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Reflections on Health Care Financing and Benefits in the U.S.

Observations and Opinions

by Anna M. Rappaport

Introduction

I had the privilege of attending the National Academy of Social Insurance (NASI) annual conference “Getting to Universal Health Insurance Coverage” on Jan. 31-Feb. 1, 2008. The conference was multi-disciplinary and included leading academics, policy experts, and representatives of various stakeholder groups including employers, workers, insurers and health care providers.

As someone very concerned about retirement security, I have increasingly been aware that the retirement challenges of the nation are closely linked to the health care challenges. Americans can have a secure life and retirement only if we make the health care system work. Drew E. Altman stated in “The Real Health Reform Debate We Need to Have,” that health care costs are the single most important economic issue facing individuals and families. While there is a lot that is good to say about the system, there is also a lot that is not working. This article provides some ideas, opinions and observations heavily influenced by the discussion at the conference. I encourage those of you who want to learn more to look at the presentations.¹ I also hope to encourage a dialogue on this topic.

As we discuss health care, we can focus on financing or the delivery of care—we should think of these two things as being separate. Either or both can be controlled by a governmental unit. The conference was mostly about financing and insurance, and this article moves in the same direction. The views presented here are mine and not those of any organization.

Directions for Change

There are three **basic sets of “solutions”** as people think about moving closer to universal coverage or helping the uninsured:

- Maintain employer/government system with government playing key roles through Medicare and Medicaid, and fill in the gaps in various ways—advocated by the Democratic candidates for President. (Note that at the time of the Conference—1/31-2/1—there were still multiple candidates on both the Republican and Democratic sides)
- Have individuals choose health insurance, rely on the market, and give individuals tax credits to help them buy health insurance—advocated by Republicans recently.
- Single payer system (like Canada or the U.K.)—not on the table for discussion currently in the U.S. political debate— involves governmental control over the payment system, but not necessarily over health care delivery.

Note that satisfaction with Medicare is very high and some people do not believe it is a government solution. Overall satisfaction with Medicare is higher than with other health insurance available. Americans aged 55 and up often can not wait until they qualify for Medicare. A reviewer of the draft of this article suggested that Medicare for all would be a good solution. And while it would be hard to agree on such a solution, it would be relatively easy to implement.

As I thought about this, I became very distressed that single payer is not a primary option in the discussion. At several points during the conference, discussants made this point. Doug Andrews, an actuary from the University of Waterloo in Canada, made comments from the floor of the meeting focusing on the need to



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¹ Presentations can be found at: http://www.nasi.org/publications2763/publications_list.htm?cat=Conference%20Proceedings%20%26%20Books.

consider single payer and its virtues. One of the conference sessions was a debate on this topic “Point-Counterpoint: Is a single payer plan the best option?”

My opinion is that the solution set that offers the best possibility for real control of costs is single payer and not the solutions currently advocated by candidates. However, it is probably the most difficult politically. Some actuaries from the United Kingdom and Canada see single payer as the obvious best choice. Putting band-aids on the current employer system will surely cost more. A market based approach with tax incentives will leave out the people who are poor risks, or it will include many regulations and subsidies, moving it away from a real free market system. The entire situation is very difficult.

These directions are based on the financing structure of the health care system. Another dimension of the problems is that our focus is largely on acute care and not preventive care. More focus on wellness or prevention can reduce the need for acute care a great deal. IBM has recently issued a white paper² focusing on the importance of wellness and offering ideas about how to improve in that regard. A focus on wellness and prevention could be joined to any of these three financing alternatives because it relates to what we cover rather than how insurance is organized.

What We Spend

By any measure, the United States spends far more for health care than any other country. It is not clear what value is derived from that in terms of better health, longer life, health status, etc. The United States generally does not measure up well on comparative health measures.

Why we spend more is very complex. Whether we can afford to spend even more is open to debate, but it seems likely that we can. However, the more we spend, the more it will

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affect the rest of the economy. Uwe Reinhardt, a very well known health economist from Princeton, gave the keynote. His presentation is available as a webcast.³ He demonstrated clearly how much more we spend as a percentage of GDP than any other country. His views of the state of health care are also well summarized in a letter to Governor Corzine of New Jersey that was distributed. He points to our inability to make a sensible compromise as a huge issue.⁴

I was very proud that Cori Uccello, senior health fellow of the American Academy of Actuaries presented a primer on insurance as part of the NASI conference. The concentration of claim dollars and the large claimant is a huge issue. The skewness of health care spending provides incentives for insurers to avoid those who are at risk for health claims. The issue was implied in the discussion by Cori, “Insurance Markets 101.” About 10 percent of the people usually account for 50 percent of the spending or more. Of the high cost claimants, many are chronically ill. In the individual market, where insurance companies can choose who they want to insure and are competing, there is a big advantage for insurers to avoid high cost people. In other markets where they can charge appropriately or pool some of the extra risk, there is no such disadvantage.

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² The IBM paper is titled “Living Well: Transforming America’s Health Care,” and can be found at http://www.businessofgovernment.org/main/publications/grant_reports/details/index.asp?GID=304

³ http://www.nasi.org/publications2763/publications_show.htm?doc_id=660901&name=Medicare

⁴ <https://www.princeton.edu/news/Reinhardtthehealthcarecommission/>

Different observers have different viewpoints about how effective the current individual insurance market is. My view is that private insurance will not work satisfactorily if the sick can't get insurance, and this has been the case up until now.

Community rating was intended to solve the problem, but it became much less common in the United States years ago. Today, some states require community rating for small groups and some for individuals. If a company tries community rating in a state that does not require it, healthy people will look for a lower price so that the company that uses community rating will get an unfair share of sick people, and its costs will spiral. Risk adjustment is an approach to dealing with this problem. My opinion is that any market based solution that will function satisfactorily for those in poor health would need to include some form of risk adjustment and access for all.

Employer Coverage—a Success or Failure?

Within the last few weeks, I have heard discussion that takes opposing positions on the role of the employer coverage—both success and failure. The NASI conference included a panel that discussed the role of the employer. The provision of health benefits by large employers was demonstrated to be quite stable. The panelists provided interesting data on the employer's approach to coverage.

Sherry Glied from the Department of Health Policy and Management at Columbia presented data indicating that employer coverage has been very stable except among small firms—those with three to nine employees—where there is a marked decline. Note that there is also some shift to employment in very small firms and there is growth in the number of contingent workers without coverage. The percentage of workers covered also declined when companies sought to have dual earner couples each get covered by their own employer, and priced dependent coverage to encourage this. She made the strong point that the employer system works for long-term employees of most companies and that there is at present no comprehensive private

alternative to employer coverage. In addition to employees of small firms, employee coverage does not work well for those without stable or regular employment and those in firms that do not offer coverage.

There are obviously different perspectives on this topic. In February I attended the Retirement Income Industry Association (RIIA) meeting where a financial planner, Chris Cooper, spoke about issues related to health benefits from the perspective of providing advice to individuals. Apparently many of his clients are independent or work for small firms. He had nothing positive to say about the employer system. He also pointed out that when one spouse loses employer coverage and is unable to obtain it from the other, it may be advisable for the couple to divorce. His rationale was that current law in all states requires that the couple would both need to apply for Medicaid together, but if they divorce and shift assets to protect them, the spouse without coverage may apply for Medicaid alone. This seemed to me to be an extreme idea, but I spoke to him about it later, and he indicated that it happens more often than one would think, particularly where the person without coverage has chronic illness.

Health Care and Bankruptcy

Health care is often a significant factor in personal bankruptcy. This can happen if someone does not have insurance or if they have a major illness and spend more than the maximum on the insurance. This was highlighted recently in a CNN special featuring Sanjay Gupta. Public awareness of these issues is clearly growing. This fit well with the discussion mentioned above from the financial planner.

Mandates

A system for universal coverage would effectively be a tentament. In other words, the design of such coverage would create a mandate. In addition, mandates in some form are a possible part of either of the first two solutions. They can be structured in various ways and there are many questions about how to structure them

- Is the employer required to offer coverage?
- Should there be an individual mandate?
- What aspects of coverage are mandated?
- How do you enforce a mandate?

One session of the conference was on mandates, and the presentations are available on the NASI Web site.⁵

Models to Look at for Change

If we focus on universal coverage, Canada and the United Kingdom are obvious models to analyze. Both countries have single payer systems and supplemental health insurance. Both countries have had these systems for a long time. Supplemental coverage can be used to pay for services not covered and in the United Kingdom, to receive treatment more quickly than under the public system. Both countries spend much less on health care than the United States. I have found that in trying to understand whether the systems work well, opinions are very mixed. Some people say they work very well and others say not so well.

There are a variety of other models that are also of interest. Individual States in the U.S. are involved in a wide variety of reforms and are interesting models to review. In many ways, the direction we are moving in would provide for the states to be like “laboratories” for national reform. The Netherlands and Switzerland have also recently changed their systems. There was a very interesting presentation on the Netherlands which has a hybrid system—something between public and private and close to universal coverage. Kieke G.H. Okma, Wagner School of Public Services, NYU, presented information about the Dutch system. Pertinent features of the Dutch system include:

- Health insurers are usually not-for-profit, but can be for-profit.
- Residents are required to take broad coverage and pay 6.6 percent of their income as earmarked taxation and in addition a community rated premium to the insurer.

- The insurers are highly regulated and the system includes subsidies for the poor, and some redistribution of funds so that the insurers with a greater share of high-cost people are compensated.
- The majority of hospitals and health facilities are independent and usually not-for-profit.
- Most family physicians are self-employed.
- Market choice has been accompanied by market concentration—opposite of what some people expected.
- The system is highly regulated with subsidies at various points and depends on social ideas of solidarity.

There is other evidence of differing perspectives. The ERISA Industry Committee’s New Benefits Platform describes an alternative that includes a very different structure. This proposal includes many interesting features, including options for individuals without coverage to buy into regional cooperatives and mandates.

Getting to a Solution—Reaching Consensus

This will be extraordinarily difficult in the U.S. environment and has been a major reason why pensions and the health care system have so many problems. There was a panel that discussed this, but I do not think they had much in the way of advice other than engaging the public.

These discussions challenged me to think about some questions:

- What is the best way to understand the key options that are on the table?
- What should be on the table?
- **How can actuaries participate in the debate in a meaningful way?**
- What should the role of the employer be?
- What are the successes and failures around the employer system?
- How important is universal coverage or universal access?

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⁵ http://www.nasi.org/publications2763/publications_show.htm?doc_id=660141&name=Medicare

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- What are the implications of mandates?
- Who can help parties with very different views come together and compromise?
- What is the impact of the level of health care spending on the economy?
- What can we learn from the states?
- What can we learn from the Netherlands and other countries?
- If we retain the employer system, how do we deal with the uninsured?

- Many countries treat health care as a fundamental right, as they do education. Why is this not true in the United States?

Note: The actuarial profession is working to cooperate with NASI. The Society of Actuaries and the American Academy of Actuaries jointly sponsored a table at the conference dinner, as they have for several years. The SOA research on post-retirement risks was presented at a conference round-table. 📷



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