Prologue: When American health policymakers discuss health care reform, what they really are discussing is reform of the financing and delivery of health care, not of the care itself. Most of health care financing deals with the flow of funds from U.S. households into health insurance funds (both governmental and private), whose responsibility it is to disburse those funds to various providers. As Uwe Reinhardt describes the process, American employers enter the picture as “pumping stations” for this flow of funds. “Whatever contribution private employers may have made to American health care is tempered by the deception, inadvertent or not, that probably has served to indoctrinate millions of American workers with a firm belief in the free lunch,” Reinhardt writes in this essay. The myth of the free lunch—that is, that employers are paying for the health care of their employees—has been the basis for “an unseemly pas de deux among employers and employees that may well have been one of the major cost drivers in American health care,” he continues. The funds that businesses spend on health care are recouped in the form of higher prices, lower returns, or reduced wages. Whatever their shortcomings, employers are firmly settled in their position in the U.S. health care system. Given this, Reinhardt argues, they should be limited to tusk for which they are well suited: collecting payroll-based premiums and passing them on to health insurance funds. In the context of managed competition, employers would simply remit payroll-based premiums to health insurance purchasing cooperatives. A governmental “fail-safe” plan would ensure universal coverage. Reinhardt is James Madison Professor of Political Economy at Princeton University. He is a prolific and often irreverent commentator whose views appear often in the nation’s medical, economic, and policy journals and the popular press.
Abstract: The essays in this volume concentrate heavily on “managed competition,” which is merely a particular form of controlling the flow of funds from an insurance pool to the providers of health care. By contrast, this essay emphasizes the funneling of money into the insurance fund. It is argued inter alia that American business has been a quite unreliable partner in the financing of American health care and also a major cost driver. A reformed health system should reduce the role of business to the mere collection of premiums at the nexus of payroll.

When Americans speak of health system reform, they typically do not think of revamping the mix of professionals and facilities that render health care. Instead, they think of the way health care is financed. They worry about their own lack of health insurance or, if they have coverage, about the prospect of losing it with their job. They may also be angry that their employer asks them to pay an ever-increasing fraction of the premiums that had hitherto been fully paid by the company. Finally, they may be upset by the ever-increasing copayments they may be asked to make at the time they are ill and receive services.

Experts on health policy, on the other hand, do believe that the delivery system itself is wanting. However, even the experts think mainly of reforming the financing of health care when they speak of health care reform, hoping that the financial flows in health care can be realigned to drive the delivery system automatically into a more desirable configuration.

The Two Facets Of Health Care Financing

Exhibit 1 presents a simplified sketch of the flow of funds in a modern health care system. The sketch divides that flow into two distinct facets: (1) the extraction of funds from private households into some collective insurance fund, and (2) the disbursement of funds from the insurance fund to the ultimate providers of health care.

Money can be funneled from households to the collective insurance fund or funds via three distinct routes. First, households may pay into the pool directly, as they do when they purchase private insurance (pipe A in Exhibit 1). If the government uses tax credits or other forms of support to subsidize low-income households in their purchase of private health insurance, then the money flows into the insurance pool through pipes C, B, and A. Second, households may pay taxes or premiums to a public authority, which then places the funds into a public or private insurance pool (pipes C and D). The Canadian and British health systems are financed this way.

Third, money may be extracted from private households by private business firms and then channeled directly to the insurance fund (pipes E and G). Some proposals would mandate employers to do this by law. These are the so-called play-or-else mandates. Alternatively, business may collect
Exhibit 1
The Two Facets Of Health Care Financing

1. Funds from households and then transmit them to government, which then funnels the money to the insurance fund (pipes E, F, and D). One might call this approach the pay-or-else mandate. It is the financing mechanism used for Medicare Part A and the one called for in the proposal developed by California Insurance Commissioner John Garamendi. Yet other proposals would mandate private employers either to purchase private insurance directly for their employees or to pay a premium to a government agency, which would then procure coverage for the employees. Here money flows into the insurance pot either via pipes E and G or via pipes E, F, and D. These are the so-called play-or-pay mandates.

Money can flow from the insurance pools to the providers of care via many different routes. The predominant methods in the United States have been direct payments to the providers (pipes H and M in Exhibit 1), usually on a fee-for-service basis, or capitation payments to integrated health systems (pipe K) whose central administration then pays affiliated individual providers on a variety of bases, including fee-for-service, capitation, or salary for professionals and fee-for-service or per diem for inpatient facilities (pipe L).

Although in the United States there is also a flow of funds directly from households to the providers of care in the form of out-of-pocket payments at the time health care is received, that flow constitutes only about 20
percent of total national health care expenditures, and it is apt to constitute an even smaller fraction after the reform of our health system. For the most part, the discussion in this essay therefore concentrates on the flow of funds through the collective insurance fund.

The two facets in Exhibit 1 are not completely unrelated. Nevertheless, they are sufficiently distinct to warrant separate treatment. This point seems widely overlooked in the health policy debate. For example, the concept of managed competition is commonly styled as an alternative to play-or-pay, and tax-financed health care is often described or decried as “socialized” or “government” medicine, terms properly reserved for health systems in which the government owns and operates the delivery system itself—such as the health system run by the U.S. Department of Veterans Affairs (which, curiously, seems immensely popular in a country that habitually casts aspersions at “socialized medicine”).

Strictly speaking, the concept of play-or-pay applies only to the cash intake side of Exhibit 1. It is a particular way of funneling money from private households into some collective insurance fund. Managed competition, on the other hand, is a facet of the disbursement side. It represents a particular way of funneling money from the collective insurance fund to providers.

Unfortunately, the term managed competition has come to be used so loosely that it describes the original concept just about as reliably as does the yard animal when one seeks to describe a cocker spaniel. As other essays in this volume of Health Affairs make clear, the central idea of bona fide managed competition is to intersperse a powerful broker between households seeking health insurance coverage and health care and the private entities that provide these services. The conventional term for this broker is health insurance purchasing cooperative (HIPC). A HIPC could be a branch of the personnel department of a large corporation working only for that corporation’s employees. Alternatively, it could be a community-based, not-for-profit cooperative or even a public agency.

Like any other cash disbursement mechanism, however, managed competition per se does not imply a particular method of funneling money from households into the collective insurance funds. The concept is fully compatible with any number of ways to extract money from households, including systems such as Canada’s that collect funds mainly through the income tax system. Although one’s preferred health care reform package necessarily represents a particular, integrated combination of cash intake and cash disbursement systems, it is best in deliberations on health care reform to treat these two facets of financing as separate issues, at least initially.

Most of the essays in this volume focus on managed competition, that is, on the disbursement side of Exhibit 1. There may be merit, therefore, in my
offering a somewhat broader perspective, one trained more heavily on the cash intake side. To that end I offer some observations on alternative methods of funneling money from private households into collective insurance funds. Thereafter I offer a few comments on methods of disbursing funds, with some emphasis on the role of fee-for-service compensation under managed competition.

**Financing The Collective Insurance Fund**

The health insurance fund in Exhibit 1 might refer to a government-run insurance system, such as Medicare, that disburses funds directly to providers on a fee-for-service basis. Alternatively, it could be a private insurance carrier that also disburses funds directly to providers. Finally, the fund could merely be a HIPC that funnels the money to integrated health plans under managed competition. Whatever the particular function, the fund must always somehow nourish itself fiscally, and the ultimate source of that nourishment will always be private households.

Although the latter point must be perfectly obvious to anyone who thinks carefully about health care financing, many Americans appear to believe that government and private employers pay for the bulk of American health care. This impression may be inadvertently fostered by the way in which data on national health spending are presented in official reports. In those reports the sources of funds for health care tend to be categorized by whoever wrote the last check in the sometimes convoluted chain that originates in private households and ends up as revenue on the books of providers. For 42 percent of all health spending, for example, the last check writer will have been a government agency. For another 33 percent it has been a private insurance carrier who, in turn, has been paid by a private employer. But government and private-sector employers alike merely act as convenient pumping stations along the way. They will have sucked out of the budgets of private households every dollar they convey to some health insurance pool. Governments do this by levying taxes or premiums on households. Private employers do it either by charging their customers higher prices, or by paying the firm’s owners (if there are any) lower returns on their equity in the firm, or by reducing their-employees’ take-home pay or other fringe benefits. Not a single dollar is paid by the “firm” itself, which is really nothing other than a legal construct tying together customers, owners, and employees.

An important question in deliberations on health care reform should be the ultimate effect of these financial contributions on the budgets of private households in different income classes. One would like to know that effect for at least two reasons. First, one may wish the bite health care takes out of
different household budgets to be roughly the same fraction of income for all households. Second, it seems desirable that citizens know roughly what bite health care does take out of their own income, lest they believe that health care is more or less a free lunch.

Unfortunately, the more pumping stations one clips into the financial flow from private households to the health insurance funds, the more uncertain the ultimate incidence of health care financing will be, and the more likely it is that individual citizens have absolutely no idea how much they truly spend on health care. The genius, and also the curse, of the American health insurance system has been the construction of a financial pumping system so indirect and so convoluted that it has literally fooled most of the people most of the time about who really pays for the nation’s health care costs. A fundamental design question in the reform of our health system is whether one should build upon that financial labyrinth and the myths it begets.

**Direct financing by households.** A family’s contribution to the financing of health care is most easily ascertained when that family is required to pay fully for its own care or health insurance. That arrangement remains the ideal among conservative commentators yearning for more “personal responsibility” in health care.

The problem has always been to combine that ideal with another, namely, the notion that access to needed health care should be equitable. While it may seem proper to extract from reckless and myopic people a commensurately high financial contribution toward the higher health expenditures their conduct may occasion, it is difficult to implement that principle. First, it violates our code of civilized conduct to withhold needed care from someone who was reckless and cannot pay for that care. Second, it is difficult in practice to segregate health spending caused by a reckless lifestyle from spending triggered by genetic factors. Consequently, the desire for personal responsibility could easily lapse into a tyranny of the healthy over the sick.  

Even so, one can conceive of a reform that would mandate the individual household to procure a basic health insurance policy but that also would publicly subsidize the purchase so as to make the ultimate distribution of health care costs equitable. Such an approach has been fully articulated by a number of authors in recent years. Although these authors do not expressly make managed competition the centerpiece of their cost-control scheme, in principle the cash intake mechanism they propose is perfectly compatible with managed competition on the cash output side.

Stuart Butler, whose Heritage Foundation proposal is most explicitly linked to a simple ethical stricture, proposes to subsidize the individual purchase of private health insurance through refundable tax credits so that
no household spends more than 10 percent of its annual income on additional outlays for health insurance premiums and out-of-pocket health spending. In that guise, the approach has considerable appeal on ethical grounds. But it raises some practical problems.

First, a system of refundable tax credits due individual households is administratively cumbersome, especially when the size of the credit depends upon both the household’s income and its own spending on health care. The idea presupposes that society falls neatly into well-defined households whose head regularly files an income tax return or at least knows enough to calculate what refundable tax credit is due the household and when and where to claim it.

Second, a mandate on individual households to procure health insurance on their own initiative presupposes widespread respect for the law. In practice, many financially pressed households may disobey the mandate, even with a tax credit, hoping that charity care will jump into the breach at times of critical illness. This shortcoming, incidentally, besets any health reform proposal that does not somehow automatically cover households that fail to take advantage of existing opportunities on their own volition.

The direct purchase of health insurance from private carriers supported by direct government subsidies to households became the centerpiece of the Bush administration’s health reform proposal. The tax credits offered in the proposal, however, were so low as to guarantee persistent wide gaps in coverage. Furthermore, the administration failed to describe convincingly how the private health insurance market for individuals and small businesses would be reformed to make private health insurance accessible to low-income families and precisely how the cost of health care would be controlled. The proposal may inadvertently have tarnished the entire concept of refundable tax credits for some time to come.

**Private employers as pumping stations.** Many current health reform proposals build on the idea of using private employers as pumping stations in the flow of funds from households into health insurance pools. That mechanism is employed in many other industrialized nations around the world, notably in continental Europe and in Asia.

The worldwide popularity of payroll-based financing of health care is not surprising. Unlike the income tax, which is based on the returns filed by individuals with varying degrees of skills and honesty, payrolls tend to be administered by highly sophisticated managers who have little personal incentive to cheat. Tapping into a nation’s income flow at the nexus of the payroll thus provides a relatively reliable source of financing. Most nations financing their health care in this way, however, merely ask employers to collect the requisite funds and to remit them to some public or private insurance pool, leaving someone else to manage the disbursement of funds
to providers. In no other industrialized country are employers directly and actively involved in the markets for health insurance and health care. That seems to be a uniquely American tradition.

The direct involvement of private employers in American health care appears to have its origin in World War II. Fringe benefits such as employer-paid health insurance were initiated then to sidestep the wage and price controls in force during the war. Since that time employer-provided insurance coverage has grown so substantially that today it embraces over two-thirds of the American population under age sixty-five. The system, however, has been entirely voluntary, and many smaller firms or low-wage industries do not offer the benefit because of higher premiums.

A number of current reform proposals—including those by Alain Enthoven and Richard Kronick and by the Jackson Hole Group—would simply extend that tradition by mandating all private-sector employers to provide their employees with a standard health benefit package. The unspoken premise, here and elsewhere in public policy, appears to be that building upon American traditions is necessarily a good thing. But some American traditions are more checkered than others, and some of them are so checkered as to warrant abandonment. The question is whether employer-paid health insurance as we have come to know it in this country is one of the traditions worth sustaining. If not, what useful role should employers play in the health system?

Private-sector employers in the United States, who traditionally have written the final checks for about one-third of all national health spending, can take some pride in having helped to finance, along with government, what is widely acknowledged to be the most innovative and most technically sophisticated health system in the world. But they have made that contribution by blithely funneling money to the health sector, without much heed to the inflated price standards they would help to set or to the overall burden that health care eventually would place upon their companies and the economy at large. Worse still, the largely uncontrolled financial flows emanating from private employers have been enlarged further by a tax preference that vastly subsidized this flow of funds but that is inherently inequitable. Finally, whatever contribution private employers may have made to American health care is tempered by the deception, inadvertent or not, that probably has served to indoctrinate millions of American workers with a firm belief in the free lunch. Because so much is made of private employers as cornerstones of a reformed American health system, it is worth examining these shortcomings at closer range.

**Disproportionate tax benefit.** First, employer-paid premiums are a fully tax-deductible business expense to taxpaying employers but not part of the employee’s taxable income. While this part of the tradition may seem
benign, it rests on a dubious social ethic. For one, it has never been extended to self-employed Americans or to families procuring health insurance on their own. Second, under our progressive income tax, tax savings accrue disproportionately to families in the higher income brackets. According to a recent estimate by Lewin/VHI, in 1991 the tax shield saved its lucky beneficiaries a total of $66.6 billion in federal taxes and an additional $8.3 billion in state taxes. Of this total, however, fully 26 percent went to households with incomes in excess of $75,000 per year and only 6 percent to households with incomes below $20,000. To a family with an annual income of $100,000, the break in federal taxes alone was worth close to $1,500 a year. To a family with an income below $10,000, it was worth only $50 per year. Ethical precepts exist to defend this skewed allocation of tax benefits, but they are not convincing.

Many current proposals, including those by Enthoven and Kronick and by the Jackson Hole Group, would continue the exclusion of employer-paid premiums from taxable income, but only up to a certain limit—for example, “80 percent of the average price of a comprehensive [health] plan meeting federal standards” or the premium of the lowest-cost health plan sponsored by the relevant HIPC. While that feature may have the desired effect of driving consumers away from more expensive into lower-cost health plans, it perpetuates the inequity inherent in the exclusion of any fringe benefit from taxable income: the regressive incidence of the benefit. A much preferred way of subsidizing the purchase of health insurance would be the scheme recently proposed by Mark Pauly and colleagues or that of the Progressive Policy Institute. Under the latter proposal, any employer contribution to an employee’s health insurance would be treated as the employee’s taxable income, but households below a certain income level and enrolled in an “accountable health plan through a HIPC” would be granted a refundable tax credit of a fixed amount. The institute’s proposal is a progressive and highly commendable break with a dubious American tradition.

The free-lunch myth. A second shortcoming of the American approach to employer-paid health insurance is that it rests on an erroneous belief, namely, the notion that “the company” is paying for the health care of employees, when for the most part the money comes from the employees themselves. That myth has been the foundation of an unseemly pas de deux among employers and employees that may well have been one of the major cost drivers in American health care.

Standard economic theory suggests that it is typically the employee who ultimately bears the cost of fringe benefits. According to that theory, which has empirical support, the price of labor that is determined in competitive or even unionized labor markets is total compensation—the total debit to
payroll expense made for an employee, including the fringe benefits allegedly bestowed upon the employee by the employer.\textsuperscript{13} From that theoretical insight it follows that fringe benefits and take-home pay tend to be substitutes for one another, certainly in the long run, as increases in the cost of one fringe benefit will come at the expense of either take-home pay or other fringes. Granted, in industries that are not subject to foreign competition and that face relatively price-insensitive customers, part of the cost of fringe benefits may be shifted forward in the form of higher output prices. But as the Congressional Budget Office (CBO) concluded in a recent report, “The rising costs for [employer-paid] health insurance explain why workers’ [real] cash wages have hardly grown over the past two decades.”\textsuperscript{14}

Traditionally, American employers have purported to pay most or all of their employees’ health insurance premiums. Only in the latter half of the 1980s have most of them asked their employees to contribute directly to their coverage out of their paychecks, often after bitter negotiations. But the employees’ official share is still relatively small—only about 20 percent according to a recent survey.\textsuperscript{15} There is every reason to believe that the typical employee responding to this survey sincerely thought that someone else—“the company”—picked up the tab for most of his or her family’s health care. Why else would union leaders fight so hard to keep low the share of the premium paid explicitly by the rank and file?

To what extent the nation’s business and labor leaders have fallen into this erroneous belief themselves is an intriguing question. One would have hoped that persons in positions of leadership might have known better, and some of them surely did.\textsuperscript{16} Perhaps both business and labor leaders have found it useful to pretend that “the company” was indeed paying for what they actually expected to be shifted back to employees in the form of lower wages. It allowed employers to charge employees more or less fully for a benefit that the employees perceived as an almost free lunch. In the context of the often tough negotiations in modern industrial relations, that form of ignorance can beget a degree of bliss.

Blissfully ignorant of the true bite their health insurance was increasingly taking out of their own take-home pay, insured American workers have been allowed by their employers to develop an entitlements mentality in health care that is evident neither among the nation’s elderly (less than half of whose health spending is covered by Medicare) nor among the nation’s poor (fewer than half of whom are covered by Medicaid and few of whom with Medicaid have unfettered access to the full range of the nation’s health care resources). American executives and their workers today balk at the mere mention that anyone might limit that “right” to limitless health care. They abhor it as “rationing”—as somehow un-American. It is an entitlements mentality not shared by workers anywhere else in the world,
and one for whose inculcation American business leaders bear most of the blame.

Throughout the 1980s private employers in the United States have routinely laid the health care cost problem at the doorstep of government, which, allegedly, has kindled an uncontrollable entitlements mentality among the poor and the aged. The reverse surely is more nearly the case. If government has found it hard to control its outlays on health care for the aged and the poor, it is mainly because it has had to limp fairly closely behind the extraordinarily high and ever-rising prices for health care that have been passively countenanced by private employers and their insurance carriers. For screening mammography, for example, Medicare now pays a fee of $55, calculated to amortize a fully used machine over its use-life with a respectable profit margin per screening film. By contrast, private payers routinely pay $100-$200 for the same service, a payment so generous as to support roughly four times as many mammography machines as this nation actually needs. One can only wonder why the private sector has been content to finance this excess capacity, along with so much excess capacity in other parts of the health system. Perhaps the answer does emerge from standard economic theory and the wondrous workings of the private sector: Those who write the final checks to health care providers (employers and their insurers) know it is not the company’s money and really do not care, while those who actually do pay (the employees) do not know that they do and therefore do not care much either.

Many current health reform proposals make much of the thesis that the exclusion of employer-paid health insurance from the taxable income of employees has insulated the latter from differences in the cost of alternative health insurance plans, which is said to have slowed the acceptance of lower-cost managed care plans among American workers. Fair enough. But is it not somewhat contradictory to press that thesis with such force-to blame the slow growth of managed care mainly on that feature of the tax law-all the while blithely proposing that we continue, vis-a-vis employees, the harmful myth that someone else—“the company”—pays for 75 percent or more of their health insurance premiums?

Social security deception. A third major failing of private employers in American health care has been their attempt to provide what usually only governments can provide: trustworthy social security, that is, promises to pay pensions and cover health care costs during an employee’s long retirement. The original intent behind these promises was undoubtedly benign: Employers wanted to do something good for their employees; for a while, they could. But once again these good intentions have been tempered by a major deception, for in many instances these promises have been just that: mere promises, some more brittle than others.
Generally Accepted Accounting Principles (the GAAP) as well as the federal Employee Retirement Income Security Act (ERISA) have forced private employers to be fairly reputable in their handling of promised pension benefits. They must acknowledge them in their financial reports and fund them when first made (although many companies nevertheless have managed to underfund their pension promises). Promised retiree health benefits, on the other hand, have never been properly secured, primarily because neither the GAAP nor the government has demanded it. As a result, private employers have literally gotten away for decades with paying their employees partly with funny money, that is, with promises whose cost (in the year they were made) was never acknowledged in the employer’s income statement, nor even so much as hinted at to the firm’s owners by way of a footnote, let alone funded.

Under the Financial Accounting Standards Board Release 106 (FASB 106) employers henceforth must openly acknowledge in their financial reports the actuarial cost of their past and current promises of retiree health benefits (although they still need not fund them). As a result of this mandated candor, some corporations will see their hitherto reported net worth literally vanish. As a result of that forced candor, too, many American companies now seek to break past promises to their employees retroactively, to the extent that the law permits it and the company’s lawyers achieve it. That strategy will help hitherto deceived shareholders, but its victims will be unsophisticated retired American workers who probably could not have known better.

Policymakers should learn from that history that any proposal seeking to make private employers the cornerstone of a reformed American health system must make sure that stone is solid. Such proposals should make sure that promises made by private employers to their employees are honestly acknowledged to all concerned and adequately funded from the start. American workers deserve no less, and so do American taxpayers who somehow always must jump into the breaches carelessly left by the private sector. That, alas, is a time-hallowed American tradition as well.

To sum up at this point: Given the rather checkered history of private-sector employers in American health care, a good case can be made for leaving employers out altogether. Alternatively, if employers are to be engaged as pumping stations in financing health care, then one ought to limit their role strictly to those tasks they can do fairly well: the collection and transmission of payroll-based premiums. Even then, every paycheck should be required to bear the following statement: “On your behalf, your company contributed this month $X for your health insurance coverage, over and above your own contribution. If your company had not made this contribution, your take-home pay would have been $X higher.”
In this respect the United States could learn a lesson from Germany’s statutory health insurance system. The sickness funds in that system are financed chiefly through premiums collected at the nexus of payroll and calculated as a percentage of gross wages, currently averaging about 13 percent. Although, ostensibly, half of that premium is paid by the employer and half by the employee, in public discussions on health care cost the two halves are always added together and discussed as one levy—the so-called Beitragssatz (contribution rate), which, one supposes, workers know comes out of their gross wages. This contribution rate is the beacon that politicians, unions, employers, and the media watch to track health care costs. Sharp increases in that rate usually trigger tough new cost-control measures. It is a simple number, easily tracked and well understood by all parties. American employees need such a clear beacon to remain involved in the campaign against rising health care costs.

**Government as a pumping station.** Many countries, notably Canada and the United Kingdom, eschew the use of private employers as money pumps in health care altogether, using government instead. These countries rely on a great variety of tax pipes, including general income taxes and sales or value-added taxes. In the United Kingdom money is funneled to providers by a mixture of global budgets for hospitals and capitation and fee-for-service payments for physicians. In Canada it is a fee-for-service system for physicians and global budgets for hospitals.

The financing mechanisms used by these nations have a number of distinct features that may be viewed as drawbacks. First, by relying mainly on general taxation, health care is inevitably pitted against all other programs under government purview. While that may be all to the good in a parliamentary system, in which the legislative and the executive branches are rarely at odds with one another and can make reasoned trade-offs, the approach is more problematic in the American context in which budget allocations are the result of an almost incomprehensible and often haphazard legislative process. If the U.S. government is to act as a pumping station in the financing of health care, it would have to do so with earmarked funds that are protected from the vagaries of the general budget.

Second, financing through general taxation totally obscures the link between the individual household’s contribution to health care and total national health spending. That, too, can trigger images of a free lunch. Although it will never be possible to trace every penny of national health spending to the individual household, there is nevertheless merit in moving as far as possible in that direction.

One approach in that direction might be the following mixture of private- and public-sector financing, an approach I have proposed earlier in this journal. Under that approach private employers would be left com-
pletely free to decide whether to make health insurance part of the total compensation package freely negotiated with workers in the labor market. Instead of mandating business to insure their workers, government would insist that every American family carry basic, comprehensive health insurance coverage. Government would also make sure, however, that such coverage would be available to all families at premiums they could afford. This requirement argues for a premium linked to a family’s ability to pay.

Thus, on the 1040 tax forms, there would be two special lines pertaining to health insurance. On, say, line 61a, the taxpayer would be asked to enter X percent of adjustable gross income as a premium (not to be confused with a tax!) for a fail-safe health insurance package that is automatically bestowed upon that taxpayer’s household, unless that household attaches evidence of a private policy that is at least as comprehensive as the fail-safe policy. The premium rate X could be a flat rate, or it could be made to increase progressively with income.

An earmarked indigent care tax (perhaps an average 1 percent or so of taxable income) would be needed to supplement the modest premiums collected from low-income families. Additional funds might be extracted from earmarked health taxes on alcohol, tobacco, and gasoline. Finally, a case can be made, once again, on grounds of both horizontal 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.

The mechanisms described above, of course, deal only with the cash intake facet of the health insurance system. For the second facet, namely, the disbursement of this money by the insurance funds to the providers of health care, one can think of at least three distinct approaches.

First, the federal government could use its fail-safe fund simply to enroll in Medicare all Americans who are not privately insured. This would be a major move in the direction of the single-payer option proposed by some health reformers and one so often decried as “government medicine” by others. An alternative would be for the federal government to distribute its fail-safe fund to the states in the form of capitation payments that would be adjusted for age, sex, and unavoidable regional cost variations. A fully operational mechanism for such capitation payments already exists for the current Medicare program. The individual states could then disburse these capitations (possibly supplemented with state funds) to providers in a manner that suits local preferences.

Some states might prefer to enroll uninsured families in their own public, state-run programs (for example, their own modified Medicaid programs). This, would still be a government-run disbursement system, albeit a decentralized one. Other states, however, may prefer to recycle the capitations
into the private sector through the process of managed competition. They could channel the federal funds to a state HIPC, perhaps supplementing the federal funds with additional funds from local sources. State residents not elsewhere insured would then be given a choice of competing health plans, some of which might even be fee-for-service plans. As is customary in the concept of managed competition, the HIPC would fully fund only the lowest-cost plan offering the prescribed, basic package of benefits. If individuals sought to enroll in a different, more expensive plan, they would have to pay the differential out of their own after-tax income.

If one coupled this fail-safe financing scheme with managed competition at the state level, it would be relatively easy to combine the approach with a top-down national health care budget. Indeed, although many proponents of managed competition are vehemently opposed to global budgeting for the entire health system, managed competition, to the extent that it relies heavily on capitation, is the ideal platform upon which to erect top-down global budgeting. Surely it is much easier to feed down a global budget from the federal level through the state government and thence to the local level of a particular health plan via a capitated system than it would be to do so under the more open-ended fee-for-service system.

The fail-safe system proposed here clearly implies a two-tier health insurance system, as it allows individuals to buy out of the fail-safe system through privately procured insurance. That feature raises two questions. First, is such tiering acceptable to the American ethos? Second, does not that system invite clever risk selection on the part of individual households or private employers?

In response to the first question, it is improbable that the American elite will trot off quietly with everybody else into closed-panel health plans that limit their freedom of choice among providers at time of illness, just as it has not passively trotted off to the public school system when the latter does not please. The elite, here as elsewhere in the world, will insist either on generous point-of-service safety valves within managed competition, or on traditional fee-for-service insurance. The fail-safe system proposed here accommodates the elite. It offers an honest and quite humane two-tier approach, which, in my view, is the only approach this nation’s elite will ultimately ever tolerate in health care in any event.

In the absence of sanctions, the fail-safe system would be subject to risk selection on the part of consumers and entire companies. Healthy people would tend to favor actuarially priced private insurance; chronically ill persons would gravitate toward the fail-safe system, driving up its average cost. If such choices were feasible on an annual basis, they could destabilize the system over time.

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

### Disbursing Funds To Providers

A health insurance fund can transfer money to the providers of care on the basis of either (1) fee-for-service, (2) a flat fee per medical case, (3) a flat fee per month or year per patient at risk, or (4) a global budget per period (which would mean a salary for individual practitioners and a budget for a facility). All of these are currently being employed in the United States, and each brings with it problems.

**Fee-for-service compensation.** The advantages of fee-for-service disbursement are twofold. First, the system establishes a tight link between the output of services (not to be confused with output of “better health”) and financial reward. Second, the system inevitably yields detailed information on the activity of individual providers, or at least on what they report to have done. These are nontrivial advantages.

But the shortcomings of the system are glaring. First, the system explicitly rewards procedure-intensive medical care, with all of the waste known to accompany that incentive. Second, the system requires one to describe explicitly each and every service or supply for which providers are to be separately paid. For physicians, that nomenclature now includes over 7,000 distinct items. For hospitals, there does not even exist such a list; it is what every hospital chooses to make it on any particular day (which explains this country's legendary and rather humorous ten-page hospital bills). Third, a fee-for-service system requires the insurance pool—be it public or private—to make explicit decisions on which services to cover. In the end, the system literally forces one to develop coverage decisions in a fishbowl, somewhat along the line of Oregon's attempt to rank procedures by priority. A common alternative in the United States has been to let the courts make these delicate decisions. Finally, the system requires one to articulate a fee (presumably a signal of social value) for every procedure, which is a difficult task in a dynamic health system with ever-new medical technology.
For all of these reasons, the operation of a fee-for-service system will always be fraught with tension, suspicion, and frustration all around. Even so, most countries base either all or at least major parts of their health systems on fee-for-service compensation. It is a safe bet that this system will survive also in the United States, at least for the next decade, the current enthusiasm for capitated managed care under managed competition notwithstanding.

A unique and truly remarkable feature of this country’s fee-for-service system, however, has been its inherent chaos. Most other nations base such fees on clearly articulated and uniformly binding relative value scales. There is one such scale for all physicians in each of the Canadian provinces. There is one such scale for all of Germany, although the monetary conversion factors can vary from state to state. Beginning with a phase-in on 1 January 1992, to be completed in 1996, the federal Medicare program is paying all American physicians on a common relative value scale, based on the estimated relative resource costs of services (the RBRVS). That scale has been half a decade in the making. The private sector, on the other hand, still compensates physicians on the basis of literally hundreds of thousands of distinct relative value scales, most of which reside in the physicians’ own heads or in their office computers.

Similarly, since 1986 Medicare has compensated hospitals with flat fees per case from a list of some 500 diagnosis-related groups (DRGs). Implicit in that list is a relative value scale based on the relative accounting costs of the DRGs. Most private payers, on the other hand, have been content so far to pay hospitals’ so-called charges, which really means undefined lists of separate fees for every bandage, pill, or ministration ever given to a patient during his or her stay, at rates that obey no known relative value scale.

That the provider community has succeeded in maintaining this chaotic pricing strategy for so long speaks to its strategic brilliance. That private payers—insurance carriers and private employers behind them—have peacefully put up with that chaos is nothing short of astounding. It represents a voluntary lapse into structural impotence that can best be explained by the economic theory of the free lunch: Deep down, private employers simply have not cared very much about this problem, and employees have not known that they should care.

The integration of fee-for-service compensation with capitated managed care under managed competition will take time and great ingenuity. A useful first step in that direction, however, would be to force all providers of fee-for-service care to quote their prices in a meaningful way, one that might support a more genuine price competition. To that end, the federal government might mandate every physician to quote the prices of his or her services to private payers on the basis of the Medicare RBRVS, albeit at a
monetary conversion factor of the doctor’s choosing. Similarly, government might mandate every hospital to quote its prices to private payers on the relative value scale implicit in Medicare DRGs, again with a monetary conversion factor.

Practically, this would mean that each doctor could reveal him- or herself to the market by publishing just one number—the monetary conversion factor—and likewise for hospitals. If the established conversion factors were announced on prescribed dates—perhaps once or twice a year—and applied to all private patients, then one could easily publish lists of conversion factors in the daily press for all providers in a community. If providers wished to retain at least some ability to price-discriminate among payers, that is, to charge some payers more for the same service than others, then one could mandate that providers publish the lower and upper bounds of their conversion factors. In any event, only if providers can be forced somehow to reveal their prices in the form of a meaningful, one-dimensional yardstick—can one ever hope to have a semblance of price competition under fee-for-service compensation.

Prepaid capitation. The early advocates of prepaid capitation saw in the concept not so much an instrument of price competition and cost control, but a means to enhance quality in the delivery of health care. It was thought that prepaid capitation would lead to integrated delivery systems that would establish superior peer review among professionals, superior medical information systems, and better continuity of care. That substantial savings might accrue was treated more as a welcome side effect.

Given this image, it may be surprising that the concept has not swept the American landscape. At this time, only a small minority of Americans are enrolled in the tightly managed systems the concept envisages. Enthusiasts for health maintenance organizations (HMOs), such as the Jackson Hole Group, tend to ascribe the slow spread of that model to the perverse incentives in the current tax code. I would place just as much of the blame on the free-lunch doctrine fostered by American business. But one should not underestimate the value American patients attach to free choice of providers at the time of illness, even if that freedom may, on balance, buy patients less genuine quality than they may think, because they know very little about the quality of particular providers.

The proponents of managed competition bank heavily on their ability to develop indices of quality that are both reliable and meaningful to consumers. This is what is meant by “accountable systems.” At this time, such indices are simply not available. To be useful, however, quality indices must withstand not only the criticism of clinicians and statisticians (many of whom will be for hire to attack poor ratings assigned to particular plans), but also the onslaught of litigation. It remains to be seen how soon truly
robust quality indicators on competing health plans will be offered to American consumers. If such indicators do not come forth, then competing health plans may well fall back on projecting images of quality through the tried and true method of the medical arms race practiced so effectively by hospitals during the 1980s: advertisements stating that they alone in the community provide their enrollees with the easiest access to this or that advanced technology.

Finally, one should not underestimate the latent opposition to prepaid capitation among the providers of care. One of the sleepers embedded in managed competition, and one surely well known to organized medicine, is the impact that the spread of tightly managed, fully integrated health care plans could have on the market for medical professionals. As Donald Steinwachs and colleagues, Alvin Tarlov, and I have noted, a substantial enrollment of Americans in such systems could trigger a sizable physician surplus in the fee-for-service sector.

Research suggests that, on average, well-managed staff- or group-model HMOs can serve about 800 patients per physician, with a mix of physicians more heavily weighted toward primary care than the existing supply of physicians is. That number implies a physician-to-population ratio of about 125 physicians per 100,000 population. The current overall ratio in the United States is about 250 physicians per 100,000 population.

If one lets $T$ denote the overall number of active physicians per 100,000 population available to the health system, $H$ the average number of physicians required per 100,000 enrollees in tightly managed, vertically integrated health plans, and $x$ the fraction of the American population enrolled in such systems, then the number of fee-for-service patients left over per fee-for-service physician ($P$) can be calculated as $P = 100,000(1-x)/T-xH$. Thus, if about half ($x = 0.5$) of the American population were enrolled in tightly managed, vertically integrated systems, such as staff-model HMOs, that could handle 800 enrollees per physician and the total physician-to-population ratio were 250 per 100,000 population, then there would be 337 physicians per 100,000 population left over for the fee-for-service sector, which implies that physicians in that sector would have to earn their livelihood from only about 267 patients at risk, or about 100 or so families. To earn their current average gross incomes of $250,000-$300,000, fee-for-service physicians would have to extract from each such family $2,500-$3,000 per year just to maintain their customary income levels. That payment would come on top of the household’s spending for all other health services.

Quiet probably, the fee-for-service sector would collapse under the economic pressures triggered by a wholesale shift to tightly managed health plans under managed competition. The pressure would be all the more
acute for medical specialists, who would be driven away from the managed care sector into the fee-for-service sector in relatively larger numbers. Whether organized medicine would peaceably countenance such pressures remains to be seen.

In opposing vertically integrated managed care systems, providers may emphasize that so far these systems have not been cheap and that they absorb sizable fractions of the premiums on administration and profits. To be sure, under truly effective managed competition supervised by a tough HIPC, the high administrative costs and profits may be forced down to paper-thin margins. But that is a hope, not a fact.

Therein lies one of the major potential stumbling blocks of managed competition in the next few years. To economists, myself included, the idea of managed competition has enormous intellectual appeal. Properly conducted, it should serve to enhance the value Americans receive for their health care dollar. However, I am not aware of any location in the United States where managed competition is truly properly conducted at this time. So far, the idea remains a bit as communism ever was: an attractive theoretical blueprint that, alas, has never been tried. We should give the idea a chance to work—but ever so cautiously.

Conclusion: On The Virtue Of HIPCs

Whether the United States ultimately goes the route of managed competition with capitated managed care systems or with a price-regulated, all-payer, fee-for-service system, one institution would be immensely useful: a nationwide network of public HIPCs, each organized at the state level but coordinated by a national body that can transmit federal directives to the local level and create some uniformity in health policy across states. Both the Jackson Hole plan and the Garamendi plan set forth the functions of public HIPCs in the context of managed competition. But HIPCs could serve also as the coordinating bodies that supervise the fee-for-service sector of a state’s health system. They could help to implement national relative value scales. They could gather and disseminate reliable information on the individual providers’ conversion factors. Finally, they could be the body that coordinates statewide negotiations of a uniform conversion factor, if the nation decided eventually to convert the fee-for-service sector on an all-payer basis (mainly to preclude cost shifting among payers).

Nations that have succeeded in keeping the growth of health spending in step with the growth of gross national product have developed for that purpose an organizational infrastructure that is totally lacking in the United States at this time. A national, coordinated network of HIPCs could serve as a basic building block for such an infrastructure. The Clinton administra-
tion should propose and the new Congress should legislate the establishment of such a network with all deliberate speed. It would be a move in the right direction.

NOTES

2. I thank Professor Jan Blanpain of the School of Public Health, Leuven University in Belgium, for this descriptive term.
4. See The President's Comprehensive Health Reform Program (The White House, 6 February 1992).
5. A family of four with an annual income of $23,000 would have received the maximum of a tax credit of $375 or a tax saving of $562 on a policy that might easily have cost that family $4,000-$6,000.
7. For firms with ten or fewer employees, loading charges tend to absorb about 30 percent of the premium. In this connection, see U.S. House of Representatives, Committee on Ways and Means, Health Care Resource Book, 107, Figure 52.
9. According to that theory, income taxes should be charged only on that portion of income that exceeds outlays for basic necessities, including health care. I thank my Princeton colleague David F. Bradford for that explanation, which would not have occurred to me.
16. See, for example, a remark by Douglas Fraser, past president of the United Auto Workers, as reported in The New York Times, 14 November 1989, B1.
17. National Cancer Institute data.
18. See, for example, “U.S. Pension Agency Is in Deep Trouble, Economists Warn,” The New York Times, 20 December 1992, 1, 22. The U.S. Pension Benefit Guarantee Corporation is a federal agency that insures private pension plans offered by business, many of which are reported to be underfunded.

19. Taxpayers will ultimately make good on underfunded private pension plans and also on broken promises of retiree health benefits, just as they were asked to the cashier’s window in the savings and loan crisis.


21. A tax is a payment to a government in return for nothing specific. Under a mandated benefit, the employer makes a payment to someone and, presumably, shifts it back to the employee via lower take-home pay or reductions in other fringes. In return for that sacrifice, however, the employee receives something very specific and personal: the fringe benefit. The mandate is a tax only to the extent that the cost of the benefit to the employee exceeds the value the employee assigns to that benefit. In this connection, see L. Summers, “Some Simple Economics of Mandated Benefits” (Paper presented at the American Economic Association Annual Meeting, December 1988).

22. A point-of-service clause would allow patients to go outside their health plan, at the cost of some financial penalty.

23. The fear among this nation’s elite—that it may have to share the strictures it would impose on the poor under universal health insurance—probably has stood in the way of universal coverage in this country. Only an honest, two-tier health system can break that logjam.


26. This general approach has already been endorsed by the American Society for Internal Medicine.