

An “All-American” Health Reform Proposal

Reforming the U.S. health care system is frequently thought of in absolutist terms: managed competition versus rate regulation; federal versus state administration; and business mandates versus individual insurance purchases. While these choices must be resolved over the long run, the transition to a new health care system will take several years and require more flexible solutions. The “All-American” Deal offers just that. It requires individual households to be insured and allows businesses to voluntarily offer health insurance; relies on the federal income tax system to collect income-based premiums and transfer funds to states through risk-adjusted payments; and lets states manage the disbursement of funds for uninsured residents.

By Uwe E. Reinhardt

The current debate on the reform of our health system tends to polarize the options. The either-or questions frequently presented include: Should we pursue regulated (managed) competition based chiefly on prepaid capitation, or a regulated, all-payer system based chiefly on fee-for-service payment to providers? Should ours be a federal- or a state-administered health system? Should we mandate business to provide health insurance for employed Americans and their families, or should that mandate be placed on individual households themselves?

These are pertinent questions for a long-run solution. In the short run, however, the choices are unlikely to be as neat. What’s needed is a system to take us from where we are now to wherever we may choose to go. The strategy proposed here is designed as such a flexible transition.

This strategy does not commit the nation to either regulated managed

competition or regulated, negotiated all-payer rates. It allows some room and time for experimentation with both approaches at the state level. Yet it provides universal health insurance coverage and various forms of cost control, including implicit budgeting. Because the media insist that every proposal have a catchy name, I dub it the “All-American Deal,” to signify that it is not just some foreign import. The specifics of the All-American Deal are as follows:

- It would not mandate business to procure health insurance for employees. Instead, it would mandate individual households to be insured, but allow business firms to offer their employees health insurance on a voluntary basis. That design feature should minimize the opposition of small business to health reform.

- It would rely on the federal income-tax or payroll-tax mechanism as a convenient vehicle for the collection of income-based premiums, (not to be confused with taxes!), but it would use the states to

manage the disbursement of these funds to the providers of health care. The federal government would transfer funds it has collected to the states through risk-adjusted capitation payments that could and, in many instances would, be supplemented by the states with their own levies. The size of the federal fund would implicitly act as a partial budget cap on the health system, although it would not be an air-tight global cap.

- States could manage the disbursement of their health fund for residents not otherwise insured in one of three ways: (1) buy these residents into the federal Medicare program; (2) buy these residents into a qualifying state-run Medicaid program; or (3) fold them into a genuine managed competition administered by a state-run or state-chartered Health Insurance Purchasing Cooperative (HIPC).

Defining the Terms

Here is a thumbnail sketch of how such an approach might work (See

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Figure 1). A clear distinction is made between the task of collecting the funds in an insurance pool from that of disbursing the funds to the providers of health care. One should always treat these two facets separately when thinking about health care reform, because any financing system for health care could be coupled with any number of alternative disbursement systems. This is an important point often lost in the debate on health policy when, for example, "managed care" or "managed competition" is presented as a complete health insurance program that is an alternative to "play-or-pay" financing. "Managed competition" per se is not a health insurance program at all; it is merely a particular form of cost control that could be attached to any mechanism of financing.

Figure 1 illustrates this point. The health insurance fund at the center could be a publicly administered insurance program, such as Medicare, or the health insurance purchasing cooperative (HIPC) called for by managed competition. The diagram

shows that any health insurance fund, privately or publicly administered, is fed solely by private households. Business firms and government merely function as pumping stations along the way, for ultimately they never pay anything for health care. Any outlays for health care they do make always will be recouped from private households in the form of taxes, if government is the pumping station, or in the form of higher prices or lower take-home pay for workers if private employers act as the pumping station.

Financing: Two Approaches

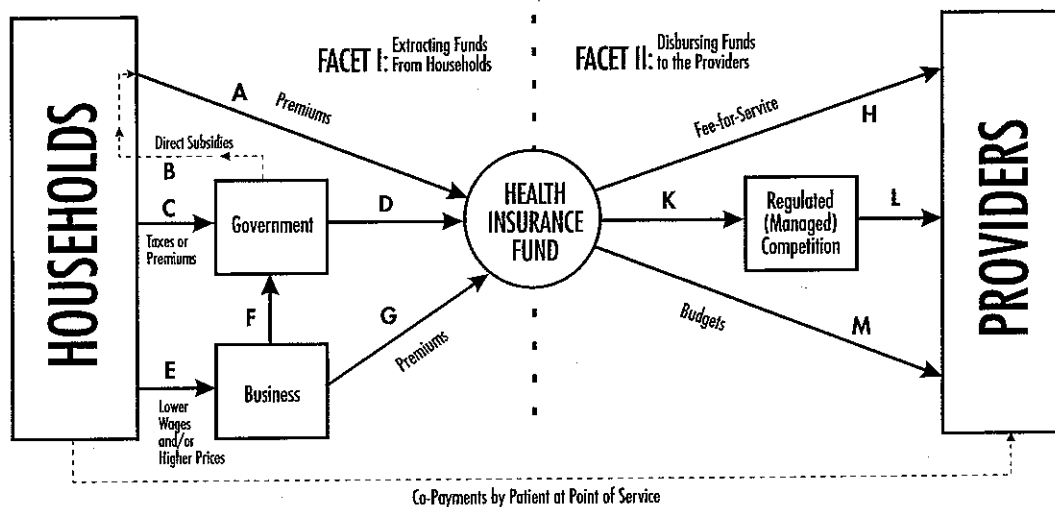
Under the All-American Plan, either the federal government or private employers, or both, could function as the chief pumping station. If government played that role, households would pay an income-based premium, probably along with their income tax, although the premium itself would not really be a tax and should certainly not be described as such in the political arena (Summers, 1988).

On the other hand, if business were selected as the chief pumping station, employers would collect an income-based premium from payroll and remit these premiums to the health insurance fund, such as a publicly administered health insurance program like Medicare, or a state-run HIPC. Our major foreign competitors, Japan and Germany, widely employ this mechanism to finance health care. Once again, however, health-insurance premiums collected at the nexus of the payroll ought not to be described to the public as an ordinary payroll tax.

If government were to be the chief conduit for financing health care, one would include among the income tax forms one strictly devoted to health insurance. On it the taxpayer would indicate either that the household has a private insurance policy at least as generous as a federally specified basic comprehensive package (and attach evidence of that coverage), or enter and pay an income-based premium for the basic package that would be then auto-

Figure 1

The Two Facets of Health Care Financing



matically bestowed upon that taxpayer's household. I call this financing mechanism the "Fail Safe" policy. If written evidence of an adequate private policy were attached to the health insurance form, the household would, of course, be excused from the income-based premium.

As already noted, this payment would be collected in conjunction with the income tax, but it ought not to be confused with a bona fide tax. It is merely a mandated *premium* for which the households receive a well-defined and personal benefit — comprehensive, portable health insurance coverage. A skillful politician ought to be able to make this point clear to the general public.

The income-based premium rate "X" could be a flat percentage of adjusted gross income, or it could be made to increase progressively with income. For example, it might be set close to zero for very low-income households and might reach at its peak, for high-income households, a level equal to the percentage of the gross domestic product the nation spends on health care. The wealthiest households, therefore, might prefer to purchase private insurance policies, particularly if the industry figured out a way to make them available without the enormous administrative loading charges now added to premiums for individual policies. That tendency could be curbed if an upper limit were placed on a family's annual premium.

Additional Financing

Any system of income-based health insurance premiums requires some transfers of income from high- to low-income households, because the contributions made by the latter will not cover the full cost of their premiums. It is therefore desirable

to look at supplementary sources of financing for these required cross-subsidies.

Households above a certain minimum income might be asked to pay, on some line of the regular 1040 tax form, a small, progressive, earmarked indigent care tax (perhaps an average one percent or so of taxable income). I would call it "Membership Fee for the Club of Civilized Nations," so named since the 37 million uninsured Americans are an anomaly among industrialized nations. These funds would be needed to supplement the modest income-based premiums collected from low-income families.

Additional funds might be extracted from earmarked taxes on alcohol, tobacco and gasoline, products known to contribute directly to the nation's health bill. A case can be made for collecting directly from the manufacturers or importers of firearms a very stiff excise tax per gun, with near prohibitive taxes on sub-machine and machine guns. Distress over the mayhem caused by firearms may have progressed to the point at which a visionary politician could sell such taxes to the body politic.

As noted, many industrialized nations, notably Germany and Japan, collect premiums through the workplace, mainly because payrolls are managed by highly competent people who have little incentive to cheat on behalf of employees. By contrast, income tax forms typically are filled in by less competent individuals who have more powerful incentives to evade taxes.

Politicians frequently prefer health insurance mandates on business to income-based premiums because these premiums are so widely misunderstood as regular payroll taxes. In fact, however, mandated benefits typically are shifted backwards to

the employees' paychecks in any event. If an employer spends an average of, say, \$4,000 for an employee's health insurance, then the bulk of that amount will be shifted backwards to highly paid and poorly paid employees alike, which makes the mandate highly regressive. Income-based premiums taken out of workers' paychecks are not nearly as regressive.

Households above a certain minimum income could be asked to pay a small indigent care tax.

Some savings could probably be squeezed from the Medicare program. Ideally, one would fuse part A (hospital care) and Part B (physician care) into one program and collect from the elderly an *income-related* premium for the package, if only to eliminate the sizable federal subsidy toward health care the high-income elderly now receive. Unfortunately, the political power of that group may stand in the way of that approach, as was so vividly illustrated by the 1989 repeal of the Medicare Catastrophic Care Act.

A case can be made on grounds of both equity and economic efficiency to include in an employee's taxable income part or all of the health insurance premiums paid by an employer on behalf of that employee, at least for employees with an income of \$50,000 or more (Butler, 1992; Enthoven and Kronick, 1989). It has been estimated that the elimination of this tax exclusion would yield an estimated \$50-to-\$60 billion in additional federal taxes, and about \$20 billion in additional Social Security taxes. If one phased

out the exclusion, starting, say, at annual incomes of \$50,000, with a complete elimination of the exclusion at incomes of \$80,000 or more, the added tax yield would, of course, be commensurately less. But it may still be in excess of \$25 billion.

Whatever the source of the additional funds that would be required by universal coverage in the short run, Americans must at long last ask themselves whether nation with a \$6 trillion economy can really stare some 37 million mainly low-income Americans in the eyes and say: "Sorry folks, we are too poor a nation to extend to you the financial protection every other industrialized nation has been able to extend to its citizens." Among the millions of uninsured are many working mothers and their children. How can we stand by idly, letting these mothers toil on our behalf without health insurance?

Disbursing the Funds

Approaches to the cash-disbursement and cost-control facet of the Fail Safe system could fall into one of two major categories: purely federal programs and federal-state partnerships.

Under a purely federal program, the federal government could use its Fail Safe fund simply to enroll all Americans who are not privately insured in the federal Medicare program. One major advantage of that approach is its administrative simplicity. All of the requisite infrastructure has already been provided for and is fully operational. Furthermore, all health care providers are fully familiar with the operation of that system. Finally, the approach would provide government with considerable clout on the demand side of the health care market.

One major political disadvantage of the approach, however, is that it concentrates so much power in the federal government. Although Americans sometimes express a preference for that approach in opinion surveys, it is not clear how well an actual move in that direction would be received. Furthermore, while the Medicare program has been able to control the prices it pays for health care, it has had much more difficulty with controlling the volume of services under that fee-for-service system. It is true that other countries have been able to control costs better than has the U.S. with fee-for-service systems. But these countries also use other forms of cost control — capacity limitation and budgets — and they, too, now chafe under the problem of controlling the volume of services.

The federal route, however, is by no means the only cash-disbursement and cost-control option one could couple with the Fail Safe financing mechanism. An alternative would be for the federal government merely to collect funds into a Fail Safe pool and then to distribute that fund to the states in the form of capitation payments adjusted for age, sex, other measurable risk factors and regional cost variations. A mechanism for such risk-adjusted capitation payments already exists for the current Medicare program — the so-called average annual per capita cost (AAPCC), although this adjuster is far from perfect. The individual state could then disburse these capitations (possibly supplemented with state funds) to providers in a manner that suits local customs and preferences, and the existing delivery system.

There are several ways to do this:

1. Medicare Buy-In: Some states might prefer to buy their uninsured families into the federal Medicare

program. Under this opt-in strategy, a state choosing that option would return the capitation received from the federal Fail Safe program to the federal government and, possibly, be asked to add some funds. This gives states the option of transferring administrative responsibility for health care to the federal government.

2. Traditional State Insurance Program: Other states might prefer to run their own public health insurance program — for example, a modified Medicaid program that owns up to the federal standards spelled out for the Fail Safe program. This would still be a government-run disbursement system, albeit a decentralized one.

3. Managed Competition: States could also have their uninsured select from a roster of competing private insurance plans under the approach now widely known as managed competition or regulated competition. Under that concept, originally proposed by Princeton's Herman and Anne Somers (Somers and Somers, 1972) and further refined by Minnesota physician Paul Ellwood, MD, Stanford economist Alain C. Enthoven, and a group of analysts known as the Jackson Hole Group, rival networks of doctors and hospitals, such as health maintenance organizations, would be made to bid for enrollees on the basis of a pre-paid capitation payment for a specified, basic package of health benefits, all under the supervision of a HIPC.

The HIPC in a region could be the state's health department, or, alternatively, a semi-autonomous, not-for-profit organization chartered by the state. It would coordinate the premium bids submitted by the plans and also collect from each competing plan information on patient satisfaction and clinical outcomes (such

as mortality rates from surgery). That information would be conveyed to consumers, along with the premium bids. The states of California, Colorado, and Florida seem ready to move in that direction.

If the Fail Safe financing scheme outlined above were coupled with some form of managed competition, large parts of the current private insurance industry would survive health care reform. For the approach to work, however, the industry would have to use its extensive resources to enhance the value-to-cost ratio in health care through managed competition and managed care rather than using them to exclude sick Americans from insurance coverage through medical underwriting.

Whether managed competition actually will control costs, as its proponents insist, remains to be seen. The approach has been tried only in small, local experiments — for example, in the California Public Employees Retirement System (CalPERS) — with some encouraging early results. It is not clear, however, how dependent the cost savings of these relatively small, local experiments have been on the ability of providers to shift costs to other payers in the area, nor is it clear whether the savings registered early in the life of these experiments can be sustained over the long run. The cost savings under full-fledged national managed competition are still hypothetical estimates.

Global Budgets

It is virtually impossible to impose an air-tight national budget upon all types of health spending in a nation as geographically far-flung and as economically heterogenous as is the United States, particular in a health system with multiple payers

and approaches to cost control. Absent a single-payer system (such as Canada's) for all health benefits and for the entire nation, attempts at top-down budgeting probably will have to be limited to controlling only segments of national health spending.

Doctors and hospitals should reveal their fees in terms patients can understand.

The federal Medicare program has achieved some apparent success with that approach by imposing on Part B of the Medicare program a so-called volume performance standard, which is really an expenditure target. That approach links updates in the fees paid by Medicare in one fiscal year to the degree of deviation from a predetermined expenditure target for the fiscal period two years earlier.

Under the Fail Safe system proposed here, the total funds collected by the federal government via income-based premiums and sundry additional outright taxes would constitute a powerful implicit national budget of sorts. The amount of money in that fund would limit the risk-adjusted capitation payments to the states and, thereby, inevitably the spending by the states on their residents without private health insurance. States still could, of course, spend more on health care if they want. The system would not directly impact that part of health spending which would occur outside the federal-state Fail Safe system. But the spending level of that presumably large system would undoubtedly provide highly visible benchmarks for private-sector spending, and would thereby indirectly exert budgetary

discipline upon the whole health system. It can be argued that this less powerful approach to top-down national budgeting would be an easier political sell than other alternatives now being contemplated.

Streamlining Fee-For-Service

It would probably take more than half a decade to fold the bulk of the American population into managed competition, even if most states chose to move in that direction. In the meantime, it would be helpful if doctors and hospitals were forced to reveal their fees more visibly in terms that patients and their insurers can easily understand.

Traditionally, American doctors and hospitals have billed their patients for each of thousands of distinct services and procedures. These fees, however, have not been based on common fee schedules, nor even common lists of procedures. This lack of uniformity has made it virtually impossible to compare the prices charged by different doctors and hospitals. The resulting lack of price transparency has made a mockery of the idea, so popular among economic theorists, that patients should "shop around" for low-cost doctors and hospitals.

Even a state embracing the concept of managed competition would presumably allow some fee-for-service carriers among the competing plans. In states not moving to managed competition, of course, fee-for-service payment would remain the dominant mode. To facilitate better price transparency in that environment, the government should impose at least common relative value scales, if not common fee schedules, upon all doctors and hospitals. A relative value scale expresses the fees for all procedures as a relative of the

fee for some base unit, for example, a routine, follow-up office visit or an appendectomy. A relative value scale becomes a fee schedule only if the dollar value for the base unit (the so-called "conversion factor") has been set.

Common relative value scales would greatly reduce administrative hassle.

Relative value scales of this sort have already been developed by the federal Medicare program for both doctors and hospitals. For hospitals, the government introduced a system of flat fees for some 500 diagnostic-related groups (DRGs) of cases. These fees are based on average accounting costs per case and are based on a well-defined set of relative values that could be extended by law to all private payers as well. For physicians, the Medicare program has developed the so-called resource-based relative value scale, which is based on the estimated relative real resource costs of producing the 7,000 or so procedures in the catalog of physician services. That scale, too, should be extended by law to all private payers.

A policy of imposing common relative value scales upon all payers and providers in the health system would not, of course, be the same as outright price controls, if the government permitted physicians and hospitals to apply their own monetary conversion factors for private patients. In doing this, providers would be able to set the absolute monetary value of the base procedures and, thus, of all other procedures on the list. If these rates were set by each physician

and hospital at the beginning of the year, they could then be published in the local newspapers and made available via an 800 number.

Chances are that the publication of this simple price index would drive doctor and hospital fees towards more uniform levels, even without direct price regulation by the government. At least during a transition period towards government-mandated uniformity in fee schedules, this idea may be worth a try. One could, of course, couple the imposition of the federal relative value scales upon the private sector with a ceiling on the conversion factor set for private payers. That would be a partial move toward a true all-payer system based on common fee schedules adhered to by all private payers within a region.

Common relative value scales would greatly reduce the administrative hassle now bedeviling American health care, for they would facilitate the use of electronic billing based on common claims forms and common software. The chaos now reigning in the private fee-for-service sector makes electronic billing difficult and has added billions of dollars to annual health care costs.

Avoiding Adverse Risk Selection

In the absence of sanctions, the Fail Safe component of the dual-track health insurance system outlined above would be subject to adverse-risk selection. Business firms with relatively older or sicker or lower-wage employees probably would prefer to dump the latter into the federal Fail Safe system, while firms with younger or healthier or better-paid workers would prefer their own private coverage. Similarly, healthy people would tend to favor actuarially fairly priced private insurance;

chronically ill persons would gravitate toward the Fail Safe system, driving up its average cost. Such trends could destabilize the system.

Other nations that do operate dual-track insurance systems — for example, Germany — have dealt with that problem by making switches between the two systems cumbersome, slow, and expensive. A German family that opts out of the statutory, semi-private health insurance into the commercial, private system can return to the statutory system only under very rare circumstances, such as a lapse into extreme poverty, (Reinhardt, 1990).

In the dynamic American economy, where a family's economic fortunes can fluctuate substantially over time, it would be difficult to outlaw returns to the Fail Safe system. Even so, it would probably be possible to make the process of switching sufficiently cumbersome and risky to avoid the clever and highly destabilizing cream-skimming that has been the Achilles heel of any multiple-track insurance system, notably the current one.

Finally, business firms that already are offering their employees health insurance might be discouraged from dumping their employees into the Fail Safe pool by a mandate forcing them to increase their workers take-home pay by an amount equal to the health insurance premiums they have hitherto paid (and presumably taken out of their employees' take-home pay).

The Best vs. The Good

Could the plan outlined above — private insurance alongside the federal-state Fail Safe system — officially sanction a two- or multi-tiered health care system in the United States? It might. Some tiers are in-

herent in the very ideas of "choice", "managed competition" and "supplemental insurance." But the system proposed here would be so much better than the multiple-tier system now in place, which literally offers nothing or brutal rationing as its lowest tier.

Furthermore, Americans favor or at least tolerate a multi-tier approach in many other important human services sectors, notably in education and in jurisprudence. For example, Americans from the entire ideological spectrum, including those who profess belief in the concept of public education, send their children to the nation's better endowed and highly selective private schools, if they have the means to do so. The prospect of being able to impose a truly egalitarian health system upon

such a nation appears dim. One should not evaluate proposed health care reforms by highly exacting ideal standards that are unlikely ever to be reached in practice. As Senator Daniel Patrick Moynihan of New York has put it so aptly, in matters of social policy many well-meaning people too often have let the [hypothetical] best become the enemy of the [achievable] good. That approach may make well-meaning people feel good; but it usually ends up hurting the poor.

References

Butler, SM, "A Policy Maker's Guide to the Health Care Crisis, Part I: The Debate Over Reform." *Heritage Talking Points*. Washington DC: The Heritage Foundation, February 12, 1992.

Enthoven, A and R Kronick, "A Consumer-Choice Health Plan for the 1990s." *The New England Journal of Medicine*, January 5, 1989: 29-37 and January 12, 1989: 94-101.

Reinhardt UE, "West Germany's Health-Care and Health-Insurance System: Combining Universal Access with Cost Control." in *A Call for Action*, final report of the U.S. Bipartisan Commission on Comprehensive Health Care, Vol. II. Washington DC: U.S. Government Printing Office, September 1990: 3-16.

Somers HR and AR Somers, "Major Issues in National Health Insurance," *Milbank Memorial Fund Quarterly*, April, 1972, Vol. I, No. 2, 177-210.

Summers LH, *Some Simple Economics of Mandated Benefits*, paper presented to the American Economic Association, December 28, 1988. ☆