PERSPECTIVE

A Relevant Universal Coverage Proposal

Praise, criticism, and suggestions for improving this ideologically neutral proposal.

by Jeff Lemieux

ABSTRACT: Karen Davis and Cathy Schoen offer a strategic vision for universal coverage that attempts to move beyond ideological battles that have stifled progress. However, I believe that there are a few specific shortcomings with the proposal’s logic that could thwart political consensus. I review some of these shortcomings and make suggestions for incremental technical improvements. In particular, I suggest that future versions of the proposal consider administering the tax credits as a “passthrough” from the government through employers to individuals. I also believe that reform proposals should address more directly the issues of provider accountability and patient information needs.

Proponents of universal health care coverage are finally homing in on realistic solutions. For decades, we’ve searched for “big bang” comprehensive health reforms: state-based single-payer programs, Medicare for all, sweeping employer mandates, and tax credits for individual insurance. However, none of these proposals achieved broad political support. Each was too disruptive to consider seriously; none could survive a fundamental clash of ideologies.

Now, Karen Davis and Cathy Schoen have crafted a universal coverage proposal that makes a simple but very relevant plea: Let’s quit arguing from the ideological poles. We need a strategic vision that all parties can accept. Then, with the big picture settled, we could focus the debate on money and smaller-scale issues and maybe make progress.1

Areas of agreement. Call it strategic incrementalism, or practical idealism, but it’s an important development. Davis and Schoen are correct on several possible components of an ideologically neutral design: (1) an individual mandate, (2) public funding for private coverage through refundable tax credits, (3) subsidized group pooling systems, (4) transitional coverage for the unemployed, (5) easy enrollment, and (6) government programs to fill in the cracks.

The individual mandate will probably be controversial, but it is the glue that holds the rest of the proposal together. With a mandate (even a mandate that is backed only by very modest penalties), people will begin to understand the need for subsidies to help lower-income people purchase coverage, the need for a better purchasing system for many individuals and small businesses, the imperative to help people who have lost their jobs, the desirability of more convenient ways to enroll, and the importance of public programs to provide a safety net.

Barriers to political consensus. In general, the Davis-Schoen proposal strikes an ideological balance. However, there are a few shortcomings with the proposal’s logic that could thwart political consensus. First, the proposal mistakenly assumes that it is an “inequity” when some employers offer health
benefits and others do not. It really is not an inequity. In general, employers pay employees according to their productivity: More-productive workers get larger compensation packages, which might include benefits and might not. In the long run, employers are quite indifferent between paying wages and paying for benefits. (Actually, the fact that employer-paid health premiums are excluded from employees' taxable wages creates a distortion—a helpful inequity perhaps—that prompts additional employer health coverage.)

This misconception leads to the mistaken conclusion that employers that do not offer health benefits are deficient and should pay. However, forcing employers to “play or pay” would squeeze the cash wages of some low-income workers. There is certainly no political consensus for an employer play-or-pay feature.

Second, Davis and Schoen argue that private health insurance is not workable for lower-income working families, because they frequently move or change jobs. Actually, frequent movement and life changes can make it difficult for neighborhood-based caseworkers and public programs to keep track of low-income workers and their families, too. It depends. For some lower-income families, the most stable system of health coverage might be public programs; for others it might be employer-based coverage, or a purchasing pool like the authors’ proposed Congressional Health Plan (CHP), or even bare-bones individual coverage. It is a stretch too far to assign families between 100 and 150 percent of poverty to public programs by default.

The Davis-Schoen proposal does not address a great discontinuity in health insurance: the switch from private insurance during our working years to the (mostly) government-run Medicare program when we retire. Their proposal would allow some people to “buy in” to Medicare at age sixty or even earlier, but it does not say whether people over age sixty-five could use their Medicare eligibility to “stay in” their CHP or other private coverage. Since universal coverage is generally a liberal crusade, and since additional private-sector options are the goal of more-conservative Medicare reformers, perhaps allowing people to keep their CHP coverage after retirement would help forge a political consensus.

**Technical problems.** The proposal may have some minor technical problems. For example, the tax credits seem open-ended—people choosing more expensive plans within the CHP would get an extra dollar-for-dollar subsidy. The tax credits also don’t seem amenable to being paid evenly throughout the year, when the insurance premiums are due.

On a factual note, I don’t think that the proposal’s COBRA subsidies would add to employers’ health costs. The cost to employers of additional enrollment in COBRA plans would be more than offset by savings from reduced adverse selection. (With no subsidy, workers with high expected health costs disproportionately purchase COBRA coverage when they lose their jobs. With a 70 percent subsidy, I believe that most COBRA-eligible workers—sick or healthy—would enroll, unless they had spousal or other family coverage.)

Future versions of Davis-Schoen should consider administering the tax credits as a “passthrough” from the government through employers to individuals. Employers could handle enrollment in the CHP, even if they didn’t contribute a share of the premium. They could handle payroll deduction of premiums and could “advance” tax credits to employees as they purchased the coverage month by month, making simultaneous bookkeeping adjustments in their income and payroll tax withholdings to be made whole by the government.

Expansions of coverage should also foster improved accountability throughout the health care system. Public programs should be required to track improvements in their performance, including reductions in avoidable health problems, such as emergency room vis-
its or hospitalizations for chronic illnesses such as heart failure or complications of diabetes, and improvements in health outcomes and quality, including reductions in error rates.

Patients also must have comparable statistics about the quality of private health plans and health care providers. The Progressive Policy Institute has proposed a federal health quality clearinghouse, patterned after the Securities and Exchange Commission (SEC), which would report on health quality and outcomes, not just at health plans, but also among individual health care providers, including hospitals and physician groups. Comparative information will help consumers make good choices and will allow consumer advocates to make sound recommendations. It should spur quality improvements in the health industry.

In conjunction with the CHP, I suggest that a Congressional Benefits Agency be added to evaluate the cost and appropriateness of health benefits. This would include studies of current benefit practices, the cost and clinical appropriateness of benefits, the extent of benefit mandates (specific benefits that are required by law or regulation, either nationally or locally) and their cost and clinical effectiveness, and so on. Benefit controversies will continue to drive the health care debate as new technologies and treatments run up against concerns about affordability and access to health care. Solid data on what is happening across the nation and what the trade-offs are will be more essential than ever.

NOTES


2. See, for example, R. Herzlinger, “Protection of the Health Care Consumer” (Washington: PPI, 1 March 1999).