

# Are We Heading toward Socialized Medicine?

## Timely Analysis of Immediate Health Policy Issues

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### Summary:

Amid a spirited campaign where health reform will be a leading issue, some have charged that proposals to restructure the nation's health care system represent dangerous steps that would move the United States toward a government-run health care system and socialized medicine. Similar rhetoric was heard last fall when President Bush vetoed reauthorization legislation for the State Children's Health Insurance Program (SCHIP) that passed the House and Senate with bipartisan support. This paper examines that rhetoric and, in short, finds no evidence to support it.

Strictly speaking, socialized medicine involves government financing and direct provision of health care services, as with the traditional British system. Neither SCHIP reauthorization nor proposals from the major Democratic presidential candidates fit this description. While these policies would provide additional public resources to help the uninsured pay for coverage and would increase the pooling of risks in insurance markets, none would overturn the dominant role of private insurance and private providers in America's health care system. However, some single-payer proposals (like former candidate Dennis Kucinich's plan) would limit the ability of individuals to obtain, and providers to render, care outside the public system – potentially giving the federal government sufficient power to constitute the functional equivalent of socialized medicine.

Some suggest that almost any expanded role for government in health care inevitably leads to strict limits on consumer choice, rationing, delays, and poor quality — all concerns traditionally associated with socialized medicine. These concerns, however, do not apply to the 2007 SCHIP proposals or to plans advanced by leading Democratic candidates, which would offer workers more choices among competing, private health plans than they currently receive from their employers.

Market-oriented approaches proposed by President Bush and some current and former Republican presidential candidates would expand coverage by granting tax subsidies that people could use to buy insurance in the individual market. But if tax subsidies are inadequate at low levels of income and there is little or no improvement in the nongroup market's pooling of risk, many low-income households and people with health problems will face difficulties obtaining essential care – exactly the problems of poor access and quality that supposedly characterize public-sector coverage.

No reform proposal under serious consideration would result in either a purely government-run system or a free market that offers entirely unregulated and unsubsidized health care. All serious proposals are on a continuum between these extremes. For example, market-oriented plans retain significant public-sector responsibilities for Medicaid, Medicare, medical research, product safety, etc. Similarly, proposals to replace the current tax deductibility of employer coverage with refundable tax credits would redistribute a substantial amount of income from higher- to lower-income households – one of the major ways the government affects Americans' lives.

The core issue in health reform is not specifically the role of government, but what policies yield the best possible consequences for the American public. Such results include the number of people with health coverage, individuals' access to quality care, curbing cost growth, and consumers' ability to make choices about their health care and health coverage. Inaccurate rhetoric about socialized medicine and government-run health care is a distraction from these much more fundamental concerns.

## Introduction

Last year, Bush administration officials claimed that congressional proposals to reauthorize the State Children's Health Insurance Program (SCHIP) could lead to an eventual government takeover of American health care. Before he vetoed the SCHIP legislation, President Bush characterized it as a "step toward the goal of government-run health care for every American."<sup>1</sup> Presidential candidates, including former Republican candidates Rudolph Giuliani and Mitt Romney, likewise labeled the health care plans from current and former Democratic presidential contenders as "socialized medicine."<sup>2</sup> Similar rhetoric was used to defeat national health care reform proposals in the 1990s<sup>3</sup> and, with less success, to argue against the creation of Medicare in the 1960s.<sup>4</sup>

This paper examines these claims. We begin by exploring the meaning of such terms as "government-run health care"<sup>5</sup> and "socialized medicine." We then analyze SCHIP reauthorization legislation, broader national reform proposals from current and former Democratic presidential candidates (some of which resemble bipartisan reforms enacted in Massachusetts), and more market-oriented reform approaches from the Bush administration and Republican presidential candidates, including some who are no longer running. We conclude that recent rhetoric is neither accurate nor helpful in clarifying the most important issues involved in health reform. The real question facing the public and policy-makers is determining not the health policy with the strongest or weakest role for government, but the policy that yields the best results for the American people in terms of coverage, quality, choice, and cost.

<sup>\*4</sup> While we focus on the claims made by some conservatives, rhetoric on the other side can be equally inflammatory and exaggerated. For example, during the SCHIP debate, comments from Democratic lawmakers included, "How many children will be dead" if the president prevents SCHIP reauthorization, and "the Axis of Evil isn't just in the Middle East, it's just down here on Pennsylvania Avenue" (Jeff Emanuel, "The SCHIP Wars: Democrats Are Fighting Dirty, but Are Not Winning in the Process," *American Spectator*, October 29, 2007).

Finally, this paper describes proposals from a number of current and former presidential candidates because they illustrate a range of policy options and arguments that frequently arise in discussing health care issues. The purpose of this analysis is to shed light on these recurring health reform concepts and their relationship to the government's role in the health care system, not to explore the advantages or disadvantages of any particular candidate's proposal.

## What Is "Government-Run Health Care" and "Socialized Medicine?"

To define these terms, this section divides health coverage systems into four categories, a modification of the approach used by the Organisation for Economic Co-operation and Development (OECD).<sup>6</sup> The four categories move from greatest to least government involvement:

➤ "The *public-integrated model* combines on-budget financing of health-care provision with hospital providers that are part of the government sector. These systems, which merge the insurance and provision functions, are organized and operated like any government department." The best example of this model is probably the United Kingdom, though recent reforms have privatized part of the system. Outside the health care arena, another example of a purely public model for service delivery is the U.S. system of public K-12 education, in which state and local governments provide free education that is tax financed and delivered by public employees.

➤ "In the *public-contract model*, public payers contract with private health-care providers. The payers can be either a state agency or social security funds." In many public-contract systems, the private hospitals and clinics are run on a for-profit or nonprofit basis. Independent private contractors generally supply ambulatory care. Most European countries, Canada, and the U.S.

Medicare program belong to the public-contract category. Some would regard these systems as comprising "socialized medicine" since the public sector organizes and finances much of the demand side of the market even though, by comparison to the first model, the government plays much less of a role in the actual provision of services.

➤ In the *public-contract/private insurer model*, public payers contract with private insurance companies to deliver care. This model—the only component of our classification system that is not directly borrowed from OECD—differs from the previous category in important ways. When programs like Medicare, Medicaid, and SCHIP deliver care through private insurers, decisions about covered services, provider networks, and provider reimbursement are made both by public payers and by the contracting private insurers. Private insurers bear some of the risk that public agencies assume in the public contracting model, and competition among insurers, not just providers, is possible. On the other hand, coverage in this category differs from the next model in that a public agency, not a private employer or individual, purchases the insurance.

➤ "A private *insurance/provider model* uses private insurance combined with private (often for-profit) providers." The private employer-based system in the United States falls in this category, as would most American reform proposals that rely on changes in tax incentives. Businesses and individuals contract directly with insurance plans, albeit with considerable government subsidies provided through the tax code.

The first OECD category of "publicly integrated" health care involves government-run systems that provide citizens with health care through public agencies, employees, or contractors, financed with taxpayer dollars. The deployment of those funds, the development of health care infrastructure, and the provision of health care services are all controlled by government policy. Only this model fully and unambiguously

meets the test of “socialized medicine,” where government, through publicly employed providers, actually furnishes health care, going well beyond financing and regulation.

Postwar Britain illustrates the broader context for this model. When the Labour government took control of coal mines, gas, electricity, rail, iron and steel, and the Bank of England, part of this systemic effort included creating the National Health Service (NHS).<sup>7</sup> The NHS classically financed and delivered care wholly through publicly owned hospitals and publicly employed physicians and other personnel. In recent years, British health care has become somewhat more privatized for some services.<sup>8</sup>

Closer to home, another example of government-run health care is the Veterans Administration (VA), which provides subsidized care to veterans who qualify. Services are typically provided by physicians and nurses employed by the VA, in facilities owned and operated by the VA. The VA determines the scope of covered services, the health care information technology that providers use, and the access and quality standards that guide system management. Yet in some ways even the VA does not represent a pure government-run system. If necessary services, such as emergency care, are unavailable in the VA system, the VA will pay for services elsewhere.<sup>9</sup> Moreover, the VA does not monopolize veterans’ health care; many eligible veterans can and do use other sources of coverage and care.

The VA is a highly unusual exception to America’s overall health care system, which relies heavily on private health care providers. Among U.S. hospitals, 77 percent are privately owned and operated, and over 90 percent of physicians work in the private sector, usually in relatively small solo or group practices.<sup>10</sup> Terminating the private character of health care providers and shifting to a publicly integrated, “government run” system of health care would represent a dramatic change.

While only the first model involves true socialism, which has as its “main institutional cornerstone” the “social or state ownership of the means of production,”<sup>11</sup> the second model can include such a strong role for government that the model becomes the functional equivalent of socialized medicine. If the government controls enough of the demand side of the market that providers have little or no choice but to operate within the public system, the government could exert such influence in terms of payment rates, covered services, quality of care standards, and the like that the system would essentially be government-run. That outcome would be reinforced by a dominant public-sector role in determining the nature of permitted capital investments in health care. This approach can certainly be defended as promoting equity and reducing the rate of growth in health care spending, but any objective observer would characterize such a system as government-run.

On the other hand, if the government buys care from providers on behalf of a significant but not dominant segment of the population, it would amass significant buying power and could thus reshape the health care system. The direct results of government purchasing are sometimes augmented by “ripple effects,” through which private insurers emulate public-sector practices. But so long as individuals and families retain meaningful access to private insurance and private-sector providers have ample opportunity to market their services outside the public system, the second model cannot fairly be characterized as a socialized or government-controlled system.

Some proposals that embody the public-contract model may leave room for ambiguity and debate in deciding whether the government’s role is so central that the health care system would no longer be pluralistic, with significant decision making responsibilities shared among a range of public and private actors. However, the proposals advanced in the SCHIP debate and the presidential campaign

involve no such ambiguity, as is made clear below.

## The U.S. Health Care System Today

Our country’s health care system reflects a long history of multiple, incremental changes, in both the public and private sectors. The result is tremendous complexity. Different portions of the country’s health care system thus embody each of the four coverage models described above:

- ▶ Publicly integrated systems play a minor role in American health care, limited to the VA (described above), state- and county-run inpatient and residential programs treating mental illness and substance abuse, and a number of county-administered systems of indigent care.<sup>12</sup>
- ▶ The public contract model is used with traditional, fee-for-service Medicare and Medicaid. This includes the majority of Medicare beneficiaries. In terms of Medicaid, this model includes a minority of beneficiaries but a majority of spending, since the elderly and disabled are disproportionately likely to be enrolled in fee-for-service coverage. This model also includes less than one in five children enrolled in SCHIP.<sup>13</sup>
- ▶ The public contract/private insurer model applies to Medicare Advantage and Medicare Part D, both of which involve the Centers for Medicare & Medicaid Services (CMS) contracting with insurers to deliver Medicare benefits. It also applies to most of Medicaid for low-income families and most of SCHIP.
- ▶ The private insurer/private provider model predominates in American health care. It includes employer-sponsored insurance and nongroup plans, which together cover 68 percent of all the country’s residents.<sup>14</sup>

From a different perspective, the government’s role in U.S. health care can be viewed in terms of demand (helping pay for coverage or care),

supply (helping finance the capacity to deliver health care services), and regulation. On the demand side, most health spending is private, but much spending is subsidized by government. Federal income-tax subsidies for the purchase of health coverage and health care, including the exclusion of employer health insurance payments from taxable income, are projected to reach \$186 billion in FY 2008.<sup>15</sup> The employer exclusion helps finance health coverage received by 58 percent of all Americans and 61 percent of the nonelderly.<sup>16</sup>

In terms of direct spending, federal subsidies for health care and coverage, provided through Medicare, Medicaid, and other programs, are projected to equal \$829 billion in FY 2008.<sup>17</sup> Medicaid and Medicare cover 42.7 million<sup>18</sup> and 42.4 million people,<sup>19</sup> respectively, with some poor seniors and people with disabilities receiving coverage from both programs. The government also provides publicly funded health care to almost 9 million current and former federal employees and dependents through the Federal Employees Health Benefits Program; 3.7 million veterans who receive health care through the VA;<sup>21</sup> and the country's active-duty soldiers and their dependents. Only 5 percent of the insured population in the United States does not receive some kind of government subsidy, either directly or through a tax benefit.<sup>22</sup> These government expenditures involve sizeable transfers of income, generally from higher-income to lower-income individuals, particularly in the case of the general revenues used to finance Medicare and Medicaid.

On the supply side, the government plays a major role supporting the nation's health care infrastructure. Large numbers of hospitals and health systems are exempt from federal income taxes and, in most of the country, state and local income, sales, and property taxes; in exchange, they are expected to provide community benefits, such as indigent care. In 2001, the most recent year for which data

are available, these entities controlled approximately \$490 billion in assets and obtained over \$500 billion in gross receipts,<sup>23</sup> suggesting a substantial value to their tax subsidies.

Outside the hospital system, government spending and tax subsidies finance the development of other aspects of the country's health care supply. For example,

- ▶ Federal resources support medical education and student loans, helping educate virtually every graduate of an American medical school, residency, or internship.<sup>24</sup>
- ▶ The National Institutes for Health (NIH) and other federal agencies finance a significant amount of basic scientific research that ultimately translates into new pharmaceuticals and medical technologies.<sup>25</sup> NIH alone spends more than \$28 billion a year to reach this goal.<sup>26</sup>

In addition to financing a significant portion of health care demand and subsidizing the development of health care supply, federal and state governments extensively regulate the provision of health care services by private entities. Those regulations include rules that bar employer-sponsored insurance from discriminating against older and chronically ill employees in providing benefits and charging individual premiums;<sup>27</sup> that forbid insurers from denying coverage for maternity care based on hospital stays that exceed certain limits;<sup>28</sup> that require insurers to meet solvency requirements, so consumers who pay premiums will receive promised services;<sup>29</sup> that prohibit fraudulent and deceitful advertising by health care providers and health plans;<sup>30</sup> that require physicians and other health care providers to be licensed; and that safeguard medical privacy.<sup>31</sup>

In short, government supports many aspects of the current health care system but with few exceptions does not "run" it. Nor would pending

proposals change this basic structure; the exception would be some single-payer systems in which individuals have little practical ability to purchase insurance outside of the government-run insurance system and providers lack any significant residual private market.

## Pending Proposals for SCHIP and National Reforms

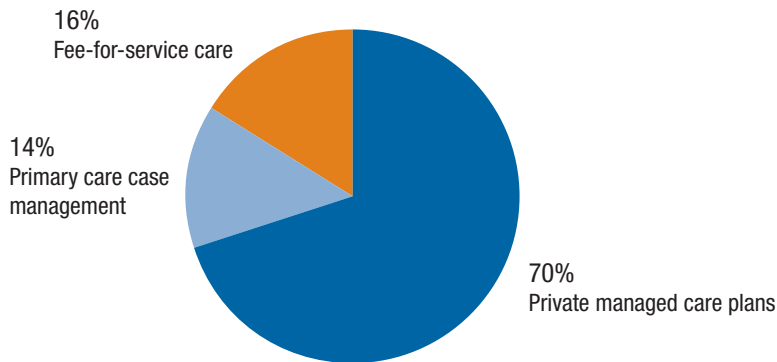
This section examines two questions: whether proposals advanced in the context of SCHIP reauthorization and the contest for the Democratic presidential nomination are accurately described as leading to socialized medicine or government-run health care, and whether such proposals create the problems of choice and quality of care that are at the heart of concerns about socialized medicine.

As a preliminary matter, by helping the uninsured purchase health insurance, each proposal would increase the amount of publicly funded health care subsidies. The same is true of more market-oriented proposals to expand coverage by giving the uninsured fully refundable federal income tax credits. However, such increases in the total amount of federal subsidies for health coverage do not seem to us to represent steps on a road to socialized medicine as long as the private sector continues to play a clearly dominant role in providing health care, as explained below.

**SCHIP Reauthorization.** In vetoing the Children's Health Insurance Program Reauthorization Act (CHIPRA), President Bush argued that the legislation was "an incremental step" toward the "goal of government-run health care for every American."<sup>32</sup> Others likewise described the legislation as a "chip off the old, socialized-medicine block."<sup>33</sup>

The basic claim seems to be that CHIPRA would establish a beachhead of socialized medicine for children, which could eventually expand to engulf the country's health care system as a

**Figure 1. Children Enrolled in SCHIP, by Type of Health Coverage: 2005**



Source: McInerney 2007.

Note: Primary care case management systems assign children to primary care providers, who serve as gatekeepers managing their overall care.

whole. That claim is inaccurate, since SCHIP provides most children with coverage through private health plans<sup>34</sup> and care from private physicians<sup>35</sup> (Figure 1). CHIPRA thus fits squarely within the “public contracting/private insurer” model that cannot reasonably be characterized as government-run or socialized medicine.

SCHIP reauthorization would not create a dominant role for the federal government in the country’s overall health care system, or even children’s health care. Within SCHIP, decision-making authority is shared between the federal government, states (which possess considerable flexibility in structuring benefits, cost-sharing, health care delivery, eligibility rules, etc.), and private insurers. Moreover, CHIPRA would result in a total SCHIP enrollment of 7.4 million children in 2012, according to the Congressional Budget Office,<sup>36</sup> or less than one in 10 children.<sup>37</sup> The vast majority of pediatric coverage and care would remain private.

### Health Insurance Exchange

**Proposals.** Along similar lines, health reform proposals from most Democratic presidential candidates resemble the policy enacted in Massachusetts as a bipartisan compromise between a largely Democratic legislature and a Republican governor. Embodied in various forms within proposals made by current and former candidates Clinton,

Edwards, Obama, and Richardson, this health reform strategy has the following key elements:

- ▶ *A new option—but not a requirement—for consumers and employers to obtain coverage through a health insurance exchange offering competing private plans* that include some diversity in out-of-pocket cost-sharing, covered benefits, provider networks, and access to out-of-network services. Most individuals who select coverage that is more costly would pay some or all of the resulting increase in premiums. The proposals forbid or limit variation of premiums and covered services based on individual characteristics like health status, age, gender, etc. Proposals differ in terms of precisely which consumers and employers may use this option and whether a public-sector plan competes for business with purely private plans.
- ▶ *In many (but not all) proposals, a requirement for some or all residents to purchase insurance.*
- ▶ *A requirement for some or all employers to help fund health coverage, by either paying a tax or contributing to the cost of their employees’ coverage.* Proposals vary in terms of the size of company to which this requirement applies and the level of contribution required from each employer.

▶ *Subsidies to help low-income consumers obtain coverage, through either Medicaid, SCHIP, or the health insurance exchange or purchasing pool.* How these subsidies are financed varies considerably.

These proposals would keep the country’s health care system anchored predominantly within the current private insurance/private provider model, although the government would play an enhanced role in organizing the market and provide additional financing. However, the proposals that allow public-sector plans to compete with private coverage would incorporate elements of the intermediate “public contract” model, through which a government agency contracts directly with private providers. None of these proposals would shift the country into “government-run health care,” or the “public integrated model,” in OECD parlance. In fact, they would all increase the amount of coverage provided by private insurers.

### “Medicare for All” Proposals.

Qualitatively different proposals have been advanced by former presidential candidate Dennis Kucinich and a number of federal legislators, including Senator Kennedy (D-MA) and Representatives Stark (D-CA), Dingell (D-MI), and Conyers (D-MI). These “Medicare for all” or “single-payer” proposals would expand Medicare by covering nonelderly Americans and adding benefits. Most proposals would fund coverage through an increased payroll tax. Some of these proposals would permit employers to opt out of the new “Medicare for all” plan. Some would allow individuals to keep private insurance but opt into Medicare for all if they deemed themselves better off under the latter arrangement.

Even this more expansive approach to reform would not interfere with the largely private character of the country’s health care providers. Accordingly, “Medicare for all” proposals would not involve “government-run health care” along the lines of the “public integrated model” described by OECD.

Such proposals would, however, shift the country's basic coverage system into a "public contract" model like that used in Canada, a number of European countries, and the current Medicare program in the United States.

Some single-payer proposals would go much further; an example is that advanced by Congressman Kucinich (HR 676). A new federal program would be the exclusive source of coverage for a broad range of services, including primary care and prevention, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, long-term care, mental health services, dental services (other than cosmetic dentistry), substance abuse treatment, chiropractic care, basic vision care, and hearing services. Private insurance would be forbidden from offering services in the areas covered by the national plan. For-profit medical care would be forbidden, and profit-making health care entities would be required to convert to charitable organizations. Government authorities would make decisions about capital investment in health care infrastructure, promulgate quality standards, define a national formulary for prescription medication, and set reimbursement levels. Providers accepting reimbursement from the public program could not accept any payments from patients. Put simply, individuals would have little or no choice over their insurance arrangements and providers would have very few options to provide care outside of the government-financed system. While health care providers would nominally remain private, the government's authority would be so all-encompassing that the system would be the functional equivalent of socialized medicine.

## Choice, Access, and Quality of Care

While we regard as overstated the claim that any but the final proposal described above moves towards "socialized medicine," many think otherwise and have real fears and

concerns involving consumer choice and quality of care. Several fundamental fears are at the heart of the opposition to an increased government role in the country's health care system. First, some believe that a strengthened public sector could take health care choices away from consumers. In the words of a recent Cato Institute report, "a patient should always be able to spend his own money on the health care services he desires. Yet that freedom is often threatened or denied when government tries to provide universal health insurance coverage..."<sup>38</sup> Second, some believe that public-sector involvement in health care inevitably dilutes health care quality. As President Bush explained to justify his veto of SCHIP legislation, "government-run health care" leads to "rationing, inefficiency, and long waiting lines."<sup>39</sup>

In analyzing the merits of particular proposals, these underlying concerns about choice and quality can and should be evaluated on their own terms, as we do in the following sections.

***Pending Proposals and Consumer Choice.*** In this section, we argue the following:

- SCHIP reauthorization proposals would expand consumer choice;
- National health reforms built around health insurance exchanges would expand choices for most consumers, though some would lose the option to remain uninsured, if the proposal contains an individual mandate, as many do;
- Proposals to enroll all Americans in an expanded Medicare program would offer significant consumer choice of health care providers and, in some versions, choice among health plans, though the option to retain current coverage would be foreclosed; and
- All of these proposals would significantly expand health care choices for uninsured consumers who gain health coverage.

As a starting point for this analysis, consumer choice is far from unlimited today. Just 49 percent of American workers have employers who offer health coverage with a choice of more than one plan.<sup>40</sup> Low-income workers are even less likely to have health coverage options at work; in firms offering coverage, the percentage of employees with a choice of more than one plan falls from 59 percent among those earning more than \$60,000 to 37 percent for workers earning less than \$20,000.<sup>41</sup>

By contrast, with SCHIP, most low-income families are offered multiple choices from competing private plans.<sup>42</sup> Within each state, all SCHIP plans offer a uniform set of benefits. Nevertheless, enrollees can "vote with their feet" if they are unhappy with their insurer—a choice not available to most low-income recipients of employer-based coverage. CHIPRA would further expand those options. It would increase states' capacity to offer families the choice of using SCHIP subsidies to enroll in employer-sponsored family coverage rather than state-contracting, private plans serving children only.

Going farther along these general lines, proposals to establish health insurance exchanges offering diverse, competing health plans represent a significant expansion of consumers' health plan choices. In the context of the Massachusetts health insurance exchange, Heritage Foundation analysts agree that this policy mechanism represents an "approach to making consumer choice and ownership of health insurance the fundamental organizing principle of a state's health system."<sup>43</sup> The same basic mechanism would give millions of American consumers a broad range of private health insurance choices under pending national policy proposals.

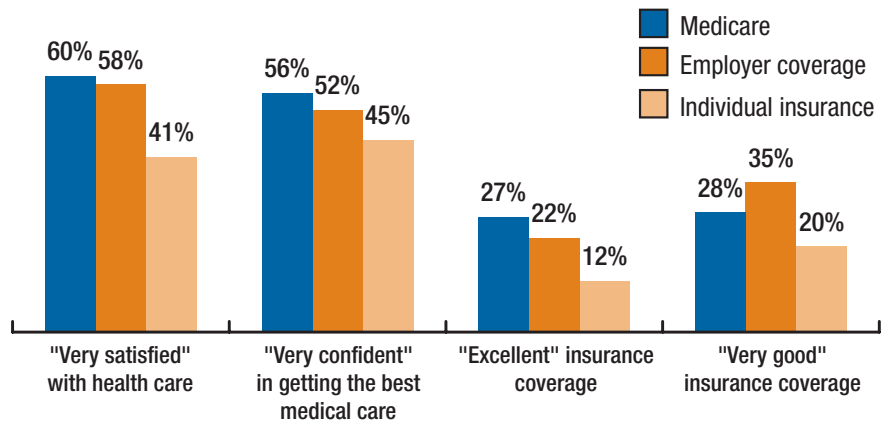
On the other hand, many Massachusetts-type proposals require some or all consumers to purchase coverage. Likewise, some or all employers would be required to make contributions

to cover health care costs. These mandates would not affect the majority of individuals or firms, since most individuals receive coverage today<sup>44</sup> and most companies offer it (particularly among firms with 25 or more workers).<sup>45</sup> However, uninsured individuals and companies that do not cover their workers today could be compelled to make significant new payments to the government, depending on the proposal's details. In sum, this set of proposals expands health coverage options for most consumers but takes away the choice to remain uninsured and removes from employers the option to contribute nothing to their workers' health insurance costs.

"Medicare for all" proposals retain consumer choice at several levels. First, if Medicare keeps its current configuration (as described above), consumers can choose between private managed care plans and "traditional Medicare," through which the federal government directly pays health care providers. Second, the traditional Medicare program offers a substantial choice of providers, greater than that offered by many (but not all) private health plans. For example, 98 and 97 percent of physicians accept new patients covered by Medicare and non-HMO private insurance, respectively, compared with 86 percent who accept new patients covered by private HMOs.<sup>46</sup>

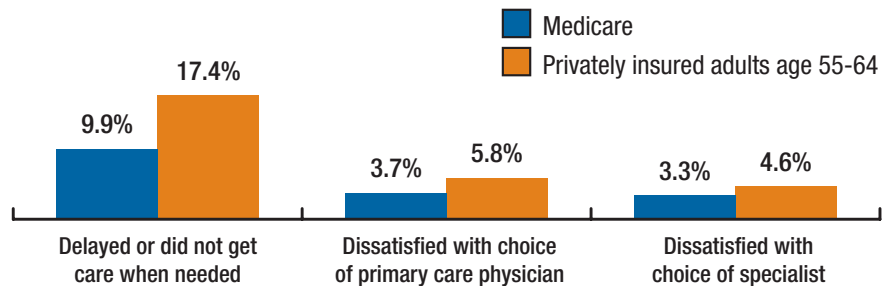
In some ways, this choice among health care providers may be more important than a choice among health insurance plans, since consumer satisfaction with health care is much more highly correlated with the former than the latter.<sup>47</sup> On the other hand, under "Medicare for all" proposals, most consumers would be unable to retain their current health plan. This loss of choice could be important. More than half of Americans with health coverage (55 percent) report that they are extremely satisfied or very satisfied with their current health plan.<sup>48</sup> Of course, the version of single-payer health care espoused by some (e.g., Congressman Kucinich) would more fundamentally limit consumer choice

**Figure 2. Consumer Satisfaction Ratings, by Source of Coverage, Adults Age 50–70: 2004**



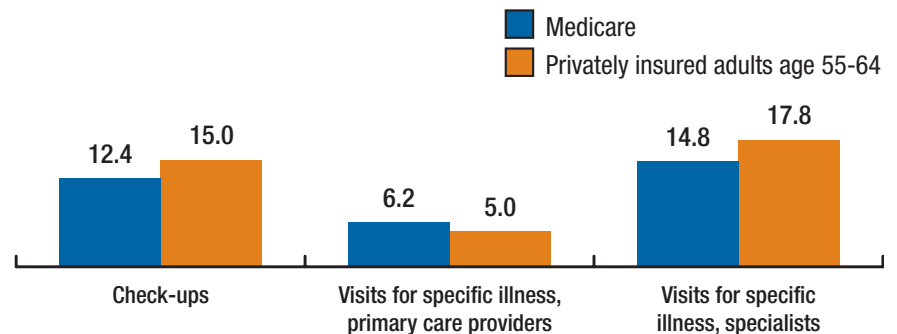
Source: Commonwealth Fund Survey of Older Adults, 2004.

**Figure 3. Percentage Reporting Various Problems with Care, Medicare Enrollees vs. Privately Insured Adults Age 55–64: 2003**



Source: Trude and Ginsburg 2005.

**Figure 4. Average Number of Days Waiting for Various Types of Care, Medicare Enrollees vs. Privately Insured Adults Age 55–64: 2003**



Source: Trude and Ginsburg 2005.

by forbidding the private purchase of most health insurance.

Finally, all of these policy proposals would significantly expand health

care choices for the uninsured by providing them with health coverage. The uninsured frequently are unable to access needed care because of cost,<sup>49</sup> and they have many fewer choices of health care providers than are available to people with any type of insurance coverage.<sup>50</sup>

**Pending Proposals and Quality and Access.** The kind of health care access and quality problems that the president described as typifying publicly run health care do not apply to SCHIP or the main national health reforms proposed in the presidential race. When children enroll in SCHIP, numerous studies document significant improvements in access to care, relative to being uninsured.<sup>51</sup> Despite low reimbursement rates that limit provider participation and access to care, much research suggests that access to primary care for children in public programs like SCHIP and Medicaid is generally comparable to or, in some cases, better than that in privately funded insurance.<sup>52</sup> One possible explanation is that, typically, benefits are more generous and out-of-pocket costs are more limited in public programs serving low-income children than with private insurance developed to meet the needs of adult workers. The exception may be access to specialty care and the latest technologies, which may be more affected by low reimbursement rates.<sup>53</sup>

Moreover, observers who believe that quality of care and access are inherently better with private insurance than publicly provided health care need to recognize that private managed-care plans deliver most SCHIP services and have financial incentives to provide high-quality care, both to maintain their contracts with state health agencies and to attract enrollees. Such market mechanisms for improving quality are even more powerful in the case of reforms based on health insurance exchanges, which are structured to facilitate competition among insurers based on quality, among other factors.<sup>54</sup>

In terms of Medicare, consumer satisfaction ratings generally exceed those for privately insured older adults (Figure 2).<sup>55</sup> Average waiting times to see physicians are now comparable for Medicare beneficiaries and the privately insured near-elderly, with Medicare beneficiaries less likely to report delays or denials of necessary care (Figures 3 and 4).<sup>56</sup>

Three final comments on this issue are important. First, as the above charts suggest, much evidence casts doubt on the belief that public involvement in health care inevitably worsens the quality of care and access to necessary services. In fact, the VA, one of the country's only health care systems that is entirely publicly administered, has been a pioneer in the use of electronic health records and the successful management of chronic conditions, outperforming most private coverage on a range of key quality indicators.<sup>57</sup> Moreover, although the American health care system provides insured residents with excellent access to the latest medical technology and is capable of rapid change to address consumers' changing preferences,<sup>58</sup> other countries with stronger public-sector roles outperform the United States on numerous quality measures, including waiting times for doctor visits to treat medical problems. On the other hand, Americans are more likely than the residents of many other developed countries to receive preventive care, to receive recommended care for certain chronic conditions, and to have only short waits for diagnostic tests, specialty care, and elective surgery.<sup>59</sup>

Second, quality and access problems encountered by publicly funded programs have resulted primarily from limits on financial support reflected in low reimbursement rates for Medicaid and, to a somewhat lesser extent, SCHIP. This is a function of funding levels, not public-sector involvement, however, and reflect the unwillingness of state legislatures to commit the resources necessary to adequately pay physicians and hospitals. Even though it is a public program, Medicare has secured better access to care than that

provided by private coverage,<sup>60</sup> thanks to reimbursement rates substantially more generous than Medicaid's. This difference in financial support and access to care between Medicare and Medicaid may ultimately result from two factors: the federal government runs the former and states essentially run the latter; and Medicare's constituency is a broader segment of the population in terms of income distribution.

Third, concerns over choice, quality, and access are fair to raise with proposals in which the government is the sole buyer of an overwhelming share of the country's health care services, leaving neither individuals nor providers much real choice beyond participating in the government-financed system. Such proposals achieve equity, since everyone has the same coverage, and they offer the ability to control the rate of growth in expenditure. But this ability to control spending can also have adverse effects on quality and access. It can lead to provider dissatisfaction, which could readily translate into consumer dissatisfaction. With centralized rather than dispersed responsibility over health care policy, mistaken decisions can have much more significant unforeseen consequences. These results are a function of the extent of government control, the lack of realistic alternative options, and budget pressures. They are unlikely to materialize if the government-administered health plan operates as one of many competing choices offered to consumers, permitting providers to furnish care in public and private insurance systems. Such a pluralistic approach, with widely dispersed responsibility for health care decisions and a significant role for consumer choice and market pressures, is essentially the model that leading Democratic contenders have espoused.

## Market-Oriented Proposals

Other proposals pursue a more market-based approach, giving people tax subsidies they can use to purchase coverage in the individual market. These approaches seek to provide a



range of health coverage choices, using market forces rather than government regulations to provide the kind of care that consumers want, at an affordable price. In this section, we argue the following:

➤ Proponents of these market-oriented proposals agree that a strong public-sector role is appropriate if it accomplishes important objectives. That is why these proposals retain most functions served by government today and, in some cases, embrace aggressive new government interventions.

➤ Many market-oriented proposals would create problems of quality and access to care for some people—the very problems some argue are characteristic of publicly run systems.

The Bush administration and current and former Republican candidates for president have proposed several significant changes in tax policy intended to expand coverage while achieving other policy goals. These changes have included refundable, advanceable tax credits for low-income, uninsured workers that were proposed during the president's first term and that Governor Huckabee and Senator McCain support;<sup>61</sup> several rounds of tax subsidies for high-deductible coverage and Health Savings Accounts (HSAs); and proposals from both the Bush administration, Senator McCain, and Mayor Giuliani to replace the current tax exclusion of employer-sponsored insurance with either a fixed deduction or a refundable, advanceable tax credit for health coverage obtained from employers or the individual market.

While many of these proposals have been couched in terms of increasing the role played by market mechanisms and consumer choice, none would make substantial reductions<sup>62</sup> to the government's current role in the country's health care system. As explained above, this role involves supporting health care demand by subsidizing the purchase of health

care and health coverage; supporting health care supply by financing the development of health services and health care infrastructure; and regulating the services and coverage that may be bought and sold. The Bush administration would also maintain (and has expanded funding for) an extensive system of community health centers, a delivery system with a major government role in financing, administration, and regulation.

Nonetheless, proposals from the Bush administration and market-oriented presidential candidates are fundamentally different than the approaches described in the previous section of this paper. Rather than having the government contract with diverse plans and letting individuals choose among them, many of these proposals would give people additional resources through tax deductions or tax credits and allow them to purchase coverage "that best suits their needs" in a relatively unfettered individual insurance market.

The tax proposals that have granted tax-preferred status to high-deductible health plans and HSAs have the intent of shifting much health care spending out of third-party payment and into direct agreements between consumers and health care providers, with the goals of increasing market competition among providers and restraining health care spending. These tax changes were introduced to counter the incentive inherent in the employer exclusion as currently structured, which favors the purchase of comprehensive coverage. The objective was to get individuals to choose less comprehensive coverage and thus reduce the incentives to overuse health services, thereby lowering health care spending and making coverage more affordable.

Also using federal tax policy to galvanize significant changes in the country's health care system, proposals by the Bush administration and Mayor Giuliani would shift millions of Americans from employer-sponsored insurance to the individual market.

This would be done by replacing the current open-ended tax exclusion of employer coverage with either a fixed standard deduction or a refundable tax credit usable in the individual or employer market. The current exclusion is highly regressive with greater tax benefits at the high end of the income distribution than at the lower end.<sup>63</sup> A fixed standard deduction is also regressive. While increasing incentives to economize on health care, it would benefit those in the highest tax brackets and do little to help those in lower income tax brackets to purchase coverage. But the Bush administration has more recently made it clear that it will also support the replacement of the tax deduction with a refundable tax credit.<sup>64</sup> A fixed dollar, fully refundable income tax credit would be equally valuable to all individuals. This could result in more people being willing to take up coverage relative to the standard deduction. But it would also mean, depending on the credit's generosity, that substantial amounts of income would shift from higher-income to lower-income households. While market oriented, the proposal thus retains a key role for government redistributing income via the tax code.

Such tax proposals could have other consequences as well, largely because of their effects on the pooling of risk. Letting people use their own money coupled with tax subsidies to purchase coverage in the individual market would likely lead to a greater range of benefit package offerings. This would likely increase the amount of risk segmentation. That is, those who do not want a particular benefit (e.g., prescription drugs) can choose a plan without it. But healthy people would be more likely to choose such a plan, not those with chronic illnesses. There would be less pooling of risk—that is, people would self-insure for the benefits that are not covered. The same argument applies to the elimination of mandated benefits; there would be no pooling of risk for benefits that disappear from coverage when mandates are repealed.

There is also generally little insurance regulation proposed in these types of market proposals. In fact, the Bush administration and current and former Republican candidates Giuliani and McCain propose to let individuals buy individual insurance sold across state lines, thereby undermining strong regulatory regimes that exist in a minority of states. A largely unregulated individual market can make it difficult for individuals with health conditions to obtain coverage or let them obtain it only at a very high premium. It would allow those in relatively good health to find plans that are much less expensive. This occurs not because of increased efficiency but because there is less pooling of risk.

High deductible plans and health savings accounts have similar effects. Individuals essentially self-finance the cost of care below the deductibles in plans. Individuals with health problems are more likely to incur health care costs that require paying these deductibles. Thus, there is more self-financing of care by the sick than under plans that have more comprehensive coverage. That is, those who have health conditions and face higher deductibles are asked to perform the rationing function that comes with facing higher prices.

Another issue with these tax proposals relates to the adequacy of subsidies. The criticism of the public contracting model (in the view of some, the basic criticism of socialized medicine) is that rationing and poor quality of care result. But if subsidies are inadequate to purchase decent coverage in the private market, or if purchase of coverage in the private market is difficult because of the presence of health conditions, then the inability to pay will lead to plans with more limited benefits, more limited access, and in the end poor quality of care. The job of rationing shifts from government to private plans. Put differently, problems of access and quality are not inherent in government contracting and can just as easily occur with more market-oriented approaches if

they involve inadequate low-income subsidies and minimal pooling of risk.

## Conclusion

In this paper, we have argued that there are four basic models for health coverage, which include considerable variation. At one extreme is the public integrated model, where the government finances, manages, and controls both the demand and supply side of the market. The other extreme envisions private insurance, loosely regulated, combined with tax subsidies helping lower-income people purchase coverage in the individual market. The debate in this country is generally not about the former and only in some circles about the latter. Most proposals involve a mixture of public- and private-sector responsibilities. The government would expand its role in both financing and, under some proposals, contracting with private insurers and/or private providers for care, but clearly would not “run” the health care system under most reform proposals.

No serious reform proposal of which we are aware would result in either a purely government-run system or a pure free market, with unregulated and unsubsidized health care. All serious proposals are on a continuum between these extremes. The real challenge facing policy-makers is finding the right spot in the continuum—the combination of public- and private-sector roles and responsibilities that yields the best outcome for the American people.

It is a significant exaggeration to claim that proposals like SCHIP reauthorization and plans advanced by the leading Democratic presidential candidates, current and former, represent steps toward socialized medicine. None of these approaches would change the country’s heavy reliance on private health care providers. In fact, both SCHIP and the most widely endorsed reforms among Democratic presidential contenders would preserve, if not expand, the central role of private insurance and

private providers while increasing consumers’ freedom of choice and access to care.

By contrast, single-payer plans can involve such a major expansion of the government’s role that they would become the functional equivalent of socialized medicine. However, federal policy-makers are unlikely to consider seriously such proposals, unlike the plans advanced by more prominent Democratic presidential aspirants and the SCHIP reauthorization legislation approved in Congress by wide bipartisan margins.

More market-oriented proposals by President Bush and current and former Republican candidates for president would use tax subsidies to give more Americans access to individual coverage. Depending on their details, these proposals may undermine access and quality, effectively imposing a form of rationing, particularly for people with limited income or significant health care needs. In addition, they would do little to change the current reliance on Medicaid and Medicare for the care of the poor, disabled, and elderly. And they would still use the power of government to redistribute a considerable amount of income and achieve other policy goals.

The core issue in health reform is not specifically the role of government, but what policies yield the best possible consequences for the American public. Such results include the number of people with health coverage, consumers’ quality of and access to necessary care, health care cost growth, and consumers’ ability to make choices about their health care and health coverage. Rhetoric about socialized medicine and government-run health care is a distraction from these much more fundamental concerns.

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