care insurance. The tax credits would range from \$1,000 to \$3,000 with the maximum credit available to those with incomes of \$15,000 (singles) to \$25,000 (families). These credits would be entirely phased out at income of \$30,000 and \$60,000, respectively.

John Edwards also tends toward tax credits but in his proposal, they extend to families up to 500 percent of the federal poverty line (FPL). If this proposal had been in place in 2003, it would have extended eligibility for credits to all families (with two adults and two children) with incomes below \$93,000. He also combines tax credits with an expansion of public coverage to families up to 250 percent of the FPL, requiring a share of the premium to be paid by families with incomes greater than 100 percent of the FPL. This makes for greater continuity in subsidies and subsidies further up the income distribution. He suggests extending Medicare down to age 55, thus targeting an age group with a relatively high proportion without coverage. As an incentive for parents to provide health insurance coverage for their children (up to age 21), he also proposes a tax penalty for those families who fail to provide such coverage.

John Kerry also proposes an expansion of public programs to provide coverage. In his case, he proposes coverage of children in families with incomes below 300 percent of the FPL, coverage of parents with incomes up to 200 percent of the FPL, and coverage of other adults with incomes below the FPL. Thus he relies more heavily on an expansion of public coverage than either John Edwards or President Bush. In Kerry's plan, tax credits are used for workers between jobs and for small businesses. Kerry argues for a plan that focuses more on employment-based coverage than the other candidates, but he suggests the government share the burden via a reimbursement of catastrophic costs over \$50,000 (at 75 percent) and the establishment of a new group insurance plan resembling the Federal Employee Health Benefit Plan. A unique aspect of his proposal is to automatically enroll school children eligible for coverage, thus eliminating the problem of low take-up rates.

The only candidate who proposes a single-payer universal plan is Dennis Kucinich. He would finance his plan via a payroll tax, additional tax revenue generated by eliminating the current tax subsidies to employer-financed

health insurance benefits, and planned Medicare savings.

Many of the other candidates for the democratic nomination had plans that shared some characteristics of those of Edwards and Kerry—expanding public coverage (Clark, Dean, Lieberman and Gephardt though Gephardt proposed a more limited expansion); automatic enrollment (Dean via the tax system); a subsidy to small businesses along with a new group insurance plan based on Federal Employee Health Benefit Plan (Dean and Lieberman though Lieberman did not include a subsidy to businesses). Gephardt and Lieberman's plans also used targeted tax credits.

The details of the candidates who remained candidates after the first round of primaries are presented in the accompanying tables. With the exception of President Bush and Representative Kucinich, all the candidates seem to be proposing packages that expand public coverage for some more disadvantaged groups while providing tax or other incentives for groups with higher incomes. Table 1 provides detail by whether or not tax credits are part of the plan, whether or not persons who are between jobs receive assistance, whether or not the current public programs for the low-income population (Medicaid and SCHIP) are to be expanded, and whether or not any new group or private-employer programs are proposed. The last column details any proposal for automatic enrollment. Table 2 shows the anticipated increase in coverage and the expected cost of each candidate's proposal. In some cases the source of funds is suggested, and when this is done, it is from a repeal of Bush's tax cuts. Finally Table 3 lays out characteristics of proposals and notes whose plans have each of these characteristics. This is the only table that includes all of the candidates from the Republican and Democratic parties.

This last table highlights both the similarities across plans and the diversity. If we remove Kucinich's plan from the set, all use incremental plans with multiple components. The two most common characteristics of these plans are tax credits extended to low- and middle-income individuals and expansion of public coverage, especially to low-income parents. Another common approach is an extension of tax credits to persons between jobs to allow them to purchase the coverage mandated under *COBRA*. This should improve the take-up under *COBRA*. Perhaps the most surprising component found in multiple plans is automatic enrollment. This is designed to reduce the problem of low take-up of many forms of coverage (public and private employer based).

The plans of these candidates suggest that they may be aware of the problem noted by Pauly—but at the same time, the candidates seem to believe that by offering plans with multiple components, they can offer something that appeals to most people.

**Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)** requires firms with 20+ employees to continue health insurance coverage for 18 months after employment is terminated, but employers are not required to pay for it.

**Table 1**  
**Details of Presidential Candidates' Health Insurance Programs**

Plan Elements	President Bush	Howard Dean	John Edwards	John Kerry	Dennis Kucinich	Joe Lieberman
<b>Tax credits to purchase health insurance</b>	\$1000/3000 income conditioned only for individual insurance	If premium >7.5% income	Refundable to 500% FPL	If low income & premium >6% of income; small firms up to 50% premium; 55-64 years olds	No	Refundable, up front 150-300% FPL; those above if premium >7.5% income & adults to 250% FPL
<b>Tax Credits for COBRA</b>		Employer pays 1st 2 months; 70% subsidy afterwards	70% if lose job and income <250% FPL	75% if eligible and unemployed	Universal coverage	65% if lose job
<b>Medicaid/SCHIP Expansion</b>	Some support for Community Health Centers	Kids to 300% FPL; adults <age 25 to 185% FPL; federal financing for new coverage	Adults <250% FPL; contribution if inc. >100% FPL; federal financing for new coverage	Kids to 300% FPL; parents to 200% FPL; and other adults to 100% FPL; feds pay for poor & disabled kids	Medicare for all—(establishes new part E)	Kids to 300% FPL; federal financing for new coverage to age 25
<b>New Group Insurance</b>	Medical Saving Accounts encouraged	New Universal Health Benefits plan—based on FEHBP; reinsurance to offset adverse selection; also for ages 55-64	Purchasing pools for firms with <50 employees; ages 55-64 can buy Medicare	Congressional health plan based on FEHBP; 55-64 eligible; reinsurance to offset adverse selection		Kids: Medikids to age 25; free to 150% FPL; standard package sm. firms and indiv. w/o access; MediChoice: Community rated; federally funded reinsurance
<b>Employer-Sponsored Expansion</b>	Support for AHPs (Associated Health Plans—pooling for small businesses)	Penalize large corporations if not offered; mandate coverage of dependents <age 25; employers required to pay first 2 months of COBRA	Mandate coverage for dependents <age 25	Fed. 75% catastrophic coverage over \$50,000; gov't reinsurance pool to reduce cost of coverage; must offer coverage to all workers to be elig; 50% refundable tax credit for small businesses	Ends—finance uses 7.7% payroll tax	Tax increase to cover part-time workers, keep level of coverage; requires employers to pay 2 months of COBRA
<b>Automatic</b>		Yes, via tax system	Yes, for kids <18; via tax system	Yes for kids in school		Yes, kids at birth (parents may decline)

**FEHBP** (Federal Employees Health Benefits Program) offers federal employees (current and retired) and their families a set of health care options ranging from fee for service to HMOs. The government contributes an average of 72% of premium (max=75%).  
**SCHIP** is the State Children's Health Insurance Plan.

**COBRA** (Consolidated Omnibus Budget Reconciliation Act of 1986) requires firms with 20+ employees to continue health insurance coverage for 18 months after employment is terminated, but employers are not required to pay for it.  
**FPL** is the federal poverty line. In 2003, it was \$18,400 for a family of four.

**Table 2**  
**Details of Costs, Coverage, and Financing of Candidates' Plans**

<b>Plan Elements</b>	<b>President Bush</b>	<b>Howard Dean</b>	<b>John Edwards</b>	<b>John Kerry</b>	<b>Dennis Kucinich</b>	<b>Joe Lieberman</b>
<b>Annual Cost</b>	\$14 billion	\$88 billion	\$55 billion	\$72 billion	\$1 trillion	\$74 billion
<b>10 Year Cost to Federal Government</b>	\$89 billion	\$932 billion	\$590 billion	\$895 billion	\$6.1 trillion	\$747 billion
<b>Predicted Increase in Coverage (everyone covered)</b>	4-6 million net increase	31 million net increase	22 million net increase	27 million net increase	Everyone covered—41 million	32 million net increase
<b>Financing</b>		Repeal 2003 tax cut	Repeal tax cuts to wealthy	Repeal tax cuts to wealthy	7.7% payroll tax; repeal business tax deduction; Medicare savings	

**Table 3**  
**Characteristics in Common: Who Proposed What?**

<b>Unique Aspects of Plans</b>	<b>Candidates</b>
Tax credits for COBRA	Dean, Edwards, Kerry, Lieberman
Tax credits targeted to low and middle income and premium relative to income available in advance	Bush, Dean, Edwards, Kerry, Lieberman Dean, Kerry, Lieberman Lieberman
Expand SCHIP to parents Federal financing	Dean, Edwards, Kerry Dean, Edwards, Lieberman
Expands children's coverage to age 25	Dean, Lieberman
Expands income eligibility for Medicaid and/or SCHIP	Dean, Edwards, Kerry, Lieberman
Allow 55–64 yr. olds to buy Medicare	Edwards
Public reinsurance to lower employers' coverage costs	Kerry, Lieberman
New plan modeled on FEBHP for self-employed, small businesses, individuals	Dean, Kerry, Lieberman
Single payer	Kucinich
Automatic coverage	Dean, Edwards, Kerry, Lieberman (Children); Kucinich (All)

*Hefty continued from page 19*

insurance, the best states only achieve auto insurance coverage of 96 percent. Either because of irresponsible individual choices or simply the unaffordability for low-income families, 4 percent of the population chooses not to have automobile insurance despite state laws requiring all drivers to have it. In comparison, the best states achieve health insurance coverage of 92 percent without a mandate. And in examining the remaining 8 percent uninsured, a substantial percentage of those are already eligible for Medicaid or SCHIP but are not enrolled. In these states, the rate of uninsurance could be reduced without the enactment of new public policies. Reforms in administrative practices that would result in a larger usage of Medicaid and SCHIP by those who are currently eligible would be a highly effective way of reducing the number of uninsured.

On a national basis, the average participation rate for eligible children in SCHIP and Medicaid is only 68 percent. Medicaid participation rates in a 2002 Urban Institute report covering 13 states ranged from 59 percent to 93 percent. The Urban Institute report finds that large cross-state differences in Medicaid participation persist, even when a large number of demographic and socioeconomic characteristics of the population have been taken into account, suggesting that state-specific program characteristics may be driving factors. Put most simply, good government and public administration are as important in achieving universality of health insurance coverage as lengthy policy debates. Or as described in a recent Center on Health Systems Change report, “Money Matters but Savvy Leadership Counts.”

Using Wisconsin as an example, we can separate the

uninsured into two categories the “market uninsured,” those ineligible for existing government programs and not served by the private market, and the “administratively uninsured,” those eligible for existing programs but not enrolled. One group can be addressed by market solutions—better regulation, better consumer information, and tax credits to encourage private purchase of health coverage. The other group can be addressed by better public administration.

From the perspective of an insurer and a major national contractor for administering government health care programs, the lessons learned over the past 30 years about the opportunities to improve health coverage are relatively clear.

The uninsured population can be reduced by nearly one-third with better public administration in outreach and enrollment. The private market can be improved by better regulation of both the individual and the group health insurance marketplace and by avoiding the negative consequences found in the studies of the combined impact of guaranteed issue requirements and rate regulations. The third opportunity is to expand the scope of government programs in targeted areas. This includes the expansion of SCHIP, the extension of the federal tax credits already enacted in the trade adjustment act, and the consideration of opening Medicare to individual buy-in for the 55–64 “young old” age group. The United States has a mixed model of public and private health coverage. Some of the states, including Wisconsin, have achieved excellent results in broad coverage for the population. The lessons learned from this success, both in market reforms and public administration, can help address the tradeoffs between cost and risk in addressing the uninsured.



## La Follette Policy Report

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