Making Sense of the National Health Insurance Reform Debate

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As we enter the full swing of the 1992 election campaign, the public is being deluged with proposals to reform American medicine. No one seriously doubts that American medical care is financially troubled and increasingly inaccessible to many.1 In 1991, total health expenditures were approximately $740 billion,2 yet thirty-four million Americans—about 14% of the population—were without health insurance and countless more were underinsured.3 Some health insurance plans are collapsing.4 Others struggle to contain premium increases two and three times the rate of general inflation with “managed care” policies that not only restrict choices but also alienate many patients and physicians alike. Survey after survey finds a majority of Americans dissatisfied with the cost of medical care and fearful about their futures.5

The array of reform proposals, from marginal tinkering to fundamental reform, can easily bewilder. Candidates, political pundits, policy experts—all frame the problems somewhat differently and characterize the “solutions” in quite incongruous ways.6 Acronyms and catchy phrases dominate. President

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1. For example, 91% of chief executives surveyed believed that U.S. medical-care arrangements needed “fundamental change or complete rebuilding.” Philip J. Hilts, Corporate Chiefs See Need for U.S. Health-Care Action, N.Y. TIMES, Apr. 7, 1991, at D1 [hereinafter Hilts, Corporate Chiefs].


3. For range of estimates, see Emily Friedman, The Uninsured: From Dilemma to Crisis, 265 JAMA 2491 (1991) [hereinafter Friedman, Dilemma to Crisis]. Most of those without insurance coverage come from families with a working parent. U.S. GEN. ACCOUNTING OFFICE, CANADIAN HEALTH INSURANCE: LESSONS FOR THE UNITED STATES 24 (1991) [hereinafter CANADIAN HEALTH INSURANCE].


6. At our last count, there were over forty proposals in Congress, a plan by President Bush, and several proposals by the top Democratic Presidential contenders. In town meetings across the country in January, Democratic congressional representatives offered three reforms options: “Medicare for All,” “Play or Pay,” and “Fully Public Single-Payer,” in contrast with a plan to “Modify Current System to Expand Access” (read “tinkering”). See, e.g., Rep. Rosa DeLauro, Remarks at New Haven, Connecticut Town Meeting (Jan. 1992).
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Bush, for instance, describes his plan for expanded tax credits, vouchers and deductions as "comprehensive," but devotes little attention to financing or overall cost control. Both the Heritage Foundation's proposal for mandatory purchase of insurance and Alain Enthoven's oligopolistic "Consumer Choice Health Plan" are advertised as "pro-competitive." Others argue for "managed care," while the New York Times regularly extols "managed competition" as the correct reform of American medicine. Commentators label proposals by Congressman Marty Russo and Senator Bob Kerrey alternatively as "single-payer," "Canadian-style health insurance," or "national health insurance." In examining the array of proposals, most Americans find it almost impossible to separate tinkering from partial, but useful, steps forward, and then to distinguish those steps from fundamental reform. A citizen's guide is needed.

In Part One, we describe some of the contemporary problems with American medicine that frustrate providers and patients alike. We then explore some of the familiar mythologies of America's medical-care debate. We focus particularly on the false claim that any form of universal health insurance, publicly financed or regulated, is incompatible with American values and institutions.

In Part Two, we turn to the relevance of international experience to the current debate. Perhaps the only advantage of being the last industrial nation
to address universal health insurance is that we can draw upon the extensive experimentation of others. From international experience, we note five broad principles of medical-care financing and administration that mark otherwise widely varying programs.

Part Three reviews some familiar frameworks used to describe existing medical-care financing and access problems and to evaluate reform proposals. The conventional labels for plans, we argue, are seriously inadequate. Moreover, the traditional policy analyst's checklist—enumeration of a reform proposal's benefit package, beneficiaries, administration, and financing—gives the appearance of comprehensive analysis without explaining how (or how well) a plan would actually work. These descriptions fail to highlight the scope of reform, the relevant principles that different plans embody, or the particular problems each proposal aims to correct. We suggest ways to distinguish programs that are badly designed Band-Aids from those incremental steps or fundamental changes that provide the basis for durable policy change. We also emphasize that the separate features of competing, viable national health insurance plans cannot be combined without contradictory outcomes. Clear choices must be made.

In Part Four we sketch several different, yet sensible, steps toward universal health insurance. We make two central points: first, regardless of the initial step forward, it is crucial that the administrative and financial structure of the overall program be properly set up at the outset; and second, organized interest groups in medicine and insurance must be challenged to obtain any workable reform.

Whatever approach medical-care reform takes, responsible analysts and policymakers must answer at least the following key questions:

- Who will be insured?
- What medical services will be insured?
- How will the financial burden for the provision of medical care be distributed?
- How will defensible borders be put on what we spend?
- How do we ensure accountability, good quality, and acceptable administration?
I. MEDICAL-CARE REALITY, MEDICAL-CARE MYTHOLOGY

A. The Troubled Reality of Medical-Care Financing and Administration

America's current medical arrangements are economically, socially, and politically unsustainable. Spiralling costs, incomplete coverage, and baffling insurance arrangements head the list of serious complaints. The United States spends more on medical care than any other nation, but dissatisfaction is high, and America's health outcomes (e.g., life expectancy, infant mortality) are comparatively disappointing. Furthermore, during any given two-year period, over sixty million Americans lack health insurance. Even the relatively well-insured worry about gaps in their coverage and the paper work frustrates everyone. Far from a "health-care system," America now labors under a confusing financial mix of private insurance, government-provided insurance for the elderly (Medicare) and some of the poor (Medicaid), Health Maintenance Organizations (HMOs) and other "managed" care programs, the Civilian Health and Medical Program of the Uniformed Services for military personnel and their dependents (CHAMPUS), the Veterans Administration (VA), and employer-provided plans, as well as tax credits, deductions and exclusions.

The American experience offers an object lesson in the inability of privately based controls to constrain overall medical-care expenditures. Instead, as we describe below, such efforts have led to higher administrative costs and growing numbers of uninsured, without significant overall cost containment. Over the last decade, as terms such as "the medical industry" replaced older expressions like doctors, patients, and health insurance, the country pursued a bewildering mix of private solutions: business coalitions at the local level, self-insurance by large firms, experiments in group practice, increases in consumer payments (deductibles, co-insurance), and utilization review and

15. See Hilt, Corporate Chiefs, supra note 1, at D1.
16. See Lake, supra note 5, in this volume.
17. In 1986, life expectancy at birth of U.S. females was 78.3 years, and of males 71.3 years, compared with 79.7 and 73.0 for Canada, and 78.4 and 71.8 for Germany, respectively. The U.S. infant mortality rate (deaths per 1,000 live births) in 1988 was 10.0 compared with 7.2 for Canada and 7.6 for Germany. At the same time, 1988 expenditures as a percentage of GNP were 10.9 % for the United States, 8.5 % for Canada, and 8.3 % for Germany. Organization for Economic Cooperation and Dev., OECD Health Database (1991) (available from OECD, CREDES File) [hereinafter OECD Health Database].
18. See Friedman, supra note 3, at 2491. In 1989, an estimated 33.4 million Americans (13.6%) had no health insurance. Of the uninsured, 25.6% were children. COMMITTEE ON WAYS & MEANS, U.S. HOUSE OF REPRESENTATIVES, OVERVIEW OF ENTITLEMENT PROGRAMS: 1991 GREEN BOOK 307, 309 (1991) [hereinafter GREEN BOOK]. The number of Americans who are without insurance at any one time is larger than the cited figure for the year because people go in and out of insurance status. Sixty percent of Americans were insured through employer plans, while another 12.8% were covered under Medicare, 6.0% under Medicaid, and 7.7% through CHAMPUS, individually purchased policies, or other sources. Id. at 309.
prior authorization arrangements that insurance companies use to monitor and control the provision of services by doctors and hospitals.20

It is no wonder that private health insurance firms have not been able to constrain overall national medical costs.21 Each insurance company makes private decisions to minimize its costs and maximize its profits; individual firms do not make societal decisions about containing societal costs.22 Premiums paid to insurers finance administrative overhead and insurance profits—both essentially waste from the patient’s point of view. Private insurance firms spend large and increasing sums on utilization reviews, marketing, and billing. The result has been a staggering growth of organizational and managerial innovations (Preferred Provider Organizations (PPOs), HMOs, case management, etc.) that have failed to restrain the relentless rise in national health expenditures or to prevent declining access to insurance protection.23 As Ken Macke, head of the Dayton-Hudson retail chain and a spokesman for the National Coalition for Health Care, told a congressional committee in June 1991:

[W]e have tried everything—increased employee cost-sharing, second surgical opinions, health promotion and prevention, and managed-care options like health maintenance organizations—and still our premiums went up 15 percent. Private cost control ... has failed.24

The “pro-competitive” reform efforts of the 1970s and 1980s, which sought to promote price competition in the medical market, have created disappointing (and sometimes perverse) results. “The increasing emphasis on competition and managed care has,” in the words of one Canadian critic, “set many new places at the health-care feast. These administrative overheads, which, from the Canadian perspective, are just so much waste motion, add $50-100 billion to American costs.”25 The U.S. spends an astonishing one-fifth of its health-

21. For an excellent account of the costs of relying on for-profit, private insurance companies in providing health insurance, see 1 CANADIAN ROYAL COMMISSION ON HEALTH SERVICES 732 (1964). Seeking profits by excluding individuals who are sick from insurance is not what insurance is supposed to be about. As Winston Churchill said, insurance is “the application of averages for the relief of millions.” Id. at 10.
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care dollars on billing and other non-medical administrative costs.26 “Indeed,” as Robert Evans has shown, “Canadians spent less per capita to administer universal comprehensive coverage than Americans spent to administer Medicare and Medicaid alone (about $26 U.S. per capita).”27

26. Amitai Etzioni, Health Care Rationing: A Critical Evaluation, HEALTH AFF., Summer 1991, at 88, 91. One estimate is between 19% and 24%. Steffie Woolhandler & David Himmelstein, The Deteriorating Administrative Efficiency of the U.S. Health Care System, 324 NEW ENG. J. MED. 1253 (1991); see also David U. Himmelstein & Steffie Woolhandler, Cost Without Benefit: Administrative Waste in U.S. Health Care, 314 NEW ENG. J. MED. 441; Morris L. Bazer et al., Canadian/U.S. Health Care: Reflections on the HIAA’s Analysis, 10 HEALTH AFF., Fall 1991, at 229, 233-34 (“average annual growth in real per capita costs for administering the U.S. system was over 5 percent; in Canada, this figure was about 1.6 percent”). Administrative costs come in many forms. Some are recorded, while others are hidden—like the countless hours spent by patients filling out forms.

27. Robert G. Evans et al., Controlling Health Expenditures—The Canadian Reality, 320 NEW ENG. J. MED. 571, 573 (citation omitted) (1989) [hereinafter Evans et al., Canadian Reality].
Cost of Health Insurance Administration, U.S. and Canada, 1960-1990 (Percent of GDP)
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An enormously frustrating aspect of contemporary American medicine—for both medical providers and their patients—is administrative intrusiveness. Many insurance plans and HMOs routinely require costly utilization reviews that monitor providers' medical decisions, limit treatment, and constrain patients' choice of doctors and hospitals. The paperwork associated with this complex system of financing and professional oversight not only contributes to substantial and rapidly rising administrative costs, but also confuses patients and angers doctors. Such controls, claims one critic, are "crippling the soul of the kind of doctor we should all want to preserve." Indeed, 30% of physicians, according to one recent survey, say they would not have attended medical school had they known what their medical practices would be like.

Private insurance companies, as well as most HMOs and many Blue Cross/Blue Shield plans, differentiate among health insurance applicants on the basis of their expected health risk. Wide-spread screening increasingly leads to outright denials, exclusion of "pre-existing conditions" from coverage, or substantially increased premiums. Small groups and individuals are the usual targets of these practices; they typically face experience-rated premiums (based on past sickness history) rather than community-rated premiums (based on the average per capita costs of insuring a larger group). Families in larger, employer-based insurance pools also routinely face experience-rated premiums. Moreover, because a lost job may mean the loss of health insurance, even employees with good coverage fear becoming "insurance hostages" to their current jobs.

Employer plans and insurance companies require "cost-sharing" (co-payments, co-insurance, and deductibles) by patients in order to shift costs to

28. Utilization review is an administrative monitoring of the services offered or provided by doctors and hospitals. This review is usually undertaken in order to determine whether an insurer or other third-party payer will reimburse the health-care provider for such services. See generally Gray, supra note 20.
patients and reduce utilization. While in 1989, 17% of insured employees had plans with maximum out-of-pocket expenses over $2,000, by 1990 the figure had jumped to 25%. Today, over half of all group/staff HMOs require co-payments (the patients' share of payments which is covered by insurance) for services.

Cost-sharing, in our view, works against the efficient provision of sensible care. It is unlikely to reduce significantly the utilization of high-cost, high-technology, high-intensity services. This is so both because the demand for such services is largely physician-determined and because the costs of such services vastly exceed almost all cost-sharing limits. Cost-sharing does, however, measurably reduce access to preventive care. It also negatively affects children’s health and reduces the life expectancy of poor individuals with high blood pressure. In addition, cost-sharing may reduce the likelihood that those with serious medical symptoms requiring medical attention will actually seek such care. Finally, cost-sharing causes “similar reductions in both appropriate and inappropriate care,” which suggests that imposing costs on patients does not aid them in determining when medical care is really necessary.

Despite having the highest level of direct patient payment of any Organization for Economic Cooperation and Development (OECD) country, American utilization rates have continued to rise. It should be noted, however, that more of the increase in national health expenditures in the 1980s was attributable to medical price inflation than to increased utilization or population

35. Insurance schemes include cost-sharing on the assumption that insurance creates a "moral hazard" that would induce otherwise healthy individuals to seek medical care, free at the point of delivery as a "merit good." Cost-sharing is an umbrella term for out-of-pocket expenses imposed by insurance schemes.


41. Keeler & Rolph, supra note 37, at 363; Kathleen N. Lohr et al., Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis and Service-Specific Analyses, MED. CARE, Sept. 1986 Supp., at S1, S72; Albert L. Siu et al., Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans, 315 NEW ENG. J. MED. 1259 (1986) (interpreting RAND data).

42. Evans, Tension, Compression, and Shear, supra note 25, at 120. The Canadian experience shows that none of the provincial governments believe that utilization is price elastic. “At present, a province which imposed user charges would have its federal grant reduced by the amount of the charges; but it would still retain all savings from reduced utilization. No province now has user charges.” Id. at 120.
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growth. Cost-sharing has not acceptably contained American medical costs. In fact, the administrative expense associated with complex mixes of deductibles and co-payments has added to America's total health expenditures.

B. Myths about American Medical Care and its Politics

Enduring myths about the financing of American medical care have greatly affected the current policy debate. Throughout the history of American medical politics, these mythologies have misshaped the views of many and have substantially distorted the available choices. Consider the following claims.

1. The Market Can Fix It

There are many who claim that what American medical care needs is a healthy dose of competition. The call for more marketplace competition in American medicine is not new. Yet, for good reason, there has not been a fully competitive and free market in medical care in America—or in any other country—in the twentieth century. Few Americans want medical care allocated or denied like ordinary goods and services, and many would fear a world in which doctors, nurses, and hospitals were completely unlicensed and unmonitored and in which drugs and medical equipment were marketed without testing for safety and efficacy. Indeed, few “pro-market” advocates would argue for such a world. In any event, inherent information asymmetries mean that near-perfect competition in the medical-care market is impossible. The question thus becomes: which form of government intervention will foster greater cost control and broader access to quality medical care? Pro-competitive reforms are unlikely to foster either cost control or efficiency, or to lead to broad, fair access to necessary medical-care insurance. The available international evidence indicates that government can restrain medical costs

43. Levit et al., supra note 2, at 30.
44. For a fuller discussion of this view, see infra part III.C.1.
45. President's Program, supra note 7, at 17-26. For a review of the literature, see Marmor et al., Procompetitive Reform, supra note 37, at 1003.
47. See Lake, supra note 5, in this volume. See also Margaret Jane Radin, Market-Inalienability, 100 Harv. L. Rev. 1849 (1987) (arguing that certain values cannot be reduced to market commodity terms).
while ensuring the availability of quality care to all of its citizens. Business-like competition and private cost control probably cannot do so, or, at the very least, never have.

2. The Government Can't Do It

The myth is that Americans mistrust government and doubt that it can do anything right. The reality is more complicated. Americans certainly are ambivalent about government, but they yearn for it to provide them with a sense of security. Historically, Americans have turned towards government in times of dire need (e.g., the Depression, world wars) and spurned it in times of apparent prosperity (the 1920s, the 1980s). For the past two decades, many of the nation's most prominent leaders have stressed government's liabilities, not its capacities, and the media have amplified this scorn. Anti-government rhetoric has further eroded American confidence in the ability of its public institutions to right the obvious wrongs of American life.

As a result, medical-care reformers are powerfully limited in what they can propose without having propagandistic attacks unleashed against them. Proposals for national health insurance prompt a familiar range of countercharges: assertions that the United States government is too corrupt, too captured by interest groups, and too incompetent for public health insurance to work. Critics point derisively at the inefficiencies of the Veterans Administration, the savings and loans scandals, bloated procurement policies at the Department of Defense, and the disgraces at the Department of Housing and Urban Development.

There is, of course, some truth in these claims. The effectiveness and quality of American government does vary. It is demonstrably competent at some tasks, notably among them—and most relevant for the purposes of health insurance reform—are the highly popular Social Security insurance programs. A clear model of incorruptibility is the Federal Reserve Board, which is entrusted with major economic decisions without any fear of scandal.

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52. See generally JAMES A. MORONE, THE DEMOCRATIC WISH (1990); THEODORE R. MARMOR ET AL., AMERICA'S MISUNDERSTOOD WELFARE STATE (1991) [hereinafter MISUNDERSTOOD WELFARE STATE].
53. See MISUNDERSTOOD WELFARE STATE, supra note 52, at 1, 242 n.2.
54. See, e.g., Alain Enthoven, Why We Can't Get There from Here, AM. PROSPECT, Spring 1991, at 20 (letter to the editor) (relying on Defense Department foibles to cast doubt on government's ability to implement national health insurance).
55. MISUNDERSTOOD WELFARE STATE, supra note 52, at 163.
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(though many may disagree with the wisdom of its policy judgments).\(^5\)

Moreover, popular doubt about government competence may wane in the area of medical care. Recent polls indicate that some 83% of Americans believe that it "definitely or probably should be ... government's responsibility to provide health care for the sick."\(^5\)

3. We Can't Afford and Won't Pay for Any National Health Insurance Plan

What of America's massive budget deficits? Can we afford to increase government outlays? Behind these questions lurks another myth: that Americans cannot (or will not) pay new taxes for a national health insurance plan. But these myths assume that Americans do not know (or are unable to understand) that year after year we are "affording" rates of increases in medical outlays that exceed both inflation and the rate of growth in national income.\(^5\)

The way we now "raise" the funds to pay for our $740 billion-plus health budget—through taxes, direct out-of-pocket payments, insurance premiums, and foregone wages for employer-provided insurance—makes it harder, not easier, to choose spending levels that we can afford.\(^5\)

The argument that "we simply can't afford it" states the problem backwards. What we are affording, but do not want, is the system we now have. America leads the world in spending, but has a complex and fragmented system that almost everyone finds objectionable.\(^6\) The problem is not simply affordability. Rather, it is dissatisfaction with the value we get for our money and the conviction of many that we could do better for less expense. Whichever method of fundamental reform the U.S. chooses, the combination of universal access and some form of public constraint on the financing of medical insurance will be critical to cost control. "What Americans have feared as too costly," Paul Starr has noted, "has elsewhere evolved into a system for controlling costs."\(^6\)

Critics claim the public will not pay new taxes to reform medical financing, even if doing so would mean the elimination of most other medical expenses.

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\(^5\) OECD Health Database, supra note 17.

\(^5\) The nominal burden of employer-based health-care costs falls among workers in the form of lower wages, consumers in the form of higher prices, employers in the form of premiums, and taxpayers in the form of lost revenue to the government from deductions and exclusions. See Katherine Swartz, *Why Requiring Employers to Provide Health Insurance is a Bad Idea*, 15 J. HEALTH POL. POL'Y & L. 779 (1990).

\(^5\) See Lake, supra note 5, in this volume.

\(^5\) Paul Starr, *The Middle Class and National Health Reform*, AM. PROSPECT, Summer 1991, at 7, 8 [hereinafter Starr, Middle Class]. See infra part III.
The critics’ assertion, recent polls tell us, is false. If one asks about specific taxes for particular government services, public support rises rapidly. We believe there would be more public support for a tax increase to finance a universal health insurance program than for a more limited but still quite expensive plan to bridge gaps in existing insurance arrangements. A recent survey reported that 63% of Americans favor increasing access to medical care for those who do not yet have it rather than lowering the nation’s health spending, if such a choice must be made. An oft-cited example of a program whose purported beneficiaries refused to pay increased taxes is the Catastrophic Coverage Act of 1988. In fact, an analysis of the Act’s demise reveals instead calculated misinformation, poor design of an otherwise sound program’s financing, and admittedly ill-managed politics. Proponents of today’s major reform proposals would be well-advised to heed the major lesson of this year’s campaign: talk straight to the American public. If Americans reject national health insurance—and with it universal access and a likely reduction in the overall cost of medical care—they should at least not be misled into thinking that hiding health costs is the same as reducing them.

4. The Entrenched Interests Are Too Powerful

American policymakers repeatedly ask if now is the time for universal health insurance. The stunning victory of Harris Wofford in Pennsylvania, the sheer volume of current proposals in Congress, the fact that a reluctant Presi-
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dent Bush was forced to come up with a plan of his own, and the polling data—all suggest that American policymakers would be ill-advised not to act.

Yet some argue that even if now is the appropriate time for a national health insurance plan, and we know how best to accomplish it, American interest group politics will block any meaningful reform. Interest groups do, of course, restrict political maneuverability, and the interests arrayed against national health insurance are particularly powerful; they are well-financed, and have concentrated stakes in avoiding financial losses. There is no way to widen coverage and restrain costs without harming the interests of some of those currently benefitting from our rapidly inflating health industry. It would be unrealistic to believe that fundamental reform is possible without antagonizing powerful political actors.

The fact that the medical pressure groups are powerful, however, does not mean national health insurance is impossible to enact. Quite the contrary. Public support, once aroused, can be overwhelming. The undeniable fact of 1992 is that a very unusual coalition of management, labor, and citizen groups has pushed national health insurance to the political foreground. Any fundamental reform will pit health insurers, as well as many doctors and hospitals, against a variety of employers, employees, unions, the unemployed, those locked into jobs, and those retired from jobs. The latter group will be joined by the growing number of doctors and hospital administrators who believe that the current system is economically and morally unacceptable. Notwithstanding the difficulties ahead, what is essential is that our political leaders take on the task.

II. LEARNING FROM ABROAD: DIFFERENT ROADS TO UNIVERSAL ACCESS AND COST CONTAINMENT

Although few would argue that Americans should or could adopt a foreign system of health insurance wholesale, we have much to learn from how others have provided universal insurance and acceptable levels of care, while simultaneously achieving fiscal stability. “By examining other people’s experi-

67. See President’s Program, supra note 7.
68. See Lake, supra note 5. in this volume; see also Taylor & Reinhardt, supra note 57, at 4.
69. See Lake, supra note 5. in this volume; see also Robert Kerrey, supra note 29.
71. MISUNDERSTOOD WELFARE STATE, supra note 52, at 209-12.

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ence,” Evans has noted, “you can extend your range of perceptions of what is possible....”73 There are two dominant models of health insurance in other advanced industrialized countries from which we believe Americans can draw valuable lessons.74

A. Learning from Canada

The first model, exemplified by Canada (as well as Australia and other nations), combines government-financed insurance with private provision of care. Canada provides comprehensive, universal coverage to its citizens. Each Canadian citizen has a computerized health insurance card which she simply presents to a doctor to receive services. Canadian patients do not have to file claims, much less deal with incomprehensible forms. Canada minimizes administrative costs and reduces frustration through such simplified operations. It wastes none of its medical-care dollars on eligibility determinations, insurance marketing, or risk evaluations to set different premium rates.75 Canadian patients are free to choose their physician and hospital, and their physicians need not obtain approval from administrators for the treatment they recommend. Physicians bill provincial authorities on a fee-for-service basis, and receive payment—to the amazement of many American observers—within three weeks.76

Canada presents a clear example of a single-payer system in operation.77 Doctors and hospitals in Canada are reimbursed from one insurance source, a provincial ministry. Doctors who choose to remain eligible for reimbursement by the provincial plan may not “extra bill” patients by charging an amount in excess of the health plan reimbursement rate.78 Private insurance plans may cover only those services not insured by the provincial plan. Provincial governments use their monopsony power to negotiate fee schedules

73. Robert G. Evans, The Spurious Dilemma: Reconciling Medical Progress and Cost Control, 4
HEALTH MATRIX 25, 26 (1986).
74. See Paul Starr & Theodore Marmor, The United States: A Social Forecast, in THE END OF AN
ILLUSION 234, 250-51 (Jean de Kervasdoue et al. eds., 1984).
75. See CANADIAN HEALTH INSURANCE, supra note 3, at 30.
76. Statement by Michael Decter, Deputy Minister of Health, Ontario Provincial Government, Toronto,
Canada (Feb. 6, 1992) (personal communication from Dr. Hugh Scully, member, Ontario Medical
Association, Committee on Fee Negotiations, Feb. 7, 1992). Canadian hospitals and other medical-care
providers save a significant amount of time and money because they do not need large billing departments
or personnel to keep track of numerous, complicated forms, eligibility determinations, or billing. CANADIAN
HEALTH INSURANCE, supra note 3, at 33; Woolhandler & Himmelstein, supra note 26, at 1253. In Canada,
doctors spend 36% of their gross income on overhead, while American doctors spend 48%. CANADIAN
HEALTH INSURANCE, supra note 3, at 39.
77. Single-payer is somewhat of a misnomer, since the ten Canadian provinces, two territories, and
the federal government are each payers. Monopsony is also somewhat of a misnomer because providers
in Canada have organized into a collective bargaining unit, thus creating a bilateral monopoly between
providers and provinces.
78. Canada Health Act, ch. 6, § 12(2), 1984 S.C.; CANADIAN HEALTH INSURANCE, supra note 3,
at 20.

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(uniform rates at which insurers reimburse providers) with physicians, and global budgets (including operating and capital budgets) with hospitals. Budget negotiations between medical-care providers and provincial health-care administrators are periodic, noisy, and contentious affairs—but unlike the negotiations of private insurance companies and providers of "managed care" in the United States, they are open to the public and therefore subject to influence through the political process. The Canadian health insurance plan is financed through income, payroll, and sales taxes.79

Canada’s universal health insurance permits a good deal of local variation. The program is largely financed and wholly administered by provincial governments and is adapted to reflect local preferences.80 The federal government does not prescribe the details of provincial administration. In order to receive federal funding, however, the provincial programs must fulfill the five basic principles of the Canada Health Act: They must be universal (covering all citizens), comprehensive (covering all "medically necessary" care), accessible to all (imposing no significant deductibles or co-payment obligations on patients), portable (recognizing the other provinces’ coverage), and publicly administered (under the control of a public, non-profit organization).81

Although Canadians express overall satisfaction with the quality of their medical care, waiting lists have developed for some services, particularly for open-heart surgery and magnetic resonance imaging.82 In response to such problems, public outcry leads to relatively quick reforms.83 While the rationing choices of an American HMO are private corporate affairs,4 Canada’s decisions about spending on hospitals and other health services are publicly debated. Queues, then, result in part from public choices about the relative medical need for particular services, and in part from questionable managerial


80. Local financing averages 60%, but there is considerable variation from province to province. See Robert G. Evans, The Canadian Health-Care Financing and Delivery System: Its Experience and Lessons for Other Nations in this volume [hereinafter Canadian Health-Care]; ROBERT G. EVANS & MAUREEN M. LAW, THE CANADIAN HEALTH CARE SYSTEM: WHERE ARE WE; HOW DID WE GET HERE? 17 (University of British Columbia Health Policy Research Unit Discussion Paper Series 1991).

81. These basic principles allow for regional variation, but the Canadian Health Act ensures that major departures from these principles result in a dollar-for-dollar reduction in federal aid. Canada Health Act, ch. 6, § 15(1), 1984 S.C.

82. CANADIAN HEALTH INSURANCE, supra note 3, at 17, 52; MICHAEL RACHLIS & CAROL KUSHNER, SECOND OPINION: WHAT’S WRONG WITH CANADA’S HEALTH- CARE SYSTEM AND HOW TO FIX IT 1-2 (1989).


84. In the United States, rationing occurs within the private sector through price, administrative pre-clearance procedures, and utilization review. This rationing is more hidden and dispersed than in publicly financed programs like Medicaid, Medicare, and national health insurance plans in other nations.
choices. Mistakes are made, but the provincial agencies are highly visible entities, held to public account for their decisions. The overall quality of care in Canada appears quite high; health status indicators are comparable or superior to those of the United States; and primary care is readily available. In fact, Canada’s overall rate of hospital and physician use per capita exceeds that of the U.S., as does Canada’s ratio of general physicians and family practitioners to the population as a whole. “Patient flight” to the United States, widely cited in the American press, actually occurs quite infrequently.

Before fully implementing universal health insurance in 1971, Canada financed its medical care in roughly the same way that the United States did. At the time, Canada spent approximately the same proportion of its gross national product on medical care as the United States did, and its costs were increasing at about the same rate as U.S. costs. Since 1971, Canada’s health expenditures in relation to its national income and population have essentially stabilized in real terms while ours have steadily increased. Canada now spends 30% less of its GNP on medical care than we do, and the difference is growing.

86. Canadian Health Insurance, supra note 3, at 16, 52.
87. Canada has nearly four times the number of general and family practitioners per person than does the United States. Id. at 37. Canada’s hospitals have more admissions and longer stays. Id. at 46.
88. Id. at 60; U.S. Bipartisan Comm’n on Comprehensive Health Care, A Call for Action: Supplement to the Final Report of the Pepper Comm’n 225-26 (1990).
89. On the debate over these numbers, see John K. Iglehart, Canada’s Health Care System, 315 NEW ENG. J. MED. 202, 778, 1623 (1986); J. Feder et al., Canada’s Health System, 317 NEW ENG. J. MED. 320 (1987); Evans et al., Canadian Reality, supra note 27, at 571; Morris L. Barer et al., Canadian/U.S. Health Care: Reflections on the HIAA’s Analysis, HEALTH AFF., Fall 1991, at 229 (reviewing Edward Neuschler, Canadian Health Care: The Implications of Public Health Insurance (1990)); Edward Neuschler, Debating the Canadian System: A Response from the Author, HEALTH AFF., Fall 1991, at 237; Clyde H. Farnsworth, Canadians Defend Care System Against Criticism, N.Y. TIMES, Feb. 17, 1992, at A14.
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Canada and U.S., 1960-1990 (percent of GDP)

Total Health Expenditures,
The U.S. General Accounting Office has estimated that a single-payer universal health plan like Canada's, if implemented in the United States, could provide universal coverage without co-payments or deductibles for less than the United States currently spends for medical care, and could result in significant long-term savings. While spending less, Canadians were the more content with their medical-care arrangements. A 1989 study, for example, showed that 56% of Canadians reported overall satisfaction compared to 10% in the American sample.

B. Learning from Germany

A second model, exemplified by Germany, utilizes "all-payer" rules to restrain costs while providing what amounts in practice to universal medical insurance coverage. Germany assures this near-universal coverage through a complex array of 1,128 non-profit insurance organizations known as "sickness funds." The sickness funds act as intermediate institutions between the ultimate payers (consumers) and the providers. The funds are financed through premiums that are related to salary, wages, and payroll, and that vary by fund. The federal government administers health insurance plans for the uninsured. Retirees usually are covered by the sickness fund of their former employer. All those who earn under $36,000 per year—approximately 75% of the population—must participate in one of the sickness funds. Those who earn more than that amount may either join the sickness funds or purchase private insurance.

The participants in the U.S. debate regularly mischaracterize the German model as analogous to America's fragmented world of medical financing, despite the sharp differences between private insurance firms in the United States and the non-profit German sickness funds. In fact, the actors in

90. CANADIAN HEALTH INSURANCE, supra note 3, at 67-68.
92. A system is an "all-payer" system when every person paying for a health-care service pays a price set by the same rules.
94. A small minority (8%) consisting of relatively wealthy eligible Germans have opted out of the sickness fund system; once they opt out they must remain out for the duration of their lives. These individuals are not covered by the all-payer rules. About one-third of those eligible to opt out choose to do so. THE EXPERIENCE OF FRANCE, GERMANY, & JAPAN, supra note 93, at 29 n.13.
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German medical politics are stable players in a well-structured, culturally distinctive game. The German federal government steers the negotiations between collective bargaining units of medical providers and labor-management representatives from the sickness funds. These negotiations set fee-for-service schedules, which are subject to regional budget limits. State governments and the sickness funds negotiate with hospitals to set per diem reimbursement rates.

Although the German medical insurance system may appear non-governmental, German public officials play a key coordinating role in the complex negotiations among labor, management, and intermediary institutions that some German experts term the "middle way." This arrangement allows for marginal variation among funds, but most Germans have what amounts to the same benefits and comparable financial burdens of premium payments and payroll taxes. Because revenue comes almost exclusively from social insurance contributions, expenditures and accountability are reasonably transparent. Most sickness funds today are pooled locally, regionally, nationally, and/or by profession, rather than on the basis of individual employment. Moreover, most German citizens remain in their sickness fund, even if an employment-related fund, for all of their life. This hardly resembles the changing public and private mix of insurance carriers, contracts, and coverage that marks American health insurance.

Germany developed its system over one hundred years ago, when Bismark coopted the arcane labor guild system. One liability of the German approach is the considerable administrative expense imposed by its multiple sickness funds. In addition, employment-based health insurance entails a nominal distribution of the substantial costs of employee medical care to firms. In that respect, the dispute over financing health insurance through employers sets one class of interests—insurance firms and related companies—against another—employers trying to shed this expensive nominal component of their labor costs. Finally, employment-based health insurance relies heavily on job continuity in Germany; that model of universal coverage would face additional

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99. That nominal burden in actuality falls among workers in the form of lower wages, consumers in the form of higher prices, and employers. See Katherine Swartz, Why Requiring Employers to Provide Health Insurance Is a Bad Idea, 15 J. HEALTH POL'Y, POL'Y & L. 779 (1990). In any event, any system that constrains health-care costs, including an employer-based system such as a pay or pay plan with strict all-payer rules, would be far better for competitiveness than maintenance of current medical-care arrangements or reforms that failed to constrain costs.
implementation barriers in the American context where workers often switch jobs.

C. Financial and Administrative Lessons from Abroad: Adaptations for the United States

No one sensibly argues that a model from abroad should or could simply be imported into the United States. But Americans can learn from countries like Canada and Germany which, with very different institutional arrangements, have managed to constrain costs, universalize coverage, and maintain satisfactory levels of quality in medical care.

1. Principles

Five principles have gained wide acceptance abroad and provide useful guidance for medical-care reform in the United States:

- Universal insurance coverage for all Americans;
- Comprehensive, broad coverage of ordinary medical care, comprehensibly formulated and described;
- Concentration of financial responsibility and political accountability to control costs;
- Freedom to choose providers and provider-patient autonomy in medical treatment decisionmaking; and,
- Portable rights to insurance not contingent on a specific job or geographic location.

Each of these principles can only be sketched briefly here.

a. Universality. Insurance coverage for all Americans is essential for several reasons. Universality avoids the problem of "free riders"—uninsured patients who receive care others have to finance. If accompanied by some form of fee limits, broad coverage helps prevent cost-shifting from patients who will not or cannot pay higher medical prices to patients who will and can pay higher prices, a practice that thwarts cost-control strategies. Universal protection (in the same or similar plans) means as well that American voters would concentrate their political attention on the cost, quality, comprehensiveness and efficiency of the national health insurance program instead of dispersing it on the countless, fragmentated insurance organizations they now separately face.
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b. Comprehensive Benefits. Benefits must be both comprehensive and comprehensible for health insurance to be regarded as a reliable source of economic security. Even those Americans who have insurance worry that the fine print of their plans will rob them of insurance protection precisely when they need it most. Comprehensive, understandable benefits promote other aims as well: reducing wasteful bureaucratic hassle, eliminating cost-shifting, and promoting autonomy in the choice of providers and in the medical decisions that doctors make with patients.

c. Political Accountability. Politically accountable administrative and financial decisionmakers appear to be the sine qua non of effective cost control. Our fragmented system for financing medical care leads cost-conscious players to address their own program's costs, not the costs of American medicine. Cost-shifting makes it quite difficult to achieve any overall cost restraint. Like squeezing a balloon, efforts to control one's own costs by cost-shifting to others spreads costs around rather than containing them.

Without political accountability, medical providers over the past two decades increased their prices and fees while consumers and payers had no means to limit total outlays. The result, predictably, has been persistent medical inflation. Countervailing buyer power, comparative research shows, has been the necessary (though insufficient) condition for balancing inflationary forces in modern medicine. When combined with political accountability, this buying power can offset the medical-care industry's obvious cultural authority and informational advantages.

Political accountability involves, in part, making medical-care expenditures visible to the public. Public financing through earmarked provincial premiums and federal and provincial taxes make Canadian health outlays highly visible. Politically visible financing in the American context may mean that individual Americans, instead of paying a mix of out-of-pocket expenses, premiums for health insurance, and direct and indirect taxes, would pay explicit premiums

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100. Plans with incomplete benefits coverage can increase cost-shifting because, to the extent uncovered-but-necessary services are nevertheless provided, someone other than the insurer will in fact pay for that service—whether the consumer, the provider, or another patient who is charged more by the provider to “compensate” for lost revenue to that provider from the uncovered service.

101. Federal efforts to restrain increases in the cost of Medicare and Medicaid, for example, do not appear to have significantly restrained medical inflation overall. Such restraints may have sometimes resulted in the denial of care to the poor because many providers refuse to treat patients at those rates; other providers shift costs to other payers through higher service fees in an attempt to recoup perceived “losses” incurred in treating poorer patients. President Bush's initial proposal to reduce payments in the Medicaid and Medicare systems to pay for tax credits for health insurance would shift costs and reduce access for the poor and elderly rather than constrain costs overall. See infra part III.C.1.


103. Id. at 35 (citing examples of Britain, Canada, and France). See also Pfaff, supra note 51, at 21-22. How such countervailing power works to restrain costs, we leave to part III.D.
to a universal health insurance program. In the aggregate, Americans could well pay less for a sensible national health insurance program than they pay under present arrangements. Federal premiums could be earmarked, or set aside in a trust fund, to assure Americans that their medical-care dollars are going only to that program. What is more important than the precise method of the levy is that the financing be publicly debated and publicly negotiated.

d. Free Choice of Providers. Most Americans want the freedom to choose their doctors and other medical-care professionals without interference, whether from health maintenance organizations (HMOs), insurance companies, or the government. Moreover, American doctors understandably want freedom to provide care without distracting second-guessing or pre-clearance procedures.

e. Portability. There are good reasons for not tying medical insurance to employment. The lack of portable coverage locks workers into jobs some would rather leave. It makes others fearful that if they lose their job, they also will lose their health insurance. It further concentrates risks and costs in relatively small groups. Particularly in a context of low union membership and fewer long-term relationships between workers and employers, linking insurance to employment makes far less sense than in earlier decades.

2. American Values

As we have shown, the political debate over medical-care reform is cluttered with numerous myths about the American philosophy of medical care financing and administration. Contrary to the rhetoric of many medical interest groups, it is the values of universal health insurance that resonate with American traditions, not those expressed by our contemporary arrangements. As Uwe Reinhardt and Humphrey Taylor have shown: "The American health-care system does not match American values"; it does not reflect “the ideology or

104. CANADIAN HEALTH INSURANCE, supra note 3, at 67-68.
105. See, e.g., H.R. 1300 (Russo); H.R. 650 (Stark); H.R. 2535 (Waxman); S. 1177 (Rockefeller) (all bills from 102d Cong., 1st Sess. (1991)).
106. See Herzlinger, supra note 30, at 69; Humphrey Taylor et al., Physicians' Responses to Their Changing Environment, in SYSTEM IN CRISIS, supra note 5, at 149.
107. Thierry Noyelle, Toward a New Labor Market Segmentation, in SKILLS, WAGES, AND PRODUCTIVITY IN THE SERVICE SECTOR 212 (Thierry Noyelle ed., 1990). Linking insurance to employment made much more sense from the 1920s to the early 1970s (an era of firm-specific internal labor markets), when it was useful to employers as a worker-bonding device and in a social sense as a means of identifying large, heterogeneous, relatively stable, risk pools. See SANFORD JACOBI, EMPLOYING BUREAUCRACY 197, 266, 276-78 (1985).
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social ethic of most Americans." Despite much protestation to the contrary, American medical values do not differ significantly from those of citizens in other industrial democracies. Large majorities of Americans, for example, believe that no one should be allowed to be bankrupted by high medical costs; that the poor and the unemployed should have access to the same care, when equally sick, as the rest of the population; that people with heart conditions or cancer should not pay more for health insurance than those who are healthy; and that government should ensure that everyone gets the medical care he or she needs. It is absurd to assume that the system we now have is the one we want simply because we have it. The system we have reflects bargains, anticipated and unanticipated outcomes, and shifting victories for particular parties and interest groups—none of it neat, simple, or satisfying.

Any national plan for universal insurance would require adaptation to American circumstances. For most industrial democracies, universalization of coverage has meant socialized sickness insurance, not socialized medicine. National health insurance relies not only on the pooling of community risks but also on individual responsibility. Sensibly designed, national health insurance is compatible with considerably greater autonomy for physicians and patients than Americans now experience. It permits the expression of voice—democratic accountability and robust public debate—to guide medical-care decisions now made by fragmented corporate actors and providers. Finally, national health insurance avoids stratifying the delivery of medical care

111. Eli Ginzberg has argued that after World War II, Americans obtained the health-care system that "they wanted and were willing to pay for," and that "[t]here is no evidence that the American people want to change this system." Eli Ginzberg, U.S. Health Care Policy in 1990: Looking Back, Looking Ahead, 30 Q. Rev. Econ. & Bus., Winter 1990, at 15, 21.
112. Marmor, American Health Politics, supra note 102, at 40.
113. Id.
114. See, e.g., 1 Royal Commission on Health Services 3-4 (1964).
115. On the concept of influencing public institutions through the options of public criticism and participation (voice), opting out (exit), and changing from within (loyalty), see ALBERT HIRSCHMAN, EXIT, VOICE & LOYALTY (1970).
according to ability to pay. Like Social Security, national health insurance complements America’s version of an insurance-opportunity welfare state. The alleged uniqueness of American values is largely pressure group propaganda.

III. MEDICAL-CARE FINANCING AND ADMINISTRATIVE REFORM

A. Competing Approaches

At the heart of the reform debate in America lie two fundamentally different approaches to controlling medical-care costs while expanding insurance coverage to all Americans.

1. Micro-Economic Medical-Care Decisionmaking

One approach, guided by neo-classical micro-economics, presumes that there is insufficient price competition in medicine and that first-dollar insurance (without cost-sharing) induces wasteful and financially costly patient demands. This view appeals especially to conventional economists like Mark Pauly, organizations like the Heritage Foundation, and pro-market advocates within the Bush Administration. The solution requires economic disincentives to seek care: deductibles and co-payments to reduce patient demand, and monitoring the services supplied to counteract the expansionary incentives of fee-for-service medicine. The model also prescribes micro-level, decentralized adjustments to determine the provision and expense of medical care. In this analysis, the point of contact between provider and patient

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116. Marmor, Mashaw, and Harvey have characterized American social welfare programs, including Social Security, as embodying two core principles: social insurance (the pooling of common risks) and the promotion of economic opportunity. MISUNDERSTOOD WELFARE STATE, supra note 52, at 31-46.


118. By first-dollar coverage, we mean insurance policies that do not use deductibles (payments required of patients before insurance reimbursement begins).

119. Mark Pauly et al., A Plan for ‘Responsible National Health Insurance’, HEALTH AFF., Spring 1991, at 5. Pauly has argued that the emergence of HMOs and managed care has made it more appropriate to analyze health care as if it were an ordinary commodity. See also Mark Pauly, Is Medical Care Different? Old Questions, New Answers, 13 J. HEALTH POL. & L. 227 (1988).

120. See A NATIONAL HEALTH SYSTEM FOR AMERICA (Stuart Butler & Edmund Haislmaier eds., 1989).

121. See PRESIDENT’S PROGRAM, supra note 7, at 31-44.

122. In contrast, we argue that in the current U.S. system, because of the inherent information asymmetry between provider and patient, and with cost-shifting and free ridership, providers can drive medical-care costs too high. The asymmetry of information is inherent in the doctor-patient relationship and is not a function of rational ignorance caused by the absence of accurate price signals. The problems of cost-shifting and free ridership are inherent in any non-mandatory, non-universal health insurance plan. We argue that only systems which create a financing structure that increases the relative bargaining power
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becomes the proper place not only for decisions about the provision of care, but also about its financing.123

Ironically, most "pro-competitive" reformers propose extraordinarily complex regulatory schemes that impose restrictions on practitioners and patients, are not likely to be implemented as planned, and, in any event, will not have the positive payoffs these advocates claim.124 American patients and doctors now rank among the most highly regulated in the world precisely because of efforts by governments, employers, and private insurers to cope with the market's fragmented distribution of cost-containing efforts.

2. Macro-Political Medical-Care Decisionmaking

An ideologically opposite approach underlies the financing and administrative arrangements of health insurance in most other industrial democracies. Nations like Canada, Germany, the Netherlands, Australia, and Japan set up negotiations between providers and payers in a manner that increases the bargaining power of the latter.125 In Canada, for instance, negotiations take place regularly between provincial governments (acting on behalf of taxpayers and patients) and medical organizations (like hospitals or physician groups). In Germany, the government sets strict guidelines for fee schedules and hospital budgets, and then permits some marginal variation among sickness funds in premiums and benefit supplements. In both cases, the aim is not to reduce services by either raising the out-of-pocket cost of care to patients (through cost-sharing) or by second-guessing providers (with utilization reviews to settle what gets paid for). Rather, the goal is to constrain the overall costs of services provided on the basis of individual doctor-patient consultation. In this analysis, the doctor's office is the proper forum for decisions about appropriate care, but not for decisions about financing. These decisions are made collectively and publicly.

Ironically, the second approach, while calling for a more unified gov-
ernment structure, presumes a more modest view of government's ability to intervene at the level of micro-economic, medical decisions about the provision of care. Instead, for example, the Canadian government sets the general rules of the game, provides the public with a collective, accountable mechanism to monitor provision and financing of care, and negotiates budgets and fees. Within those overall constraints, doctors and patients are then free to make their choices.

In reality, American decisionmakers do not face a stark choice between "competition" on the one hand and "regulation" on the other. Their real dispute is over what mix of regulation and competition will best promote cost control, equity, access, and quality of care. The "pro-competitive" approach taken by the Heritage Foundation focuses on price competition among providers. The Enthoven proposal emphasizes competition among a small number of insurers but rejects patient-shopping among competitive hospitals and doctors as a cost-control strategy. The macro-political approach presumes competition among providers on the basis of quality, and relies on administered budgets and negotiated prices to restrain inflation.

B. The Political and Programmatic Consequences of Ideology

The political myths described in Part One can easily distort the political-legislative process—drafting of bills and negotiations over their provisions. Because legislators must pay attention to these supposed truths while working on legislative proposals, they often make concessions to myths. Reform proposals—even ones that set out to be transformative—all too often combine irreconcilable ways to provide and finance health care. Admittedly, the authors are not agnostic about which route towards reform makes the most sense in the American context. We find most of the pro-competitive proposals unpersuasive. We also believe that Canadian-style national health insurance would more likely produce universal coverage and cost control in the United States than would a modified German version of universal access by the aggregation of numerous non-profit sickness funds. Nevertheless, either of the latter two routes, coherently structured and properly administered, would assure universal access to better insurance protection at lower cost than our current arrangements or modest tinkering. Both strategies offer serious reform alternatives. Yet, whichever approach legislators choose, they must avoid confusing tinkering with steps (even small ones) forward.

Some reformers want changes in medical-care finance, but would settle for

partial adjustments in the rules of medical malpractice and insurance underwriting. Others like the Heritage Foundation press for financing to be shifted from employers to individuals through changes in the tax code, in order to discourage what they regard as excessively generous benefits. Still others, like Congressmen Stark and Gibbons, want to use Medicare as the basis of reform, extending its benefits to everyone. These efforts conflict in a number of ways, though it is quite possible that legislators would, in the course of complex bargaining, end up with elements of all three. For example, suppose that in 1993 the Congress, unable to agree on an overall reform of medical-care financing, changed the tax laws to limit deductions for employer-provided health insurance, extended Medicare in marginal ways, and required health insurance firms to ignore pre-existing conditions in selling policies, but did not require community rating for health insurance. The resulting aggregation of changes would likely have these effects:

1. The political momentum for universalizing coverage while changing the fundamental financing rules would be substantially dissipated while inflationary pressures would increase.

2. Insurance firms would face both competition in rates (experience-rating) and restrictions on whom they could legally exclude on the basis of risk. The forces of competition would, in the presence of increased inflation, drive risk selection (avoiding those more likely to use medical care) underground. In short, these changes would increase, not decrease, the incentives to avoid those most at risk for substantial medical expenses.

3. The changes in tax laws would reduce the generosity of coverage without much effect on the determinants of medical inflation. That would mean increased total expenditures at the very time political support was mobilized—a sure recipe for disappointment.

In the United States, perceived political constraints have led to a stalemate in health policy. This situation arises in part from American constitutional design and in part from current political practice. In the American version of liberal democracy, politicians never know if they have enough votes for a particular legislative proposal. Coalitions form and generate endless varieties of proposals. The combination of agreed-upon medical-care financing ills and imagined or real political constraints has brought us an array of reform proposals. For example, the perceived constraint that reform must build upon current employer-based health insurance guides many plans. Yet our current insurance arrangements did not come about because they perfectly mirror American


beliefs and desires. We stumbled upon employer-based insurance partly because during World War II wages were strictly controlled and fringe benefits were less tightly regulated. There is very little evidence that Americans prefer the employer-based aspect of our present arrangements, rather than the tax-subsidy aspects of it. There are, however, some who incorrectly believe that when employers pay for health insurance, workers have not really paid for it in reduced wages.

Presumed constraints affect the details of specific proposals as well. For example, reform plans often incorporate co-payments designed, theoretically, to reduce patient demand, but which also permit the purchase of private insurance to cover co-payments. This combination, of course, sharply reduces the cost-containment benefit that patient charges are meant to produce. The concession to private insurance for co-payments proceeds from both a frank acknowledgement that co-payments are unpopular and a political judgment that leaving market opportunities for private health insurance firms will reduce the number of opponents to reform within the insurance industry. We suggest that two flawed reforms will never make a good one. Such scenarios illustrate how important it is to examine reform provisions in logically related steps and to understand the tradeoffs, politically and substantively, among strategies of reform. This in turn highlights the significance of differing strategies for balancing cost, quality, and access in medical care.

In evaluating plans for health-care reform, we first distinguish among the problems to which the proposals are differentially directed and then classify the proposed solutions as tinkering, steps forward, or fundamental reform. For example, we argue that proposals to increase tax credits for health insurance, tinkering par excellence, are incomparable to comprehensive plans that universalize health insurance coverage and transform how financial resources are raised and providers are paid. Second, we differentiate among three ideal types of fundamental reform: (1) competitive insurers and medical-care providers within a system of universal insurance; (2) universal plans that use all-payer regulations to constrain costs; and (3) universal programs that constrain costs through global budgets and negotiated fee schedules. We then analyze a number of specific reform proposals, paying particular attention to the degree and manner in which they fall short of the ideal-types to which they aspire. In evaluating the current proposals, we also highlight some of the incompatible

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130. Even before World War II, American employers experimented with employer-sponsored health insurance as an instrument of personnel policy. In 1942, when the War Labor Board decided that employee fringe benefits up to 5% of wages would not be considered inflationary, employers increased fringe benefits, including health insurance, to attract and retain workers. The great expansion of employer-sponsored health insurance did not occur until after World War II, when unions gained the right to bargain for health benefits. STARR, supra note 14, at 311.

131. Moreover, politically, these cost-sharing "taxes" on the sick reduce what would show upon the public budget as new outlays for any universal health insurance plan.
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components of individual plans.

Many health insurance reforms that merely tinker with the current system are put forward as if they were substitutes for real steps towards fundamental reorganization. Such plans focus, for example, on how to cover the presently uninsured, or how to change the rules of medical malpractice or insurance underwriting. Tinkering proposals are often justified by claims that we need to retain the outstanding features of American medicine. It is important to distinguish obstructionist rationales for tinkering from the valid claim that American politics will not easily permit a single step to universal health insurance. In Part Four of this essay, we discuss what steps, over time, would produce movement towards an ultimate desired goal. The problem with the “tinkering” proposals is that they promise real reform, but provide few reliable benefits to the American public, distract policymakers from more serious work, and consume large sums of the political capital required to transform America’s financing of health insurance.

C. Reforming the Private Insurance Market through Tax Changes or Underwriting Regulations

1. Tax Credit Plans

A number of reform plans rely on expanding health insurance coverage through tax incentives, whether credits, deductions, or changes in who receives such subsidies. While the details vary, the approach is similar: use the tax system to make health insurance more affordable or to distribute more fairly the financial burden of expanding coverage. In this section, we will discuss three variants of this approach: the 1991 plan of the Senate Republicans, the Bush Administration’s proposal of February 1992, and the Heritage Foundation’s proposal for mandatory health insurance with tax reform.

Senator Chaffee and his Republican colleagues on the “GOP Task Force” introduced their reform proposal in the summer of 1991: a plan to increase access to health insurance through tax credits and deductions for small business employees, the self-employed, and those with incomes up to 200% of the poverty line. The plan relies on tax incentives to encourage more widespread

132. President Bush’s health proposal takes this tack, and at the same time highlights the alleged failure of “nationalized systems” of medical care. PRESIDENT’S PROGRAM, supra note 7, at 69-77.
enrollment in health maintenance organizations. In addition, the bill makes insurance more affordable for small businesses through regulatory changes. It also offers federal matching funds to states that create insurance programs for poor people not eligible for Medicaid. The Chaffee bill, like that of President Bush, makes changes in malpractice liability a central part of its reform strategy.

President Bush’s health reform plan also centers on tax credits and deductions to assist in the purchase of health insurance. Poor families not on Medicaid could receive up to $3,750 in tax credits, while families with incomes up to $80,000 could receive some form of tax deductions. Such subsidies would barely cover the annual cost of insurance for an average, healthy family of four. The insurance cost for the same family when one member is chronically sick is nearly three times that amount.

Beyond the tax credits, deductions, and vouchers, the Bush plan is a collection of more modest reforms, wrapped in exaggerated claims. For example, the plan requires states to develop basic health insurance packages and create small business risk pools, and allows states to combine current Medicaid funding with new tax credits to develop a single plan for low-income residents. The plan also calls for tort reform.

The Republican response to the heightened policy competition of recent months is remarkable. President Bush has proposed, however reluctantly, a $100 billion expansion of federal expenditures. His plan also acknowledges most of the problems in health insurance practice that critics have attacked: pre-existing conditions, the lack of open enrollment, inadequate spreading of the risks of those most likely to use medical care extensively, and so on. All of this reflects a substantial change in the President’s presumptions of what is required and possible.

Both the Bush and Chaffee tax credit plans, however, make rather reluctant steps towards universal health insurance. They were slow in coming, do not assure universal protection, and clearly were brought forward only after bolder Democratic reforms introduced in the spring of 1991 had assumed unexpected political prominence. They fail to address seriously the underlying causes of medical inflation and that alone qualifies them as steps in the wrong direc-

134. S. 1936, 102d Cong., 1st Sess. (1991). See also H.R. 3084, 102d Cong., 1st Sess (1991) (would expand current health insurance credit available to qualified families (only $426 in 1991), and limit the amount of health benefits that employees may deduct from income).

135. President’s Program, supra note 7.


137. Id.

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Any increase in financial access, in the absence of cost-containment policies, would worsen the very inflation that has itself prompted much of the reform movement. Moreover, the tax credits and vouchers would be too modest to finance comparatively expensive individual and small group policies, and offer no catastrophic protection.

The most noticed feature of the Bush plan is its failure to specify what new revenue would pay for the $100 billion in new outlays. The President originally had planned to pay for the plan by slowing increases in Medicaid and Medicare. Not only would such financing mechanisms be insufficient to finance the new program, but they also would result in denial of care to the poor and the elderly as a means of paying for the tax credits and vouchers. Congressional Republicans prevailed on the President at the last minute to leave these cuts out of his proposal.

The tax credit plan of the pro-market Heritage Foundation, while sharing the tax incentive feature of the Bush Administration’s reform approach, is a much more fundamental reform proposal. The Heritage approach to financing universal health insurance and to controlling costs reflects a distinctive disciplinary and ideological orientation. It bears all the markings of neoclassical micro-economic theory and conventional public finance. Heritage diagnoses American medical care as suffering from market failures in the private health insurance industry. Thus, to remedy the problem of free ridership in the current voluntary system, Heritage calls for universality through mandating the purchase of health insurance. The legal requirement that everyone be insured is in fact common to practically every system of national health insurance. The Heritage plan, however, differs from other universal insurance programs in that mandatory purchase rather than compulsory taxes (whether social insurance levies or other taxes) serves as its finance instrument. Consistent with conventional public finance theory about subsidizing government intervention to correct market failures, Heritage proposes a financing plan that, in combination with the benefits provided, would be distributionally progressive. Accordingly, Heritage proposes refundable tax credits that would be

139. For a critique of the Bush proposal from those advocating different tax reform, see Tax Credits for Health: Wrong Rx, supra note 10, at A18 (arguing that tax credit plans will not constrain costs and insurance complexity will prevent comparison shopping); A Tax Cap, to Cap Costs, supra note 10, at A16 (proposes limiting employee’s tax deduction for employer-provided health plans as means of cost control).


142. See Butler, Tax Reform Strategy, supra note 8, at 2541.
related to the proportion of one's income spent on medical care. Grounded in neoclassical micro-economic theory, the Heritage Foundation's proposal seeks to foster cost-conscious shopping in the insurance market through reliance on out-of-pocket patient payment to ration the use of medical services. The structure of the tax credits would, for instance, favor purchase of plans with higher levels of co-insurance and deductibles. In favoring high cost-sharing, Heritage applies ordinary micro-economic reasoning about the purchase of commodities to medical-care allocation. In addition, by concentrating on plans that insure against catastrophic medical expenses, the Heritage plan further exemplifies conventional economic analysis that the "proper aim" of insurance is to protect against catastrophic, as opposed to everyday, medical expenses.

Finally, taking its micro-economic premises to their logical conclusion, Heritage advocates the elimination of current tax subsidies for health insurance. At the very least, Heritage calls for capping the deductibility of employer-provided insurance. This measure would force everyone to pay for health insurance with after-tax dollars, as we noted above, to foster more "cost conscious" shopping in the insurance market. The Heritage proposal does recognize that this newly structured market would require some regulation. The plan would require states to establish risk pools for especially hard-to-cover cases and, to maintain an adequate supply of insurance policies, states would be required to enforce a number of market-protecting regulations.

Typical of the pro-market thinking of American conservatives, the Chaffee, Bush, and Heritage Foundation proposals rely on a common explanation of America's present troubles. They blame spiralling health costs not so much on health insurers or providers, but on misguided patients overly insured at work. "Free" health insurance, like any other free good, is to the market mind an overused good. Americans, they argue, have an understandable, but insatiable appetite for seemingly "free," first-dollar insurance coverage.

Leaving aside for the moment the incorrect assumptions of this economic theory, if tax credits are left as low as proposed in the various "pro-

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143. See id. at 2541. A refundable tax credit is one that the government will pay regardless of whether one earns enough money to pay at least as much in taxes as is provided by the credit. A refundable tax credit thus subsidizes the working poor.


145. This assumption is quite heroic. Pfaff, supra note 51, at 10; BARER & EVANS, supra note 79; Cf. Hibbard & Weeks, supra note 48, at 1019; Newhouse et al., supra note 48, at 316.

146. Cost-sharing has the potential to lead to inflationary pressures rather than, or even in addition to, reduced utilization rates. This is so because, given information and authority asymmetries in the doctor-patient relationship, doctors can "induce" patient demand for a given service. Physician-induced demand
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competitive" plans, they will result in denial of care to some sick people. Yet, if the credits are made more generous, without countervailing monopsonistic bargaining power, medical inflation most likely will rise at even faster rates. Moreover, the government will end up financing a large part of that increased health insurance bill through lost taxes. The so-called competitive plans rely on an altered insurance market to allocate care to the sick, presume that citizen demands explain most ills of the medical industry, and hold little prospect, even if politically desirable, of constraining future costs.

These plans-gone-awry, in our judgment, reflect a misguided emphasis on euphemistically termed "managed care" and a misplaced focus on patient cost-sharing. Managed care can result in some savings, but reliance on these cost-control efforts themselves is administratively expensive, and "only a minority of companies think that they have been effective. Furthermore, no slowdown in total health-care spending is detectable over the period when managed care has come into widespread use."147

In addition, insurance market reforms that rely on cost-sharing assume that a major cause of cost escalation is consumer "moral hazard," that is, the notion that consumers seek care that they do not really need because they do not have to pay for it directly.148 It is unlikely that consumers view hospital stays—as opposed to health—as a good to be sought out. In any event, OECD data, "do not support the claim that higher consumer payments and cost-sharing—or more generally, more market-type pricing—would lead to lower health expenditures per capita or as a share of GDP."149 Indeed, such data "clearly contradict the theoretical propositions derived from micro-economic demand theory about the rationing function of prices and cost-sharing."150 In addition, cost-sharing unacceptably rations medical care by ability to pay.151

coupled with cost-sharing would thus lead to higher prices rather than reduced utilization. On physician-induced demand, see HENRY J. AARON, SERIOUS AND UNSTABLE CONDITION 14-16 (1991). On the inflationary impact of such physician-induced demand, see sources cited supra note 80.


149. Id. at 14.

150. Id. at 20.

151. Another indicator of the current medical economy—the supply of providers—is further evidence that the medical-care market is not curable by altered economic incentives alone. Would increasing the supply of lawyers reduce the amount of costly and needless litigation? Even the most ardent supporters of competition would generally acknowledge that more lawyers create more litigation. The same appears to be the case for doctors. Sharp increases in physician supply have strengthened the pressures for increased utilization and expenditures over recent decades. Canadian physician supply, for example, has increased by over 70% in the last two decades, with the supply of physicians exceeding the growth in population by 2.3% per year. Fascinatingly, this rate of growth in physician numbers practically matches the increased per capita utilization of medical-care services over the same period. A belief that excess numbers of physicians will restrain expenditures is, according to cross-national evidence, a very serious and expensive
In sum, the prescriptions of the market ideologues rest on a number of mythological assumptions. An imperfectly competitive market has not led to cost restraint or universal access. A perfectly competitive market for medical care in a market fraught with asymmetric information and biased risk selection is impossible. Medical care is not just another commodity like automobiles. Obtaining hospital care "is hardly like shopping for a new car. It is more like looking for a tow truck and a mechanic at 2:00 A.M. on a deserted road in the middle of nowhere. You take what you can get, you do what they say, and you pay what they charge."

Even if such a perfect market for medical care were possible, it would be undesirable in many respects as a way to allocate and finance medical care. Market allocation restrain consumption at an unacceptable price for most Americans: rationing needed care by ability to pay while wasting a good deal of money on administrative complexity. A recent survey reported that nine out of ten Americans believe that "everybody should have the right to get the best possible [medical] care" and that 66% of Americans think it is unfair that some people can afford better health insurance than others. In another survey, 63% stated that they "favor making [medical] care more available to everyone who does not yet have it rather than lowering the nation's health-care spending," if such a choice must be made.

Some plans labeled "pro-competitive," at least in theory, have some chance of success in restraining costs while expanding financial access. Perhaps the foremost among these approaches is the one proposed by Alain Enthoven. Enthoven's approach, while often described as "pro-competitive," actually seeks to develop an oligopolistic health insurance market. Enthoven advocates empowering a small number of purchasing agents (large employers and state-created "public sponsors") to select a small number of insurance plans among which its employees or members must choose. Enthoven's plan is far from unfettered competition. Rejecting the model of price-conscious patients shopping around for doctors and hospitals, Enthoven favors strictly regulating consumer choice of insurance plans and relies on the oligopoly power of sponsors and competition among a limited number of insurers to restrain medical inflation.

mistake. See Evans, 20 Year Experiment, supra note 51, at 496, 504.

152. See Herzlinger, supra note 30, at 69 (arguing that, with reform, consumers could shop around for medical care in similar ways to shopping for an automobile); Mark V. Pauly, Is Medical Care Different? Old Questions, New Answers, 13 J. HEALTH POL. POL'Y & L. 227, 235 (1988) (arguing that medical care is becoming more like any other commodity).


156. Enthoven & Kronick, Consumer-Choice, supra note 8, at 29, 94.
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2. *Tinkering with the Regulation of Underwriting*

Another category of proposals focuses on changing the regulation of underwriting practices. Senator Bentsen’s bill, S. 1872,\(^{157}\) includes new federal regulations for underwriting small groups, federal grants to fifteen states for small employer purchasing programs, tax changes, and adjustments in the Medicare statute to provide benefits for colorectal screenings, immunizations, well-child care, and mammography. Bentsen would also pre-empt state regulations of managed care with federal certification requirements and utilization review programs. Tax deductions for the self-employed would be increased to 100% from the current 25%. Representative Rostenkowski’s proposal (“Rostenkowski I”) parallels the Bentsen plan, with minor variations.\(^{158}\) H.R. 1230, H.R. 3084, and S. 314 propose federal preemption of mandated state benefit laws, while H.R. 2121, and S. 1177 call for reinsurance pooling mechanisms.\(^{159}\) These proposals do not directly address universal access or cost control. Adjustments in underwriting practices may expand access to some, but will not provide the capacity to control the costs of that access over time. Problems of free ridership and cost-shifting will continue. Underwriting adjustments are, in one sense, better than no reform at all, yet to press for them now risks spending substantial political capital on reforms that will not deliver fundamental relief to the American public.

3. *Malpractice Liability Reform*

Finally, another group of what we have termed tinkering proposals concentrates on tort reform.\(^{160}\) The problems of medical malpractice are undeniably serious. Medical malpractice insurance premiums alone cost $5.5 billion; legal fees and malpractice awards amount to $4.1 billion more.\(^{161}\) The indirect costs, popularly termed “defensive medicine,” undoubtedly add to that bill.\(^{162}\) Yet the concerns go beyond legal and medical costs. The threat of malpractice litigation has become a major concern of American doctors. In contrast to the experience of American doctors, Canadian physicians “are only one-fifth as

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likely to be sued."163 The current system is also capricious. For example, experts have found, on the one hand, that there was no medical negligence in 80% of cases in which patients sued, and, on the other hand, that 97% of patients who did suffer from medical negligence never brought suit.164 To complicate matters further, however, malpractice litigation is positively correlated with a reduction in the incidence of malpractice.165

Tort reform thus has a place in any fundamental plan for health insurance reform. By itself, however, liability reform will neither constrain costs nor improve access.166 Moreover, tort reform that limits recovery might also increase the incidence of negligent medical care. We therefore term such liability reform efforts as tinkering. Focusing on tort reform as a panacea to America’s medical ills poses two risks: (1) that we will lose sight of the need for larger-scale reforms; and (2) that we will lose the opportunity to use malpractice reform as political leverage in an overall strategy for medical insurance financing reform. It might, for example, induce otherwise hesitant medical groups to support wide-ranging financial and administrative change.

D. Fundamental Reform through National Health Plans with All-Payer Rules

The widely noted “play or pay” proposals take their particular shape in an effort to build on current employer-based insurance plans. We have grouped the play or pay plans under the heading of fundamental reform through all-payer rules because such plans have the potential, if properly structured at the outset, to control costs through government regulation of fee schedules and reimbursement rates. We pay particular attention in this section to how well these plans address the key role of all-payer rules.

In general, these play or pay proposals attempt to provide universal coverage by requiring employers either to provide health insurance to their employees (“play”) or to pay a tax (“pay”) into a public fund that would cover the uninsured. They all attempt to deal with problems of job “lock-in” by requiring forms of community-rating and limits on pre-existing condition clauses. They provide relatively comprehensive benefits, but with limitations that may exclude some necessary care or undermine patients’ sense of security. All of these plans require significant out-of-pocket payments (cost-sharing) by pa-

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166. See Troyen Brennan, Improving the Quality of Medical Care: A Critical Evaluation of the Major Proposals in this volume.
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tients. Financing comes from a variety of tax sources. In each of these plans, private insurance would continue to play a central role.

The Mitchell-Kennedy-Riegle-Rockefeller bill, known as "AmeriCare,"\textsuperscript{167} embodies the most prominent play or pay proposal. Under its provisions, employers must purchase coverage for employees or contribute a percentage of their payrolls to the public plan. Employees not covered by their employers, those eligible for Medicaid, and other low-income individuals would be eligible for the public plan, which would replace Medicaid. AmeriCare would be administered by the states under federal guidelines and financed through employer and employee payroll contributions and unspecified federal revenues. As with the other employer-based plans, AmeriCare would allow significant out-of-pocket patient payments. A Federal Health Expenditure Board would have the authority to set national spending goals and to negotiate binding fee schedules, in effect creating the potential for an all-payer system. States would be empowered to form consortia to negotiate with providers over reimbursement rates. AmeriCare would require that private insurance plans offer a basic range of benefits, prohibit insurers from excluding pre-existing conditions, and mandate that premiums be based on community rating.\textsuperscript{168} Because of its expansion of access, the Congressional Budget Office estimates that S. 1227 would add an additional $28 billion to national health expenditures.\textsuperscript{169}

Representative Dan Rostenkowski also has introduced a play or pay variant known as the Health Insurance Coverage and Cost Containment Act of 1991 ("Rostenkowski II").\textsuperscript{170} As with the other play or pay proposals, the public part of this proposed insurance plan would be similar to Medicare. States would act as fiscal intermediaries, but the federal Department of Health and Human Services (HHS) would administer the program. A Cost Containment Commission would set national health expenditure targets, negotiate physician payment rates, and prepare global capital budgets for hospitals. As with AmeriCare, Rostenkowski’s bill thus has the potential to set in place all-payer rules to constrain costs. Employers would directly finance 80% of the cost of premiums or pay a 9% payroll tax for all full-time workers in their employ. The benefits package would be similar to Medicare. For physicians, the public plan would set reimbursement ceilings (using Medicare’s resource-based, relative value scales (RBRVS)), but, unlike a fully all-payer system, would also permit extra billing. Enrollees in the public plan would pay a premium, but the government would subsidize premiums for the poor. Medicaid would be

\textsuperscript{168} Community rating refers to setting premiums on the basis of geographic location rather than on the basis of an individual’s past experience of sickness or medical-care use.
continued, but with higher reimbursement rates. Rostenkowski's proposal would raise revenue through the 9% payroll tax, a surtax on income of individuals and corporations (rising from 6% in 1993 to 9% in 1996), higher hospital taxes, and individual contributions of 20% of the premium. Like AmeriCare, the Rostenkowski variant would require a standard set of minimum benefits in private insurance, mandate community rating for their insurance premiums, and limit the use of preexisting conditions in enrollment practices. The cost-sharing provisions would be nearly identical to those of AmeriCare.\footnote{\textit{AARON}, supra note 146, at 125.}

The Waxman and Rockefeller plans\footnote{\textit{H.R. 2535}, 102d Cong., 1st Sess. (1991) (Waxman); \textit{S. 1177}, 102d Cong., 1st Sess. (1991) (Rockefeller).} would follow the play or pay route, preserving Medicare, encouraging employer-based plans, and creating a new public plan which would incorporate Medicaid benefits. For those covered by the public plan, physicians would be reimbursed using adjusted Medicare payment rates. Such rates would be optional for the qualified employer plans. Because these rates would be optional only for employer plans, rather than required for all payers, however, the Waxman-Rockefeller proposal offers the least potential for effective cost-control of all the play or pay proposals.\footnote{\textit{See also H.R. 3535}, 102d Cong., 1st Sess. (1991) (Roybal) (negotiated fee schedules for public plan are optional for qualified employer plans). The Roybal plan has two interesting features not found in other play or pay proposals. First, Roybal's bill would establish an independent federal agency to administer the program. Second, it would incorporate a German-style system for prescription drug payments with use guidelines and pharmaceutical equivalents.}

Under the plan, employers would pay a 7% payroll tax or 80% of premium costs. Corporations and individuals would pay an income surtax. As with the other play or pay plans, employees would pay 20% of premiums, and face deductibles and out-of-pocket expenses with a cap of $3,000. The federal government, as is generally the case for play or pay plans, would provide subsidies for low-income people to enroll in the public plan.

Brookings Institution economist Henry Aaron provides yet another variation of the play or pay plans. His proposal includes "quasi-independent state regulatory agencies" authorized to set fee schedules for physicians, to establish hospital budgets, to finance "regional centers for the provision of particular services," and to serve as the "conduit for federal payments."\footnote{\textit{AARON}, supra note 146, at 142-43.} The federal government would limit total spending, while the state agencies, on the basis of medical efficacy and cost/utility studies not yet widely available, would...
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decide which medical services to fund.\textsuperscript{175} Aaron calls for a gradual transition to community-based rating and government payments for medical expenses that exceed a fixed limit on the financial liability of insurers (stop-loss protection). Depending on the precise liability protected, this “stop-loss limit would be the focus of debate on whether the United States is to retain a mixture of employer-sponsored and public insurance or will shift gradually to all-public financing, with the gradual elimination of private companies from the health insurance business.”\textsuperscript{176} In other words, as the stop-loss limit was lowered, the government plan would assume more of the insurance risk.

The play or pay proponents urge adoption of their plans now, “while leaving for later debate the divisive question of what role private insurance should ultimately play.”\textsuperscript{177} We disagree for several reasons. First, we do not believe that the survival of an industry that most Americans dislike should be allowed to block fundamental reform. Second, why set up a program one anticipates will not work in the hope that it will fall apart in the direction of good policy? If one worries that the United States cannot achieve a fundamental reform now, would it not be better to achieve a step in the direction one considers substantively desirable and politically feasible?\textsuperscript{178} Third, all the play or pay schemes suffer from the same problem: they leave in place a complex, costly administrative apparatus, one that already annually drains billions of insurance dollars away from the provision of medical care.\textsuperscript{179} Moreover, were such plans enacted without strict all-payer rules, America might well be left with “an open-ended ... system, [involving] a multiplicity of payers and managed fee-for-service [that] is inherently inflationary.”\textsuperscript{180}

Most play or pay reform proposals seek to minimize the appearance of taxation and fail to embrace the clear statement that we need fundamental reform—not shoring up a failing private insurance industry. A reasonable forecast is that most of these proposals, if enacted in their original form, would prove unsatisfactory over time. Offering employers a choice of whether to use private or public plans creates perverse incentives. It makes it very likely that the residual governmental program will attract the worst risks and incur the

\textsuperscript{175} Id. at 143, 150. By medical efficacy, we mean the impact on health status of medical interventions; by cost-utility studies we mean investigations of the financial cost per unit of improvement in health status, sense of well-being, etc.

\textsuperscript{176} Id. at 143-44.

\textsuperscript{177} Id. at 152.

\textsuperscript{178} See Lake, supra note 5, in this volume. See also infra part IV.

\textsuperscript{179} Kevin Grumbach et al., Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal, 265 JAMA 2549, 2549-54 (1991); Himmelstein & Woolhandler, supra note 26, at 441-45; Woolhandler & Himmelstein, supra note 26, at 1253-58.

\textsuperscript{180} Morrison, supra note 129, at 16. See also Stuart Butler, 'Play or Pay' Health-Care Plan Is Bound to Be a Loser, WALL. ST. J., Jan. 3, 1992, at A6 [hereinafter Butler, Play or Pay]. Butler argues that the benefits package and laws preventing discrimination on the basis of health characteristics will eventually turn play or pay into pay, pay, pay, and then into a Canadian or British system once we revolt from the excesses of these plans.

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highest per capita costs. How could the government plan not be perceived as a failure under those circumstances? Additionally, implementing such a program would likely lead not to stability, but to a sharp division between the more expensive government program and the less expensive private ones. (This prediction would hold unless the government discourages enrollment in the public plan by setting its premium very high in relation to average health insurance costs. Under that condition, the cost pressures would shift back towards private insurers—hardly the proven recipe for cost containment.) Thus, despite all the talk about “mandatory cost controls,” continuing to use our present insurance apparatus would perpetuate the intrusive, complicated, and costly administration that so bedevils us, while promising little restraint on rampant medical inflation.

Some advocates support play or pay because it appears more “doable” than the more desirable options. For example, Ron Pollack and Phyllis Torda concede that “a pay-or-play system with cost controls is inherently more complex than a Canadian-style system and produces less administrative economy,” but they claim that play or pay “has the political advantage of requiring far less money to be raised in new taxes, thereby making it easier to enact.” We argue that the perceived political constraints and the political feasibility of play or pay are substantially overstated and misunderstood. Employers will not, in general, favor plans that impose more costs on them than they are currently paying in health benefits. Play or pay cannot fail to do so, especially for firms whose employees lack health insurance or have very restricted coverage. More crucially, a plan without effective cost control will not reduce the overall financial burden of medical costs that weigh on the competitiveness of American firms. In addition to problems facing employers under such programs, insurers will not favor a plan that cuts into the private insurance market, as any successful play or pay plan must.

A play or pay program would also retain the high administrative costs of the current system. It would perpetuate the fragmented pools of insured, uninsured, and insured-at-high cost persons, and would diffuse accountability across many actors. Such plans might also burden small businesses and produce discrimination against employees on the basis of health characteristics—not to mention expensive litigation in response. “The key question is not who operates the insurance system,” as Paul Starr has noted, “but under what

182. Pollack & Torda, supra note 181, at 96. Of course, the political feasibility of a given plan is difficult to determine. The stalemate between Nixon and Kennedy over health-care reform in 1974 would indicate that politicians should settle early for less and worry about getting more later; the lesson of the 1965 compromise over Medicare, where early compromise needlessly undermined the ability of reformers to achieve more fundamental ends, would indicate the opposite.
rules it operates."\textsuperscript{184} In large part, the play or pay proponents appear to have learned the first lesson well but have not paid enough attention to the second. Myths about American medical politics, combined with well-financed lobbying by anxious interest groups, have convinced some legislative reformers that what is really desirable is not politically feasible. However, if the play or pay plans that are politically feasible are also unlikely to be desirable, should we not be searching for better combinations of political feasibility and policy design? We believe that there are effective and acceptable alternatives available, if our congressional leaders and the President move beyond conventional wisdom about political possibilities.

Movement toward that goal has been striking in the period since May 1991, when the AmeriCare bill was first introduced with considerable fanfare. As the sponsors sought support, they found disappointingly few converts. Many critics insisted that the bill's cost controls required strengthening and that the incorporation of bargains in the initial formulation had produced too weak a reform package. As a result, a number of play or pay models, including AmeriCare, now do incorporate a serious all-payer regulatory structure and consequently have some promise of constraining costs. The combination of universal coverage and such regulatory provisions leads play or pay plans towards fundamental reform along the German model of politically negotiated, financially responsible fee schedules and budgets. Nonetheless, even these plans retain very substantial administrative costs and promise less restraint on costs than other fundamental reform plans discussed below. Furthermore, the adjustments in these bills have been made in successive stages; the obvious danger is that the coherence of such bills may have fallen victim to partially incompatible and administratively costly "improvements."

E. Fundamental Reforms through Universal Health Plans with Concentrated Buying Power

While it is possible to design workable forms of national health insurance using multiple insurers, international experience suggests that reforms that concentrate financial responsibility and political accountability are more likely to constrain costs over the long run while making health insurance universally available to Americans. Under single-payer arrangements, all Americans would be eligible for the government's insurance plan, but would remain free to choose their medical providers. Such a program, according to estimates of the General Accounting Office, could save over $67 billion in its first year—enough to finance universal coverage without co-payments or deductibles.\textsuperscript{185}

\textsuperscript{184} Starr, \textit{Middle Class}, supra note 61, at 11.
\textsuperscript{185} \textit{Canadian Health Insurance}, supra note 3, at 7.
Why does a single-payer arrangement tend to constrain costs? Pressures to spend more on medical care exist everywhere among the industrial democracies. In fragmented finance systems, each payer is interested in her medical costs, not the overall costs of medical care. Any cost shifted represents a 100% gain to that payer; hence the competition under pluralistic financing to have someone else pay whenever possible. In the United States, this incentive manifests itself in attention to cost-sharing by patients (shifting costs backward), the government requirement that private insurance pay Medicare benefits for certain retired workers (shifting costs sideways), and the reverse, as when companies reduce or eliminate their health insurance benefits and turn employees into potential charity cases for local hospitals and doctors. Under such systems, total costs are discovered, not decided, at the end of the year. The results are expensive, as the American experience demonstrates.

Two countervailing forces appear to be at work in single-payer systems that address medical inflation and unwanted cost-shifting. First, other bureaucratic institutions compete for the tax funds that medical-care claims. These competitors, whether departments of education, transportation, or finance, have obvious organizational incentives to voice what economists term the ‘opportunity costs’ of medicine. Second, concentrating political accountability for insurance powerfully constrains any cost-shifting back to patients. Over the past two decades, Canadian governments have been able to withstand persistent efforts to introduce patient cost-sharing or, with some lapses, to permit extra-billing. The Canadian health professions face what amounts to a consumer’s cooperative in bargaining over what a provincial health budget will be in any particular year. Some provincial politicians have been interested from time to time in off-loading this pressure onto patient charges. The Canada Health Act of 1984 reasserted the public’s ethical presumption against such practices and backed it up with financial penalties on provinces that allow extra-billing. Without the law’s force, it is safe to say that Canadian physician expenditures would no doubt have grown more rapidly through increased patient payments.

This argument for concentrated payer power presumes that bargaining imbalances in the current medical market allow providers to drive up costs. Because every marginal dollar of expenditure for medical services translates

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186. Extra-billing (or "balance billing" as it is known in Canada) is the process by which medical-care providers charge patients more than the negotiated fee for a given service. It is a particular form of patient cost-sharing.

187. CANADIAN HEALTH INSURANCE, supra note 3, at 35-36. After passage of the 1984 Act, the Canadian financial sanctions for extra-billing by physicians became quite simple: every dollar a province allows in extra-billing reduces the federal block grant by a dollar. If any of the provinces believed the physician contentions that patient cost-sharing through extra-billing would reduce needless and wasteful medical care at a rate where there was more than a dollar’s reduction in care given for every dollar of penalty, that province presumably would have permitted cost-sharing to continue. None have. See Evans, Canadian Health-Care, supra note 80, in this volume.
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into income for identifiable and organized health-care providers, the payer side must have a correspondingly concentrated interest in those marginal dollars to balance those stake-holders who regard each unit of expenditure as benefit, not cost. Balancing these interests does not mean health expenditures will assume any particular level and stay there, but it does appear to provide a necessary condition for establishing publicly selected limits on expenditure levels.\(^{188}\)

To the degree single-payer cost control works, it necessarily disappoints the income aspirations of at least some health professionals. Physicians’ fees, for example, are approximately 234% higher in the United States than in Canada,\(^ {189}\) and the take-home pay of American physicians averages more than 50% higher than that of Canadian doctors.\(^ {190}\) The chief executives of American hospitals earned an average base salary of over $103,000 in 1990, while those receiving incentive pay averaged $125,000. The salaries of American hospital executives grew 8.5% in 1989, while the CPI increased by only 4.6%.\(^ {191}\) Even with the purchasing power of Canada’s national health insurance, its doctors remain well-paid. They were the highest-paid professionals in Canada prior to the introduction of universal medical insurance and they remain so.\(^ {192}\)

Cost control may, of course, threaten the quality of care as well as medical incomes—a vastly different result. But medical-care professionals can justifiably mobilize public support to make sure that cost restraints do not seriously lower the quality of care. These fights—which always mix considerations of income with those of quality of care—make the regular determination of hospital budgets, and especially doctors’ fees, very contentious matters. It is of the utmost importance to anticipate such contentiousness and, within the limits set by budgetary goals themselves, to design formats, select negotiators, and employ modes of public explanation that do not worsen the pain which such struggles entail.

Several prominent bills in Congress adopt a single-payer approach to the

\(^{188}\) A single-payer system with providers who organize to negotiate is technically not a monopsony, but rather a bilateral monopoly. Of course, a single-payer system does not guarantee cost control. The buyer will have to weigh the pressures exerted in favor of cost control against those in favor of greater expenditure. Providers will sometimes be able to mobilize voter support for additional financing of services that they believe are in short supply. For example, public outcry over a perceived shortage of cardiac surgery in Ontario lead to an increase in hospital budgets to allow for more surgery. See Detsky et al., supra note 83, at 565.


\(^{190}\) Evans et al., Canadian Reality, supra note 27, at 571-72.

\(^{191}\) Herzlinger, supra note 30, at 74.

financial reform of American medicine. The Russo Bill’s Universal Health Care Plan, all American citizens would receive a national health insurance card that they would present to their provider of choice when seeking medical care. Benefits would be quite broad, including what most would consider the full range of modern medicine: inpatient care, nursing facilities, home health services, hospice, physician and other professional services, preventive services, (including pre- and post-natal care and well-child care), limited mental health services, and home-based services, as well as prescription drugs, long-term care, dental and vision care. The plan would eliminate all forms of patient cost-sharing, and no “extra” billing would be permitted for insured services. The Russo bill seeks to contain costs through national health expenditure budgets.

Hospitals would have to work within global budgets, negotiated annually, with separate budgets for capital outlays and medical education. The Secretary of HHS would set national fee schedules, with geographic variations, for physician payment. The proposal would permit, not require, alternative payment methods or health maintenance organizations: financing group practices on global budgets, fee schedules, prospective payment systems, or capitation, within federal guidelines.

Administration and financing under the Russo plan would occur on both federal and state levels, with the federal government setting expenditure targets for the states. The states or the federal government would contract with one organization in each state to process financial claims. Private insurance companies would no longer serve an underwriting function, but might act as fiscal intermediaries or sell supplemental insurance for services not covered. The revenues for the Russo program would come from a variety of tax sources: employer payrolls, corporate and personal incomes, premiums on the elderly for long-term care, and the taxation of social security benefits; states would be required to contribute $85 per capita plus 85% of the state’s current Medicaid contribution. All of these funds would be placed in a National Health Trust Fund. The Russo bill would simplify health insurance administration greatly.

Representative Stark’s “Mediplan,” H.R. 650, 102d Cong., 1st Sess. (1991) would offer Medicare insurance to all American citizens. Physicians and hospitals would be reimbursed under Medicare payment rules. To pay for the program, he would raise individual income taxes, and apply a new payroll tax and a new 4% corporate income tax to a federal health-care trust fund. Except for pregnant women, children, and the poor, Stark’s plan would allow patient cost-sharing with a cap on out-of-pocket expenses. Although termed “Medicare for All,” Stark’s bill would set up essentially the same payment structures as Kerrey’s Health USA Act or Mitchell’s AmeriCare.
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by eliminating all other federal programs, setting fee schedules and common benefit packages, and restricting private insurance to the role of fiscal agents.\textsuperscript{194}

Senator Bob Kerrey's Health USA Act of 1991 is almost as far-reaching as the Russo bill.\textsuperscript{195} It would provide universal coverage independent of employment status in private plans or in state plans. The proposal would prohibit private insurers from excluding those with "pre-existing conditions," and would mandate a basic benefits package. Consumers would have a choice among competing insurance plans. Instead of paying premiums to their private insurers, Americans would pay taxes into a health care trust fund, a symbol of the link between the taxes and their programmatic use. The states then would pay each private plan a standard amount for each enrollee. States would also be required to sponsor a public insurance program as a payer of last resort. The Kerrey proposal would require patient cost-sharing, but would limit out-of-pocket expenses. It would permit no cost-sharing for preventive services or inpatient care. The state plan or private plans would pay providers on the basis of national fee schedules modeled on Medicare's Resource-Based Relative Value Scale (RBRVS) system. These rates would constitute ceilings for private insurance plan reimbursement schedules. Hospitals would be financed by the state program, based on individual hospital negotiations. Private plans would be charged for their patients use of hospital services. Separate capital budgets would be established. Finally, an independent federal commission would oversee the program's operation.

Kerrey estimates that his national health insurance program would have saved $11 billion in 1991 alone, and $150 billion over the period 1991-95.\textsuperscript{196} Revenue would be drawn from existing federal and state sources; payroll, corporate and unearned income taxes; a new top individual income tax rate; and an increase in both the wage base for social security contributions and the amount of Social Security benefits subject to taxation. Health-care budgets would be set annually by the federal commission, based on demographic changes and other factors.

Kerrey's plan combines federal financing and state regulation with competitive bidding among insurers. The question of what role, if any, private health insurance firms should play is relevant to all the plans we have discussed, but

\textsuperscript{194} A bill introduced by Senator Paul Wellstone (D-MN) is essentially the Senate version of the Russo bill, with only minor variations. S. 2320, 102d Cong., 1st Sess. (1991). A more recent variant is S. 2513, 102d Cong., 2d Sess. (1992) (Daschle), which has two key innovations: (1) Federal administration would center on a Health Board, an independent agency modeled on the Federal Reserve; (2) States would have the authority to negotiate provider reimbursement rates and hospital global budgets.


\textsuperscript{196} SEN. BOB KERREY, THE HEALTH ACT OF 1991: A PROPOSAL TO MAKE HEALTH CARE AFFORDABLE AND AVAILABLE TO ALL AMERICANS 5 (July 11, 1991); \textit{see} Daniel N. Mendelson & Judith Arnold, \textit{Evaluating the Cost of Health-Care Reform Plans} in this volume.
it is particularly salient for universal, single-payer proposals. Allowing multiple insurers to compete as underwriters, rather than restricting them to "post office" roles, would dissipate some of the monopsony gains of a single-payer system. The key distinction between the Kerrey and the Russo plans is that Kerrey allows such an underwriting and competitive role for private insurers while Russo, drawing on the Canadian experience, rejects any such major role for private insurers. A number of Canadian provinces introduced universal physician insurance in the 1960s and retained traditional health insurance organizations as financial intermediaries and political buffers for a limited period; 197 such insurers, however, did not play an underwriting, competitive function, and soon become useless appendages. It is theoretically possible to have effective all-payer regulations and competitive insurers without having any differentiation on the basis of risk, but without such differentiation, private insurers will have lost a major basis for their ability to compete. With such differentiation, cost and access difficulties would arise again and significant opportunities for administrative simplification and cost reductions would be lost.

F. Reforming Medical-Care Financing and Administration through State Models

Whatever happens on the federal level in the next few years, states almost surely will continue to innovate in medical-care financing. 198 State experimentation in medical-care reform may prove useful in spurring reform on the national level, and several bills have been introduced in Congress to encourage such experimentation. 199 (In Canada, the province of Saskatchewan led the way towards a national health insurance program.) State plans have the advantage of local adaptation and, perhaps, greater local voter participation in the formation of any medical-care insurance plan. State implementation efforts also raise important questions regarding the appropriate locus of financial and political accountability that will, in turn, have to be addressed by any national health insurance plan.

Cross-national evidence suggests that it is the concentration of financial responsibility, not its precise location, that chiefly restrains inflationary health

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199. See, e.g., S. 1227 (Wellstone amendment to the Health America bill) (encourages states to develop single-payer plans); H.R. 2530 (Sanders) (encourages individual states to adopt single-payer systems); H.R. 8 (Oakar) (essentially the same as Sanders); H.R. 2114 (Sabo) (state plans for the poor); H.R. 1230 (Grandy) (state plans for those with uninsurable risks); H.R. 16 (Dingell) (new state insurance plans) (all bills from 102d Cong., 1st Sess. (1991)).
pressures. It so happens that Canada, by constitutional requirement, must use its ten provincial governments and two territories as the administratively responsible agents of its national health insurance program. The lesson for the United States: other administrative options exist, as long as financial power remains concentrated and public agents are accountable. An American single-payer system could focus that accountability in the states and the federal government, in regional entities, or in local entities; non-governmental or quasi-independent agencies could play a role as well. The more buyers, levels of government, and other agencies involved, however, the more diffuse that countervailing power is likely to be.

Hawaii has had a mandatory employer-based health insurance program since 1974 that covers 95% of its population. In 1989, Hawaii added a public program with a minimum benefits package to attempt to cover the remaining 5%. Hawaii has achieved very high coverage rate at per capita costs approximating the national average. Numerous other states have started programs or proposed them: Massachusetts (a play or pay scheme that still awaits funding); Washington (subsidies for health insurance); Minnesota (state-subsidized insurance for uninsured not eligible for Medicaid who earn up to $37,000 for a family of three, based on a sliding-scale premium, and free preventative care for children); Colorado, New Jersey, New York (some increased funding for children’s benefits); Rhode Island and Kentucky (minimum benefits requirement, with a waiver for small companies without health insurance); Connecticut (non-exclusion of certain individuals from private plans; reinsurance to back-up); and Oregon (rationing of services under Medicaid). Other plans have been introduced in California, Connecticut, Florida, Illinois, Indiana, Missouri, New York, Ohio, Vermont, and Washington. Maryland has administered a relatively cost-effective system of hospital all-payer rate regulation since 1974, lowering its hospital costs as a result.

As but one example of the current reform movement in the states, the New York State Department of Health has proposed a plan known as Universal New York Health Care (UNY*Care). New York’s UNY*Care plan is still in

200. See Evans, Canadian Health-Care, supra note 80, in this volume.
201. AARON, supra note 146, at 123-24.
205. HOFFMAN ET AL., supra note 169, at 14 & n.24 (listing states where single-payer legislation has been introduced).
its political infancy, but the plan as of the spring of 1990 combined incongru-
ous elements of play or pay, single-payer, all-payer, and private insurance.
The plan includes a so-called single-payer that would function not as a monop-
sonistic purchaser, but rather as a rate-setter for all providers; it would also
act as a single conduit for payments among providers, private insurers, and
consumers. UNY*Care would limit private insurance liability for an individual
to $25,000 for inpatient care and $25,000 for outpatient care annually (the
“stop-loss” limit). The state plan then would cover costs over $25,000 and the
bills of the uninsured. The limit on insurance outlays for particular cases aims
to reduce variations in experience-based premiums across plans. If not adjusted
for inflation, this cap would gradually shift more insurance from private
insurers to the public plan. Disqualification for coverage because of preexisting
conditions would be prohibited for employer-based plans.208

The prospects for these plans are rather modest, however, without consid-
erable federal cooperation and financial assistance. States face numerous
obstacles in implementing any health plan, including problems of raising
sufficient revenues, developing administrative mechanisms, and wrangling with
the federal government over waivers from the requirements of the Employee
Retirement Income Security Act (ERISA), Medicare, and Medicaid.209 More-
over, poorer states will face even more burdensome forms of each of these
obstacles. For these reasons, federal legislation, such as the Wellstone amend-
ment to the Mitchell bill, are of critical importance in moving states towards
cost-effective, universal health insurance plans.210

IV. TOWARDS NATIONAL HEALTH INSURANCE: STEPS FORWARD

The central claim of our article is this: A straightforward version of
national health insurance is ethically and financially desirable, politically
feasible, and administratively implementable. It does not necessarily follow,
however, that the American political system will produce such an outcome in
the near future. In this section, we describe several steps forward the federal
government might take. These measures—as opposed to the patchwork tinkering
described earlier—could become the building blocks of a national health
insurance plan. The crucial factor in implementing any such step forward is
to ensure that it begins with the proper structure, and that key financing and
administrative choices are made clearly at the beginning of the process. In
particular, cost-control mechanisms through fee schedules and hospital reim-

208. Id.
209. See Deborah Stone, Why the States Can't Solve the Health Care Crisis, AM. PROSPECT, Spring
1992, at 51.
210. See infra note 199 and accompanying text.
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bursentment rates or global budgets need to be put in place at the outset. Access then may be increased sequentially by population group or type of service. We propose four steps forward below; the first three steps forward rely on financing through sliding-scale premiums paid to federal or state governments, while the fourth proposal would not necessarily alter current private premium payment schemes.

A. Universal Maternal and Well-Child Insurance Plus Stopgap Measures in Medicare Reform and Tax Credits for Catastrophic Coverage

Lack of access to affordable prenatal and childhood care remains one of America’s largest failures. Such care, however, is highly cost-effective. One can begin to build a political and social community that supports universal health insurance by focusing on a group that most Americans readily regard as needing and deserving health care. Because doctors tend to be the most concerned about access for this group, a program designed for them might lessen provider opposition. Furthermore, beginning a national health insurance plan by providing universal insurance coverage for prenatal and well-child care would set Americans down the road towards thinking about health insurance in the same way that we currently think about social security insurance—that is, as a universal program, not as a means-tested, targeted program for the poor. To lessen opposition to tax increases, premiums based on income would be paid into a national or state trust fund.

In addition, to expand coverage for the elderly—a group already largely covered for many essential procedures—Medicare reform could be used to bridge gaps and simplify administrative procedures. Finally, catastrophic protection with a high deductible (e.g., 15% of income) could then be provided for all Americans through refundable tax credits, but only as a stopgap towards fundamental reform. These steps forward admittedly would not achieve comprehensive cost control or complete access reform. Yet they would increase access and financial security, begin moving the United States toward universal coverage, and refrain from adding more complicated layers of tinkering to the already-muddied American medical-care scene.

B. Universal Hospital Insurance

Providing universal hospital insurance for all Americans would constitute a more fundamental first step forward, one acknowledging that universal access is essential for each form of care. Hospital care constitutes the most expensive and largest component of health expenditures (about 40%), but one-third of our hospital beds are empty; there clearly is excess supply. Nearly all American hospitals already receive reimbursement for some of their patients under
Medicare's prospective payment system. The existing Diagnostic Related Group (DRG) reimbursement system rewards efficient and quality provision of care, and can be expanded to assume a wider role. To make effective cost control more likely, a governmental body could set global state budgets for hospital care. Such budget-setting would add a major element of monopsony power without necessarily adding much to present overall expenditures (since most hospital care is "paid for" in some way or another already). Financing universal hospital insurance would address the problem of uncompensated care and medical bankruptcy, particularly relieving the stresses now being placed on large urban hospitals. Again, income-based premiums could be placed in a national medical-care trust fund. Finally, such a step forward could draw on the wealth of experience in Canada, which, as Robert Evans describes in another article in this issue, began its national health program with universal hospital insurance.

C. Universal Physician Coverage

An alternative starting point would provide universal physician coverage. Such a step forward would likely require a less substantial form of governmental expenditure, since physician services currently comprise less than 20% of total health expenditures. The United States already has experience in designing fee schedules for physician services in the Medicare program that could be expanded to cover all population groups. Recent changes in the Medicare fee schedules increase payments for general practitioners and family doctors, while reducing those for specialists. Fee schedules for all payers are potential vehicles for constraining physician expenditures. Moreover, doctors currently feel many cross pressures: they are dismayed by the large number of uninsured patients, irritated by complicated and intrusive forms of utilization review, and burdened with massive paperwork, but they have an obvious hostility to price setting and budget limits. A national insurance plan for physician services, quite obviously, also could be financed with premiums paid to a trust fund.

211. Under a DRG system, hospitals are reimbursed on the basis of a pre-determined rate for a given illness. Morone and Dunham have called for "an extension of DRGs to cover all payers, factoring into the rates the cost of uncompensated care." James A. Morone & Andrew B. Dunham, Slouching Towards National Health Insurance: The New Health Care Politics, 2 YALE J. ON REG. 263, 280 (1985). The advantages they predict include: competition among hospitals, hidden taxes in the form of public and private premiums and payments, help for urban hospitals under pressure, and quasi-monopsony power that could help reduce medical inflation. Id. These advantages, however, are more incremental and technical than broadly programmatic.

212. Evans, Canadian Health-Care, supra note 80, in this volume.

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D. All-Payer Rules

The alleged American fear of new taxes—even ones earmarked for health care—may cause some Americans to ask: is it possible to have the right level of countervailing power without fusing taxing and negotiating responsibility as the Canadians now do? Put another way, what would be lost if state regulatory authorities set the terms of medical-care financing, negotiated fee schedules with physicians and budgets with hospitals, and required that employers finance health insurance directly or pay a fixed amount per employee into a state fund?

In some European countries, Germany in particular, national and state governments have played a powerful role in guiding negotiations among physicians, hospitals, and sickness funds without fully channeling health insurance financing through conventional public tax accounts. It is possible to do so, as long as one recognizes that the sickness funds in Germany are nonprofit; that they cannot compete in any meaningful way with each other for consumers; and that the government sets strict rules that make the sickness funds essentially agents of the government.

Play or pay plans with strict all-payer rules do have the potential to move towards a system of cost control like that of Germany. Again, if play or pay focuses first on setting up mandated all-payer rules, then the precise financing and administrative choices to be made later in the game at least can rest on solid foundations. All-payer rules can be developed that are regionally based, and that build upon the current prospective payment system and/or the RBRVS. Optimally, no extra billing above the fee schedule would be allowed; however, it may be necessary initially to allow such extra billing during a transition period. In any event, if this compromise route were chosen, a large portion of the savings from eliminating administrative duplication would be squandered.

As noted, some Canadian provinces used pre-existing health insurance firms as “post office” intermediaries (for the flow of funds and the processing of claims) between the provincial authorities and physicians. In the mid-1960s, that seemed a politically important concession to the sensibilities of some Canadian physicians, particularly in Ontario. One can imagine the United States using such intermediaries in the initial stages of national health insurance, as it has done with Medicare since 1965 (through an arrangement that draws upon private expertise and cuts down on public employees). Within a few years, however, the Canadians found such indirect management cumbersome and much more expensive to manage than direct administration. Moreover, while contracting out financial tasks is certainly compatible with political accountability—as the Canadian experience demonstrates—this approach is incompatible with continued competition among insurance companies as
medical underwriters. Playing that game means a continuation of the uneven insurance coverage and adverse risk selection of the 1980s. Instead, if play or pay plans focus on getting all-payer rules in place at the outset, they may provide a promising path for fundamental reform over the long-term.

V. CONCLUSION

Any review of the policy choices in medical-care reform must distinguish proposals to tinker with present arrangements from those that would lead to fundamental reform. Tinkering proposals focus on how to enable more people to have insurance, either those not now covered or on those who might lose coverage easily (job-changers with a serious illness). None of these proposals acknowledges that American medical care requires fundamental change in financing and administration. None provides a serious means for cost control or universal coverage.

Among the fundamental reform plans, three serious options exist. Each commits to universal coverage and to reasonably comprehensive medical-care provision. The key differences lie in their approaches to cost containment as a counterweight to the necessarily increased inflationary pressure brought by widened coverage. The “modified competitivists,” such as Alain Enthoven and Stuart Butler, recognize subsidization of universal coverage as a precondition for ethically defensible reform. Both are drawn to the presumptions of neo-classical micro-economics and its commitment to price competition as the best allocator of goods and services. Both adhere to the rhetoric of “consumer choice” among health insurance packages. They differ considerably in the details, however, especially with regard to how many insurance intermediaries there should be and who should act as consumer agents. Butler advocates high co-payments and deductibles to prod consumers into cost-conscious medical choices. Enthoven eschews price competition through out-of-pocket payments and instead favors price competition among a limited number of insurers. Both underestimate the extent to which Americans value the choice of their caregiver over the choice of their insurance firms. While either of these micro-economic approaches may work in theory, neither has been systematically implemented anywhere else in the world.

In contrast to this “pro-competitive” approach are the single-payer proposals, all modeled largely on Canada’s universal health insurance program. While single-payer refers only to the financial architecture, the effect of this approach extends beyond financing. It combines financial accessibility, countervailing buyer power, and political accountability in a way that maximizes patient choice and medical autonomy within overall constrained budgets and supply of capital. It is a necessarily contentious process of decisionmaking.
to borrow Hirschman's expression, is its mode, where exit is the key element in the former, so-called competitive model.\textsuperscript{214}

Although contrasted with the pro-competitive model, anyone who thinks a national health insurance program lacks competition is misinformed. The competition is for patients: doctors under fee-for-service, capitation, or other forms of remuneration require them. Hospitals compete for fame and regard, countervailed by political control over the budgets within which they operate.

The final major reform options—based on the German model—attempt to adapt all-payer rules and employer-based insurance to the American medical-care setting. These proposals, in current form, stray far from their ideal all-payer model, but do hold out the prospect of beginning a process towards national health insurance. The key to the success of these plans will be to establish strict all-payer regulations early in any reform agenda, and to control tightly the rules of medical underwriting. Then, depending on the level at which health-care taxes and premiums are set, the plans may gradually move towards more fundamental reform. The danger with such plans is that the continued explosion in medical-care costs may overwhelm the reform agenda before serious steps forward can be made.

American medical-care reform ranks indisputably high on the contemporary political agenda. The extraordinary consensus—across the ideological spectrum—on the need for far-reaching change foreshadows policy adjustments in the 1990s. There is not, however, any certainty about the effectiveness of the policy changes we anticipate. To find the right combination of effective and acceptable reform, we need to explore what our historical experience and the lessons of other countries tell us about programmatic desirability and political feasibility. In doing so, we ought seriously to consider the widespread use, in political systems both similar to and different from our own, of politically accountable single-payer methods of financing modern medical care.

Nevertheless, there are wide variations in the particular ways in which countervailing financial and political authority is and can be organized. We have discussed some of these variants and emphasized the important distinction between operational principles and institutional expression. Moreover, we have stressed the primary lesson of comparative health finance: the United States can move towards any chosen model of universal health insurance in stages, or even one state at a time. The United States has in fact already taken decisive steps toward universal coverage, expanding the government's role in covering one population sub-group after another.\textsuperscript{215}

We must keep these choices clearly in mind in the months and years ahead.

\textsuperscript{214} HIRSCHMAN, supra note 115, at 4.

\textsuperscript{215} Examples include veterans after World War II, the elderly poor in Kerr-Mills, the elderly (Medicare) and categories of the poor (Medicaid) in the 1960s, the disabled, victims of kidney failure, and so on.
The very range of choices, when combined with our fragmented political structure and its undisciplined debate, is as likely to produce confusion and stalemate as steps forward toward fundamental reform. This symposium issue, one hopes, will help in a small way to reduce the former and enhance the latter.