

**A PRIMER FOR JOURNALISTS ON  
REFORMING AMERICAN HEALTH CARE:  
Proposals in the Presidential Campaign**

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**DISCLOSURE OF POTENTIAL BIAS**

Although I have done my best in this primer to present a detached depiction and analysis of the various health-reform proposals injected into this fall's election campaign, it must be acknowledged that no social scientist is free of personal bias in his or her work. In the present case, I must disclose that I favor universal health insurance coverage that extends the peace of mind and unfettered access to needed health care--taken so much for granted by well insured Americans--also to the families of low-income, uninsured Americans, the bulk of whom work very hard, at poorly paying jobs, to look after their families and, in the process, to make, with their work, life so comfortable for Americans in the upper half of the nation's income distribution. This personal bias, based on ethical principles forged long ago in post-war Germany and in Canada, and also by a long apprenticeship of growing up in poverty myself, is very likely to shine through in this primer. That personal bias should be kept in mind at the outset.

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## ABSTRACT

President Bush and Senator Kerry offer voters a clear choice among two vastly different visions for health-reform, two quite different commitments of new federal spending to solve the problem of the uninsured, and two commensurately different numbers of otherwise uninsured Americans that would be brought under health insurance coverage. The purpose of this Primer is to help journalists work through the complex details of these proposals and to put them into a broader and simpler overall framework.

More specifically, President Bush would not allocate substantial new federal funding for health reform. On the other hand, he offers voter a radically new vision for the entire American health insurance sector. As I understand the thrust of that vision, the President's preferred health insurance system would be one based on health insurance policies with very high deductibles (\$1,000 to \$2,000 per year for individuals and \$2,000 to \$5,000 for families), coupled with Health Savings Accounts (HSAs) into which employers and households can make tax-deductible deposits to defray the high deductibles. In this vision, ideally health insurance would be purchased by individuals in the non-group markets and, thus, be portable from job to job and from job into self-employment or unemployment. The current employer-based system health-insurance with its traditional, comprehensive and nearly first-dollar coverage would be tolerated in this vision, but it would not be explicitly further encouraged through public policy, any more than it already is through a major tax preference.

In contrast, Senator Kerry would allocate vastly more federal dollars to health reform and help commensurately more Americans gain health insurance coverage than would President Bush. On the other hand, the Senator does not offer Americans a radically different vision for the structure of American health insurance. Instead, he would strengthen with federal dollars the three main components of the already existing health insurance system with which Americans have long been familiar, to wit: (1) the employment based system for private health insurance, (2) the publicly administered Medicaid and SCHIP programs and (3) the non-group market for individually purchased health insurance. Senator Kerry would strengthen the latter by allowing individuals to purchase health insurance through a sister institution of the Federal Employee Health Benefit Program, long used by members of Congress and federal employees.

In terms of new federal dollars, neither proposal would add very much to total national health spending over the next decade.

In this connection, journalists should guard themselves against comparing projected 10-year new federal budget outlays with one year's current health spending. To illustrate, in its very detailed, recent analysis of the two candidates' health-reform plans, the Lewin Group estimates that Senator Kerry's proposal might add about \$900 billion in new public sector health spending over the decade 2006-2015. (\$1.25 trillion of new federal sending minus about \$340 billion in lower spending by the states). That seemingly large sum, however, would constitute only slightly more than 3% of the total national health spending of about \$28 trillion currently one would project for 2006-2015, on the basis of projections published by the Centers for Medicare and Medicaid Services (CMS).

For over three decades now, the main problems besetting the U.S. health-care system always have been the same, to wit:

- I. the ever growing number of Americans without health insurance,
- II. the ever rising cost of health care, and
- III. the highly uneven quality of health care.

These three issues have been talked about in every political campaign, often with lofty promises on their resolution. In practice, however, few inroads have been made on them, mainly because it is so easy to confuse and scare the public in any debate on health policy. Therefore, in the end, people seem to prefer the *status quo* over the scary unknown.

Reform proposals that would force the middle- and upper-income classes in America to help low-income Americans gain access to health care no longer have enough political appeal to carry the day in legislatures. Telling voters in the middle- and upper income brackets forthrightly that helping uninsured and poorly-paid waitresses, sales clerks or cab drivers in this regard necessarily entails added taxes tends to be the kiss of death of the very idea. Politicians can safely disregard the lower-income groups that would benefit from universal health insurance, because only a small fraction of these Americans (usually around 30% or so) bother to vote. The elderly of all income classes, on the other hand, do vote in higher numbers, which is why they typically do get gratification from the legislatures. It is why Congress thinks nothing of subsidizing the use of prescription drugs by high-income elderly Americans while leaving millions of hard-working, low-income Americans fend for themselves in the health-care market.

Although the general public knows that health care costs are high in this country and rising rapidly, in the heat of an election campaign voters can easily be persuaded that constraining the growth of health-care costs will lead to the rationing of health care by the queue, a general erosion of the quality of their health care and less rapid technological progress in health care. As long as the bulk of Americans are reasonably well insured against the cost of their own health care—as about 80 to 85% are—they will typically not press for truly effective cost control via the ballot box.

Finally, having been told over and over again by pundits and politicians that American health care is the best in the world, Americans simply will not believe that the quality of their own health care could possibly be wanting. It does not seem to be an issue with political traction.

In short, the deck does seem stacked in this country against anything but small, incremental reforms of the U.S. health system, which does not mean, however, that proposals for major reforms are completely futile. The political stars might align some day to make such a reform feasible.

In what follows, I shall review health-reform proposal for each of the three problems listed above, after some general observations on measuring the number of uninsured and on methods of covering them..

## I. THE GROWING NUMBER OF UNINSURED AMERICANS.

Not all Americans agree that the problem of the uninsured is one of the nation's major problems.

The editors of *The Wall Street Journal*, for example, and pundits at the conservative Manhattan Institute, believe that the problem of the uninsured problem has been vastly exaggerated by some policy analysts and in the media.

On the other hand, The *Institute of Medicine* of the *National Academy of Sciences*<sup>1</sup>, the *Henry J. Kaiser Commission on Medicaid and the Uninsured*<sup>2</sup> and the *Commonwealth Fund*<sup>3</sup> believe the plight of the uninsured truly is a serious problem, as do many other health policy analysts.

### A. The Number of Uninsured

One problem with fashioning a targeted policy response to the uninsured is that they represent a diverse group, in different economic circumstances. There is a difference, for example, between being temporarily without insurance (e.g., in between jobs) and being without insurance for long stretches or permanently. Not surprisingly, then, the public is being bombarded by politicians and pundits with a great variety of different statistics on the uninsured and different interpretations of the social problem they represent.

**Some Metrics on the Uninsured:** The number of Americans who find themselves without health insurance at some time during a given year—e.g., at the time a survey is taken—tends to exceed 60 million. The number of Americans who, at any time, report that they did not have health insurance at that moment now is about 45 million. Finally, the number of Americans who, at any time, report that they have been without insurance coverage for the past year or more tends to fluctuate between 20 and 30 million.

In addition, of course, many millions more Americans, who formally do have health insurance, have spotty and shallow coverage, with numerous exclusions noted in the fine print of insurance policies.<sup>4</sup> Although in surveys these Americans are scored as being “insured”, when they fall critically ill they may discover that they are either only semi-insured or completely uninsured for certain health services deemed necessary by their physician but not covered by their policy.

According to the most recent Bureau of the Census survey data, in 2003 roughly 45 million Americans were uninsured at the time the survey was taken, up by 1.4 million from the year before and by about 5 million since the year 2000. As is shown in the top graph overleaf, most of the uninsured are members of relatively low-income households. Furthermore, eight in ten uninsured Americans are members of working families, a fact that is at variance with the

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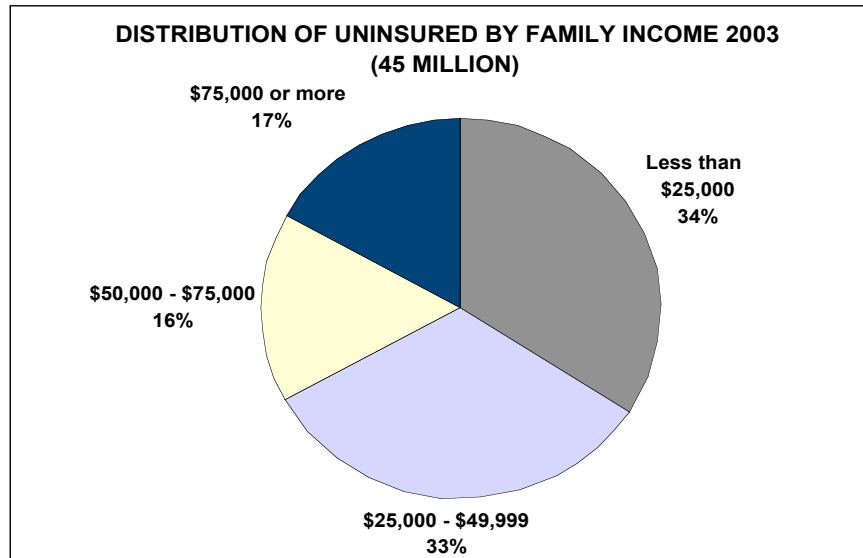
<sup>1</sup> See, for example, Institute of Medicine, *Hidden Costs, Value Lost*, Washington, D.C.: National Academy Press, 2003, and Institute of Medicine, *Insuring America's Health: Principles and Recommendations*, Washington, D.C.: National Academy Press, 2004.

<sup>2</sup> See its website [kff.org](http://kff.org).

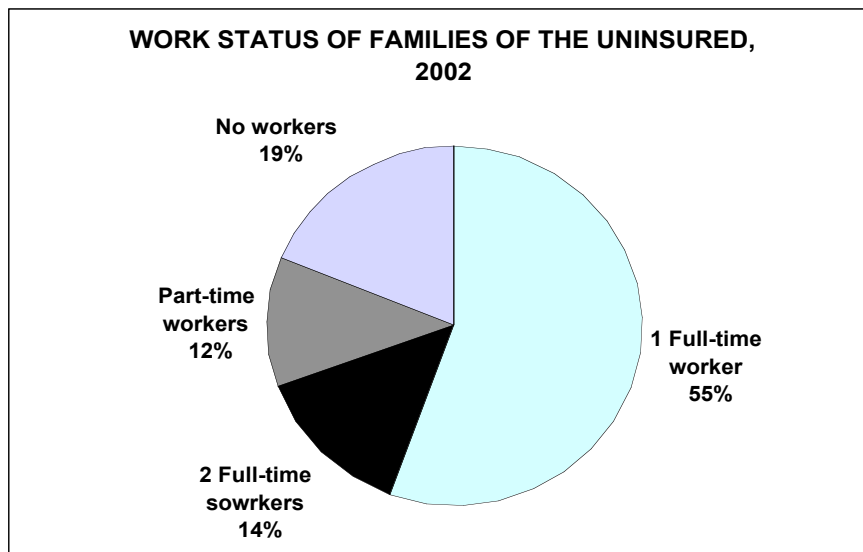
<sup>3</sup> See its website [cmwf.org](http://cmwf.org).

<sup>4</sup> See, for example, “It's Enough to Make You Sick: Scams are proliferating as more families scramble for affordable health coverage,” *Business Week* (September 13, 2004): 59-61.

belief that the uninsured do not contribute to society. (See the bottom graph overleaf.) For the most part they and their dependents are part of the cadre of Americans who work hard at low-wage jobs that help make the life of better situated Americans more comfortable—waiters and waitresses, other restaurant workers, grounds people, taxi- and limousine drivers, and so on.



SOURCE: U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2003; Table 5, p. 15.



SOURCE: Diane C. Rowland, "Uninsured in America," Testimony before the Committee on Ways and Means, U.S. House of Representatives, March 9, 2004, Figure 2.

A peculiar feature of the public programs designed to cover otherwise uninsured, low-income, non-elderly Americans—Medicaid and SHIP—is that millions of Americans eligible for these public programs are not enrolled in them. One recent estimate put that number as high as

14 million.<sup>5</sup> Most probably these individuals are not aware of their entitlement, or they have not been able to navigate the bureaucratic obstacles put up by these programs. Enrolling these individuals into Medicaid and SCHIP would not require new legislation. It would, however, entail additional outlays by the federal and state governments, above current and projected future baseline levels.

Journalists interested in more detail on the uninsured may wish to consult the website of the *Henry J. Kaiser Family Foundation* ([www.kff.org](http://www.kff.org)), which represents probably the best source of well-structured data on the uninsured and on the health-care of low-income Americans in general.

If I had to put a number on it, my rough and ready guess would be that some 20 to 25 million of the currently uninsured in this country most likely would need substantial public subsidies to be able to afford health insurance of the sort known to the rest of Americans. Evidently, an additional 10 to 15 million need help navigating the road to public programs to which they are already entitled. The remainder of the uninsured probably could purchase health insurance on their own, if they had access to an efficient market for individual health insurance policies (as distinct from the group-policies bought by employers for their employees). Providing the uninsured with such markets –e.g., a market like the *Federal Employees Health Benefit Program (FEHBP)* long operated for members of Congress and for federal employees nationwide– has to be part of any sensible health-reform proposal.

As I shall argue in Section II below, on “*CONTROLLING THE GROWTH OF HEALTH SPENDING*,” Americans in the bottom third of the wage and income distributions are likely to find themselves increasingly priced out of health insurance and modern health care as the decade proceeds. Thus the number of Americans requiring federal or state assistance to obtain health insurance coverage will grow inexorably in the decade ahead.

Finally, I may be noted that no other industrialized country has as any significant number of uninsured citizens or underinsured citizens. It has been and remains a uniquely American phenomenon.

## **B. A General Primer on Proposals to assist the Uninsured**

It is often said, for example, that proposals to help the uninsured make little headway in our democracy, because they are so complex as to be beyond comprehension. Not so. Stripped to the essentials the citizenry needs to know, all such proposals are built from a few components that can easily be understood by anyone.

Therefore, before proceeding to the specific health-reform proposals put forth by the two major presidential candidates, it may be well to offer readers a more general framework that may help them order these seemingly complex proposals in their mind.

**The Mechanics of Coverage:** There are basically only three major approaches to helping the otherwise uninsured procure health insurance coverage:

1. The uninsured themselves can be given purchasing power (vouchers, or refundable tax credits) towards the purchase of individual, private health insurance in the non-group market.

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<sup>5</sup> See National Institute for Health Care Management, *The Uninsured: A Study of Health Plan Initiatives and the Lessons Learned*, March, 2003.

2. Government can bribe employers in various ways to provide their employees health insurance purchased, on the employees' behalf, through group-health insurance policies.
3. Government can enroll the uninsured in already existing, government-run health insurance programs (such as Medicaid, the State Children's Health Insurance Program (SCHIP) or Medicare) or new publicly financed- and administered programs.

All proposals to help the uninsured represent one of these three techniques or a particular combination of all three, with greater emphasis upon one or the other. That is really all there is to it, and all the general public needs to know.

To be sure, each of these three options comes in various flavors, which may give reform proposals the false appearance of complexity. Going into such detail may have some virtue, but it runs the risk of boring the public or, worse still, confusing it.

For example, the first option—granting the uninsured vouchers or refundable tax credits—could be imposed simply on the existing, unorganized market for individually purchased health insurance, where premiums are relatively high, because they must cover high administrative and marketing costs. Alternatively, the option could be coupled with the establishment of large risk pools by means of health-insurance purchasing cooperatives (HIPCs) that now go by various names. One can think of them as the analogue of farmers' markets, but here for health insurance. The aforementioned *Federal Employee Health Benefits Program (FEHBP)* for federal employees and members of Congress is a frequently cited model for such a co-operative.

The second option—bribing business into providing their employees health insurance—can be achieved through tax credits or other direct subsidies to business—for example, Senator Kerry's proposal to have the federal government share in the cost of health care for catastrophically ill employees (e.g., health bills exceeding \$30,000 per year for an employee).

**Is Insurance Mandatory?:** Journalists should inquire whether or not a health-reform proposal calls for mandatory coverage, as voluntary coverage always exposes these reforms to the problem of adverse-risk selection by households—"free-loading," in plainer English.

Health policy analysts generally are persuaded that truly universal health insurance can be achieved only if having basic coverage is mandatory upon all individuals in society. The mandated, basic package need not be a policy with comprehensive benefits and first-dollar coverage. It could be a policy with only a basic package of benefits (including, however, effective preventive care), and it could have high deductibles and coinsurance.

The coverage must be mandatory to prevent the kind of freeloading that occurs now, as individuals who could afford at least a high deductible policy go without coverage when they are healthy and then expect society at large to step up to the cashier's window when catastrophic illness strikes. They will then either try to obtain insurance coverage, if they can do so in states with community-rated premiums (i.e., premiums that are independent of the insured's health status). Alternatively, the freeloaders who could have afforded health insurance *ex ante* may seek charity care at hospitals when they fall critically ill, or they simply leave doctors and hospitals with uncollected debt. Allowing freeloading of this sort is an unseemly feature of our current health-insurance system.

**The Proposed Budget:** Fundamental to any reform proposal for the uninsured is the budget the proponent would allocate to it. The size of that proposed budget, on a yearly basis, is

the most reliable indication of how serious a problem a political candidate believes the plight of the uninsured to be, and how extensively he proposes to respond to it..

In this regard, a rough rule of thumb is that universal health insurance coverage, based on the traditional, comprehensive policies Americans seem to prefer, could be achieved with additional federal budget outlays of somewhere between \$80 billion to \$100 billion per year, in the near term, depending on how generous the assistance to low-income uninsured Americans would be.

For example, if someone proposed to spend, say, about \$100 billion on the uninsured over the entire next decade—not per year—we can infer that only about 10% or so of the currently uninsured will thereby find coverage over the longer haul, give or take a percentage point.

**Washington's Ten-Year Budget Folly:** Seasoned adults in our nation's capital pretend to take quite seriously two wondrously humorous endeavors: (1) forecasts of what fraction of total payroll in 2075 (yes, 2075!) will go towards the Part A Medicare Trust Fund in that year, and (2) what the 10-year (yes, 10-year!) prospective, federal budget outlay will be for any particular health-reform proposal. Nowhere else in America would sensible people have much faith in forecasts over such long periods, when so many variables can change unpredictably. In Washington, citing them in all earnestness, and fighting over them, is one of that culture's mannerisms.

The mannerism of 10-year budget forecasts has seduced presidents and members of Congress into truly cynical budget-accounting shenanigans that make the accounting foibles of the Enron Corporation, of WorldCom and of other corporations now in the dock over these practice appear positively pristine by comparison.<sup>6</sup> Journalists should know better than to take any such numbers too seriously. Each such forecast is but one point estimate of a wide range of possible outcomes.

Another problem with 10-year budget figures is that, somehow, they naturally tend to be large and, thus, blow the minds of people who may, in fact, compare them instinctively with the annual numbers they know. Thus, when we hear that the 10-year cost of candidate A's proposal is, say, \$1 trillion, we may instinctively compare it to the \$1.7 trillion total national health spending per year we now devote to health care. In fact, over the next ten years total national health spending is likely to add up to \$28 trillion. Thus, when dealing with 10-year federal budget numbers for a proposal, journalists should always remind readers of the 10-year total spending numbers to which the 10-year additional federal spending can be meaningfully compared.

Readers should also always be warned that 10-year budget forecasts are very shaky—worse than weather forecasts. Just how much any particular health-reform proposal would cost over the entire next decade actually is anybody's guess.<sup>7</sup> It will depend crucially on

1. the often unpredictable future growth in per-capita health spending overall, and

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<sup>6</sup> The ten-year budget for the Medicare reform bill (MMA) passed in late 2003 starts the clock in 2004, although the actual program will begin with significant budget outlays only in 2006, and even in that year only at half-steam. It was a shenanigan to keep the budget forecast below \$400 billion. And even that cooked-up number has, in the meantime, been increased twice by the Office of Management and Budget of the White House, to \$570 billion at this time of rising.

<sup>7</sup> To illustrate how hard such projections are, the studiously politically neutral Congressional Budget Office (CBO) had estimated in 1993 that total health spending in the U.S. by the year 2000 would be close to \$1.7 trillion or close to 20% of the GDP. The actual spending in 2000 turned out to be only \$1.3 trillion, or 13% of the GDP.

2. the number of Americans who will need public assistance with their health insurance, a number that also is beset by great uncertainty.

With respect to the first number—future growth of per-capita health spending—we should remind ourselves that the first-rate analysts at the highly respected and non-partisan Congressional Budget Office (CBO) had projected, as late as October 1993, that total U.S. health spending in the year 2000 would be \$1.7 trillion, or close to 20% of GDP. No one questioned these estimates at the time. The actual numbers in 2000 turned out to be only \$1.3 trillion of total U.S. health spending, or 13% of GDP. In other words, even with all of its analytic prowess and access to data, the CBO overestimated total U.S. health spending only 7 years hence by as much as 30%!

With respect to the second number—the number of uninsured in future years who will need financial help—the open question is how fast private health insurance premiums in general will be rising over the next decade. As noted earlier, and as will be explained in more detail in Section II on “Cost Control” further on, if the annual increases in these premiums continue at their current rate (between 8% and 20%, depending on the region, the size of the business firm, and the health of its employees), more and more of the currently insured, low-wage workers will see themselves priced out of health insurance altogether.

**Added Public Spending vs. Added National Health Expenditures (NHE):** A common confusion in debates on health reform arises out of the distinction between (1) added public budgeted outlays and (2) added national health spending (NHE). They are not just two sides of the same coin.

A proposal that will entail an additional \$100 billion of annual public health spending typically will result in a much smaller addition to total national health spending. It is so because part of the new public spending almost inevitably will replace private health spending that would otherwise have occurred in any event.

For example, a low-income family may have paid for health care out of pocket all along, but would have that out-of-pocket spending reduced through newly available public assistance. Similarly, small business firms with low-wage workers may decide to cease offering their employees high priced private insurance in response to the availability of a new public insurance program.

**The “Crowding In” Effect of Public Insurance Programs:** The previous paragraph touches upon a phenomenon known among policy analysts as the “crowding in” effect: new public health-insurance initiatives for the uninsured usually attract the already insured, unless the bureaucratic hurdles protecting the new program are so onerous as to keep out even the uninsured for whom the program is designed to help.<sup>8</sup> This effect substantially increases the new public-budget cost per currently uninsured brought under coverage.

To illustrate, the annual expected average health spending for currently uninsured adults under age 65 may be only about \$2,000. Without a “crowding in” effect, it would therefore cost about \$20 billion to cover 10 million such individuals. With “crowding in” of already insured individuals, however, the program actually may entail \$40 billion of new public funding, thus raising the new public-budget cost to \$4,000 per net additionally uninsured. If one compares that figure with the average cost of a privately insured person, one may easily fall into the trap of ascribing the higher figure for the new public program as the legendary “government inefficiency.” It has nothing to do with efficiency. It is a problem of targeting.

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<sup>8</sup> These bureaucratic hurdles can explain why so many Americans who are actually entitled to Medicaid or SCHIP are not enrolled in these programs.

**Summary of this Primer on Insurance Coverage:** The point made in the preceding paragraphs is that journalists and other laypersons need not delve deeply into the details of health-reform proposals to understand their general thrust.

A logical starting point in reacting to such proposals is to examine the budget being proposed for it. It indicates how serious a candidate believes the problem of the uninsured to be and to what length he would go to solve the perceived problem. Knowing what dollar amount is budgeted for a proposal to help the uninsured, and keeping in mind the rough benchmark figure of an additional \$100 billion or so per year in public spending to achieve comprehensive, universal coverage in the near term, helps one *gestimate* roughly how many of the currently uninsured would be likely to be covered by the proposal

Next, all a layperson really needs to know is what mixture of the 3 major mechanisms is used in the proposal: (1) an expansion of public programs, (2) bribing employers to extend coverage or (3) granting the uninsured vouchers or other forms of direct subsidies toward the purchase of health insurance in the non-group market for individually purchased health insurance.

All of the rest is merely fluff that occupies the policy wonk but befogs the public debate on health policy.

### C. What President Bush would do about the Uninsured

**Refundable Low-income Tax Credits:** President Bush proposes to grant the uninsured means-tested, refundable tax credits towards the purchase of non-group health insurance, where “refundable” means that persons not owing any income taxes can nevertheless collect the amount of the credit from the government. In the President’s earlier budget messages, the total 10-year commitment for these credits was put at \$90 billion.<sup>9</sup> More recently, the Lewin Group estimated these outlays as \$129 billion over 2006-25.<sup>10</sup>

Specifically, the President’s proposal would grant individuals or families a credit of up to 90% of private market premiums for health insurance. They would be income-related and subject to a maximum credit of \$1,000 for a single adult and \$3,000 for a family. The full credit of \$1,000 would be available for individuals with an adjusted gross income of up to \$15,000 and phase out completely at \$30,000. The full credit of \$3,000 would be available for families with an adjusted gross income up to \$25,000 and phase out completely at \$40,000 for families with one adult and \$60,000 for families with two adults.

These maximum credits appear small relative to the private market premiums for traditional, comprehensive health insurance policies, which now run around \$10,000 for families if the policies are bought on a group-basis by an employer for large risk pools. The policies

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<sup>9</sup> If one assumes that health insurance premiums over the decade will rise at, say, about 6 percent per year, then a spending stream that starts out with about \$7 billion in tax-credits in 2006 and ends up with tax credits of \$11.5 billion in 2015 would sum to exactly \$90 billion over the entire decade.<sup>9</sup> At an assumed 8% premium growth, the corresponding numbers would be \$6.2 billion in 2006 and \$12.4 billion in 2015. Evidently, these numbers fall far short of the previously discussed annual \$100 billion benchmark required for truly universal health insurance coverage.

<sup>10</sup> The Lewin Group, *BUSH and KERRY HEALTH CARE PROPOSALS: COSTS AND COVERAGE COMPARED*, Washington, D.C.; September 21, 2004; Figure 7. See [http://www.lewin.com/Lewin\\_Insight/default.htm](http://www.lewin.com/Lewin_Insight/default.htm)

would cost much more if they were bought on the individual insurance (non-group) market, because these markets tend to be segmented by risk class and the premiums charged carry large loads for marketing (including brokers' commissions) and administration.

It fair to wonder how much "uptake" the credits would have among the uninsured. Would a family with a \$25,000 annual income be willing and able to pay the additional sum (which could be as high as \$9,000 per year) it would have to pay for a comprehensive insurance policy bought in the non-group market? The President appears to have in mind instead that households should purchase only so-called catastrophic insurance policies with high annual deductibles (\$2,000 to \$5,000 per family per year), whose premiums would be lower. (More on this approach in the next section.) Families with chronically ill members, however, would then be saddled, year after year, with the high out-of-pocket deductible, year after year.

In view of these additional outlays required of the family, there is great uncertainty among health policy analysts about how many of the currently uninsured low-income families would actually be enticed into insurance coverage by refundable tax credits.

**Consumer Directed Health Plans (Health Savings Accounts and Catastrophic Policies):** As noted in the preceding subsection, the overall thrust of the President's health policy is to encourage a gradual switch, over time, from the traditional, comprehensive public or private health insurance policies to which Americans have long been accustomed to merely catastrophic private health insurance with very high deductibles (\$2,000 to \$5,000 per year per family). It is this vision that has earned the President's proposal the label "radical."

The President would encourage this transition by making the premiums for catastrophic health insurance purchased in the non-group market policies tax-deductible. Deposits into Health Savings Account (HSAs) to meet the high deductibles, made by either employers or individuals, already are tax deductible under current law, but only if they are coupled with a high-deductible, catastrophic health insurance policy (at least \$1,000 for an individual or \$2,000 for a family).

It is widely recognized by actuaries and health services researchers that a switch from the current, more comprehensive insurance policies to catastrophic policies coupled with tax-favored Health Savings Accounts (HSAs) would have two redistributive effects:

1. By making deposits into the HSAs and the premiums for catastrophic health policies tax deductible, one effectively makes the after-tax dollar cost of health care at the time health care is received cheaper for high income families (facing high marginal tax rates) than for low-income families. (This highly regressive effect could easily be avoided, of course, simply by allowing all households, in all income groups, to claim a refundable tax credit equal to a flat X% of whatever the household spends on deposits into the HSA or on premiums for catastrophic coverage. The fact that this fix is so easy and obvious suggests that the Administration and the Congress actually prefer the more regressive approach to health-care financing—a fact that should pique the curiosity of journalists).
2. High deductible health insurance would redistribute the overall financial burden of health care in society from the chronically healthy (who normally would not have to spend the whole deductible) to the chronically ill who probably would have to spend out of pocket the whole deductible, year after year.

In connection with the second point, it is worth noting that total national health spending in any modern nation—or for any large employer--tends to be concentrated among a few, very sick individuals, many of whom are chronically ill and have these high expenditures year after year. (As will be argued later in Section II on "Cost Control," that

high skew also limits the ability of high-deductible health policies to control a nation's overall health spending. )The exhibit shown overleaf illustrates this point with data for Americans under age 65, for the year 1996. Such a table would look very similar, if it were based on 2004 data, although the average spending numbers (in dollars) for particular groups would, of course, be at least 60% higher overall, because overall per-capita health spending in the U.S. rose by at least that much over the period from 1996-2004.

### Concentration Of Health Expenditures And Average Expenditures, By Plan Type, For Persons Under Age Sixty-Five With Employment-Related Health Insurance, 1996

Percentile	HMO		Any managed care (HMO or gatekeeper)		Other plans (Indemnity/PPO)	
	Percent of spending	Average spent	Percent of spending	Average spent	Percent of spending	Average spent
Top 5 percent	51%	\$17,474	50%	\$17,025	53%	\$18,986
Top 10 percent	64	11,002	63	10,829	66	11,991
Top 30 percent	86	4,960	86	4,920	88	5,335
Top 50 percent	95	3,268	95	3,248	96	3,473
Bottom 50 percent	5	174	5	177	4	145

**SOURCE:** 1996 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

**NOTES:** See Note 9 in text for a description of the health plan types used in each column. HMO is health maintenance organization. PPO is preferred provider organization.

SOURCE: Mark L. Berk and Alan C. Monheit, "The Concentration of Health Care Expenditures Revisited," *Health Affairs* (March/April 2001): 9-18.

It may be noted in passing that the HSA approach has been eagerly awaited by the financial community. They see in the account balances that chronically healthy individuals will accumulate in their tax-preferred HSAs over time a close cousin of the 401(K) plans or Roth IRAs. The mutual fund industry and other financial managers are just chomping at the bit to manage these funds on behalf of the chronically healthy. As is well known—or should be well known—these financial managers charge their customers anywhere between 1% to 2% of net asset value in an account they manage, regardless of the actual financial returns earned by the managers on those funds. Thus, if a large number of Americans were to switch to the HSA-plus-catastrophic coverage approach, Wall Street stands to gain billions of additional fees each year for managing the HSAs. (It is the same reason, of course, why Wall Street eagerly awaits the partial or, ideally, full privatization of Social Security).

**Help to Small Employers:** To promote his concept of HSAs and high-deductible, catastrophic insurance coverage, the President would grant small employers tax credits (\$200 for individuals and \$500 for families) towards the purchase of these kinds of policies.

In addition, President Bush would assist small employers by allowing them to band together in so-called *Association Health Plans (AHPs)*, which can be thought of as health

insurance purchasing cooperatives. The idea is that these cooperatives would be able to bargain with insurers over premiums than the individual firm can.

Although the *AHPs* have great intuitive appeal, they are forever open to adverse risk selection. Specifically, an employer with relatively sicker employees will flock to the larger risk pools offered by the *AHPs*, in the hope that the larger pool will be relatively healthier than the pool of the firm's own employees, so that the premium charged by the *AHP* will be below the actuarial cost of the firm's own employees. Employers with healthier employees, on the other hand, may be able to get better bargains on their own. Over time, the *AHPs* therefore may be subject to a death spiral, as their risk pools become ever costlier, driving ever more firms with healthier employees out of the pool.

There is the further question how the *AHPs* would be regulated. To assume that they would invariably behave properly is belied by the checkered history of such organizations. As *Business Week* notes in its issue of September 13, 2004:

Regulators say that some health insurers market policies through associations that claim they are independent but often aren't. Their alleged independence often exempts them from state insurance laws, allowing big, unexpected rate hikes. An estimated 6 million people are covered by such association group insurers (p.60).

Journalists therefore should probe carefully just how the newly proposed would be structured and regulated, and by whom.

**Neighborhood Health Centers:** Finally, the President would provide unspecified added funding for neighborhood health centers catering to the uninsured. Neighborhood health centers have the advantage of specializing in the treatment of the lower income groups in society who find it easier to access them than, say, the bureaucratic Medicaid and SCHIP programs. From a political perspective, they have the added advantage of allowing the politician to ration health care without openly admitting it, simply through tight annual budgets granted the centers.

**Number of Newly Insured under the President's Proposals:** Estimates on the number of otherwise uninsured that would be covered under the President's proposal vary. The *American Enterprise Institute (AEI)*, a Washington think tank generally aligned with the President's domestic and foreign policy, projects that as many as 6.7 million currently uninsured Americans would gain coverage under the President's sundry proposals. The previously cited Lewin Group projects that as many as 8,2 million of the projected 49 million uninsured in 2006 would be covered by the President's proposal.<sup>11</sup> Emory University economist Kenneth Thorpe, aligned with the Kerry camp, had put that number at \$90 billion, covering only 2.4 million newly insured.<sup>12</sup>

On either of these estimates, the President's plan evidently would not make a major dent into the number of uninsured Americans (projected, as noted, by the Lewin Group to be close to 50 million in 2006).

Lay persons may be frustrated by these diverging estimates and wonder what drives them. Health policy analysts come to different estimates on the cost and additional coverage implied by particular health-reform proposals mainly because they feed different assumptions about human behavior into their forecasts. Prominent among these assumptions are:

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<sup>11</sup> See <http://www.kcautv.com/Global/story.asp?S=2327904> and [http://www.lewin.com/Lewin\\_Insight/default.htm](http://www.lewin.com/Lewin_Insight/default.htm)

<sup>12</sup> Kenneth EW. Thorpe, "Proposals for Covering the Uninsured and Reducing Health Care Costs: President Bush and Senator Kerry," (Slide presentation, June 3<sup>rd</sup>, 2004)

1. the assumed uptake of tax credits among the uninsured (i.e., whether a family offered a \$3,000 tax credit will spend the additional several thousand dollars out of its own budget to purchase a health insurance policy);
2. the number of employers of low-wage Americans who might drop their employer-provided health insurance if and when premium subsidies for individually purchased insurance becomes available to their employees (the previously discussed "crowding in" effect of new public programs).

Unfortunately, selecting assumptions for one's forecasting efforts is not invariably free of ideological predilection. For that reason, journalists should always inquire into the forecaster's political allegiance when reacting to a particular health policy forecast.

**Total Estimated Cost of the President's Proposals:** Because the President proposes a diverse basket of measures, it is anybody's guess what the total package may cost over the next 10 years.

The *American Enterprise Institute (AEI)* has estimated that the total package may cost the federal government \$125 billion between 2006 and 2015. That sum is composed of (1) direct outlays for tax credits and (2) forgone tax revenue from the tax-preference accorded Health Savings Accounts and catastrophic insurance policies. Of the total of \$125 billion, however, only about \$37 billion would subsidize Americans now without insurance. \$88 billion would go to Americans who already have insurance. It reflects the "crowding in" effect discussed earlier in this Primer.

As noted above, Emory University economist Kenneth Thorpe has estimated the total cost of covering the uninsured at \$90 billion.

According to the previously cited Lewin Group report, the President's entire plan would occasion an additional federal outlay of \$227.5 billion over the 10-year period following full implementation in 2006.

#### **D. What Senator Kerry would do about the Uninsured**

Senator Kerry proposes to allocate anywhere between 6 to 8 times as much federal money to solve the problem of the uninsured than does the President, depending on what forecast one believes. This much larger budget allocation makes his approach bolder financially, and more far-reaching, covering an estimated 25 to 27 million or so of the uninsured in 2006.

On the other hand, Senator Kerry's proposal is not nearly as radical in concept as is the President's preference for high-deductible policies. It is so because Senator Kerry would merely strengthen the three already existing components of the current health insurance system, which would be left more or less unchanged overall. He would (1) fold millions more into the already existing Medicaid and SCHIP programs that are administered by the state under a federal-state cost-sharing formula. (2) grant subsidies to employers, to assure the future sustainability of the employment based health insurance system.<sup>13</sup> Finally, (3) he would grant the unemployed and self-employed subsidies toward the purchase of non-group health insurance policies through the Federal Employee Health Benefits program (FEHBP) used by members of Congress and federal employees.

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<sup>13</sup> Full disclosure requires me to mention that I personally have expressed serious misgivings of the employment-based health insurance system. See, for example, Uwe E. Reinhardt, "Employer-based health insurance: a balance sheet", *Health Affairs*, November/December 1999; 18(6): 124-132.

**Expansion of Medicaid and SCHIP:** Senator Kerry proposes a swap with the state governments of financial responsibility for children currently insured by the joint federal-state Medicaid program for the poor.

The federal government would assume full financial responsibility for some 20 million children now enrolled in Medicaid. In return the states would expand SCHIP (or Medicaid) coverage for children in families up to 300% of the federal poverty level (about \$56,000 for a family of four). They would also cover working parents in families up to 200% of poverty (about \$37,000 for a family of four) and cover all adults with incomes under the federal poverty line. The swap would be structured so as to be financially attractive to the states. Presumably, for these expansions at the state level there would still be a federal match for additional dollars spent by the states.

My own reservation concerning these two public programs has been that the fees they pay providers tend to be unreasonably low, often not even covering the providers' cost. Not surprisingly, many physicians simply refuse to accept Medicaid patient, an option, however, that is not practical for hospitals.

**A New Purchasing Cooperative for Health Insurance:** Senator Kerry would allow individuals and small business firms to procure health insurance through a new sister institution of the *Federal Employee Health Benefits Program (FEHBP)*. As noted earlier, the FEHB is a giant, nationwide health-insurance purchasing cooperative (farmer's market for health insurance, so to speak). At the moment, this co-op is available only to federal employees and members of Congress, who purchase through it their health insurance on a defined contribution approach (i.e., an approach under which the federal government makes a defined dollar contribution to the purchase of health insurance).

To offer the uninsured and small business the benefit of such a co-op, Senator Kerry would mandate the *FEHB* to establish a separate risk pool (to be called the "*Congressional Health Plan*" (*CHP*)) in which all insurers offering their policies under the *FEHBP* would have to participate as well. The idea here is to sidestep the high cost of health insurance in the market for individual (non-group) health insurance, in which the commissions of insurance agents and other selling and administrative costs eat up so much of the premium.

An allied idea is to create large risk pools under which chronically health individuals subsidize indirectly (with their premiums) the premiums of chronically sick people. That form of indirect income redistribution from the chronically health to the chronically sick has been the cornerstone of all employer-based health insurance country—really a form of private-sector socialism—and also of the *FEHB* used by members of Congress.<sup>14</sup>

**Premium Subsidies for Small Businesses, the Self-Employed and other Individuals:** The Senator would offer small employers refundable tax credits up to 50% of the premiums small business firms pay for their employees, if all employees are covered by the firm. At the moment, only about 60% of such businesses (with fewer than 50 employees) offer their

<sup>14</sup> Actuarial purists, many economists often among, would prefer not to use the health insurance mechanism as a vehicle for the redistribution of income. Instead, they would allow the insurance market to segment itself by risk class and to charge "actuarially fair" premiums that reflect the individual insured's health status. Social equity would then be sought by redistributing income outside the health insurance mechanism—for example, by subsidizing families with refundable tax credits so that no family would be required to spend more than X% of its household budget on health care (premiums and out of pocket payments at the time health care is used. It can be doubted that the general public would be ready for so radical a departure from traditional American health insurance, based on larger risk pools with their implied redistribution of income.

employees health insurance, and that number is shrinking as premiums charged these firms increase at rates in the mid- and high teens.

Premium subsidies also would be extended to individuals—e.g., a 75% tax credit for temporarily unemployed workers, and subsidies that would limit to premiums paid by self-employed Americans to 6 percent of their income. Retirees between age 55 and 64 also would receive tax-credit assistance toward their purchase of health insurance, and they would be able to do so through a new health-insurance purchasing co-operative described above.

**Federal Sharing of the Cost of Catastrophically Sick Employees (called the “Premium Rebate”):** Arguably the boldest and most innovative part of the Senator’s proposal is a provision under which the federal government would absorb part of the cost of high-cost employees who are insured by employers. In effect, he proposes to have the federal government function as a tax-financed reinsurance company for employer-provided health insurance.

The premium rebate would be granted to an employer if the annual health-care cost for an employee exceeds a certain threshold (e.g., the government would pay 75% of the annual cost of such employees above a threshold of \$30,000 in 2006 or in excess of \$50,000 in 2013). The objective of this provision would be to lower the actuarial cost for self-insured or other company health plans per employee by about 10% of what these costs would otherwise be. It is this feature that has Senator Kerry claim that he would lower health insurance premiums for employed Americans.

To qualify for this “premium rebate,” employers would have to (1) extend health insurance coverage to all of their workers without the restrictions increasingly common among employers today, (2) adopt health plans with disease management programs and (3) share the premium savings from the rebate with employees.

The premium rebate would transfer several hundred billion dollars a year out of the payroll expense accounts of employers and into the federal budget. Emory University economist Kenneth Thorpe, aligned with the Kerry camp, has estimated the size of the transfer at about \$250 billion or so over the 10 years 2005-2014. The *American Enterprise Institute*, aligned with the Bush camp, has estimated the transfer in excess of \$500 billion over the same time span. The Lewin Group puts the number as high as \$700 billion.

Critics of this proposal object to it not only because it would transfer billions of dollars of health spending from the private to the public sector, but also because it would cement in place the employment-based health insurance system with all its shortcomings (e.g., the fact that insurance is not portable).

On the other hand, the measure clearly should have a positive impact on the labor market and increase employment, other things being equal.<sup>15</sup> Indeed, as far as the business sector is concerned, the idea could be styled as *bona fide supply-side economics*, as it would be cut in the “taxes” that the health sector can impose on the labor market (although that “tax rebate,” of course, would then be financed by current or future general taxes, which would have to cover the premium rebates to employers). One should think, therefore, that, in principle, the business community should welcome this part of Senator Kerry’s health-reform proposal.

Will business executives be likely to welcome Senator Kerry’s premium rebate plan? Not necessarily. When reacting to domestic-policy proposals, all business executives are subject to a

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<sup>15</sup> In the jargon of economics, the measure should shift up the demand for labor (as it would be cheaper for employers) and shift out the supply of labor curve (because lower premium contributions effectively amount to an increase in take-home wages).

serious conflict of interest, as each of them presides over two quite distinct financial enterprises: (1) one that belongs to distant shareholders as whose agents the executives function, and (2) the executive's own family fortune. One should expect that business executives are normal economic creatures who instinctively will favor public policies that benefit their own family enterprises, even at the expense of the other enterprise they manage.<sup>16</sup> Tax policies--or Senator Kerry's proposed cost sharing for health-care costs--that might benefit shareholders could hurt the executives personal enterprise through higher taxes on personal income. Therefore, corporate executives might not, in fact, favor the Senator's proposal, particularly as he has announced that he would finance his health-reform proposal by rolling back the Bush tax cuts for the top 2% wealthiest of the nation's tax payers, a group to which most business executives belong.

**Number of Newly Insured under Kerry's Proposals:** Senator Kerry's proposal has been estimated to cover anywhere from 25 to 27 million newly insured Americans in 2006. The low estimate has been made by the Lewin Group.<sup>17</sup> Both the American Enterprise Institute and Kenneth Thorpe would put that number at about 27 million.

If one plausibly assumes these additional insured to be mainly low-income Americans, then the bulk of the problem of the uninsured would have been solved by Senator Kerry's plan. The remainder could either purchase insurance on their own or, if they remained uninsured, be taken care of by doctors and hospitals through a mixture of self-pay and charitable care.

**Total Estimated Cost of Senator Kerry's Proposals:** The total price tag in terms of additional federal outlays attributed to Senator Kerry's proposals for the ten-year period 2005-2014 ranges from a low of \$653 billion (estimated by Emory University economists Kenneth Thorpe) over the period 2005-2014 to a high of \$1.4 trillion over that same period and \$1.5 trillion over the period 2006-2015 (presented by the American Enterprise Institute).

In between is an estimate the Lewin Group, according to which the Kerry Plan would entail a total additional federal budget outlay of \$1.249 trillion over the 10-year period following full implementation in 2006. As the Lewin report points out, however, the added federal spending would be offset by a lowering of private market health insurance premiums of \$774 billion of reduced spending by states in the amount of \$51 billion, all over the period 2006-2015.

In short, the Kerry plan envisages a massive transfer of funds from the private sector and the states to the federal sector.

## E. Summary of the Bush and Kerry Plans

As is shown in the summary graph presented on the next page, in health policy, as elsewhere, one gets roughly what one pays for.

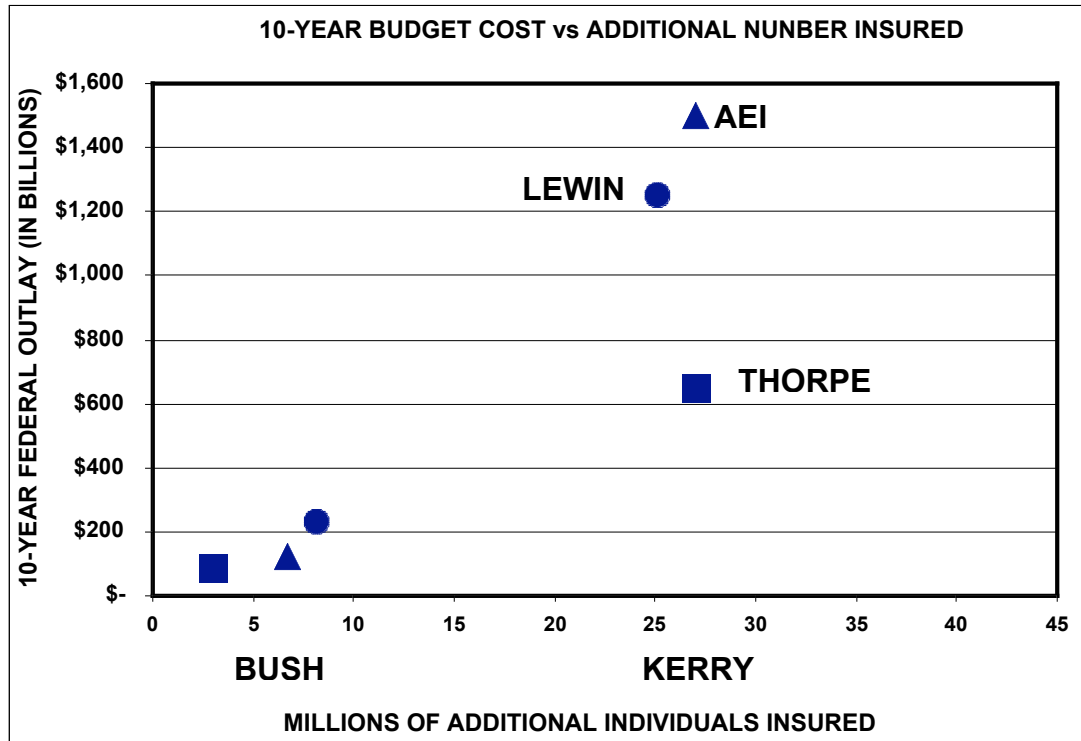
Senator Kerry proposes to extend health insurance coverage to many more otherwise uninsured Americans than would President Bush. On the other hand, he also would spend vastly

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<sup>16</sup> This conflict of interest, incidentally, could explain also the curious fact why there never has been more of a constituency among corporate executives for eliminating the corporate income tax (aside from loop holes granted especially to individual firms).

<sup>17</sup> See <http://www.kcautv.com/Global/story.asp?S=2327904> and [http://www.lewin.com/Lewin\\_Insight/default.htm](http://www.lewin.com/Lewin_Insight/default.htm)

more federal dollars on that program than would the President. That conclusion emerges from all three rival forecasts cited in this Primer, even though these forecasts exhibit some variance.



In contemplating the numbers on additional federal spending for health care—especially the much higher numbers attributed to the Kerry Plan—it is important to keep in mind two important points:

First, additional federal spending in a health-reform proposal rarely constitutes a dollar-for-dollar addition to national health spending (NHE), as a sizeable fraction of the new federal spending merely replaces health spending by state governments or the private sector. The Lewin Group, for example, whose analysts is arguably the most detailed and most sophisticated of the three forecasts cited in this Primer, has estimated that the \$1.249 trillion of new, 10-year federal spending during the period 2006-2015 is offset by \$343.5 billion in spending by the states. The net public-sector outlay triggered by the Kerry Plan therefore would be only \$906 billion, according to the Lewin Group.<sup>18</sup>

Second, these are projections for an entire decade! Based on projections published by the Centers for Medicare and Medicare Services (CMS) of the Department of Health and Human Services (DHHS) the CMS actuaries,<sup>19</sup> the projected total health spending for the 10-year period 2006-2015 can be projected to be as much as \$28.8 trillion. Thus, additional projected public-

<sup>18</sup> I did not find in the Lewin Group report an explicit estimate for the net addition to total national health spending likely to be triggered by the Kerry Plan. In a private e-mail communication, John Sheils, the chief author of the Lewin Group report, puts that number at about \$950 billion over 2006-2015, or about 3 to 4% of total national health spending. (E-mail dated September 29, 2004). Once again, however, these are highly uncertain projections over so long a period.

<sup>19</sup> See <http://www.cms.hhs.gov/statistics/nhe/default.asp#download>

sector spending of \$906 attributed to the Kerry Plan represents only about 3.14% of projected total national health spending over the decade 2006-2015. Total public sector health spending (of all levels of government) during 2006-2015 can be projected to be about \$13 trillion. The \$906 billion added public sector spending attributed to the Kerry Plan is only 6.8% of that total.

Senator Kerry is being accused by his critics of proposing a “government take-over of American health care,” the same label once applied to the much more ambitious and far-ranging Clinton Health Plan. That may be expedient campaign rhetoric, and it may even be acceptable by today’s political etiquette. To fair observers, however, proposed additional government spending that represents only about 3% of total health spending hardly qualifies for the label of a “government takeover of American health care.”

The truth is that the Kerry Plan, and the President’s even more so, are rather small, incremental reforms of the health system.

## F. Who of the two Candidates has the better Plan for the Uninsured?

I am often asked this question, sometimes in earnest, as if it could be answered objectively. It cannot. Ultimately the answer depends on one’s preferred *social ethics* regarding health care, on which Americans cannot agree. Therein lies one major obstacle to effective health reform.

**The “Health-Care-is-a-Private-Consumption-Good” School:** One school of thought among Americans believes that health care is just another private, basic consumption good (such as food, housing and clothing) whose financing should be mainly the individual’s responsibility and for which only a bare-bone package of services should be guaranteed the individual regardless of ability to pay. The implication is that members of this school accept the idea that all health care outside the bare-bones package should be rationed among Americans by price and ability to pay.<sup>20</sup>

Typically, this school also believes that, unfettered by government intrusion, private market forces would allocate health care resources efficiently, in a way that maximizes “social welfare.” The vision is that patients, covered by high-deductible health insurance policies, would have the incentive to shop around smartly for cost-effective health care, that is, for the combination of prices and quality they prefer or can afford. People in this school of thought also believe that patients themselves would be the best monitors of the quality of care they receive. This school of thought naturally would prefer the President’s approach to health reform.

**The “Health-Care-is-a-Social-Good” School** On the other hand, another school of thought among Americans believes that health care is quite unlike other basic commodities—that it is a social good that should be available to all who need it on roughly equal terms, without regard to the individual’s ability to pay for the care they receive. These people probably would favor Senator Kerry’s plan, because he proposes to cover so many more uninsured Americans than does the President and he does not emphasize high-deductible health insurance policies.

This school of thought questions the merits of high-deductible health insurance, because its members doubt that the individual patient will ever be able to function as a smart shopper for

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<sup>20</sup> The idea that prices in a market economy are an instrument for rationing health care can be found in standard textbooks on economics, even those of politically conservative market devotees. In this connection, see Larry L. Katz and Harvey S. Rosen *Microeconomics*, Homewood, IL.: Irwin, 1991; and Uwe E. Reinhardt, “Rationing Health Care: What it is, What it is Not, and Why We Cannot Avoid It,” in Stuart A. Altman and Uwe E. Reinhardt, eds. *Strategic Choices for a Changing Health System*, Chicago, IL.: Health Administration Press, 1996: 63-100.

health care and thus control the quality of care. There are, after all, thousands upon thousands of separate items in the price lists of doctors, hospitals and other providers of health care (over 9,000 items in the physician fee schedule alone). One can legitimately wonder how such price information can be meaningfully conveyed to individual patients, especially because, in a free market, doctors and hospitals can price-discriminate (i.e., charge different patients different prices for the same service).

Prices alone, however, do not determine the health care bill. It is a product of prices times the quantity of health services used. To assess the relative “costliness” of a physician, patients would also have to know in advance which doctors practice very service-intensive medicine, with many tests and revisits, and which among them prefer more conservative and cheaper practice styles. It is not clear to this school of thought how that information on practice styles could be meaningfully conveyed to patients. This school of thought wonders whether patients will ever be able to control effectively the clinical quality of their care, apart from the amenities of the setting in which it is delivered.

**Social Ethics:** Finally, which one of the two plans one favors as a voter also depends crucially on the extent to which one personally wishes to be one’s poorer and sicker brothers’ and sisters’ keepers in health care.

Evidently, the two candidates have in mind quite different price tags (in terms of added taxes and transfers) for their proposals. One’s ethical perspective on being one’s poorer brothers’ and sisters’ keeper in health care will determine indirectly one’s tolerance for higher taxes.

**So who has the better plan?** In short, it is not sensible to ask a social scientist which of the two candidates has the better health reform proposal for the uninsured. It is an inherently ideological issue.

## II. CONTROLLING THE GROWTH OF HEALTH SPENDING

### A. The level and Growth of U.S. Health Spending

Although the United States has one of the youngest populations in the industrialized world, it spends 53% more per-capita on health care than does Switzerland, the next most expensive country in the OECD, with a much older population. The U.S. spends 80% more per capita than does neighboring Canada, with a population of roughly the same age and a similar culture. Even so, in spite of its high spending the U.S. ranks lower than most other industrialized countries on health status indicators such as infant mortality and life expectancy. Furthermore, it does not consistently rank higher on measures of the quality of health care or on patient and physician satisfaction.

Private-sector health insurance premiums since about 2000 have risen at annual rates between 10 and 20 percent, depending on the region and size of business establishment purchasing these policies on behalf of employees. This growth in insurance premiums will inexorably price more and more low-skill, low-wage workers out of health insurance and modern American health care as we know it. These low-wage workers and their employers are sailing into a perfect storm.

## B. Sailing into the Perfect Storm

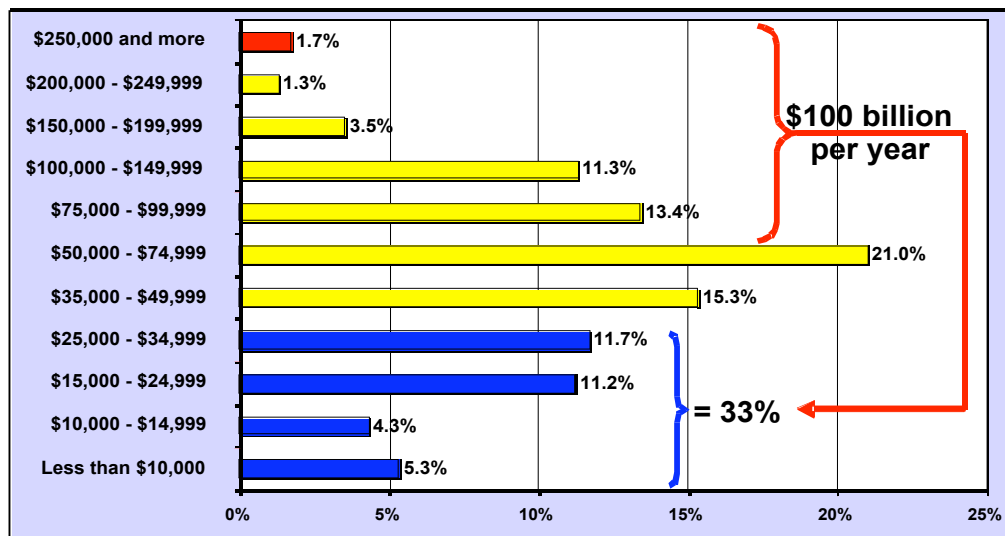
To illustrate the perfect storm into which America's low-wage workers are sailing, one must appreciate what economists have long known, namely, that all of an employee's wages, taxes and fringe benefits must be financed by his or her "wage base." By the latter is meant *the total dollars of debits that a firm can make to its payroll-expense account for a worker and not lose money on hiring that worker.*

Suppose that a worker's total wage base were \$30,000 now, and suppose it grew by a steady 3.5% per year during the next decade. Then that wage base would be \$42,000 ten years hence. It would have to finance (1) the worker's take home pay, (2) all income, Social Security, Medicare and Unemployment Insurance taxes and contributions to health insurance premiums withheld from the worker's paycheck, (3) all contributions employers must make, by law, to Social Security, Medicare, and Unemployment Insurance for that worker and (4) all fringe benefits, such as health insurance, pensions, vacations, sick days and so on, which employers voluntarily provide their workers.

If health insurance premiums in this country grew by "only" 8 percent per year during the next decade, a family policy that now costs \$10,000 would cost \$21,600 ten years hence. That premium would have to be borne by a wage base of \$42,000. It would constitute about half of that wage base. If, on the other hand, premiums grew by 10% per year (still low by recent standards), then close to 62% of the gross wage base of \$42,000 would have to be set aside just for health insurance.

Clearly, that wage base would be too small a donkey to carry so heavy a load for health insurance alone. Initially employer might respond to these trends simply by shifting more and more of the health care cost of employees into the employees' budgets, through premium contributions, reduced benefit packages, ever higher deductibles and coinsurance. At the extreme, they would stop providing health insurance at the work place altogether.

### DISTRIBUTION OF FAMILY INCOME, UNITED STATES, 2002 Average income \$66,970 (Median about \$50,000)



SOURCE : Bureau of the Census website <http://ferret.bls.census.gov/macros/032003/faminc>.

The question is whether Americans in the, say, upper third of the nation's income distribution will then be willing to step up to the cashier's window to help subsidize the health insurance of families in the lower third, as this storm takes on force. (See the graph below). The federal budgets passed by Congress in recent years suggest that the answer is "No."

### **C. President Bush's Proposals for Cost Control**

**Consumer Directed Health Care:** As already noted earlier, in connection with insurance coverage, President Bush sets much store by the idea that individuals can be "empowered" in the health care market through catastrophic insurance policies with high deductibles.

The implied financial incentives, it is assumed, will metamorphose patients from their hitherto passive status as mere recipients of health care into active, smart shoppers for care, who will not only help drive down the prices of health services, but also exercise vigilant control over the quality of health care. This idea appeals especially to economists, although even they would admit that such a market cannot function without useful and reliable information on the prices, practice patterns and quality of care offered by competing doctors and hospitals. So far, that information infrastructure is still in its nascent stage, and only in a few localities.

By how much a wholesale switch from traditional, comprehensive insurance with low deductibles to HSAs, coupled with high-deductible policies, would reduce total national health spending is a controversial issue. It depends significantly on the assumptions fed into the analyst's forecast, to wit:

1. how high the deductibles of the catastrophic insurance policies are;
2. how price-sensitive people in given income groups are to the out-of-pocket cost of the health care they would like to use; and
3. what the household income is of people who chose to elect the high-deductible policies.

Journalists should realize that the assumptions a policy analyst will make about these three factors will powerfully drive that analyst's projected cost savings. These prior assumptions may be driven merely by strong belief. They may also, however, be driven by ideology or partisan politics. Unfortunately, social science is like that, as is actuarial science.

With respect to the third assumption listed above—the income distribution of households with high-deductible policies—it is reasonable to assume that to families in, say, the upper 20 percent of the nation's income distribution (see the earlier graph on the income distribution) even a \$4,000 annual deductible for the family's health care is easily digestible. Practically, their behavior will be impervious to cost sharing. It is hard to imagine, for example, that such a family would forgo, say, a physician visit, a surgical procedure or an \$800 MRI scan recommended by a doctor for one of the family members simply because the family will have to pay up to \$4,000 out of pocket. On the other hand, for families on the bottom third of the income distribution the deductible would be likely to be a much more powerful deterrent to the use of an added physician visit or an MRI. They might be likely to self-ration themselves out of the use of that MRI, even if their physician recommended it. It is in this sense that the income distribution among the families enrolled in catastrophic health insurance plans will drive the effect of these plans on overall cost savings.

In short, the idea of high-deductible health insurance policies accepts tacitly that the self-rationing by consumers in health care for the sake of cost control should be done

mainly by households in the bottom half of the income distribution. Because it is purely a value judgment, economists cannot comment on its merits other than to describe the mechanism.

Given all these uncertainties surrounding the idea of “consumer driven healthcare,” what can be said about its likely impact on overall health spending in this country? In a study of the effect that HSAs (then called MSAs) with high-deductible, catastrophic health insurance would be likely to have on overall health care costs, health services researchers the Rand Corporation concluded that “Medical Savings Accounts would have little impact on health care cost of Americans with employment based insurance.” The authors remark that that

If all insured nonelderly Americans switched to MSAs, their health expenditures would decline between 0% and 13%, depending on how the MSAs are designed. However, not all nonelderly Americans would choose MSAs; taking account of selection patterns, health spending would change by +1% to -2%.<sup>21</sup>

Because these Rand Corporation researchers are very highly regarded in the research community for their analytic prowess and for their scientific objectivity, I find their work compelling although, as they note, much depends on the particular design features of an HSA program and, as I explain above, on the income distribution among families enrolled in them.

**Information Technology:** President Bush recently established the office of a so-called IT czar in the Department of Health and Human Services.<sup>22</sup> The idea is that the federal government’s sundry initiatives in IT should be coordinated and better focused. How powerful that czar, physician-economist David Brailer, ultimately will depend in part on the budget put at his disposal. It is a facet worth watching. Because the application of IT to health care is partially a public good, economists can make a good case for sizeable federal subsidies for IT to the providers of health care.

A new information infrastructure for competitive markets has been promised by the advocates for “consumer driven health care” for over two decades now, ever since President Reagan proclaimed the so-called “pro-competitive health care strategy in the early 1980s. Unfortunately, that promise so far has remained broken, for at least three reasons:

1. the establishment of a health-care IT system involves numerous technical challenges so far unsolved—e.g., how to present to the public in a useful way information on fee schedules that contain many thousands individual items, and how to measure the “quality” of health care and convey that information to the average citizen;
2. the extraordinarily high cost of modern IT systems for health care, which must be updated year after year in this fast moving technology; and, last but not least,
3. the general reluctance of the supply side of the health care system to subject itself to greater transparency on prices and quality.

It remains to be seen whether the U.S. will be able to overcome these obstacles in the decade ahead. In the meantime, talk about IT on the part of either presidential candidate will remain substantially a hope-and-prayer chant.

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<sup>21</sup> Emmett B. Keeler, et. al., “Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?” *Journal of the American Medical Association*, June 5, 1996, p. 1666-71.

<sup>22</sup> See Michael Romano, “Information=Power,” *Modern Healthcare* (August 23, 2004).

**Malpractice Reform:** The President also appears to set much store by the ability to constrain the growth in health spending through malpractice reform, by which is meant mainly capping the malpractice awards granted by the courts.

There are many reasons for advocating malpractice reform, especially if the reform includes alternative dispute resolution, outside the tort system. But I doubt that many health policy analysts would argue seriously that merely capping malpractice awards will make more than a tiny dent into the growth of overall health spending. To be sure, the caps have been shown to lower malpractice premiums somewhat in the states that have adopted them, the total premiums paid by all hospitals and physicians is only a very small percentage of total national health spending. (My guess is not more than 2% at most, although I do not have a precise figure.)

Now, it is often said that the main cost driver inherent in the current, tort-based medical malpractice system is not the malpractice premium *per se*, but the clinically unnecessary medical procedures performed simply as a defense against malpractice. Here it must be kept in mind that the procedures now applied as defensive medicine constitute revenue and net income for the providers of health care. The question is whether, with the malpractice caps in place, these providers would voluntarily give up that revenue to which they have become accustomed. I personally doubt it.

In short, I concur that malpractice reform should be on the health-reform agenda, but I do not judge it to be an effective, major instrument for controlling health spending and would love to be shown robust, empirical evidence to the contrary. The Lewin Group comes to the same conclusion, scoring the total cost savings due to malpractice reform at only \$26.8 billion over the entire 10-year period 2006-2015.<sup>23</sup> On an annual basis, and relative to total national health spending, that trivial saving would get lost in the decimal.

#### **D. Senator Kerry's Proposals for Cost Control**

**Information Technology:** Senator Kerry, too, sets great store by the power of modern information technology (IT) to control health spending. He proposes to support, with federal funding, more widespread adoption of information technology among the providers of health care. I have already commented earlier on the obstacles that will be faced by attempts to implement a better IT infrastructure for U.S. health care.

**Disease Management:** Senator Kerry expects substantial cost savings from the more widespread use of “disease management,” especially in its application to high-cost, chronically ill patients who account for so much of national health spending.

The idea behind “disease management” is that professional case managers, along with the patient’s own physician, will constrain costs and enhance quality in the care for chronically ill Americans who account for the bulk of health spending in modern societies.

Alas, disease management has yet to be widely applied, here or abroad. Furthermore, in many instances it will increase rather than reduce health spending, as chronically ill patients now may be underserved by the health care sector. Whether or not disease management would actually reduce national health spending therefore remains an open question.

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<sup>23</sup> The Lewin Group, *op. cit.*; Figure 12.

**Prescription Drug Spending:** Senator Kerry would support measures designed to temper the rising cost of prescription drug therapy.<sup>24</sup> On his website *JohnKerry.com*, the Senator states in a comparison of his with the President's health-reform proposal that he would "allow the HHS Secretary to negotiate lower drug prices and bring generic drugs to market faster."<sup>25</sup> That proposal is not explicitly included in the more detailed *John Kerry's Plan To Make Health Care Affordable To Every American*.<sup>26</sup> There it is mentioned that he would force greater transparency on price on pharmaceutical benefit management companies and assist states in bargaining more effectively with pharmaceutical companies over prices, especially those charged the uninsured. I did not find in that document an explicit proposal to allow the federal government to negotiate prices directly with the drug industry. He would also seek to speed up the introduction of generic drugs by limiting the litigation now used to slow down that process.

Senator Kerry also would assist the states in seeking to constrain their outlays on prescription drugs through the importation of drugs from other countries, notably Canada. While that policy might give some relief to individual states, it does not strike me as a sensible solution to America's problem with spending on prescription drugs. By importing drugs from, say, Canada, Americans are saying, in effect, "Because we are reluctant to have our government control drug prices, we shall let the Canadian government do it for us." Lou Dobbs of CNN might call it "outsourcing government price controls." If Americans wish to go the price control route, they should do so within the U.S., relying on U.S. governments to do the job.

In connection with pharmaceutical prices, it must also be noted cost controls there shoot at a relatively small target from an overall national perspective. Total drug spending at retail prices in the U.S. is still only about 11% to 12% of total national health spending. Whatever savings can be squeezed out of this slice of the national health spending pie therefore will not solve America's overall health-care cost problem. It might, however, significantly help individuals now hard pressed in financing their pharmaceutical therapies. These patients, however, could be helped just as easily—indeed more easily—simply by better insurance coverage for drug therapy.

It is my sense that talk about drug importation by politicians on either side of the aisle tends to be used more like Damocles' Sword hung over the heads of the drug industry. (For plainer spoken folks not steeped in classical literature, a Damocles Sword can be thought of as a two-by-four being swung threateningly over the heads of some people needing to be taken behind the woodshed.) Threatening drug re-importation may be thought to provide the government added leverage in its dealing with drug companies.

It should be noted R&D based drug companies now spend about 13 to 14 cents of every revenue dollar earned on R&D.<sup>27</sup> A question any policymaker must ask him- or herself is what impact proposed policies might have on that R&D effort. Of course, part of that consideration and any dialogue with drug manufacturers is the added question whether it is really necessary for technical progress to allocate as much as 33 to 35 cents of every revenue dollar to "SG&A," which means marketing and general administration.

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<sup>24</sup> See [http://www.johnkerry.com/issues/health\\_care/health\\_care.html](http://www.johnkerry.com/issues/health_care/health_care.html).

<sup>25</sup> See [http://www.johnkerry.com/issues/health\\_care/compare.html](http://www.johnkerry.com/issues/health_care/compare.html)

<sup>26</sup> See [http://www.johnkerry.com/issues/health\\_care/health\\_care.html](http://www.johnkerry.com/issues/health_care/health_care.html)

<sup>27</sup> See Uwe E. Reinhardt, "Perspectives on the Pharmaceutical Industry," *Health Affairs*, September/October 2001; 20(5): 136-149.

## E. Is talking about Cost Control a Smart Political Move?

From a political perspective, it actually is not wise to talk too much about cost control in health care—certainly not in a specific way that makes providers expect truly effective cost control in the future. The reason can be found in *Alfred E. Neuman's Cosmic Law of Health Care*, to wit:

**Every Dollar of Health Spending = Someone's Health Care Income<sup>1</sup>.**

<sup>1</sup> Including "fraud, waste and abuse."

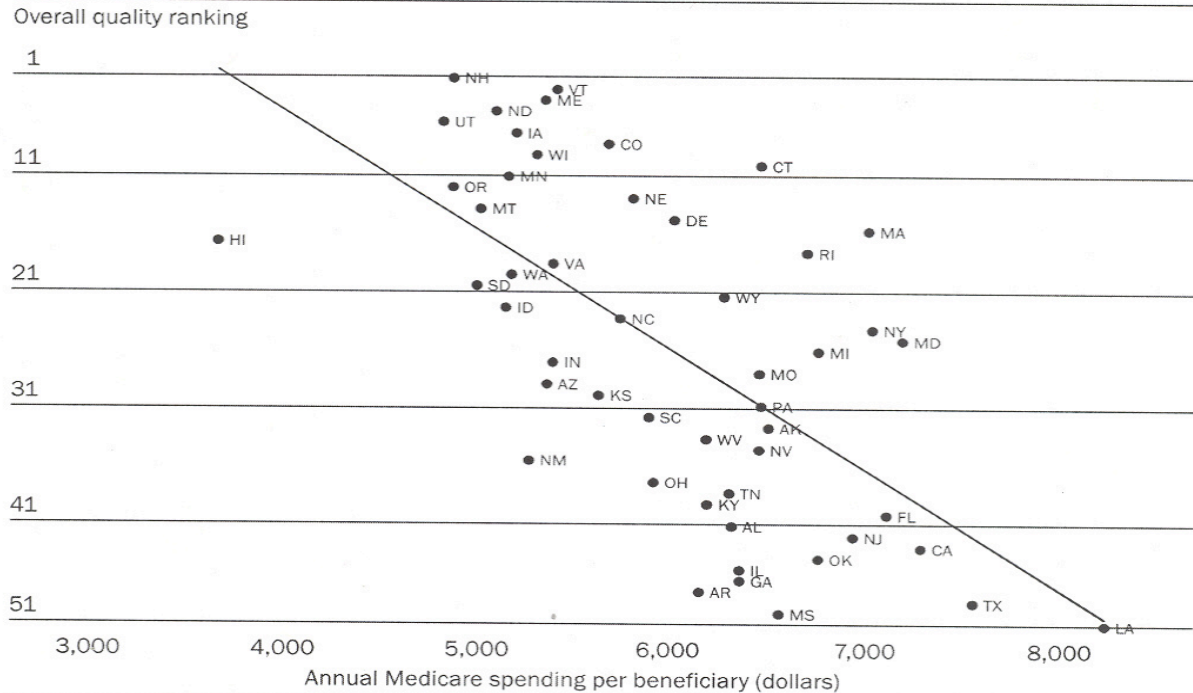
To the providers of health care, the words "cost control" naturally come across as "income control." Smart politicians therefore will use the words "cost control" only in general terms, without getting too specific, lest they upset and mobilize against them the politically powerful supply side of the health-care sector which books "health spending" as "revenue."

## III. THE UNEVEN QUALITY OF AMERICAN HEALTH CARE

### A. The Problem

Americans of all walks of life firmly subscribe to the *credo* that theirs is the best health system in the world. The empirical basis for this *credo*, however, is lacking, unless by "quality" one means strictly the amenities of the clinical setting in which health care is being delivered. . On the issue of *bona fide* clinical quality, the empirical record is actually disturbing.

First, age-sex adjusted health spending per capita in the U.S. has been found to vary by a factor of 2 to 3 across regions without any correlation to the quality of health care (measured by treatment processes or outcome). Indeed, one recent study showed a negative correlation between per-capita health spending on elderly Americans and state rankings in the quality of treatment processes. In the display below, the horizontal axis depicts Medicare spending per elderly in 1996, after statistical adjustment for inter-regional variations in the age-gender mix of the elderly population, practice costs and prices for health care. In other words, the spending numbers on the horizontal axis reflect differences strictly in utilization of health care per statistically similar elderly. The vertical axis represents the overall ranking of the 50 states in a study that scored each state on the quality of a variety of treatment algorithms. Ideally, we would like to have a health system in which the line in that display is up-ward sloping. That the U.S. Congress has never shown much interest in exploring these variations in spending is a sad commentary on federal policy making.

**EXHIBIT 1****Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000-2001**

**SOURCE:** Katherine Baicker and Amitabh Chandra, *Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care*, *Health Affairs Web Exclusive*, April 7, 2004.

The conclusion that the quality of American health care is seriously wanting has emerged also from highly sophisticated, recent research by health-services researchers (including clinicians) the RAND Corporation and published in *The New England Journal of Medicine* last year.<sup>28</sup> Their nationwide study led to the startling finding that, on average, American patients receive widely agreed-upon, state-of-the art medical treatments for specific medical conditions only about half of the time, although there was a wide variance around the averages.

Finally, research summarized by a panel of clinical experts at the prestigious *Institute of Medicine (IOM)* of the *National Academy of Sciences (NAS)* indicates that, each year, somewhere between 50,000 to 100,000 Americans die in hospitals from preventable medical errors that could have been avoided with better operations and information systems.<sup>29</sup> These death rates exceed mortality rates from traffic accidents, or from breast cancer, or from AIDS. The range of estimates is driven by what recent study of the matter one accepts as most representative of the U.S. as a whole. Indeed, the latest such study, still highly controversial, actually estimates the annual death toll from preventable medical errors in the U.S. at 150,000.

<sup>28</sup> See Elizabeth A. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine*, Volume 348, No. 26, (June 26, 2003); pp. 2635-45.

<sup>29</sup> Institute of Medicine, *To Err is Human: Building a Safer Health System*, Washington, D.C.: National Academy Press, 2000.

A subsequent volume published by the Institute<sup>30</sup>--*Crossing the Quality Chasm*-- paints a highly unflattering portrait of the fragmented U.S. health system which, according to the Institute, “does not make the best use of its resources, “lacks even rudimentary clinical information capability” and, consequently, has “poorly designed care processes characterized by unnecessary duplication of services” (p.3). As indictments of human services systems go, this one is severe.

In fairness to the typically hard working professionals of the U.S. health system, however, it must be mentioned that other countries are likely to be plagued by similar problems—fragmented health care processes, poor clinical information systems, high rates of preventable medical errors—and almost surely also have serious problems with the quality of health care. These problems seem universal. Even so, the fact that other nations have similar problems is no excuse for overlooking them in the expensive U.S. health system.

## **B. What the Presidential Candidates would do about “Quality”**

As noted earlier, President Bush recently has established a health-care information initiative within the Department of Health and Human Services, and he has also supported experiments with paying providers of health care explicitly for better quality. I did not find it as a major initiative in his campaign literature, however, nor did I find a budget for it.

Senator Kerry’s health-reform platform on his campaign website includes lengthy sections on the use of information technology, pay-for-quality reimbursement and disease management to enhance the quality of health care in America.

Health policy wonks, however, have for years felt that references to the spotty quality of American health care have little political traction, as every American sincerely believes that their own physician and their neighborhood hospital is the best in the world. Refraining from focusing on the issue therefore is a wise strategy in a political campaign, other than general allusions to the desirability of “better quality.” It probably is too technical an issue for easy communication to lay persons.

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<sup>30</sup> Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> century*, Washington, D.C., National Academy Press, 2002.