

COWLES FOUNDATION FOR RESEARCH IN ECONOMICS  
AT YALE UNIVERSITY

Box 2125, Yale Station  
New Haven, Connecticut 06520

COWLES FOUNDATION DISCUSSION PAPER NO. 1073

Note: Cowles Foundation Discussion Papers are preliminary materials circulated to stimulate discussion and critical comment. Requests for single copies of a Paper will be filled by the Cowles Foundation within the limits of the supply. References in publications to Discussion Papers (other than mere acknowledgment by a writer that he has access to such unpublished material) should be cleared with the author to protect the tentative character of these papers.

HEALTH CARE REFORM AS SEEN BY A GENERAL ECONOMIST

James Tobin

May 1994

## Cowles Foundation Discussion Paper 1073

### HEALTH CARE REFORM AS SEEN BY A GENERAL ECONOMIST

JAMES TOBIN

#### ABSTRACT:

Universal coverage, it is argued, implies universally required insurance, to avoid adverse selection into last-resort care implicitly guaranteed. It also entails community rating, such that insurers cannot choose among risks. Individual mandate makes more sense than employer mandate. A system is proposed in which individuals can choose among a government Medicare-like plan and private insurance offering equivalent services. Means-tested assistance would help individuals pay premiums.

George Seltzer Lecture  
Industrial Relations Center  
School of Business  
University of Minnesota  
April 29, 1994  
Revised June 9, 1994

HEALTH CARE REFORM AS SEEN BY A GENERAL ECONOMIST  
JAMES TOBIN

**Universal Coverage, Entitlement and Requirement**

How did health care reform rise to its present high priority on the nation's agenda? There were evidently two main reasons. One was increasing consciousness among ordinary people -- those favorites of Bill Clinton who work hard and play by the rules -- of the insecurity of their entitlements to medical services. Forty million Americans have no insurance at all, and most others are vulnerable to losing their insurance when they become unemployed or change jobs or retire or change family attachments or, worst of all, become seriously in need of care. The other was the inexorable rise in the costs, relative to Gross Domestic Product, wages, family incomes, employers' revenues, and government budgets. Overall outlays have reached 14 percent of GDP, and this percentage has been rising about a point every two or three years. This industry is America's prime growth industry and source of jobs, rivalled only by "corrections." The index of medical care prices has been rising three percentage points faster than overall inflation. In the absence of reforms, Medicare and Medicaid outlays are projected to add 2 to 3 percent of GDP to the annual federal deficit in the six years after 1996.

A magic moment it was last September when President Clinton and Hillary Rodham Clinton seemed to have wrought a revolution in American attitudes concerning medical insurance. They had achieved a broad consensus for

universal coverage, without regard for ability to pay or risk of poor health. No one is to be denied medical care because of inability to pay fees or premiums, actual or potential illness or disability, losing a job, moving, or changing family status. This principle has some very important and inescapable implications, by no means transparent to many of the enthusiasts of fall 1993. The Congress and the public were not prepared for many of the difficulties now arising in transforming the principle of universal coverage into practical legislation and find some of them distasteful.

Universal coverage has to be a requirement, not an option, a mandate, not just access. One reason is paternalism. We don't want to allow a child or even an adult to behave in ways likely to do irrevocable self-damage. But generally protection of individuals from themselves is intertwined with protection of society. In the case of medical care, this society will not in the end deny some kind and degree of treatment, if only life-saving, to residents who have not paid for it in advance and cannot pay for it. They won't be turned away from all emergency rooms, hospital beds, and physicians. We do have even now messy unsystematic last-resort informal insurance, private or public or some mixture. It's inefficient and expensive insurance, just because it comes so late.

Adverse selection is a serious problem. The poor, the improvident, the bad risks are not covered by the health insurance policies most Americans have, and so they wind up as responsibilities of the providers of last resort, paid for by the general public in taxes, fees and premiums, and lower incomes for physicians and other medical personnel. The only way to avoid adverse selection is to require everyone to be adequately insured and to make it financially feasible for all. For similar reasons, most states require auto

owners to carry liability insurance.

A more germane precedent is social security. The risk being insured against is that an elderly person outlives his or her means of support. Society offers life annuities as an entitlement, but it also requires participation in Old Age Survivors and Disability Insurance (OASDI). The reason is to avoid adverse selection. If persons were allowed to opt out, many of them would in old age become charges on their fellow-citizens, given that the society will not in the last analysis let its unlucky and improvident old people starve or go homeless. (Or at least that used to be true.) If, as many conservatives advocate, individuals were allowed to invest their payroll contributions in personal IRAs, the social security system would be left with the least affluent and most dependent elderly. The system works because it is universal, in both senses.

#### Limiting the Domain of Inequality

The national ethos on universal social security and universal health coverage is a manifestation of what I call "specific egalitarianism," or "limiting the domain of inequality." Americans are quite tolerant of inequalities of incomes and consumption standards, much more so than most other advanced democratic capitalist societies. Only 17 percent of Americans surveyed say they resent the egregious compensations of stars in business, finance, sports, and entertainment. But Americans do want to see certain necessities of life distributed fairly equally. Those basics make up our "safety net." One of them, the principal one nowadays, is medical care. The instant implication is that medical care is a commodity, or rather a whole bundle of commodities, that cannot be left wholly to free markets.

Does this specific-egalitarian ethic dictate that individuals should not be allowed to buy more and higher-quality health care than what society guarantees to everyone regardless of ability to pay? I think the answer is yes if an essential service, included in the standard package, is scarce and incapable of being increased in supply for a long time. The ethic says that life-saving procedures, for example organ transplants, should not be auctioned to highest bidders. But the situation is different if we are talking about services of which the supply is elastic in response to demands. It makes no sense to say that rich people may spend their wealth on yachts and diamonds but not on cosmetic surgery and orthodontics.

#### **Community rating and risk equalization.**

If everyone is to have and to be compelled to have insurance for a common basic package of services, independently of ability to pay and of state of health, then clearly the insurers cannot be allowed to select risks or charge risk premiums. "Community rating" will be a revolutionary change in the conduct of this business. But what community? The whole nation? This is the practice of OASDI and Medicare, precedents suggesting a "single-payer" system for universal health care.

Is a decentralized system, to which most customers and providers are attached, consistent with community rating? It seems improbable, really impossible, that every insurer, every HMO, every health alliance, can have a representative sample of health risks, even if they are all prohibited from denying or discontinuing membership on the basis of existing or predicted costs of service. There are natural communities, related for example to location, employment, or school and university affiliations. They are bound to

have quite different distributions of individuals by age, occupation, environment, life style and other characteristics related to risks of ill health.

Even so, the principle of community rating could be implemented. The risks facing a given insurer can be rated from the characteristics of the clientele. On the basis of the deviation of the rating from that of a national representative sample, the insurer would either pay or receive an annual "risk equalization payment." These payments would balance out in total. They would be based on advance ("ex ante") risk assessments. If insurers were charged or paid on the basis of their actual ("ex post") experience, they would have no incentives to control costs. The same statistical sophistication that now guides insurers in selecting risks and setting differential premiums, a highly developed calculus, would be used to determine the formulas for risk equalization payments.

#### **Moral hazard and cost control.**

Universal coverage would extend the already prevalent institution of "third party payment" for medical services. The "moral hazard" involved deprives patients and providers -- physicians, hospitals, pharmacists, and pharmaceutical companies, laboratories, etc. -- of incentives to hold costs down by eschewing procedures of low expected marginal benefit. If someone else is going to pay, why take any chances? For this reason many existing and proposed plans involve co-payments, like the deductibles in home-owners' and automobile insurance policies. They may not be worth the trouble. They cannot be big enough to overcome moral hazard among the upper quartiles of the income distribution. For patients in the bottom quartile, they are all too likely to

be an incentive to avoid needed visits to the doctor and needed treatments, often with expensive consequences for patient and for society at later times.

A deeper and subtler form of moral hazard is that guarantee of no-questions-asked treatment dulls incentives to adopt and maintain healthful life styles. Smokers, drinkers, drug abusers, over-eaters, habits of careless sex -- make your own list -- should we charge them extra for health insurance before they need help and can't pay, or give them fair advance notice that they will not be treated for infirmities resulting from their own behavior? Too often there is no way to detect hazardous behavior until it is too late and no foolproof way to distinguish between misbehavior and bad luck. Probably the best we can do is to tax products hazardous to health and use the proceeds not only for delivering services to alleviate their consequences but also for programs of education and prevention, reinforcing the considerable nonfinancial incentives for non-self-destructive life styles.

#### Can Market Competition Discipline Costs?

It's hard to imagine how anyone who faces honestly the implications of universal coverage can expect that ordinary market competition can keep costs down in this industry in economics textbook fashion. That is why economists invading the field have sought to contrive institutions for "managed competition" -- among providers for the custom of insurers and among insurers for the custom of group or individual buyers. The idea of health alliances is to give the ultimate customers more clout by combining them into big group buyers -- less managed competition than managed monopsony. But these devices necessarily bring with them bureaucratic surveillance, kibitzing of physicians and hospitals, some fee-setting, and indeed some rationing.



In any case, the commodities bought and sold in this industry are unlikely material for those informed consumer choices on which we rely for competitive discipline in other markets. Consumers cannot know enough about the products they are buying -- or someone else is buying for them. They are not in a position to do comparison shopping. They are in the market irregularly, usually under unique circumstances. Often money, even the patient's own money, is no object. The provider is not just a seller but the customer's trusted expert counselor.

### **"Baumol's Law" and the Rise in Relative Costs of Medical Care**

Why are medical costs rising faster than other prices, and faster than population and GDP? One answer is that they aren't, that conventional numbers exaggerate medical price inflation and understate the growth in the quantity and quality of services delivered per visit to the doctor or day spent in the hospital. Spectacular progress has surely been made in many aspects of medicine. It would be nice to see more of its fruits show up in statistics of mortality, morbidity, and public health, especially in comparison with countries that spend smaller amounts both absolutely and relative to GDP.

The increasing cost of medical care is a manifestation of a general phenomenon. Although it is an obvious point well known in economics from time immemorial, Senator Daniel Patrick Moynihan recently learned it from William Baumol, a professor at Princeton and NYU, and Moynihan baptized it "Baumol's Law," a convenient enough label. Baumol's law says that in a progressive economy the costs of products that rely heavily on personal services rise relative to other prices. Technical progress in manufacturing, transport, communications, utilities, and agriculture typically saves labor and relies on

new machinery and equipment. Wages rise as a result, and competition for labor compels the higher wages to be paid throughout the economy, for example in schools and universities where 1900 vintage technology and equipment are still employed. Despite all its new high-tech procedures, medical care is still a labor-intensive activity. It's quite reasonable for a society to choose to direct some of the fruits of technical progress in some industries to maintaining or increasing its consumption of the services of industries that did not share such labor-saving advances. Given the spectacular increase in output per farmer since 1900 we would have been crazy to eat it all rather than shifting the children of Minnesota wheat farmers into arts, computers, recreation, tourism, and, yes, medical care. If society doesn't want to spend increasing shares of its income on labor-intensive products like universities and medical care, it will have to be content with consuming absolutely less of such products.

Baumol's law is a particularly thorny problem when those "backward" activities are provided through government budgets, as they frequently are to a disproportionate degree. Politics focusses on the overall ratios of government outlays and tax revenues to GDP or taxpayers' incomes. If it is a political crime for these ratios to increase, then resources will not be made available to meet the increased relative prices of government services and transfers. In the debate on health care reform, it is difficult to keep politicians and pundits and public focussed on the nation's overall health care budget, combining what goes through governments and what does not, rather than worrying just about what outlays are counted in government budgets and what charges are scored as taxes rather than insurance premiums.

Like me, you have doubtless heard George Will and many other critics of

the Clintons' health care reform plan refer to it as socialism, an expansion of the size of government unprecedented in the United States. This might be true, and not necessarily bad, if the Clintons were planning to put all the physicians in the country on government payrolls and take over ownership of all the hospitals, and in other respects actually realize the old AMA nightmare of socialized medicine. But buying goods and services from private enterprises is not socialism in that sense, nor is transferring funds to private individuals so that they can buy goods and services, nor, even, is mandating private businesses to provide insurance to employees and facilitating such arrangements by tax incentives and subsidies. The republic has survived, and capitalism has survived, the public roles in Social Security, Medicare, and Medicaid.

I don't want to exaggerate the role of Baumol's law in medical care. For one thing, wages have scarcely been rising in the United States these past two decades, especially for the unskilled workers medical facilities employ in abundance. Increased costs reflect the increased use of highly educated and highly paid specialists and of advanced technology and equipment, presumably to the benefit of patients. However, competition appears to work sometimes in bizarre and perverse ways in this industry. For example, superfluous hospitals do not die or fade away. They modernize to survive, adding expensive equipment and services, duplicating under-utilized facilities nearby. This is a syndrome known to economists as monopolistic competition with trivial product differentiation, typified by four gas stations on one corner. It's clear that free market competition is not going to discipline costs in this situation. It will take a bit of overall budget control to prevent uneconomic duplication and achieve efficient utilization of high-tech medicine.

### **Can Price Controls Work?**

Earlier this year some 500 economists subscribed to a well publicized statement objecting to imposing price controls on medical services. They rounded up the usual arguments, the failures and disasters attributed to price controls from the Emperor Diocletian and the fall of Rome to the ill-fated controls of oil prices in this country at the time of the OPEC embargo and price-gouging in 1973-74. The economists' manifesto said nothing at all about prices in the health care industry or about the handicaps that free markets face in that industry, as I outlined them above. Perhaps the signatories don't know that we already have price controls, notably Medicare's setting of the fees they will pay. According to Joe White of the Brookings Institution such ceilings are prevalent throughout the world, and they work. So in suitable circumstances do limits on overall budgets. I was not particularly proud of members of my profession who signed the statement, and especially not of those among them who were designers and advocates of "managed competition," itself a contrivance to control costs in the same way Medicare does, by creating and deploying market power.

### **Employer Mandates v. Individual Mandates**

In implementing the basic principle of universal coverage, at the same time entitlement and mandate, the major issue is between an individual-based and an employer-based system. The Administration proposes employer mandates. Since employers are already the locus of most health insurance, making their responsibilities compulsory seemed the least disruptive way of moving to a universal system and the least politically painful way of financing it. I believe, however, that sticking permanently to an employment-based system is a

great mistake. The several current revolts against employer mandates suggest that they may also be a political mistake, endangering the crucial goal of reform, universal coverage. Apparently the Administration has not succeeded in keeping employer mandated payments of insurance premiums out of the federal budget and free of the label "taxes." The Clintons might do better not to make employer mandates a symbol of their legislative success and a test of loyalty to their cause.

Employer-based medical insurance is a historical accident -- a path that no designer would choose now if given a clean slate. During World War II, trade unions and employers circumvented federal wage ceilings by negotiating medical fringe benefits. Their popularity and generosity boomed after the war, as Congress sheltered them from personal income and Social Security taxes.

Much of the Administration's 1342-page proposal is devoted to expedients intended to mitigate difficulties and anomalies intrinsic in employer mandates. It's an endless and hopeless task. Some families, even among the non-elderly, have no employed members; some have two or several, usually with different employers. Many employees work part time; some have more than one job. Americans frequently change jobs, employers, work locations, places -- even states -- of residence. The stereotypical family with one breadwinner attached to the same employer from youth to retirement is more and more obsolete.

Under the Clintons' plan, responsibilities for paying a family's premiums would generally be divided among several sources -- various employers, governments, supplementary insurers, and the family itself -- in proportions varying from year to year and indeed from month to month. Keeping track of these liabilities would involve enormous paperwork and administrative

hassle, contrary to Mrs. Clinton's claim that an employer mandate decentralizes the system and eliminates the need to track individuals.

Nor would the Clintons's system be fair in either of the usual two senses of equity. Vertical equity demands that public subsidies, direct or via employers, be a larger share of premiums and of income the poorer the family. Horizontal equity requires that families' subsidies be the same if their incomes are the same. In the Clintons' plan, subsidies depend more on the size of employers' payrolls than on individuals' families ability to pay. Their plan is also full of bad incentives for both employers -- don't hire workers with dependents -- and individuals -- best to work for big companies with generous health plans exempted from the standard rules.

It's individuals who get sick and need medical services. It's individuals and families whose ability to pay is the proper criterion of equity. It's individuals who must be guaranteed to coverage. So it's individuals who must be required to have insurance. Let employers help pay the employees' premiums if they wish, but count those payments as incomes taxable to the employees. Treat self-employed in exactly the same way.

Bill Clinton properly made a big thing of his goal that every individual would have a national health card that would be perfectly portable, honored in case of need throughout the land. Social security and Medicare are universal entitlements and mandates for individuals, and those cards are perfectly portable and honored throughout the land. Those individual-based systems work, very economically too; the Clintons should learn from the precedents.

## **The Graetz-Tobin Plan -- "Fedmed"**

In February Michael Graetz, a Yale law professor with experience in the U.S. Treasury 1990-92, and I sketched a reform proposal in a New York Times Op-ed article advocating universal coverage enforced by individual mandate. Our plan is directed to the population not now covered by Medicare, essentially people under 65. (It is not that Medicare needs no changes. The agenda would include coverage for catastrophic illness; provision for long-term care outside hospitals; higher fees for Part B, scaled to ability to pay. But those matters don't have to be solved this year.) Individuals would be required to buy insurance promising at least a national standard package of services, the same as contemplated in the Administration proposal. The federal government would help lower-income individuals and families pay the premiums.

People could buy this insurance wherever they choose; it would be up to states to make sure that carriers actually can and do deliver the standard package and others offered. However, the central institution of the plan would be a Medicare spinoff, which we call Fedmed. A similar institution is envisaged by Congressman Stark's bill and other proposals in Congress. Our Fedmed would set actuarially fair premiums such that it would break even overall every year. In addition to offering the required standard package, Fedmed might offer more inclusive packages, for example the choices available under the Federal Employees Health Insurance System.

One of Fedmed's initial tasks would be to enroll the currently uninsured and the acute care clients of Medicaid, which would be wound down. But other individuals could join Fedmed if they wished, and any of Fedmed's members could move to other insurers during annual re-enrollment periods. Community

rating, with the help of risk equalization payments, would apply to the private competitors of Fedmed.

Those provisions would protect Fedmed from becoming the last-resort receptacle for bad risks. As in Medicare itself, people could choose their own clinics, HMOs, physicians, and other providers. A fee-for-service version of the basic package might cost a bit more. Like Medicare, Fedmed would have low administrative costs and would wield enough clout to limit payments to providers. But Fedmed need not be a monopoly: its competition would be sufficient discipline to make its private competitors offer good value, without the need for much else in the way of price and cost controls.

Our proposal dispenses with the Clintons' bureaucratic layer of health alliances between the ultimate consumers and the insurance carriers or HMOs or combination insurers and providers.

#### Equitable Premiums and Subsidies

Federal subsidies to individuals and families would take the form of refundable tax credits, "vouchers", excuse the expression, payable to Fedmed or other certified insurers. For poverty or near-poverty persons, below an income threshold, the subsidies would cover the whole premium of the basic package. No individual or family would be out-of-pocket more than 8 or 10 percent of income above the threshold. That is, if the premium exceeds that amount, the government will pay the difference. Most people -- about the same population that is not above the 28% marginal income tax bracket -- will get some help. More affluent people will pay the whole premium themselves. This system is direct, simple, and fair. It avoids unnecessary channeling of funds through ordinary taxes into outlays for health services. It does not make



health services for the whole population a burden on general taxpayers, disconnected from the health insurance the taxpayers receive.

Table 1 reports calculations for four alternative plans.

Where will the money come from? From discontinuing Medicaid acute care (\$75 billion a year in 1999) from eliminating the exclusion of employer-paid health care fringe benefits from employee taxable income and earnings (\$100 billion in 1999). From new cigarette taxes and whatever other sources the Clintons intend to get the \$100 billion a year in 1999 they will need for their subsidies to employers and low-income people.

The biggest political obstacle would be the elimination of the current tax exclusion, an indefensible subsidy disproportionately of benefit to higher-income brackets. Our subsidies would make this up for persons not above the 28% marginal income tax bracket. Moreover, these reforms all can and should be phased in gradually. The Clintons' solicitude for existing institutions and interests is understandable. But they should not be frozen permanently into the health care system of the next century.

Opportunities for fundamental reform of institutions come rarely and must not be wasted in incrementalist politics as usual. The President and Congress have a historic opportunity comparable to the enactments of Social Security in 1935 and Medicare in 1965, and indeed a much more difficult challenge because it is remaking existing institutions, not just creating new ones.

Above all, President and Congress must not compromise away or long delay universal coverage, the unifying purpose of the whole crusade. Michael Graetz and I believe our proposal is the best way to fulfill that basic promise.

Table 1

## Characteristics of Plan, Assumptions, and Estimates for 1999

|   |           | # II      | # II      | # IV      |
|---|-----------|-----------|-----------|-----------|
| Net cost of basic package to family is \$0 for per cap inc below threshold of       | \$3,500   | \$5,000   | \$6,500   | \$7,500   |
| Equivalent threshold in 1992  | \$2,944   | \$4,206   | \$5,468   | \$6,309   |
| Net per cap cost to family not to exceed x% of (per cap inc minus threshold). x is: | 10.0      | 8.0       | 9.0       | 6.0       |
| Full premium for basic package per person assumed                                   | \$1,750   | \$1,750   | \$2,250   | \$1,550   |
| Equivalent premium in 92\$  | \$1,197   | \$1,197   | \$1,539   | \$1,060   |
| Population growth 92-99 %/yr  | 1.25      | 1.25      | 1.25      | 1.25      |
| Per cap real inc growth %/yr  | 1.50      | 1.50      | 1.50      | 1.50      |
| General inflation 92-99 %/yr  | 2.50      | 2.50      | 2.50      | 2.50      |
| Excess med infl %/yr  | 3.00      | 3.00      | 3.00      | 3.00      |
| TOTAL COST TO GOVT IN 1999 (\$ billion)   | \$153     | \$206     | \$313     | \$231     |
| approx marg cost of extra \$100 premium in 1999 (\$billion)                         | \$17      | \$20      | \$21      | \$21      |
| Lowest non-subsidized income four-person family                                     | \$84,000  | \$107,500 | \$126,000 | \$133,333 |
| 28% of 4-pers family premium  | \$1,960   | \$1,960   | \$2,520   | \$1,736   |
| income at which plan subsidy equals 28% of premium                                  | \$64,400  | \$83,000  | \$98,000  | \$104,400 |
| top income of 28% bracket   | \$100,000 | \$100,000 | \$100,000 | \$100,000 |