Economists, policy entrepreneurs, and health care reform

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Prologue: Many voices joined in the health care reform debate of 1993-1994, and many of the difficulties that ultimately killed health reform legislation arose from the fact that not all of the parties understood, or cared to listen to, what the others were saying. Two prominent “teams,” if you will, were health economists and what Joseph Newhouse, borrowing from Paul Krugman, calls “policy entrepreneurs.” Although certain propositions in health care financing are widely accepted by economists, they did not fare well in the debate, which was dominated by the policy entrepreneurs—that is, those who purvey solutions (“magic bullets”) to social problems. Economists, on the other hand, tend to focus more on diagnosis than on treatment, and maintain their reputation as “dismal scientists” by insisting that solutions are not possible most of the time. One central issue deemed important by the policy entrepreneurs, which overrode many other issues, was the cost of health care and of reform. Although many economists agreed that health costs were unacceptably high, they did not necessarily agree that costs were rising too fast; nonetheless, that view pervaded the debate and drove the quest for solutions. In this paper Newhouse suggests ways that economists might have framed the debate differently. The paper is based on Newhouse’s Curl Taube Memorial Lecture, delivered in September 1994 in conjunction with the National Institute of Mental Health’s Biennial Conference on the Economics of Mental Health Care. Newhouse, who holds a doctorate in economics from Harvard, is the John D. MacArthur Professor of Health Policy and Management at Harvard University and directs Harvard’s Division of Health Policy and Research Education.
Abstract: Economists would have formulated several aspects of the health care reform debate differently than policy entrepreneurs did. Economists would have questioned whether health care costs must be contained and whether either competition or global budgets were a “magic bullet” for doing so. They also would have emphasized the distortive costs of subsidies and taxes necessary to reach universal coverage, as well as the shakiness of the arguments about international competitiveness and excess insurance industry profits.

In Peddling Prosperity, his recent book on macroeconomic policy, Paul Krugman distinguishes between economists and policy entrepreneurs. The latter purvey solutions—Krugman’s less charitable term is “magic bullets”—for social problems. The macroeconomic policy entrepreneurs who concern Krugman come from both the left and the right, and he contrasts them with the “good guys”: academic economists. Although there is some blurring of the lines at the margin, economists as a group tend more toward diagnosis than treatment. When it comes to policy, economists tend to explain why things cannot be much improved, or in any event focus on the trade-offs. They thus preserve their reputation as dismal scientists.

In this paper I discuss how certain health care financing propositions that are widely accepted among academic economists fared in the health reform debate, which was dominated by policy entrepreneurs. I emphasize two main points. First, although curbing growth in health care costs would ease the lives of federal budget officials, from a broader viewpoint the growth rate may not be too high. Second, financing universal coverage involves hard choices because of the distortions the financing introduces. Because the lecture on which this paper is based is dedicated to the memory of Carl Taube, I use mental health benefits in many of the examples.

What Economists Had To Say

What did economics as a discipline have to say about health care reform? To answer this question, I have chosen five findings about the workings of the health care economy that are widely accepted by health economists.

Trade-off between risk aversion and moral hazard. The greater the protection of people from the random expenses of sickness, the greater the potential overconsumption of medical care, at least in the traditional fee-for-service system. Most US. economists believe that the best resolution of this trade-off involves some initial cost sharing. The empirical results of the RAND Health Insurance Experiment, which found no measurable positive effect on the health of the typical person as a result of the additional services consumed when care is free, bolster this conclusion. There are caveats, however, both theoretical and empirical: The poor cannot afford much cost sharing, and the more well-to-do may be willing to pay something on behalf of the poor, which reduces the optimal cost...
sharing, for them at least, perhaps to zero. Furthermore, if chronically ill persons have to pay the cost sharing year after year, there is, in effect, less insurance against becoming chronically ill. These two caveats have been stressed at a theoretical level by Robert Evans. At an empirical level, the Health Insurance Experiment found some support for altering cost sharing for the poor and chronically ill.

The second caveat applies to the chronically mentally ill. If mental health or other services are excluded from a stop-loss provision, then the mentally ill are poorly protected from risk. Cost sharing can, however, be modified to address these caveats: It can be reduced or eliminated for the poor, albeit at some increase in their marginal tax rate; and there can be a form of a multiyear “circuit breaker,” whereby if the cost sharing is satisfied in some number of successive years, it is reduced or eliminated for some period, with some diminution in incentives to economize.

A different approach than cost sharing to the risk aversion/moral hazard trade-off is managed care. In this case, persons commit to a contract with a health plan, which in principle can reduce the amount of care that brings negligible benefit. The rapid growth of managed care suggests some considerable appeal of this approach.

Open-ended subsidy for employer-paid health insurance. This subsidy increases and distorts the demand for health insurance. Martin Feldstein and Bernard Friedman first popularized the notion that the demand for insurance is distorted by the excludability of employer-paid premiums from individual income tax. Although the literature is not conclusive about the magnitude of the distortion, the great majority of American economists believe that the subsidy induces too much insurance and should be capped.

Adverse selection. Insurance markets may lack equilibrium because of adverse selection. Selection behavior—bad risks differentially signing up for insurance—can explain why a public program is probably necessary for the elderly, why employers heavily subsidize health insurance premiums, why small businesses have a lower rate of insurance coverage than large businesses do, why insurance contracts have preexisting condition clauses, and why many employers do not voluntarily provide mental health coverage. The literature on selection provides a rationale for government intervention in the insurance market, whether by way of abolishing preexisting condition clauses, mandating employers or individuals to purchase insurance, mandating benefits, or financing universal insurance through taxes.

Price levels and payment to providers. Price levels affect provider behavior, and a single basis of payment such as capitation is unlikely to be optimal. Randall Ellis and Thomas McGuire introduced the concept of “supply-side cost sharing” into the theoretical literature, pointing out that
one could reimburse providers a lump sum for each person on their “list” and in addition pay a fee for each service.\textsuperscript{9} The traditional fee-for-service system is one extreme (no lump sum), whereas capitation or the Medicare prospective payment system (PPS) (at the case level) is the other extreme (only a lump sum). Supply-side cost sharing is a combination of the two.\textsuperscript{10} Outlier and reinsurance schemes (in a risk-adjustment context) are forms of supply-side cost sharing. Medicare reimbursement of psychiatric hospitals and units also involves supply-side cost sharing because there is a hospital-specific target cost, based on experience, and a risk window (sharing of cost) for a range above and below the target. As in the case of the tax subsidy, the empirical literature has not reached consensus on the magnitude of responses to variation in payment levels, nor on the weights to be applied to various bases of payment if mixed schemes are used.

**Employer-paid premiums and other forms of compensation.** Most economists agree that total compensation relates to labor productivity. If one part of an employer’s payroll increases, another part will decrease or increase less rapidly than it otherwise would. This means that higher employer-paid health insurance premiums come at the expense of lower cash wages or other fringe benefits.”

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**What Politicians And The Public Had To Say**

How did what economists had to say stack up against what politicians and the public defined as important issues and how they proposed to address them? The two most prominent issues in the public debate on health care reform were framed as access and costs. Perhaps because of the oft repeated though seldom documented claim that U.S. medicine is the best in the world, the broader public debate focused much less on issues of quality.\textsuperscript{12} 

**Access.** Access meant different things to different people, but a common meaning was some kind of universal insurance entitlement. In economic terms, both universal coverage and insurance market reform could be seen as responses to market failure brought on by selection. Moreover, as economic theory would predict, these failures were most acute in the individual and small-business markets, which led some to focus there.

There was, of course, opposition to universal coverage, and one can give an economic interpretation to that opposition. At current levels of insurance premiums—say $6,000 a year for family coverage—poor families cannot be expected to purchase coverage on their own; it simply takes too large a portion of their income. Thus, their care will have to be financed in some fashion by those who are more fortunate. The steady increase in medical care costs, however, has continued to raise the cost to persons with higher incomes of providing insurance to those who are less fortunate. Thus,
although one might naively expect the increase in national income over time to make achieving universal coverage easier, the even more rapid increase in medical care costs appears in fact to make it more difficult.\textsuperscript{13}

Costs. In the public debate, universal coverage and medical costs were sometimes linked differently, such as in the argument that universal coverage would in fact lower costs by inducing more preventive care or by shifting patients away from inappropriate care settings. For the most part, economists did not concur; their dominant view was that universal coverage would add to spending, perhaps by 5-10 percent.\textsuperscript{14}

Independent of the universal coverage issue, many public figures argued that medical care spending was too high. The press carried numerous stories comparing both the absolute level of U.S. health care spending with that of other countries, as well as the percentage of U.S. gross domestic product (GDP) spent on health care. On both criteria the United States was an outlier, even when income was controlled for.\textsuperscript{15} Most economists agreed that costs were too high, although there was dissent on certain specifics of the exorbitant cost argument.\textsuperscript{16}

Based on all of their writing that insurance raised costs, economists can, I think, take some credit for the prominence of costs in this debate vis-a-vis prior debates over national health insurance. That focus, however, missed an important issue: the degree of inefficiency or waste in the rate of increase in medical care costs, which has been at an annual real per capita rate of around 4 percent for more than fifty years (Exhibit 1).\textsuperscript{17} As a result, since 1940 real per capita medical care costs have increased by a factor of ten. How much of that increase represents waste?

There is an emerging consensus among economists that a major component of the 4 percent figure represents the increased capabilities of medi-

\begin{center}
\begin{tabular}{|c|c|c|}
\hline
 & Spending growth rate\textsuperscript{a} & Index of real spending per person at end of decade \\
\hline
1940-1950 & 3.7\% & 144 \\
1950-1960 & 3.7 & 207 \\
1960-1970 & 5.8 & 364 \\
1970-1980 & 4.1 & 544 \\
1980-1990 & 4.8 & 870 \\
1990-1993 & 4.3 & 985 \\
\hline
\end{tabular}
\end{center}

\textbf{Exhibit 1}
Real Per Capita Personal Health Care Spending And Its Growth, By Decade, 1940 - 1993

\textsuperscript{a} Annual percentage rate.

\textsuperscript{b} 1940 = 100.

Source: Author’s calculations from National Health Accounts data, Office of the Actuary, Health Care Financing Administration. The gross domestic product (GDP) deflator is used to convert to real dollars, and the resident population is used to convert to per capita spending.
There is, however, much less consensus on the key issue: For how many of those increased capabilities would the public be willing to pay an insurance premium if no subsidies were present? On this question the evidence is thin, but two pieces of data suggest that the waste may not be as large as much of the public debate implies. First, the real per person rate of increase in other countries is not so different from ours, suggesting that commonly cited factors for the excess in the United States, such as the tax treatment of insurance premiums, are not at play in distorting the rate of increase, however much they may be at play in distorting the level (Exhibit 2). Second, as best we can tell, the rate of cost increase in health maintenance organizations (HMOs), the closest thing to a market test domestically, is not so different from that of the rest of the medical care system. Admittedly, this latter computation is fraught with problems, including the difficulties of correcting for selection and differential benefits changes.

Past willingness to pay does not imply future willingness; the opportunity costs keep rising along with the share of GDP spent on health care. Perhaps for that reason the administration’s health care reform proposal included a global budget for health care costs, with the intent of holding those costs below where they otherwise would have been.

**Views of policy entrepreneurs.** Regarding access, all of the policy entrepreneurs on the left and some on the right began with a commitment to universal coverage, although there was some backsliding on the right as the debate progressed. Regarding costs, those on the right emphasized market incentives, especially the tax cap, and either managed or unmanaged competition. Some on the right emphasized large deductibles, usually in the form of tax-subsidized medical savings accounts (MSAs) to finance out-of-pocket payments. Those on the left tended to emphasize global budgets. Some proposed both competition and global budgets.

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**Exhibit 2**

Real Per Capita Health Care Spending Growth In Seven Major Industrialized Countries, 1960-1990

<table>
<thead>
<tr>
<th>Country</th>
<th>Spending growth rate $^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>4.7%</td>
</tr>
<tr>
<td>France</td>
<td>5.5</td>
</tr>
<tr>
<td>Germany</td>
<td>4.4</td>
</tr>
<tr>
<td>Italy</td>
<td>6.1</td>
</tr>
<tr>
<td>Japan</td>
<td>8.2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>3.7</td>
</tr>
<tr>
<td>United States</td>
<td>4.8</td>
</tr>
</tbody>
</table>


$^a$ Annual percentage rate.
What would economists have said about these proposals? First, there probably would be reasonable agreement among economists on the desirability of both a tax cap and (income-related) deductibles, at least outside of managed care settings. A tax cap could lead to increased cost sharing in indemnity plans or increased enrollment in managed care, both of which should reduce point-in-time inefficiencies. A tax cap, however, is markedly less popular among noneconomists. Perhaps for that reason, there is some advocacy for MSAs, which would, relative to current law, bring about neutrality between the tax treatment of health insurance premiums and that of out-of-pocket payments. Although most indemnity insurance plans already include deductibles, an increase from roughly $400 to $2,000 or more, as with an MSA, could induce a further 10 percent or so reduction in demand relative to current indemnity plans with a $400 deductible.22

However, enrollment in indemnity plans, to which deductibles and MSAs are most relevant, is falling rapidly. Managed care can in principle reduce inefficiency, as already noted, but competition among managed care plans poses the problem of selection; that is, it may lead to competition for good risks, or good risks within categories, rather than to competition for efficient delivery of care to a given mix of risks. This is the rationale for the word managed in “managed competition.”23

Increased deductibles through MSAs, a tax cap, or increased enrollment in managed care are all likely to induce one-time reductions in costs. It is much less clear that they would have much effect on the ongoing rate of increase in costs.24 For example, changes in cost sharing over time do not appear to have significantly affected the rate of cost increase decade by decade, save for the more rapid increase in the 1960s that presumably reflected the one-time costs associated with the enactment of Medicare and Medicaid (Exhibit 1). Thus, for those who define the problem as the ongoing rate of increase in cost, rather than or in addition to the point-in-time inefficiencies, the cost problem remains.

### Cost Increases And The Federal Budget: Six Options

Among those who define the problem as the ongoing rate of increase are those charged with looking after the federal budget. Medicare and the federal share of Medicaid now represent approximately 16 percent of federal outlays. The costs of the two programs have been rising even more rapidly than all health care costs, and of course much faster than federal tax revenues (Exhibit 3). If the enhanced capabilities of medicine are a major component of the cost increase, there is no good reason to think that the rate of cost growth will slow down anytime soon. Moreover, Medicare costs are likely to rise faster than all health costs simply because of increased
Exhibit 3
Growth In Medicare And Medicaid Spending, By Decade, 1970-1993

<table>
<thead>
<tr>
<th>Period</th>
<th>All personal health</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Federal tax revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970-1980</td>
<td>4.1%</td>
<td>7.9%</td>
<td>8.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>1980-1990</td>
<td>4.8%</td>
<td>5.6%</td>
<td>5.2%</td>
<td>1.4%</td>
</tr>
<tr>
<td>1990-1993</td>
<td>4.3%</td>
<td>6.8%</td>
<td>11.5%</td>
<td>-0.3%</td>
</tr>
</tbody>
</table>


Notes: All figures are deflated by the gross domestic product (GDP) deflator and by resident population. Per beneficiary growth in Medicare and Medicaid (rather than per person in the total population) is at approximately the rate of growth of all health care spending for the 1970s and 1980s.

numbers of eligible beneficiaries. The number of Medicaid beneficiaries also is likely to increase because of the greater number of elderly persons in need of nursing home care and poor children eligible for coverage.

There are six options for addressing the rising costs of Medicare and Medicaid. The first five have been used to finance past increases.

Increase taxes. The payroll tax rate was increased in 1978, 1981, and 1986 to pay for increased Medicare Part A costs; additionally, all earnings are now subject to the payroll tax. Further tax increases are an option for financing future cost growth, and they likely will be part of the way the increased costs are financed. But the failure of the Kerrey Commission on entitlements to reach a consensus reflects the public’s current antitax mood, and I assume that a tax increase is not an option for now.25

Reduce other government spending. It is difficult to claim that past reductions in other government spending resulted from increased Medicare and Medicaid costs. Nonetheless, one can reasonably attribute the enactment of caps on discretionary spending as part of the 1990 budget agreement to increased entitlement spending, a major driver of which was increased Medicare and Medicaid costs. Looking forward, however, it is hard to see that reductions elsewhere could be much of an answer to financing increased Medicare and Medicaid costs.

Increase the deficit. As with decreased spending elsewhere, it is difficult to attribute the deficit to Medicare and Medicaid spending, but the deficit surely would be easier to solve if those programs were not so large. Under current law, deficit financing is not an option for Medicare Part A, but it is an option for Part B and for Medicaid. Increasing the deficit, however, does not appear to be a promising source for financing future cost increases. The current mood among at least part of the public is antideficit; also, the tax rates for future generations implied by current tax and spending policies make increased deficits appear unsustainable in the long run.26

Increase beneficiary cost sharing or tax Medicare benefits. There
have been steady increases in the Part A deductible over time, as well as a recent increase in the Part B deductible and premium.\textsuperscript{27} The possibilities for greater cost sharing among Medicaid recipients or among lower-income Medicare beneficiaries, however, are exceedingly limited; thus, this option really applies only to higher-income Medicare beneficiaries. Several proposals have been made to increase the Part B premium for this group, and I suspect that this group will in fact finance part of the increased costs of the Medicare program.

\textbf{Decrease Medicare and Medicaid provider payments.} Medicare and Medicaid physician payments have fallen relative to those for private payers and now stand at 59 percent and 48 percent of private rates, respectively.\textsuperscript{28} Further decreases in this ratio will have one of two effects. Most economists would predict that more providers may decline to treat beneficiaries. Others, however, would predict a cost shift, that is, increased rates for private payers as public program rates are cut, thereby further decreasing the ratio. The large number of physicians who limit the size of their Medicaid practices suggests that at some spread between private and public rates, many providers will decline to treat the programs’ beneficiaries, or alternatively that managed care plans will not wish to bid for these patients. Once we have reached that point, financing further cost increases through rate cuts is not an option without defeating the programs’ aims.

\textbf{Decrease provider payments for all persons, through either rate setting or global budgets.} All-payer hospital rate setting, of course, has been employed in a few states; its effects on costs are controversial.\textsuperscript{29} Global budgets, however, have not been used in the United States.

The limited possibilities for many of the first five options—not to mention the current political unpopularity of most of them—suggest to me that the last option, global budgets, will remain on the table. What can an economist say about the effects of this option on economic welfare?

A central uncertainty of global budgets is how medical care resources will be allocated within the population. With a truly global budget—one that sets a ceiling on national health expenditures—there must be some limitation on individuals’ ability to pay out of pocket for medical care services; otherwise, such spending could violate the budget. This in turn implies that price will not be used as an allocation mechanism.\textsuperscript{30} For those concerned with reducing inequality, this is a plus; nonetheless, just who will receive what services is far from clear. In a standard market one can presume that only the least valued services are reduced when prices increase; persons with higher incomes, of course, have more say in the valuation. For a reduction in services caused by a global budget, however, this presumption does not hold. I suspect that uncertainty on this point is partly behind the public’s skittishness about “rationing” of medical services.
Moreover, if the market is not used to allocate services among patients with different types of illnesses, the political process is by default likely to play a more prominent role. In this case, groups that have been politically weak—for example, the chronically mentally ill—may not fare well.

Although one can intellectually support a global budget as a means of managing the federal budget, most advocates of a global budget see it as a tool for addressing overall medical care costs, not just federal costs. This brings me to a principal difference distinguishing policy entrepreneurs from economists. Many policy entrepreneurs on both the left and the right started from the premise that health care costs must be contained to forestall economic calamity. By contrast, most economists would have said that no great harm would befall the economy if additional resources went to medical care, and certainly not if (unsubsidized) consumers wanted to buy the costly fruits of technical progress.31

**Financing Universal Coverage: Subsidies And Single Payer**

Even though universal coverage may not add a large percentage to the nation’s total health care bill, financing it poses a nasty problem. This problem tended to be glossed over in much of the early reform debate but gradually emerged. To appreciate the issue, one needs to step back and examine the three broad approaches to universal coverage: employer mandates with a public plan for those without an employment connection; individual mandates; and tax financing or single payer.

**Subsidies.** Both employer and individual mandates require some type of subsidy for low-income persons, and of course voluntary schemes have such subsidies. Alas, subsidy schemes almost always pose substantial risks of distorting behavior.

The fundamental problem is that the subsidy declines as income increases, thereby adding to the marginal tax rate (or creating a notch, if the subsidy is a lump sum, as with Medicaid currently). Unfortunately, given the costliness of health insurance, the addition to marginal tax rates is potentially large, and some substantial distortion from subsidies therefore seems inevitable. This point is hardly original; economists as diverse on the political spectrum as Henry Aaron and Martin Feldstein have pointed it out. For example, if a family plan costs $6,000 and that is the amount of the subsidy for anyone below the poverty level and there is to be no subsidy for families above 200 percent of poverty, the increment to the marginal tax rate for families with incomes between 100 percent and 200 percent of poverty is on the order of fifty percentage points.32 When combined with the existing income and payroll tax structure, as well as existing subsidy programs, the implied marginal tax rate in this range of income is in the
70-80 percent range or even higher—in other words, highly distortive.

The marginal tax rate can be reduced in only two ways: (1) Raise the income limit at which the subsidy goes away, for example, to 240 percent of poverty. The total distortion may not change much, however, because this increases the number of people whose behavior will be affected by the now smaller change in marginal tax rates. Moreover, the upper part of this range is not far from the median income. Hence, increasing the limit moves into an increasingly thick part of the income distribution. (2) Lower the amount of the subsidy. The subsidy could be decreased if the premium could be decreased, and such a decrease is possible if excess fees and wages or administrative waste in medical care could be decreased. One can, however, question how large this excess is; for example, although physician fees are much higher in the United States than in Canada, wages of hospital nurses are higher in Canada than in the United States. Furthermore, one can question how politically feasible it is to decrease fees. Setting aside any large free lunch here for the sake of argument, the subsidies can only be decreased by increasing cost sharing or by decreasing covered services. The former is not much of an option for the near-poor, and the latter, such as eliminating mental health coverage, defeats the purpose of insurance.

In addition to potentially coercive marginal tax rates through some range of the income distribution, existing subsidy proposals have many other possible distortive effects. (1) Subsidy schemes with no mandate run the risk that existing firms that employ predominantly low-wage workers may drop insurance coverage to maximize the subsidy. If the subsidy is keyed to firms’ average wages, as in the Health Security Act, existing firms may split into high- and low-wage firms or outsource to low-wage firms to maximize the subsidy. (2) Subsidies conditioned on firm size encourage the breakup of firms into smaller units; the degree to which this would happen and the resulting loss of economic efficiency can only be guessed at. (3) The availability of subsidies may encourage early retirement, adding to the problems of financing Social Security and Medicare.

On the other hand, breaking the link between employment and insurance, as the Health Security Act would have largely done, presumably would end or greatly mitigate job lock and also would encourage adults eligible for Aid to Families with Dependent Children (AFDC) to enter the labor force. Similar logic may apply to mentally ill persons on Social Security Disability Insurance (SSDI) and the disabled, including the mentally ill, eligible for the Supplemental Security Income (SSI) program. Thus, the efficiency losses just cited have potential offsets.

**Single payer.** The only method that avoids the need for subsidies is a fully tax-financed scheme, the single-payer option. But just as with subsidies, the single-payer method affects economic efficiency. It requires a
substantial addition to marginal tax rates, because financing for everyone, not just for the currently uninsured or the poor, comes through taxes.

Private insurance, including self-insurers, financed approximately $300 billion of personal health care services in 1993. Even assuming no benefit expansion as part of a single-payer option, financing that $300 billion through a payroll tax would add about ten percentage points to payroll taxes, which would surely affect labor-force behavior. Efficiency losses could be substantially less with a value-added tax, however.

Aaron has made the further point that any tax-financed plan would involve more redistribution than a plan built on the employer-based system would and that greater redistribution is likely to make a fully tax-financed plan politically infeasible. Even the subsidies that an employer or individual mandate would entail imply substantial redistribution. Little wonder that the health reform effort did not achieve universal coverage.

Policy Entrepreneurs On Canada, Competitiveness, And Excess Profits

Canada. For years single-payer advocates have pointed to the repeatedly better performance of Canada’s health care system; this claim is hotly disputed. I do not wish to enter into this dispute except to note that without question Canadians are happier with their system than Americans are with theirs. Rather, I wish to emphasize a point that seems to be eluding all parties to this dispute. Unlike the United States, there is essentially no capitation in Canada; virtually all reimbursement is fee-for-service. The Canadian system thereby gives up some potential gains in production efficiency but sidesteps most selection problems.

As a practical matter, it is hard to imagine that we will soon change traditional group- and staff-model HMOs to straight fee-for-service reimbursement. Indeed, the trends are all in the other direction; competition among capitated, integrated health plans is growing almost everywhere in this country. Thus, we are not likely to replicate an essential ingredient of the Canadian delivery system even if we, for example, adopted a single-payer system by making everyone eligible for Medicare.

The other side of this coin is that under both the present system and all of the prominent reform bills that have been introduced, including the single-payer bills, selection behavior may well distort price and quality signals among competing insurance plans; the world will not necessarily beat a path to an efficient plan whose premium is above average because of its above-average share of poor risks. Whereas the single-payer policy entrepreneurs tended to ignore this issue, or to assume that it applied only to managed competition, those emphasizing competition often tended to assume the existence of a good risk adjuster that would “solve” the selection
problem. In my view, such a risk adjuster does not yet exist.  

**Competitiveness.** Some policy entrepreneurs claim that high health care costs impair U.S. competitiveness, presumably because they raise the prices of American goods relative to those produced in other countries. If, however, the incidence of employer-paid premiums is almost entirely on wages, then the competitiveness argument fails. Even if higher health care costs mean higher prices, not lower wages, the competitiveness argument would fail because exchange rates would adjust. Although health care-intensive industries that export products such as automobiles would be hurt by that adjustment, nonhealth care-intensive industries that export such things as agricultural products would be helped. Economywide, things would be approximately a wash.  

**Excess profits.** The public debate also has focused on the excess profits of insurance companies; like the competitiveness argument, this seems mostly wrong. The percentage of personal health care spending that the Health Care Financing Administration (HCFA) accounts for as going to program administration, including insurance companies, is around 6 percent, and these monies mostly represent costs, not profit (for example, they include the wages of the clerks who process the claims). Behind these statistics is the reality that most large and medium-size employers self-insure and contract with third-party administrators to process claims. The third-party administrator business is highly competitive, and there is no reason to expect any real savings from making it a public monopoly; indeed, there is every reason to expect an increase. Some true savings are possible from small-market reform and the resulting reduced loading charges in that market, but my back-of-the-envelope calculations suggest that those savings are under 1 percent of all personal health care spending.

### Mental Health And Health Care Reform

To say that economists played an important role in the debate on mental health benefits within the context of health care reform is not to say that the debate followed a script that they would have written. Economists should have raised their voices against two quite different—indeed, opposed—positions on mental health coverage in health reform.

On the one hand, there was and is a strong advocacy group for “parity” in mental health benefits. One can interpret this as a demand for parity in insurance principles; that is, insurance should treat mental health risk like any other health risk and apply the same principles in determining the proper extent of insurance. Most economists probably would have no problem with such an interpretation. I have little doubt, however, that virtually all of those who argued for parity in the treatment of mental health
benefits did not mean parity in insurance principles, but rather that mental health services should be insured on the same terms as any other services. Because of the differential response of mental health services to the terms of insurance, however, most economists would not agree with the identical insurance terms for mental health services.

At a very different point in the spectrum were persons favoring the exclusion of mental health benefits from the package, or at least their sharp restriction, to keep the package from being too rich. Economic reasoning would not have supported this view, either, but would have argued for parity in insurance principles across services. In general, an economic approach to the benefit package would not lead to generous coverage of some services and complete exclusion of others, at least assuming that those other services are efficacious.

To be sure, existing insurance plans often violate the principle of parity for mental health services. For example, presumably because of selection problems, existing insurance plans often have very low annual maximum limits on mental health benefits, say $500-$1,500. Clearly, there are instances in which mental health problems require treatment with much higher costs, and I see no justification for replicating these low limits in a public plan. Thus, there is substantial room to apply the maxim of parity in insurance principles across services, to benefit consumers.

**The Way Forward**

Although this makes for a somewhat dissatisfying conclusion, like Krugman in Peddling Prosperity, I do not have a “solution” for several key health care issues. In particular, I am reasonably sure that expanding coverage and enjoying the fruits of what is in the medical pipeline will increase costs. There are, however, a number of ways to reduce the waste and inefficiency that are clearly present in both our and other countries’ health care systems, despite the uncertainty surrounding their magnitude. Thus, even if there is no free lunch, lunch might be marked down for awhile.

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**NOTES**

2. At the time of Carl Taube’s death he was professor of mental hygiene at The Johns Hopkins University. For many years prior to that he was director of the Division of
Applied and Services Research, National Institute of Mental Health.


13. In economic jargon, this is the difference between an income effect and a price effect.


17. To an economist, any service that costs more than the value of the benefit, even if the benefit is positive, represents inefficiency. Strictly speaking, waste should mean a zero or negative benefit. Here, however, I am using the term waste to mean inefficiency in the economist’s sense.


22. This calculation comes from Newhouse et al., Free for All?, page 130, using the difference between a $200 and a $1,000 maximum dollar expenditure (MDE) in 1983 dollars and interpolates between the 50 percent and 100 percent coinsurance lines to account for the tax subsidy. The overall magnitude of savings would be diluted to the degree that the full MSA (deductible) would not be applied to the poor.


27. Given the widespread Medigap coverage, however, the deductible increases mostly translate into higher Medigap premiums.


30. Some proposals, including the Health Security Act, apply a global budget to insurance payments only, which leaves a potential role for price with respect to full out-of-pocket payment. This assumes that balance billing is prohibited. Few people are likely to choose to pay entirely out of pocket for expensive procedures, however; that was the rationale for health insurance in the first place!


32. It will be exactly fifty percentage points if the subsidy phases out over an income range of $12,000, for example, from an income of $12,000 to $24,000.


34. For example, in the process of implementing the new Medicare fee schedule, we now have separate fee schedules for surgical services, for evaluation and management
services, and for other services.


36. This behavior could be mitigated by having more favorable tax treatment for individually paid premiums than for employer-paid premiums.

37. Single payer could be thought of as a subsidy scheme with no upper limit on eligibility. There could be income-related cost sharing in a tax-financed scheme, in which case there is some modest addition to the marginal tax rate for the poor.


39. Sometimes the argument is made that any tax would replace current premiums and that those premiums are like a head tax. The implication seems to be that somehow it is all a wash except that tax financing would be more equitable. But, in fact, there will be economic effects. A head tax is a fixed cost on working and hence may affect participation decisions, but it does not affect behavior at the margin (assuming that the employer-paid premium is in the form of a lump sum and not a certain amount per hour), whereas a payroll tax would. Furthermore, assuming one must work half time to obtain insurance, the current head tax does not even affect participation decisions for those working part time (of course, they have no coverage, either).


42. In the mental health area, Canada maintains a large public mental health delivery system. Just as in the Medicare PPS, it is attractive for budget-constrained, Canadian acute care hospitals to shift patients to the public mental health care system. See D.A. Rochefort, “More Lessons of a Different Kind: Canadian Mental Health Policy in Comparative Perspective,” *Hospital and Community Psychiatry* 43 (1992): 1083-1090.


44. The automotive industry (and certain other industries) have a different reason for not cottoning onto health care cost increases: They have a large (and growing) health care obligation to retired workers, and those costs, unlike the health care costs for current workers, very likely cannot be passed on in the form of lower wages, nor, to the degree the product market is competitive, can they be passed on in the form of higher prices. Thus, health care costs for retirees are simply a reduction in the firm’s net worth.

45. Because of possible gains from reducing inappropriate services, I am setting aside utilization review functions of administrative costs in insurance companies and focusing simply on “profits.” Administrative costs in hospitals and physicians’ offices are not counted in the 6 percent figure, but while there could be some gains here, I see no reason to expect that these would be greatly affected by a single-payer plan; the information requested by the various payers solely for purposes of payment (not considering utilization review) is reasonably standardized now.


47. Those principles would have dictated that the overall generosity of the package (the magnitude of costs left to the individual) be determined by such factors as the degree of risk aversion and moral hazard, the magnitude of externalities, and the deadweight loss from financing the shared costs.