

A Century Foundation Report

# A NEW DEAL FOR HEALTH

**How to Cover  
Everyone and  
Get Medical  
Costs under  
Control**



**Leif Wellington Haase**



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HOW TO COVER EVERYONE  
AND GET MEDICAL COSTS UNDER CONTROL

*Leif Wellington Haase*

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## FOREWORD

In the eleven years since President Clinton's proposal for universal health insurance failed to become law, Congress has focused mainly on reforming the Medicare and Medicaid programs that provide coverage to older and low-income Americans. Throughout that period, the share of the population without medical insurance has continued to rise, while health care inflation has consistently exceeded price increases throughout the rest of the economy. Today, workers are spending substantially more on health care as their employers have tried to reduce the burden of increasingly expensive health insurance by shifting some of the costs to them.

In other industrialized nations, government's role in the medical system is much more clearly defined than it is in the United States. Here, we depend on a mix of government-sponsored programs and a large private sector health complex that receives substantial tax benefits. The resulting mix seems to satisfy no one. But there is not much of a consensus about solutions. The professional and political debate over how to provide health insurance for millions of Americans who have none, what constitutes adequate medical care, and how to improve the health of the population without spending more than necessary is enormously complex and fractious.

In this context, The Century Foundation has sponsored a number of studies intended to explain as clearly as possible for the broad public the nature of the nation's health care challenges and possible approaches for improving the system. We take no position as an institution on the various remedies offered by these authors, but we feel strongly that public education and debate needs to be sharpened and continued.

Among our most recent publications in this area are Joseph White's *False Alarm: Why the Greatest Threat to Social Security and Medicare Is the Campaign to "Save" Them*; Marilyn Moon's *A Place at the Table: Women's Needs and Medicare Reform*; Eliot Fishman's *Running in Place: How the Medicaid Model Falls Short, and What to*

*Do about It; Medicare Tomorrow: The Report of The Century Foundation Task Force on Medicare Reform; and The Basics: Medicare Reform* (revised for 2001). In addition, we are currently supporting a number of book-length analyses of these issues, including Arnold Relman's study of a possible health care system for America, Bradford H. Gray and Mark J. Schlesinger's examination of non-profits and health policy, Robert Friedland's look at the long-term care challenge facing this nation, Jonathan Oberlander's proposal for a new approach to Medicare reform, and Henry Aaron and Robert Reischauer's ideas on how to strengthen Medicare. And we have been and are continuing to publish many idea briefs and shorter works on this subject, which are available on our Web site: [www.tcf.org](http://www.tcf.org).

This analysis by Leif Wellington Haase, Century Foundation health care fellow, clarifies why reform is needed and the trade-offs involved in differing approaches, while making the case for a particular set of changes. It is an attempt to bridge the gap between a status quo that produces so much dissatisfaction and some future program that may be a product of a more thoughtful consensus about the long-term provision of essential medical services. We offer it in that spirit and in the hope that it stimulates further debate on this important topic.

In the long run, America's health care system will certainly be altered over and over again. If universal coverage is ever enacted, the final product probably will be in place for only a few years before it too is reformed. This process of continual change is inevitable in a democracy where the issues are complex and views are evolving. In addition, health care itself is a rapidly changing field. There is much more in the way of prescription drugs, procedures, and knowledge that will come to pass in the years ahead that we cannot even fully imagine today. In these circumstances, to the extent their preferences can be satisfied, Americans certainly will want to spend more buying health care for themselves and their families. The key question is how much they are willing and able to pay, not only for relatives but also for those without the resources to purchase what they need, let alone what they desire.

Richard C. Leone, *President*  
The Century Foundation  
April 2005

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## INTRODUCTION

Eleven years ago the Clinton administration's health care plan came before Congress. At that time, stories of a U.S. health care system in crisis dominated the front pages and preoccupied legislators. After this plan failed to pass, conventional wisdom predicted that any health care reforms would come about gradually. Large-scale reform appeared doomed for generations.

Now calls for broader health care reform have returned to the headlines and to the campaign trail. John Kerry, the recent Democratic nominee for president, championed a plan that would have covered 27 million uninsured Americans.<sup>1</sup> A group of more than eight thousand physicians is lobbying for national health insurance. The president of Blue Cross and Blue Shield of California, one of the nation's largest health insurance plans, has outlined a universal health care system of "essential health benefits" for the state.

These reform efforts are drawing strength from troubling trends in the overall cost of health care, the growing numbers of uninsured Americans, and concerns about the quality of care:

- ◆ U.S. spending on health care in 2003 reached nearly \$1.7 trillion, or more than 15 percent of the gross domestic product. This is more than six times the \$246 billion spent in 1980. Health spending grew at double-digit rates for each year from 2000 to 2002. Even though the increase in spending slowed somewhat in 2003, it still outpaced the rates of inflation and economic growth.<sup>2</sup>
- ◆ The number of Americans without health insurance, which remained steady at around 40 million during the economic boom years of the 1990s, is rising. The Census Bureau reported in August 2004 that the number of Americans without insurance reached 45 million in 2003.<sup>3</sup> Families USA, a nonprofit health care consumer advocacy group, and The Lewin Group, a health consulting firm, estimate that about 82 million Americans went without health insurance at some point during 2002 or 2003.<sup>4</sup>

- ◆ One reason for the increase in the number of uninsured Americans is that businesses, especially small businesses, are dropping health coverage for both current employees and retirees. After several years when employers' premiums remained flat and sometimes declined, these premiums are now going up sharply. According to the Kaiser Family Foundation's annual survey of employer-based coverage, premiums for such coverage rose on average 11.2 percent from 2003 to 2004, far outpacing inflation and growth in wages.<sup>5</sup> This was the fourth straight year of double-digit increases in premiums. With underlying health costs soaring and premiums rising even more rapidly, many middle-class Americans now fear that their health coverage will be reduced or lost altogether.<sup>6</sup>
- ◆ In lieu of a government-run national health care program, employers turned to managed care to slow the growth of health costs in the early 1990s. However, managed care plans for the most part now have abdicated their efforts to control costs in the face of hospital and physician "push-backs" and consumer dissatisfaction. By and large, these plans have failed to implement innovations in the care of the chronically ill—steps that would lower costs over time by keeping patients out of the emergency room and the doctor's office.
- ◆ State budget crises have squeezed enrollment in Medicaid, the joint state-federal program for poorer Americans who meet other eligibility criteria. Twenty-five states reported tightening eligibility requirements for the program in 2002. Tennessee, which had expanded Medicaid coverage to the working poor, announced its intention to drop 323,000 from the rolls in 2005. Despite such cutbacks, states expected to spend 22 percent of their budgets on Medicaid in 2005, up from 10 percent in 1987.<sup>7</sup> Meanwhile, Medicare, the federal health insurance program for older and some disabled Americans, faces the dual problems of inadequate coverage and fiscal difficulties that loom once the baby-boom generation retires. Though an outpatient prescription drug benefit was included in legislation passed in November 2003, this coverage will not take effect until 2006.
- ◆ The performance of doctors and hospitals is coming under unprecedented scrutiny. In July 2004 a private research group,

HealthGrades, reported that as many as 195,000 Americans may be dying in hospitals each year because of medical errors. This finding updates a widely publicized 1999 Institute of Medicine report, which calculated that up to 98,000 Americans lose their lives annually to medical error, the equivalent of a jumbo jet crash every day of the year.<sup>8</sup>

Successful health reform depends in part on a public worried about its health coverage. The issue is gaining traction. In December 2004 a poll conducted by the Kaiser Family Foundation found that more Americans are personally worried about health care costs than about losing their jobs, paying their rent or mortgage, or being the victim of a terrorist attack.<sup>9</sup> Americans ranked health care behind only the war in Iraq and economic issues as a priority for the president and Congress.<sup>10</sup> In late 2003 pollster Bill McInturff reported that the percentage of voters dissatisfied with their health care coverage was the highest since 1992.<sup>11</sup> While the public's anxiety has yet to reach the peaks of the early 1990s, history suggests that such concern can build quickly. In October 1989 just over one in five Americans felt that the health care system needed major reforms. By November 1991 that figure had skyrocketed to 42 percent.<sup>12</sup> This upsurge of concern was principally responsible for catapulting Harris Wofford, Jr., a little-known, appointed Pennsylvania senator who campaigned on a platform of health care reform, to an election victory over a heavily favored challenger, former U.S. attorney general Richard Thornburgh.

Public anxiety over health insurance also provided the backdrop against which the launch of the Clinton health care plan took place.<sup>13</sup> The demise of this proposal points out that such anxiety is necessary but not sufficient for enacting significant U.S. health care reform. Making headway will depend on the cooperation, or at least the acquiescence, of the "800-pound gorillas" that dominate the system: hospitals, doctors, employers, insurers, and federal and state governments. The Clinton plan forged a temporary consensus among health policy intellectuals, but it failed to elicit substantial support from these critical interests.<sup>14</sup> Ironically, the administration's efforts to appease businesses and insurers simply added to the complexity of the plan, leading these groups successfully to denounce it as an example of big government run amok.<sup>15</sup> To solve the crisis of rising medical costs, employers wholeheartedly

embraced managed care, a private sector solution that paid short-run dividends but has come unraveled over time.

Ten years later, the pillars of the U.S. health care system have shifted. From the 1920s through the 1970s, the power of the nation's hospitals, doctors, and labor unions led to this system's distinctive shape, with its emphasis on private, employer-sponsored health care plans. In the 1980s and 1990s the embrace by businesses of managed care represented a frontal attack on the historic domination by the medical establishment over pricing and control of its practices. Now that this assault has been largely beaten back, the medical system retains centers of power but lacks a dominant one. This rough balance of power, to be sure, raises the possibility of stalemate in the health reform arena. But it also means that no one interest can single-handedly thwart a proposal for national health reform, as the American Medical Association did to the 1948 Truman and the 1973 Nixon reforms and employers largely did to the Clinton plan in the early 1990s.

A decade ago, each of these groups preferred the status quo to the Clinton reforms or favored alternative reforms. Now their implacable opposition to national health insurance is waning, and some convergence of interests among them may be taking place around the need for comprehensive reform. When Bruce Bodaken, the chief executive officer of Blue Shield of California, launched a universal health care proposal, he remarked that "health insurance is the key that unlocks the door to the healthcare system. For too many Americans, that key is missing."<sup>16</sup> William McGuire, chairman and CEO of UnitedHealth Group, has called for greater federal government involvement in health insurance.<sup>17</sup> Employers are restless. William C. Ford, Jr., who heads the Ford Motor Company, has been vocal about the need for a complete overhaul of U.S. health care. "I just think that as a country, if we have a model that isn't working and a model that's driving jobs overseas, then we'd better take another look at it."<sup>18</sup> Various states are designing universal coverage plans for their residents, with an eye toward influencing the national debate. In July 2004 Maine launched its Dirigo health plan, which aims to achieve universal coverage for state residents through a combination of new group policies and the expansion of public programs.

Combined with growing middle-class anxiety, this new receptiveness among the big health care interests opens a window for enacting universal health care reform. This report proposes, outlines,

and defends the design of a new national health insurance system. Such a system would be government sponsored, though not government run. What does this mean? The government would negotiate with private insurers, set minimum benefit packages for several levels of care, and make an annual contribution for each American toward the purchase of a premium for a health care plan. This system would offer a basic and decent health care plan—a “floor”—to all Americans while encouraging those who want more comprehensive coverage to join higher-end insurance plans.

This proposal tries to bring better-off Americans and the uninsured into the same insurance risk pools while retaining a strong element of consumer choice among health insurance plans. The expectation is that this approach will use the savings generated from lower administrative costs, higher participation levels, competition among health plans, and selective coverage of new technology to cover more services for more people, especially those previously without insurance. In so doing, the proposal attempts to reverse the insidious trend toward ever greater segmentation of risk in health care and in other aspects of American life.

## HOW THE PLAN WILL WORK

The principal elements of the proposal are the following:

- ◆ American families will be required to purchase their own health insurance, and government subsidies will be offered to make insurance coverage affordable for everyone.
- ◆ The existing federal tax subsidy for employer-based insurance—under which employers can deduct the cost of health insurance from their tax base and employees do not count their benefits as taxable income—will be phased out. The new revenues from eliminating this subsidy will pay for a part of the financing of this proposal.
- ◆ For every American household, the government will make a contribution to the purchase of a premium for a basic health insurance

plan (premium support). The level of this contribution will be set to allow each household to enroll in a basic plan at a modest premium or, in some cases, at no additional cost. Older Americans, the disabled, those with low incomes, and veterans will receive a larger subsidy that allows them to purchase a mid-level plan.

- ◆ The federal government will establish and sponsor three national health insurance options and will specify a minimum level of benefits that must be offered at each level of coverage. It will negotiate premiums annually for each insurance package with national and local health plans.
- ◆ Purchasing at least the basic level of coverage will be mandatory for individuals. Individuals will be able to change plans on an annual basis and will not pay higher premiums upon entering or switching plans based on preexisting medical conditions.
- ◆ Medicaid will be phased out, along with all other government insurance plans based on categorical eligibility, such as the Veterans Health Administration. Medicare will continue to function for current beneficiaries, but it also will be phased out. Current Medicare beneficiaries will have the option of joining the new national health program.
- ◆ Subject to federal approval, insurers will be allowed to offer different plan designs, such as restricted physician networks and copayments. At any level of coverage, insurers may offer a benefit package that exceeds the federally mandated minimum. They must, however, offer all tiers of insurance coverage should they choose to offer any one of them. Moreover, they may not pay providers different amounts for medical procedures based on the patient's level of insurance coverage.
- ◆ An independent government board will be created to evaluate the cost-effectiveness of medical therapies and procedures, with a focus on assessing new technologies.
- ◆ A large new investment in the public health system will be made to encourage Americans to practice healthier lifestyles. Each of

the insurance programs will require generous coverage of preventive care, including vision and dental coverage.

- ◆ The plan will be paid for through a payroll tax, a dedicated corporate tax, general revenues, and the revenues from eliminating the employer-based tax subsidy.

## RATIONALE FOR THE PROPOSAL

Liberals ought to like this plan's universal coverage, insurance risk pooling, government sponsorship, and emphasis on public health. Conservatives ought to applaud the greater visibility of health care costs to consumers and the emphasis on choice and competition under this plan. Liberals will want much more equalized coverage, while conservatives will dislike this level of government involvement. But the true test is not whether this plan satisfies either ideological criteria or utopian dreams but whether it would be superior to the existing system, workable in practice, better than the alternatives, and politically feasible. The following sections take up these points in turn, beginning by analyzing the two critical trends that frame the need for comprehensive reform: the implosion of our existing, employer-based health system and the exploding cost—and uncertain value—of new medical therapies, drugs, and procedures. By eliminating employer-based coverage, this proposal will redress a wrong turn made in the past. By accommodating medical innovation, it adapts itself to the major issue of the future.

### WHY EMPLOYER-BASED CARE IS THE WRONG FOUNDATION FOR REFORM

The flaws of the existing U.S. health care system stem from its basis in employer-sponsored health insurance, which is unique among developed nations. Some 160 million American workers, their spouses, and dependents receive health insurance coverage through their employers.

This system took shape in the middle years of the twentieth century. It was influenced by a fiercely independent and autonomous

medical profession and by failed efforts, dating back to the Progressive Era, to enact a government-run national health program. In the 1930s Blue Cross became the dominant insurer and the most important insurance model. Blue Cross successfully sold middle-class Americans on hospital coverage, the aspect of health care most likely to strain a budget. Appealing to physician fears of a government plan that would limit their autonomy and (putatively) their fees, Blue Cross and later Blue Shield overcame the wariness of doctors and gradually built up insurance networks of physicians. The Blues focused on selling to Americans with jobs because such people were likely to be in better health and to have the income necessary to buy policies. The disabled, the young, and the elderly were less desirable clients.<sup>19</sup> Because of generally favorable selection of healthier workers into Blues plans, the benefits offered also could be generous.

Private coverage grew rapidly during World War II, when companies faced wage and price controls and competed for labor by offering more generous in-kind benefits. After the war, health benefits were further extended to employed Americans. Unions included benefits in their collective bargaining demands. Several federal tax decisions in the 1950s confirmed that these benefits would not be counted as income for the employee and could be deducted from a company's taxes. With these rulings, the pillars of the modern American health insurance system were in place. Though public programs have expanded rapidly since the 1960s, and more than half of all dollars spent to finance care now come from public spending, Medicare and other government programs were grafted onto a system that was already established. The Medicare benefit package mirrored that of a standard Blue Cross/Blue Shield plan, and Medicare turned over most of its claims processing to the Blues.<sup>20</sup>

Bill Clinton's proposed Health Security Act aimed to "sever the linkage" between jobs and health insurance coverage.<sup>21</sup> However, this proposal included a "pay or play" provision that would have kept employers that currently offered coverage in the health benefits business. Still, Clinton's advisers were on the right track. Despite the centrality of private, employer-based coverage, it is not the right model for a new national health system. As Paul Starr, who had a large hand in drafting the Clinton health plan, aptly remarked, "It is one thing to build on a solid foundation, another to build on a collapsing one."<sup>22</sup>

Statistics suggest that job-based health insurance is indeed collapsing in slow motion. The trend is most pronounced among small businesses. Just 65 percent of companies with fewer than two hundred employees offered health coverage at all in 2002, down from 68 percent the previous year.<sup>23</sup> Less than half of firms with fewer than twenty employees offer any coverage at all. Premiums are rising faster for small businesses (those with 3 to 199 employees)—an estimated 15.5 percent in 2003—than for larger companies, at 13.2 percent.<sup>24</sup>

While almost all large firms continue to offer health insurance coverage, increasing numbers of employees are unwilling or unable to participate in these plans, owing to rising premiums, increased cost sharing, and eligibility restrictions. In 2001 almost 10 million uninsured Americans, more than one-quarter of the nation's uninsured population, either worked for large companies or were dependents of those who did.<sup>25</sup> Such firms also are rapidly phasing out medical coverage for their retirees, putting an increasing strain on public insurance programs.

The gap between work and health coverage is widening. Twenty million working Americans lack health insurance, or about one in every ten workers. In Texas, where the decoupling of work from coverage is highest, the proportion has risen beyond one in four. If workers lose this coverage, they frequently have no means of obtaining an affordable alternative. A recent study by the Urban Institute estimated that 43 percent of low-income workers and 31 percent of middle-income workers would be unable to afford alternative coverage should they lose their employer benefits.<sup>26</sup>

Premium and out-of-pocket costs to employees have risen substantially. Since 2000 the average annual cost of insurance premiums for family coverage has risen to \$9,068 from \$6,230, and a worker's average share is now \$2,412, up from \$1,619.<sup>27</sup> This trend has led directly to a rise in the number of employees who do not elect to take up the coverage that their employers offer. From 1999 to 2002 the percentage of Americans under sixty-five with employer-based coverage fell from 69 to 66 percent (meaning 5.9 million fewer Americans had such coverage than would have if the rate had remained steady). Researchers estimate that two-thirds of this drop stems from the greater likelihood that employees did decline offered coverage.<sup>28</sup>

Some employers are busily trying to transfer the risks and costs of health care to employees. Wal-Mart, the nation's largest private employer, dropped retiree coverage, instituted a six-month waiting period for benefits for new hourly employees, and declined to pay for flu shots and childhood vaccinations, among other preventive services.<sup>29</sup> In so doing, it reduced health benefits costs per employee to about 40 percent below the average of large American companies; its methods are being eagerly studied and emulated by other businesses.

The starkest form of employer pullback involves the touting of cafeteria-style, "consumer-directed care," in which an employer makes a fixed payment to an employee for care, usually in conjunction with a high-deductible plan to cover catastrophic costs. According to one survey, 26 percent of employers intend to offer health savings accounts or similar plans in the upcoming year. Although such plans cover about one-half of 1 percent of the population, concern over them will grow as people find out that they will face much higher costs when they are very sick or suffer from a chronic illness.<sup>30</sup> As one health care consultant puts it, such consumer-directed plans may be a trial balloon in the direction of eventual employer withdrawal from the health benefits business. "Companies are getting employees prepared should they cut the cord. . . . If costs don't abate, the likely possibility is that employers will just want to get out of the business."<sup>31</sup>

These developments are taking a toll on Americans' confidence in the future of private, employer-based health care provision. Though some studies still show a preference for this system (others show a majority favoring a government-run system), the expectations that employer coverage will be available are dropping fast. In 2003, according to the Employee Benefit Research Institute, just 61 percent of employees with employer-based benefits were confident that their firm would continue to provide them, down from 68 percent in 2000. As workers increasingly fear the loss of their existing insurance, they should become more receptive to new health coverage models. The benefit package under the proposal presented here will likely be more secure and equivalent to or better than the one that they would be offered at the workplace in the future, even if it does not match the most generous combination of benefits, premiums, and cost sharing that they may once have received.

Even if the existing, job-based system could be salvaged, there are many structural reasons why it would be unwise to do so. First,

the system discriminates against groups that are more likely to be unemployed or to have tenuous connections to the labor market, such as young people and minorities. Nearly one in three adults between the ages of nineteen and twenty-four lacks health insurance. Often they risk financial ruin if they suffer a major illness and make too much to qualify for government assistance but lack the resources to pay health premiums for an individual or group health plan. As Ellen Mosaidis, a twenty-something mother and part-time waitress in Binghamton, New York, lamented, “Honestly, the whole system is a catch-22. I got caught in the middle. You can’t build your life and have health insurance at the same time.”<sup>32</sup>

Employer-based care distorts labor market decisions.<sup>33</sup> As a recent ad on the New York City subway for [www.FreelancersUnion.org](http://www.FreelancersUnion.org) proclaimed: “The flaw with linking health insurance to your job: You better not lose your job. Welcome to Middle-Class Poverty.” Individuals stay with jobs they dislike or take such jobs solely for the purpose of obtaining coverage or remaining covered after developing a serious medical condition. This may steer them toward large corporations (except during the dot.com boom) rather than in the direction of innovative start-ups. Workers postpone retirement because they need to retain a job with health benefits or to pay for their coverage as their retiree benefits erode. The tax exclusion makes the current system of much greater value to full-time, high-income workers, adding insult to injury for those who work in small businesses and lack coverage. Employers are prone to hire temporary workers rather than permanent ones because they can thus avoid the extra expense of health insurance. The system barely made a dent in the ranks of the uninsured even during the flush years of the 1990s, when new workers were in strong demand.

Since well-insured employees bear relatively little of the cost of their care directly, employer-based coverage contributes greatly to the overuse of medical care, as well as to the misunderstanding of the nature of insurance. Because of benefit caps, providers lobby employees to “max out” on their existing coverage, while insurance sometimes fails to fulfill its essential purpose: the prevention of financial ruin in a time of serious health need.

Paying for health coverage is affecting the bottom line for larger companies, particularly American manufacturers. Helen Darling, the president of the National Business Group on Health, a trade group focused on health care issues, calls the way the employer-based system

is currently structured “an unsustainable business model.”<sup>34</sup> The figures bear out her charge. While premiums paid by employees continue to rise, the employer share has not dropped, reflecting the rising costs of care. The National Association of Manufacturers estimates that employee benefits account for almost 6 percent of the overall cost of their products, affecting the global competitiveness of companies. General Motors spent \$5 billion on health care in the United States in 2002, or an estimated \$1,200 per vehicle that left the assembly line. Its health care debt related to pension obligations hit \$63.4 billion in 2002. Princeton economist Uwe Reinhardt describes the U.S. auto industry as “a social insurance system that sells cars to finance itself.”<sup>35</sup> Given that manufacturers have been the most dependable sources of health insurance coverage in the past, their changing attitudes regarding their obligations bode especially poorly for the future of a private, employer-based system.

To be sure, many employers have made strides in trying to improve the quality of care for their employees through exercising their clout as purchasers; however, the limits of these successes are perhaps more telling. For instance, the Leapfrog Group, a national association of influential employers, has made slow headway in convincing other employers to purchase health care on the basis of getting the best value for their spending.<sup>36</sup> Because no single employer has the ability to do more than negotiate a version of a “separate peace” with the medical industry, employers lack the leverage either to lower the costs of care or to improve the health of the population at large.

These flaws would be forgivable, though probably still insurmountable, if employers wanted to be in the health benefits business. But, despite some perfunctory statements to the contrary, they do not.<sup>37</sup> Organizing benefits is a hassle. It leads to internal dissension and labor strife. Employers, in short, would not be in the least unhappy to be relieved of these obligations. To be sure, some paternalistic and conscientious companies will try to do a good job if they are in the field—many of these are championing “prudent purchaser” initiatives—but this should never be confused with having their hearts in it.

Employer coverage is not set in stone, though it may seem that way after having been in place for decades in the United States. Other than history and expedience, there is no reason why the employer should be the basic sponsor of health coverage. But expedience is overrated, and the arrangements on which the system has

been constructed (the employer deduction and employee tax break) should not be sacrosanct. The political scientist Jacob Hacker has referred to those current arrangements as being the result of “path dependency”—the tendency of institutions to adapt to decisions made earlier and with little foresight of their consequences.<sup>38</sup> The mechanism for change, whatever its pedigree, is amazingly simple in practical if not political terms: end the employer-based tax subsidy. Without this subsidy in place, employers, save for a very few, will exit the business, and the way will be cleared for a new organization of health financing and delivery. During the debate over the Clinton health plan, those in charge of drafting the proposal toyed with the idea of cutting back employer subsidies but rejected this approach. It is time to revisit it in earnest.

#### WHY MEDICAL TRENDS MAKE THIS PLAN NECESSARY

This proposal aims to offer excellent insurance coverage to all Americans. To reach this goal, premiums for the basic insurance plan must remain modest. To accomplish this, in turn, the costs of health care covered by the plan must be kept under control. There are many reasons why health insurance premiums, in general, may be higher or lower in the short or medium term. For instance, larger groups get lower premiums, insurers and employers gain or lose leverage with hospitals and physicians, and insurers raise or lower prices depending on whether they are in a period when they are trying to attract business (the underwriting cycle). But, in the long run, trends in premiums relate closely to trends in U.S. health care costs. Both have risen sharply over the past three decades and continue to do so.

As virtually everyone knows, the United States, on both a per capita and an absolute basis, pays more for its health care than any other country in the developed world. Its closest competitor, Switzerland, spent 10.7 percent of its GDP on health care in 2000, well below the 13 percent the United States spent in that year (as of 2003, this figure has risen to 15.3 percent).<sup>39</sup> The usual culprits also are well known: high administrative costs, high prices for services (physician salaries, hospital stays, and procedures), and a preponderance of specialists. Most important, though, is Americans’ preference for resource-intensive medicine. Americans actually visit a physician or go to a hospital

less often than people in other developed countries.<sup>40</sup> Once in treatment, however, they receive more tests and more services, often using new and expensive medical devices and diagnostic equipment.

Higher spending on technology has been substantially responsible for the rapid growth in U.S. health costs since the 1970s.<sup>41</sup> William Schwartz, a medical writer and researcher, estimates that about half of the annual rise in spending from the mid-1970s to the mid-1990s stemmed from advances in technology.<sup>42</sup> Researchers from the Organization for Economic Cooperation and Development have found that the United States has more CT scanners and MRI units per person than most other developed countries. Further studies have linked higher spending on diagnostic imaging and other procedures to higher health care spending, or shown that the United States adopts new medical technologies earlier than other countries and diffuses them quickly, a “fast start, fast growth” model.<sup>43</sup> The other reasons commonly cited as to why U.S. health spending outpaces the world’s—a greater concentration of specialists, weak government controls on spending—also appear to reflect this strong American preference for technologically intensive care.

What is wrong with our spending so much on health care, especially on new health technologies? The overall level of health costs, as a percentage of GDP, is not the most critical indicator. What matters most is to what extent this spending takes place on tests, procedures, and medical devices that offer value in terms of longer, better, and healthier lives.

To go one step further, it is not even especially troublesome if total spending on medical services of marginal or uncertain value is high, so long as such spending is paid for more directly by individual consumers of medical care, not by governments or taxpayers. What is grossly inequitable is to limit or deny basic treatment to some Americans, or to shift resources from other social goods such as education, while financing procedures with an enormous price tag and uncertain outcome for others.<sup>44</sup> This is what happens when premiums rise or employers drop coverage, substantially because of rising technology costs. Increasingly, Americans with inadequate or no insurance coverage subsidize those with good coverage, either directly in some cases through payroll taxes or indirectly through massive tax subsidies to employers.

As extremely costly treatments, such as genetic tests and therapies, become more prevalent, a basic feature of the proposal presented

here—selective coverage of medical therapies based on their value—will become even more critical. Determining which medical services, under which circumstances, will be covered by different levels of insurance plans will ensure that such services, at least when they are introduced, do not make premiums for more basic coverage unaffordable. This strategy will encourage higher spending on treatments that have the biggest impact on national health. At the same time, since the demand for new and potentially lifesaving procedures will remain great and the prospects for good, employer-based coverage so uncertain, better-off Americans will have an incentive to choose more expensive insurance plans with more extensive coverage.

One of the most challenging dilemmas for would-be health care reformers is that medicine can do so much. Many new therapies offer some potential gains to the individual but at a very high cost. What most of these new high-cost, high-tech treatments have in common is lack of evidence about their clinical value. It is generally not known whether they work better than older therapies, whether they live up to their manufacturers' claims, and whether they are cost-effective beyond an extremely narrow set of patients. Given the well-documented linkage between technological advances and rising health care costs, there is remarkably little scientific assessment of how much these medical innovations are contributing to the value of the care given and received. This is true not only of pharmaceuticals, for which many new brand-name drugs appear to have little advantage over older and established ones, but also true across the board.<sup>45</sup> The National Institutes of Health, for example, spends less than 1 percent of its annual budget on research related to assessing technology and best clinical practices.<sup>46</sup>

A brief review of several new drugs, tests, and medical procedures reveals the dimensions of these costs and the dilemmas of coverage they produce. Erbitux, a bioengineered drug for the treatment of colon cancer, recently received approval from the Food and Drug Administration. Treatment costs \$17,000 a month. Another targeted therapy for colon cancer, Avastin, manufactured by Genentech, weighs in with a \$4,400 per month price tag. With more than one hundred thousand Americans diagnosed annually with colon cancer, the editors of the *New England Journal of Medicine* calculated that using the latter drug as a standard treatment would add about \$1.5 billion a year to the nation's health care costs.<sup>47</sup>

Xigris, an antiseptic drug that assists the body's immune system in fighting infections, costs almost \$7,000 for each treatment. According to Eli Lilly, which manufactures the drug, 750,000 Americans contract severe sepsis, usually after surgery, and about 250,000 die from the condition. Xigris is expected to save one of each sixteen patients who receive it, though some researchers think this figure is too high.<sup>48</sup> Many other new drugs, though less expensive than Xigris on a per dose or treatment basis, are widely used despite no evidence of their superiority over older, less costly medications or alternative treatments. Paxil, an antidepressant manufactured by Glaxo SmithKline, is among the fastest-growing drugs in sales to children despite no conclusive clinical evidence of its benefits. Older Americans with generous drug coverage are more likely to use the pain relievers Vioxx (recently removed from the market) and Celebrex (both drugs belong to a class known as COX-2 inhibitors, with annual sales of \$4.5 billion) even when ibuprofen may be equally suited to their condition.<sup>49</sup> Likewise, according to a study in the *Journal of the American Medical Association*, expensive hypertension drugs are prescribed to patients who need no more than diuretics, at an estimated additional annual cost of \$1.2 billion.<sup>50</sup>

Similar examples for diagnostic screening, surgery, and medical devices—expensive therapies, unproven or doubtful outcomes—abound. In June 2004, after extensive lobbying from manufacturers of scanning equipment, the Medicare program approved the use of positron emission tomography (PET) screening for beneficiaries who were suspected of having Alzheimer's disease—a \$2,500 test, with some 4 to 5 million potential candidates. This decision took place despite earlier findings by the federal Agency for Healthcare Research and Quality (AHRQ) that the value of the test was inconclusive. Diagnostic imaging, including magnetic resonance imaging, computerized tomography, and PET scans, is now close to a \$100 billion industry annually, covered partly by insurance, with a 40 percent increase since 2000 alone.

Medicare also has approved, on a limited basis, left ventricular assist devices, which help failing hearts to pump. Because many beneficiaries may qualify under even fairly restrictive guidelines (the device costs \$60,000, plus an estimated \$150,000 in hospital costs for implanting it), this ruling could push up annual Medicare spending by as much as \$12 billion. And because Medicare coverage decisions

strongly influence decisions made by private insurers, the overall cost to the health care system may rise by considerably more.

Driven by consumer demand and lucrative fees, surgical procedures such as spinal fusion and stomach stapling for obesity are driving up health care costs despite little or no evidence that they are superior to alternative procedures or even useful to many patients who seek them out. Medicare reimburses doctors \$4,000 for spinal fusion, and a hospital, around \$16,000, versus \$1,000 and \$7,000 for a simpler laminectomy. Influenced by the high-profile experience of an NBC weatherman, Al Roker, overweight Americans are skirting guidelines meant to limit complex stomach-shrinking surgery to the extremely obese. The number of operations has grown from around 16,000 a year in the early 1990s to an estimated 150,000 today, prompting a backlash by insurers who are trying to set tighter limits on the procedure's use or decline to cover it altogether. Insurers contend that covering such procedures will raise premiums for their plans or make further expansion of important benefits less likely.

Occasionally the cost of caring for a single individual illustrates, though in extreme fashion, the trade-off between covering expensive therapies and funding more broad-based care.<sup>51</sup> In 2002, a sixty-five-year-old patient, suffering from a rare form of anemia, was treated at the Duke University Medical Center. His treatment required a scarce and expensive drug, which accounted for most of the \$5 million cost of his care. (Though the treatment conceivably might have cured him, the patient did not recover.) Medicare paid for only part of the cost. As a result of having to absorb roughly \$1 million of unreimbursed outlays in this case, the university hospital had to suspend a program for children who were underweight at birth.

Clearly, some uses of newer technologies, such as administering beta blockers after heart attacks, may save money by averting the need for hospitalization or further procedures. New devices offer the promise of heading off debilitating diseases and vastly improving the conditions of many uninsured patients. Researchers at Columbia University have estimated, for example, that use of the latest medical technologies by uninsured Americans aged fifty-five to sixty-four for three common conditions—heart attacks, cataracts, and depression—would have saved \$1.1 billion annually through averting unnecessary illness and death.<sup>52</sup> Such innovations belong in the benefit package of all insurance plans.

Some will argue that we Americans should not look to selective coverage of new technology to keep health care costs manageable. Other developed nations achieve health outcomes that are comparable to or better than the United States, despite spending much less on health care relative to the size of their overall budgets. Perhaps more spending on medical care does not correlate with better health, or perhaps other sources of high U.S. spending—such as high physician salaries—should be the main target for reformers. To be sure, health spending could be reduced drastically if physicians adopted the more modest practice styles of Europe or lower-cost areas in the United States, if fewer specialists were trained, and if hospitals resisted the irresistible tendency to expand.<sup>53</sup> But directly taking on the practice patterns and incomes of physicians is a much more formidable task than curbing the overuse of technology, hard as the latter may be.

Taking a different approach, the medical researcher David Cutler contends that medical spending in the aggregate is indeed worth the cost: “We spend a lot on medicine, but we get more in return. That is not to say that everything is good. There is a good deal of waste. But a central feature of the medical system is the increasing value it provides over time.”<sup>54</sup> However, his evidence shows that it is just one category of treatments—for heart disease—that has generated enough value to justify the level of U.S. medical spending as a whole. Most health spending has had a more ambiguous effect. Moreover, with spending on medical technology as with stock market returns, history is no guarantee of future positive returns.

How should this country finance care that may be consistent with the most up-to-date medical practice but helps patients, at best, only a little? How should it decide who ought to receive new treatments that are extremely expensive—either because the cost of the service is very high or because it conceivably may benefit many patients or both?

The familiar answer would be to let doctors decide, but this approach is no longer fully tenable. Doctors frequently make individual decisions to limit certain procedures and therapies (their reluctance to use Xigris, the expensive antiseptic drug, is a good example), but they cannot be expected to resist the onslaught of technology. In many situations, using the new drugs or procedures can be personally lucrative. Moreover, the canons of medical ethics and practice were conceived when relative scarcity in medicine was the norm. Ironically, when a doctor could do next to nothing for his

patients, acting as much as priest as caregiver, his authority was unquestioned. Medical advances have led to even more outsized public expectations for medicine. This has been encouraged by advertisements for pharmaceuticals and hospitals that promise miraculous cures, as well as the increased availability of information over the Internet. As one Yale University–based hip surgeon noted, with a touch of incredulity, “Patients are coming to me with fifty pages of information on this procedure from the Internet.” The now ubiquitous language of service provision—“providers” and “consumers”—has been applied to health care. This encourages the expectation that more can always be done and increases the demand for care. As a result, the authority of doctors to ration care informally has been substantially undermined.

Rising costs partly reflect the work of conscientious physicians with an unprecedented array of tools at their disposal. Costs also spiral upward in part because of defensive medicine, as physicians try to preempt malpractice lawsuits. Most choices do not involve heroic end-of-life care of the terminally ill elderly; rather, they involve additional tests, new therapies, new brand-name drugs. As the pediatrician and author Geoffrey Kurland, the son of a renowned scientist, puts it: “Even as recently as when my father was an intern, there wasn’t as much that could be done to (not just for) patients. Only fifty years ago, antibiotics were a novelty, routine cardiac bypass surgery was a half century away, and cancer chemotherapy was in its infancy. Now medicine and surgery can truly do wonders, but often at enormous costs (physical, emotional, and, yes, financial) to patients.”<sup>55</sup>

The federal government should fill this breach. Either through the National Institutes of Health, AHRQ, or a new independent agency, the proposal presented here would establish an office to review the cost-effectiveness of medical procedures, therapies, and drugs. This agency, with contributions from experts and the public, would fix the basis for coverage decisions for different plan benefit levels, making the most promising treatments available to the largest number of Americans and distinguishing these from treatments that deserve lesser subsidies. Such a policy would encourage the development of true breakthrough drugs and medical procedures. One model for this would be Britain’s National Institute of Clinical Excellence (NICE). The Office of Technology Assessment in the U.S. Department of Health and Human Services conducted research of

this kind before it was disbanded in 1994. Federal programs are moving in the direction of incorporating cost-effectiveness criteria. Under a provision of the Medicare Modernization Act of 2003, a new program has been launched under AHRQ's auspices to conduct outcomes research aimed at improving the efficiency and effectiveness of care within federal programs.

Objections can and will be raised that basing coverage levels on determinations of cost-effectiveness amounts to rationing care and that this is unacceptable. What this overlooks is that the current system is based squarely on haphazard rationing. Leaving some 45 million Americans without insurance coverage is only the most obvious example, but rationing takes place in a thousand ways at the hands of doctors, hospital administrators, and insurers. The U.S. health care system resembles a lottery. Under the current regime, some will get care—mostly those who are sympathetic victims or who share an illness with a celebrity who has publicized it—but many will get substandard treatment or none at all.

With a basic universal plan in place, charging some Americans higher premiums for access to the most expensive and unproven procedures can be justified. We accept a private education system in large measure because a public system exists, even though this system is threadbare in many places. Some are philosophically opposed to any kind of explicit rationing of health care by price. But the American taxpayer will never be willing to subsidize the full range of what conceivably can be done by medicine at present, let alone in the future. This is true even if, as Cutler observes, many new procedures prove to be cost-effective after their effects are studied.<sup>56</sup> This plan argues for keeping incentives in place so that new medical technologies continue to be developed, not necessarily for covering them broadly at first. In fact, heavily subsidizing highly experimental and expensive procedures raises premiums and taxes, lowers salaries, and makes it less possible to do a host of simpler and highly beneficial things.

Requiring the purchase of at least a minimal level of insurance expresses the social contract element of this proposal—the recognition that basic health care is a right for all and in everyone's social interest. Making higher-level insurance plans available acknowledges that health care above a decent basic level shares many characteristics of a commodity and should be in part rationed by price. Preserving distinctions between levels of coverage is necessary to limit spending, to keep premiums affordable, and to encourage

those who seek the newest (and often unproven) treatments and therapies to buy the more expensive coverage. As William Schwartz has put it, “The rapid rise in our health care costs resulting from our medical successes cannot be controlled without the acceptance of painful but necessary limits on the availability of certain expensive treatments to some or all patients.”<sup>57</sup> The proposal advanced here, which preserves a market for such expensive treatments, is the fairest and most sensible way to finance care in this era of proliferating medical therapies and procedures.

Characteristically, new medical technologies receive tremendous amounts of media attention and hype. This will help make the proposal a success. A major dilemma for U.S. health care reformers has been, in effect, how to get wealthier, well-insured Americans to subsidize coverage for lower- and middle-income Americans, especially when they do not want to share a plan with “those” people. This proposal appeals frankly to the snobbery of the rich and their desire for the latest medical advances, even if they are of questionable merit. With payment for such procedures uncoupled from a basic plan, modest coverage that almost all Americans can afford should be on the horizon.

## OVERCOMING WEAKNESSES, PRESERVING STRENGTHS

This proposal, by combining market incentives with government sponsorship and regulations, attacks the drawbacks of the existing U.S. health care system without fatally compromising its strengths. These are laid out schematically in Table 1 (see page 22).

### COVERING THE UNINSURED

Achieving universal health care coverage is one of the primary advantages of this proposal. According to the Census Bureau, 45 million Americans, or about 15.6 percent of the population, lacked health insurance coverage at some point during 2003. Another study estimates that 57 million Americans may have gaps in their coverage

TABLE 1. WEAKNESSES AND STRENGTHS OF  
THE CURRENT U.S. HEALTH SYSTEM

WEAKNESSES
<ul style="list-style-type: none"> <li>◆ Major gaps in insurance coverage and lack of access to care</li> <li>◆ Erosion of the principles of insurance coverage</li> <li>◆ Administrative and clinical fragmentation</li> <li>◆ Insufficient investment in public health</li> </ul>
STRENGTHS
<ul style="list-style-type: none"> <li>◆ Superior physician and medical workforce</li> <li>◆ Encourages medical innovation and the diffusion of new technology</li> <li>◆ Excellent access to care for the well insured</li> </ul>

during a particular year, while about 21 million are without insurance for an entire year.<sup>58</sup> Having insurance coverage makes a substantial difference as to whether Americans get the care they need. Fifteen percent of uninsured people, for example, reported an unmet medical need in 2001, compared to a little more than 4 percent of those with coverage.<sup>59</sup>

To be sure, contrary to much misconception, the uninsured can receive and do seek health care, often in the emergency rooms of major hospitals. From the point of view of the health care system, using the emergency room setting as a *de facto* primary care center is astoundingly wasteful. Emergency room visits nationwide climbed to 107.5 million annually in 2001, up from 89.8 million in 1992, even as the total number of emergency departments fell by 15 percent.<sup>60</sup> A study by a private data analysis firm, Solucient, discovered that 58 percent of emergency visits in 2001 could have been treated in a less expensive and less acute setting. The finding is largely attributable to the high numbers of uninsured who use emergency rooms as their only portal to the health care system.<sup>61</sup> Hospitals that handle a large number of uninsured emergency room patients are each losing hundreds of millions of dollars annually in unreimbursed care. These costs are shifted to paying patients and end up being absorbed in other ways, such as higher Medicare costs for programs that pay for additional medical residents at such facilities.

The uninsured, contrary to another widely held belief, do badly under this arrangement. The Institute of Medicine has calculated that eighteen thousand Americans die annually as a direct consequence of lacking health care coverage.<sup>62</sup> Brandeis University researchers recently found that almost half of the uninsured who go to a hospital owe money to the hospital. This practice can be taken to extremes. For example, Yale–New Haven Hospital in Connecticut was found to be seeking foreclosure on the homes of poor patients who had not paid their bills, even as money remained in a state hospital fund designated for defraying the cost of unreimbursed care.<sup>63</sup>

Bringing the uninsured into the mainstream of American health care is both good ethics and sound policy. But the goal of helping the uninsured cannot be the starting point of major reforms to the U.S. health care system. The uninsured are composed largely of younger Americans, recent immigrants, and laid-off workers in their fifties and early sixties; they are too diffuse and politically weak to have a major political impact without allying with those who are currently insured. As Robert Blendon, a Harvard specialist in public opinion, has pointed out, the uninsured represent about 15 percent of the U.S. population but only about 8 percent of the registered voters.<sup>64</sup>

## EROSION OF PRINCIPLES OF INSURANCE COVERAGE

Insurance succeeds when the costs of the sick are spread over a larger risk pool of healthier beneficiaries.<sup>65</sup> Relatively stable pools and straightforward insurance benefits lead to low administrative costs and modest premiums. Each corner of the American health care system has been moving away from insurance principles and toward a reliance on the segmentation of risk: whether it is managed care plans cherry-picking healthier Americans, doctors who are reluctant to treat patients with complicated illnesses because it may blemish their ratings, employers who shun employees with prior medical conditions, or hospitals that treat only conditions with high reimbursement potential. Numerous Web sites offer “medical coverage” to Americans under the guise of insurance, when what is actually offered are price discounts on medical care.

Consumer-directed plans such as health savings accounts retain insurance coverage by covering catastrophic costs. However, the high deductibles and potentially large out-of-pocket spending for

individuals associated with such plans shift the risks of rising health care costs from employers toward workers. This “end of insurance” affects the most those who cannot afford to pay a substantial amount out of pocket for their care. For healthy people who know their bodies and can control their risks more fully, it is a good deal to withdraw from arrangements in which they subsidize others. But this leaves behind the poor, the sick, and the uninsured as the mechanisms of market segmentation become more refined.

Under the plan presented here, by contrast, subsidies will be offered to the poor, sick, elderly, and chronically ill, but they will be covered under the same plans and treated in the same settings as other Americans. Instead of trying to squeeze payment rates to doctors, insurers will pay them the same rates but distinguish among benefit and coverage policies for patients.<sup>66</sup> This will help prevent the access problems associated with, say, the Medicaid program, which typically has comprehensive benefits on paper but attracts relatively few doctors who are willing to accept the very low fees that the federal program pays.

## REDUCING ADMINISTRATIVE AND CLINICAL FRAGMENTATION

One of the greatest plagues of the American medical system is administrative and clinical fragmentation. Indeed, the remarkable extent to which payers, insurers, and medical providers are uncoordinated raises questions as to whether the word “system” applies in more than a sociological sense. As the health consultant J. D. Kleinke aptly puts it, we have not one but “ten thousand little health care systems” in the United States, the result of the coverage decisions of particular employers.<sup>67</sup> In addition, the legacy of local control of hospitals, the historic independence and autonomy of physicians, and the ways in which public insurance coverage was grafted onto a private, employer-based model worsen this fragmentation.

The problems of an uncoordinated system will be familiar to anyone who has set foot in a doctor’s office. Because of the need to fill out new paperwork, each visit to a new doctor or hospital can feel like a patient’s first encounter with the health system altogether. Each change of job or other change in insurance coverage requires a blizzard of forms and a new reassessment of covered services or

providers. Claims forms differ from doctor to doctor, insurer to insurer, and hospital to hospital. Even for patients who have consented to the use of data by a new physician, incompatible electronic data standards make these exchanges onerous and time-consuming. The absence of a single plan sponsor, along with the proliferation of varying insurance plans, makes it extremely difficult to educate the public about its health care choices. And for researchers seeking to understand how to improve American medical care, the hodgepodge of data produced by the private, employer-based system is a thicket to navigate.

This duplication of functions contributes to the enormous administrative costs of American health care. Officially, these are estimated at around \$90 billion per year, but may reach as high as \$294 billion annually, or more than 20 percent of the \$1.4 trillion annual U.S. health care bill.<sup>68</sup>

The fragmentation endemic to the system also encourages each payer to attempt to solve its own financial difficulties in isolation by shifting its costs onto another insurer. State Medicaid programs, for example, try to steer as much coverage of their over-sixty-five beneficiaries onto Medicare as possible. Employers do the same. Any reforms aimed at expanding public coverage attempt to weigh the effects of “crowding out” employer coverage, anticipating that employers will drop or reduce coverage when a government-funded alternative is in place. The new outpatient prescription drug benefit in Medicare, for example, is expected to reduce employer coverage of retirees despite measures aimed at retaining such coverage. Cost shifting absorbs a great deal of bureaucratic effort and has little or no positive impact on overall health spending or public health.

Hospitals and other medical facilities play similar games to maximize their reimbursement from different payers. For instance, nursing home patients sometimes are shifted to hospitals because Medicare will reimburse certain tests in that setting and not in long-term care facilities or in the home. Reimbursement considerations, rather than those of the appropriate environment for a patient, tend to drive decisions about where a patient is seen and which tests and procedures he or she receives.

Newer developments are worsening this problem as sophisticated efforts to chase the reimbursement dollar take place among doctors and hospitals. These include the rapid growth of specialty hospitals that concentrate on profitable procedures such as heart surgery and

orthopedics, at the expense of general medicine, and the evolution of “concierge” medicine: physicians who forgo all insurance coverage and build a stable of wealthy, dues-paying patients.<sup>69</sup> Formerly, hospitals could offer a variety of services, including money-losing services, and could use profitable lines of business to cover the unprofitable ones. But as managed care and government payers increasingly insisted on justifying the costs of each procedure, margins shrank, and the previously extensive use of cross-subsidies dwindled.

The proposal being introduced should markedly lower administrative costs by reducing the number of health plans and by consolidating federal health programs. Under it, marketing costs for insurers should drop, while enrollment in plans should be much more stable than under an employer-based regime. Much of the responsibility for selecting a health plan and managing their own care will shift to individuals, but a private industry can be expected to emerge that will assist in this transition. The harbingers of this industry are already in place. Because plans will roughly resemble one another (much like automobiles with standard and optional features), it will become much easier for this industry to develop and for individuals to share their expertise with one another. Opportunities for cost shifting should decrease substantially because fewer payers will be in the game. Administrative costs would remain much higher than under a single-payer reform plan, and hospitals and insurers would continue to joust over relative market power. But the aim of this plan is not to reduce administrative costs to their absolute minimum; rather, it is to strike a balance that preserves choice while avoiding counterproductive fragmentation.

## INVESTING IN PUBLIC AND POPULATION-BASED HEALTH

Increasing U.S. investment in public health goes hand in hand with seeking to obtain greater value for the nation’s health care spending. Researchers for years have pointed out that the health of populations largely depends on “nonmedical” determinants of health—what people eat, how much they exercise, how clean their environment is—rather than on the quality of care delivered in hospitals and clinics.<sup>70</sup> The term “public health,” in this sense, refers to government’s efforts to improve the overall health of its population, not—as has

become prevalent—to refer to spending on individual health services for poorer Americans provided through clinics. Taking on this role as a “safety net” provider, moreover, has compromised the public health system’s core function of detecting and preventing the spread of infectious diseases.<sup>71</sup>

Despite its importance, public health is the unloved stepchild of the American health care system. According to a 2002 study from the Institute of Medicine, the United States spends at least 95 percent of its health dollars on individual medical care and biomedical research—a staggering differential.<sup>72</sup> Increasing the investment in public health, which currently stands at around \$46 billion, would improve tremendously the health and the quality of life of Americans. Over the long haul, it also will save a great deal of money for the health care system.

Some areas in which new public health spending could make a significant difference include the promotion of healthy behavior and personal responsibility, funding essential preventive services, improving health literacy, and building systems of electronic exchange of health information.

*Promoting Health Education and Personal Responsibility for Health.* Although not all overweight Americans are necessarily unhealthy, the correlation between obesity and ill health is indisputable. Recent studies have estimated that obesity costs the U.S. economy about \$93 billion annually, although it also generates huge incomes from various dieting-related products.<sup>73</sup> The Centers for Disease Control and Prevention estimates that 55 percent of American adults do not get the recommended minimum daily thirty minutes of exercise, even when the definition of “exercise” is expanded to include housework and gardening. Use of tobacco products is reliably blamed for about four hundred thousand deaths annually.<sup>74</sup> Still, the reduction in U.S. smoking rates brought about in large part through public education campaigns is a model for improving personal health behavior in other areas.

The Centers for Disease Control and Prevention recently estimated that one in three Americans, and one of every two black and Hispanic Americans, will be diabetic in the year 2050 based on current trends.<sup>75</sup> Most alarming is the rise of “adult-onset” diabetes in children and young adults. Since diabetes—which if untreated can lead to blindness and amputation of limbs—can be successfully

managed in most cases through diet and exercise, the benefits of early intervention with regard to both costs and quality of life are obvious. However, the current combination of fragmented care and widespread lack of insurance means that large numbers of Americans are diagnosed with diabetes only after it has reached an advanced stage.

***Ensuring that Essential Preventive Services Such as Dental and Eye Care Are Part of a Basic Insurance Benefit.*** Many existing insurance plans do not cover preventive services or impose strict caps on them. Some preventive services (especially screening and physical exams) are expensive and of marginal value, but covering others would have an enormous social payoff. For instance, around 44 percent of Americans lack dental insurance, and one in ten report not being able to get treatment for a dental problem in a given year.<sup>76</sup> Forty percent of adults and more than 60 percent of children do not visit the dentist annually. Oral health is worst among poor and minority Americans, with more than half of all black men reporting untreated tooth decay. The results: 164 million hours of work lost to oral health problems each year;<sup>77</sup> a high percentage of emergency room visits related to treatment of toothache and dental crises; elevated rates of oral cancer; and unknown effects on the psychological health of those afflicted. Dental coverage is frequently among the first insurance benefits dropped by employers looking to pare costs; yet, as a public health concern, it ought to be routinely offered, along with eye care, rather than treated as an expense that patients can meet substantially out of their own pockets.

***Improving Health Literacy.*** “Health literacy” refers to the patient’s ability to read, understand, and respond to the oral and written health information given by doctors and other medical professionals. Though definitions vary, the consensus is that such literacy is shockingly low. In 2004 the Institute of Medicine estimated that at least 90 million Americans have trouble understanding health care information, a number that weighs heavily against any proposal based on patients taking more responsibility for selecting their own health plans, doctors, and treatments. Funding the development of user-friendly ways of conveying information, in both print and audiovisual form, will pay dividends.<sup>78</sup>

*Building Systems to Exchange Electronic Health Information.* Developing secure electronic medical records and systems in hospitals and doctors' offices that can quickly exchange information between institutions ("interoperable systems") may seem to be outside the purview of public health. However, the inability to locate and process records swiftly and easily contributes to medical errors, substandard and inefficient care, and poorer population health. The problem is that individual providers, at least initially, lack strong incentives to install such systems since the health and economic benefits tend to accrue to the system as a whole, not to the particular institution or clinic. Hospital administrators and doctors are typically sympathetic to the goals of improving population health, but the economic circumstances facing hospitals all too often work against this goal. As the head of a major New York hospital system delicately put it, in most hospitals, "There is no inherent interest in promoting health from an economic standpoint."<sup>79</sup> Building interoperable systems, according to one recent study, could save as much as \$78 billion over ten years, to say nothing of its salutary impact on public health.<sup>80</sup> Since the upfront investments in these systems should yield returns as more hospitals and doctors become part of the network, it seems natural for the federal government to take the lead in the early stages.

Spending more on public health and raising its visibility will encourage a focus on the best way to achieve desired health outcomes instead of on the process of delivering acute medical care, which emphasizes technical innovation and virtuosity. It will encourage the comparison of different treatment methods—surgery, drugs, diet, or exercise?—on the basis of their cost-effectiveness. Over time ingenious proposals about paying for better health results will move closer to reality.<sup>81</sup> As Daniel Callahan has argued, fixing a population-based perspective on health in the public's mind and applying it to the operations of hospitals and other health care facilities is critical to the concept of "sustainable medicine." The public's willingness to accept a national basic health care plan rests in large part on the evolution of this attitude. Callahan contends that "we should discourage technologies that will increase costs with comparatively little population benefit. The question in the future is not whether a technology will serve *some* people—not a hard standard to meet—but whether it will help *most* people by addressing conditions of which most people will be at risk, and in a way that can show community, not just individual, benefit."<sup>82</sup>

In the current system of U.S. health care, there is no danger that spending on individual health needs will be slighted, but the proposal presented here will accommodate both an emphasis on population health and the development of new technologies. While the balance of compassion in the U.S. system is wrong—it is currently skewed toward seeking the miraculous revival of individuals suffering from extreme trauma—it would be a mistake to swing the pendulum entirely in the direction of improving aggregate population health. The health care system of a wealthy nation should improve the overall health of the population; encourage medical innovation that will make future generations healthier; offer hope for individuals to survive unexpected illness, injury, and trauma; and allow the terminally ill to die with as much dignity and comfort as possible. From a purely utilitarian perspective, treating the conditions that, say, cause severe asthma among Harlem schoolchildren, where at least a quarter of children are asthmatic, would surely be more valuable than prolonging the life of a single individual with a failing heart. However, medicine is valued in part because it treats, and sometimes cures, even the apparently hopeless cases—a response to unexpected illness and injury that speaks to people’s greatest moment of vulnerability and need, and thus to a shared humanity.

#### MAINTAINING A SUPERIOR PHYSICIAN WORKFORCE

The proposal presented here would retain the strong incentives (relatively high incomes, choice of specialty) that encourage qualified U.S. university graduates to enter the medical profession and draw many of the best and most ambitious doctors in the world to our shores. According to the Association of American Medical Colleges, applications to medical school have increased slightly over the past two years, following a six-year decline as other careers such as law and business seemed more attractive.<sup>83</sup> While competing for talent, medical schools must continue to hold their own. At the same time, the United States remains a magnet for foreign doctors. The equivalent of the graduating classes of two to three Canadian medical schools, or about 250 doctors, leave Canada permanently each year to work in this country. The United States also is the destination of choice for wealthy individuals from around the world who seek cutting-edge medical treatment.

## ENCOURAGING INNOVATION

Medical innovation is underrated as an engine of productivity, economic growth, and social prosperity, in large part because the impact of innovation is hard to see or measure. Many new therapies, medical devices, and pharmaceuticals are marginally useful. To be sure, medical innovation is not limited to technical improvements; it also can include changes in the way that health care is delivered that yield lower costs and better results for patients, such as reducing racial and geographic disparities in access to care.<sup>84</sup> But American researchers, supported by private industry, government, and not-for-profit organizations, have achieved numerous breakthroughs: joint replacements, statins, antihypertensive drugs. Moreover, the positive effects of seemingly unproductive innovation may take decades to develop, as has been the case for the computer industry. The national health care systems of other countries depend heavily on American research and development, but the higher expectations of their populations are putting these systems under strain.

The design of the plan developed in this paper is prompted by a desire to preserve a climate that rewards medical innovation. Some policy researchers and health industry leaders have advocated creating a single basic plan and compelling Americans to pay more out of pocket if they want more expensive procedures than are covered by their insurance. As Richard L. Huber, the former chairman and CEO of Aetna, expressed it, “Insurers never make medical decisions, only coverage decisions. If we the insured really feel that some experimental medication will cure our ailment even though it isn’t covered, we can pay for it out of our own pockets.”<sup>85</sup> This assumes resources that are far beyond the means of most Americans. And if such procedures had to be paid for out of pocket, the market for them would be comparatively small, meaning that the process of medical innovation and its diffusion would suffer. By contrast, under this proposal, even the wealthy will benefit by banding together in insurance pools to afford the cost of expensive treatments. By providing a market for innovations, it will cause the cost of these procedures to drop, and many will be able to avail themselves of such progress in care more quickly. Absent this pooling, the likelihood is that medical advances will indeed increasingly become the province of the very few, or none at all.

## MAINTAINING EXCELLENT ACCESS TO CARE FOR THE INSURED

Many positive features of the U.S. system do not bear directly on longevity, mortality, or morbidity. These are mostly related to ease of access to care and quality-of-life issues. Those with insurance can generally schedule procedures promptly, without the waiting lists (such as one year for a non-life-threatening hernia in many Canadian provinces) that are common in other countries.<sup>86</sup> One striking comparison makes this point clear. Ordinarily American surveys do not even measure waiting times to see specialists in the United States since this is not perceived as a problem. A recent survey of fifteen cities, however, found that patients in Boston had to wait a month on average to see a specialist, the longest time of the cities surveyed.<sup>87</sup> In Great Britain, by contrast, in 2004 fewer than one in three outpatients had seen a specialist within a month of referral by a general practitioner, and more than one in nine was still waiting after three months.<sup>88</sup> This follows several years in which waiting times have markedly improved.

## MAKING THE PROPOSAL A REALITY

Once this new system is fully in place, how would it look from the standpoint of someone seeking to buy health care insurance? Each year, the government would make a payment to you, and to every American household, that would be used toward paying for the premium of a health plan's policy. You would choose a health care plan and pay the difference, if any, between the government's payment and the price of the plan's premium. This payment (which, in practice, would be paid directly to the insurer after you had selected a policy) would always be pegged high enough to allow you to pay for a basic coverage policy in your area. If you are a senior, disabled, very poor, or a veteran, you would receive a higher payment.

Well in advance of the decisionmaking period, you would receive information from the government about your choice. This would explain the standard benefits available under each type of policy. These would be adjusted on a year-to-year basis based on the decisions of the independent government board charged with determining the efficacy of medical treatments and procedures. The information

would highlight any important changes from previous years, a list of the health plans offering these products, and their network of doctors.

Would every plan be exactly the same? No. Each would have somewhat different rules and benefits, subject to approval by the federal government. If the basic analogy for this proposal is to economy, standard, and luxury vehicles, this distinction would resemble the variations between automobiles in the same classes (say, a Pontiac Grand Am versus an Oldsmobile Alero). Some people, for instance, will prefer a wider physician network and will accept higher co-payments for benefits; others will prefer the reverse. The government would require that some benefits—such as “stop-loss” or catastrophic protection after an individual has spent a very large amount on hospitalization or prescription drugs—be offered by all insurers.

If you are currently covered by an employer, this scenario probably won't look so unfamiliar. In effect, the government will replace your employer as the “sponsor” of your insurance coverage. The difference, in most cases, is that you probably will have more options to choose from and more variation in what you pay for your premium than at present. Many employers don't offer any choice of plan and employees tend to pay fixed premiums and co-payments. If you are in Medicare or another government program with a standard benefit package, making this decision will be more unfamiliar and more challenging. But even though you would be buying health insurance as an individual, the government would be closely regulating the health care marketplace. This means, assuming that the regulations work properly, that you won't be faced with good or bad choices, but decent or better ones. Ensuring this “fail-safe” option is critical. Most of your friends and neighbors, of all ages, would be enrolled in roughly similar plans. This should make it much easier to decide on which plan would be best. And because this would be the case, you would be far less likely to be a member of a plan in which many of the members were older and sicker. (The strong likelihood that this would happen if only older Americans joined such plans is a major flaw of proposals that have sought to apply a version of this premium support approach only to Medicare beneficiaries.<sup>89</sup>)

What's the advantage to preserving competition among insurers in the first place? The intent here is that both insurers and patients have a strong incentive to pressure medical providers to offer procedures at the lowest cost and highest quality. Insurers will be competing with one another for business; individuals purchasing

policies will have a financial incentive to pay as low a premium as possible. This approach strikes a balance between preserving the advantages of competition (pressure on prices, with the drawback of discrimination among patients based on their health risks) and the advantages of large buyers and large insurance risk pools. Another advantage of this general approach, first proposed by health care experts Henry Aaron and Robert Reischauer, is that it can easily be adjusted on a year-to-year basis as the cost of health care changes.<sup>90</sup> In principle, a premium support model would allow flexible spending on health care. While this model is often associated with the goal of reducing health care costs, it doesn't mandate this particular stance. What it does do is to offer administrative flexibility within the normal constraints of politics, and puts the issue of health costs and who pays out in the open. Another practical and political advantage, noted below, is that adopting this strategy should keep disruptions to a minimum between insurers, physicians, and hospitals.

Joining at least a basic plan would be mandatory. It's necessary to get all Americans into this system, in particular younger and healthier Americans, so that premiums for coverage will be affordable. (Health care reform plans not infrequently call for "individual mandates" in conjunction with tax credits and high deductible insurance plans, but this broader restructuring and regulation is needed to ensure that Americans can really afford a basic plan.) Opportunities for enrollment would be heavily publicized in the media and through government agencies such as the Social Security Administration. Contact with individual Americans would be made through the Internal Revenue Service, the Selective Service, and other federal databases. The remarkable response to disaster-relief Medicaid after the 2001 terrorist attacks, in which four hundred thousand New Yorkers enrolled in just four months, gives some indication of how quickly such coverage can be taken up when programs are publicized and the scope of coverage and the terms are desirable.<sup>91</sup> If you don't purchase insurance, you will be enrolled and billed when you seek care in a hospital or a clinic. If you don't choose a plan during the annual period, you will be placed by default in a basic plan. If your circumstances don't permit you to pay the premium for the basic plan, a means test, similar to that used in existing Medicaid programs, will be used to determine whether you qualify for additional subsidies.

Enrollment in only the basic health insurance plan will be mandatory. In theory, supplemental insurance plans (like the existing Medigap products purchased by Medicare beneficiaries) could complement the basic plan or compete with the standard and luxury products. But since insurers will be held to a “take one, take all” mandate with respect to offering different levels of coverage, since high-end coverage will be available, and since there will be financial advantages for individuals to join larger risk pools, there is reason to expect that most insurance plans offered will become variations on the three basic options. These would resemble options available in the existing private market and in public programs. For example, these three levels might emerge from a combination of government decisions on coverage and insurers’ rules:

*Cadillac (Luxury) Plan.* This plan would guarantee access to all the latest approved treatments and pharmaceuticals, with few limits on hospital stays or physician consultations and a comprehensive long-term care benefit. It would resemble the high-end coverage certain large companies currently offer to their CEOs.

*Buick (Standard) Plan.* This plan—equivalent to the best plans firms make available to their workforce—would resemble the range of benefits and options available through CalPERS, the California state pension plan, which covers more than 1.2 million active and retired state and local government employees and their family members. It would cover most new procedures and therapies and would have low or modest co-payments and high or no caps on prescription drug coverage.

*Chevrolet (Basic) Plan.* This plan—the basic option for which all Americans would qualify—would have certain benefit limits and restrictions, notably on the number of emergency room visits, and modest to substantial copayments on some treatments and services. Unlike most insurance programs aimed at those with modest incomes or health needs, it would include extensive coverage of preventive services such as vision and dental care. It would limit certain heavily used benefits, such as home health care and rehabilitation therapy, along with new and very expensive treatments, especially those of uncertain or unproven value. In essence, it would be similar to the existing Medicare benefit package.

How large will the government premium contribution be? As illustrated by the explanation in the text box, it is possible in principle to convert existing spending on health care, following the changes made in this proposal, into a substantial subsidy. The precise amount of the contribution will depend on a number of variables. Some of these are political; others depend on how the proposal evolves as it is implemented. These include the generosity of subsidies to lower-income Americans, the scope of benefits offered at different levels of coverage, the number of Americans who elect plans of different types, and the effect of competition among plans on lowering health care costs. While payments to particular individuals and households would vary according to family size, a ballpark estimate of the average government payment would be \$3,860 per person. As annual premiums for employers range from just under \$4,000 for individual coverage to just under \$10,000 for family coverage, this should be adequate to cover a basic health plan in most areas and to keep premium payments affordable—in the \$200 per month range—for most individuals and families who choose a standard plan. One would expect the premium for the basic plans in many areas, especially rural areas, to be lower, so many lower-income Americans wouldn't have to pay a premium at all—beyond what the government contributes.

Of course, no one's situation is exactly the same as the theoretical average. This presents a challenge to this plan, and to all others like it that rely on some form of managed competition. A major potential problem is adverse selection—the tendency for the sick to cluster in particular plans, driving up premiums, and making the government payment insufficient over time to purchase an affordable policy. This problem can plague all insurance programs but is especially pronounced in private, competitive markets for health care. Insurers have an incentive to select healthier individuals and to receive premium payments while making a lower outlay on medical spending, while the historically well have a financial incentive to band together with the similarly healthy to seek lower premiums.

Another possible roadblock involves geography. Health care costs much more in some places than others, due partly to differences in labor and other costs and partly due to the way physicians practice—whether they order more or fewer tests, treat patients more or less aggressively, or are more or less up-to-date on recent developments in medicine. These differences can be stark. The Medicare program, for

## CALCULATING THE AVERAGE PREMIUM CONTRIBUTION

The figure for the average government payment combines public spending, employer contributions, and potential new revenues from eliminating the tax exclusion for employer-based coverage. According to the most recent estimate from the National Center for Health Statistics at the Centers for Medicare and Medicaid Services, federal, state, and local government spending on health care totaled around \$728 billion in 2003.<sup>92</sup> (This excludes around 37 billion dollars that Medicare beneficiaries pay in premiums and taxes; Medicare also funds the education of medical students but this isn't included in this ballpark estimate.) Again excluding premiums and cost-sharing paid by individuals, employers spent about \$443 billion on health care in 2004.<sup>93</sup> To ensure that businesses have an incentive to support this plan, and so that savings for them under the proposal would exceed those from deducting health costs from their tax base, a corporate tax would be enacted to capture one half of this current spending, or about \$222 billion. (To be sure, the rate and amount of this tax would vary among larger and smaller firms—the intent here is to show the general workability of this approach.) Employers have an interest in helping to maintain a healthy workforce, which this provision would reflect. The expectation is that companies will use any savings in part to raise salaries. This will help employees pay the higher out-of-pocket costs associated with buying comprehensive family or individual insurance policies. Based on a recent estimate, the employer-based tax subsidy cost the government an estimated \$189 billion a year in tax revenues.<sup>94</sup> Assuming that the federal treasury can capture this revenue, the total from the three streams amounts to \$1,139 trillion. Divided by an estimated 295 million Americans, this yields an average payment of \$3,861 per person.<sup>95</sup>

Under the plan, additional premium subsidies would be made to Medicare beneficiaries and other beneficiaries of government programs, who would be eligible for mid-level insurance plans, and the full premium would be paid for the truly indigent. About 55 million Americans are eligible for Medicare, VA coverage, or other

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publicly funded health insurance coverage (excluding Medicaid). If these beneficiaries were paid an additional \$2,000 per person to ensure that they could afford the standard plan, this would amount to \$110 billion. Many of those currently covered by Medicaid should be able to afford the premiums for a basic plan in much of the country, especially those who live in rural areas. As a rough estimate, those in severe poverty (defined by the Census Bureau as those with incomes of one half or less of the poverty threshold) would have their premiums for health insurance paid. This group numbers just over 14 million Americans. If their annual premiums cost \$5,000, that would result in an additional \$70 billion in annual spending. Including these subsidies would reduce the average payment to around \$3,250 for the remainder of the population.

instance, spends in excess of \$8,000 annually per beneficiary in Miami and just a bit more than \$3,000 per beneficiary in Minneapolis, mainly because more services, at higher prices, are performed in Miami. Because of these differences, if the contribution isn't varied by region, beneficiaries may pay much more or less for their coverage depending on where they live. In addition, insurers might not choose to offer coverage in some places altogether if they think that the government's payment is insufficient to support a network of doctors and hospitals and to make a profit.

The usual response to these problems, in theory, would be to vary payments depending on the health of individuals ("risk adjustment") and depending on where they live. It may turn out that such adjustments are necessary. Adjusting these payments minutely would require a larger bureaucracy, present large technical demands, and make the payment structure unintelligible to anyone other than a few experts. There are reasons to believe that these problems wouldn't be as severe under this approach than they might seem to be on paper. Given that the new program will be the biggest, if not the only, game in town, it will be difficult for either urban or rural doctors and hospitals to avoid serving those covered. The size of the health plans probably will be considerably larger, and the population served much more varied, than in most employer-sponsored plans or in any public program. Because the government contribution to individuals in

certain groups that are more likely to incur high medical costs—older Americans, veterans, and the disabled—already will be higher, the affordability problem will be mitigated. For these reasons, the problems associated with adverse risk selection and geographical variation in costs may be manageable. One possibility would be to vary the standard payment by region and attempt to distinguish between the amount of spending that is due to input costs like labor and that which is due to doctor's practice style, paying for the former but not the latter. Over time, one goal of this proposal would be to bring payments in line with the value gained from the best examples of medical practice.

There is an existing U.S. program in place, based on a premium support approach, that gives some confidence that this approach is workable in practice. This is the Federal Employees Health Benefits Program (FEHBP), which covers Congress and government employees and enrolls some 9 million beneficiaries. While the FEHBP is a poor model for Medicare reform, mainly because many seniors tend to incur high and predictable costs and consequently would wind up in expensive insurance pools, it is a much better model for covering the entire population, where costs would be spread over much larger groups.<sup>96</sup> From a political standpoint, invoking FEHBP as a model has the tremendous advantage of its being the health insurance program used by members of Congress and most federal employees.

In this proposal, as in the FEHBP, the federal government will negotiate with insurers on premiums and coverage standards. All individuals within the same insurance plan will pay the same premium. Both national and local health insurers participate in the FEHBP, including a national Blue Cross and Blue Shield preferred provider organization. Multiple plan choices exist in every part of the country. Unlike the FEHBP, this proposal would standardize benefit packages, making comparison between different insurers more feasible. Most FEHBP plans in the same area in fact offer similar packages of benefits, except for variations in dental and other secondary coverage. In this proposal, reducing costs and prompting genuine competition mean that the benefit packages would have to be truly distinct.

Estimates of administrative costs in the FEHBP range from 7 to 15 percent of benefits, which is higher than Medicare but modest relative to most private sector health insurance plans.<sup>97</sup> Premium increases have been smaller for FEHBP than for most

private insurance plans, apparently thanks to tough negotiating with insurers.<sup>98</sup> But because the federal program does not vary its payments by health risk or geography, the level of premiums probably reflects biased selection into plans, and hence sicker patients face higher costs. Adverse risk selection has been an Achilles heel of the FEHBP, as the premium costs (and out-of-pocket costs) vary considerably even within a relatively small area, such as metropolitan Washington, D.C.<sup>99</sup> This problem has grown as retirees, who have higher health-related expenses on average, have become a larger proportion of FEHBP enrollees.

## PAYING FOR THE REFORMS

As suggested above, the government premium contribution essentially could be financed through redirecting the payment streams that currently pay for U.S. health care. Reaching universal coverage, streamlining the health care system, and bolstering public health will result in changes to overall health care spending. In the long run, many of these changes (such as the improved health of the population, or greater longevity) will lead to fundamental changes in health cost trends that are impossible to predict.

In the nearer term, an estimate of new costs and savings can be hazarded in general terms. New areas of spending will involve covering the uninsured, funding catastrophic long-term care coverage, paying for preventive services, and bolstering the nation's public health system. Major savings will come from a reduction of administrative costs, more selective coverage of technology and higher out-of-pocket payments for certain expensive procedures, the lowering of hospital expenses (especially on emergency room coverage), and gains through time from a healthier population. While health care costs will rise in absolute terms, largely because of an aging population, they should be significantly below current expectations.

Because the uninsured use fewer health services than the insured population, health care spending would rise if universal coverage were adopted. Researchers at the Urban Institute have estimated that the cost of additional medical care should the uninsured be covered would be between \$33.9 and \$68.7 billion dollars annually.<sup>100</sup> Operating on the assumption that most of the currently uninsured will be enrolled in a basic plan, we will use the lower end figure. A subsidy will be made

to help defray the very high cost of long-term care coverage, a benefit of critical importance to the disabled. Such a subsidy might be pegged initially at \$20 billion per year, roughly half of the \$38.6 billion that is currently spent by Americans out of pocket on long-term care.<sup>101</sup> New spending on public health and preventive services would be in the range of \$50 billion annually.

There will be significant administrative costs associated with implementing this proposal, such as informing Americans about their new options and building an adequate regulatory framework. Other savings in administrative costs will be large over time. For instance, consolidating the many federal agencies and sub-agencies that run health insurance programs would reduce costs greatly. The bewildering variety of existing health benefit plans also will be reduced, as each insurer offers three standard products rather than many products with minor differences tailored to particular employers. The administration of care at the state and local level would be greatly simplified. Hospitals and providers would economize on the large existing costs of verifying the insurance status of patients and providing unreimbursed care. Following the initial transition phase, at least \$30 billion in administrative savings annually would be a reasonable expectation, and over time higher savings could be achieved. Given that the coverage of many new tests and therapies is credited with raising the cost of public and private insurance programs by tens of billions of dollars, let us suppose that \$20 billion dollars a year can be credited to the savings side of the ledger from the selective coverage of new procedures and therapies.

This leaves about \$35 billion in new spending projected under this proposal. This could be paid for through an increase of around 35 percent in the existing Medicare payroll tax (e.g., it would rise from the current 2.9 percent to about 3.9 percent of payroll).

## ALTERNATIVE APPROACHES TO REFORM, AND WHY THEY ARE UNLIKELY TO SUCCEED

Other recently proposed health care plans are unlikely either to result in a system that is as efficient or equitable as the one proposed here or to achieve political support:

- ◆ A plan based on employer mandates is unlikely to take wing because employers are increasingly interested in getting out of the health benefits business rather than providing additional resources. Employers should help finance a universal plan, but the tax incentives for keeping them involved in administering benefits should be dropped, not refined.
- ◆ A single-payer plan, such as that proposed by numerous consumer advocacy groups and some physicians, would require restructuring the nation's insurance industry—a daunting proposition—and would squelch over time the medical innovation that is the principal advantage of the current American health system.
- ◆ Plans that propose tax credits and the purchase of care by individuals (individual mandates) are unlikely to be taken up by most Americans or to induce health plans to offer packages that are both affordable and comprehensive.
- ◆ Plans that rely on the incremental expansion of public coverage, generally through state Medicaid programs, underestimate the vulnerability of such plans to changing fiscal circumstances. The current fiscal crisis of the states, for example, may result in the significant dismantling of the carefully crafted Medicaid expansions that have slowly widened coverage since the late 1980s, especially for children. Such gains are built over decades and can be lost at a stroke. Their proponents are like Sisyphus, endlessly pushing the rock up the hill only to have it roll back again.
- ◆ A group of policymakers, advocates, and employers think that the medical system can be thoroughly reshaped by focusing on weeding out medical errors and bringing new standards of quality control to bear on hospitals and doctors, much as industries perfected assembly-line techniques or airlines reduced accidents. While much of this work is laudable, it cannot in and of itself provide a solution to the cost and access problems that bedevil American health care. This is precisely because a major source of new costs is that treatments work, if only at a high price, not that they are wholly ineffective or unnecessary.

## WHY BUILDING ON EMPLOYER-BASED INSURANCE COVERAGE IS A MISTAKE

The opening section of this report gave evidence as to why employer-based coverage is a weak foundation for universal health reform—it has characteristics that intrinsically discourage broad insurance coverage and lead to overspending on care, while employers are losing enthusiasm for offering health benefits. Moreover, there is little or no momentum behind proposals that would expand employer-based coverage at either the federal or state level. Voters did not flock to John Kerry’s plan for achieving large reductions in the numbers of the uninsured by expanding incentives for employers to offer insurance. In November 2004 in California, voters narrowly rejected a universal coverage plan based on employer mandates. (A version of this proposal, to be sure, had previously passed in the legislature and had been suspended during the special gubernatorial election in fall 2003.) While some large employers backed this plan, others opposed it vigorously, and it was generally unpopular among owners of small businesses.

## WHY A U.S. SINGLE-PAYER SYSTEM IS UNATTAINABLE AND PERHAPS UNDESIRABLE

Why not adopt a Canadian-style single-payer plan, a form of “Medicare for all,” with a set benefit package for which all Americans qualify? Physicians for a National Health Program, a group of more than eight thousand physicians, has proposed a national single-payer plan, in which the federal government would take responsibility for the financing of care.<sup>102</sup> The advantages include a huge projected reduction in administrative costs (the authors of the physicians’ proposal estimate \$200 billion) and ease of understanding for beneficiaries.

A major obstacle to expanding Medicare in its current form or adopting a Canadian-style single-payer plan is political: though slightly more than one-third of Americans express a positive opinion of such reforms, this number has not gone up substantially over time. Since most of the powerful health care interests oppose this approach, large majorities would probably have to back a single-payer plan for it to make headway. But there are reasons other than the cultural and

political to make one doubt that such a reform is the right path. These boil down to three main points: the difficulties of removing the insurance industry from health care markets, the likelihood of reduced choice and access, and the potential effects on medical innovation.

It is possible to have a single-payer plan that uses insurers as claims-processing intermediaries: Medicare is basically such a model. With the advent of a single-payer system, most private insurers would be unlikely to remain in the health care business and would no longer play this intermediate role. If insurers were out of the equation, the upheaval in the health care financing and delivery system would be immense, as new relationships among government, hospitals, and patients would have to be created. One of the advantages of the proposal advanced here is that the patient's day-to-day experience of the system would not be radically different, even though it would be streamlined. The continued involvement of insurers will neutralize their political opposition, will prevent flare-ups of the characteristic American mistrust of government, and will help deal with the reality of administering such a huge program.<sup>103</sup> Moreover, the health insurance business is a profitable one, so it is difficult to imagine insurers accepting being eased out of the picture with equanimity.

Access to modern medical care is in part a social right and in part the purchase of a commodity. Single-payer systems are prone either to curtail the access to expensive procedures or to try to provide them in egalitarian fashion, leading predictably to long waiting lists for nonemergency (and sometimes for vital) therapies. In Canada, for example, only forty-three of the hundred new drugs launched in the United States from 1997 to 1999 have made it through national and provincial review boards.<sup>104</sup> Of course, many such drugs may be of little real utility, but others are potentially important. Canadians use the United States as a safety valve to seek cutting-edge procedures and drugs: should this country go the single-payer route, a reciprocal option will not be open to Americans.

The potential effect on innovation is the most troubling issue. It is too easy for the government to stifle the path of medical innovation in its eagerness to preserve fiscal stability. The pressure to hold the line on spending means that many techniques with considerable potential would not be covered or would be given inadequate reimbursement, impeding their development and diffusion. Currently industry pays for about 57 percent of biomedical

research; the government (through the National Institutes of Health), about 36 percent.<sup>105</sup> While a single-payer system might cover new therapies and drugs, it would be far riskier for a company to seek returns in these areas unless it expected a market to develop. Keeping higher-level insurance plans in the mix is a way to make sure such markets remain open.

### WHY TAX CREDITS AND INDIVIDUAL MANDATES ARE INADEQUATE

A number of analysts both inside and outside of government have proposed a combination of tax credits and individual insurance mandates to reach near universal coverage, plus subsidies for those who pay little or no federal taxes.<sup>106</sup> The attraction of this approach is that it seems to elide the need for “big-government” involvement in the health care system and thus seems poised to gain political support. The problem is that without direct government involvement in restructuring the system these credits are likely to buy no more than a pittance in anything resembling today’s insurance market. For this reason the mandates are sure to be hollow. The proposal outlined here, by contrast, links the mandates to the guarantee of a basic insurance plan.

### WHY INCREMENTAL STEPS TOWARD UNIVERSAL COVERAGE ARE UNRELIABLE

Building incrementally on existing public coverage, especially through Medicaid, has accomplished some breakthrough successes in recent years, notably in covering uninsured children, since the mid-1980s and especially since the demise of the Clinton plan. It is backed by experts of tremendous knowledge, long experience, and good intentions, many with decades of government service. It also has met with surprising goodwill from the public, at least in times when the economy is flush. And therein lies the problem. It is politically feasible and yet terribly precarious. It can be built painstakingly over years and lost in a week, or at least in a single state legislative session.<sup>107</sup>

This approach is similar to focusing on different categories of the uninsured and gradually adding coverage to these groups until near

universal coverage is reached. But piecemeal expansion is built on a political and financial foundation of sand. For one thing, the uninsured really are different from the insured population. They churn in and out of coverage rapidly, leaving a much smaller core of permanently uninsured than many imagine.<sup>108</sup> This means that it is hard to hang a middle-class face on the picture of the uninsured. They are politically vulnerable: downsized older employees trying to hang on until Medicare kicks in, young people just out of college, immigrants working in small businesses or off the rolls. Because they lack clout, when times are tight—as currently they are in many states—coverage for the recently uninsured is among the first major programs rolled back.

#### WHY QUALITY IS NOT THE LEVER THAT WILL MOVE THE HEALTH CARE WORLD

Many uninsured Americans receive much less care than they need, and often in the wrong place. At the same time, millions of well-insured Americans receive care that routinely does them little good, or, worse, actively does them harm, or results in modest or uncertain health gains at a large social cost. The extent of poor-quality and harmful care (apart from malpractice) has been increasingly well documented. RAND researchers, for example, have calculated that Americans receive slightly more than half the therapies and procedures that are recommended for a variety of common injuries and illnesses such as heart disease, diabetes, and hypertension.<sup>109</sup> Based on a study of Medicare outlays on end-of-life care, Dartmouth University researchers found that areas with higher Medicare spending, with no evidence of underlying differences in medical need, did not produce better outcomes than those with much lower spending.<sup>110</sup>

While eliminating substandard and unnecessary care is a worthy goal, focusing on quality is not the catalyst that can bring about comprehensive health care reform. This is because improving quality is more likely to raise costs for hospitals, doctors, and employers, at least in the short run. Implementing the kinds of procedures generally recommended to improve quality, such as electronic patient information systems, would present hospitals with tens of millions in up-front costs, without an obvious source of funding. Meanwhile, despite several decades of studies that demonstrate how doctors fail

to act on the best scientific evidence, it is still a rare medical practice that points out and reviews mistakes. This is in part because of medical liability concerns but more fundamentally because retooling skills requires time, resources, and motivation that most physicians do not have. The argument for quality is irrefutable, but the incentives are lacking.

## ANSWERING THE HARD QUESTIONS: WHY THIS PROPOSAL IS THE RIGHT APPROACH, AND HOW IT CAN SUCCEED

### WHAT WILL HAPPEN TO MEDICARE, MEDICAID, AND OTHER GOVERNMENT PROGRAMS?

This proposal will phase out Medicare, Medicaid, and other government programs. Eliminating Medicaid has been proposed many times in the past, notably under the Clinton plan and by Senator Bill Bradley during his bid for the 2000 Democratic presidential nomination. Phasing out Medicare is a far more radical but necessary proposal.

Backers of Medicare always conceived of it as a building block en route to a national health care system. Thanks first to its rising costs and then to the conservative trend in American politics, it has become ever more an anomaly, an exposed bulkhead rather than a foundation stone. Its defenders are increasingly championing a critical ideal—that of social insurance and the dignity of autonomy in old age—rather than the program itself, which is increasingly out of step with modern medicine. The defense is necessary because so many conservative would-be reformers are in fact intent on dismantling the program rather than preserving it in any viable form.

But it makes far more sense to take the offensive and champion a national health program for all Americans rather than to defend a program that will increasingly, and in large measure unfairly, be seen as a case of unsupportable government excess. Medicare spending and spending on private health care have grown basically in tandem,

though not in lockstep, over time.<sup>111</sup> Because Medicare is a major part of the federal budget and is funded through a payroll tax and general revenues, its spending is a matter of public scrutiny and concern.

What should be the essence of the Medicare debate—how much is society willing to spend on the health care of older Americans, and who should pay?—is lost amidst a welter of politically motivated rhetoric about the solvency of trust funds and the obsolescence of government-run health care. The current debate also obscures the even more basic point that the problems of Medicare are those of the American health care system, magnified in certain ways. Under the proposal here, current Medicare beneficiaries would receive a benefit package that is better than the one they receive now, unless they are fortunate enough to have supplemental insurance through one of the few remaining companies that offer generous retiree coverage.

Because it isolates a group—the aged and disabled—with the highest spending on health care, Medicare separates from broader risk pools precisely the group that needs them the most. This has led to an increase in direct government subsidy. (Seventy-five percent of Medicare's Part B, for physicians' and other services, is funded through general revenues, and this is growing faster than Part A.) A social insurance approach makes much more sense for funding Social Security pensions, in which costs are relatively predictable and the link to employment is logical, than for Medicare, which faces the uncertainty of rising health costs and the well-known demographic problems of an aging population.

Medicare represents a significant political triumph and is an overwhelmingly important program. However, segregating the elderly distorts the relationship between generations, magnifies unduly the power of seniors as a voting bloc, and fosters resentment and an unwarranted backlash. It has produced an unhealthy "shadow politics": even proposals to change the program in relatively modest ways, such as relating premiums to incomes, produce a high level of indignation and suspicion.

When Medicare was enacted in 1965, seniors were truly a group apart: their incomes were much lower than those of the working-age population, and more than half had no access to health insurance whatsoever. Now, even though some 40 percent of older Americans still have incomes below 200 percent of the poverty line, the percentage of seniors in poverty has dropped substantially since the mid-1970s, and the median net worth of seniors who head their

households exceeds that of middle-aged household heads.<sup>112</sup> Payroll taxes cover a diminishing fraction of the program's costs.

It is conceivable that Medicare's costs, which are growing much more rapidly than Social Security's, could unhinge the whole architecture of government pension programs, with disastrous results. Certainly, the Bush administration's tax cuts have greatly worsened the government's long-term ability to pay for these social insurance programs, but the combination of a shrinking payroll base and the price exacted by advances in medical care is not auspicious even in the best-case scenario.

There is a possible opening here for a grand historical bargain: the end of Medicare as we know it for the creation of true national health insurance. It makes no sense, fiscally, politically, or morally, to cover seniors and not to cover tens of millions of working-age Americans. Proponents of a premium-support reform for Medicare were being disingenuous, at best, when they spoke of the advantages of bringing seniors into the same system of medical care as other Americans and children.<sup>113</sup> After all, satisfaction with Medicare greatly exceeds that for HMOs and employer-based private coverage.<sup>114</sup> But in a fully revamped system, in which all Americans participate in the same plans and the linkage to employment is sun-dered, the grand bargain makes a great deal of sense.

### IS THIS PROPOSAL JUST MANAGED CARE ALL OVER AGAIN?

One may wonder how the recommended approach differs from managed care, which dominated discussions of health policy during much of the 1990s. Managed care plans were supposed to accomplish many of the goals laid out here: covering appropriate care and discouraging the overuse of unnecessary or highly expensive care, steering patients toward care in the right setting, and consolidating the medical system. Managed care foundered for many reasons: its abysmal public relations strategy; the greed of managers for short-run profits at the expense of long-term relationships; the adversarial nature of its dealings with doctors and hospitals, who responded in kind; and especially its having been pushed by employers without any input or choice from employees. The tiered system called for in this report promises a network of structured choice, without most of the restrictions on the use of doctors that infuriated many patients.

Decisions will be greatly simplified for patients and health providers. While insurers will be able to make a profit, this design should eliminate many of the more questionable business practices that characterized some managed care plans and stuck strongly in the public mind.

WHY DOES THE GOVERNMENT NEED TO GET INVOLVED IN ESTABLISHING DIFFERENT LEVELS OF INSURANCE COVERAGE? COULD INSURERS SIMPLY MAKE COVERAGE DECISIONS ON A CASE-BY-CASE BASIS? ARE THERE ANY PRECEDENTS FOR THIS PROPOSAL?

Even if new technologies are in fact driving the rise in health care spending and opportunities for achieving medical value are being overlooked, this does not necessarily mean that the government should take the lead in establishing coverage decisions based on standards of cost-effectiveness. Why not let insurers, public and private, determine which procedures they can and cannot cover, using a combination of outright coverage denials and higher copayments for more expensive procedures?

The answer may be summed up this way: stronger countervailing power and greater public awareness, as well as sufficient authority to resist legal challenges, is needed. In order to restrain spending on new technologies, a moral and social consensus must be developed. Americans must recognize that covering expensive and unproven procedures will drive up their premium costs sharply. They are more likely to do so when such spending is no longer disguised through employer-based coverage. No single insurer or well-intentioned employer—or even a consortium of insurers and employers—is powerful or visible enough to bring this consensus into being. Universal standards backed by government are the only realistic way to develop such public awareness.

During the 1990s, many high-profile cases involved challenges to the denial of procedures by insurers—perhaps most notably a cluster of cases regarding the denial of bone marrow transplants as a treatment for breast cancer. These cases generally turned on the question of whether the denial was arbitrary and capricious. Whether HMOs are justified in limiting care is a matter still being adjudicated in state and federal courts. The point here is that a national standard would be far less vulnerable to legal challenge than the specific coverage decisions of individual insurers. Lawsuits would not be forestalled, but the bar for bringing suit would be raised.

There is some precedent for limiting coverage of certain medical procedures in order to make broader coverage more available. The Oregon Health Plan, inaugurated in 1993, sought to extend coverage to a wider cross section of the state's poor and near-poor population through explicitly listing the treatments that would or would not be covered under the plan, based on which procedures were found to be the most important to the health of the population. By covering fewer of the treatments felt to be of lesser medical value, the OHP was able to extend coverage to one hundred thousand additional Oregonians in the plan's first year of operation.<sup>115</sup>

The plan took a considerable thrashing from critics, principally for its upfront willingness to ration care on the basis of need and medical value. In recent years, it has been affected badly by state budget cuts. More low-income individuals joined than expected, and it was harder to draw lines at an acceptable level of coverage when the pool was expanded and resources capped. Moreover, the methodology for ranking procedures was crude, as it failed to take account of the fact that certain treatments may have markedly different values for different patients.<sup>116</sup> Despite these obstacles, its basic premise remains sound. As former Oregon governor John Kitzhaber, its principal architect, summed up the dilemma the plan responds to: "Instead of giving everyone coverage for something, we give some people coverage for everything and others coverage for nothing."<sup>117</sup>

The Oregon plan is the most ambitious attempt to try to reallocate resources so that a greater percentage of the population, not just the truly poor, can obtain access to the most essential treatments and procedures. Other states—including Maryland, Idaho, and Utah—are experimenting currently with efforts to provide a basic coverage package that would permit insurers to decline paying for certain procedures while offering incentives in the form of tax credits for the uninsured to join these plans.<sup>118</sup>

### WILL THE PROPOSAL BE FAIR? WILL CHRONICALLY ILL, DISABLED, AND OLDER AMERICANS GET THE CARE THEY NEED?

One big concern with this plan is that the chronically ill and disabled, who are disproportionately poor, will have to settle for coverage that is unsuited to their needs. What is more likely is that, in almost all cases, a mid-tier insurance plan would be an improvement

over their existing benefits. Most disabled Americans lack decent coverage, face long waiting periods for Medicare, and confront “phantom” provider networks (doctors listed by plans who will not take on new patients) and bureaucratic red tape in Medicaid. Apart from a lucky few—who may be able to “buy up” in any case—the disabled will be better served under a system that places them in the mainstream rather than relegates them to being an afterthought in various government-run programs. Unless America chooses to abandon the disabled and long-term ill, it will have to pay for their care in some fashion, and slightly higher premiums as part of large risk pools would be a more efficient way than via direct subsidies and welfare.

WOULD DOCTORS AND HOSPITALS GO ALONG WITH THE PROPOSAL? WOULD PROVIDERS BE COMPENSATED FAIRLY? WOULD THEIR INCOMES DROP? WOULD THE MEDICAL INDUSTRY SUFFER?

Doctors dislike uncertain and inadequate reimbursements and hassles with insurers. Under this new system, reimbursement will be more secure, not to mention higher for many patients, although some of their more lucrative patients may no longer be covered by such generous insurance policies. There will be fewer restrictions at the patient’s point of entry into the system, which should be advantageous both for doctor and patient. Worries about a patient’s having insurance coverage at all will be a thing of the past, and issues about allowable length of hospital stay and coverage of elaborate procedures will, for the most part, come later in the treatment process. Moreover, patients should have a much better sense of how their coverage works: what is covered and what may not be. This will alleviate a great deal of pressure on physicians. With fewer incentives to “game” the system by steering patients to a more generous payer or facility, doctors should find that simplified insurance coverage makes it easier to exercise good clinical judgment.

Because most Americans will choose a government-sponsored plan, it is unlikely that doctors and their staffs, including specialists, will choose to turn their back on those seeking treatment. The pools of patients on lower insurance levels will be too large to shun, while the higher levels will be too profitable to ignore. Doctors in groups will not be able financially to pull up stakes.

Hospitals have proved themselves to be highly adaptable to almost any changes in health care financing and structure. This has been shown by their response to prospective payment in Medicare (when the federal program began making payments based on the cost of an average treatment, not on actual costs incurred) in the 1980s and by their seeking mergers that weakened the clout of managed care plans. It is the sharp rise in inpatient hospital costs, not the more ballyhooed prescription drug costs, that represents the chief culprit behind today's increasing health care spending. Under the proposal, hospitals would lose reimbursements on some high-paying cases but would gain through an elevated volume of more routine cases, which would be especially advantageous for hospitals that are trying to maintain a generalist approach in their communities. The dwindling number of hospitals that have emergency rooms would save a considerable amount of money that they are currently losing to unreimbursed care.

To be sure, this plan—both in its basic design and in its emphasis on technology assessment—would certainly be opposed by some prosperous specialty hospitals and specialist physicians. However, if costs continue to grow, and the anarchy of the existing system increases, such a proposal may well be viewed as preferable to more restrictive and intrusive government programs.

This subject is tricky, not least because unnecessary and overly expensive health care constitutes income for those that offer the services—not insignificant for an economy in which health care accounts for one of every seven dollars spent, and more in some regions like New England. The point of a health care system, however, is not primarily to provide jobs nor to guarantee a particular income for health care providers and medical personnel, even though the supply of well-qualified doctors, nurses, and technicians should be a matter of concern.<sup>119</sup>

## WOULD HIGHER-END PLANS SUFFER FROM ADVERSE SELECTION?

Why won't people just pay for the basic level of coverage and self-insure for what it does not cover, driving up premiums for the higher-level insurance plans? Some people will. But there are many among the affluent who will prefer peace of mind. There is a competitive

element as well. Used cars of all kinds do just about everything a new car will, but people are willing to pay a huge premium for the status and reliability of a brand-new car. To be sure, one cannot flaunt a health insurance plan in quite the same way as a new Porsche Boxster, but just a few cases in which wealthier people cannot see their preferred doctor or have to pay the full freight for a procedure of choice available only on a higher level will likely convince them to join a higher-end plan. The availability of long-term care coverage under the top-end plan also should encourage better-off Americans to elect it.

High-end coverage may appeal to certain kinds of individuals other than the affluent, among them the risk-averse and those who want assured access to new treatments. Conversely, having lower rungs in the ladder will allow those with preferences for less extensive benefits to pay less and assume a greater risk. Not only younger and poorer Americans will choose the basic plans. It will capture the preferences of those who have little interest in prolonging their lives through largely untested and heroic measures.<sup>120</sup>

Purchasing at least the lowest level of coverage will be mandatory, as with most automobile insurance, while moving up to the remaining tiers will be voluntary. The point will be to make the benefits generous enough to obviate purchasing extra, supplemental insurance, though doubtless some will want to do this. Politically, the sense that one is not “locked in” to the government program is important. Over time, and with the elimination of the employer health subsidy, sustaining such outside private policies will become difficult. No doubt a booming market in alternative medicine not covered by the publicly sponsored program will remain.

WOULD AMERICANS BE WILLING TO GIVE UP THEIR  
EMPLOYER-BASED COVERAGE? WOULD SOME EMPLOYERS STILL  
PARTICIPATE? WILL ORGANIZED LABOR RESIST THE  
IMPLEMENTATION OF THE PLAN?

As the historian David Rothman writes, “If Americans do not have national health insurance, it is because the middle classes have been unwilling to support it.”<sup>121</sup> The late Richard Neustadt, a political scientist, put it more bluntly, “Americans are too selfish to support national health care.”<sup>122</sup>

Many Americans—including those who retain good health coverage—think that the current system is inequitable and inefficient, and most support covering the uninsured in principle.<sup>123</sup> But a critical mass of well-insured people have been satisfied with their care under a private, employer-based system and think that any alternative system will be much worse.<sup>124</sup> Or, if they can envision an alternative (a Canadian-style, single-payer plan is the best example), no majority consensus can be formed on any specific proposal.

This may be changing as employers pare back their coverage. Many Americans are uncertain that they can weather a health crisis. Just as their pensions may be in jeopardy, and their savings look precarious, they could face a potentially steep rise in medical costs. Hedging against retirement costs and living more frugally is one thing, but budgeting for unanticipated health care costs is another. Indeed, personal bankruptcy filings by Americans and indebtedness among older Americans have reached an all-time high, and the underlying cause for many is a health emergency.

Union members and leadership can be expected to dislike this proposal perhaps most of all. Samuel Gompers and other leading union figures of the nineteenth and early twentieth centuries were skeptical of national, government-run health insurance ideas from their inception, and union support was critical to cementing the employer-based system in place. Truly severing the linkage between jobs and health benefits would remove what has been a pillar of solidarity in the dwindling U.S. labor movement. Few strikes and “job actions” fail to have health benefits as a central point of contention. However, the trend is toward job mobility, and having many jobs in a lifetime militates against this sort of organized opposition to a shift in health coverage paradigms. The alternative is the renaissance of more robust unions across more sectors of employment, but this appears unlikely to occur.

Inevitably, many Americans will pay more out of pocket for insurance under the new system since they no longer will be shielded by their employer subsidy from the true costs of health care. This is a potentially fatal obstacle. But this source of opposition may dissipate if people understand the degree to which they are paying for their current insurance indirectly in the form of lower salaries and higher payroll and income taxes. This is a task for public education and strong political leadership. Current beneficiaries of government programs will indeed bear more of the risk of rising medical costs. But because the government has more leverage in negotiating with

insurers than any individual employer, it will have a greater ability to manage increases in premiums and underlying health costs.

As noted above, raising out-of-pocket costs and premiums for currently well-insured Americans would until recently have been a political nonstarter. However, the rapidly accelerating trend toward cost sharing in the private insurance sector will increase support for a clearer and more efficient way of financing and delivering care. Fewer and fewer employees will continue to receive the generous subsidies that have been characteristic.

Moreover, polls have consistently shown a substantial degree of altruism among the public in its views toward covering the uninsured.<sup>125</sup> The public will back this proposal if premiums and taxes can be kept affordable and if care is meaningfully better or at least no worse than at present.

## CONCLUSION: WHY UNIVERSAL COVERAGE IS CLOSER THAN YOU THINK

An October 2003 ABC News/*Washington Post* poll suggests that the prospects for universal coverage may be rising. By 62 to 32 percent, the one thousand adults in the sample preferred a universal health insurance program over the current employer-based system. Fifty-four percent of respondents expressed dissatisfaction with the overall quality of the U.S. health care system, the highest level found in surveys since 1993.<sup>126</sup>

Such support will surely ebb once particular plans are discussed. And even promising proposals face high hurdles to success. The political scientist Jonathan Oberlander offers a caution to those who characteristically overestimate the chances of achieving wide-scale U.S. health care reform. "Designing an ideal health reform plan that assures access, quality, and cost control is, in comparison, the easy part; designing an ideal plan or even a decent one that has a compelling political strategy to survive the legislative process is the difficult task."<sup>127</sup> Oberlander notes that the main obstacles to passage of such a bill include fragmentation of legislative coalitions, the opposition of interests that wish to maintain the medical status quo, and American skepticism about federal power.

Moreover, because the health care system is so fractured, implementing even modest reforms can be enormously complicated and time-consuming. For instance, a bill enacted in 1997, the Health Insurance Portability and Accountability Act, which established new ground rules for patient privacy, is expected to occupy thousands of hospital administrators for years to come. The inclination is to add layers of complexity to the system and to accommodate each interest that is in place. Because these interests and the media tend to exaggerate the sweep of any health care reform that is under consideration, genuinely far-reaching reform seems ever more elusive.

These doubts notwithstanding, a multilevel, government-sponsored system can be defended as politically feasible. It does not overturn the private structure of American health care. This is a point of great importance for those who are suspicious of encroaching federal power and for those who are accustomed to delivering and receiving health care through private insurance plans. While it will provoke resistance among many sectors of the medical industry, it will appeal to others. It would be far less objectionable to these interests than the single-payer universal coverage proposal that recently passed in Maine or the employer-mandate model rejected in November 2004 by California voters. It should appeal to Americans who are looking for relative simplicity in their health care decisions but wish to retain access to new medical procedures and drugs.

Americans, it is said, will never accept the rationing of medical care. In fact, they accept it now in a myriad of haphazard ways. As premiums continue to rise, it remains to be seen just how resistant Americans will be to options that offer access to excellent care at a reasonable price. This proposal can right a massive social wrong—the lack of insurance coverage for tens of millions of Americans—while creating a solid foundation for financing and delivering the next generation of medical achievements.



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