CONFLICT AND COMPROMISE OVER TRADEOFFS IN UNIVERSAL HEALTH INSURANCE PLANS

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Introduction

The proportion of the population without health insurance has remained roughly stable over the past decade, in the
face of both a large government program (CHIP) to cover uninsured children and a period of high prosperity. Given
current trends in health insurance premiums and macroeconomic activity, the uninsured percentage is widely
predicted to increase.

Why is such a significant minority of the population uninsured? And why doesn’t the political system do something
about this situation? I will address both of these questions, the first economic and the second political.

I will argue that there are some difference in values and beliefs, which have impeded policy action. But my main
point is that the primary problem is related to political strategy and bargaining (or the lack thereof). In fact, a
majority of citizens and a majority of participants in the debate share core values in terms of objectives, but differ
both on how to get to those objectives and which tradeoffs they are willing to make among them. I will argue that
the key element in breaking the log jam would be for those whose first preference is universal single-payer coverage
to compromise and accept a voucher-based multiple payer approach. Success cannot be guaranteed even with this
compromise (given the current state of the federal budget). But, without it, we will be condemned to get more years
of fruitless debate and inaction. I will also discuss key design issues in voucher/credit programs, and conclude with
a proposal for a phased introduction of a variety of options that deals with important fears on all sides and with
integration with what currently exists.

Policy Preferences

A majority of Americans would prefer to institute programs that would significantly reduce the ranks of the
uninsured. A recent poll reported by Robert Blendon at Harvard reports again what has been shown before: a
majority (in his poll, 74-%) of voting age respondents indicates they favor a program to provide coverage to the
uninsured.\footnote{1} Why then, in a majoritarian democracy, do we fail to see action?
I believe that, among a number of reasons, the strongest influence has been identified by Stuart Altman, a former government official and dean at Brandeis University. I call this argument “Altman’s Conundrum” (“conundrum”: a question or problem to which only a conjectural answer can be given; a puzzle or problem which is usually intricate and difficult of solution): simply put, Altman argues that the various groups in society advocating different programs all with the goal of covering the uninsured do indeed represent a majority of decisive agents (in whatever model of the complex political process one cares to use). (Blendon’s study in fact shows that several different alternatives receive equally strong support, with the only option not garnering a majority being single payer plans). The problem is that, for each group, the next best alternative to its preferred solution is to do nothing, and no single group constitutes a majority. Informally, Altman argues that the various groups advocating for the uninsured kill each other off politically. The uninsured remain as they are.

In what follows, I will present a simple model of Altman’s Conundrum. This model shows that compromise is needed for those who favor universal governmental tax-financed single payer reforms. This group, which I reluctantly (given the political overtones) label “liberals,” needs to compromise with those who favor the other major alternative: vouchers usable for private insurance; I borrow a term suggested by Sherry Glied and label those people “marketists.” I will also consider employer mandates of the pay-or-play variety and argue that they represent the worst of both worlds and so are even less likely to emerge as a majority rule winner.

I approach this task with humility: predicting politics is even more risky than predicting the economy. It is surely possible that the next presidential election could shift political power enough for one or the other interest to have a veto-proof, filibuster-proof majority, and that voters will end their affection for divided government.

But I wouldn’t bet on it.

**Altman’s Conundrum Semi-Formalized**

We assume that there are three groups of voters or decisionmakers. There are liberals (L’s) who prefer governmental action but who do not represent a majority of decisionmakers. (There are many liberals who believe
that more voters would agree with them if the voters would come to their senses and re-embrace the New Deal coalition that collapsed in the 1970s; I will not assume that this is so.) There are marketists (M’s), who are concerned about the uninsured (more on this below) but who want to use private markets to furnish coverage to many (though not necessarily all) of the uninsured. This group is also a minority, but the liberals and marketists together constitute a decisive majority. Finally, there is a third group (the 26% in Blendon’s study) who are “negativists” (N’s); they do not at present favor any plan to reduce the number of uninsured, presumably because they felt that problems caused by the absence of insurance are not severe enough to justify action that may impose some negative effects on them (such as higher taxes or more restrictions on their health insurance and health care choices). No one of these three sets is a majority, but any two are a majority. Voting is by sequential binary choice, in which each of a discrete set of proposals is put up against all other proposals in that set. If one proposal can get a majority against all others, it becomes law.

Table 1 shows a “voting matrix,” which displays Altman’s conundrum. The three proposals are: universal tax financed single-payer government insurance (G), tax-financed partial vouchers for private insurance coverage (V), the status quo (S). The columns display preference orderings; the entry at the top of each group’s column represents its most preferred option, and the entry at the bottom its least-preferred option.

As set up, Table 1 indicates that liberals most prefer G, marketists most prefer V, and negativists most prefer S (no action to reduce the number of uninsured). For liberals and marketists, the second choice to their most preferred alternative is S. As set out, it is easy to see that the majority rule winner in Table 1 is S. It defeats both G and V, by a 2-1 margin.

Now we explore what happens if both of the groups favoring reducing the number of uninsured make a modest compromise. They switch the ordering between the status quo and the alternative way to increase the number of uninsured; their second choice is no longer the status quo. Table 2 shows two voting matrices that differ depending on whether liberals compromise (left panel) or marketists compromise (right panel). Negativists are assumed to retain their original preference ordering.
If the liberals compromise, the majority outcome now changes from S to V. A program is enacted that reduces the number of uninsured. The negativists continue to oppose any move away from the status quo, but they lose to V by a margin of 1-2, and the proposal for government coverage also loses both to V and to S. (The same outcome would occur if both groups compromised.) If, in contrast, the marketists compromise, there is no majority rule winner. G defeats S, V defeats G, but then S defeats V. This voting cycle will be associated with instability precisely because the “swing vote,” the N’s, switch from V to S after either of these alternatives has defeated G. Put slightly differently, in order to make G the outcome even if the marketists compromise, it would be necessary that those who most prefer the status quo also prefer government insurance to vouchers.

Making the leap from theory to practice, I therefore conclude that a good way to make a plan to reduce the number of uninsured a politically viable and stable alternative to the status quo would be for liberals to compromise and support vouchers, not as their first choice, but as their second choice. I next discuss in detail what changes in values among liberals or compromises on strategy among marketists would be needed to make this more likely to occur.

**Moving Liberals toward a Compromise**

Despite the fact that the option for increased coverage which received the smallest proportion of loyalists in Blendon’s survey was the single-payer, government financed, comprehensive public insurance model, I believe that if a compromise could be brokered with that viewpoint, the other lukewarm versions of government control, like employment-based pay-or-play, could easily be disposed of as well. What would be taken and what would be given in moving to a compromise?

First, and most obviously, adherents of the single payer view would have to sacrifice the hope, however faint, that the dominance of the national political system by the liberal Democratic model that ended in 1990 could be revived if only it could properly be framed and the voters would come to their senses. As the *New York Times* recently noted, “many liberals cling to an old dream, of finding a candidate who appeals both to the base and the majority, and rebuilding the old coalition that seemed to shatter 35 years ago, argued Michael Kazim, a political historian at Gerorgetown University. “They think that Americans, in their heart of hearts, really agree with them…”

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Holding onto that dream, either with regard to political power in general or national health insurance in particular, is not likely to be either realistic or successful.

There are several tenets associated with this dream that will need to be sacrificed. One is the view that it is a very high priority to eliminate inequality in the use of medical services and medical spending, across the board. This contrasts with the view of voucher advocates that what is desirable is getting highly effective care to those who need it, but not preventing those with the will and the means from spending their own resources on additional care, possibility of lower health benefit and modest effect on quality of life (if this is what they choose to do). It may be possible to sugarcoat the transition by citing voluminous evidence that, faced with nominally equal and identical health insurance (especially if it involves some cost sharing in the interests of economy), higher SES people will have access to more and better services and obtain better health outcomes than the disadvantaged. Voucher advocates want to build on the common-sense perception that in order to achieve greater (though not necessarily perfect) equality in outcome, in a world where resources, education in how to work the system, and contacts are unequally distributed and correlated with unequal incomes, one needs to have unequal insurance, with greater benefits for the less able than for the more able. An unyielding devotion to nominal uniformity in health insurance in a world where incomes and wealth are and will remain distributed unequally can only prevent any forward movement.

It probably goes without saying, but is worth saying nevertheless, that using health insurance, as the vehicle to achieve redistribution of overall welfare is obviously inefficient and ineffective. Health care is not the place to start the revolution.

A second, watershed issue has to do with reservation of trust to public production and high levels of suspicion to private profit seeking firms. Set aside baser motives for favoring government control, such as to provide jobs, favor allies like unions, or to generate rents that can be transformed later into campaign contributions and foundation presidencies. There certainly are some people who believe, as they have a right to believe, that they will get a better deal in transactions with civil servants or institutions controlled by non-profit organizations or community activists than the rip-off they have come to expect from the capitalist sector. There are, of course, others who read both
history and their personal experiences to come to exactly the opposite conclusion. Neither theoretical arguments nor anecdotes can be persuasive here: perfect markets can be an object of veneration, and perfect government can always do things right, but in the real world in which flawed human beings staff imperfect government and imperfect markets, the call has to be based on empirical judgment, not ideology, and the empirical evidence is almost always less than definitive. “Good” states like Maryland, Minnesota, and Vermont contrast with less good states like Louisiana, New York, and Florida, so that examples don’t prove anything.

A final issue, which may also be defining, has to do with means testing. It is beyond question that both insurance coverage and spending on medical care given insurance coverage is higher for higher income people at a given level of health. If the social problem raised by the lack of insurance is inadequate use of medical care and/or inadequate financial protection from medical bills (with “inadequate” yet to be defined), then it seems logical that programs to affect insurance purchasing need not touch higher income households except to collect tax revenues. And yet one of the articles of faith for many liberals is that insurance coverage take the form of social insurance with coverage uniform for almost all. (It is noteworthy that the prototype for social insurance, the German sickness fund system, exempts individuals with incomes above about $80,000 from the obligation to take the social insurance.) The usual argument against means testing is political: it is felt that if the upper middle class is not included in the socialized insurance system, that politically influential group will not support generous insurance for lower income people.

I do not accept that the positive political prediction is necessarily true. But, even if it is, this “ends-justify-the-means” political argument is difficult to fit into any respectable normative model of the democratic process. One would hope that, facing transparent political choice institutions, the non-poor would be willing to support the poor. If they are not, what rationale can be advanced for creating a more complex process that traps them into doing more good than they would like? Mumbo-jumbo about hypothetical intergenerational contracts doesn’t help. Moreover, it is by no means obvious that requiring uniformity will induce middle class support; if the burden of transfers becomes large enough, and the possibility of private alternatives exists, the middle class may bail out altogether on helping low income uninsured just as they have bailed out on helping poor children in many inner city public school systems. Finally, and to my mind most decisively, one of the things voucher supporters explicitly dislike is the idea
of being trapped in a single public system, not so much because they oppose transfers they have been tricked into accepting, but because they dislike the uniformity of final product that necessarily accompanies that system.

**Moving Marketists toward a Compromise**

The single most important feature of competitive markets that marketists seek to preserve is the ability for citizens to choose their own insurance, in multiple dimensions. However, it seems likely that there will have to be some restrictions on insurance choices, for three reasons. The first is simply economy: to offer a low priced decent plan to currently uninsured, some way of reducing administrative costs for private and public insurers will need to be found. Settling on a relatively small number of plans is a way to economize that will not do much harm if the plans do indeed span the spectrum of options. The second reason is one many are concerned about: the need to avoid adverse selection. One way to deal with this is to prohibit plans so generous that they would only be chosen by high risks eager to engage in adverse selection, and in a similar fashion avoid very skimpy plans that no one would choose if they were priced in ways properly reflective of risk. Finally, some people will not be able to make reasonable choices. They need to have their choices restricted.

The compromise should not be pushed too far, and may raise political problems of its own. Some people may not have sufficient knowledge to choose reasonably among plans, or may be cognitively impaired. Rather than limit the choices for all, a better solution from a pure planning perspective would be to identify those unable to choose, and limit the choices only of those persons, while allowing others the full range of options. One could, for example, propose that a test of knowledge or cognitive ability or familiarity with actuarial science needs to be passed before a person could be allowed to select among a wide range of health plans. One wonders whether those unable to choose among health plans (but still permitted to vote in elections) will be happy to be denied options available to others. However, as long as all options are reasonably decent, the potential loss from a mistaken choice is definitely bounded.

A second compromise is to permit there to be a publicly administered insurance option (with no special favors) available to people, which would presumably be chosen by people who trust public management rather than private
management. Such a government option would also be a good candidate for fallback insurance. To a considerable extent, this is the current model on the table for Medicare reform: permitting alternative plans, private for-profit, private non-profit, or run by state governments, to compete directly with the traditional government managed Medicare, but making sure that the government option is on the (flat) table.

To make competition work properly all plans must abide by the same rules in terms of accepting higher risks, and that task will be eased if a reasonably good method of risk adjustment of the government contribution can occur. “Reasonably good” does not mean that the government needs to know what God knows about what a person’s future health will be, only that it knows approximately what insurers can tell. Observable variables can at present provide a serviceable method for measuring high risks; it would also be possible and probably desirable to ‘overshoot’ with risk adjustment—to overpay modestly for apparent higher risks—to provide plans with incentives to recruit and retain them as members, and perhaps compete by enhancing the quality of care for high risks a little. No one can guarantee that every single high risk will have all options, that some private plans will not exit, that competition could or should control cost as much as some would like, or that FFS Medicare will not make arbitrary changes in payment methods and levels that will reduce access to some sick people. All of this has happened in the past, and I personally do not regard FFS Medicare (which I will have to consider as an option a few years hence) as reliable as the private Blue plan that I stuck with and that stuck with me for 35 years. But to some extent I believe that we should be willing to risk a little more risk in order to have a much wider set of options and the use of market rather than political discipline to incentivize efficient and sensitive plan performance.

Convincing the Skeptics

While the simple political theory says that we right thinking people can ignore the skeptics who are not sure of the social benefit or the value to themselves or reducing the number of uninsured, I think it would be wise to err on the side of caution and try to take some steps to convert some of the negativists. In this task the recent large scale and expensive Institute of Medicine project on the uninsured is, in my view, a tragic failure, precisely because it directed its arguments and analysis toward those already convinced of the need to cover the uninsured—the aforementioned liberals and marketists—and did not seriously address what the skeptics are skeptical about. That is, despite the
need to address currently unconvinced “opinion leaders” that was expressed by the IOM committee and the foundations that supported it, there was no effort to identify who those unconvinced nonsupporters are and what they think. (I know some of these people and know that they do not think the IOM reports speak to them.) Beyond the straw man of an unthinking clod who believes (incorrectly, of course) that all of the uninsured can get all the care they need through charity, there was no attempt to reach out to legitimate skeptics or to identify the debatable points about covering the uninsured in order to debate them.

The primary task here should be to develop persuasive information. The major issue about which information in the IOM report, or in the literature generally, is woefully inadequate is evidence on how much of a health improvement increasing coverage would cause, for all of the uninsured. There are some skeptics who believe (correctly) that the uninsured have some access to care, and conclude (incorrectly, I suspect but cannot currently prove) that additional access furnished by insurance will not do enough good to cover the extra cost they (or “society”) will have to pay. What we know is that some of the uninsured (by many measures) have worse health status than the otherwise apparently similar insured, but what we do not know is the contribution of “uninsurance” to that difference. The literature the IOM relied upon largely consisted of correlations between insurance status and (mostly) process measures (like “person reports not being able to get needed care”) and (occasionally) outcome measures like self reported health status or hospital admission for avoidable causes, while controlling for some observable (mostly demographic) characteristics. While this correlation would be persuasive to an advocate such as myself who is predisposed to believe that insurance is good for medical care and medical care is good for people, it may well not convince a skeptic who is not willing to give insurance and medical care the benefit of the doubt.

There are two flaws, the skeptic would point out. The first, already suggested, is that correlation is not causation. By not delving seriously into why the uninsured fail to obtain the insurance that the great bulk of Americans are somehow able to afford, the analysis cannot refute the alternative hypothesis that the same thing that causes a minority of people to choose not to get insurance also causes them to choose activities which reduce health and avoid activities which increase it. No repetition of correlational studies that find the same relationships, and no expansion of sample size, can establish cause-and-effect. The one randomized trial we have, the RAND health insurance experiment, did not include a comparison of people totally without insurance: everyone in the trial at least
had income-conditioned catastrophic coverage. But, at least according to the economists who managed the trial, it failed to show that more insurance coverage (than catastrophic) had any appreciable effect on health except for low income people at initially high risk.

There is other evidence, primarily from natural experiments in the form of Medicaid cutbacks, that does convey a consistent message: not having insurance is quite harmful to the health of poor sick people. The skeptic’s response, however, is to note that the great bulk of the uninsured are neither poor nor sick. If all we wanted to do was to get “insurance” (a little late) to poor people who are already sick, we would only need to cover a tiny fraction of the currently uninsured population. The real question, to justify a policy of substantial reductions in numbers of uninsured, is how much of a difference insurance would make to the health status of initially well (and mostly young) lower middle income people (as the primary distinguishable group among the uninsured), followed in numbers by middle income and above households at all health levels. So far our country has been unwilling to subsidize insurance of poor able-bodied adults without dependents. Evidence that coverage would make a difference to their future health would matter, and we do not have the evidence. The difference could never be as large as the difference for sick people, but these able-bodied adults are much cheaper to cover—so that the cost effectiveness of coverage for them might well be higher than it is for those who already are high risks with chronic illnesses.

The other issue (which also has skeptics) is the cost to the insured middle class of doing something about the uninsured. The real resource cost of covering the uninsured, as I pointed out years ago and received recent confirmation, is actually quite small—precisely because the uninsured are a small minority of the population and because they already use substantial amounts of care. The rest of us currently pay for that care primarily in the form of higher charges by health care providers who choose to or are obliged to treat the uninsured (along with some explicit fiscal transfers for Medicare DSH payments and tax subsides to nonprofits (largely wasted).) The idea, I tell my skeptical neighbor, is that if you will agree to pay higher taxes to cover the uninsured, you will get two thirds of that back in lower prices charged by hospitals who now will no longer need to cover charity care and bad debt, and then your insurer will translate those lower charges into lower premiums. The gap in my argument is painfully obvious—how can I guarantee that hospitals (much less for profit providers like imaging centers and physician
group practices, or for-profit insurers) will cut their prices, rather than finding some other uses for the excess funds in terms of medical education, research, or more helicopters for the emergency medical service? I cannot guarantee that the nonprofit tax exemptions will be cancelled, or that Medicare taxes will be cut now that DSH payments are no longer needed. I cannot guarantee those refunds of overcharges, and neither can anyone else. It is not that hard to be a skeptic.

To sum up: the typical uninsured person is not poor, sick, and miserable. The most precise statement is that there is no typical uninsured person today. (This contrasts dramatically with the situation of the elderly when Medicare was passed; at that time (but no longer) being old was synonymous with being poor, uninsured, and sick or at high risk for being sick.) There is no analogous “objective” characteristic of the uninsured (like age) which is a good predictor of being uninsured or one that cannot be manipulated in response to subsidies. Being uninsured, or even not being offered job based insurance, is eminently manipulable, as the substantial crowd out from expansion in Medicaid coverage has shown. A poor person is likely to be uninsured, but an uninsured person is not likely to be poor. So poverty is not a good characteristic. All of this means that it will be hard to construct tidy programs well targeted at the uninsured, and therefore hard to provide simple designs that will convince skeptics. I will return to the question of targeting later.

**Why Not Make Employers Pay?**

Probably the most frequently discussed method for covering the uninsured is the one that makes the least sense in terms of economic logic or political transparency. (It is possible that economic logic could be wrong and political opacity a good thing, but I cannot support either of those views.) The argument, if I have it right, goes as follows: the great bulk of private insurance is obtained in connection with the job of one or more wage earners in the household. While employees are explicitly charged some premiums for this coverage (an amount which is increasing at about the same rate as the total premium, so dollar payroll deductions grow even as the fraction paid by workers remains about the same), most employers pay the bulk of the premium. But there are some employers who are not willing to give their employees this benefit, especially small employers. Even though those employers assert that they cannot afford to pay for such coverage, it is only fair that they too should be required to pay, either for
coverage they choose or (as a default option) toward coverage provided by a government managed source of fallback coverage. “Play or Pay” seems like a fair and reasonable thing to do. Fair, because it addresses “a fundamental inequity between employers that help finance coverage for their workers and those that do not.” Reasonable, because it provides coverage that the great bulk of the non-poor are used to (as will be shown later).

So isn’t this an approach, a compromise between public regulation and private production, that makes sense and that has bright political prospects?

One can always hope, but I think the answer is likely to be negative. The source of the problem here is not only values and self-interest, but flat-out confusion. The confusing question is: who really pays the “employer’s share” of the premium? Or, more precisely, how will a firm’s profits be affected if employers are required to turn over money for health insurance premiums? Economic theory and some strong empirical work gives an answer: the great bulk of this cost will fall, not on profits or employer net income, but on worker money wages and levels of other benefits. The depressive effect on wages could come about as and if employers lay off workers they now find more costly, but it is actually in employer interest to reduce money wages immediately, relative to what they would have been, rather than cause unemployment and experience lost output. The impact is not necessarily instantaneous or perfect: it must wait until the next time period when money wages are set, employers may be reluctant to cut money wages (rather than raises), and those employers whose workers did not value health insurance enough to warrant offering it may not be able to capture quite all of the increase in costs in the form of lower wages.

If everyone understood these economic principles, the opposition to “Pay or Play” then would come from those workers who presumably preferred to receive their compensation in the form of take-home pay rather than benefits. In effect, an obligation on the employer to “pay or play” is, in simplest version, like obligating the employer to be a tax collector, imposing a head tax on workers or a mandate that they sacrifice some cash to obtain insurance that they didn’t value enough to take a job that offered it. To the extent that other voters realize and care about what is happening, they may at a minimum be upset about the regressive nature of this charge. Still, given the small fraction of uninsured workers it does not seem that the directly-affected group would be decisive enough to matter.
What is likely to produce more effective opposition, based on our experience with the Clinton health reform plan which also tried to use an employer mandate, is opposition from employers not offering coverage—almost entirely small firms—and their lobbyists. Because these employers apparently and confusedly feel that they pay for health insurance (rather than view it as just a matter of the division of some total compensation cost), and because they think they cannot “afford” to pay more (as if they determined what money wage to pay by what they could afford), the opposition is likely to be as fierce again as it was before.

There are some subtle issues here. Attempts to produce equity by capping the percentage of payroll the employer must turn over to insurance (with the difference made up from subsidies) will both increase government budgetary cost and potentially induce greater inequity as low wage workers in high wage firms see their take-home money wages cut even further. If subsidies are limited to small firms, there will be inefficient subsidies of such firms (who may be small precisely because they are not very well managed). How people will feel about turning over the choice of something they did not want in the first place to some predetermined government option depends on how that option is structured, and whether they at least have the choice of a relatively low cost, low coverage plan.

But most fundamentally, I think requiring small business either to play or to pay is likely to be a third rail issue. Given the perception that small businesses create jobs, given the effectiveness of their lobbies, and given that large firms really don’t have a stake in this game, this seems like an unnecessarily provocative act. It might be possible to use this method if employers were explicitly permitted to reduce money wages by the amount of the mandated cost or, less aggressively, if employer “contributions” across the board were accounted for on employee pay stubs and treated for tax purposes as the wages they are, but “taxing benefits” raises issues of its own. There is a rationale in permitting employers to arrange insurance if that is what employees prefer. On balance, however, making clear that an employer- (or union-arranged) option exists and making workers who arrange their coverage that way eligible for the same subsidy as those who prefer the individual market would seem to be the best way to go, far preferable to requiring people to let their boss arrange their health insurance whether their employer is (in the view of workers) up to that task or not.

Variation among the Uninsured
If these broad gauge plans cannot receive high levels of political approval, can we at least identify some subset among the uninsured for which the benefits to all from a particular type of coverage would be large relative to the cost? To answer this question we are forced again to confront the issue of the extent and form of heterogeneity among the uninsured. Table 1, taken from recent Current Population Survey data, shows that the uninsured are not poor, but they are not rich either. In the three broad household income categories described, no single category contains a majority of the uninsured. Indeed, my main conclusion from this data is that there are three reasonably distinct levels of “need” among the uninsured, which divide the adult population roughly into thirds.

To begin at the top, about a third of uninsured adults are in households with incomes at or above the median income for the country as a whole. At the other extreme, about a third of the uninsured have household incomes at or within hailing distance of the official poverty line (which is itself felt to understate poverty). Finally, about a third of the uninsured are “tweeners,” with incomes between an augmented poverty line and the median income.

Table 2 cuts the data slightly differently, exploring whether income is a very good way of predicting both unemployment and the absence of private insurance. The data suggest that it is not: over a fairly wide range of income, most but by no means all households are privately insured. There is no obvious threshold income at which the great bulk of households switch from being uninsured to being insured. Put slightly differently, most of the uninsured are a minority in their own socioeconomic stratum (or whatever other measure might be used to describe resources). They are (for some reason) unusual, in not choosing to devote the resources to insurance that most people like them do choose. What would really help is a better understanding of why these people are unusual. Do they face usually high prices for insurance or for other things? Are they heavily in debt? Do they behave in risky ways with regard to other aspects of their behavior?

Research suggests that one reason why some non-poor are uninsured is a high price for insurance (but not necessarily a high premium). Young people face much lower premiums in the individual insurance market than middle aged people, and yet lower middle income young people not offered employment-based coverage are significantly less likely to choose individual insurance than lower-middle-income middle aged people. The reason,
we think, is the perception, and in some states the reality, that health insurance is not a good deal for what you can expect to get if you are young. Middle aged people also apparently search more aggressively for lower premiums than do younger people. Beyond this, we are left to speculate about tastes, decision processes, and the like. What we do know, however is that many more of these “tweeners” would be willing to spend their own money if a decent subsidy made insurance a deal too good to refuse.

The Way Forward

Any program to cover a significant number of the uninsured will require major new government funding to be devoted to this purpose (whatever the predicted effect on total medical care spending or on the net income of taxpayers). With the substantial deficit currently in prospect at the federal level, and with the substantial limits on state spending power, is there any point in talking about a large new program at the present time? I do not see any realistic reason to discuss short run strategies with large impact; that would be impossible. However, it may be possible, most realistic, and perhaps most hopeful to begin now preparing for a program to be implemented gradually at some time in the future.6

We already have a mini-program in place, in the form of credits for coverage under the Trade Assistance Act. For workers who were adversely affected by imports, the option of an advanceable and refundable credit for a flat 65% of premium is now available, as long as the insurance is offered by anyone except a private individual insurer. Plans offered by former employers, trade associations or unions or state governments all qualify. The Treasury Department has taken great care in designing this program. At least we know that it is possible to write rules for tax credit programs without causing the bureaucracy (even at Treasury, which would rather not) to melt down.

In addition to making a virtue out of necessity and phasing in whatever program we implement, I think it also desirable to treat the different subpopulations of the uninsured differently by having the first-round fallback or default plan for them be what is most common among their otherwise similar insured brethren. Two groups are an easy match. For poor and near-poor people, the default option should be Medicaid, with zero beneficiary premium. For lower middle income and middle income young adults and their children, it should be private insurance; they
should be offered reasonably generous tax credits (say, in the range of $1500 per year per person, adjusted for future increases in premiums) for either group or nongroup coverage; they would pay the difference between the credit and the premium. In the case of group coverage, the value of any tax exclusion would be offset against the credit.

For the quarter to a fifth of the uninsured adults with incomes above the median (who are these people, anyway?), it is less clear what should be done. My most preferred strategy would simply be to mandate that they have insurance (enforced by a heavy tax penalty if they do not), and let them figure out the best way to obtain coverage. If we need to sweeten the deal with a modest subsidy, offer to all a credit equal to the value of the tax exclusion at the median income. Those with incomes above the median will find a better deal in group insurance, but those who prefer individual coverage will at least get some help. This arrangement is not ideally neutral, but at least it does not require us to come up with a big subsidy to the uninsured rich to match the big subsidy we now pay (through the tax exclusion) to insured rich people like you and me.

The final group (the smallest) that might be helped by something a little different is the non-young, non-poor, non-rich uninsured. Think of the people over age 55 with household incomes below the median but well above the poverty line. If offered a tax credit like younger workers and turned loose to find their own insurance, this group will face more of a challenge. Getting a job that carries coverage may be harder than for younger people. Relatively modest tax credits ($1500) will still leave them paying thousands out of their own incomes for coverage supplied by often-reluctant insurers. I hasten to add that I am not certain that there is a real problem as noted; this age group is even now the most likely (controlling for income) to buy individual coverage entirely with their own after tax dollars when they don’t have a job that carries coverage. The reason, presumably, is that they can even less well “afford” not to be insured (and run a high risk of a big bill) than to buy coverage; even if they might themselves pay a thousand or two for coverage, that is a much better deal than risking a bankruptcy producing stroll through a hospital’s admissions office as an uninsured person.

However, there is an alternative for them, one we might call “Medicare for Some.” The notion would be to permit people over 55 to enter the Medicare program, with partial subsidy (more later on age, premiums, and the subsidy rate). They could choose the same benefits in the government-run Medicare as today’s elderly, disabled, and
kidney-diseased do. This would not, however, be their only option, as it is not for current Medicare beneficiaries. They could also choose among a variety of managed and less-managed-care private plans that Medicare approves, possibly with a supplementary premium for additional benefits.

In all cases, these target plans (Medicaid, neutral private insurance vouchers, Medicare for Some, and slightly sweetened deal to the rich) would only be put in place temporarily. Careful and timely monitoring of performance and behavior would occur, and, if any given plan worked reasonably well, it would be made available to those out of the target group (if suppliers were willing). Thus the poor could receive 100% vouchers for private coverage, the non-poor (whether young or old) could sign up for Medicaid run by their state or Medicare (run by their federal government). All plans would, in this situation, be in direct competition with each other. There would be no special favors for Medicaid, traditional Medicare, Medical Savings Account plans, or private HMOs.

**Designing Credits and Vouchers**

There has been considerable progress in research and thinking about how to design credit and voucher programs, even though legislative action has so far been on a small scale. Some questions, such as exactly how people will respond to programs which require them to add their own private payment to credits in order to use the credits to obtain insurance, can only be answered definitively by experience, while others, such as how the private insurance market in which credits are used might be reconfigured (or might reconfigure itself in response to a large scale program) are necessarily speculative. In my narrative here I am going to give these programs the “benefit of the doubt” in terms of guesses where the evidence is mixed, but my conclusion will be that such programs have a good basis for expecting good outcomes when used in the right form for the right populations.

There are, first of all, some administrative issues which seem fairly well settled among policymakers interested in such programs and which can avoid some of the problems a skeptical public might anticipate. The proposed designs envision **advanceable, refundable credits with prospective income conditioning**. These terms can be explained by reference to the problems they are supposed to solve. Letters to the editor of the *New York Times* in response to a recent story on using tax credits to deal with the uninsured raised two issues: “Congress (should adopt) some
method for allowing people to buy the health insurance before receiving the credit” and “a tax credit will not help the millions who pay sales and payroll taxes but no income taxes.” The solution to the first problem is to reverse the timing and make credits available before the person buys health insurance. A credit can be prospective and advanceable, administered to pay toward a person’s monthly insurance premium as that premium comes due. Either the credit can offset tax withholding, or there can be direct payments from the government to the insurer of choice. The solution to the second problem is to make the credits refundable, so that if the value of the credit is greater than the person’s tax liability, the excess is refunded as a positive payment. (Many proposals also envision applying federal credits to payroll taxes as well.) Finally, a way to administer any income limits is to base eligibility for credits on a person’s previous period income; small errors from so doing are judged to be a much less serious problem than the benefit from assured payment to people who need to plan ahead.

A less easily solved question is that of what the insurance eligible for the credit must cover, at a minimum. There is a tradeoff here: for any given level of credit, the chances that a person will not use it at all are probably larger the more costly the premium (and therefore the more the person must pay), and the premium will be larger the greater the benefits. My own preference is to have minimum coverage requirements set low even though that may run the risk of incomplete coverage, since I view some coverage for many of the formerly uninsured to be preferable to really good coverage for a really small fraction.

Finally, the most serious design and policy question is how to treat variations in risk, either in designing the credits or in regulating the private insurance for which credits will be used. Basic economics tells us that if insurers (for profit or not) are to be able and willing to cover people whose expected expenses for a given nominal insurance policy are higher than average, the best design is one that provides more revenue when an insurer sells to a higher risk person. Even if total revenues could cover average costs, any process in which everyone pays the same net premium will discourage insurers from seeking to cover the more expensive customers. However, it is administratively difficult to adjust for risk perfectly in the subsidy program, and complex even to adjust for it imperfectly.
If lowish income person A has higher expected medical expenses (risk) than person B, there are three subsidy options: (1) Adopt the simplest policy of paying the same subsidy, and hope that person A will be sufficiently additionally willing to pay for insurance that (s)he will be as likely to obtain coverage as is person B. (I have already mentioned that higher risk older people are more likely to be willing to pay the premium for individual coverage than younger people of similar incomes.) (2) Adjust the size of the credit or subsidy on a person-specific basis to account for each person’s higher risk. (3) Make larger subsidy payments to insurers who cover people known to be higher risk, either in the form of an assigned high risk pool or by reinsuring some portion of each insurer’s high expected risks.

The great bulk of the uninsured are not high risk, although the proportion of those who are high risks is moderately greater than among the privately insured who are “screened” for risk by the need to be able to work to get the insurance at a reasonable cost. However, among people in uninsured families where there is a full time worker there is much less difference in risk, and, in any case, the great majority of the uninsured report their health as “good” or better, probably because they are relatively young. Thus focusing on high risk uninsured is guaranteed to have a small effect on the total head count of the uninsured. At a minimum, introducing a public program for those with costly and chronic illness should be able to take the few tragic cases off the table. That leaves people who are initially not severe risks, but who will within the next time period incur a majority of medical costs, both for minor illness and for serious, expensive, but unforeseen illness.

For reasons already discussed, I do not think it is necessary to make special adjustments to that portion of premium variation which is due to something highly predictable: older age. The question is what to do about variation due to the initially unpredictable onset of a high cost chronic condition. The simplest approach, which I am inclined to favor, is to require insurers to adopt “adjusted community rating bands” for new insureds and guaranteed renewability for those who they have previously covered. Guaranteed renewability is in fact already in effect for individual insurance. If I buy individual insurance, my insurer is required to renew my coverage and is forbidden from singling me out for additional premium increases (above the average) based on my experience. If I get my coverage through my job I do not have this protection if I change jobs, but otherwise I do. For people new to a given insurance company (or employer), there is a temptation to try to tell if that person is high risk or has high risk
 dependents. That temptation is very strong currently in individual insurance markets because that insurance is so expensive for what you get; insurers correctly fear that someone who wants to buy it knows something secret about their future use of medical care. I allow for “bands” or some kind of penalty do deal with the egregious case of someone who waits to seek coverage until they are really sick could face a penalty for waiting, but that event should be rare if the subsidy is generous and the program well marketed.

Offering to provide new insurance coverage to anyone whenever they feel like it at average premiums cannot work as a business proposition and does not provide good incentives for proper behavior—which is to seek coverage before you get sick. I think the combination of subsidies and modest penalties for irresponsible delays in purchase can be implemented with relatively little harm to the truly and blamelessly unlucky, with a combination of high risk pools or reinsurance and modified community rating with some penalties for delay in seeking coverage. Of course, if we set up a system of subsidies we think is fair, there is no obvious reason not to take the final step and make insurance purchase an obligation rather than a choice—but I do not think the electorate is ready for such control yet.

It is obviously more complicated to incentivize people to buy coverage (unless the subsidies approach the 90% rates for Medicare, which seems unlikely). It is also more complicated to permit choice of coverage, since any opportunity for choice also is an opportunity for the higher risks to seek to take advantage of insurers. If I thought that there was a single insurance plan that all Americans could agree was close to best for each and every one of them, and a single management (public or private) that would do a good, honest, and waste-free job without the pressure of competition, I would go for a single system. But my perception (which could be wrong, but it is my perception) is that these thoughts are not the ones I would have. I think there is irrefutable evidence that Americans value choices in the health insurance in two senses: in the ability to select costly insurance that permits them greater choice of providers and treatments, and in the desire to be able to select plans of different degrees of permissiveness matched with different costs. I also think it unlikely that even the best motivated managers, whether public servants or private employees, will always be motivated to do the right thing or even to know what the right thing is. So, at least initially, I would think it appropriate to offer choice to people (the non-poor) who are used to choice. Time will tell if some single model of insurance and/or some single firm or organization turn out to be universally best. I doubt that will happen but would permit it to happen if that is the way things turn out, but I would be quite unwilling
to prejudge the case. The credit system does use a voucher strategy, and in some circles the “V-word” is a dirty one. But I think compromise requires getting over that.

One way to help to do so is to emphasize in theory, and make sure in practice, that one of the major options available to people is insurance designed, administered, and selected by public organizations, organizations whose leaders were chosen collectively not entrepreneurially (or, more precisely, with a different kind of entrepreneurship). Of all the differences among Americans, the relative willingness to trust market-based organizations compared to trusting government- (or community-) based organizations seems to go deepest and cause the most difficulty with compromise. I would offer insurance in a setting where the same choice does not have be made for everyone, where people could move toward whichever method of organization they felt most comfortable with, but which would not allow them to disenfranchise their fellow citizens who felt differently. Of course, the realities of competition means that no organizational form gets a free ride, but must ultimately please at least enough people to survive. But that seems like a test we would want to impose anyway, so I have no problems doing so.

**Making Individual Insurance Respectable**

A key element in credit plans designed by advocates of credits (as opposed to credit plans designed by their opponents) is that one of the kinds of insurance eligible for credits would be individual or nongroup health insurance. Some even advocate that only such insurance (which individuals are said to “own”) be eligible for credits. My own view, as already noted, is offer credits that are neutral with regard to the way insurance is obtained. But, even so, to many skeptics of credits this emphasis on individual insurance seems especially misplaced. Individual insurance, after all, appears to be skimpier, more costly in terms of administrative cost, and more discriminatory against higher risks than employment-based group insurance. Why would anyone even want to permit (much less encourage) such an obviously inferior product? This view leads to contorted and distorted attempts to design untested employment group surrogates (“Health Marts,” state government employee programs) to which those currently not offered or taking group insurance are to be shunted.
There are some poorly understood facts which make the choice less stark. To begin with, group insurance is heavily subsidized through the tax exclusion of employer premium payments for all and the exclusion of employee premium payments in cafeteria plan settings, while individual insurance receives virtually no such breaks. Some results of subsidies are predictable: subsidized insurance will be more generous in terms of coverage. Some other results less obviously follow from subsidies: when an insurance product is subsidized, the insurer needs to spend less on selling and billing costs because the insurance “sells itself,” and empirical evidence in states and countries which have subsidized individual insurance is consistent with this conjecture. So the causes of these problems are not intrinsic to individual insurance; they come from the absence of the subsidy. Comparing individual insurance unfavorably with group insurance is like criticizing Cinderella for poor fashion sense.

Moreover, the high administrative loading and absence of subsidies means that individual insures must be very wary that potential buyers of their overpriced insurance are higher risk than they seem, and therefore require aggressive underwriting. But a subsidy directed at a largely healthy population changes everything. Insurers would know that people armed with credits are seeking to buy insurance because of the credits, not because they are secretly high risk, and the relative scarcity of high risks in a sea of normal risks means that intensive screening through underwriting will cost more than it is worth. Finally, once a health person obtains individual insurance, that person in guaranteed the right to renew coverage at nondiscriminatory premiums—so, over time, the problem of uninsured high risks should go away.

My main point here is that there is good reason to be optimistic that individual insurance chosen in response to the availability of credits will be less costly to administer than current individual insurance, and could well be a better deal than the small group insurance that the employers who do not offer insurance rejected. In addition, the part of workforce that is uninsured is not a good candidate for individual firm based insurance: it experiences both high turnover across jobs and is heavily weighted by secondary wage-earners in families—and group insurance has a terrible problem dealing with people with either of these characteristics. Finally, there is something good to be said for health insurance that you do not lose if you change your job or your boss gets panicky about benefits costs—just as you do not lose your automobile insurance because of something that happens at work.
Conclusion

There is no costless painless way to get nearer to universal health insurance coverage in the United States. If we want to make something—anything serious—happen, people are going to have to compromise some of their tastes and even some of their principles. My preferred approach, though (I fancy) magnanimous in its tolerance for public programs, still does have a steel spine: it postulates that Americans can and should ultimately and individually be given the power to choose in health insurance. But the first choice I see adults (qualified to vote) making for themselves is a choice of whether to choose, or whether alternatively to hand over this complex issue to some other entity, whether collectively chosen, semi-randomly selected based on the job they happen to be in and the company they happen to work for, or aggressively individual with insurance that “you, Ms. Consumer, own” and manage with your skills. The alternative, of making a collective choice of a single payer system binding on all is still a potential political choice, and might still be made. My judgment is that such a degree of uniformity is not needed, and is not likely to lead in any case to unanimity. Even though we are “all in this together,” that does not mean that we cannot be clever and creative in allowing those of us who want to have different outcomes be able to express those differences, with “solidarity” expressed primarily in the form of transfers to others rather than uniform consumption.

Is the time ripe for action? I hope so, but it may be that things will have to get worse before they get better. Perhaps the great insured middle class will have to feel threatened with loss of coverage. Rising medical spending alone, representing the adoption of new technology that must be worth its cost (or we would all join the health plan that “refuses to cover the frills”) will not be sufficient motivation. Alternatively, and more hopefully, we research types may be able to do what we should have done long ago: assemble information on the value and effects of insurance for the non-poor, non-sick that will be sufficient to convince a skeptic, and dig a set of channels for old transfers to drain off and new transfers to flow that will allow the middle class taxpayer to feel that spending serious money on this problem is, at long last, a worthwhile thing to do.
Table 1
Those without Health Insurance, at Ages 0–64, by Income as Percentage of Federal Poverty Line, 1999
(N=115,474)

<table>
<thead>
<tr>
<th>Family Income (% of poverty line)</th>
<th>Percent of the Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100</td>
<td>25.1</td>
</tr>
<tr>
<td>100–124</td>
<td>7.5</td>
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<tr>
<td>125–149</td>
<td>8.1</td>
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<tr>
<td>150–174</td>
<td>7.5</td>
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<tr>
<td>175–199</td>
<td>6.0</td>
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<td>200–249</td>
<td>10.4</td>
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<tr>
<td>250–299</td>
<td>7.9</td>
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<td>300–399</td>
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<tr>
<td>400–499</td>
<td>6.5</td>
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<tr>
<td>500 and more</td>
<td>11.1</td>
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</table>

Total: 100

Note: The table uses post-1996 CPS health insurance variables and appropriate CPS March Supplement weights to reflect national population. Data set is CPS March Supplement for 2000 and reflects coverage in 1999.
Table 2

Private or Employment-Based Health Insurance, at Ages 0–64, by Income as a Percentage of Federal Poverty Line, 1999

(Percent of those in poverty category; N= 115,474)

<table>
<thead>
<tr>
<th>Family Income as Percent of Poverty Line</th>
<th>Percent with Some Private or Employment-Based Health Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100</td>
<td>26.3</td>
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<tr>
<td>100–124</td>
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<tr>
<td>125–149</td>
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<td>150–174</td>
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<td>175–199</td>
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<tr>
<td>200–249</td>
<td>73.2</td>
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<tr>
<td>250–299</td>
<td>80.1</td>
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<tr>
<td>300–399</td>
<td>85.8</td>
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<tr>
<td>400–499</td>
<td>89.1</td>
</tr>
<tr>
<td>500 and greater</td>
<td>92.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>74.2</strong></td>
</tr>
</tbody>
</table>

Note: The table uses post-1996 CPS health insurance variables and appropriate CPS March Supplement weights to reflect national population. Data set is CPS March Supplement for 2000, reflecting coverage in 1999. Any private or employment-based health insurance is defined as employment-based or individually purchased coverage, as a policyholder or a dependent, and includes CHAMPUS, CHAMPVA, VA, and military health care.
Figure 1
Voting Matrix of Altman’s Conundrum

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Figure 2

<table>
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<th>Liberals Switch</th>
<th>Marketists Switch</th>
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<td>S</td>
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<tr>
<td>S</td>
<td>G</td>
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6 For more details, see: Pauly MV. An Adaptive Credit Plan for Covering the Uninsured. *Covering America: Real Remedies for the Uninsured*, Wicks E, ed. (Economic and Social Research Institute: Washington, 2001), 137-152.