
Health Care in Three Acts

Eric Cohen & Yuval Levin

AMERICANS SAY they are very worried about health care: on generic lists of voter concerns, health issues regularly rank just behind terrorism and the Iraq war. And politicians are eager to do something about it. To empower consumers, the White House has advanced the idea of Health Savings Accounts; to help the uninsured, it has explored using Medicaid more creatively. Senator Edward Kennedy of Massachusetts, the Democrats' leader on this issue, has backed "Medicare for all." The American Medical Association has called for tax credits to put private coverage within reach of more Americans. A number of recent books have proposed solutions to our health-care problems ranging from socialized medicine on the Left to laissez-faire schemes of cost containment on the Right. In Washington and in the state capitals, pressure is building for serious reforms.

But what exactly are Americans worried about? Untangling that question is harder than it looks. In a 2006 poll, the Kaiser Family Foundation found that while a majority proclaimed themselves dissatisfied with both the quality and the cost of health care in general, fully 89 percent said they were satisfied with the quality of care they themselves re-

ceive. Eighty-eight percent of those with health insurance rated their coverage good or excellent—the highest approval rating since the survey began 15 years ago. A modest majority, 57 percent, were satisfied even with its cost.

Evidently, though, this widespread contentment with one's own lot coexists with concern on two other fronts. Thus, in the very same Kaiser poll, nearly 90 percent considered the number of Americans *without* health insurance to be a serious or critical national problem. Similarly, a majority of those with insurance of their own fear that they will lose their coverage if they change jobs, or that, "in the next few years," they will no longer be able to afford the coverage they have. At least as troubling is what the public does not seem terribly bothered about—namely, the dilemmas of end-of-life care in a rapidly aging society and the exploding costs of Medicare as the baby-boom generation hits age sixty-five.

All of this makes it difficult to speak of health care as a single coherent challenge, let alone to propose a single workable solution. In fact, America faces three fairly distinct predicaments, affecting three fairly distinct portions of the population—the poor, the middle class, and the elderly—and each of them calls for a distinct approach.

FOR THE poor, the problem is affording coverage. Forty-six million Americans were uninsured in 2005, according to the Census Bureau. This is about 15.9 percent of the population, which

ERIC COHEN is the editor of the *New Atlantis* and director of the program in Bioethics and American Democracy at the Ethics and Public Policy Center in Washington, D.C. YUVAL LEVIN, a fellow at the Center, formerly served on the White House domestic-policy staff and as chief of staff of the President's Council on Bioethics.

has been the general range now for more than a decade, peaking at 16.3 percent in 1998.

But that stark figure fails to convey the shifting face and varied make-up of the uninsured. On average, a family that loses its coverage will become insured again in about five months, and only one-sixth of the uninsured lack coverage for two years or more. In addition, about a fifth of the uninsured are not American citizens, and therefore could not readily benefit from most proposed reforms. Roughly a third of the uninsured are eligible for public-assistance programs (especially Medicaid) but have not signed up, while another fifth (many of them young adults, under thirty-five) earn more than \$50,000 a year but choose not to buy coverage.

It is also crucial to distinguish between a lack of insurance coverage and a lack of health care. American hospitals cannot refuse patients in need who are without insurance; roughly \$100 billion is spent annually on care for such patients, above and beyond state and federal spending on Medicaid. The trouble is that most of this is emergency care, which includes both acute situations that might have been prevented and minor problems that could have been treated in a doctor's office for considerably less money. The real problem of the uninsured poor, then, is not that they are going without care, but that their lack of regular and reliable coverage works greatly to the detriment of their family stability and physical well-being, and is also costly to government.

For the middle class, the problem is different: the uncertainty caused in part by the rigid link between insurance and employment and in part by the vicissitudes of health itself. America's employment-based insurance system is unique in the world, a product of historical circumstances and incremental reforms that have made health care an element of compensation for work rather than either a simple marketplace commodity or a government entitlement. This system now covers roughly 180 million Americans. It works well for the vast majority of them, but the link it creates between one's job and one's health coverage, and the peculiar economic inefficiencies it yields, result in ever-mounting costs for employers and, in an age of high job mobility, leave many families anxious about future coverage even in good times.

The old, finally, face yet another set of problems: the steep cost of increasingly advanced care (which threatens to paralyze the government) and the painful decisions that come at the limits of medicine and the end of life. Every American over sixty-five is eligible for at least some coverage by

the federal Medicare program, which pays much of the cost of most hospital stays, physician visits, laboratory services, diagnostic tests, outpatient services, and, as of 2006, prescription drugs. Established in 1965, Medicare is funded in part by a flat payroll tax of 2.9 percent on nearly every American worker and, beyond that, by general federal revenue. Most recipients pay only a monthly premium that now stands at \$88.50, plus co-payments on many procedures and hospital stays.

But precisely because Medicare is largely funded by a payroll tax, it suffers acutely from the problems of an aging society. In 1950, just over 8 percent of Americans were over sixty-five. Today that figure stands at nearly 15 percent, and by 2030 it is expected to reach over 20 percent, or 71 million Americans. Moreover, the oldest of the old, those above the age of eighty-five, who require the most intense and costly care, are now the fastest growing segment of the population; their number is expected to quadruple in the next half-century.

For Medicare, therefore, just as for Social Security, the number of recipients is increasing while the number of younger workers to pay the bills is declining. But Medicare faces a greater danger still. Its costs are a function not only of the number of eligible recipients but of the price of the services they use. Over the past few years, health-care spending in America has increased by about 8 percent each year, most steeply for older Americans who have the most serious health problems. As these costs continue to rise much faster than the wages on which Medicare's funding is based, the program's fiscal decline will be drastic, with commensurately drastic consequences for the federal budget.

Three different "crises," then, each of a different weight and character. The crisis of the uninsured, while surely a serious challenge, has often been overstated, especially on the Left, in an effort to promote more radical reforms than are necessary. The crisis of insured middle-class families has been misdiagnosed both by the Right, which sees it purely as a function of economic inefficiency, and by the Left, which sees it as an indictment of free-market medicine. And the crisis of Medicare has been vastly understated by everyone, in an effort to avoid taking the painful measures necessary to prevent catastrophe. In each case, a clearer understanding may help point the way to more reasonable reforms.

IN THE case of the uninsured, the best place to begin is with the solution most frequently proposed to their plight: a government-run system of health care for all Americans.

Under such a system—which exists in some form in most other industrialized democracies—the government pays everyone’s medical bills, and in many cases even owns and runs the health-care system itself. The appeal of this idea lies in its basic fairness and simplicity: everyone gets the same care, from the same source, in the same way, based purely on need. In one form or another—actual proposals have varied widely, with Hillary Clinton’s labyrinthine scheme of 1993 merely the best known of many—this “single-payer” model remains the preferred health-care solution of the American Left. But it is ill-suited to the actual problems of America’s uninsured, and adopting it would greatly exacerbate other problems as well.

Everywhere it has been tried, the single-payer model has yielded inefficient service and lower-quality care. In Britain today, more than 700,000 patients are waiting for hospital treatment. In Canada, it takes, on average, seventeen weeks to see a specialist after a referral. In Germany and France, roughly half of the men diagnosed with prostate cancer will die from the disease, while in the United States only one in five will. According to one study, 40 percent of British cancer patients in the mid-1990’s never got to see an oncologist at all.

Such dire statistics have in fact caused many Western democracies with single-payer systems to turn toward market mechanisms for relief. The Swedes have begun to privatize home care and laboratory services. Australia now offers generous tax incentives to citizens who eschew the public system for private care. To send a message to the government, the Canadian Medical Association recently elected as its president a physician who runs a private hospital in Vancouver, actually illegal in Canada. “This is a country in which dogs can get a hip replacement in under a week,” the new president told a newspaper interviewer, “while humans can wait two or three years.”

Defenders of the single-payer concept often point out that, despite patient complaints about the quality of care, overall measures of health in countries with such systems are roughly equivalent to those in America. That may be so, but the chief reason lies in social and cultural factors—crime rates, diet, and so forth—that make life in many other Western nations safer and healthier than life in America, and that would not be altered by a single-payer health system. Besides, citizens in those other nations benefit enormously from medical innovations produced and made possible by America’s dynamic private market; if that market were hobbled by a European-style bureaucracy, their

quality of care would suffer along with ours.

And quality of care, it is important to remember, is one thing that most Americans are happy with. Any reform that promises to replace immediate access to specialists with long waiting lines, or the freedom to choose one’s own doctor with restrictive government mandates, is certain to evoke deep hostility, and thereby to cut into public support for efforts to help the uninsured.

ON THIS score, proponents of socialized medicine would do well to consult the cautionary example of the health-maintenance organization (HMO). HMO’s are insurers who contract directly with providers, often for a flat fee, reviewing physician referrals and medical decisions in order to prevent unnecessary procedures or expenses. By the mid-1990’s, this capacity for cost-containment had made HMO’s very attractive to policy-makers and families alike. And they delivered on their cost-cutting promise. In those years, as David Gratzner notes in his recent book *The Cure*, private health-care spending per capita grew by just 2 percent annually (today the figure is nearly 10 percent, though the reasons for this, as we shall see below, go beyond just the decline of HMO’s).*

But the public soon chafed under the authoritarian character of a system in which case managers were entrusted with decisions that often seemed arbitrary, while doctors resented having their medical judgment questioned by bureaucrats. Participation soon declined, and HMO’s themselves began to take on the characteristics of traditional insurance plans. By the middle of this decade, they had joined the bipartisan list of stock American villains: in the 2004 presidential campaign, President Bush accused Senator John Kerry of getting “millions from executives at HMO’s,” while Kerry pledged to “free our government from the dominance of the lobbyists, the drug industry, big oil, and HMO’s—so that we can give America back its future and its soul.”

In a single-payer government system, everything Americans dislike about HMO’s would be worse: rationing, top-down control, perverse incentives, and, for patients, very little say. As has happened in Europe, a single-payer approach would also turn health-care costs entirely into government costs, grossly distorting public spending and threatening to crowd out other important government functions. The result would be a political, fiscal, and social disaster.

* *The Cure: How Capitalism Can Save American Health Care*. Encounter, 325 pp., \$25.95.

There is a better way to assist the uninsured: not universal government health care but universal private insurance coverage. Such an effort could begin by identifying the populations in need. Those who are uninsured by their own choice could be offered incentives to purchase at least some minimal coverage, or be penalized for failing to do so. Those who cannot afford insurance could be given subsidies to purchase private coverage based on their level of income, and then pooled into a common group to give them some purchasing power and options. Their coverage would still not equal that available to people in the most generous employer-based plans, but it would offer reliable access to care without destroying the quality and flexibility of the American system.

Although such a plan might not be cheap, it would not be nearly so expensive or complex as a single-payer system. The money for it could be taken, in part, from Medicaid funds now used to pay doctors and hospitals for care already provided to the uninsured, with such “uncompensated-care” programs gradually transformed into a voucher system for purchasing private coverage. But though it might rely on some federal dollars, the reform itself would best be undertaken and managed at the state level. After all, health insurance is regulated by the states, Medicaid is largely managed by the states, and different states face different challenges and possess different resources.

In Massachusetts and Florida, ideas like these are already being tested, although it is too early to judge the results. The federal government can help other states try this more practical approach by clearing away regulatory obstacles and by providing incentives for experiments in creative reforms.

THIS BRINGS us to the health-care anxieties of middle-class Americans. Although these concerns are in most respects much less pressing than those of the poor, they are real enough. Middle-class families are, besides, the heart and soul of America’s culture and economy, as well as the essential political force for any sober assessment and improvement of America’s health-care system.

Generally speaking, the worries expressed by these Americans stem from the peculiarities of our employer-based insurance market. It is, indeed, a very odd thing that more than 180 million Americans should be covered by insurance purchased for them by their employers. The companies we work for do not buy our food and clothing, or our car and home insurance. They pay us for our labor, and we use that money to buy what we want.

No less odd is the character of what we call health *insurance*. Insurance usually means coverage for extreme emergencies or losses. We expect auto insurance to kick in when our car is badly damaged in an accident, not when we need a routine oil change; homeowner’s insurance covers us after a fire, flood, or break-in, not when we need to repair the deck or unclog the gutters. But when it comes to health, we expect some element of virtually every expense to be covered, including routine doctor checkups and regular care.

America’s insurance system is largely a historical accident. During World War II, the federal government imposed wage controls on American employers. No longer able to raise salaries to compete for employees, companies turned instead to offering the lure of fringe benefits, and the era of employer-based health care was born. Thanks to a 1943 IRS ruling allowing an exemption for money spent by employers on health insurance, an enormous tax incentive was created as well. Rather than giving a portion of every dollar to the government, employees could get a full dollar’s worth of insurance through their company.

Of course, wage controls are long gone, but the system they inadvertently created, including the tax exemption, remains in place. Although this system has served most Americans very well, it has two significant drawbacks. First, by forging a tight link between one’s job and one’s health insurance, it makes losing a job, or changing jobs, a scary proposition, especially for parents. Second, it lacks any serious check on costs. Because insurance often pays the bulk of every single bill (instead of kicking in only for emergencies or extreme expenses), most American families do not know, or attend to, the actual cost of their health care.

Any car owner can tell you the price of a gallon of gas or an oil change. But what is the price of knee surgery? Or even a regular doctor’s visit? Does one hospital or doctor charge more than another? Most patients pay only a deductible that, while often not cheap, bears almost no relation to the price of the service they receive. As a result, they do not behave like consumers, shopping for the best price and thereby forcing providers to compete for their dollar.

Inured to such issues, families worry most about the lack of portability of their insurance, leaving it to economists to worry about the distorting effects of price inefficiencies. To gain the support of middle-class parents, any reform to the system would therefore need to address the former issue first.

Policy-makers on the Left have tended to un-

derstand this, but have over-read the anxiety of families, seeing it as a broad indictment of America's free-market health care. They have thus offered the same bad solution to the problems of the insured as they do to the problems of the uninsured: a government-run system that will replace our present one. As for conservative policy-makers, they sometimes tend to overlook the concerns of middle-class families altogether, focusing on inefficiency before portability.

THE CONSERVATIVE health-care solution of the moment is the health savings account, or HSA. It has two components: a savings account to which individuals and employers can make tax-free contributions to be drawn on exclusively for routine health-care costs, and a high-deductible insurance plan to help pay for catastrophic expenses.

Since individuals can take their HSAs with them when they change jobs (provided the new employer allows it), this option can indeed help promote insurance portability. But, generally speaking, that is neither its foremost aim nor its effect. Instead, it is seen by its proponents as helping to level the playing field by giving to individuals the same tax breaks that employers get in purchasing coverage, and as helping to train people to think like consumers, since in spending their own money they will have an incentive to spend as little of it as possible. In short, proponents of the HSA want to use market mechanisms to achieve lower costs and improved quality.

This is certainly a worthy goal—but does it meet the concerns of most Americans? David Gratzer, an advocate of the HSA, tells the story of a woman who used such an account in exactly the desired way. Needing foot surgery, and impelled to spend her own money wisely, she

took charge of the situation and thought about what she really needed. When a simple day-surgery was suggested, she looked around and decided on a local surgery center. She asked about clinic fees and offered to pay upfront—thereby getting a 50-percent discount. When she found out that an anesthetist would come in specifically to do the foot block, she asked her surgeon just to do it. She also negotiated the surgeon's compensation down from \$1,260 to \$630. Finally, she got a prescription from her doctor for both antibiotics and painkillers, but only filled the former. "In the past, my attitude would have been, 'just have all the prescriptions filled because insurance was paying for it, whether or not I need them.'"

Although Gratzer offers this as an ideal example, it will surely strike many people as a nightmare. Haggling with doctors, ignoring prescriptions, bypassing a specialist to save money—is this the solution to middle-class health-care worries? Who among us feels confident taking so much responsibility for judgments over his own health, let alone over the care of his children or his elderly parents?

IF THE HSA is to have wide appeal, it must be sold first and foremost as a means not of efficiency but of portability—and as part of a broader effort to expand the portability of health insurance generally. Nor should such an effort be aimed, at least at first, at undoing our employer-based system. Perhaps, given a blank slate, no sensible person would ever have designed the current system. But we do not have a blank slate. We have a system providing care that the vast majority of insured Americans are quite happy with—and that has also helped America resist the pressure for government-run health care of the kind for which every other developed nation is now paying a heavy price.

We have, in other words, a system that works but is in need of repairs, most notably in the realm of improved portability. Making this happen will require better cooperation between state and federal policy-makers. An exclusively national solution would require federalizing the regulation of health insurance, which is both undesirable and politically unachievable. Instead, states should be encouraged to develop insurance marketplaces like the one now taking shape in Massachusetts. Mediating between providers and purchasers, these would allow employers, voluntary groups, and individuals to select from a common set of private options. Whether working full-time, part-time, or not at all, individuals and families could choose from the same menu of plans and thus maintain constant coverage even as their job situations or life circumstances change. For those who cannot afford insurance and do not receive it from an employer, Medicaid dollars could be used to subsidize the purchase of a private plan.

The federal government, meanwhile, could ensure that Medicaid dollars allotted to states can be used to support such a structure of subsidies. It could also pursue other, smaller measures, like extending or eliminating the time limit on the COBRA program, which allows individuals leaving a job to keep their employment-based plan by paying the full premium. As states begin implementing marketplace reforms, the federal government could also find ways to encourage regional and

eventually national marketplaces, which would enable the purchase of insurance across state lines.

In any such scheme, Health Savings Accounts would surely have a place. So would other measures of cost containment like greater price transparency. But the key to any large reform must be its promise to address the real worries of insured American families by preserving what is good about the current system while facing up to its limits and confronting its looming difficulties.

UNFORTUNATELY, when it comes to paying for the health care of older Americans, there are few attractive options. Costs have risen steeply in recent years, while the economic footing of the Medicare program has been steadily eroding. Nor are demographic realities likely to change for at least a generation; to the contrary, they may only worsen. So the solution *must* involve some form of cost containment.

This will not be easy. As Arnold Kling points out in *Crisis of Abundance*, costs are rising not because of increasing prices for existing medical services but because of a profound transformation in the way medicine is practiced in America.* Between 1975 and 2002, the U.S. population increased by 35 percent, but the number of physicians in the country grew by over 100 percent. The bulk of these were specialists, whose services cost a great deal more than those of general practitioners. New technologies of diagnosis (like MRI exams) have also become routine, and not just for the old, and the number and variety of treatments, including surgeries, have likewise increased. We spend more because more can be done for us.

All of this spells heavier demands on the Medicare budget, to the point where the program's fiscal prospects have become very bleak. Already accounting for roughly 15 percent of federal spending, Medicare will be at 25 percent by 2030 and growing. In David Gratzer's words, "Medicare threatens to be the program that ate the budget."

Worse yet, one of the most expensive and complicated burdens of an aging society is not even covered by Medicare. This is long-term care, involving daily medical and personal assistance to people incapable of looking after themselves. The Congressional Budget Office estimates that Americans spent roughly \$137 billion on long-term care in 2000, and that by 2020 the figure will reach \$207 billion. Longer lives, and the high incidence of dementia among the oldest of the old, are bound to impose an extraordinary new financial strain on middle-income families, whose consequent de-

mand for government help will only worsen our already looming fiscal crisis.

Medicaid, which covers health care for the poor, does pay for some long-term care in most states. To qualify for this, and to avoid burdening their children, a growing number of the elderly have opted to spend down their assets when the need arises. But this ends up burdening their children anyway, if less directly. States already spend more on Medicaid than on primary and secondary education combined; if Medicaid comes to shoulder the bulk of long-term costs in the coming decades, it will bankrupt state coffers and place enormous strains on the federal budget.

Of course, the challenges of an aging society reach well beyond economics. As more and more Americans face an extended decline in their final years, elderly patients and their families will confront painful choices about how much care is worthwhile, who should assume the burdens of care-giving, and when to forgo additional life-sustaining treatment. Compared to this profound human challenge, fiscal dilemmas can seem relatively paltry. But they too necessitate hard and unavoidable choices.

One way or another, the Medicare program will have to be adjusted to a society with radically different demographics from the one it was designed to serve. If "seventy is the new fifty," as a popular bumper sticker tells us, then the age of Medicare eligibility must begin to move up as well. That will inevitably impose a hardship on those who are already not vigorous in their sixties, as well as on those whose jobs are too physically demanding for even a healthy sixty-five-year-old. So hand in hand with raising the age of eligibility will need to go programs encouraging (or requiring) health-care savings earlier in life. At the same time, Medicare benefits will gradually have to become means-tested, so that help goes where it is most needed and benefits are most generous to those with the lowest incomes and fewest assets.

More fundamentally, the structure of the Medicare program will have to change. Its benefits now increase in an open-ended way that both reflects and drives the upward movement of health costs; if Medicare is to remain sustainable, constraints will gradually have to be put in place, so that benefits grow by a set percentage each year. The program will also need its own distinct and reasonably reliable funding source, which will require an adjustment in the design of the payroll tax.

* *Crisis of Abundance: Rethinking How We Pay for Health Care*. Cato Institute, 120 pp., \$16.95.

Any such reforms will be politically explosive, to put it mildly. No politician in his right mind would run on a platform of limiting Medicare eligibility and capping its benefits. And yet, a decade from now, caring for aging parents will have become a burning issue for a great swath of America's families as parents find themselves squeezed between the needs of their own parents and the needs of their children. Every politician will be expected to offer a solution, and will be subject to dangerous temptations: promising limitless care at the very moment when fiscal responsibility requires setting limits, or promising to "solve" our fiscal problems by abandoning the elderly. The least that responsible policy-makers can do now is to familiarize Americans with the realities of our aging society, so that when the time comes for difficult choices, we will not be blind-sided.

UNDERSTANDING America's three distinct health-care challenges, and the deficiencies of conventional responses to them, is the first step toward reform. Any approach we take will assuredly cost the taxpayers money. Already, nearly a third of the federal budget is spent on health-care, and that portion is certain to grow. The choice, however, is between paying the necessary price to ame-

liorate our genuine problems or paying far more to satisfy ideological whims or avoid politically painful decisions.

Neither socialized medicine nor a pure market approach is suited to America's three health-care challenges, while the bipartisan conspiracy to ignore the looming crisis of Medicare in particular will return to haunt our children. Coming to grips with the true nature of our challenges suggests, instead, a set of pragmatic answers designed to address the real problems of the uninsured, of middle-class families, and of the elderly while protecting America's private health-insurance system and looking out for the long-term fiscal health of the nation.

Even as we pursue practical options for reform, however, it behooves us to remember that health itself will always remain out of our *ultimate* control. Medicine works at the boundaries of life, and its limits remind us of our own. While our health-care system can be improved, our unease about health can never truly be quieted. And while reform will require hard decisions, solutions that would balance the books by treating the disabled and debilitated as unworthy of care are no solutions at all. In no small measure, America's future vitality and character will depend upon our ability to rise to this challenge with the right mix of creativity and sobriety.