



# UNIVERSAL HEALTH INSURANCE: A Guide to the Debates

---

*Sherman Folland*

When you buy a car on line, the company displays a complete brand name auto and also invites that “you build your own model” one feature at a time. This paper invites you to create your preferred health plan and compare its features with Obama’s plan. It describes the options in the manner that most health economists describe them, although some health economists differ. It evaluates several health plans or plan components, provides empirical support for the reasoning, and sometimes offers personal views, recognizing throughout that the final judgment lies with the reader and ultimately with the public at large.

## *Medical Savings Accounts (MSAs)*

These plans allow employees to deposit cash or money from their employer into a tax free account dedicated to health. MSAs (or similarly named plans) generally encourage the recipient to buy a high deductible policy. It is intended that the consumer of the health care becomes a good shopper, saving money and forcing the health care firms to sharpen up and become more efficient. Consumers, it is hoped, also will avoid buying care they don’t need.

A good idea in theory, nevertheless it puts a large burden

on consumers, not just the burden of estimating their annual health expenditures, but also the challenge of learning how to choose health care wisely. MSAs may require clear headed decision making even under very stressful medical situations. Most of us aren't experts at everything and we don't want to be.

MSAs are mainly supported by conservatives, which makes sense because they have great faith in the individual and great faith in the market. This "market solution" creates more responsibility and risk for the consumer, and maybe that's good. Yet its unpopularity with consumers comes as no surprise.

### *The Single Payer Plan*

Canadian style health care transplanted to the United States requires that Washington nationalize or destroy the private health insurance industry, and perhaps even to nationalize America's health care facilities. This would save physicians and their staff from the burden of handling today's blizzard of insurance forms, bringing substantial savings in clerical and physician time. More savings might accrue if central control rationalizes the health system as the Progressives hope, that is it might eliminate "fragmentation" of our health care system. At least that was Paul Krugman's claim before he became a promoter of the individual mandate, he argued then that "fragmentation" figured as the primary cause of America's high average costs.

Krugman deserves his Nobel Prize, which he earned in international trade theory. But he makes mistakes when he ventures outside of his area of expertise. "Fragmentation" is a vague concept to measure, and I am aware of no empirical research in health economics studying its relation to costs. On the other hand, efficiency studies of U.S. hospitals and nursing homes report high levels of efficiency. And, more importantly, alternative plausible theories for U.S. costliness exist with data

to support them, theories that are sufficient to explain the high costs

But Pres. Obama spotted the biggest drawback in the single payer argument. He pointed out that our Canadian neighbors' single payer health system developed over many decades, whereas to impose it on America, as if overnight, would be for us a radical shock with unforeseeable consequences. An effort to destroy the private health insurance industry would create a second front in the battle to insure the uninsured, thereby risking the primary goal. Does anyone imagine that the health insurance industry won't fight like bloody hell to keep their perceived property rights? Will the private insurers come out meekly like the Burghers of Calais with the noose already placed around their necks? Hardly. Instead the uninsured would be held hostage to the outcome of that side show perhaps having to wait 15 years for another chance.

### *The Individual Mandate*

This plan begins with a law requiring everyone to purchase health insurance at least as good as a government defined standard policy. Auto insurance works much like this. Those too poor to buy it themselves receive subsidies, but only the poor receive subsidies.

Fewer property rights get usurped. Unlike the single payer plan, the mandate forces only the small minority who had wished to go without insurance to act against their own wishes. Those taxpayers who want a universal plan, get the plan with the least increase in the government budget.

In its bare bones version, however, it achieves neither cost control nor any other reform. These must be added as amendments. But the individual mandate accommodates various amendments in practice, and the Massachusetts plan, which became a model for the Obama plan, illustrates some of these.

## *Massachusetts*

Massachusetts installed an individual mandate health reform in April of 2006. It requires citizens of that State to purchase at least a minimum health insurance policy or face penalties for failing to do so. Insurance companies must accept all customers irrespective of preexisting conditions, and firms must contribute in some way to their employee's health expenses. Following Diane Archer of the Institute for America's Future, the Massachusetts plan has achieved one big success and incurred one big failure. The accompanying table illustrates their success, they substantially reduced the numbers of uninsured.

**Table: The Percent Uninsured in Massachusetts**

	Fall 2006	Fall 2007	Summer 2008
Percent of All Adults Who Were Uninsured	13.0%	7.1%	3.7%
Percent of Adults With Incomes Above 300% FPL* Who Were Uninsured	5.2%	2.9%	3.8%**
Percent of Adults with Incomes Below 300% FPL* Who Were Uninsured	23.8	12.9%	7.9%

\*FPL=Federal Poverty Level

\*\*This number is only for adults with incomes between 300% and 500% FPL.

Source: Diane Archer, "Massachusetts Health Reform", Institute of America's Future, March 2009.

Massachusetts has not been successful at cost control, the plan lacked any cost control measures. The State, which had high average health care costs at the start, now has the highest in the United States. Insurers increased average premiums by 8–12 percent per year. In contrast, those who designed Obama’s health plan recognized that cost control was essential.

### *Obama’s Health Plan*

Like Massachusetts it features the individual mandate, every American must purchase a minimally acceptable health insurance policy or pay a penalty. Business firms must provide or subsidize policies for their employees. The poor acquire subsidies from the government.

Cost containment? Obama pays part of the cost by taxing the rich, a hard sell. The rich became very rich recently and pose a fat target, but their money also buys political influence and the outcome remains to be seen. There are several pure cost control measures. The Obama plan targets “unnecessary” procedures and services. We Americans consume much care that serves little purpose, and we holler when denied those services. Eliminating unnecessary services implies rationing and rationing poses political difficulties. The Obama plan “ration” by supporting research on the effectiveness of various treatments, physicians and their patients then decide.

He also promises to reduce Medicare cost growth. Without rationing of some sort genuine cost control will not be possible. Economists view the controversy over “rationing” with some uneasy amusement. Any scarce resource must be rationed or else its supply will be quickly exhausted. Market price serves as the common rationing device, but in health reform it is the market price that we wish to mitigate.

In cost control, the administration places great reliance on the “the public option”. This means that the government would offer a health insurance policy, which by competition

with private insurance, it is hoped, will keep the escalation of premiums in check.

### *The Public Option*

Much irony surfaces in the debate over the public option. Conservatives complain of unfair competition. But conservatives often say that they believe that government can't do anything right, so why do they worry that the public option will destroy private enterprise?

Yet, conservatives may have a point. If taxpayers money will be used to subsidize the public option, then it could easily threaten private health insurance. And a public option can't go bankrupt, a decided advantage over private insurers. I wouldn't worry either way though, because governments, privates, and nonprofits compete in the hospital industry without any trouble. Consider the situation. If the public option must sink or swim in the general market, the only way it could threaten private insurers is to be simply much more efficient, whereas elsewhere in the health industry efficiency levels are similar between governments and other ownership forms.

Health economists show frustration on hearing the persistent belief even among some top players that skyrocketing premiums can be stopped by disciplining the health insurers. The insurers certainly serve their own interests, and they often interpret their interest extremely narrowly. But they also serve an explosively inflating health system, which they neither created nor control.

### *The Causes of High American Health Care Costs*

Before looking into the causes for U.S. high costs, let us make sure that our costs are in fact really high. The total U.S. national health care expenditures in 2007 were \$ 2.2412 trillion.

The Table below breaks this into costs per capita for the several countries that we frequently compare ourselves to.

Clearly we are the high cost country, the highest in the world as it turns out. So why are our health costs so high?

Forget health insurers. Insurance costs make up only 10 percent of total health costs. About 85 percent of insured Americans get group policies whose loading costs, what the insurers charge, hovers around 15% of premiums. Group policies are bearable, it is the minority of individual policies that are so expensive as to put a crushing burden on the insureds.

The public discussion of health care costs exasperates health economists, because the sources of health inflation were studied for decades and this research yields quite different conclusions from public perceptions. After all, suppose we squeezed 20 percent more efficiency out of health insurance costs, that would hypothetically lower total health costs by only two percent.

A more likely cause of our high health costs lies in the astonishingly rapid development of new health care technology and the public's insatiable demand for it. Of course the public wouldn't buy the technology unless insurance covered it. But in this 'chicken or the egg' puzzle the technological imperative dominates.

Of course, all advanced economies develop health care technologies, enough to meet the demand. Does America have

**Table. Per Capita Health Costs for Several Countries in 2006**

Country	Cost per capita
United States	\$ 6,714
Canada	3,678
Czech Republic	1,490
France	3,449
Germany	3,371
United Kingdom	2,760

Source: OECD Health Data, 2008.

a greater demand for it? The Table below shows the availability of MRI, CAT scanners, and radiation therapy units per million people. These are just a few of the health technologies that we use, but they suggest our tastes for technology. The numbers show that we do have a greater taste for MRI and CAT scanners than many countries, but not for all technologies. Take the MRI, a case of high U.S. utilization. The U.S. rate of use per capita is high and the scans cost \$500 to \$3000, this suggests that our total MRI cost is about \$20 to \$30 billion per year. Many technologies exist, and our love of technology could cost us many dollars in excess of what other countries pay. However, we need to bear in mind that total health care costs in the United States per year are about \$ 2.5 trillion, and it seem unlikely that this source of excess costs could explain more than a moderate portion of the total.

So why are we so much costlier? If you have ever tried to start your car on a ice cold winter day, you probably learned to suspect a dozen things: starter motor, plugs, points, wires, oil viscosity, battery . . . For our health system, there are two suspects that stand out.

Some years ago, a health economist from the University

**Table: Use of Three Technologies Across Several Countries**

Country	MRI Units	CAT Scanners	Radiation Therapy Units
United States	26.5	33.9	4.0 b
Canada	6.2	12.0	NA
Czech Republic	3.8	13.1	9.2
France	5.3	10.0	6.0
Germany	7.7	16.7	10.6 b
United Kingdom	5.6	7.6	3.3

Notes: Data in each case are for units per million. U.S. data for 2005–6 were not available.

Source: OECD Health Data 2005–6. b=2001. Other data for radiation units are for 2003.

of Pennsylvania developed a simulation of what the health systems of the developed countries would cost if health professionals' incomes would equal only their opportunity costs. "Opportunity costs" are the salary they would have made in their next available opportunity. The economist, Mark Pauly correctly suspected that U.S. physicians were making unusually high incomes by world standards. The Table below reveals a comparison of physician salaries in several countries.

When traveling in Eastern Europe in 1992 on a research trip, the physicians I met in Prague were making \$400 a month. Tomas, the physician character in "The Unbearable Lightness of Being", turned down an opportunity to practice in the West preferring to stay in his home country, Communist Czechoslovakia. His opportunity cost must have been extremely high!

Pauly found in simulation that the United States, with average physician and other health professional's incomes adjusted in all countries as described, no longer ranked as the

**Table: General Physician Monthly and Salary Income  
Across Countries\* (Year=2005)  
\*Compared by Purchasing Power Parity.**

Country	Monthly Income
United States	\$8189
Australia	3903
Czech Republic	1471
France	3210
Italy	3160
Japan	4685
United Kingdom	4874

Method: Defines a "general physician" as similar to our General Practitioner. Deducts all taxes and other compulsory fees. The original number estimates are from the International Labor Organization.

Source: Web. General Physician Salaries International Comparisons.

most expensive health system but dropped back into the pack. Suspect Number One: Health professional salaries.

Next consider obesity. Get off the plane in Scandinavia and immediately you notice that people look different. Everyone is tall and thin! Compared to Europeans, Americans are much more likely to be obese. The health economist, H.E.Frech III, knowing this, developed estimates of our country's health costs per capita if we reduced our Body Mass Indices to be comparable to other developed countries. His results showed the United States to drop back into the pack. Clearly Suspect Number Two: Obesity.

### *So, Which Choice?*

Do nothing? The sole benefit of dumping the Obama health plan would be a lower government budget. But the costs of achieving this budget savings are the forgoing of the substantial benefits of the plan. The biggest benefit? We insure the uninsured, many of whom are too poor to buy their own health insurance. Polls show that Americans want this. We are a generous people and our charity promises to be more effectively accomplished via our government, we can ensure that it gets done, mostly.

Too costly? By the Congressional Budget Office estimates, the Obama plan would cost \$1 trillion over 10 years. The administration promises to pay for much of it through cost savings, but, cost savings are always iffy. For a broader perspective suppose that all of it came out of taxes. The individual mandate, by subsidizing only the poor, ranks as the least expensive universal coverage plan that is likely to work. The Obama plan, at \$100 billion per year constitutes only about of one percent of GDP and four percent of health spending. The plan establishes that insurers accept customers without regard to preexisting conditions, helps to dislodge health insurance from dependence on employment, and encourages research into which medical treatments actually work. Health reform offers

a very good bargain. Any successes in costs control enhance the net benefit.

The plan creates another major benefit, one that almost always gets overlooked in public debate. Universal health insurance insures everyone against the loss of income. Today, if we lose our job or lose revenue in our business we risk not being able to afford health insurance. Reform assures that health insurance will be there.

When should we look to government to solve a problem? A good rule of thumb is to count up the true benefits to people. Theoretically these benefits should be large enough net of costs to generate a large enough majority of voters at the polls. As of this writing, August 2009, this last part remains to be seen.

## **EPILOGUE**

For me, it has been over 20 years since coming to believe that a national health insurance plan could be devised that would provide a large net benefit to the public. During those years, Ted Kennedy defended the idea in the Senate. Though commonly disagreeing with Kennedy's politics back then, circumstances have changed. I wish the Senator could have seen the day that the bill passes.