



Mandatory and Affordable Health Insurance

Len M. Nichols

This paper asserts that America's health care system is broken and cannot be repaired with timid half-measures. It suggests that we need both universal coverage *and* a more efficient delivery system and that these are not competing objectives: Each is necessary to make the other possible. It further states that if we do not make health care more affordable and our delivery system more efficient and sustainable, a majority of Americans will be uninsured in short order. And the persistence of millions of uninsured impairs the efficiency we need to make health care and insurance affordable for all. Thus, contrary to conventional wisdom, this paper asserts that both universal coverage and delivery system reform must be pursued *simultaneously*. (JEL I110, I180)

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Health care costs continue to grow faster than incomes, and more and more working families are finding health insurance unaffordable. Four million Americans have lost private coverage since 2000, mostly because they cannot afford the contribution their employers require for increasingly less generous offerings. At this rate, by 2010, fewer than half of all Americans, the lowest percentage since 1960, will have employer-sponsored coverage. We may be near the breaking point of our mid-20th century employer-based system. Forward-thinking labor leaders, such as Andy Stern, president of the Service and Employees International Union, are voicing the compelling reality: The employer-based health insurance system as we have known it is unsustainable in a 21st century economy. Understanding their own impotence to reverse these trends, many employers agree, and like Lee Scott, CEO of Wal-Mart, are searching for ways to jump-start a national conversation about feasible alternatives.

There are only three credible universal financing arrangements: (1) tax-financed single-payer

insurance, or Medicare for all, (2) employer plus individual mandates to purchase private health insurance, or (3) individual mandates alone. (Each of the last two also requires low-income subsidies.) "Medicare for all" is technically feasible but requires a level of trust toward government decisionmaking that is simply not present now, nor likely to spread soon. In addition, most of the efficiencies of a single-payer system could be obtained within any program of mandatory coverage that eliminates the profit from avoiding high-risk patients.

Without purchase mandates, however, no insurance system can approach the level of efficiency we need; these mandates would prevent insurers and providers from using many scarce resources to avoid high-risk patients. So, in addition to the moral case—the Institute of Medicine estimates that 20,000 Americans die each year because the lack of health insurance prevents them from obtaining timely but routine care—there is a strong economic case for universal coverage.

Among the private insurance alternatives, the "individual mandate alone" option is by far the

Len M. Nichols is director of the Health Policy Program of the New America Foundation.

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most congruent with the 21st century U.S. economy. That economy must remain flexible and reward mobile workers, so tying insurance to citizen-workers and not to firms makes perfect sense. At the same time, the U.S. economy will continue to generate many jobs with productivity levels that simply cannot support employer-provided health benefits plus a market wage. Thus, a mandate on employers would be counterproductive to efficient and shared economic growth, for many low-wage jobs would be lost. Finally, an individual mandate is consistent with individual responsibility, a central—but by no means the only—element of a new social contract that can spread opportunity and well-being through redefined social responsibilities as well. The New America Foundation will have more to say about that full social contract soon.

But universal coverage is not enough. Our health care system is so inefficient and prone to unsustainable cost growth that to pursue universal coverage without simultaneously seeking to contain costs would very soon add to our mounting fiscal problems.

We spend at least twice as much per capita on health care as our major trading partners, and we finance far more of it through employers, which puts us at a significant competitive disadvantage in the global economy. This is why health care system reform has become a “C-suite” issue: CEOs, COOs, and CFOs are focused on it like never before. Moreover, the health gains from our spending are mediocre compared with the rest of the world. The United States ranks an embarrassing 37th in the World Health Organization’s evaluation of health systems worldwide, next to Slovenia and Costa Rica.

We compare poorly because our three linked problems—high costs, mediocre quality, and unequal access—do not yield to the timid, incremental reforms we have tried to date. Despite our high spending, Americans get appropriate care only about 55 percent of the time. Individuals at the higher income levels get appropriate care only 2 percent more often, while individuals at the lowest income level get appropriate care only 2 percent less often. Thus, money actually buys very little quality per se. Geographic variation in the quality of care is stunning: An individual living in Utah

has a one-third higher chance of surviving cancer than a person living in North Carolina. Ineffective care adds unnecessarily to costs, which reduces coverage and stifles access.

We also suffer over 150,000 unnecessary deaths each year from avoidable errors and substandard care. The average person in Canada, Australia, or France is healthier and will live longer than the average American. Far more equitable access to high-quality primary care is a big part of the reason. There are 46 million uninsured in the United States, and their lack of timely access results in the lowest quality of care of all. The total economic costs of the uninsured—shifted medical costs plus lost productivity from extra absenteeism and premature death—have been estimated to be roughly equal to the public cost of the low-income subsidies necessary to finance universal coverage in this country. It is time we made a smarter economic bargain for health care.

The first step is to recognize that comprehensive health care reform—achieving universal coverage *and* cost growth containment—is not only necessary, it is doable. We can provide better care for more people, we can afford the necessary subsidies for our low-income population, and we can bridge the divides in our polarized national debate and politics. It will take leadership, compromise, and hard work, but political leaders in Massachusetts have shown us that it is certainly possible. There, a Republican governor and presidential aspirant was willing to use the word “all,” the Democratic legislature accepted the word “limit,” and together they are taking a giant step toward universal coverage.

Politically, the possibilities for national reform are greater today than ever before, not least because the barometers of system stress are worse than they were when Bill Clinton became president and health reform was on the agenda. In 1992, there were 33 million uninsured Americans; 13 million people have been added to the rolls of the uninsured since then. The average family health insurance premium today claims 18 percent of median family income, compared with 10 percent then.

Three qualitative differences may matter even more.

First, employers are increasingly determined to force politicians to address the question of reform because high health costs make it harder for them to compete in international markets.

Second, as cost growth forces companies to reduce benefits and shift costs to workers, more and more workers worry about losing coverage altogether, even in a strong economy. This is a sea change from the early 1990s, when the fear of coverage loss was recession-based. Now it is based on cost growth outstripping income growth, with no end in sight. As presidential aspirants in both parties are learning—in their home districts, in Iowa, and New Hampshire—voters are deeply worried about unaffordable health care.

Third, and most importantly, growing public awareness of the linkages among cost growth, quality gaps, and losing coverage makes the reform discussion different this time around. The Clinton-era debate was mostly about covering the uninsured and the income redistribution that would have been required to accomplish this. That argument was largely “zero sum”: some would gain coverage, and others would have to pay higher taxes to finance it. But if none of us is assured of getting quality care, and if all of us—including employers—are vulnerable to rising costs, then there is a positive-sum or win-win dimension to comprehensive reform now that makes it far more likely.

A WIN-WIN FORMULA FOR REFORM

Positive-sum reform provides something for everyone and demands shared responsibility as well. Essentially it entails building a universal coverage financing system on the backbone of a sustainable delivery system. Therefore, it must have numerous elements.

- ***It must be bipartisan.*** Effective reform will require features that moderates in both the Democratic and Republican parties can embrace—a program that preserves enough of the core values of each party’s base to permit each side to recognize its own narrative in the outcome. To achieve this, there must be individual responsibility as well as shared

responsibility, cost-containment as well as universal coverage.

- ***It must create an effective health insurance market.*** In this market, individuals and groups without good options today can benefit from administrative economies of scale and risk pooling. Market rules must be fair to individuals and reasonable for insurers, like those that govern very large employers, employer coalitions, and federal- or state-worker purchasing pools today.
- ***Individuals must be required to purchase health insurance.*** Even with subsidies and a functioning marketplace, some individuals will be unlikely to buy health insurance on their own, thereby shifting costs onto others in the event of their need for expensive care. To avoid such “free riding,” individuals must be required to pay their fair share toward health access for all. Purchase mandates are therefore essential under any formula for achieving universal coverage. Individuals could purchase insurance through their employers or efficient purchasing pools.
- ***There must be substantial subsidies for low-income individuals and families.*** A basic insurance package must be required, but in exchange it must also be affordable. This is essential for reasons of equity and efficiency alike. We cannot force people to buy policies they cannot afford. Even if this were politically feasible, it would force them to forego other necessities, which could have bad health consequences. If we try to mandate insurance without subsidies, some will remain uninsured and we will continue to pay for their late, inefficient care like we do now. A supplemental benefit package at zero or low cost is needed to cover cost-sharing for individuals with very low incomes or those with substantial health care needs, e.g., those who are in households with incomes below 150 percent of poverty or who are currently enrolled in Medicaid because of disability status. The basic package must be comprehensive (i.e., cover necessary physician, hospital, pharmaceutical, dental, and mental health services), but still have a cost-

sharing structure (coinsurance is preferable to high deductibles) that unsubsidized families could afford.

- ***Household subsidies should be financed by a dedicated and limited new tax.*** These subsidies can be partially financed, especially over time, with savings from the reform program, but there will need to be additional revenues dedicated to them, at least in the short run. It would be best to fill the gap with a dedicated stream from a new tax (e.g., a progressive consumption tax or a progressive value added tax), which would also serve as a budget constraint. Budget constraints and tax rates can and should be revisited over time as circumstances warrant, but having annual budget limits on subsidies may be necessary to construct a majority coalition for comprehensive reform.
- ***The new system should be citizen based, phasing out the employer's role.*** There are a number of options here, but it is important that employers should be seen as only one among many possible financing sources for health insurance coverage, with the understanding that they are not likely to be able to continue indefinitely in that role. The goal ought to be to keep current employer “money” in the game while relieving employers of the burden of negotiating health premium increases every year. A new insurance market pool and subsidy structure could aid such a transition. For example, firms might enroll their workers in a plan through a purchasing pool in year one, while maintaining their historical premium contribution levels. In year two, they could give their workers a raise at least equal to the previous year's premium contribution, plus some agreed-upon inflation factor, and from that higher base the workers could be expected to purchase insurance on their own unless eligible for a subsidy. (Tax preferences could also be converted at that point, perhaps from the open-ended exemption for employer-plus-employee section 125 plan tax-sheltered contributions today, to a fixed tax credit that might vary by income and/or risk class.) This transition would keep the “right”

amount of money flowing to health insurance in year two; thereafter, cost growth and affordability would be settled in the politics of citizen, state, and health care delivery systems, with the employer out of the picture.

This brings us to delivery system reform, which is central to the success and sustainability of the entire reform enterprise. In short, we urgently need to reorganize our delivery system to yield far more health “value” per dollar spent. There are three critical elements to creating a delivery system with a “culture of value.”

- ***An electronic health information system.*** This would give any clinician anywhere instant access to a patient's medical history, plus diagnosis and treatment options. The system would include web-based electronic health records, as well as medical-decision support tools so that best practices could be applied to every clinician-patient encounter. Today, a Las Vegas casino can determine the precise details of an individual's credit worthiness in real time, but no emergency room doctor in that city (or anywhere else in the United States) can find out what medications an unconscious person is on (unless that individual is being treated in the Veterans Administration system). An electronic information system will help us monitor care, protect patients, and improve the overall quality of health care in the United States.
- ***Turbo-charged incentives.*** We need a new set of payment incentives for both patients and providers. Today, we pay providers for conducting tests and carrying out procedures that may or may not be necessary or effective. And patients are often required to pay no more for expensive tests and procedures than for less expensive but equally effective treatment. This system encourages unnecessary treatments and results in low-value care. Smarter incentives would encourage patients and clinicians to use resources prudently while promoting high-quality, cost-effective care. Incentives for patients and providers should be mutually reinforcing, and they can be if they incorporate the same performance targets. For example,

HEALTH CARE FOR ALL AMERICANS

How to Fix Our Broken Health Care System:

- Create a health insurance market
- Require everyone to buy health insurance
- Subsidize low-income Americans
- Define a transitional role for employers
- Improve outcomes using an electronic information system
- Offer “turbo-charged” payment incentives to lower costs
- Provide high-quality care based on comparative technology assessment

clinicians should be paid more if diabetics under their care obtain all appropriate tests each year, and the patient’s copayment for such cost-effective, evidence-based tests should be zero. We will also need to reform our dysfunctional malpractice legal system. Evidence-based medicine, i.e., statistically supported best practices, must be a safe harbor against spurious malpractice claims. Guidelines can be developed and disseminated by private specialty societies and public research agencies to ensure their effectiveness and a smooth transition to evidence-based safe harbors.

- ***Comparative technology assessment.*** Advances in medical technology have saved lives and improved the quality of life for many, and future advancements are likely to have possibilities nothing short of breathtaking. However, the overuse of new technology has been the main culprit in driving up costs. Future advancements are likely to drive up costs even further, to the point of their being potentially catastrophic for the health of the U.S. economy. We need to establish processes for assessing the clinical value-

added of new technologies compared with existing treatment or diagnostic options prior to their widespread adoption and use. The FDA’s drug approval process is a case in point. Today, to get a drug approved for a specific use, a manufacturer must simply prove that the proposed new drug did not manifest serious side effects and is more effective than a placebo. We should require a higher standard for approval: New and more expensive drugs should be shown to be better than the best existing treatment for any given patient subpopulation. To compensate for the longer and more expensive trials this would require, we would probably need to lengthen the life of drug patents. We should apply the same logic to medical devices and new diagnostic or surgical techniques. Then we can become far smarter purchasers of costly new technologies.

THE POLITICAL GROUNDWORK IS BEING LAID

The good news is that a critical mass of stakeholders, opinion leaders, CEOs, union officials, and politicians agree that our health care system is on an unsustainable trajectory and must be reformed. Massachusetts has shown that comprehensive and bipartisan compromise is possible, and the American Medical Association’s recent call for an individual mandate approach to universal coverage is proof that former adversaries of wholesale reform now see its necessity.

The coming presidential campaign season will be an opportune time to debate larger visions about necessary and wise changes to our existing health care system. Large majorities of the electorate support and are willing to pay to ensure that all Americans have access to at least basic health insurance. Announced and potential presidential candidates have heard the rumblings of discontent and fear among the electorate. Our political system can find a bipartisan way for those fears to be addressed and the public’s preferences to be translated into affordable and effective health care for all Americans. The leaders that facilitate this transformation will be highly regarded indeed.